NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

DRAFT GUIDELINE

Transition between inpatient mental health settings and community or care home settings

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Contents

Introduction

A range of health, social care and other services are involved when children and young people (CYP) and adults with care and support needs move into or out of inpatient mental health hospital settings from community or care home settings. Families and carers also play an important part in supporting the person.

Problems can occur if services and support are not integrated, resulting in delayed assessment and admission, inadequate support after discharge, readmissions and poor care throughout. Hospital discharge problems also occur:

- when discharge is not planned
- when the person and their carer(s) are not involved in planning
- when people's rights to information, advocacy and support are not observed
- when the person and their carer(s) have not been helped to manage the mental health symptoms and other problems which contributed to the admission
- when the community services which address the different needs of the person are not involved in planning and reintegration.

The population experiencing transitions into and out of mental health inpatient hospital services are vulnerable in a number of ways. For example, transitions are associated with suicide (see the Context section below), and people with severe mental health disorders often have other conditions, such as learning disability or dementia, which make it difficult for them to advocate for their own needs.

The Department of Health asked the National Institute for Health and Care Excellence (NICE) to develop a guideline to help address these and related issues (see the scope). For information on how NICE social care guidelines are developed, see Developing NICE guidelines: the Manual.

This guideline covers all children, young people and adults of all ages. It covers transitions (admissions and discharges) between mental health acute hospital settings and community or care home settings. It does not include general inpatient health settings. A separate NICE guideline on transition between inpatient hospital settings and community or care home for adults with social care needs has been developed.

This guideline considers how person-centred care and support should be planned and delivered during admission to, and discharge from, mental health hospitals. It addresses how services should work together and with the person, their family and carers, to ensure transitions are timely, appropriate and safe.

The guideline is for health and social care practitioners; health and social care providers; service users and their carers (including people who purchase their own care). Commissioners of mental health services should ensure any service specifications take into account the recommendations in this guideline when it is finalised.

This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the Care Act 2014. The Care Act and other legislation describe what organisations must do. This guideline focuses on ‘what works’, how to fulfil those duties, and how to deliver care and support.

The Care Quality Commission use NICE guidelines as evidence to inform the inspection process and NICE quality standards to inform ratings of good and outstanding.

Context

Current practice

Poor transition between inpatient mental health settings and community or care home settings has negative effects on people using services and their families. A key issue affecting transitions between inpatient mental health settings and the community is a lack of integrated and collaborative working between mental health and social care services, and between inpatient and community practitioners. This can often result in inadequate and fragmented support for people using mental health services, just when they are most vulnerable to risk of harm (see below).

Shortage of inpatient beds, timing of admission and delays in transferring people from an inpatient mental health setting may mean that people cannot access services when they most need them, or remain in hospital unnecessarily after they have been assessed as ready to go home (or to another setting). Although there is some research into the extent and causes of delayed transfers of care from inpatient mental health settings, official monitoring and routine data collection is limited. The scale of the problem is therefore difficult to estimate.

Poorly managed transitions can have very high costs for individuals and their families. The Royal College of Psychiatrists' 2015 Survey of inpatient admissions for children and young people with mental health problems illustrates the level of risk – of self-harm, suicide, sexual and violent assault and restraint by security forces – to which children and young people are exposed when appropriate CAMHS beds cannot be found. The University of Manchester's 2014 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that, between 2003 and 2013 in England, 2368 mental health patients died by suicide within the first 3 months after discharge from hospital (compared to 1295 inpatient deaths in the same period). The peak time for risk of suicide is 1 week after leaving hospital.

Transition can be particularly difficult for certain groups including: people with communication difficulties or sensory impairment; people who have other complex problems such as physical or learning disability; children and young people and people from minority ethnic groups. These people are more likely to be placed out of area, and experience particular difficulties, including less contact with family and friends, increased risk of social exclusion, and reduced opportunities for employment and education. Case management and assessment of a person's readiness for discharge is also particularly challenging to deliver when a person is placed out of area. This can result in longer stays in hospital and delayed discharges.

If inpatients remain in hospital after they have been assessed as ready to go home (or to another setting), there are negative consequences for the person. They can become dependent on inpatient care and lose coping skills and functions. Key personal relationships may be damaged and housing or jobs may also be lost. However, a rushed or poor transition creates significant anxiety, leaving people uncertain about the management of their symptoms and about sources of further support.

Delayed discharges can cause overcrowded wards, so that staff being overstretched, and there is increased risk of serious incidents, delays in admitting 'at risk' patients, the premature discharge of others, and negative effects on staff morale, retention and recruitment (A positive outlook: a good practice toolkit to improve discharge from inpatient mental health care National Institute for Mental Health in England). A lack of communication and joint working between inpatient and community-based practitioners, including those delivering housing services, is a major cause of delayed discharges.

New models of practice are emerging, involving the independent sector as well as voluntary and community services to support sustained recovery. These include various models of peer support. A common aim is to ensure that, where care and treatment in a hospital environment is really needed, people are admitted for the shortest possible episodes. Another aim is to support advocacy and self-advocacy. Crisis plans and advance decision making, used to ensure people can exercise choice when they are unable to express their wishes, may be used for people who are subject to episodes of severe mental illness, people who are in the early stages of dementia, or people who have other forms of cognitive or communication impairment.

The experience of admission, inpatient care and discharge for children and young people (generally under 18) is generally less well covered by legislation and policy guidance, much of which is specific to adult care. A House of Commons Health Committee report on Children's and Adolescents' Mental Health and CAMHS (published November 2015) described a range of problems in the delivery of mental health services to children and young people, including the need for more rapid access to assessment and services, long waiting times for Tier 4 services and the consequent use of beds in distant parts of the country, making contact with family and friends difficult, and leading to longer stays. The Royal College of Psychiatrists' 2015 Survey of inpatient admissions for children and young people with mental health problems reiterated these points from a provider perspective. Over 70% of the 330 psychiatrists working with children and young people said that they experienced difficulty either 'often' or 'always' in finding suitable inpatient accommodation. Because of 'the increasing complexity and risk that characterises the children and young people presenting to services', many are placed in unsuitable generic or paediatric, or out-of-area, beds. Hospital-based psychiatrists responding to the survey reported unnecessarily delayed discharges and rapid readmissions indicating premature discharge. The survey called for greater investment in community CAMHS services which are resourced to manage high risk CYP in the community.

This guideline focuses on admission into or discharge from inpatient mental health settings. It draws on both experimental evaluation of approaches to admissions and discharge, and on qualitative literature on views and experiences of people who have been admitted to inpatient mental health services. The guideline aims to describe what people should expect (and are entitled to) in relation to their transition; and to raise awareness and improve practice among professionals involved in transition processes and cross-sector working.

Legislation

This guideline has been developed in the context of important legislative and policy developments which have a significant impact on people with care and support needs moving between inpatient mental health settings and community or care home settings.

Together the Care Act, the Mental Health Act and the Mental Capacity Act describe what organisations must do. First, the Mental Health Act 1983 as amended by the Mental Health Act 2007 allows people with a mental disorder to be admitted to hospital, detained and treated without their consent, and placed on Community Treatment Orders following a period of detention in hospital. In addition, the Mental Health Act Code of Practice contains guidance which should be followed in such circumstances and was revised in 2015.

Second, the Mental Capacity Act 2005 is designed to protect and empower people who may lack the capacity to make their own decisions. All people are deemed to have capacity unless there has been an assessment which deems otherwise. The Mental Capacity Act is also accompanied by its own Code of Practice.

Third, the implementation of the Care Act 2014 establishes new provisions as well as updating existing ones, bringing together relevant policy and guidance affecting people with care and support needs.

Each Act has a set of distinct yet overlapping guiding principles, which include:

- that people must be involved in decisions about their care as fully as possible
- that people's wishes should be taken into account
- that people should be treated in the least restrictive way possible.

The Mental Health Act 1983 (amended by the Mental Health Act 2007) governs the involuntary admission, treatment and detention of people in mental health inpatient settings. The Act also covers discharge from inpatient mental health settings. Section 117 entitles people to free aftercare when they are discharged from hospital under certain sections of the Act. The NHS and Community Care (NHSCC) Act 1990 covers the support of people receiving voluntary treatment in an inpatient setting, and the requirement that health and local authorities put in place arrangements for the care and treatment of people with a mental health problem in the community.

The Care Act 2014 introduces new legislation to make social care more personalised, fairer across the country and more supportive of carers. It seeks to ensure that people's wellbeing and the outcomes that matter to them are at the heart of every decision made. In relation to transitions, the Act includes a new right to advocacy to help people navigate the care and support system, and the introduction of a specific definition of 'after care services'.

The Care Act also requires that local authorities carry out their care and support responsibilities with the aim of promoting greater integration with National Health Service (NHS) and other health related services, such as housing. This reflects similar duties placed on NHS England and clinical commissioning groups (CCGs) to promote integration with care and support set out in the National Health Service Act 2006.

The Children Act 1989, supplemented by the Children Act 2004, stipulates that all organisations working with children have a duty to safeguard and promote their welfare.

Policy

A key part of the UK mental health system, the Care Programme Approach (CPA) was introduced in 1990 as the UK model for assessing, planning and reviewing care for people with mental health needs. The most recent update placed emphasis on supporting only people at higher risk or with more complex needs through the new CPA (Refocusing the Care Programme Approach Department of Health). Children and young people can also receive treatment and support through the CPA approach.

The Department of Health's National Service Framework for Mental Health, published in 1999, had a significant effect on service provision, including the establishment of 3 functional teams: assertive outreach, early intervention in psychosis, and crisis resolution and home treatment teams. These teams can prevent unnecessary admissions and support people after discharge from hospital. However, there is some doubt (see for example, the Royal College of Psychiatrists' 2015 Survey of inpatient admissions for children and young people with mental health problems) that there are enough of these resources for all who might benefit from them.

The national mental health strategy No health without mental health was published by the Department of Health in 2011 and sets out the government's long-term objectives for the transformation of mental healthcare. This includes improving the health and wellbeing of the population and providing high quality services that are accessible to all.

The national dementia strategy Living well with dementia was also published by the Department of Health in 2011 and aims to ensure that major improvements are made to dementia services. The strategy makes 17 recommendations focused on 3 key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care.

In addition, policy changes echo the principles underpinning the Care Act. For instance, No voice unheard no right ignored (Department of Health 2015) sets out proposals to strengthen rights and choices of people with learning disabilities and mental health difficulties.

Effective joint working, especially at the interface between hospital and community, requires partners to be clear about their responsibilities. To support this, Care and Support Statutory Guidance (Oct 2014) seeks to clarify where boundaries of responsibilities lie as well as where joint working is required.

Person-centred care

This guideline offers best practice advice on the care of people of all ages who are being admitted to or discharged from inpatient mental healthcare settings. It should be read alongside the Care Act 2014. It is also written to reflect the rights and responsibilities that people and practitioners have as set out in the NHS Constitution for England.

Care and support should take into account individual needs and preferences. People should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners. Practitioners should recognise that each person is an individual, with their own needs, wishes and priorities. They should treat everyone they care for with dignity, respect and sensitivity. If the person using the service agrees, families and carers should have the opportunity to be involved in decisions about care and support. If the person is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their care.

If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

NICE has produced guidance on the components of good patient experience in adult NHS services. All healthcare professionals should follow the recommendations in Patient experience in adult NHS services.

NICE has also produced guidance on the components of good service user experience. All health and social care providers working with people using adult NHS mental health services should follow the recommendations in Service user experience in adult mental health.

1 Recommendations

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Overarching principles

1.1.1 Ensure the care and support of people in transition is person-centred and focused on their recovery.

1.1.2 Work with people as active partners in their own care and transition planning. Refer to the section on relationships and communication in NICE's guideline on service user experience in adult mental health services.

1.1.3 Record the needs and wishes of the person at each stage of transition planning and review.

1.1.4 Identify the person's support networks. Work with the person to explore ways in which the people who support them can be involved throughout their admission and discharge.

1.1.5 Enable the person to maintain links with their home community by:

- supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport costs
- helping them to keep links with employment, education and their local community.

This is particularly important if people are admitted to mental health units outside the area they live in.

1.1.6 Mental health services should work with primary care and local third sector (including voluntary) organisations to ensure that people with mental health problems in transition have equal access to services. This should be based on clinical need and irrespective of:

- gender
- sexual orientation
- socioeconomic status
- age
- disability
- cultural, ethnic and religious background
- whether or not they are receiving support through the Care Programme Approach
- whether or not they are subject to mental health legislation.

1.1.7 Give people using mental health services who are in transition comprehensive information, at the time they need it, on the nature of, and treatments and services for, their mental health problems. If needed, provide:

- information in large-print, braille or Easy Read format
- information on audio or video
- translated material.

See the sections on relationships and communication and providing information in NICE's guideline on service user experience in adult mental health.

1.2 Before hospital admission

Planning and assessment

1.2.1 Mental health and primary care practitioners (including GPs) and specialist community teams supporting people during transition should respond quickly to requests for mental health assessment from:

- people with mental health problems
- family members

- carers
- staff such as hostel, housing and community support workers.

1.2.2 Allow more time and expertise to support people with more complex needs to make transitions to and from services, if necessary. This may include:

- children and young people
- people with dementia, or cognitive and sensory impairment
- people placed outside the area they live in.

1.2.3 When admission is being planned for a specific treatment episode involve:

- the person who is being admitted
- their family members, parents or carers
- community accommodation and support providers.

1.2.4 When planning the treatment the person will have, take account of the expertise and knowledge of the person's family members, parents or carers.

1.2.5 Offer people an opportunity to visit the inpatient unit before they are admitted. This is particularly important for:

- young people
- people with dementia
- people with learning disabilities and other additional needs
- those placed outside the area they live in.

1.2.6 If it is not possible for the person to visit the inpatient unit they will be admitted to in advance, consider using online and printed information to support discussion about their admission.

1.2.7 During admission planning, record a full history or update that covers the person's cognitive, physical and mental health needs and identifies the services involved in their care.

1.2.8 If more than 1 team is involved in a person’s transition to, within and from a service, ensure there is ongoing communication between those teams, which may include:

- the community mental health team
- the learning disability team
- the team that works with older people
- child and adolescent mental health services (CAMHS)
- the inpatient hospital team.

Crisis plans

1.2.9 Support people who have had more than 1 admission to develop a crisis plan as part of their care planning process. This should include the following:

- relapse indicators and plans
- coping strategies
- preferences for treatment and specific interventions
- advance decisions.

See the section on community care in NICE’s guideline on service user experience in adult mental health services.

1.3 Hospital admission

General principles

1.3.1 At admission offer all people access to advocacy services that take into account their:

- language needs
- cultural and social needs
- protected characteristics (see the Gov.UK page about discrimination).

1.3.2 Health and social care practitioners admitting someone with cognitive difficulties should try to ensure the person understands why they have been admitted.

1.3.3 Start building therapeutic relationships as early as possible to:

- lessen the person's sense of being coerced
- encourage the person to engage with treatment and recovery programmes and collaborative decision-making
- create a safe, contained environment
- reduce the risk of suicide, which is high during the first 7 days after admission.

1.3.4 During admission, discuss with the person:

- any strategies for coping that they use
- how they can continue to use, adapt and develop positive coping strategies on the ward.

1.3.5 Practitioners involved in admission should refer to crisis plans and advance statements when planning care. In line with the Mental Capacity Act 2005, advance decisions must be taken into account.

1.3.6 Start discharge planning at admission.

1.3.7 For recommendations on assessing and treating people who have been detained under the Mental Health Act see NICE's guideline on service user experience in adult mental health services.

Out-of-area admissions

1.3.8 If the person is being admitted outside the area they live in, identify:

- a named practitioner from the person's home area who has been supporting the person
- a named practitioner from the ward they are being admitted to.

1.3.9 The named practitioners from the person's home area and the ward should work together to ensure that care planning, recovery goals and discharge plans are regularly reviewed as the person's needs change.

1.3.10 At all stages of planning treatment, take into account the higher risk of suicide after discharge for people admitted to hospital outside the area they live in (see the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness). This should include:

- assessing the risk
- discussing with the person how services can help to keep them safe.

Legal status and restrictions

1.3.11 The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should:

- use clear language
- discuss rights and restrictions with the person
- provide written and verbal information
- make the discussion relevant to the ward the person is being admitted to
- explain whether they are under observation and what this means (see recommendation 1.3.16).

1.3.12 A senior health professional should arrange follow-up with the person being admitted to ensure:

- they have understood the information they were given at admission
- they know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish

- they understand that any changes to their legal status and treatment plans will be discussed as they occur.

Addressing personal concerns

1.3.13 At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:

- physical healthcare needs
- advice about immediate addiction issues, treatment and support
- mental health treatment.

1.3.14 The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements. This may include:

- people they have a responsibility to care for, such as:
  - children
  - frail or ill relatives
- domestic arrangements, in particular:
  - home security
  - tenancy
  - benefits
  - home care service
  - pets.

1.3.15 Ensure that the ward to which the person is admitted is a safe and therapeutic environment. People, particularly children and young people, should know who they can talk to if they are frightened or need support. See also the section on hospital care in NICE's guideline on service user experience in adult mental health services.

Observation

1.3.16 The admitting nurse or person responsible should tell the person what level of observation they are under and:

- explain what being under observation means
- explain clearly the reasons why the person is under observation and when, or under what circumstances, this will be reviewed
- explain how they will be observed and how often
- explain how their rights to privacy and dignity will be protected
- explain how observation will support their recovery and treatment
- offer the person an opportunity to ask questions.

1.3.17 Ensure that restrictions, including restrictions on access to personal possessions:

- are relevant and reasonable in relation to the person concerned
- take into consideration the safety of the person and others on the ward
- are explained clearly to ensure the person understands:
  - why the restrictions are in place
  - under what circumstances they would be changed.

1.4 Support for families, parents and carers throughout transitions

1.4.1 Identify a named practitioner who will make sure that the person's family members, parents or carers receive support and timely information including:

- the purpose of the admission
- information (either general, or specific if the person agrees) about the person's condition
- the practicalities of being in hospital
- preparing for discharge

- other sources of support for carers.

1.4.2 Practitioners should start to build relationships with the person's family members, parents or carers during admission. This should be done:

- in an empathetic, reassuring and non-judgemental way
- acknowledging that a first admission can be particularly traumatic for families and carers.

1.4.3 Arrange for parents to have protected time at an early point in the process of admitting their child to discuss the process with the relevant practitioners.

1.4.4 Give families, parents or carers clear information about the inpatient unit in a format they will be able to understand. This should include information about:

- the ward and the wider hospital environment
- resources that are available, including accommodation for families
- visiting arrangements
- the treatment, care and support the person is receiving.

1.4.5 Give young carers (under 18) of people in transition relevant information that they are able to understand.

1.4.6 Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay. See the section on involving families and carers in NICE's guideline on service user experience in adult mental health services.

1.4.7 At the point of admission, give carers information about carers' support services in their area that can address emotional, practical and other needs. This is particularly important if this is the person's first admission.

1.4.8 Try to accommodate parents' or carers' working patterns and other responsibilities so that they can attend meetings (if the person they care for wants this). This should include:

- Care Programme Approach meetings
- discharge planning meetings
- other meetings concerning the care of the person.

Carers' assessments

1.4.9 Practitioners involved in admission and discharge should always take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge.

1.4.10 Identify carers (including young carers) who have recognisable needs. Make a referral to the carer's local authority for a carer's assessment, if the carer wishes it (Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.

1.5 During hospital stay

Planning support

1.5.1 Ensure regular review of the person's care plan and progress toward discharge.

1.5.2 Work with the person throughout their hospital stay to help them:

- keep links with their life outside the hospital, including:
  - family and friends
  - social and recreational contacts
  - education, training or work
- restart any activities before they are discharged.

This is particularly important for people who need a long-term inpatient stay and people who will have restricted access to the community.

1.5.3 Identify whether the person has any additional need for support, for example, with daily living activities. Work with carers and community-based services, such as specialist learning or physical disability services, to provide support and continuity while the person is in hospital.

Education – for people under 18

1.5.4 Children and young people under 18 must have continued access to education and learning throughout their hospital stay, in line with the Education Act 1996.

1.5.5 Before the child or young person goes back into community-based education or training:

- identify a named worker from the education or training setting to be responsible for the transition
- arrange a meeting between the named worker and the child or young person to plan their return.

1.6 Discharge from hospital

Helping the person prepare for discharge

1.6.1 Before discharging people with mental health needs to their home or care home, ensure it is suitable for them. Discuss and plan housing needs with the person and their family or carers.

1.6.2 Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation. This should:

- be started before discharge

- continue after discharge for as long as the person needs support to stay in secure accommodation
- focus on joint problem-solving, housing and mental health issues.

1.6.3 Offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness before discharge. Sessions should:

- start while the person is in hospital
- continue after discharge so the person can test new approaches in the community
- cover:
  - symptoms and their causes
  - what might cause the person to relapse, and how that can be prevented
  - psychological treatment
  - coping strategies to help the person if they become distressed
  - risk factors
  - ways in which the person can be helped to look after themselves
- be conducted by the same practitioner throughout if possible.

1.6.4 Consider a staged, group-based psychological intervention for people with bipolar disorder who have had at least 1 hospital admission and are being discharged from hospital. This should include:

- evaluation by a psychiatrist within 2 weeks of discharge
- 3 sequential sets of group sessions led by trained practitioners that focus on, respectively:
  - people's current mental health and recent experiences in hospital
  - psychoeducation or cognitive behavioural therapy
  - early warning signs and coping strategies

- group-based psychoeducation sessions for families and carers.

1.6.5 Consider psychoeducation sessions (see recommendation 1.6.3) for all people with other diagnoses as part of planning discharge and avoiding readmission.

1.6.6 During discharge planning, offer carers group psychoeducation support. Ensure this is tailored to the specific condition of the person they care for.

Recovery plan to support discharge

1.6.7 Ensure that there is a designated person responsible for writing the recovery plan in collaboration with the person being discharged (and their carers if the person agrees).

1.6.8 Ensure the recovery plan describes the support arrangements for the person after they are discharged. Send a copy to everyone involved in providing support to the person at discharge and afterwards. It should include:

- possible relapse signs
- where to go in a crisis
- budgeting and benefits
- handling personal budgets (if applicable)
- social networks
- educational, work-related and social activities
- points of contact
- details of medication
- details of treatment and support plan
- physical health needs
- recovery goals
- date of review of the recovery plan.

1.6.9 Write the recovery plan in clear language. Avoid jargon and explain difficult terms.

Peer support

1.6.10 For people being discharged from hospital, consider a group-based, peer-delivered self-management training programme as part of recovery planning. Sessions should:

- continue for up to 12 weeks
- be delivered in groups of up to 12 members
- provide an opportunity for social support
- cover:
  - self-help, early warning signs and coping strategies
  - independent living skills
  - making choices and setting goals.

1.6.11 Consider providing peer support to people with more than 1 previous hospital admission. People giving peer support should:

- have experience of using mental health services
- be formally recruited, trained and supervised.

Discharge planning

1.6.12 Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For detailed recommendations on discharge and transfer of care, see NICE's guideline on service user experience in adult mental health services.

1.6.13 Before discharge arrange:

- phased leave (the person can have trial periods out of hospital before discharge)
- phased return to employment or education (the person can gradually build up hours spent in employment or education).

This is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community.

1.6.14 Before discharging a person who is in education or training, arrange a planning meeting between them and a named person from the education setting to plan their return to learning.

1.6.15 If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning.

1.6.16 Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should:

- relate directly to the setting the person is being discharged to
- fully involve the person
- be shared with carers (if the person agrees)
- explore the possibility of using a personal health or social care budget
- cover aspects of the person's life including:
    - daytime activities such as employment, education and leisure
    - food, transport, budgeting and benefits
    - pre-existing family and social issues and stressors that may have triggered the person's admission
    - ways in which the person can manage their own condition.

(See also information about psychoeducation sessions in recommendations 1.6.3–1.6.5.)

1.6.17 Recognise that carers' circumstances may have changed since admission, and take any changes into account when planning discharge.

1.6.18 Before the person is discharged:

- inform their carers of the plans for discharge
- discuss with carers the person's progress during their hospital stay and how ready they are for discharge
- ensure that carers know the likely date of discharge well in advance.

Follow-up support

1.6.19 Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:

- contact details, for example of:
  - a community psychiatric nurse or social worker
  - the out-of-hours service
- support and plans for the first week
- practical help if needed
- employment support.

1.6.20 On discharge:

- the hospital psychiatrist should ensure that a discharge summary is emailed to the person's GP on the day of discharge and a copy given to the person
- include information in the discharge summary about why the person was admitted and how their condition has changed during the hospital stay
- consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.

1.6.21 If the person has a learning disability or dementia, the hospital team should lead the communication about discharge planning with the various services that support the person in the community. These agencies could include:

- older people's services
- learning disability services
- the home care service.

1.6.22 When a person is being discharged to a care home, look for opportunities for hospital and care home practitioners to exchange information about the person. An example might be a hospital practitioner accompanying the person when they return to the care home.

1.6.23 In collaboration with the person, identify any risk of suicide as part of the needs and safety assessment. Incorporate this into the discharge planning and follow up within 7 days. Follow up earlier if the safety assessment indicates a risk of suicide.

1.6.24 Consider contacting people admitted for self-harm after discharge, who are not receiving treatment in the community. Give them advice on:

- services in the community that may be able to offer support or reassurance
- how to get in touch if they want to.

Community treatment orders

1.6.25 Decide whether a community treatment order (CTO) or guardianship order is needed (see the Mental Health Code of Practice), based on:

- the benefit to the person (for example, it may be helpful for people who have had repeated admissions)
- the purpose (for example, to support the person to follow their treatment plan)
- the conditions and legal basis.

1.6.26 Ensure that the person who will be subject to the order has the opportunity to discuss why it is being imposed. Explain:

- the specific benefit for the person
- what restrictions it involves
- when it will be reviewed
- what will happen if the person does not comply with the order, and that this may not automatically lead to readmission.

1.6.27 Ensure that the conditions, purpose, legal basis and intended benefit are explained to families, carers and others providing support.

Research recommendations

The guideline committee has made the following recommendations for research, based on its review of evidence, to enhance care for people in the future and improve NICE guidance. The committee selected the research recommendations that they think will have the greatest impact on people's care and support.

1 Care and support for people with dementia

What is the effect of specific interventions to support people with dementia during transition between inpatient mental health settings and community or care home settings?

Why this is important

The review did not identify any studies about transition for people with dementia from or to inpatient mental health settings. This is one of the groups identified in the equality impact assessment that require special consideration.

Mental health disorders may be under-diagnosed in people with dementia due to ‘diagnostic overshadowing’, in which a person's symptoms may be wrongly attributed to dementia. If they are admitted to a psychiatric ward, being able to support them to communicate and function in a new environment, and to return to the community, may help ensure that they do not stay on inpatient wards longer than necessary. It is also important to consider how to achieve continuity of care if the person’s usual residence is, or will be, a care home.

Effectiveness studies are needed to evaluate different approaches and interventions to support people with dementia during transition between inpatient mental health settings and community or care home settings. Qualitative studies exploring views and experiences of people with dementia and their families would also be welcome.

Criteria	Explanation
Population	Older people with diagnosed or suspected dementia who are being admitted to or discharged from mental health inpatient settings. While older people usually implies those over 65, people with early onset dementia should also be within scope. Unpaid or family carers of this population are also within the remit. The views of care home staff are also relevant, as people with dementia may be admitted from, and discharged to, care homes.
Interventions	Assessment, admissions and discharge planning within mental health inpatient settings to support people with dementia and their family and carers. Specific interventions that support people with dementia to be involved in care planning and deliver safe and timely transitions. Interventions adopted within specialist geriatric care settings which involve these activities.
Comparator(s)	Assessment, admissions and discharge planning within mental health inpatient settings that are not specific to people with dementia.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including unplanned hospital readmission and admission to acute mental health services. Delays in transfer. Inappropriate admissions to residential or nursing care. Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes.
Study design	In-depth comparative studies (which might be those of RCT or case control design, for example) of interventions would be useful. Qualitative studies, or components of comparative studies, concerning the views and experiences of this population, and what they think is helpful, are also required.

Timeframe	Studies should be of sufficient duration to capture outcomes such as mortality, hospital readmissions and transfer to residential services.

2 People with complex needs other than dementia

What is the effect of specific interventions to support people with complex needs (including people with long-term severe mental illness, people with a learning disability and people on the autistic spectrum) during transition between inpatient mental health settings and community or care home settings?

Why this is important

As the population ages and people live longer, the number of people with severe and complex mental and physical care needs is increasing. They may need ongoing intensive support from rehabilitation and other mental health services to live in the community after discharge. Although they are a relatively small group, expenditure on care for people in this group accounts for around 25% of the total mental health budget.

Studies are needed to evaluate different approaches and interventions to support people with complex needs during transition. Qualitative studies exploring views and experiences of people with complex needs and their families are also needed. These should include the views of staff from the receiving care home.

Criteria	Explanation
Population	Adults of all ages with more than one severe and complex health condition or disability who are being admitted to or discharged from mental health inpatient settings. Such conditions may include learning disability, physical disability or long term condition. Unpaid or family carers of this population are also within the remit. The views of practitioners based in community and care home settings are also relevant, especially where the person lives in a residential or supported setting (permanently or for temporary rehabilitation).
Interventions	Assessment, admissions and discharge planning applied within mental health, physical health or generalist inpatient settings to support people with severe and complex health

	conditions and their family and carers. Specific interventions that support people with mental health and other conditions to be involved in care planning and deliver safe and timely transitions. Interventions adopted within specialist care settings which involve these activities, and are able to address the needs of people with at least two complex conditions.
Comparator(s)	Assessment, admissions and discharge planning within generalist inpatient settings, or inpatient settings designed for a single specific mental or physical health condition.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including unplanned hospital readmission and admission to acute mental health services. Delays in transfer. Inappropriate admissions to residential or nursing care. Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes.
Study design	In-depth comparative studies (which might be those of RCT or case control design, for example) of interventions would be useful. Studies should include cost-effectiveness of interventions. Qualitative studies, or components of comparative studies, concerning the views and experiences of this population, and what they think is helpful, are also required.
Timeframe	Studies should be of sufficient duration to capture outcomes such as hospital readmissions, time to readmission and transfer to residential services.

3 Peer support

Is peer support that is provided during and after discharge from mental health inpatient settings effective and cost effective in reducing rates of readmission?

Why this is important

Peer support may promote a range of improved outcomes for people who have been admitted to mental health inpatient settings. The committee acknowledged the diverse nature of peer support, which includes mutual support such as group work, organised volunteering or befriending, as well as formally employing and training people who have experience of using services themselves to deliver peer support. Being a peer support worker may have positive and negative outcomes for a person.

The committee identified the ENRICH study, which is in an early stage of development. This appears to be a good prospective randomised controlled trial (RCT) looking at effectiveness and cost-effectiveness (reducing readmissions) of paid peer support workers. The trial is expected to report in 2019. At the time of consultation there is no published protocol that can be included in the guideline. It is unclear at this stage which aspects of peer support the ENRICH study will cover and which may still constitute gaps where further research is needed.

Criteria	Explanation
Population	People of all ages who are being admitted to or discharged from mental health inpatient settings. Although a lower age threshold may be applied, there is interest in the application of different types of intervention that might be of interest to young people, such as social networking.
Interventions	Peer support interventions, delivered as part of orientation to an inpatient mental health setting; through an admission episode, or discharge. Support ranging from informal internet-based support, through group sessions and one-to-one buddying to formally trained, recruited, paid and supervised workers who have experience of service use. Peer support may also be based around a particular task, such as drawing up a crisis plan. It is important that research should follow a strict protocol to formalise the type of peer support being evaluated.
Comparator(s)	Services in which people are admitted, treated or discharged from an inpatient mental health setting where there is no peer support intervention. Wait list controls may be used.
Outcomes	Health-related quality of life. Social care-related quality of life. Health and social care service use including hospital readmission and admission to acute mental health services. Past use of services (admissions history) may be of interest in illustrating the impact of peer support Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care

	- dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes. Impact upon the peer supporters or support workers.
Study design	In-depth comparative studies (which might be those of RCT or case control design, for example) of interventions would be useful. Studies should include cost-effectiveness of interventions, particularly because the range of service investment in setting up support may vary widely. Qualitative studies concerning the views and experiences of this population are already available and are somewhat inconclusive, although these could be undertaken alongside more formal studies.
Timeframe	It is important that there is a reasonable length of follow-up to ascertain the sustainability of any outcomes, and this may be linked to the length of the intervention and service investment in setting up the intervention.

4 Children and young people in transition between settings

What is the effect of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

Why this is important

Young people admitted to inpatient mental health settings may have a range of associated difficulties, and may be more likely than adults to be admitted to out-of-area or specialist units.

The committee highlighted particular gaps in the evidence about children and young people during transitions. These included gaps in evidence on:

- child protection and safeguarding
- voluntary compared with involuntary admission
- understanding by children and young people of their status
- how looked-after children are best supported through transitions and reintegration into the school system after hospital discharge
- self-directed support or peer support for children and young people and their parents.

Effectiveness studies are needed to evaluate the different approaches and interventions to support children and young people through safe and timely transitions. These need to be supplemented with views and experiences studies.

Criteria	Explanation
Population	Children and young people (under 18) who are in transition between inpatient mental health settings and community or care home settings and their families, parents and carers, including self-funders and people who organise their own care, or whose families organise their care. Inpatient mental health settings may include Tier 4 CAMHS inpatient settings, secure units for children and young people, specialist autism units and specialist units for (children and young) people with mental health problems and additional needs. Young people under 18 admitted to mainstream adult mental health settings. Looked after children in transition to and from inpatient mental health settings.
Interventions	Personalised and integrated assessment, admission, discharge planning, care and support specifically for children and young people. Specific services that support children and young people to continue to participate in, and reintegrate into mainstream education, and social and leisure activities.
Comparator(s)	Usual treatment (compared to the effectiveness of an innovative intervention).
Outcomes	Continuity of care Continuity of education and training Health-related quality of life. Social care-related quality of life. Health and social care service use including hospital readmission and admission to acute mental health services. Service user and carer experience: - satisfaction - social, emotional and psychological support - choice, control and involvement in decision-making - quality and continuity of care - dignity and independence - quality of life and health status - independence and ability to carry out daily activities - safety and safeguarding outcomes.
Study design	In-depth comparative studies (which might be those of RCT or case control design, for example) of interventions would be useful. Studies should include cost-effectiveness of interventions, particularly because the range of service investment in setting up support may vary widely. Qualitative studies concerning the views and experiences of children and young people are also of interest, and may be undertaken

	alongside more formal studies.
Timeframe	It is important that there is a reasonable length of follow-up to ascertain the sustainability of any outcomes, and the impact on the lives of young people.

Terms used in this guideline

Carers

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.

Coping strategies

Coping strategies are the methods a person uses to deal with stressful situations. The term is used in this guideline to refer to ways that people cope with their mental illness or related symptoms. Some coping strategies themselves can have negative consequences for a person using them or for the people around them.

Observation

An intervention in which a healthcare professional observes and maintains contact with a person using mental health services to ensure that person’s safety and the safety of others. There are different levels of observation depending on how vulnerable to harm the person is considered to be.

Psychoeducation

Education sessions for people affected by mental illness and their families and carers. Psychoeducation uses shared learning to empower people to cope better. Sessions can cover areas such as recognising symptoms and triggers, preventing relapses and developing coping strategies. Carers learn how best to support the person. Sessions typically start while the person is in hospital and run beyond discharge so the person can test approaches in their home setting.

Recovery

There is no single definition of recovery for people with mental health problems, but the guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. In this guideline it is used to refer to someone achieving the best quality of life they can, while living and coping with their symptoms. It is an ongoing process whereby the person is supported to build up resilience and set goals to minimise the impact of mental health problems on their everyday life.

Recovery plan

A recovery plan is a document written by or with a person affected by mental illness. It focuses on their goals, and the activities and services that will support them to build resilience, improve their mental health and stay in control of their life.

Therapeutic relationships

Relationships based on mutual trust, kindness and respect, focusing on the person's recovery goals.

For other social care terms, see the Think Local, Act Personal Care and Support Jargon Buster.

Please see the NICE glossary for an explanation of terms not described above.

2 Evidence review and recommendations

Introduction

When this guideline was started, we used the methods and processes described in the Social Care Guidance Manual (2013). From January 2015 we used the methods and processes in Developing NICE Guidelines: The Manual (2014). The included studies were critically appraised using tools in the manuals and the results tabulated (see Appendix B for tables). Minor amendments were made to some of the checklists to reflect the range of evidence and types of study design considered in the evidence reviews. For more information on how this guideline was developed, including search strategies and review protocols, see Appendix A.

Rating the included studies was complex as the ‘best available’ evidence was often only of moderate quality. Studies were rated for internal and external validity using ++/+/- (meaning good, moderate and low). Where there are 2 ratings (for example +/-), the first rating applies to internal validity (how convincing the findings of the study are in relation to its methodology and conduct). The second rating concerns external validity (whether it is likely that the findings can be applied to similar contexts elsewhere). The internal quality rating is given in the narrative summaries and evidence statements with both the internal and external rating reported in the evidence tables in Appendix B.

The critical appraisal of each study takes into account methodological factors such as:

- whether the method used is suitable to the aims of the study
- whether random allocation (if used) was carried out competently
- sample size and method of recruitment
- whether samples are representative of the population we are interested in
- transparency of reporting and limitations that are acknowledged by the research team.

Evidence rated as of only moderate or low quality may be included in evidence statements, and taken into account in recommendations, because the guideline committee independently and by consensus supported its conclusions and thought a recommendation was needed.

A further table reports the details (such as aims, samples) and findings. For full critical appraisal and findings tables, arranged alphabetically by author(s), see Appendix B.

Economic studies, in addition to being rated for their internal and external validity, have also been rated for their applicability (applicable, partially applicable, not applicable) and rated for their economic methodological quality (very serious limitations, potentially serious limitations, minor limitations). Methodological appraisal detailing the limitations of these studies is fully described in Appendix C1.

The presentation of evidence in this section

The review questions in which we sought to examine effectiveness of different interventions and approaches (4, 5, 6, 7, 8, 9 and 10) are used as the themes for the review areas reported below (for example, admissions into inpatient mental health settings, transitions in and out of inpatient mental health for children and young people with mental health problems). For every review area, we also sought evidence on views and experiences relating to the different approaches or interventions (1 (a), 1 (b), 2(a), 2(b), 3 (a), 3 (b)). The result is that for each review area reported in this section, evidence is presented from studies of effectiveness and from studies of views and experiences as they relate to that review area. Where relevant, evidence from economics studies is also reported.

The same views and experiences questions were applied for every review area, so as to supplement the more measurable data on effects. The views and experiences review questions which delivered material to supplement effectiveness studies are:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example, in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example, in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Due to the interrelatedness of some of the review areas, evidence was found to be overlapping. This was particularly so for the hospital discharge and reducing readmissions review areas. As the review work progressed through the development phase, the guideline committee had an increasing body of evidence on which to develop recommendations. They were able to consider findings from 1 review area and apply them to the refinement of recommendations in other areas. Where evidence from 1 review area was used to inform recommendations in another area, this is described in Section 3, including the ‘Linking evidence to recommendations’ tables (3.8).

2.1 Admissions into hospital

Introduction to the review questions

The purpose of the review questions was to examine research about the effectiveness and cost-effectiveness of specific interventions or approaches to support people with mental health problems during admission to mental health inpatient settings from community settings such as care homes. The questions also aimed to consider research which systematically collected the views and experiences of admission from people using services, as well as those of their carers and those of care and support staff involved in the admission process (in line with the scope). Transitions involving inpatient general healthcare settings are not part of the remit of this review question.

From 180 titles and abstracts which seemed relevant to admissions, we ordered the full text of 82 papers which appeared to concern admission into a mental health setting, of which 73 were retrieved. At full text review, a further 54 papers were excluded from full appraisal as the paper was found to be not on topic, descriptive rather than evaluative, or reporting views but not on interventions to support admissions. Nineteen papers were within our scope and met our inclusion criteria. All except 1 reported studies describing views and experiences. One ‘impact’ or ‘effectiveness’ study of moderate quality was found.

Of the views papers 8 were of high quality and 10 were of moderate quality. No papers with a low quality rating were included.

Review question for evidence of effectiveness

4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings?

Review question for evidence of views and experiences

The review questions in relation to views and experiences of admission were:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example, in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify different approaches to assessment, care planning and support during admission to inpatient mental health settings from community or care home settings and the ways in which they improve outcomes and experiences
- identify and evaluate the effectiveness of models of coordinated assessment and care planning approaches and associated outcomes
- identify and evaluate variation between formal and informal admissions, and opportunities for improvement, in approaches to admission for people subject to the provisions of the Mental Health Act, Ministry of Justice restrictions or Mental Capacity Act
- consider the impact of out-of-area placements (placement in specialist services or to services with available beds) on the process of admission to, and discharge from inpatient mental health settings.

For the views and experiences review questions, the protocol sought to identify studies, specifically related to admission to inpatient mental health settings that would:

- describe the self-reported views and lived experiences of people using services, their families and carers about the care and support they receive during admission to inpatient mental health settings
- consider specifically whether people using services and their families and carers think that their care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and where appropriate, housing, education and employment services
- consider what service users, families and carers think supports good care during transition, and what needs to change
- describe the views and experiences of people delivering, organising and commissioning mental and general healthcare, social care (and other relevant services such as housing, employment and education) about the

care and support provided during admission to inpatient mental health settings
- collect evidence on key practice and workforce issues which may impact on transitions and should be considered within the guideline
- highlight aspects of the admission to inpatient mental health settings which work well, and are i) personalised and ii) integrated, as perceived by practitioners, managers and commissioners.

Population

All children, young people and adults in transition from community or care homes to inpatient mental settings. Self-funders and people who organise their own care and who are experiencing a transition from community or care homes to inpatient mental health settings are included.

Families and carers of all children, young people and adults in transition from community or care homes to inpatient mental health settings.

Health and social care commissioners and practitioners involved in delivering care and support to people during transition from community or care homes to inpatient mental health settings; approved mental health professionals; advocates; personal assistants engaged by people with mental health problems and their families. General practice and other community-based healthcare and mental health practitioners; psychiatrists and ward staff in inpatient mental health settings (especially those with a role in admission and discharge procedures). Where relevant, the views of housing, employment and education practitioners and police and ambulance personnel involved in supporting people during transition into or from inpatient mental health settings will be considered.

This is a whole population topic. The population of interest included those with protected characteristics, and people without stable accommodation; people of minority ethnic background; people with co-morbidities including substance misuse; people with communication difficulties, sensory impairment or learning difficulties; people treated under a section of the Mental Health Act (and/or people under Ministry of Justice restrictions and people treated under

Mental Capacity Act), and people placed out of their local area (see Equality Impact Assessment).

Intervention

Personalised and integrated assessment and admission processes including Mental Health Act assessments. Usual treatment compared to the effectiveness of an innovative intervention. Admission of people treated under CPA, provisions of Mental Health Act, Mental Capacity Act and Ministry of Justice restrictions.

Settings

Service users' own homes, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes, care homes for children, and all inpatient mental health settings for adults, older people, children and young people and specialist units for people with mental health problems and additional needs. Additional specialist services such as triage units and crisis or PACT teams may also be considered where they contribute to assessment and care planning for admission.

Outcomes

User- and carer-related outcomes (such as user and carer satisfaction; quality of life; quality and continuity of care; independence, choice and control; involvement in decision-making; suicide rates) and service outcomes such as use of mental health and social care services, unplanned or inappropriate admissions to inpatient mental health settings, length of inpatient stay and need for unpaid care and support.

The study designs relevant to these questions are likely to include:

- systematic reviews of studies of different approaches to admission assessment, care planning and support including those conducted under the Mental Health Act
- RCTs of different approaches to assessment, care planning and support during admission
- economic evaluations

- quantitative and qualitative evaluations of different approaches
- observational and descriptive studies of process
- cohort studies, case control and before and after studies
- mixed methods studies.

The study designs relevant to the views and experiences questions were expected to include:

- systematic reviews of qualitative studies on this topic
- qualitative studies of user and carer views of social, mental health and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational, cohort and cross-sectional survey studies of user experience.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care, and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units’ or hospitalised patients with mental disorders, and b) the process of ‘transition’, discharge or admission, to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology. Therefore, terms on leaving or returning to home or community settings are also used to capture transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept is used to focus the search on particular study designs to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups, and economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also undertaken.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transition between community and care home to inpatient hospital settings. The search was restricted to studies published from 1999 onwards. This is on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a ten year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken in January 2015 will be updated in March 2016 to identify new studies that might meet the inclusion criteria and may alter the recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)

- language (must be in English)
- population (must have a mental health disorder)
- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions)
- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, randomised controlled studies and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions. In some cases it was decided that the search output was too large to review in full text, and that we should select according to relevance and methodological quality (for example, by prioritising UK views studies if there was a good quantity of views studies).

When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) were carried out. (Where evidence was very sparse, which did not apply to the admissions topic, the team revisited the set to see whether any of the material not retrieved in full text might be relevant – for example qualitative studies from outside the UK.) The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see

Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

Results

From 180 titles and abstracts which seemed relevant to admissions, we ordered the full text of 82 papers which appeared to concern admission into a mental health setting. These were broadly of 2 types: studies which used experimental methods and aimed to demonstrate the effectiveness of approaches or components of admissions (impact studies); and those which reported on people’s views and experiences of admission to mental health settings (views studies). We decided to retrieve only those views studies which were carried out within a UK setting, in the expectation that they would most clearly relate to, and be generalisable to, the English context.

We were able to retrieve and review 73 of the 82 papers. At full text review, a further 54 papers were excluded from full appraisal as the papers were found to be not on topic, descriptive rather than evaluative, or reporting views but not on interventions to support admissions. Through this process, we found 19 papers that were within scope and fulfilled our inclusion criteria.

We only found 1 effectiveness study (Goldberg et al. 2013) concerning admission and this was of moderate quality. There were no papers which evaluated the effect of particular components or approaches to admission. There were some effectiveness studies which measured the effects of joint crisis plans on (as a primary outcome) reducing readmissions and the costs of these, and these are covered in the review question on reducing readmissions. The overwhelming bulk of the literature was about the views and experiences of service users and the values and principles they wish to be considered on admission (n=18).

The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables.

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting impact or effectiveness of approaches to admission (n=1)

1. Goldberg S, Bradshaw L; Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial

Outline: the authors of this RCT rated +/+ developed a specialist medical and mental health unit for older people with suspected dementia or delirium, admitted for an acute physical health problem, as a model of best practice and evaluated it against a standard ward (general or geriatric) in an RCT. Their hypothesis was that admission to the specialist unit would increase the number of days spent at home in the 90 days following admission, and that admission to the unit would improve quality of life outcomes, experience and satisfaction compared with standard care. Six hundred older people described as ‘confused’ were randomised to the specialist unit or to a general or geriatric ward (310:290).

The specialist medical and mental health unit (MMHU) of 28 beds included:

- specialist mental health staff, an occupational therapist and weekly psychiatric ward rounds
- staff trained in dementia and person-centred care
- a programme of organised therapeutic and diversionary activities
- an environment appropriate for people with cognitive impairment
- a proactive and inclusive approach to family carers.

Results: results failed to show a significant difference in days spent at home between the specialist unit and standard care groups (median 51 vs 45 days; 95% confidence interval for difference -12 to 24; p=0.3 by Mann Whitney test; p=0.7 from a likelihood ratio test using the 2-part model after adjustment). The observed quality of the patients experience on the ward suggested that patients were more engaged and active during their stay, and less often in a negative mood. Carers were significantly more satisfied with care, but there was carer dissatisfaction in both groups. This study is rated +/+, as there are significant flaws (for justifiable reasons) in the allocation and follow-up (which could not be blind to investigators). Although admission to a specialist ward for older people with dementia or delirium was not shown to reduce days spent in hospital or provide other measurable benefits, there was some 'softer' evidence that their experience of the hospital stay was improved.

Studies reporting views and experiences data (n=18)

1. Bindman J, Reid Y, Szmukler G (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up

Outline: this study follows up a sample of 100 people (from 118 consecutive admissions to a UK psychiatric unit) to consider whether patient perceptions of coercion at any type of admission were associated with poor engagement at follow-up after discharge. The study is rated +/+ for methodology, moderately sound but with a limited sample (100 admissions to 1 unit). Structured measures of experience and perceived coercion were used shortly after admission and before discharge, supplemented with case notes which recorded engagement (for an average of 10 months following discharge). 'Coercion' was associated (by the research team) with use of the Mental Health Act, involvement of police (24 cases) or any other use of force, such as physical restraint, forcible medication, forced entry to a home or use of seclusion.

Results: although the Mental Health Act was used to admit 19 patients (and a further 39 were detained later, after initially agreeing to voluntary admission), some people did not (when interviewed) accurately know their status at admission. Fifteen patients (15%) believed their admission status had been involuntary or 'formal', and 81 (81%) believed it was voluntary or 'informal' (though in fact 15 of these were formally detained), and 4 did not know. Twenty-nine of the 66 cases who correctly believed they had voluntary status (44%) believed they would be detained if they tried to leave hospital and a further 15 (23%) were unsure whether they would be allowed to leave if they wished. Only 22 (33%) thought they could choose to leave hospital. None of the patients believing they were free to leave were rated as perceiving high coercion, but 5 of the 15 (33%) who were unsure and 14 of the 29 (48%) who believed they would be detained were rated as perceiving high coercion. The study did not demonstrate any association between perceived coercion and poor engagement with services (for example attendance at appointments, known adherence to treatment) after discharge.

Use of the Mental Health Act is highly associated with perception of coercion, but the study suggests that patients admitted ‘voluntarily’ also feel coerced, and may be uncertain of where they stand if they try to leave. This suggests their information needs are unmet.

2. Campbell J (2008) Stakeholders’ views of legal and advice services for people admitted to psychiatric hospital

Outline: this is a study of moderate quality (+/+) which attempted to gain insight into the scope of information and legal advocacy services which are made available to people and their carers during and after compulsory admission to psychiatric hospital in Northern Ireland. The study involved 44 people who had either been detained, or were carers of those who had (categories not split) in 4 focus groups, but had limited success in obtaining the written views of lawyers and hospital service managers (23 of 300 solicitors responded to a survey; 4 of 12 hospital managers sent a letter gave some response). The study had limited scope and the methods relating to the 4 focus groups (3 with detained patients, 1 with carers) are not well described.

Results: findings from the focus groups revealed a number of inadequacies in the process of formal admission and subsequent review. At this point (probably no longer the case), family carers had the right to have people detained in collaboration with a GP, and without a further professional (such as an approved social worker). This was felt to be an unfair responsibility that could have repercussions on relationships, and family members said they had not realised how difficult it might be to overturn the detention.

Patients said they were sometimes detained in public without warning, denying them dignity, privacy, an explanation or any right to advocacy or appeal. Staff might brush aside any request for advocacy.

Following detention, the status of the patient might be unclear, and since the burden of proof at a mental health review tribunal (MHRT) rests with the responsible medical officer to justify detention, staff may feel pressured not to give the patient or carer information about the tribunal and any relevant information to be presented.

Five service users and 7 carers had experienced MHRT, 1 woman after extensive ECT, which the tribunal ordered be stopped. ‘People started to listen to me’ (when the tribunal was involved) (p226), and (as corroborated by the solicitors responding to the study) some patients found their detention revoked when application to MHRT was made.

Some carers felt that the tribunal reports were light on detail (including that which they had supplied to them). Tribunals should be more aware of carers’ views and the patient’s community circumstances (which the MHRT cannot insist be improved).

Only 1 hospital manager could provide comprehensive information about the rights of the detained person.

3. Chinn D, Hall I, Ali A (2011) Psychiatric inpatients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities

Outline: in this small, moderate quality (+) qualitative study, the sample was 17 people with intellectual disability (ID) placed in specialist mental health units on average 40 miles from home. The study is small, and does not focus directly on admissions, but our interest was in the impact of out-of-area placement on the total experience of admission and treatment.

Results: 13 of the participants had been detained, some had been associated with aggressive behaviour, and many viewed the placement as ‘punishment’ rather than treatment. Patients told of occasions when they had been belittled or intimidated by staff, and this seemed to be particularly undermining, as contact – for example by phone – with family and friends was subject to staff permission and facilitation. Most wanted to be closer to local, familiar surroundings and amenities. Although some were not on good terms with family, a majority felt upset that families, often older, could not visit as often as they would wish. One person could not speak their native language as none of the staff spoke it.

4. Commander M, Cochrane R, Sashidharan S (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, inpatient and after-care

Outline: this is a small cross-sectional local study, based in Birmingham, which is of moderate quality (+/-) and possibly out of date in its conclusions and approach. It tracks the progress of the psychiatric hospital (admission) and the provision of inpatient and aftercare for Asian, black and white patients with non-affective psychoses. Researchers aimed to recruit the first 120 admissions who met the inclusion criteria, and the first 140 discharges to the 4 participating inpatient units between April 1995 and January 1996 (so quite old data). There were to be 40 in each of the racial groups (Asian, black and white). There is an overlap of 64 people in the groups at different time points (i.e. some will be in both samples). The total sample is 216 people, 120 of whom contributed to assessment at admission using structured tools concerning Encounter (experience, including satisfaction), Insight (into psychosis) and Social Behaviour Scale. These scales were completed by clinicians, and it is not clear how disparities between the patient-reported experience and the case notes, also consulted, were handled.

Results: key findings on the experience of black and Asian patients at admission were:

- Black and Asian patients more likely to be compulsorily admitted, and to not see themselves as having psychiatric needs, than white patients. ‘While the majority of white patients felt that they needed to come to a psychiatric hospital, this applied to only one-third of Asian and black patients’ (p486).

- Black and Asian patients were rated more highly by clinicians on destructive behaviour, hostility, inappropriate sexual behaviour and incoherent speech (Social Behaviour Scale) than were white patients.
- Black and Asian patients were more likely to be less satisfied with the admission process.
- Both black and Asian patients were more likely to have contact with police leading to admission.

There is limited insight to be gained from this paper, and a danger of cementing stereotypes, but it is included as a rare example of the experience of black and Asian people coming into mental health units.

5. Donner B, Mutter, R, Scior K (2010) Mainstream inpatient mental health care for people with intellectual disabilities: service user, carer and provider experiences

Outline: this small but well conducted study of good quality (++) also uses qualitative methodology to report the concerns of people with intellectual disabilities: service users (n=9) and carers (with permission of the service user) (n=9) were interviewed, and providers also contributed (within a small focus group). Admission here is to a mainstream mental health unit, and the paper goes beyond our remit by describing views of the entire hospital episode.

Results: themes relevant to the admissions aspect are:

- Respite: in all except 1 of the cases, at least some feature of the admission was perceived as providing respite, either for the person with intellectual disability or more frequently the carer.
- Disempowerment: in all but 1 case, the inpatient admission and experience was seen as disempowering, for example being threatened with a MHA section if they did not agree to admission. Some were not told why they were being taken to hospital.
- A daunting environment: half of the respondents reported examples of violence committed by other service users against ward property, staff and

patients. Carers viewed the ward as ‘depressing’, ‘intimidating’ or ‘frightening’ and counter to promoting recovery.

- The impact of having an intellectual disability complicated the whole admission experience.
- A barrier to access: the search for help from services before admission was fraught with difficulty, often manifest in a lack of knowledge in the areas of mental health and intellectual disability by staff in primary care and accident and emergency services. It was also felt that staff in mental health services were often hesitant about assessing someone with an intellectual disability.

Service providers agreed that there were particular difficulties in supporting good practice in working with people with intellectual disabilities. Communication needs arising from the person’s intellectual disability were poorly understood by mental health staff. Lack of joint working, and confusion over roles and responsibilities, of mental health and intellectual disability teams and personnel was a problem. Respondents voiced their concern about what they saw as a very narrow understanding by staff in mainstream inpatient settings about the implications of intellectual disabilities (for example failure to take account of additional support needs). This amounted to a lack of a person-centred approach, at admission and thereafter.

6. Farrelly S, Brown G, Rose D et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans

Outline: this study reports on one aspect of a multi-site RCT of joint crisis plans (JCPs) and is linked to 2 papers which consider the cost-effectiveness of joint crisis plans (Barrett et al. 2013; Thornicroft et al. 2013) as a means of reducing readmissions. (These studies are reviewed in relation to RQ6.)

This high quality qualitative sub-study (rated ++) seeks to analyse the content – what service users want, which was recorded verbatim – of 221 JCPs drawn up by the intervention group as part of the trial. The trial population all had diagnoses of a psychotic disorder and at least 1 previous admission in the past 2 years. The JCP differs from an advance plan in that it specifically involves agreement between the care team and the service user and any advocates or carers, is agreed within 2 sessions with an independent facilitator, allowing time for reflection, and uses a menu of options, to which the service user can add. The 2 aspects of the JCP concern the manner in which care is delivered and particular treatment options.

Results: the 4 major interlinking themes around the delivery of care (p1611) were:

- ‘Treat me with respect.’ This included taking the time to explain what was wrong, and proposed treatment (rather than being coerced into, for example, an injection); being mindful of the whole person (for example by arranging a haircut for people on a long admission); and giving notice and respecting privacy if the home treatment team were planning to visit.

- ‘Understanding what is illness, and what is not.’ An individual with manic behaviour found that this was mistakenly interpreted as aggression. People felt it was important also that clinicians knew their histories and could interpret symptom changes. ‘I have been in and out of hospital because the assessment was done by people who do not know me and didn’t pick up that I was becoming unwell so kept discharging me’ (p1612).

- ‘Continuity/consistency/clarity.’ Continuity of staff – seeing the same people in the crisis team, for example, and having a clear account of the medication or treatment plan, was important to people.

- ‘Control and involvement.’ People wanted to feel they had some control over what happened to them. Being a voluntary patient was felt likely to facilitate this. ‘I would prefer to be in hospital on an informal basis so I can be involved in decision making around my care’ (p1613). A minority of people identified a carer or friend who they would like to advocate or make decisions for them if they were unable to do so.

Specific alternatives to admission and approaches to treatment are out of our scope, but there was strong support for being supported to stay at home, or staging interventions with hospitalisation as a last resort. ‘By far the most prevalent first preference for treatment in a crisis was for home treatment team support (35% of the sample), followed by hospitalisation (19%), and medication changes (14%)' (p1613). There was support for enabling other approaches and activities – for example, yoga, talking therapies or having a sympathetic and familiar person outside the family to talk to – but also for avoiding or using particular medication. Many of the sample found hospitalisation problematic, making them feel 'bored, heavily medicated and trapped' (p1614), but only 8% (18/221) refused admission (half of these in any circumstances, and half in relation to particular wards or as an involuntary patient). There were also people who felt rapid hospitalisation was essential when particular symptoms were apparent.

The paper shows that the JCP is an important intervention, and suggests that the process of discussing a person's preferences about admission could in itself improve understanding of the person and help to make admission less traumatic and disempowering.

7. Hunt I, Bickley H, Windfuhr K (2013) Suicide in recently admitted psychiatric inpatients: a case-control study

Outline: this is a case control study (rated ++/+) of suicides from the National Confidential Inquiry of a consecutive group of people under 65 who committed suicide within 7 days of admission to a psychiatric unit. The study aimed to identify, using logistic regression techniques, what risk factors or associations might be connected to suicide. Data was derived from clinicians on 107 (of 120 eligible) people who killed themselves in these circumstances, and compared with case controls who did not kill themselves. This is a high quality study and the findings are of obvious importance at admission.

Results: 42 suicides (40% of 107) died within the first 3 days of admission; 34% were absent from the ward without staff permission (as were only 1% of controls), but 20% were on authorised leave at the time. The factors identified as potentially significant in identifying people who might be at risk of suicide are:

- history of self-harm OR 2.57 (95%CI 1.39-4.77) p=0.003
- recent self-harm OR 3.50 (1.41-8.67) p=0.007

- adverse life events in past 3/12 OR 3.08 (1.61-5.91) p=0.0001
- duration of illness under 12/12 OR 4.00 (1.64-0.79) p=0.002
- male sex: OR 2.87 (1.59-5.16) p=less than 0.001.

The first few days of admission for people with specific characteristics (including recent adverse events, previous self-harm and acute but perhaps only recently diagnosed mental illness, especially if male) are a time of acute suicide risk. Most suicides happen off the wards, with patients having absconded or being leave. More rigorous risk assessment and greater vigilance, and possibly a less distressing ward environment, may lessen the risk.

8. Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study

Outline: this is a high quality study rated ++/++ with a mixed methods design which aimed to investigate factors related to perceived coercion at admission and during treatment among legally voluntary patients. Consecutively admitted patients were recruited from across 9 acute wards in 2 hospitals in East London. Both quantitative and qualitative methods were used concurrently during data collection. First the quantitative and qualitative data were analysed separately and later they were combined when interpreting findings.

Results: out of 446 eligible patients, 270 (61%) agreed to participate. All 270 participants rated their perceived coercion using the McArthur Perceived Coercion Scale (MPCS), a scale which measures 5 dimensions of perceived coercion. Three researchers also conducted in-depth semi-structured interviews with patients selected from the quantitative sample group who had given additional consent to be interviewed qualitatively. A purposive sample of 39 patients – 23 who felt coerced on admission and 13 who did not – were invited to take part in the interviews.

Out of the 270 patients who completed the MPCS, 91 (34%) had a total score of 3 or more and were therefore considered coerced. The majority of patients who felt coerced (91%) believed they needed help for their mental health problem. However, they held alternative treatment (day hospital, crisis houses, community treatment, for example) to be preferable to hospital treatment, which they regarded as restrictive rather than therapeutic. A total of 91% of coerced patients did not feel that they participated sufficiently in the admission process, and 57% did not feel that the staff involved in their admission and treatment cared about them or respected them.

Patients who did not feel coerced reported opposing experiences: they felt a need for hospital treatment (provided by confinement in hospital); they felt included in the admission and treatment process; and they felt respected and cared for.

9. Katsakou C, Rose D, Amos T, et al. (2012) Psychiatric patients' views on why their involuntary hospitalisation was right or wrong: a qualitative study

Outline: this is a good qualitative study (++), in which 59 patients (of 69 asked) from 22 hospitals agreed to be interviewed about their perception of having been ‘sectioned’ (involuntarily admitted). Patients were interviewed between 3 months and 1 year after index admission, and always after discharge. The sample was purposive to reflect positive or negative response to a question applied 3 months after admission: ‘Today, do you find it right or wrong that you were involuntarily admitted?’ (p1170). The study aimed to understand perspectives on involuntary admission (rather than frequency of such admission).

Results: 28 patients were generally positive about IA (involuntary admission); 19 were negative about IA (7 of whom had reflected on the necessity but decided it was wrong) and 12 were ambivalent. Some had changed their minds over time.

Within the sample:

- Total 90% had felt unwell or at risk at admission. Experience to back this included taking an overdose, dramatic mood changes (distress, feeling frantic or elated), risky behaviour and recognising themselves as being aggressive or argumentative.

- Total 92% felt out of control during hospitalisation: this entailed not being informed or involved in the decision to section, informed of their rights or treatment alternatives. ‘They never told me why I was sectioned, it’s like taking you and locking you up, never telling you why you are being locked up! I felt like a prisoner!’ (participant 38, ‘negative’ group) (p1172–3). Many of this group recalled coercion, restraint and forced medication.
- Total 63% felt the need to avert risk and feel safe in hospital: this included most of the positive group, but others also recognised the ‘need’ for help with social welfare and housing.
- Total 53% felt the need for non-coercive treatment: although 89% of negative view-holders believed they needed help, they did not see the need for such intensive and coercive treatment and felt that community services should have been able to support them.
- Total 42% felt an ‘unjust infringement in autonomy’: 74% of patients with a negative view found the involuntary admission had meant a huge and unnecessarily harsh interruption in their lives, interrupting work and family commitments.

In conclusion, though most involuntary patients recognised the need for some help, and felt unwell, it was the forced and coercive aspects of admission, and the failure to consider alternative options, that they objected to.

10. Manktelow R, Hughes P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland

Outline: although approved social workers (ASWs) have now been superseded by AMHPs, 1 somewhat old study of ASWs in Northern Ireland was identified. Manktelow et al. (2002) is a good quality (++/+) mixed methods study which used a variety of methods to explore the practice of ASWs in Northern Ireland from the different perspectives of stakeholders, using survey data from ASWs, focus groups with users and carers and interviews with mental health service managers. A survey included 243 ASWs (84% of total); 2 focus groups included 17 service users, 12 of whom had been sectioned by

ASW (1–5 times); while a third focus group included 13 people with intellectual disability and mental health problems. Five mothers and 1 sister caring for a person who had experienced ASW detention formed a further focus group.

Results: findings from ASWs reflected their difficulties in making an application for admission to hospital for an assessment (which was required in Northern Ireland if the nearest relative objected); difficulties in contacting and consulting other professionals; difficulties in interviewing the person in a suitable manner and in forming a judgement. In Northern Ireland, if a relative objects, a second ASW must be present. More than half said the main difficulty in conducting the assessment arose from the person being too disturbed to engage. Forming a judgement was made more difficult because GPs were often not available: only 14% of ASWs said the GP was present in 80–100% of interviews, and 41% reported difficulty in contacting the GP. The GP presence is not mandatory, but ASWs reported wanting help in assessing a person they might never have met before. Arranging transport or police help was also problematic. ASWs were also required to complete a social circumstances report within 14 days when a person was admitted by a relative: this entailed considerable effort to engage with carers, the GP and others, and might have little influence.

Users expressed concern about the nearest relative's ability to get them 'put out of the way' (p456), and some suggested an advocate other than an ASW was needed. While some recognised that the ASW had tried to be supportive, and ASWs said they waited with the person for assessment at the admitting unit, none of the users recalled this, and many said they were left alone for 2 hours or more, frightened and with no information or support. A lack of community alternatives to admission was recognised by users.

Carers felt strongly that they should not have the responsibility of having to sign the application, but were often forced to do so out of concern for their loved one.

This study is included for information only, as it does not reflect the current situation in England. However, the findings are consistent with those of (Campbell 2008 +/+): see Evidence statement HA8 below.

11. Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute inpatient admission

Outline: this is a qualitative study of moderate quality (+) which uses a specially designed, 17-item, non-standardised interview schedule, with 44 participants (of 90 considered) who had been admitted to an acute ward in a single mental health trust for at least 2 weeks.

Results: the study found that participants' beliefs on admission fell into 3 categories – positive, negative and uncertain – and their sample was designed to include representation from each group. Among positive beliefs was the view that hospital was a safe haven and the best place to be assessed and to recover: this belief was reinforced by confidence from previous admission experiences for some who had connected with good and kind mental health staff and with other patients experiencing similar mental health problems, and recognition that admission would provide the best opportunity to rest. The authors conclude that these findings suggest that service users can be helped to reconsider their beliefs through genuine, consistent and empathic relationships, thereby improving their perception of admission.

Those with negative beliefs (12 respondents) did not believe admission was in their best interests. A woman with 5 previous admissions said that every time she informed community staff that she was feeling unwell, admission was always the first option offered, so she had thought about not providing an honest assessment of her mental health. Negative beliefs were also reinforced by staff who were pessimistic, poor listeners and had little time to engage with service users. Four women in this group felt cynical about interventions, and felt they would never be fully well again.

Of the 'undecided' or neutral, 6 women with more than 2 previous admissions stated that the benefit they received from being on the ward was outweighed by anxiety about what would happen to them after discharge in terms of having to return to the pressures at home. The authors conclude that these findings suggest that service users can be helped to reconsider their beliefs through genuine, consistent and empathic relationships, thereby improving their perception of admission.

12. Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital

Outline: this good quality study (++) is a participant observation study of Mental Health Act (MHA) assessments which included informal and in-depth interviews with the practitioners involved, and follow-up interviews with the people who were assessed (20 candidate patients and 1 carer). The aim of this qualitative study was to describe the non-clinical and extra-legal influences which affect professionals' decisions about compulsory admission to psychiatric hospital. A grounded theory approach was used to collect data.

The fieldwork was conducted across 5 teams: 2 hospital-based social work teams in outer London, 2 community mental health teams (CMHTs) and an out-of-hours emergency team in inner London. These different contexts provided a good range of working environments (both hospital- and community-based), and were selected on account of their vastly different sectioning rates. Twenty assessments were observed in total, 10 in each borough.

Results: factors found to lower practitioners' threshold for compulsory admission were work pressures and resource constraints (which encouraged a more pragmatic approach), and a lack of alternatives to inpatient care. These factors all impede safe continuity of care for a person in the community undergoing a crisis. Factors which were more likely to increase the compulsory admission threshold were support across the team in decisions to care for someone in the community, an ethos which encourages compulsory admission to be seen as a 'last resort', wherein peers may ask each other informally to justify their commitment decisions, and high bed occupancy rates on acute psychiatric wards.

13. Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003

Outline: this is a moderate quality (+) qualitative study which aims to assess the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. As part of a larger study (views of carers and professionals are reported elsewhere – Ridley 2010), 49 service users with experience of compulsion under the MHCT Act were interviewed about their experiences and perceptions of treatment under this legislation. Interviews were face to face and semi-structured and took place at 2 different stages approximately 12 months apart. They were conducted by pairs of interviewers, 1 trained peer researcher, who was a mental health service user, and a professional researcher.

Results: the general consensus from the interviewees was that coercion was unwelcome, with 42% judging compulsion to have been ‘completely unnecessary’ at Stage 1. However, over half (52%) of the 39 people interviewed at Stage 2 reflected that compulsion had been the right thing for them at the time. Overall, service users felt that there was an increased chance for their voices to be heard, but that ultimately they did not have any increased influence over professionals’ decision-making. The MHCT strives to perpetuate a person-centred and holistic approach, but unfortunately the findings indicate that treatment under compulsion is still largely equated with drug therapies.

The paper is only relevant to this guideline in part. Not only is it only strictly relevant to 1 country in the UK, but as it addresses all compulsory treatment under the MHCT Act, it does not exclusively deal with hospital admission. The Act introduced legally enforceable community compulsory treatment, and while 15 service users of this sample were detained in psychiatric hospital, the majority of the people interviewed were living in their own home or supported housing, having received a Community Treatment Order. Although no evidence statement is developed from this paper, the findings accord with the sense of powerlessness, and not being listened to, demonstrated within other evidence. The participants also questioned whether compulsion (in detention or treatment) was necessary, and this may reflect a lack of alternatives.

14. Scior K, Longo S (2005) Inpatient psychiatric care: what we can learn from people with learning disabilities and their carers

Outline: this qualitative study of moderate quality (+) is about the experience of people with learning disability and their carers of inpatient psychiatric care. Although the study does not relate specifically and solely to admission, and is somewhat small, especially when there is potential for comparison (specialist vs generic wards), it is included as this is an important group. The sample included 29 service users: 14 on generic wards, with 15–25 beds, 50% of whom were admitted formally under the MHA; 15 on specialist LD assessment and treatment units, 6 of whom were admitted formally under the MHA. Ten carers of users admitted to each setting (20 in total) were interviewed.

Results: service users' views on admission were often related to the environment and social network they were admitted into. For some, admission was a respite and offered more social alternatives (to home): 'I saw lots of people there. I talked to the nurses. I liked their drinks and food and everything. I wish I was back there again' (GenSU11) (p25). Within the generic ward, service users appeared to find more (a wider range?) of patients they could talk to (consistent with the fact that the specialist units had a significant proportion of people with challenging behaviour). On the other hand, staff on generic units were said to be less attentive, interested or even present. Learning disabled patients in generic settings felt more vulnerable and disempowered and experienced less freedom.

Carers reported the difficulty of accessing mental healthcare. Carers of people in general hospital did not trust staff to understand, support or protect their loved one: they sometimes felt medication was too freely used to keep the person quiet. They felt more involved in specialist units, and more 'welcome' to visit and help the person, and to be involved in discussion of care and treatment. In terms of assessment at admission and in the early days of the stay, carers felt that in the generalist ward, insufficient attention was made to the daily physical needs they had supported (for example, help to dress, ensuring the person ate all their food), and this was exacerbated by staff’s lack of involvement of carers. There was also a tendency noted in generalist settings to attribute learning disability patterns of behaviour to mental illness.

15. Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association?

Outline: this cross-sectional study of moderate quality (+/+) sought to explore the relationship between perceived coercion and therapeutic relationships with mental healthcare staff.

Results: although perceived coercion was associated with involuntary admission, the logistic regression analysis suggested that the quality of therapeutic staff relationships modified the perception of coercion, even among involuntary patients. Hospital admission was seen as more coercive when patients viewed the admitting clinician negatively. However, it is not clear precisely which clinicians were involved – i.e. it could be ward staff generally, or an individual, familiar or previously unknown to the incoming patient – or it could be that a person’s general experience of mental healthcare staff is the relevant factor.

Other studies have suggested that involuntary admission causes poor relationships, but this study suggests that we cannot take for granted that involuntary admission will enhance perceived coercion (i.e. through causality). Improving therapeutic relationships can mitigate perceived coercion, and may have an impact on patients’ experience of treatment, adherence to treatment and even outcomes.

16. Smith V, Chouliara Z, Morris P et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients’ perspectives

Outline: this is a rare qualitative study, rated (+), of the experience of 21 adult women (18-41 years old) admitted to a specialist ward for treatment of anorexia nervosa.

Results: admission to the unit was experienced as a ‘handing over of control’ of an illness which had governed the lives of the interviewees. This could be experienced as a relief or as a threat to personal safety and integrity. ‘It was very scary thinking if I come into treatment I have to hand over all control the eating disorder gave me. That made me feel very unsafe’ (participant 3) (p5). While interviewees realised the need for control – over food behaviours, meals, eating, etc. – it contravened their ‘coping strategies’, as exercised before admission. Leaving home was also traumatic: ‘I had gone from a stress-free home, you are just living with your illness … Then I came in here … I had a headache for the whole first week because it was so much’ (participant 11) (p6).

It was clear that handing over control was in conflict with the way people with this condition had lived and coped in the community. Some participants thought that they should be more involved in treatment reviews, decisions and targets, which suggested that they were not routinely involved in such matters.

17. Valenti E, Giacco D, Katasakou C et al. (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients

Outline: this is a well-conducted qualitative study with a high quality rating (++) of the experience of people admitted involuntarily to inpatient mental health settings, which appears to use the same sample as that from Katsakou et al. (2012) above. The study aims to establish the values that are important to them at this time. The recruited sample included 59 people, discharged with ‘index’ admission between 3 and 12 months previously (mean length of stay this admission 68 days – SD 58.9) from 22 hospitals. As people were interviewed after discharge, it is difficult to distinguish experience of admission from that of the whole hospital episode.

Results: people highlighted the following perceptions or consequences of being sectioned:

- Lack of control over decision-making on treatment and sense that their rights were violated (92% reported this). Total 41% felt they were ‘overpowered’ by staff and treated ‘paternalistically’: ‘Well, it’s the way the staff … they sort of overpower you … they tell you what to do all the time’ (participant 2, male, aged 24).

- Medication was given almost immediately without explanation or consent.
- Having no freedom to go out or to do things (not having books or computer, for example) was a considerable burden for 54%.
- Total 56% reported a lack of information on involuntary hospitalisation and treatment, but 17% said they had had some involvement in decision making on treatment.
- Respect from staff, including willingness to listen to the patient, emerged as an important value. This value was especially important because people were dependent on staff, having little autonomy or influence. Total 36% felt labelled and stigmatised by staff: ‘oh leave her, she’s only faking it anyway’ (participant 40, male, aged 41) (p834).

A total of 86% agreed they had been unwell on admission, with most agreeing they had needed treatment and 27% needing a place of safety; 56% agreed they had been a risk to self or others, including their children. However, patient accounts suggest that their values of freedom, safety and respect may not be consistent with staff values or behaviour.

18. Van Den Hooff S, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. (The included studies are qualitative, not on effectiveness)

Outline: this exploratory qualitative synthesis rated moderate (+) aimed to explore the literature on patients’ and professionals’ perspectives on involuntary admission. The question the review aimed to answer is: Which quality themes are reported by patients and professionals during involuntary admission?

Five different databases were searched: Academic Search Elite, Cinahl, Medline, PubMed and Social Science Journals. All studies had to have the patient or healthcare professional's perspective of coercion during involuntary admission or the evaluation of the admission process as a central focus. Both qualitative and quantitative studies were included.

Twenty-two articles were included in the final synthesis and were arranged into categories of inside and outside perspectives of the patient and the professional.

Results: most experiences of patients can be traced back to 1 core experience: Am I being listened to?

Negative experiences reported by patients included 'not being listened to', as well as commonly cited experiences of powerlessness and humiliation. Positive experiences for patients included being guarded and seen (and, of course, being listened to). Patients expressed a desire to feel safe, protected and cared for – these feelings enhanced respect, an ethical principle of prime importance for patients undergoing involuntary admission.

The major limitation of this review is that the studies included were not assessed for quality. Studies appear to have been included solely on the basis of whether they match the inclusion criteria or not, with no attention to study design or quality.

Evidence statements

HA1	There is good evidence from 1 mixed methods study (Katsakou 2011 ++/++) and 1 cross-sectional study (Bindman 2005 +/+) that people admitted to mental health units may feel coerced into accepting admission, whether or not they are formally admitted under the Mental Health Act. There is also evidence (Bindman 2005 +/+) that people do not necessarily know whether they are voluntary or involuntary patients, and may suspect they will be sectioned if they do not cooperate. Although most felt they needed help, they held alternative treatment to be preferable and less restrictive, and did not feel respected or cared for. Those not reporting a sense of coercion felt included in the admission and treatment process, respected and cared for.
HA2	There is moderately sound evidence from a cross-sectional study (Bindman 2005 +/+) that perceived coercion at admission is not associated with poor engagement in follow-up care after discharge.
HA3	There is moderately good evidence from 1 cross-sectional study (Sheehan and Burns 2011 +/+) that the relationship between involuntary admission and therapeutic relationships with staff is not necessarily causal – i.e. that sectioning a person need not damage relationships.

	This means that fostering therapeutic relationships may mitigate perceived coercion.
HA4	There is moderate quality evidence (Nolan et al. 2011 +) from a qualitative study that admission is experienced by some people with mental health problems as positive, if their experience of services is connected with good, empathetic and kind mental health staff, contact with other patients experiencing similar issues, and recognition that admission would provide the best opportunity to rest and recover. For other patients, a negative perception of services, staff and the value of past treatment will impact on their view of admission.
HA5	There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++) that most people admitted under the Mental Health Act recognised that they were unwell (10 of the total 59 did not feel this), and 63% of the total sample felt the need for a safe haven. However, 92% (54 people) experienced involuntary admission as a loss of personal autonomy similar to 'imprisonment' and some recalled coercion, restraint and forced medication. People felt that less coercive treatment given in the community would be less 'unjust', and less disruptive of work and other commitments.
HA6	There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by: • improved involvement in, information about, and explanation of decisions and treatment • being listened to • having some concessions to freedom of movement and activity • staff showing respect to people and listening and responding to patients' concerns • sense of safety, being protected and being cared for by staff.
HA7	There is evidence from a relatively old participant observation study (Quirk et al. 2003 ++) of assessment for compulsory admission that community mental health assessment is more likely to lead to compulsory admission when staff experience high workloads, resource constraints and a lack of alternatives to inpatient care. Being able to offer higher support in the community, and a shortage of inpatient beds, appeared to discourage compulsory admissions as the outcome of 'last resort'.
HA8	There is moderate evidence of indirect relevance (based on Northern Ireland law) from a mixed methods study (Campbell 2008 +/+) that detentions under the Mental Health Act in Northern Ireland may not respect people's privacy, dignity and rights (to explanation and information, for example about appeals to MHRT). Detention might be rescinded if such an appeal was made, throwing doubt on the need for detention. MHRT reports were often poorly documented, and failed to take account of contributions from family carers. Family carers may not wish to be involved in decisions about use of detention, but might be pushed into this role due to poor availability of ASWs.
HA9	There is evidence from 1 moderately good qualitative study (Smith et al. 2014 +) that people admitted for treatment for anorexia nervosa

	experienced admission as a ‘handing over of control’ which could be experienced as threatening to existing coping strategies. This raised conflicts and could be felt as threatening to personal safety and integrity. The patient experience of involvement in decision-making may be different from that in other mental health settings.
HA10	There is evidence from 1 small qualitative study (Chinn et al. 2011 +) that people placed in specialist units for people with intellectual disabilities (IDs) with mental health problems were probably more likely than those without IDs to be placed at a distance from their homes. This made contact with families, community resources and minority language speakers more difficult, and increased dependency on staff. People detained might experience the detention as punishment, and some residents felt belittled and intimidated by staff.
HA11	There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that people with ID admitted to mainstream mental health inpatient units: • sometimes viewed the admission as motivated by respite for their carer(s) • did not always know why they were being admitted • felt disempowered and vulnerable, especially in inpatient units not designed for people with ID. On the other hand, some people enjoyed the wider range of social contact on the generic wards.
HA12	There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that carers of people with ID eventually admitted to mainstream mental health inpatient units: • had experienced great difficulty in accessing mental health assessment and care • viewed the mainstream wards as ‘depressing’, ‘intimidating’ or ‘frightening’ • did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care • thought staff did not properly distinguish mental health and ID issues • did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and ID services and lack of understanding among mental health staff of person-centred care for people with ID, were echoed by ID service providers (Donner et al. 2010).
HA13	There is moderate quality evidence from a small cross-sectional study in Birmingham (Commander et al. 1999 +/-), that black and Asian patients are more likely than their white counterparts to be compulsorily admitted, are viewed by service providers as more likely to display negative behaviour such as hostility, were more likely to be admitted with police involvement, and were less satisfied with the admission process.
HA14	There is good evidence from a high quality qualitative sub-study (Farrelly et al. 2014 ++) of the content of joint crisis plans that service users who become unwell want: • to be treated with respect, with all their needs considered

	• staff to be able to distinguish between behaviour and attributes that relate to mental illness, and those which do not; familiarity is a factor • to have continuity of staff, and consistency and clarity, e.g. in the treatment plan • to be involved and in control as far as possible; this is more likely if the person is admitted voluntarily • other alternatives to hospital admission to be considered, as well as non-clinical interventions that might help (e.g. yoga), possibly delivered during the hospital episode to alleviate boredom.
HA15	There is good quality evidence from a case control study (Hunt et al. 2013 ++/+) that people admitted to psychiatric hospitals are at high risk of suicide within the first 7 days of admission (40% of the sample within 3 days). Factors associated with predictable risk of suicide are: • being off the ward (on leave or having absconded) • having a history of self-harm • having experienced adverse life events in preceding 3 months • having had a mental illness for less than 12 months • being male.
HA16	A moderate quality trial (Goldberg et al. 2013 +/+) of a ward developed to offer specialist care to older people with dementia or delirium needing acute medical care, compared with general or geriatric wards in the same hospital, failed to find any significant differences in the primary outcome (days spent at home in the 90 days following admission). There was some observational evidence that inpatients were more active and engaged on the specialist ward, and carers were significantly more satisfied with care in that environment.

Included studies for the admission review question (full citation, alphabetical order)

Bindman J, Reid Y, Szmukler G, et al. (2005) Perceived coercion at admission to psychiatric hospital and engagement with follow-up. Social Psychiatry and Psychiatric Epidemiology 40(2): 160–6

Campbell J (2008) Stakeholders' views of legal and advice services for people admitted to psychiatric hospital. The Journal of Social Welfare & Family Law 30: 219–32

Chinn D, Hall I, Ali A, et al. (2011) Psychiatric inpatients away from home: accounts by people with intellectual disabilities in specialist hospitals outside their home localities. Journal of Applied Research in Intellectual Disabilities 24: 50–60

Commander M, Cochrane R, Sashidharan S, et al. (1999) Mental health care for Asian, black and white patients with non-affective psychoses: pathways to the psychiatric hospital, inpatient and after-care. Social Psychiatry and Psychiatric Epidemiology 34: 484–91

Donner B, Mutter R, Scior K (2010) Mainstream inpatient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities. 23: 214–25

Farrelly S, Brown G, Rose D, et al. (2014) What service users with psychotic disorders want in a mental health crisis or relapse: thematic analysis of joint crisis plans. Social Psychiatry and Psychiatric Epidemiology 49: 1609–17

Goldberg S, Bradshaw L, Kearney F, et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial (NIHR TEAM trial). BMJ 347: f4132

Hunt I, Bickley H, Windfuhr K, et al. (2013) Suicide in recently admitted psychiatric inpatients: a case-control study. Journal of Affective Disorders 144: 123–8

Katsakou C, Marougka S, Garabette J, et al. (2011) Why do some voluntary patients feel coerced into hospitalisation? A mixed-methods study. Psychiatry Research 187: 275–82

Katsakou C, Rose D, Amos, T et al. (2012) Psychiatric patients’ views on why their involuntary hospitalisation was right or wrong: a qualitative study. Social Psychiatry and Psychiatric Epidemiology 47: 1169–79

Manktelow R, Hughes, P, Britton F, et al. (2002) The experience and practice of approved social workers in Northern Ireland. British Journal of Social Work 32: 44–61

Nolan P, Bradley E, Brimblecombe N (2011) Service users' beliefs about acute inpatient admission. The Journal of Mental Health Training, Education and Practice 6: 142–9

Quirk A, Lelliott P, Audini B, et al. (2003) Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital. Journal of Mental Health 12: 119–30

Ridley J, Hunter S (2013) Subjective experiences of compulsory treatment from a qualitative study of early implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003. Health & Social Care in the Community 21: 509–18

Scior K, Longo S (2005) Inpatient psychiatric care: what we can learn from people with learning disabilities and their carers. Learning Disability Review 10: 22–33

Sheehan K, Burns T (2011) Perceived coercion and the therapeutic relationship: a neglected association? Psychiatric Services 62: 471–6

Smith V, Chouliara Z, Morris P et al. (2014) The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients' perspectives. The Journal of Health Psychology 2016 Jan;21(1):16-27. doi: 10.1177/1359105313520336. Epub 2014 Feb 6

Valenti E, Giacco D, Katasakou C, et al. (2014) Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. Journal of Medical Ethics 40: 832–6

van den Hooff S, Goossensen A (2014) How to increase quality of care during coercive admission? A review of literature. Scandinavian Journal of Caring Sciences 28: 425–34 (The included studies are qualitative, not on effectiveness)

2.2 Discharge from inpatient mental health settings into the community or care home

Introduction to the review questions

The purpose of the review questions was to examine research about the effectiveness and cost-effectiveness of specific interventions or approaches to support people with mental health problems during discharge from mental health inpatient settings to home or care home. The questions also aimed to consider research which systematically collected the views and experiences of discharge from people using services, as well as those of their carers and those of care and support staff involved in discharge. (In line with the scope, transitions involving inpatient general healthcare settings are not addressed by this review question.)

From 23 papers fully reviewed and critically appraised, we found 12 papers that evaluated discharge interventions using randomisation techniques, although some of the samples were small and the study was a ‘pilot’ (with no follow-up study). At first screening, there was some overlap in material used with the subsequent review question (review question 6 on reducing readmissions): the criteria by which we allocated the material was the primary outcome, and the point of time at which the intervention was applied (as part of discharge or not).

We also found 15 papers that had been identified in some way as reviews or systematic reviews, and that might be relevant to either of these questions. We retrieved these in full text, but only 1 (Omer et al. 2014) met methodological criteria, and was included in the discharge evidence review. Reasons for discarding reviews included poor review quality (limited searches, poor studies), a lack of ‘fit’ with our topic and less than 70% of studies meeting our inclusion criteria (date, population, intervention delivered at transition). We extracted any relevant studies not already identified in the main search for individual inclusion in review questions 5 and 6.

In including papers, we found that discharge interventions were likely to begin before the point of discharge, and might continue for some time after discharge. The 13 included effectiveness studies (12 RCTs, 1 review) were of moderate to good quality: 3 had high internal validity, 2 had low internal validity because of very small samples, and the rest were of moderate quality.

We found 5 papers on the views and experiences of people involved in discharge. Two were of high quality, 2 of moderate and 1 of poor internal validity.

Review question for evidence of effectiveness

5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

Review questions for evidence of views and experiences

The review questions considered in relation to views and experience of discharge were:

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of specific services, interventions or approaches through which people are supported through safe and timely transfers of care from inpatient mental health settings to community or care home settings
- identify models and approaches to care, assessment and discharge planning and associated outcomes
- assess the cost-effectiveness of interventions designed to facilitate transfer of care from inpatient mental health settings
- identify which services or aspects or components of services improve discharge
- identify and evaluate variation between people admitted as formal and informal patients, and opportunities for improvement in approaches to discharge for people subject to the provisions of the Mental Health Act, Ministry of Justice restrictions or Mental Capacity Act
- consider the impact of out-of-area placements (placement in specialist services or to services with available beds) on the process of discharge from inpatient mental health settings.

For the views and experiences review questions, the protocol sought to identify studies specifically relating to discharge from mental health inpatient settings that would:

- describe the self-reported views and lived experiences of people using services, their families and carers about the care and support they receive during transition from inpatient mental health settings to community or care home settings
- consider specifically whether people using services and their families and carers think that their care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and where appropriate, housing, education and employment services
- consider what service users, families and carers think supports good care during transition, and what needs to change
- describe the views and experiences of people delivering, organising and commissioning mental and general healthcare, social care (and other

relevant services such as housing, employment and education) about the care and support provided during transition from inpatient mental health settings to community or care home settings

- collect evidence on key practice and workforce issues which may impact on transitions and should be considered within the guideline
- highlight aspects of the transition from inpatient mental health settings to community or care home settings which work well, and are i) personalised and ii) integrated, as perceived by practitioners, managers and commissioners.

Population

All children, young people and adults in transition from inpatient mental settings to community or care home settings and their families, partners and carers. Self-funders and people who organise their own care and who are experiencing a transition from inpatient mental health settings to community or care home settings are included.

Families and carers of all children, young people and adults in transition between inpatient mental settings and community or care home settings.

Health and social care commissioners and practitioners involved in delivering care and support to people during transition between inpatient mental health settings and community or care home settings; approved mental health professionals; advocates; personal assistants engaged by people with mental health problems and their families. General practice and other community-based healthcare and mental health practitioners; psychiatrists and ward staff in inpatient mental health settings (especially those with a role in admission and discharge procedures). Where relevant, the views of housing, employment and education practitioners and police and ambulance personnel involved in supporting people during transition into or from inpatient mental health settings were considered.

This is a whole population topic. The population of interest included those with protected characteristics, and people without stable accommodation; people of minority ethnic background; people with co-morbidities including substance misuse; people with communication difficulties, sensory impairment or learning difficulties; people treated under a section of the Mental Health Act (and/or people under Ministry of Justice restrictions and people treated under Mental Capacity Act), and people placed out of area (see Equality impact assessment).

Intervention

Personalised and integrated assessment, discharge planning and care and support. Usual treatment compared to the effectiveness of an innovative intervention. Aspects or components of models and approaches which improve discharge. Discharge of people treated under Care Programme Approach, provisions of Mental Health Act (including s117), Mental Capacity Act and Ministry of Justice restrictions. Access to reviews and mental health tribunals for people detained under the Mental Health Act.

Setting

Service users' own homes, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes; care homes for children; and all inpatient mental health settings for adults, older people, children and young people; specialist units for people with mental health problems and additional needs.

Outcomes

User- and carer-related outcomes, such as user and carer satisfaction; quality of life; quality and continuity of care; independence, choice and control; involvement in decision-making. Also suicide rates and years of life saved. Service outcomes such as use of mental health and social care services, delayed transfers of care from inpatient mental health settings, length of inpatient stay, readmissions and need for unpaid care and support.

The study designs included for the effectiveness question on discharge from inpatient mental health settings were:

- systematic reviews of studies of different models of assessment, care planning and support at discharge

- RCTs of different approaches to discharge assessment and care planning and support
- economic evaluations
- quantitative and qualitative evaluations of different approaches
- cohort studies, case control and before and after studies
- mixed methods studies.

The study designs relevant to the views and experiences questions were expected to include:

- systematic reviews of qualitative studies on this topic
- qualitative studies of user, carer and practitioner views of social, mental health and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational, cohort and cross-sectional survey studies of user, carer and practitioner experience.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care, and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units‘ or hospitalised patients with mental disorders, and b) the process of ‘transition‘, discharge, admission to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept used focused the search on particular study designs (see above) to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups; economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also carried out.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The search was restricted to studies published from 1999 onwards, on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken (January 2015) will be updated in March 2016 to identify new publications which meet inclusion criteria and may alter recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder)

- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions)
- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, randomised controlled studies, and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 members of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions. In some cases it was decided that the search output was too large to review in full text, and that we should select according to relevance and methodological quality (for example, by prioritising UK views studies if there was a good quantity of views studies).

When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. (Where evidence was very sparse, which did not apply to the discharge topic, the team revisited the set to see whether any of the material not retrieved in full text might be relevant – for example qualitative studies from outside the UK.) The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

Results

In our initial screen (on title and abstract), we found 296 studies which appeared relevant to the review questions on discharge from mental health inpatient settings. Following a review by the team, we ordered full texts and reviewed 98 papers for final inclusion. At full text review, a further 75 papers were excluded from full appraisal as the paper was found to be not on topic, descriptive rather than evaluative, or reporting views but not on discharge. Twenty-three papers were data extracted and critically appraised. Five papers were not included in the tables or summaries as they were assessed as being of very low quality and did not score positively in terms of internal or external validity. Eighteen papers were included in this summary.

Effectiveness studies were restricted to 1 systematic review and 12 RCTs. For views and experiences research, studies from a UK setting were prioritised, and 5 were fully assessed and included in the review. Two papers reported cost-effectiveness data (n=2); Simpson et al. (2014) (which was not included in the general evidence review) and Chiverton et al. (1999).

The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables.

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies are described in 2 sections, the first about the effectiveness of interventions, and the second on views and experiences: an alphabetical list of studies is included at the end of the section.

Studies reporting effectiveness data (n=13)

1. Chiverton P et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes

Outline: this US RCT (rated +/+) is described as a 'demonstration project' and sought to demonstrate it was worthwhile funding this service. The intervention trialled is transitional case management provided by (trained) inpatient psychiatric nurses to people discharged from the unit for up to 3 months. 'Case management is a purposeful interaction coordinated among multiple providers ... with the intention of meeting the client's needs' (p47). Nursing actions included a minimum of 3 home (or care home) visits and 5 telephone contacts, based on patient need. Care plans designed for the project included medical stability, medication adherence, symptoms sufficiently controlled to maintain discharge, sleep, suicide risk and violence potential reduced, attendance of outpatient services. Nurses provided education to patient and family on how to implement the plan of care. Support could be very practical, for example arranging food for a family when the parent had no money and would have sought admission. The nurse care managers would also visit those readmitted and redesign the discharge plan.

Results: in relation to the intervention (transitional case management for 3 months post discharge), there was evidence of mental health improvement (on BDI but not on MMSE), high patient and carer satisfaction and fewer readmissions and ED use within the 10 weeks from discharge. However, no comparative ratings were made on the first 2 outcomes above – TAU patients' records were investigated only for service use, so the other findings cannot be attributed to the intervention. The main objective comparative measure is service use (as this was taken from hospital records for both groups). It is from the US and also somewhat old, but it is an innovative approach to have inpatient psychiatric nurses visit patients in their own homes.

Between discharge and end of the project, those in the intervention group showed some improvement on the Beck Depression Inventory (p=.0001), but those in TAU group were not measured, and no effect size was given. Nine patients in the intervention group and 16 patients in TAU were readmitted during 10 weeks. One patient in intervention group, and 18 in the control group were seen in emergency department during the 10 weeks. The survey (27% of the intervention group responded) showed 96% of these were very pleased with the services received; 95% of carers were very pleased. TAU group satisfaction was not surveyed.

This study also conducted an economic evaluation. These results are presented in the section ‘Studies reporting evidence of cost-effectiveness’.

2. De Leo D and Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care

Outline: this very small Australian RCT, rated -/+, randomised 60 men with a history of suicide attempts and psychiatric illness. The study drew on data showing high suicide rates among people recently discharged from inpatient psychiatric care. The aim of the study was to evaluate the potential role of providing intensive case management (ICM) for 12 months following discharge to reduce suicide among those who had previously attempted suicide. Intensive case management for 1 year included:

- weekly face-to-face sessions with ICM, at home where appropriate
- focus on problem-solving, improving help-seeking behaviour
- empowering clients to function in the community (for example accommodation and work)
- having same case manager throughout
- access to telephone counselling service, consisting of 2 calls per week from trained counsellors.

Other features of the intervention included small caseloads, emphasis on skills-building and empowerment, linkage and brokerage with other services. TAU patients were eligible to receive standard case management as well as GP and other psychiatric services (but no telephone counselling).

Results: there were no suicides in either group. Levels of depression (Beck Depression Inventory) and hopelessness improved significantly over the first 6 months, and levels of suicidal ideation dropped significantly at 6 and 12 months in the intervention group. Quality of life improved over the 12 months in the intensive case management group. Therapist–client relationships were significantly better on the Bond sub-scales at 6 and 12 months in the intervention group, and satisfaction with services (overall, professional skills, information, access and efficacy) were all significantly higher for these clients. However, the numbers remaining in the study at 12 months (in intervention group 14 and TAU 8) are too small to base conclusions on.

3. Dixon L et al. (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization

Outline: this study (rated +/+) describes a small US RCT (sample of 135) conducted among veterans in USA which uses a brief 3-month intervention to integrate people discharged from psychiatric inpatient care into community-based care and other services. The Brief Critical Time Intervention (B-CTI) is a 3-month intervention to integrate people discharged from psychiatric inpatient care into community-based care, social support and other services (based on a longer intervention). The intervention is delivered by a trained nursing or social work practitioner (unclear if an inpatient practitioner) and begins with meeting up before discharge, to establish rapport, develop goals, identify barriers and plan case management. Overall aims are to bridge the transition and facilitate engagement with community-based services. Systems coordination and psychiatric stabilisation, together with 2–3 other targets (from a list of 7 other possible targets, including life skills training, practical needs assistance) are selected. The B-CTI clinician conducts home visits after discharge (mean of 4.95 visits in first 30 days; 12.67 throughout 3 months – SDs were given). Fidelity to the model was rated independently.

Results: overall satisfaction with services did not differ, though participants in the B-CTI group reported receiving more help in making and keeping medical and mental health appointments, making family contact and community connections and receiving information on prescribed medications. Compared with controls, the intervention group had significantly fewer days between discharge and first mental health appointment: 3.5 vs 15 days (medians): 2.73

@ 95% CI, 1.80–4.15, df 1, p=<.001. A greater proportion of intervention group had 1 or more such appointments within 30 and 180 days (both given), and a greater number overall during that time (20.8 vs 10.08, effect size 3.24@ 95% CI 1.58–2.91, df 1, p=<.001). Participants in the B-CTI group reported receiving more help in making and keeping appointments for mental healthcare: difference 7.15 @ 95 CI, 2.99–17.14, df 1, p=<.001. Similar differences applied to appointments for physical healthcare. Within the QOLI, intervention group members described significantly higher levels of satisfaction with legal and safety issues (5.30 +/-1.5 vs 4.72 +/- 1.5, p+.026) and greater frequency of social contact (2.92 +/- 1.15 vs 2.40+/- 1.08, p=.013).

The study suggests that B-CTI targeted at point of inpatient discharge can help promote continuity of care. Changes to mental health were not identified, but patients did appear to have more contact with community health services, which is 1 definition of continuity of care.

4. Ebert D et al. (2013) A trans-diagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial

Outline: this high quality (++/+) RCT from Germany aimed to evaluate the effectiveness of a trans-diagnostic internet-based maintenance (TIMT) intervention. Four hundred participants, primarily with affective, neurotic, stress-related or somatoform disorders were randomised into 2 groups of 200: treatment as usual (TAU) or the intervention (TIMT+TAU) group. Those with psychotic diagnoses, alcohol or substance dependence, or at significant risk of suicide, were excluded from the study. Participants required access to a computer with an internet connection; however, internet literacy was not required as training was offered. Treatment as usual allowed all participants access to outpatient psychotherapy and standardised outpatient group-based face-to-face maintenance treatment. In addition to TAU the intervention group received 12-weeks of internet-based support which supported patients to integrate the skills they acquired during their inpatient stay into their daily routines.

During the last 10 days before hospital discharge those in the TIMT group created a personal development plan through face-to-face sessions. Participants were encouraged to include highly relevant personal goals, including details of how they would achieve them and barriers which might prevent them from doing so. Realisation of these goals were evaluated and monitored in the post-discharge period through a combination of personal web diaries, online peer support groups and online asynchronous support from a therapist.

Results: significantly more patients from the intervention group were in remission at each follow-up than in the TAU-only group. Intervention patients were 68% more likely to be remitted at 3-month follow-up than TAU-only patients (odds ratio=1.68), and they were more likely to be in remission at 12-month follow-up (odds ratio=2.21). After having achieved remission, significantly more intervention participants were still remitted at 12-month follow-up and achieved recovery compared to TAU-only patients. Intervention participants were 73% more likely to be recovered at 12-month follow-up than TAU-only patients (odds ratio=1.73). The study's main limitations were sample exclusions, its reliance on self-reporting of outcomes, and attrition (missing values: at 12 months up to 22% of the control and 15% of the intervention group did not provide data).

5. Forchuk C et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and 'no fixed address'

Outline: this moderate (+/-) quality pilot cluster RCT from Canada aimed to develop and test an intervention to prevent homelessness associated with discharge from psychiatric hospital to no fixed address. The sample size was very small (n=14). Participants aged between 18–75 with a diagnosis of serious mental illness were randomised either to receive treatment as usual (n=7) or the intervention (n=7). Those in the intervention group received a visit from a community housing advocate from the Canadian Mental Health Association (CMHA) immediately. Ordinarily, high caseload and backlog means that around half of the patients who are referred are discharged before the housing advocates can see them. Participants in the intervention group also received a streamlined process of obtaining community start-up funds to cover rental deposits (the aim was to have this in 1 day).

Results: all individuals in the intervention group attained independent housing prior to, or within 2 days of, discharge and maintained housing when interviewed at the 3- and 6-month period. All but 1 individual in the control group did not attain housing and remained homeless at the 3- and 6-month period (Pearson c2, fisher exact, p<0.001). The exception joined the sex trade to avoid homelessness. Authors report that the findings of the pilot were so convincing that they stopped randomising to the control group and they planned to routinely implement the intervention to this population. The study is of limited generalisability, due to tiny numbers, requirement to have ‘a secured source of income’ (not explained), and some stringent exclusions (people refusing treatment; people with substance misuse problems).

6. Hanrahan NP et al. (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions

Outline: this very small US pilot RCT of a transitional (90 day) post-discharge model is based on a very small sample (n=40), a short follow-up time (90 days) and limitations in implementation (by a single nurse), but although the study scores low on internal validity, the intervention may be generalisable (-/+ rating). The intervention group received TAU plus the care of a psychiatric nurse practitioner (NP) for 90 days post-discharge. The NP visited patients in hospital and at home within 24 hours of discharge, and was then available to the patient 24/7 via email and phone. The NP focused on managing risk of decline, problem behaviours, assessing and managing physical symptoms and preventing functional decline, promoting adherence to therapy and helping case managers understand an integrated mental and physical care approach. She could also prescribe repeat prescriptions.

Results: both groups showed some improvement in HRQOL, including in mental health aspects, over the 12 weeks of the study, and the intervention group (the authors’ suggest, but not convincingly) showed ‘clinically significant improvement’ in general health scores over the study. The intervention group

(IG) had significantly higher use of rehospitalisation (56%) compared with the control group (23.5%). 22% of IG had hospitalisations for medical care, compared with none in the control group. The IG showed a slightly lower, non-significant use of the emergency room for psychiatric and medical problems. It appears that the intervention increased readmissions – especially for medical care (non-psychiatric), though the numbers are too small to be conclusive. The limitations of a single NP working alone suggest that potential benefits could not be realised, though there may be evidence here that better surveillance, especially of physical health, led to more hospitalisation. This may of course be a positive outcome (and the study did not set out to demonstrate reduction in hospitalisation).

7. Herman DB et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge

Outline: this high quality (++/+) US RCT aimed to assess the effectiveness of a critical time intervention (CTI) model in reducing homelessness for persons with severe mental illness who were discharged from inpatient psychiatric treatment facilities. A sample population of 150 people who had a diagnosis of a psychotic disorder and were homeless at the index hospitalisation or who had experienced homelessness 18 months before admission were randomised to TAU or to the intervention (CTI) group. While the study initially aimed to recruit participants while they were in hospital, a change in policy meant that they were recruited before discharge from a transitional residence within the hospital grounds, and this meant that post-discharge housing arrangements were typically coordinated by discharge planning staff located at the transitional residence. These arrangements ranged from community residences and other structured programmes to supported apartments and independent housing, either alone or with family members. The following steps were taken to obtain data: when a participant had missed an interview, the interviewer documented where the participant had spent each night since the last completed assessment. In some instances when participants could not be directly interviewed, residential data was gathered from a family member, caseworker, or a close associate to the participant, who the researchers had been given consent to contact.

All patients received basic discharge planning services and access to psychiatric treatment. After discharge, participants in both conditions received a range of usual community based services, depending on the individual’s needs, preferences and living situation. In addition to the above, the experimental group received 9 months of CTI.

Results: logistic regression was used to model the impact of assignment to CTI on a dichotomous measure of homelessness over the 18 months. The odds ratio for the CTI group was 0.28 (95% CI=0.78–1.02), indicating that assignment to CTI was associated with a substantial reduction in the odds of homelessness in comparison with assignment to usual care, although the result was at the borderline of statistical significance. Among those assigned to CTI there were 1812 total homeless nights, while among those assigned to the control group, there were 2403 homeless nights. Using Poisson regression to control for baseline homelessness, this difference was statistically significant at the p<.001 level. Among those with complete follow-up data, 3 out of 58 (5%) of subjects assigned to the CTI group experienced homelessness during the final 3 follow-up intervals. Eleven out of 59 (19%) of subjects assigned to the control group experienced homelessness during this period. Using logistic regression to model the impact of assignment to CTI on homelessness during the final 3 follow-up intervals the odds ratio for treatment assignment was OR=0.22 (95%CI=.06º.88). Assignment to CTI was associated with a statistically significant 5-fold reduction in the odds of homelessness compared to assignment to usual care only.

8. Motto JA and Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention

Outline: this US RCT rated ++/+ also addresses suicide prevention among patients who have been discharged following an episode of depressive or suicidal illness. The investigators hypothesised that ‘lack of connectedness’ to care services was a probable factor in suicide. The intervention therefore targeted 843 discharged patients (of 3005 eligible) who refused an invitation to have ongoing care in a letter sent 30 days after discharge; 389 then had the intervention and 424 did not. The intervention consisted of making contact with the intervention sample with a number of letters of concern after discharge, asking if the person was OK and inviting a response if they wanted to make contact. They were personalised as far as possible, and worded differently, but made no demands for action or information from the patient. Contact letters were sent monthly for 4 months; then every 2 months for 8 months, and then every 3 months for 4 years – in total, 24 contacts over 5 years.

Results: deaths were confirmed through the official records. In the analysis, those accepting treatment were also used as a comparator. At 5 years, the contact group had the lowest rate of suicides of all 3 groups (in treatment 6.2%; contact by letter 3.9%; and no contact 4.6%). Plotting the 3 groups (total 2782 after removing non-suicidal deaths), the greatest advantage for the contact group is within the first 2 years after the intervention began – i.e. the years most associated with suicidal death. At 15 years, the study groups had converged (in treatment 8.2%; contact 6.4%; and no contact 5.7%), except that the suicide rate among those in treatment continued to exceed those in the trial (which authors suggest may indicate particular severity of conditions).

This intervention was explored in Bennewith et al. (2014): see below in the Views and experience section.

9. Naji SA et al. (1999) Discharging psychiatric inpatients back to primary care: A pragmatic randomized controlled trial of a novel discharge protocol

Outline: this UK RCT (+/+) of 343 patients discharged from psychiatric inpatient units aimed to evaluate a new protocol to improve engagement of newly discharged patients with primary care services. Discharge by the novel procedure involved the hospital doctor routinely phoning the GP and informing them of discharge, and ideally discussing the patient. In addition, an appointment within 1 week of discharge was arranged. A copy of the discharge summary was posted to the GP, and the patient was given a copy to deliver to the general practice as soon as possible. Conventional discharge did not require hospital doctor to phone the GP, and patients were asked to deliver the discharge summary and make an appointment with the GP themselves. Both groups had a 7-day supply of medication. A comparative assessment of mental health was undertaken at discharge and repeated at 6 months, when there was also assessment of readmission rates and time to readmission within that period, efficient transfer of discharge info to GP, speed and frequency of contact between patients and primary care services and continuation of medication.

Results: there were no significant differences between the arrival of discharge letters to the GP between the groups (2 days). The median number of GP appointments in the 6 months (apart from the initial one) for mental health-related matters was significantly higher in intervention group (3.0 and 95% CI 1–5 versus 2.0 and 95%CI 0–4, p=0.016). 33 (19.6%) of novel discharge patients were readmitted in the 6 months following hospital discharge, vs 48 (27%) of conventional discharge patients (7.4%, 95% CI for proportions, p=0.09). There were no significant differences in the mean time to readmissions. However, the protocol was not adhered to in all cases. Psychiatrists sometimes felt a call to GP was necessary despite the patient being in TAU group. Phone calls to the GP concerning the intervention group took place in 124 (86%) of cases, and appointments with GP were made in 103 (72%) of cases in the intervention group. Interviews (with GPs and junior psychiatrists) showed that both parties felt that phone contact was not always necessary, was inconvenient, difficult to implement and took time they couldn’t easily find.

10. Omer S et al. (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review

Outline: this review is a moderate quality (+) systematic appraisal of evidence comparing ‘continuity of care’ against ‘specialist’ systems of care. A continuity system was defined as one where care was provided by the same clinicians across inpatient and outpatient mental healthcare services. A specialisation system (possibly a rather ambiguous term in this context) was defined as system where care was provided by different clinicians in inpatient and outpatient services.

Results: 21 articles (from 17 unique studies) from a range of counties – Australia, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, UK and USA – were included in the review. No RCTs were identified. Thirteen non-randomised comparative studies compared outcomes of continuity and specialist systems; 3 survey studies investigated staff and patient views towards both systems and 1 qualitative semi-structured interview study on staff views was included.

The evidence suggests better outcomes and stakeholder preferences for continuity of care systems. However the quality of existing evidence was insufficient to draw definitive conclusions. The review had considerable limitations regarding the lack of robustness of the study designs which had been included: individual studies would not have met the standard study quality inclusion criteria for intervention studies on discharge (experimental controlled study designs). One of the major concerns within the study findings was a tendency for novel systems to show positive results regardless of which system was being implemented.

11. Puschner B et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: multicentre randomised controlled trial

Outline: this moderate quality (+/+) German multicentre RCT aimed to test the effect of a needs-oriented discharge planning intervention on the number and duration of psychiatric inpatient treatment episodes, as well as on outpatient service use, psychopathology, depression and quality of life. A sample of 491 people currently receiving psychiatric care with a primary diagnosis of schizophrenia, bipolar affective disorder or major depressions and previous high utilisation of psychiatric inpatient care were randomised to TAU or a manualised needs-led discharge planning and monitoring intervention. Those in the intervention group received 2 intertwined sessions: 1 at hospital discharge and another 3 months after. Using the results of the needs assessment (using the Camberwell Assessment of Need) the intervention worker had a structured discussion with the patient on areas of identified need. A standardised summary was entered into the discharge plan that was signed by all participants and sent to the outpatient treating physician. This plan discussed every need with a precise problem definition, objectives, time-frame of its achievement and the person(s) responsible for implementation. Three months after discharge, the discharge monitoring took place with patient, outpatient clinician, carer (if desired by patient) and intervention worker.

Results: intention-to-treat analyses revealed no significant differences between intervention and control groups on primary or secondary outcomes. Participants who received (or rather were intended to receive) the intervention did not exhibit less inpatient service use during the follow-up period, and did not utilise more outpatient mental health services, or show any superior outcomes with regard to unmet need, psychopathology, depression and quality of life.

12. Rosen CS et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial

Outline: this moderate quality (+/+) US multisite RCT aimed to assess whether adding a telephone management protocol to usual aftercare improved the outcomes of veterans in the year after they were discharged from residential treatment for post-traumatic stress disorder (PTSD). A total of 837 consecutive admissions to 5 VA residential PTSD treatment programmes were randomised to TAU or the telephone care intervention group. Active duty military personnel were excluded from the population sample because they received aftercare outside the VA system.

Results: participants in the telephone care and TAU groups showed similar outcomes on all clinical measures. Time to rehospitalisation did not differ by condition. Participants in both telephone monitoring and treatment as usual completed a mental health visit an average of once every 10 days in the year after discharge.

13. Swanson AJ et al. (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients

Outline: this moderate quality (+/+) US RCT aimed to study the effect of a brief motivational interviewing intervention on attendance at the first outpatient appointment among psychiatric and dually diagnosed inpatients. (Dual diagnosis here refers to substance misuse problems coexisting with other psychiatric disorders.) A total of 121 psychiatric or dually diagnosed patients were randomly assigned to receive either treatment as usual (TAU) or TAU plus the motivational interviewing (MI) intervention.

All patients received an assessment by a multidisciplinary team, resulting in an individualised treatment plan, which identified psychiatric, psychological, medical and social service needs. Patients in the intervention group received an additional 15-minute session of feedback on their change assessment scores (using the University of Rhode Island Change Assessment scale (URICA) at the beginning of their hospitalisation, and 1-hour motivational interview 1 or 2 days before discharge. Therapists drew on the 5 principles of motivational interviewing: a) express empathy; b) note discrepancies between current and desired behaviour; c) avoid argumentation; d) refrain from directly confronting resistance; and f) encourage self-efficacy, or the patient’s belief that he/she has the ability to change.

Results: the proportion of patients who attended their first outpatient appointment was significantly higher for the TAU+MI group than for the TAU group (47% vs 21%; [chi]2=8.87, df=1, p<.01) overall; and for dually diagnosed patients (42% vs 16%; [chi]2=7.68, df=1, p<.01). Although more non-substance-abusing psychiatric patients in TAU+MI group attended their first appointment than did those in ST, this difference did not reach statistical significance (63% vs 42%; [chi]2=1.20, df=1, p=.274).

Studies reporting views and experiences data (n=5)

1. Bennewith O et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study

Outline: this pilot study of moderate quality and mixed methods (+/+) based in south-west England aimed to assess the benefit and feasibility of a contact-based intervention, i.e. supportive letters, for patients recently discharged from inpatient psychiatric care. This group are at great risk of suicide and self-harm, with 6% of all suicides in England occurring in the 3 months after discharge. The authors aimed to establish if supportive letters led to a reduction in self-harm or suicide, drawing on the Motto and Bostrom (2001) intervention (see above), and including reminders of contact details and follow-up arrangements (in first 3 letters) and enclosing a leaflet detailing local sources of support and advice. Unlike those used in the US RCT, these letters did not offer recipients the ability to contact the ward. The letter was piloted with a sample of 102 participants on 3 psychiatric inpatient wards – on 2 wards a series of 8 letters were sent to patients over 12 months and on the third ward 6 letters were sent over a 6-month period. All 102 patients received at least 1 letter, but only 45 (44.1%) received the full series of letters.

Numerical data was collected in 3 areas: information from intervention wards on the number of (a) psychiatric readmissions, and (b) emergency department attendances/general hospital admissions for self-harm, during the 12 months post-discharge; numbers of admissions and readmissions to intervention wards A and B and other general (non-intervention) adult acute inpatient psychiatric wards (X, Y, and Z) at the same hospitals for the 12-month period prior to and during the pilot study (this data is also reported in the evidence for RQ6 on reducing readmissions); number of community mental health service contacts in the 12 months after discharge on a subset of study participants to assess the role of the letter-based contacts as part of the patients' overall care.

In addition, qualitative interviews on the usefulness of supportive letters were carried out with discharged patients 2.5–11 months after the index discharge.

Results: according to the qualitative interviews, generally participants appeared to be supported well after discharge by a number of services and professionals. As the study sample comprised largely long-term service users, most knew which services to call in a crisis situation, so certain aspects (i.e. contact numbers/ information) of the supportive letter intervention were redundant. Some thought they were more useful to 'first timers' after a first admission. For some, the letters were a negative reminder of hospitalisation; and others felt they were impersonal, and questioned why they did not suggest contacting the ward from which they were despatched. Overall, participant accounts demonstrate that the letters add little to the experience of post-discharge support.

In terms of engagement with community mental health contacts, trust policy required that local crisis services initiated face-to-face contact with at least 70% of patients discharged from inpatient psychiatric care within 48 hours of discharge. There was a mean number of 12 contacts (either face to- face or by telephone) during the first month after discharge within the sample. This number of contacts varied over the year after discharge and was lowest around 4 months after inpatient discharge. This relatively high level of support may also have made the intervention less useful or relevant.

This study did not meet the methodological criteria for responses to the reducing readmissions (RQ6) as there is no comparison group or randomisation (with comparison based on before/after extrapolation). However, it does report on readmissions in the event of self-harm, and the lack of impact here is worth reporting as a potential outcome of the post-discharge series of letters.

The relatively high proportion of psychiatric readmissions and general hospital admissions following self-harm, also raise doubts about the effectiveness of the intervention. For instance, 12 (15.0% 95% CI: 6% to 21%) of the 80 patients receiving the intervention on those wards attended a local emergency department for treatment after a self-harm incident in the 12 months after discharge. Most (72.7%) of these participants were still receiving the letters at the time of self-harm. Thirty-three (41.3%) of the 80 intervention patients discharged from wards A and B were readmitted to a psychiatric ward within 12 months of the index discharge. There was no clear evidence of a reduction in readmissions to the pilot wards compared with (non-pilot) wards. For example, on the first hospital site (wards A, X, and Y) there was a 0.4% (95% CI 22%–17%) increase in readmissions in the intervention period for participating ward A, whereas readmissions declined by 2.6% (95% CI 20%–15%) and 11.4% (95% CI 4%–28%) on the non-pilot wards.

2. Fahy GM et al. (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams

Outline: this small retrospective survey of low internal validity (-/+) sought the views of patients within an assertive outreach team and early intervention team in the Merseyside area. Of the 26 patients under supervised community treatment orders (CTOs) within these teams, 17 (65%) agreed to take part. The mean duration of the CTO was 15.6 months (range 2 months to 25 months). Introduced in England and Wales in 2008 via Section 17A of the amended Mental Health Act 1983, supervised community treatment through a Community Treatment Order (CTO) aims to enable certain patients with a mental disorder to be discharged from detention and live in the community, subject to the possibility of readmission to hospital if necessary while facilitating mental health services to monitor and respond in case of potential or actual relapse. In this research, a structured interview was administered to study participants and included 14 questions based upon 4 main themes: involvement in planning of the CTO; quality of information provided; awareness of CTO process and legal rights; and outcomes and satisfaction.

Results relevant to discharge: views of study respondents ranged from seeing CTOs positively – possibly due to their belief that it facilitated early discharge from hospital and had not affected their autonomy at the time of interview – to being infuriated when they restricted individuals’ lives, especially when a person was recalled to hospital. Thirteen (of 17) interviewees agreed that being supervised helped to promote earlier discharge from an inpatient unit, but only 6 agreed that they were involved in the decision to initiate a CTO, 5 agreed that they were involved in planning the conditions of the order, but most felt the key decisions were made by the responsible clinician. A participant patient commented: ‘I just got told I was going on it. I had no say in it and if I wasn’t going on it I wasn’t leaving hospital.’

A common theme identified was anxiety that the person would be detained if they did not adhere to the conditions of the CTO. Some felt quite restricted by the order. ‘The police can come to my flat whenever they want. They own my life. I’ve got no liberty.’

Authors comment on a common misunderstanding that the patient must firmly abide by the conditions of their CTO to remain in the community, and there was a lack of awareness that recall was dependent on the ‘harm criteria’ as detailed in ‘Section 17E (1) (a) (b) – namely the consideration of risk to the patient’s own health or safety, or the safety of others.’ The author posits that ‘the effectiveness of supervised community treatment may be thought to be based on a perception that is fallacious’. However, a significant proportion of patients lacked the motivation or ability to understand the verbal and written information affecting their legal rights at the time it was given, usually immediately prior to hospital discharge. A regular theme identified in the research was support or indifference to supervised treatment if it did not impact significantly on the patient’s life: ‘I wish I wasn’t on it. But it’s not too bad.’

Findings related to patients’ views of the impact of a CTO on readmissions are presented in the summary of evidence for RQ6.

3. Offord A et al. (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults’ retrospective views of treatment and discharge

Outline: this moderate quality (+) small qualitative study asked young adults their views on the treatment they had received for anorexia nervosa after admission to a general adolescent psychiatric unit (where a significant proportion of adolescents continue to be treated). Views about the process of discharge and eventual adjustment to life back in the community were also recorded. Fifty participants were invited to take part in the study and 7 opted in. All participants were white, female, British nationality and aged 16 to 23 years. All had been discharged from inpatient care 2–5 years before the study.

Results: the following key themes emerged:

- Removal from normality vs connecting with the outside world. The majority of participants experienced a pervasive sense of being removed from the outside world upon admission. This brought with it a sense that their development was temporarily suspended. This affected their emotional wellbeing and sense of self, and posed a challenge to later readjustment to the ‘real world’ following discharge. Many participants felt that they were actively discouraged from taking part in real-world activities. This added to the feeling that life moved on for their peers (many of whom were reaching key educational milestones) while theirs remained stagnant. Several people felt that a ‘normal’ activity outside of the unit would have helped their transition after discharge and also served as an incentive to get well. Similarly, after discharge the key to successful readjustment for many involved having incentives such as a college course, new friends or a job which provided a motivation to stay well and diverted attention away from eating difficulties.

- Contrasts in structure and support at discharge. Participants felt that the divergence between high levels of structure and support in the unit and the lack of structure and support in the outside world proved challenging. This often created high levels of dependency and painful emotions on discharge, with no continuity in staff providing support. Sudden transitions were experienced as negative compared to those planned in a gradual and collaborative manner.
  Preparing for discharge – handing back control. Participants often felt they had little control over their lives while in inpatient care and thus suitable preparation for discharge, giving them gradual freedom and ability to make their own decisions, was vital.

4. Owen-Smith A et al. (2014) ‘When you’re in the hospital, you’re in a sort of bubble.’ Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study

Outline: this high quality (++) study examines the lived experience of psychiatric discharge, as well as service users’ experiences after discharge. In-depth interviews were conducted with a purposively selected small sample of service users (n=10) with a range of primary diagnoses, who had recently been discharged from psychiatric hospital within the previous 4 months. All participants reported suffering from anxiety and depression regardless of whether this was recorded as their primary diagnosis, while 7 reported a history of self-harm.

Results: interview data identified the following themes:

Attitudes to discharge and the immediate post discharge period

Most participants felt their period of hospitalisation had been of benefit, but while 3 seemed unequivocally happy to have left, and 3 were pleased to have been discharged despite some ongoing anxieties about their fitness, the remaining 4 individuals had not wanted to be discharged and said they had felt urges to harm themselves since discharge (2 had done so), with 3 reporting suicidal feelings during this period. One individual had felt bad enough to check on the availability of getting access to a particular means for suicide.

Post-discharge stressors

Participants described issues that had made the post-discharge period difficult. These included problems that had existed prior to admission and had re-emerged after discharge, and difficulties that had been provoked or escalated by their inpatient stay. Recurring problems included social isolation, financial difficulties, challenging familial relationships, childcare responsibilities and dealing with everyday household responsibilities.

Participants talked about a number of difficulties that had arisen as a result of, or had been made worse by, their stays in psychiatric hospital. Ironically, the provision of constant availability of support and reassurance while in hospital often contributed to feelings of vulnerability after discharge, especially for those who lived alone.

Participants also spoke about coming to terms with the change in their health status following their hospital stay, and for some (those for whom this had been their first inpatient stay) this feeling seemed to have changed their sense of personal identity. This was intensified by concerns about the social stigma attached to having been a psychiatric inpatient, and expectations that they would experience discrimination on discharge. Additionally, inpatient stays sometimes disrupted existing family relationships and social networks, making readjustment to home life more difficult.

Unmet expectations of care were also a key stressor for some following discharge. Some had little confidence, based on prior experience, that care plans would be met.

Factors affecting the impact of stressors

All participants identified helpful factors that had offset the impact of difficulties they had faced since discharge, including preparation for discharge while they were inpatients and support from within the non-statutory and statutory sectors following their return home. These included:

- Preparation for discharge, including home leave, which most participants found useful. None of the participants recalled any efforts made by staff to prepare them for the psychological impact of being discharged.

- Support from families and from services within the non-statutory sector. Wider networks of social support were generally of less significance, although ongoing relationships with other service users were very important to some in helping them to manage their continuing symptoms of mental distress. Half of the informants had accessed voluntary sector agencies for practical or emotional support.

- Support within the statutory sector. Most had no ongoing contact with the ward nursing team apart from a post discharge telephone call, which is now part of recommended post-discharge care throughout England (National Confidential Inquiry 2006). There were mixed views about this lack of contact, with some feeling excluded by the sudden cessation of support, and others having no desire to maintain any ongoing links with ward staff.

- Community mental healthcare. The most important source of post-discharge support within the statutory sector was community mental health services, and all participants had some links into this form of support, especially that provided by community psychiatric nurses (CPNs) or specialist social workers. Important aspects of the care provided included the regular contact with 1 professional, the flexibility to meet them at home, and attention to both clinical and social needs. Some individuals also received short daily visits from members of crisis teams immediately after discharge, but their purpose was often not clear. Additionally, 9 informants recollected being provided with a 24-hour crisis contact plan, which was generally felt to be reassuring, but there were concerns about the reliability of the service.

5. Simons L and Petch A (2002) Needs assessment and discharge: a Scottish perspective

Outline: this study (++/+) presents the needs and unmet needs of patients discharged from acute psychiatric wards as assessed by themselves and mental health community staff on the Camberwell Assessment of Need (CAN). The CAN aims to identify needs in a number of domains covering basic, health, social, functioning and service issues. In previous research, the CAN has been shown to be a reliable and valid assessment, with independent ratings from both service users and staff (Phelan et al. 1995). By assessing needs of patients soon after discharge the authors aim to identify the key areas of need at this critical time with the purpose of helping to assess how effective discharge policy and procedures are in meeting need. The study sample consisted of 173 adult patients interviewed face to face 6 weeks after discharge from acute psychiatric units. Staff assessments were also completed with 98 personnel to compare perception of need.

Results: patients' views and experience – only 15 patients had no access to service support at 6 weeks after discharge and 60% of the sample had contact with a community psychiatric nurse. The satisfaction levels patients reported with both formal and informal help was relatively high, but only 26% were satisfied with information provision. The mean number of needs identified by discharged patients was 5.8 (range 0–17). The mean number of unmet needs was 2.5 (range 0–11). Key need areas identified (and ranked by responses here) by recently discharged patients are psychological distress (including psychotic symptoms); daytime activities and company; information about condition and treatment; food and transport; budgeting and benefits. Patients with a diagnosis of a non-psychotic illness (n=112) reported higher levels of need and unmet need than those patients with a diagnosis of a psychotic illness (n=61). In most of the domains, well over half the patients who identified a need were getting some level of help from relatives or friends.

Staff views: the mean number of total needs identified by staff was 5.6 (range 0–12), and mean number of unmet needs was 2.9 (range 0–9). Staff and patient average scores for total and unmet need did not differ significantly. The top 5 ranked needs identified by staff were: daytime activities; psychological distress; company; psychotic symptoms; and obtaining and preparing food. Staff-rated unmet needs again had some common areas with total needs: company; psychological distress; and daytime activities. Although there was no domain in which staff rated all the need as met, they considered that 97% of need for information about condition and treatment as met, as opposed to half of patients believing their need to be unmet.

Studies reporting evidence of cost-effectiveness (n=2)

1. Chiverton P et al. (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes

This study was included in the review of effectiveness evidence (above). This is a moderate quality US study (Chiverton 1999 +/+) focusing on all discharged psychiatric inpatients aged 18+ with a range of mental health diagnoses. The evaluation compares individuals receiving transitional case management provided by a nurse plus usual care services compared to usual care services alone. The study has very limited applicability and has very serious methodological limitations. For this reason, cost-effectiveness of transitional case management is not clear without additional economic analyses. Additional economic analyses are needed to understand the transferability of US result to the UK context. The transferability of results depends on the extent of differences in institutional context (i.e. patterns of service use are likely to be different) in addition to differences in the unit costs of health and social care services.

Critical appraisal of this study is included in Appendices B and C.

2. Simpson A et al. (2014) Results of a pilot randomised controlled trial to measure the clinical and cost-effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK

Outline: this is low quality UK cost-effectiveness study on peer support workers in addition to usual care services to assist in discharge (compared to usual care services). The study focuses on all inpatients discharged from hospital (excluding those with dual diagnosis of substance misuse, serious personality disorder, pregnant or caring for children and those at risk to others). This study has limited applicability to the guideline because findings are based on a single poor quality UK pilot study (Simpson et al. 2014 -/+), which is severely limited by its small sample size (n=15). Results are based on findings from 3-months follow-up from randomisation.

The analysis was conducted using the public sector perspective (NHS, social services and criminal justice sector) using 2010 prices.

Results: in relation to public sector costs, there were no statistically significant differences between groups and this was true across primary, secondary and mental health and social care services in addition to no differences in costs to the criminal justice system. Mean costs per patient in 2010 prices were, for the intervention, £2,154 (SD=£4,919) (these include intervention costs) and for the control group, £1,922 (SD=£3,046).

The cost-effectiveness results indicate that peer support workers have a 40% probability of being cost effective for the Beck Hopelessness Scale (BHS) if the decision-maker’s willingness to pay is £0. The maximum likelihood that peer support is cost effective if the decision-maker is willing to pay any additional cost is 55% (increasing willingness to pay does not change the probability). The incremental cost-effectiveness ratio was £12,555 for 1 unit of improvement in BHS. For the outcome of quality of life using the EQ-5D, the probability that the intervention is cost effective is 33% for any value that the decision-maker is willing to pay (higher or lower values of willingness to pay do not alter the probability of cost-effectiveness).

The results of the cost-effectiveness analysis need to be considered with caution due to the study’s serious limitations (noted above). Generalisability is unclear and further research is needed with larger sample sizes and longer follow-up periods.

(Critical appraisal of this study is confined to Appendix C as it was not judged to be of sufficient quality to include in the general evidence review.)

Evidence statements (including economic evidence statements)

DC1	There is moderate quality evidence from 1 US RCT (Chiverton et al. 1999 +/+) that transitional case management by nurses based in the inpatient setting can be cost effective by reducing readmissions and the use of the emergency department, in the 10 weeks after discharge. (Patient and carer satisfaction and improvements in clinical symptoms of depression were not measured in the comparison group, so conclusions cannot be drawn on the effect of the model on the intervention group.)
DC2	There is moderate evidence from 1 small US RCT (Dixon et al. 2009 +/+) that a brief (3-month) critical time intervention to promote continuity of care across hospital and community health services (systems level), and to engage patients in community health services (individual level), can increase the individual’s use of community services. Service use recorded showed that the intervention group had significantly earlier first post-discharge appointments to discuss mental health, and twice as many appointments of this nature during 180 days post discharge. They also reported having more help to make and attend health appointments, and attended more medical appointments for physical healthcare.
DC3	There is poor to moderate evidence from 1 small (n=40) US pilot RCT (Hanrahan et al. 2014 −/+) that a brief (3-month) transitional care intervention for people with severe mental illness (involving a pre-discharge session, a post-discharge home visit and access to a support line) which focused on managing risk of decline, problem behaviours, assessing and managing physical symptoms and preventing functional decline, promoting adherence to therapy, doubled readmissions in the IG compared to control group during the 12 weeks following discharge. Around half of these admissions were for physical health problems. The study is too small to be conclusive, and, being delivered by a single NP, the intervention may be understaffed and the focus on purely clinical aspects may have been too narrow to address patients’ needs.
DC4	There is moderately good evidence from a US RCT (Swanson et al. 1999 +/+) that 2 sessions of motivational interviewing (a technique widely used with people with problem substance misuse) pre-discharge can significantly increase the proportion of patients – a mixed population of those with psychiatric problems only, and those with psychiatric and substance misuse problems – who attend their first outpatient appointment. The difference between those with the additional intervention and the controls was particularly evident for subjects with a dual diagnosis.
DC5	There is moderately good evidence from a UK RCT (Naji et al. 1999 +/+) that a

	protocol requiring psychiatrists to routinely speak with the GP of a person approaching discharge, make the first follow-up appointment within a week of discharge and post a discharge summary to the GP, can significantly increase the number of GP appointments for mental health-related matters within the 6 months following discharge. This intervention was designed to engage and inform GPs, and encourage patients to use general practice services for mental health problems, and showed near significant reductions in readmissions. However, the practice was not observed by all study practitioners, and feedback suggested it was too time-consuming and not always thought necessary.
DC6	There is no good evidence from a good systematic review (Omer et al. 2014 +) that can tell us whether people with ongoing mental health disorders that are admitted to inpatient units have better outcomes if their care is provided by the same teams when they are discharged back into the community who provided care in the hospital (a continuity of care system). The contrast condition is when care is provided by different consultants and care teams in the 2 different settings or sectors (called specialised care in this review). This may be an area in which further research could be encouraged.
DC7	There is moderate evidence from a multicentre German RCT (Puschner et al. 2011 +/+) that a comprehensive assessment of needs at hospital discharge (using the Camberwell Assessment of Need or CAN), and using this as a basis for the discharge plan, did not improve outcomes at 3 months for the intervention group in relation to psychiatric inpatient treatment episodes, outpatient service use, psychopathology, depression or quality of life. No significant differences could be attributed to the assessment and planning approach.
DC8	There is weak evidence from a tiny Australian study (De Leo and Heller 2007 -/+) that intensive case management including weekly meetings, focus on problem-solving and telephone counselling may improve mental health and quality of life, and reduce suicidal ideation, depression and hopelessness, as well as improving therapeutic relationships with providers. However, the study is too small to be conclusive.
DC9	There is good evidence from a US RCT (Motto and Bostrom 2001 ++/+) that regular, personalised letters of concern restating how to contact the service for further support if desired, reduce death by suicide. The effect (comparing those in treatment, those in the intervention group, and those not in neither) appears most pronounced in the first 2 years following the admission for suicide or self-harm.
DC10	There is good evidence from a German RCT (Ebert et al. 2013 ++/+) that treatment and personal goals set before discharge can be maintained through 12 weeks of internet-based personal web diaries, online peer support groups and online asynchronous support from a therapist. Outcomes (remission and recovery reported by the participants) were shown to have improved at 3- and 12-month follow-up (compared with those on TAU, which included psychotherapy and outpatient support which was available to all study participants). However, this study excluded people with psychotic disorders, so results relate only to a specific population.
DC11	There is moderately good evidence from a US RCT (Rosen et al. 2013 +/+) that mental health outcomes, including time to rehospitalisation, for people discharged from residential care for PTSD are not improved by the provision of telephone contact with a counsellor.
DC12	There is (methodologically) poor evidence from a very small Canadian pilot RCT (Forchuk et al. 2013 +/−) with an initial sample of 14 that people discharged from hospital to hostels or no fixed address can be housed quickly after discharge with the support of a housing advocate and that they can maintain their tenancies at 3 and 6 months after discharge. This study was curtailed when it was decided that all

	participants should be offered the intervention.
DC13	There is a good evidence (Herman et al. 2013 ++/+) that a critical time intervention to combat homelessness among people recently discharged (to a variety of shelters and transitional settings) can achieve significant results. The comparative number of homeless nights in 18 months of follow-up in the intervention group was 1812 vs 2403 in the control group ($p<0.001$). Although there was difficulty in contacting people in the later stages of follow-up, among those with complete follow up data, 3 out of 58 (5%) of subjects assigned to the CTI group experienced homelessness during the final 3 follow-up intervals, and 11 out of 59 (19%) of subjects assigned to the control group experienced homelessness during this period.
DC14	There is moderately good evidence from a qualitative study (Offord et al. 2006 +) that people discharged from a general adolescent unit after treatment for anorexia nervosa experience are concerned and dismayed about the huge differences in everyday life and activities, sense of control and self-efficacy and available support between the hospital and the home environment. They may also feel they have lost touch with their peer group and fallen behind in education. Respondents suggested that discharge should be graduated and personalised according to individual need, and that introducing more ‘normal’ activities on the ward, and handing back ‘control’ gradually during discharge, would be helpful. These findings may be generalisable to other adolescents, and other inpatients, who are facing discharge.
DC15	There is good evidence from a relatively large assessment by interview study conducted 6 weeks after discharge (Simons and Petch 2006 ++/+) that people discharged from a psychiatric unit have unmet needs (ranked) for help with psychological distress (including psychotic symptoms); daytime activities and company; information about condition and treatment; food and transport; budgeting and benefits. People with a non-psychotic illness expressed higher unmet need than those with a psychotic illness. Staff ranked the most common unmet need among patients as need for daytime activities; help with psychological distress; company; psychotic symptoms and obtaining and preparing food. Staff considered that 97% of need for information about condition and treatment had been met.
DC16	There is good evidence from a qualitative study (Owen-Smith et al. 2014 ++) that the challenges faced by people leaving hospital after a psychiatric admission are concerning, and that the high incidence of suicide after discharge could be explained in those terms. Four of the 10 interviewed did not agree with the decision to discharge, and had had thoughts of self-harming. Most of the sample cited the need to return to problems which had existed prior to admission – social isolation, financial difficulties, challenging familial relationships, childcare responsibilities and dealing with everyday household responsibilities. They felt that social networks and families had disintegrated, and the sudden absence of care and support would be particularly difficult to deal with. Although 9 of the 10 had support plans, there was some cynicism about whether support would materialise or be adequate.
DC17	There is a moderate quality pilot study (Bennewith et al. 2014 +/+) which used a modified intervention developed by Motto and Bostrom (2001). Letters of concern were developed including reminders of contact details and follow-up arrangements (in first 3 letters) and enclosing a leaflet detailing local sources of support and advice. Generally, recipients were long-term service users (unlike the recipients in the original study), who know who to approach in a crisis situation, so much of the information was redundant. Some thought they were more useful to ‘first timers’ after a first admission. It was also noted that there was no invitation (unlike the earlier prototype) to contact the sender of the letter. The letters were generally felt to add little to post-discharge support and were felt by some to be impersonal, and/or a negative reminder of hospitalisation.
DC18	There is a (methodologically) poor study (Fahy et al. 2013 −/+) which researched

	the views of (17) people who had experience of having a CTO. Although some saw CTOs positively because they were a 'ticket' to early discharge from hospital, others felt they were restrictive and hung over them as a threat of recall to hospital. Only 6 agreed that they were involved in the decision to initiate a CTO, and most felt the key decisions were made by the responsible clinician.
Ec DC1	There is low quality UK evidence regarding the cost-effectiveness study on of peer support workers in addition to usual care services to assist in discharge from inpatient stay (compared to usual care services). The study focuses on for all inpatients discharged from hospital (excluding those with dual diagnosis of substance misuse, serious personality disorder, pregnant or caring for children and those at risk to others). This study has limited applicability to the guideline because findings are based on a single poor quality UK pilot study (Simpson et al. 2014 -/+), which is severely limited by its small sample size (n=15). Results are based on findings from 3-months follow-up from randomisation. The analysis was conducted from using the perspective of the public sector perspective (NHS, social services and criminal justice sector) using 2010 prices. Results indicates that peer support workers have a 40% probability of being cost effective for the Beck Hopelessness Scale (BHS) if the decision-maker's willingness to pay is £0. The maximum likelihood that peer support is cost effective if the decision-maker is willing to pay any additional cost is 55% (increasing willingness to pay does not change the probability). The incremental cost-effectiveness ratio was £12,555 for 1 unit of improvement in BHS. For the outcome of quality of life using the EQ-5D, the probability that the intervention is cost effective is 33% for any value that the decision-maker is willing to pay (higher or lower values of willingness to pay do not alter the probability of cost-effectiveness). The results of the cost-effectiveness analysis need to be considered with caution due to the study's serious limitations (noted above). Generalisability is unclear and further research is needed with larger sample sizes and longer follow-up periods.
Ec DC2	There is 1 moderate quality US study (Chiverton et al. 1999 +/+) that focuses on all discharged psychiatric inpatients aged 18+ with a range of mental health diagnoses. The evaluation compares individuals receiving transitional case management provided by a nurse plus usual care services compared to usual care services alone. The study has very limited applicability and has very serious methodological limitations. For this reason, cost-effectiveness of transitional case management is not clear.

Included studies for the discharge review question (full citation, alphabetical order)

Bennewith O, Evans J, Donovan J, et al. (2014) A contact-based intervention for people recently discharged from inpatient psychiatric care: a pilot study. Archives of Suicide Research 18: 131–43

Chiverton P, Tortoretti D, LaForest M, Walker PH (1999) Bridging the gap between psychiatric hospitalization and community care: cost and quality outcomes. Journal of the American Psychiatric Nurses Association 5: 46–53

De Leo D, Heller T (2007) Intensive case management in suicide attempters following discharge from inpatient psychiatric care. Australian Journal of Primary Health 13: 49–58

Dixon L, Goldberg R, Iannone V, Lucksted A, Brown C, Kreyenbuhl J, Fang L, Potts W (2009) Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. Psychiatric Services (Washington, DC) 60(4): 451–8

Ebert D, Tarnowski T, Gollwitzer M et al. (2013) A trans-diagnostic internet-based maintenance treatment enhances the stability of outcome after inpatient cognitive behavioral therapy: a randomized controlled trial. Psychotherapy and Psychosomatics 82(4): 246–56

Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64

Forchuk C, MacClure SK, Van Beers M, et al. (2008) Developing and testing an intervention to prevent homelessness among individuals discharged from psychiatric wards to shelters and ‘No Fixed Address’. Journal of Psychiatric Mental Health Nursing 15: 569–75

Hanrahan NP, Solomon P, Hurford MO (2014) A pilot randomized control trial: testing a transitional care model for acute psychiatric conditions. The Journal of American Psychiatric Nurses Association 20: 315–27

Herman DB, Conover S, Gorroochurn P, et al. (2011) Randomized trial of critical time intervention to prevent homelessness after hospital discharge. Psychiatric Services 62: 713–19

Motto JA, Bostrom AG (2001) A randomized controlled trial of post-crisis suicide prevention. Psychiatric Services 52: 828–33

Naji SA, Howie FL, Cameron IM, et al. (1999) Discharging psychiatric inpatients back to primary care: a pragmatic randomized controlled trial of a novel discharge protocol. Primary Care Psychiatry 5: 109–15

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

Omer S, Priebe S, Giacco D (2014) Continuity across inpatient and outpatient mental health care or specialisation of teams? A systematic review. European Psychiatry: The Journal of The Association Of European Psychiatrists 30: 258–70

Owen-Smith A, Bennewith O, Donovan J, et al. (2014) 'When you're in the hospital, you're in a sort of bubble.' Understanding the high risk of self-harm and suicide following psychiatric discharge: a qualitative study. The Journal of Crisis Intervention and Suicide Prevention 35: 154–60

Puschner B, Steffen S, Volker K, et al. (2011) Needs-oriented discharge planning for high utilisers of psychiatric services: multicentre randomised controlled trial. Epidemiology and Psychiatric Sciences 20: 181–92

Rosen CS, Tiet QQ, Harris AH, et al. (2013) Telephone monitoring and support after discharge from residential PTSD treatment: a randomized controlled trial. Psychiatric Services 14: 13–20

Simons L, Petch A (2002) Needs assessment and discharge: a Scottish perspective. Journal of Psychiatric and Mental Health Nursing 9: 435–45

Simpson A, Flood C, Rowe J, et al. (2014) Results of a pilot randomised controlled trial to measure the clinical and cost-effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. BMC Psychiatry 14: 30

Swanson AJ, Pantalon MV, Cohen KR (1999) Motivational interviewing and treatment adherence among psychiatric and dually diagnosed patients. The Journal of Nervous and Mental Disease 187: 630–5

2.3 Reducing readmissions to inpatient mental health settings

Introduction to the review questions

The purpose of the review questions was to examine research about the effectiveness and cost-effectiveness of specific interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings. The questions also aimed to consider research which systematically collected the views and experiences of people using services, as well as those of their carers, and those of care and support staff, who might receive or deliver such interventions.

From 15 papers fully reviewed and critically appraised, we found 12 papers that evaluated interventions to reduce readmissions using randomisation techniques. We found 2 additional papers which concerned patients' and providers' experience of such interventions, so that 14 studies were included in the review. One paper scored poorly on internal and external validity, so was not included in the analysis. At first screening, there was some overlap in material used within the review question on discharge (review question 5, see above), as some discharge interventions have considered reducing readmission as an outcome. The criteria by which we allocated the material was that the primary outcome had to be to reduce readmissions, and the intervention had to imply some logical connection to this outcome.

Three additional caveats were observed in screening papers for inclusion. First, the design of the evaluation needed to demonstrate convincingly that readmission was reduced, as 'avoiding readmission' was not in scope. Demonstration was clearest within large randomised controlled trials, and we did not include studies which used a simulated before/after comparison by extrapolating from the past admissions history of individual participants. Secondly, readmission outcomes might concern a number of measures: number of admissions within a specific follow-up timeframe; the number of days spent in hospital within a specific follow-up timeframe (i.e. length of admissions); or the time from discharge to readmission. All were felt to be relevant to the review question, and to the cost and benefit realised through interventions. Thirdly, in considering evidence for this topic, we were mindful that the scope included '4.3.1(e) Interventions and approaches to prevent or reduce readmissions to inpatient mental health settings', but also that these needed to be consistent with the review question, i.e. 'delivered as part of discharge and admission processes'. This did not necessarily place limitations on the timing of these interventions, as some are delivered to those at risk of readmission during an inpatient episode, following discharge or (as in restrictive orders) put in place as a condition of discharge. However, we were clear that evaluations of community-based services such as assertive outreach teams and hospital at home which aim to avert admissions by supporting the person at home were not in scope, unless there was evidence of effective practice in their approach to transitions specifically. We found no evidence reflecting innovative practice in transitions by community treatment teams.

In including papers, we found that interventions to reduce readmissions might well begin during the inpatient hospital admission, perhaps shortly after admission, and could straddle the discharge itself, while others concentrated on post-discharge support.

The evidence on effectiveness found for this question was generally of good quality: all the included studies were randomised controlled trials although generalisability (external validity) to the UK context was less certain for 2 studies. The quality of the 2 papers on views of interventions was less convincing.

In November 2015 the review team carried out forward citation searching and presented relevant findings to the guideline committee at GC11. Forward citation searching of all included studies in the review furnished 5 new papers from 4 distinct studies. Three of these studies related to the reducing readmissions review question; 2 UK views studies of Community Treatment Orders (Canvin et al. 2014; Stroud et al. 2013, 2015) and 1 meta-analysis of randomised controlled evidence for the effectiveness of Community Treatment

Orders (Kisley et al. 2014). As the meta-analysis pooled results from just 3 individual trials which were already included in the reducing readmissions review area – Steadman (2001), Swartz (1999) and Burns (2013) – Kisley et al. (2014) was not presented to the guideline committee as this would have constituted double counting evidence. However, the 2 UK views studies on Community Treatment Orders, which both solicited views from service users, carers and mental health professionals, were included.

After forward citation searching, 16 papers from 15 distinct studies were included for this review question: 11 effectiveness studies, 4 views and experience papers and 2 cost-effectiveness studies (Kessing et al. 2013 was just on1 paper which featured both effectiveness and cost-effectiveness data).

Details of included studies are given in the narrative summary below.

Review question for evidence of effectiveness

6. What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

Review questions for evidence of views and experiences

The review questions considered in relation to views and experience of interventions delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings were:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify the effectiveness of health and social care (and where relevant housing, education and employment) interventions designed to reduce the likelihood of a person being readmitted following discharge from an inpatient mental health setting
- identify and evaluate models or aspects of assessment, planning, care and support in relation to outcomes such as prevention or reduction of readmissions and reduction in length of time spent in inpatient settings
- assess the cost-effectiveness of interventions designed to reduce readmission to inpatient mental health settings
- identify and evaluate variation and opportunities for improvement in approaches to reducing readmission and time spent in inpatient mental health settings for people subject to the provisions of the Mental Health Act, Ministry of Justice restrictions or Mental Capacity Act
- consider the impact of out of area placements (placement in specialist services or to services with available beds) on readmissions and length of stay in inpatient mental health settings.

For the views and experiences review questions, the protocol sought to identify studies, specifically relating to discharge from mental health inpatient settings that would:

- describe the self-reported views and lived experiences of people using services, their families and carers about the interventions they receive during transition between inpatient mental health settings and community or care home settings which are designed to reduce readmissions
- describe the views and experiences of people delivering, organising and commissioning interventions designed to reduce readmissions
- collect evidence on key practice and workforce issues which may impact on the delivery of interventions designed to reduce readmissions.

Population

All children, young people and adults in transition from inpatient mental settings to community or care home settings and their families, partners and carers. Self-funders and people who organise their own care and who are experiencing a transition from inpatient mental health settings to community or care home settings are included.

Health and social care commissioners and practitioners involved in delivering care and support to people during transition between inpatient mental health settings and community or care home settings; approved mental health professionals; advocates; personal assistants engaged by people with mental health problems and their families. General practice and other community-based healthcare and mental health practitioners; psychiatrists and ward staff in inpatient mental health settings (especially those with a role in admission and discharge procedures). Where relevant, the views of housing, employment and education practitioners and police and ambulance personnel involved in supporting people during transition into or from inpatient mental health settings were considered.

This is a whole population topic. The population of interest includes those with protected characteristics, and people without stable accommodation; people of minority ethnic background; people with co-morbidities including substance misuse; people with communication difficulties, sensory impairment or learning difficulties; people treated under a section of the Mental Health Act (and/or people under Ministry of Justice restrictions and people treated under Mental Capacity Act), and people placed out-of-area (see Equality impact assessment). In reviewing the evidence, we were mindful that some of these characteristics may play a part in increasing the likelihood of readmission. In addition, some interventions are directed specifically at people with multiple problems and needs, specific mental health diagnoses or people with a history of multiple admissions.

Intervention

Personalised and integrated assessment, discharge planning and care and support, including application of interventions such as the Care Programme Approach, Community Treatment Orders and other interventions which support people to live in the community and aim to reduce their use of inpatient mental health services. Usual service compared to the effectiveness of an innovative service or intervention.

Setting

Service users' own home, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes, care homes for children and all inpatient mental health settings for adults, older people, children and young people and specialist units for people with mental health problems and additional needs.

Outcomes

Readmissions to psychiatric inpatient facilities during a specific time frame, length of stay or cumulative bed days spent in inpatient mental health settings. User and carer-related outcomes (such as user and carer satisfaction; quality of life; quality and continuity of care; choice and control; involvement in decision-making; also suicide rates and years of life saved). Service outcomes such as use of mental health and social care services and need for unpaid care and support (see 4.4 in the Scope).

The study designs relevant to these questions are likely to include:

- systematic reviews of studies of different models of, assessment, planning and care and support on discharge
- RCTs of different approaches to assessment, planning and care and support on discharge
- economic evaluations
- quantitative and qualitative evaluations of different approaches
- observational and descriptive studies of process
- cohort studies, case control and before and after studies
- mixed methods studies.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care, and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units‘ or hospitalised patients with mental disorders, and b) the process of ‘transition‘, discharge, admission to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept used focused the search on particular study designs (see above) to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups; economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also carried out.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The search was restricted to studies published from 1999 onwards, on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken (January 2015) will be updated in March 2016 to identify new publications which meet inclusion criteria and may alter recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder)

- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions, and for this review question, have a primary outcome measure of reducing or preventing readmission)
- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Titles and abstracts of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, randomised controlled studies, and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions. In some cases it was decided that the search output was too large to review in full text, and that we should select according to relevance and methodological quality (for example, by prioritising UK views studies if there was a good quantity of views studies).

When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. (Where evidence was very sparse, which did not apply to the reducing readmissions topic, the team revisited the set to see whether any of the material not retrieved in full text might be relevant – for example qualitative studies from outside the UK.) The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

In November 2015 the review team carried out forward citation searching as outlined in the ‘Introduction to the review questions’ section above.

Results

In our initial screen (on title and abstract), we found 162 studies which appeared relevant to the review questions on reducing readmissions into mental health inpatient settings. Following a review by the team, we ordered full texts and reviewed 82 papers for final inclusion. At full text review, a further 67 papers were excluded from full appraisal as the paper was found to be not on topic, descriptive rather than evaluative, or reporting views but not on interventions to reduce readmissions. Sixteen papers were data extracted and critically appraised. One paper was not included in the tables or summaries as it was assessed as being of very low quality and did not score positively in terms of internal or external validity (-/-). Fifteen papers were included in this summary.

Effectiveness studies found were all RCTs (n=11). For views and experiences research, studies from a UK setting were prioritised. Two studies were originally assessed and included in the review, with a further 2 studies (Canvin et al. (2014) and Stroud et al. (2015)) found in November 2015 through forward citation searching, making 4 views and experiences studies in total (n=4).

Two papers reported cost-effectiveness data (n=2); Barrett et al. (2013) was an economic evaluation of the Thornicroft et al. (2013) RCT on joint crisis plans, and Kessing et al. (2013) also reported economic findings.

The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables.

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=11)

1. Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the re-hospitalization of psychotic patients: a randomized controlled trial

Outline: this RCT (rated +/+) is a US study of a cognitive behavioural therapy intervention for people affected by ‘positive’ symptoms of psychosis (i.e. delusions and auditory hallucinations or voices). Acceptance and commitment therapy (ACT) was delivered by the first author in 4 sessions during an inpatient stay once the inpatient was sufficiently well, and then spaced approximately every 3 days, with the last one either 72 hours pre- or post-discharge. The premise behind the approach is that people with such symptoms can be better enabled to recognise and contextualise them, understanding them as distinct from reality, and overriding their impact by employing acceptance and coping strategies which incorporate personal goals. Therapeutic outcomes were assessed at 4 months, primarily by the effects of the therapy on hospital readmissions.

Results: of the 35 participants in the study in each condition, 7 of the ACT participants (20%) and 14 of the TAU participants (40%) were re-hospitalised during the 4 months following release. ACT participants were hospitalised at a significantly lower rate than were TAU participants (at 0.05 significance): Wilcoxon’s statistic (1, n=70=4.26, p=0.05). ACT participants remained out of the hospital an average of 22 days longer than control participants during the 4-month follow-up period. The difference between the 2 conditions in the number of days to hospitalisation during follow-up was statistically significant, F(1, 60)=4.74, p=0.03. There were no significant differences measured in the distress felt by individuals at baseline or follow-up (both groups showing similar measures and reductions across time), nor in medication compliance (which might have accounted for other effects).

ACT respondents were more likely to report symptoms (which may for some patients have been an admission likely to lead to readmission). Authors suggest that the ACT sessions made them more aware of delusions and more accepting of them. ACT patients also seemed to show less likelihood of believing in their symptoms as reflecting reality.

The findings are not conclusive, and the participants all received other complex packages of interventions as TAU (treatment as usual) both within acute services and after hospital discharge (including assertive outreach) which may have affected readmissions. Any 1 or combination of these might be responsible for the impact on rehospitalisation. However, there have been recovery-based approaches to support people in dealing with psychotic symptoms in the UK which may prove useful (though we found no studies of these).

2. Burns T et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial

Outline: this UK study, highly rated (++/++), is an RCT of the use of Community Treatment Orders (CTOs) rated for people discharged from hospital vs the use of s17 leave orders. A total of 336 patients were randomly assigned to each option (167 to CTOs; 169 to s17 leave orders). The study drew on a number of trust inpatients across the Midlands and Southern England. A CTO is ordinarily imposed when the responsible clinician (normally consultant psychiatrist) and an approved mental health worker consider a patient who is being discharged after a period of involuntary hospital treatment to be at risk of relapse and/or readmission. It can stipulate that the patient must take medication outside of the hospital but does not authorise the clinicians to administer medication by force. Instead the clinician can recall the patient for up to 72 hours to review treatment without formally readmitting them. A range of conditions can be imposed – including place of residence and attendance at assessments. Median length of the CTO in the study population was 183 days.

Section 17 leave is used for brief periods to assess suitability of a patient’s recovery after and during a period of involuntary hospitalisation. The treatment order remains active and the patient can be immediately readmitted without additional legal processes. Median length of s17 in this arm of the study population was 8 days.

Results: at 12 months, there were no significant differences between the 2 groups: 59 (36%) of 166 patients in the CTO group were readmitted, versus 60 (36%) of 167 patients in the Section 17 group, RR 1.00 (95% CI 0.75–1.33). There were no differences in time to readmission, or length of stay. The authors therefore conclude that there is no justification for imposing the more restrictive CTO on patients, and its fairly common use should be reviewed.

Although there were a high number of protocol violations in each group (based on legal requirements of CTOs, need for clinicians to make treatment decisions without recourse to randomisation and reorganisations of mental health services), a sensitivity analysis suggested these did not affect conclusions, and these ‘obstacles’ to implementing new processes render the study more realistic and generalisable.

(See also Fahy et al. 2013 on patient perspectives of supervised community treatment, below.)

3. Dush DM et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care

Outline: this small, US RCT (rated +/+) is an evaluation of a brief intensive transitional support programme intended to support people eligible for admission (as assessed in emergency room), or actually admitted, to a psychiatric hospital. The aim was to avert admission, facilitate early discharge if admission took place, and reduce readmissions and length of stay, and hence costs. The trial area was rural, with high levels of poverty. The clinical team delivered an acute, intensive short-term transitional support programme, targeting people who might be at high risk of readmission, or perhaps unknown to services (for example if they came through the emergency room). This was intended to be ‘a brief, hospital-based bridge to other resources’ (p29). Support ended with transfer to community mental healthcare services at the first follow-up appointment, though active treatment could be resumed. Elements of the support package varied, but typically were:

- assessment and treatment plan for stabilisation and transitional support
- brief individual behavioural therapy, with the family if possible, oriented to problem-solving and reassurance
- an 8-session cognitive behavioural relapse prevention group was introduced to the standard service after a few months
- home care and home assessments – follow-up care in home, possibly psychological treatments and assistance with practical problems such as transport.

Results: of the total difference in hospital use and costs, about 34% was produced by averting initial hospitalisation altogether for 12 of 17 participants treated initially in the emergency room (p<.001). Twenty-six of the intervention group of 90, and 50 of the control (TAU) group of 92, were admitted during the year of follow-up. Average length of stay was 6.18 days for the experimental group (SD=6.18) vs 7.22 days for controls (SD=5.84). There were further (non-significant) differences in the rates of rehospitalisation of those who were seen for a further episode qualifying for admission: 23 control participants had at least 1 readmission (25%), compared to 12 in the experimental group (13%). There were no significant differences between groups in relation to mental health and functioning measures.

There were differences in the population entered into the study and the possible 244 consecutive admissions who might have taken part – for example, 30 individuals who had more problematic conditions were not approached at request of CMH team. These patients differed from participants in the study, and had longer admissions, so may have had more complex needs.

4. Kessing LV et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial

Outline: Kessing et al. (2013) is a moderate quality (+/+) RCT from Denmark which aimed to investigate whether treatment in a specialised mood disorder clinic (pharmacological treatment plus group psychoeducation) early in the course of illness among patients discharged from their first, second or third admission to hospital for bipolar disorder reduces hospital readmissions and rates of relapse compared with standard psychiatric outpatient treatment. A total of158 patients with a primary diagnosis of a single manic episode or bipolar disorder were randomised to TAU (n=86) or to the intervention, a mood disorder clinic group (n=72). The 2-year intervention was a combination of evidence-based pharmacological treatment and group psychoeducation. A medical doctor evaluated all patients in the clinic as early as possible following discharge from an inpatient admission and no later than 2 weeks after discharge. The physician followed the patients with regular appointments depending on their clinical status and needs.

Results: the rate of readmission was significantly decreased for patients treated in the intervention group. A total of 26 (36.1%) patients treated in the mood disorder clinic vs 47 (54.7%) patients treated with standard care were readmitted (Log rank test; p=0.034). Using the Major Depression Inventory (MDI), 25 patients (35.1%) in the intervention group relapsed into a depressive episode compared with 37 patients (43.5%) in the standard treatment group, but this difference was not statistically significant (p=0.4). Similarly, there was no statistically significant difference in relapse rates for a hypomanic or manic episode according to the Mood Disorder Questionnaire (MDQ). Intervention n=45, 62.9%, control n=49, 57.1% (p=0.6).

Satisfaction with treatment showed a statistically highly significant difference between patients in the mood disorder clinic v the standard care group (VSSS-A total score: 132.2 (SD = 16.9) v 114.9 (SD = 31.6), unadjusted p=0.001, adjusted p=0.01).

A shortcoming of the trial is that the patients in the control group received very different interventions – community psychiatric centres, private specialists in psychiatry or a local psychiatrist. Data is not available on the frequency of outpatient visits for this group.

This study also conducted an economic evaluation. These results are presented in the section below, ‘Studies reporting evidence of cost-effectiveness’.

5. Lay B et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psychoeducation and monitoring: feasibility and outcomes after 12 months

Outline: Lay et al. (2015) is a Swiss RCT (rated +/+) which evaluates an individualised psychoeducational programme together with crisis cards and 24-month preventive monitoring for adults who have been admitted as compulsory patients during the past 24 months. This paper reports on the main outcome of reducing admissions – including compulsory ones – and time spent in hospital at 12 months (interim findings). The programme starts at the interface of in- and outpatient care (discharge).

The intervention programme was based on individualised psychoeducation focusing on behaviour prior to and during crisis, looking at individual needs, abilities, etc. Sessions were delivered by the same worker (implied but not stated that they are not those that provided care on wards). Sessions ranged from 1–11, totalling 3–4 hours. It is implied these start at inpatient stage. Prior to discharge a checklist of personal risk factors for relapse and information on who to contact, medications, etc., was drawn up. This became a crisis card, and study participants are said to have used these in a (unexplained) variety of ways. After discharge, each person in the intervention group was contacted every fourth week by telephone, for 24 months. The contact worker reviewed mental health status, crisis card information and signs of escalating risk of relapse, offering support as needed. The approach attempts to support self-management as a supplement to usual treatment. The control group (referred back to outpatient care in community settings as usual) were contacted at 3 month intervals to validate continuation in the study.

Results: 67% and 86% remained in the intervention group and the control group at 12 months. The number of compulsory readmissions per patient for the intervention group was 0.3 per patient (SD=8); versus 0.7 (SD=1.2) per patient in control group, p=0.04. The length of compulsory readmissions was shorter for those in the intervention group: 9.1 SD 21.8 days, versus 14.8 SD 31.2 days for control group, p=0.08. Compulsory inpatient readmissions were registered in 22.5% of the intervention group, compared with 35.3 % in TAU group during the 12-month follow-up. The rates and lengths of voluntary admissions observed in the intervention group did not reach statistical significance, possibly because the target of 400 in the study was not met.

6. Papageorgiou A et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial

Outline: this moderate quality (+/-) UK RCT aimed to assess whether the use of advance directives by patients with mental illness reduces rates of compulsory readmission to hospital. A total of 156 people who were compulsorily admitted to hospital with serious mental illness were randomised to receive TAU (n=77) or the advance directive intervention (n=79). Those in the intervention group were provided with a booklet ‘Preferences for care’. It contained:

- name of GP, community psychiatric nurse, keyworker, consulting psychiatrist and social worker
- 8 statements on future preferences for treatment, which the patient was requested to fill in according to their preferences (assisted by a researcher if preferred).

The booklet was then signed, and copies sent to the keyworker and GP.

The advance directive was not intended to address compulsory treatment directly but it aimed to give patients an opportunity to consider their future treatment on a wider basis and in doing so increase their trust and compliance – potentially reducing the need for compulsory treatment. A rider at the end of the booklet indicated that professionals were not legally bound to comply with preferences for care (see note on use of terminology below).

Results: there were no significant differences between the groups in the numbers of subsequent compulsory readmissions (15 or 19% vs 16 or 21%), numbers of patients readmitted voluntarily, or days spent in hospital. There was no difference in self-efficacy at follow-up (advance directives grouped median 42.66; control arm grouped median 42.25).

Note: the authors describe ‘advance directive’ as a ‘preference statement’ which was not ‘intended to address compulsory admission directly’ and was not legally binding. The British Medical Association’s Code of Practice, Advance Statements About Medical Treatment, draws a distinction between the terms ‘statement’ and ‘directive’, which are often used interchangeably.

- Advance statements – ‘People who understand the implications of their choices can state in advance how they wish to be treated if they suffer loss of mental capacity.’ The code then offers a list of different types of statements, 1 of which is an advance directive.
- Advance directives (refusal) – ‘Competent, informed adults have an established legal right to refuse medical procedures in advance.’ The use of ‘directive’ emphasises the legally binding refusal of specific medical treatment or procedure, which is as valid as a decision made at the time treatment options are being considered. The Mental Capacity Act 2005 gives people a legal right to refuse medical procedures in advance, for example, electroconvulsive therapy.

7. Pitschel-Walz G et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study

Outline: Pitschel-Walz et al. (2006) is a moderate quality (+/+) German prospective, randomised, multicentre study. The trial aimed to examine the long-term outcomes of the psychoeducation intervention, the Psychoeducation Information Project (PIP). A total of 236 people with schizophrenia were sampled from 3 different psychiatric hospitals but some were excluded at early stages and attrition rates were high. A total of 79 patients and 125 carers received the PIP intervention. Patients and their relatives in this group were encouraged to attend 8 sessions of psychoeducational programmes over a period of 4 to 5 months – sessions were separate for patients and carers but consisted of similar material to help them ‘speak the same language’. Sessions 1 to 4 took place weekly, mostly during the patients’ inpatient stay (after reduction of acute symptoms), and sessions 5 to 8 took place monthly, predominantly during the outpatient period. Information was given to patients about symptoms, aetiology, acute treatment, relapse prevention and psychological treatment of schizophrenia; adequate coping strategies were discussed and individual crisis plans were drawn up.

Relatives’ sessions covered similar information to the patients’ groups but also allowed relatives to discuss how they can better help the patient with schizophrenia and how they can obtain support and emotional relief for themselves.

Results: after 1 and 2 years, patients in the control group had on average nearly twice as many hospitalisations as those in the intervention group: 0.6 (SD 1.1) vs 1.1 (1.4), p=.031. In addition, those in the control group spent almost twice the number of days in hospital compared to the intervention group: 39 days (SD90.4) vs 78(127.2), p=.034. Although the treatment was discontinued at 2 years in all but 1 of the hospitals, there was some evidence of continued benefit at 7 years in a small sub-group (34 people) who remained in the study. As the intervention was aimed at both people being discharged from psychiatric hospital and their carers it is not possible to isolate the effect of the intervention to either group (carer or patient) which received it.

8. Sledge WH et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations

Outline: Sledge et al. (2011) is a moderate quality (+/+) US RCT which aimed to examine the feasibility and effectiveness of using peer support (recovery mentors) to reduce recurrent psychiatric hospitalisations. A sample of 89 people who had experienced 2 or more psychiatric hospitalisations in the 18 months before the index hospital admission and had a diagnosis of schizophrenia, schizoaffective disorder, psychotic disorder not otherwise specified, or major depressive disorder were randomised to usual care (n=43) or the peer support group (n=46). Recovery mentors were recruited via formal job postings and once recruited, 8 mentors received training and ongoing weekly supervision sessions from PRCH (Program for Recovery and Community Health). The mentors were instructed not to aim for any specific goal other than to support their participant partners in a partnership relationship. They were trained to use their own first hand experiences as a basis from which to provide support. The frequency of contact was determined by the mentee in collaboration with his/her mentor.

Results: participants allocated to the recovery mentor group had significantly fewer admissions than those in usual care (.89±1.35 and 1.53±1.54 admissions; F=3.07, df=1 and 71, 1-tailed p= .042; partial η2=.04) and significantly fewer hospital days (10.08±17.31 and 19.08±21.63 days; F=3.63, df=1 and 71, 1-tailed p<.03; η2=.05).

However, around a third (34%) of the members of the intervention group did not have any contact with their peer mentor during the study period, and information about the number of contacts (0–39) during the study period was obtained from only 55% of patients in the peer mentor group.

9. Steadman HJ et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program

Outline: Steadman et al. (2001) is a moderate quality (+/+) US RCT which aimed to evaluate the effectiveness of a 3-year outpatient commitment pilot programme established in 1994 at Bellevue Hospital in NYC. A sample of 142 people with 2 previous involuntary hospitalisations with a history of non-compliance to treatment were randomised to receive court-ordered treatment, which included the enhanced service (n=78), and the other group received enhanced services only (no court involvement) (n=64). Enhanced services included: an inpatient assessment, a comprehensive person-centred post-discharge treatment plan, arrangements for ongoing case management and continued oversight of the patient by the outpatient commitment coordinating team. For the group that received court-ordered treatment, the outpatient treatment plan was formalised by a court proceeding and an explicit judicial order.

Results: on all major outcome measures, no statistically significant differences were found between the 2 groups. Of the court-ordered group 18% were arrested at least once and of the control group 16% were arrested at least once, though none of the arrests were for violent offences. (Note that arrest was the only procedure in place for those who violated the order, so it would be difficult to distinguish outcomes that implied violation of the order, rather than committing of any other offence.) The percentage rehospitalised during follow-up was similar for both groups – 51% and 42% respectively. The groups did not differ significantly in the total number of days hospitalised during the follow-up period. Participants' perceptions of their quality of life and level of coercion were also similar.

10. Swartz MS et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism? Findings from a randomized trial with severely mentally ill individuals

Outline: Swartz et al. (1999), rated (+/-), is another RCT of US restrictive orders for outpatients with severe mental illness, involuntary outpatient commitment (IOC), with a primary outcome of hospital readmission. Subjects who were hospitalised involuntarily were randomly assigned to be released without restriction (n=135) or to continue under outpatient commitment (n=129) after hospital discharge, and followed up for 1 year. All subjects received case management services plus additional outpatient treatment.

Results: the findings are not clearly presented, with authors suggesting that IOC reduced hospital admissions by over 50% in the year in the IOC group relative to controls, but that this 'trend' did not show statistical significance. The analysis breaks down results in relation to both length of time the person was on an IOC; and the diagnosis (psychotic or other disorder). Results were divided among participants as follows: Group 1: control (n=135); Group 2: IOC <180 days (n=82) and Group 3: IOC <180 days (n=47). Groups shown here as 1, 2, 3 as above.

Total psychiatric admissions in 12 months: (1) 1.04 mean, SD 1.55; (2) 0.91, SD 1.23; (3) 0.45, SD 0.80. Summary x2 6.27, df2, p=0.04. Total hospital days:

(1) 27.92, SD 51.05; (2) 37.66, SD 61.37; (3) 7.51, SD 15.90. Summary x2 8.51, df2, p=0.01.

Sub-group analysis by type of psychiatric disorder suggested that reductions in mean readmissions for subjects with non-affective psychotic diagnoses (i.e. schizophrenia, schizoaffective disorders or other psychotic disorder) were significant. Results were divided as follows: Group 1: controls (n=83); Group 2: outpatient commitment <180 days (n=60) and Group 3: outpatient commitment >180 days (n=35).

Total psychiatric admissions in 12 months: (1) 1.23 mean, SD 1.73; (2) 0.95, SD 1.28; (3) 0.34, SD 0.80. Summary x2 11.81, df2, p=0.003.

Total hospital days: (1) 32.84, SD 55.72; (2) 40.08, SD 61.67; (3) 4.57, SD 12.96. Summary x2 14.29, df2, p=0.001.

Having more outpatient appointments was associated with lower cumulative hospital admissions for the participants with psychotic disorders across the 12 months, particularly for those with more than 180 days’ IOC (as the controls and those with less than <180 days IOC converged at around 6 months). Authors therefore suggest that the intensive long-term outpatient treatment received in particular by the psychotic patients on longer IOCs contributed to better outcomes.

11. Thornicroft G et al. (2013) Clinical outcomes of joint crisis plans to reduce compulsory treatment for people with psychosis: a randomised controlled trial

Outline: Thornicroft et al. (2013), an RCT rated +/++ and Barrett et al. (2013) (an economic evaluation separately appraised) derive from the same UK study of joint crisis plans (JCPs), trialled as an intervention to reduce hospital readmissions. ‘The Joint Crisis Plan is a negotiated statement by a patient of treatment preferences for any future psychiatric emergency, when he or she might be unable to express clear views' (p1634, abstract). A total of 569 patients (admitted at least once in the past 2 years and on enhanced Care Programme Approach) were included, so these patients were subject to severe episodes of illness. Subjects were randomised to either JCP plus treatment as usual, or treatment as usual alone. This was a large study across 64 generic and specialist community mental health teams in 4 English mental healthcare provider trusts. Primary outcomes were a reduction in compulsory (or formal) psychiatric admissions, a reduction in all psychiatric admissions; shorter psychiatric inpatient stays; lower perceived coercion; improved therapeutic relationships; and improved engagement.

Results: no significant treatment effect was seen for the primary outcome, compulsory or formal admissions (56 [20%] sectioned in the control group and 49 [18%] in the JCP group; odds ratio 090 [95% CI 0.58-1.39, p=0.63]). Mean duration of compulsory admissions was 20·6 (SD 73·4) days in the control group and 22·3 (72·0) days in the JCP group. For any admission (compulsory or voluntary), the mean durations were 26·4 (76·2) days in the control group and 29·5 (75·7) days in the JCP group. There were a total of 158 admissions: 81 (29%) in the control group and 77 (29%) in the JCP group. No significant effect was seen within other secondary measurable outcomes, with the exception of an improved secondary outcome of therapeutic relationships (173 [76] vs 160 [71]; adjusted difference -1.28 [95% CI -2.56 to -0.01, p=0.049]).

There was some surprise from the research team that the JCP did not improve readmission outcomes. Qualitative data also collected suggested that the JCP could improve therapeutic relationships, as it was meant to be an opportunity for collaboration. JCPs could make patients feel respected and more understood by clinicians. However, some patients did not recall the JCP being discussed as it did not stand out from the general CPA process and meetings, and it seemed that there had been poor engagement in the majority of cases by clinicians with the process, who did not think the JCP planning was a worthwhile intervention which added anything to CPA, nor that it needed to be patient-led. (This is not consistent with the authors' reporting of high fidelity with the intervention, see p1637.) The nurse facilitators may have found it difficult to ‘steer’ psychiatrists, who are of higher rank. In addition, many patients complained that the agreements in the JCPs were not referred to in practice. Although the trial findings showed no difference, the external validity of the finding is high because it appears likely that the problems of implementing JCPs in other UK contexts would be generalisable.

This study also conducted an economic evaluation. These results are presented in the section below, ‘Studies reporting evidence of cost-effectiveness’.

Studies reporting views and experiences data (n=4)

1. Canvin K, et al. (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study

Outline: a UK qualitative study using in-depth interviews with 25 psychiatrists, 26 patients, and 24 carers from a range of settings within England. The aim of the study was to examine participants’ experiences of the mechanisms via which the Community Treatment Order (CTO) was designed to work in practice. In particular, the researchers sought views and experiences relating to the conditions that form part of the order, the power of recall, legal clout and impressions of the CTO’s effectiveness.

Results: all 3 groups perceived the main purpose of the CTO to be enforcement of medication, and that the legal clout was instrumental in achieving medication adherence. Even so, all 3 groups also acknowledged that the CTO was only effective for certain patients and a range of shortcomings were identified:

- The focus on medication - to the exclusion of additional support of service provision – was considered a major flaw by carers, and one that impeded their relative’s recovery.
- In contrast, psychiatrists emphasised that people with CTOs were not treated preferentially, perhaps because they wanted to emphasise that

there were no perverse incentives (such as additional support), for placing a patient on a CTO.

- The way that the CTO's mechanisms worked in practice could be influenced by people's understanding of those mechanisms. Participants' understanding of how those mechanisms worked varied drastically. All groups expressed uncertainty over the enforceability of discretionary conditions, and the exact criteria for recall.

A wide range of experiences was identified in each group, implying that there is no such thing as a definitive patient, psychiatrist or carer experience of CTOs.

Considerations: the study used purposive sampling to recruit participants. Carers were recruited via carer organisations and health trusts which introduces a risk of bias – carers involved in carer organisations are more likely to be proactive and have an active involvement in patients' care. An overwhelming majority of carers interviewed were parents (n=22/24) and the views and experiences of this group may differ from those of family carers who were siblings or spouses, for example. Furthermore, patients and psychiatrists were invited to take part from the OCTET RCT sample; concerns have been raised about the OCTET trial's generalisability to 'real world' CTO patients. The study only includes psychiatrists, rather than other mental health professionals, such as AMHPS who are heavily involved in administering CTOs.

2. Fahy GM et al. (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams

Outline: Fahy et al. (2013) reports patient perspectives of supervised community treatment orders (CTOs) in 2 Merseyside mental health teams. This was a small retrospective survey of low quality (-/+) that sought the views of patients within an assertive outreach team and early intervention team in the Merseyside area. Of the 26 patients under supervised CTOs within these teams, 17 (65%) agreed to take part. The mean duration of the CTO was 15.6 months (range 2 months to 25 months). Introduced in England and Wales in 2008 via Section 17A of the amended Mental Health Act 1983, a supervised community treatment through a CTO aims to enable certain patients with a mental disorder to be discharged from detention and live in the community, subject to the possibility of readmission to hospital if necessary, while facilitating mental health services to monitor and respond in case of potential or actual relapse.

This study was also included in the evidence on discharge. In this research, a structured interview was administered to study participants and included 14 questions based upon 4 main themes: involvement in planning of the CTO; quality of information provided; awareness of CTO process and legal rights; and outcomes and satisfaction.

Results relating to reducing readmissions: views of study respondents ranged from seeing CTOs positively – possibly due to their belief that it facilitated early discharge from hospital and had not affected their autonomy at the time of interview – to being infuriated when they restricted individuals' lives, such as when a person was recalled to hospital. Thirteen (of 17) interviewees agreed that being supervised helped to promote earlier discharge from an inpatient unit. However, most (11 of 17) felt they had not been involved in planning the conditions of the Order. Most patients (59%, n=10) believed that supervised community treatment prevented readmission to hospital because it encouraged them to maintain medication regimes. However, some patients felt that other measures, such as depot medication (slow release medication given by injection, weekly or fortnightly) and a more holistic consideration of activities and lifestyle choices, could also have been employed to help prevent readmission. Authors comment on a common misunderstanding that the patient must firmly abide by the conditions of their CTO to remain in the community, and there was a lack of awareness that recall was dependent on the 'harm criteria' as detailed in 'Section 17E (1) (a) (b) – namely the consideration of risk to the patient's own health or safety, or the safety of others'. The survey was conducted within 25 months of the introduction of CTOs in England and Wales and most of the patients had not been readmitted to hospital so measurable outcomes were not available within this small sample.

3. Papageorgiou A et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals

Outline: this views study (rated -/+) is a companion paper to the first RCT of the use of advance instruction directives in patients compulsorily admitted to hospital under the Mental Health Act (1983) in the UK (Papageorgiou et al. 2002: see above). The trial compared usual psychiatric care with usual care plus the completion of a patients' advance directive, and the primary outcome was rate of compulsory readmission over 12 months. This study presents the views of patients and practitioners concerning the content, implementation and usefulness of advance directives (administered in the form of a 'preference for care' booklet) containing details of key professionals such as GPs, community psychiatric nurses (CPNs), key-workers, psychiatric consultants and social workers. Also included were 8 statements containing instructions about a patients care preferences, which had been completed by the patient. Three completed copies of the directive were signed by the patient; 1 was retained in the psychiatric case notes, 1 was sent to the patient's GP and 1 to his/her keyworker.

Patients in the intervention group filled in a questionnaire about their experience of the advance directive and how to improve it. A follow-up questionnaire was administered to 59 patients in the intervention group a year after their discharge from hospital and this sought their views on the preference for care booklet, including whether they had used it in the last year, and if they would recommend it to other patients. At 12 months follow-up, consultant psychiatrists and keyworkers were sent a questionnaire examining issues such as their awareness of the preference for care booklet, their views on its usefulness for managing patients, and suggestions on how it could be improved. Consultant psychiatrists returned questionnaires on 31 (39%) of the 79 patients in the intervention arm. Seventy-nine advance directives were analysed.

Results: the findings of the associated RCT concluded that there were no differences between the intervention group and the control group in the number of subsequent compulsory psychiatric readmissions. The views findings from both patients and professionals in this study focus on the content and use of advance directives.

In terms of content of the ‘preference for care booklet’, patients’ fundamental preferences were about reduced coercion or enhanced human rights, the increased availability of alternative therapies, counselling, psychotherapy, better hospital facilities (such as ‘my own room’) and staff contact with their families. In terms of content, patients said if they became ill again they would like various options including: more talking therapies (29%), more service input (29%), support to take medication (25%), and family and/or social support (24%). It was unclear if they felt that availability of these options might reduce the likelihood of readmission.

Three-quarters of patients at follow-up remembered having drawn up an advance directive but over half did not remember what had become of it. A small percentage found advance directives useful mainly as a therapeutic tool to help them evaluate their condition, or as a way of seeking care and engaging themselves in activities that might improve their condition and quality of life. While over 40% reported that they would want to use the directives again or would recommend them to others, the authors suggest that a similar number did not find the current advance directives useful because the professionals involved in their care did not refer to, or acknowledge them in subsequent care.

The majority of psychiatrists could not recollect the existence of the patient’s directive (71%) and/or did not find it useful in the management of that patient’s care (61%). The authors remarked how despite briefing of health professionals about the directives and putting an additional copy at the front of patient medical notes, this did not raise awareness or use of the directives. Those staff who did not find it useful said that it was not integrated into the patient’s care plan or they were not involved in the procedure of drawing up the booklet. The authors suggest that embedding the advance directive into the CPA might improve compliance, as may the integration of advance directives into relapse prevention programmes.

Patients did not always recognise the significance of the directives either, and were not subsequently encouraged to do so by mental health clinicians, who claimed they were either unaware of them or were sceptical of their value. Respondents of either type did not suggest it had a role in reducing readmissions.

4. Stroud J, et al. (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives

Outline: a UK qualitative study using semi-structured interviews to explore the experiences of 21 service users, 16 care coordinators, 10 responsible clinicians, 9 AMHPs, 7 nearest relatives and 9 housing service providers with the aim of identifying significant issues and good practice in relation to community treatment orders (CTOs). The same study is described in 2 separate but linked papers – Stroud et al. (2013) and Stroud et al. (2015).

CTOs are described as the ‘legislative power by which patients with mental health difficulties who are treated involuntarily in hospital can be discharged into the community but still remain subject to compulsory treatment’ (Stroud et al. 2013, p6). The study sample were recruited from 1 mental health NHS trust in Southern England.

Results: experiences and legal interpretations affecting practice are diverse. Across all groups the CTO was seen as providing a valuable ‘safety net’. Specific advantages being:

i) the speed with which recall could be issued
ii) that a new mental health assessment was not needed upon admission
iii) that the service user could come into hospital for 72 hours and then be discharged back into the community on the same CTO.

Nearest relatives particularly valued having clear contacts to call and that an emergency appointment could be triggered.

Success of CTOs is largely dependent on the perceptions of the service user. They can be considered most useful when service users are accepting of their authority, but potentially counterproductive for those antagonised by it. Some practitioners said that for the ‘wrong’ kind of services user, the CTO is ineffective and potentially harmful for therapeutic relationships.

However, CTOs were also seen to facilitate increased support, owing to the associated legal obligations on the part of the practitioners and the increased motivation of services users to comply with medication.

The issue of service users needing to accept the authority of the CTO raised ethical concerns, with a sense of unease among practitioners (particularly AMHPs) that legal powers were weaker than presented. While service users often believed mistakenly, that to break a condition would automatically result in recall, nobody had explained that they would only be recalled if there was a significant deterioration in their mental health. Practitioners were not incentivised to ensure that users were fully informed, for fear that is would lessen the respect for the power of the CTO.

Still, CTOs may be used beneficially for a restricted group of ‘revolving door’ patients with certain needs and perceptions for whom other options have been unsuccessful. CTOs were found to be more successful when they were carefully planned interventions, rather than where they were made almost as a matter of course.

Considerations: this study covered a wide-ranging population of service users, nearest relatives and practitioners and this constitutes a sample that is different, and arguably more representative than the OCTET sample. Stroud et al. offers experiential findings surrounding a controversial and complex area of mental health practice and research.

Studies reporting cost-effectiveness (n=2)

1. Barrett B et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: economic outcomes

Barrett et al. (2013) was a large sized sample from the UK rated with moderate internal validity and good external validity (+/++). It is an economic evaluation of the same RCT on joint crisis plans (JCPs) reported in Thornicroft et al. (2013) (see effectiveness studies section above). This study evaluated the impact of joint crisis planning in addition to ‘standard care’ compared to ‘standard care’ only. This study included individuals aged 16+ years with a previous history of at least 1 hospital admission and at least 1 admission in the past 2 years and were registered on the Enhanced Care Programme Approach (i.e. indicating that they had complex needs). Individuals were excluded if they were subject to the Mental Health Act to reduce perceived pressure to participate. Approximately 50% of the sample was female, 44% lived alone, and the mean age was 40 years. In terms of diagnosis, 75% and 25% were classified as schizophrenia spectrum disorder and affective disorders, respectively. Median length of stay in this group was 59 days with an average of 1.5 admissions to acute psychiatric care in the past 2 years.

The intervention, JCP, is a statement that the patient develops in collaboration with the staff containing their preferences for treatment for future psychiatric admissions as it is assumed that preferences are more clearly expressed in advance of an admission. A JCP was provided in addition to standard care services and was compared to standard care.

The evaluation is very applicable to the guideline as it has very minor limitations. The author undertook appropriate economic methods in carrying out the cost-effectiveness analysis. The evaluation was conducted over an 18-month period.

The cost-effectiveness analysis is presented for the whole group and also for subgroups based on ethnicity (white, black, Asian). The perspective of the analysis includes both the public sector perspective and the societal perspective. The public sector includes costs to health and social care services, accommodation and the criminal justice system. The costs to society include public sector costs in addition to productivity losses (due to days of lost work) and costs of crime to society.

The results of the analysis for the whole sample indicate that, from the public sector perspective, joint-care planning has an 80% probability of being cost effective for every value that the decision-maker is willing to pay. From a societal perspective, there is a 44% chance of being cost effective if the decision-maker does not want to pay any additional cost, however, this rises to a probability of 55% if the decision-maker is willing to pay at least £9,000 per 1% reduced in compulsory admissions. These results are driven by the finding that, for the whole sample, there were no statistically significant differences in compulsory admissions and that there were non-statistically significant differences in costs between groups. From the public sector perspective, intervention group costs were £17,233 (SD=£21,013) and for the control group, £19,217 (SD=£28,133) (p=0.414). From the societal perspective, intervention costs were £22,501 (SD=£28,103) and for the control group, £22,851 (£34,532) (p=0.902). These analyses include the costs of the intervention, which is £224 (SD=£367) per person.

However, results for the whole sample masks wide differences in cost-effectiveness between ethnicities. For the sub-group analysis and from the public sector perspective, the intervention is more cost effective for black ethnicity (90% probability of being cost effective across all values that a decision-maker is willing to pay per 1% in reduced compulsory admission). For black ethnicity, individuals had better outcomes (fewer compulsory admissions) and lower costs; this is compared to white ethnicity that had no difference in compulsory admissions but higher costs (the intervention had a 25–35% probability of being cost effective). The intervention was not cost effective for Asian ethnicity, with a 20% chance that the intervention is cost effective if decision-makers were willing to pay between £0 and £10,000 and likelihood decreases at higher values (worse outcomes [higher proportions with compulsory admissions] and higher costs). From a societal perspective, sub-group results were similar.

The authors undertook appropriate sensitivity analyses and results of cost-effectiveness did not change. Sensitivity analyses were conducted on the costs of the intervention, value of productivity losses, and using imputation for missing data.

The strengths of the study are that it captures a wide range of individuals in relation to ethnicity and age (16+). Furthermore, the study is recent (2008–10) and it covers 4 geographical sites (Lancashire, South London, Manchester and Birmingham). It also includes a broad perspective for the economic analysis (including all relevant sectors: health, social care, accommodation, criminal justice, and societal perspective: productivity losses and societal costs of crime) and that it is measured over an adequately long enough time horizon (18 months). While not a major limitation, the analysis is not presented in terms of QALYs or other measures of wellbeing or physical and mental health symptoms; however, the authors justify this as they did not believe that the intervention would affect QALYs but would primarily attempt to improve the admission process and reduce compulsory readmissions in the future (the primary outcome). Another important consideration is the exclusion criteria, excluding those subject to the Mental Health Act. The authors justify this on ethical grounds that including them may put perceived pressure to participate. Therefore, one must consider this when attempting to generalise to this group.

The study has high reporting quality and measures data at all-important points (baseline and follow-up) over adequately long time horizons (18 months post-randomisation). The collection of resource use was adequate using a self-report survey that had been previously used in mental health populations and were supplemented with data from clinical databases. Appropriate approaches were used to calculate unit costs and costs of the intervention (using bottom-up micro-costing approach). The authors also undertook appropriate statistical analyses and sensitivity analyses to account for uncertainties. In particular, they consider where productivity losses are costed at zero because of the possibility that workers can be replaced from a pool of unemployed people. Appropriate sensitivity analyses were also carried out when assuming that a greater number of joint-crisis plans could be facilitated (from 2 to 4 per week) as experience increases.

2. Kessing LV et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: randomised clinical trial

Kessing et al. (2013) was a non-UK study from Denmark rated with moderate internal and external validity (+/+). This study evaluated the impact of a specialised outpatient bipolar clinic compared to generic outpatient services. The study included all psychiatric inpatients discharged from acute care for the first, second, or third time with a diagnosis of single manic episode or bipolar disorder as the primary diagnosis. Individuals were allowed in the study even if they had substance misuse. Most individuals were employed (70% intervention group, 50% control group) and had a median age of 37.6 years old (IQR=27-48 years old).

The specialist outpatient clinic is staffed by a full time psychiatrist, psychologist, nurse, and social worker who has specific training in bipolar disorder. The treatment consists of staff providing an evidence-based combined pharmacological and non-pharmacological intervention for 2 years. House visits were not made as a general rule but if treatment was not attended the GP or psychiatrist specialist was notified. House visits are made only in the event of acute suicidal danger (Personal communication, Kessing 2015). Treatment was provided in 3 stages plus an intervention for relatives of patients. In the first stage, treatment is aimed at discussing ‘current clinical status, beliefs, and experiences in relation to the recent hospitalization’ (Kessing et al. 2013, p4). Individuals are in this group until they are partially remitted from symptoms (<14 for mania and depression on the Hamilton Depression Score and the Young Mania Rating Scale). This usually lasts between a few months to half a year. The second stage of treatment is either group psychoeducation or group cognitive behavioural therapy, decided in collaboration by patient and clinician. Sessions last 12 weeks for 1.5 hours each week. The last stage is a 3–6-month training discharge group prepared the individual for ‘re-referral to the initially referring physician with the aim of identifying individual early warning signals prospectively in practice and training of how to change upcoming personal conflicts and cognitive distortions’ (Kessing et al. 2013, p4). The relatives of patients are also able to receive services. They receive a manual based psycho-educative group for 6 weeks lasting 2 hours each week.

The evaluation has limited applicability to the guideline because there are potentially serious limitations in study design. First, generalisability of results to the UK is unclear due to differences in institutional factors and that unit costs are different. Second, the economic analysis was conducted taking the perspective of direct treatment costs only and does not include the costs that may have arisen to other health services, local authority, or society. In light of these limitations the study is informative in relation to changes in acute care resource use.

In light of these limitations and from such a limited perspective, the results are presented as a cost–consequence analysis. The economic evaluation is also presented as a cost–consequence analysis. The results show that the total costs of the intervention, inclusive of the direct treatment costs are lower due to cost-offsets from reduced use of acute care services and from greater time in the community before first readmission and lower total duration in inpatient care. There were no differences in symptoms, either depressive or manic but results may be flawed due to low response rates. Satisfaction with treatment was also better for the intervention group and there was higher use of medications (statistically significant greater use of antipsychotics [p=0.02] and mood stabilisers [p=0.004] but no difference in use of anti-depressants [p=0.8]). Inpatient costs were lower in the intervention group compared to the control group by €7,024 over the 2.5 year period using 2012 prices (intervention, €14, 487 vs control, €21,511, no confidence interval provided). Direct treatment costs were estimated to be €9,604 for the intervention group compared to €6,604 for the control group (no confidence interval provided). As a result of lower inpatient costs, total net costs are lower for the intervention group by €3,194 (intervention, €25,953 vs control, €29,147).

Understanding whether results are transferrable to the UK context would requires further analysis. This is due to differences in institutional context (different patterns of service use) in addition to differences in unit costs.

Evidence statements (including economic evidence statements)

RR1	There is moderate evidence from 1 small RCT (Dush 2001 +/+) that people attending open access emergency clinics who have been assessed as needing admission may be diverted from admission with intensive support, including home visits, cognitive and psychological treatments and assistance with practical issues. Although the suggested approach is from a clinical team, the intervention may be cost effective.
RR2	There is moderate evidence from 1 small RCT with a short (4-month) follow-up period (Bach and Hayes 2002 +/+) that rehospitalisation, and the time to readmission, may be reduced through the use of psychological treatment, delivered in pre-discharge sessions, which impacts on psychotic delusions and auditory hallucinations (or voices). The therapy aims to equip the person to contextualise the symptoms (e.g. by identifying events which bring them on), distinguish them from reality, promote coping strategies to reduce the distress caused and to encourage ‘acceptance’ of the symptoms, so that they do not lead to hospital readmission.
RR3	There is moderate evidence from 1 small RCT (Lay et al. 2015 +/+) that a mixed individualised intervention beginning in hospital and including needs and strengths assessment, relapse prevention, triggers of rehospitalisation, crisis card production and telephone monitoring (monthly for 2 years after discharge) may reduce the number and length of formal (involuntary) psychiatric readmissions in patients with a history of such admissions.
RR4	There is moderate evidence from a German RCT (Pitschel-Walz et al. 2006 +/+) that a programme for people with schizophrenia of (8) psychoeducational sessions (some delivered before and some after discharge) focussing on symptoms, aetiology, acute treatment, relapse prevention and psychological treatment of schizophrenia may help to reduce readmission rates. Adequate coping strategies were discussed; and individual crisis plans were drawn up. The study sample suffered high attrition rates, and the inclusion of carers in the programme may have affected outcomes (in either direction) for individual patients.
RR5	There is moderate evidence from a UK RCT (Papageorgiou et al. 2002 +/-), and good evidence from a high quality UK RCT (Thornicroft et al. 2013 +/++) that advance directives and joint crisis plans drawn up while a person is able to consider their preferences for care do not reduce the number and length of compulsory admissions for patients with psychotic illness.
RR6	There is good evidence from a study of moderate quality (Papageorgiou et al. (2002 +/-), and from a high quality UK RCT (Thornicroft et al. 2013 +/++) that the legal status of advance directives and joint crisis plans (JCPs) as an influence over how people are treated in the event of a crisis is unclear to all parties, and that many (but not all) practitioners do not consider them to be an important aspect of co-production, and do not refer to them or implement them when a person comes into psychiatric care. Evidence of a small improvement in the secondary outcome of therapeutic relationships with nurse facilitators of the JCP (from Thornicroft 2013) may arise from the collaborative approach to drawing up JCPs which some facilitators adopted.
RR7	There is high quality evidence from a UK RCT (Burns et al. 2013 ++/++) that Community Treatment Orders (CTOs) for patients with psychosis offer no advantages to those on them, and no significant differences in number and length of admissions. A lesser quality pilot study (Steadman et al. 2001 +/+) of US Involuntary Commitment Orders also found no differences in outcomes (despite enhanced and more intensive outpatient services being made

	available to the intervention group).
RR8	There is evidence of a poorer quality older US RCT (Swartz et al. 1999 +/-) to suggest that Involuntary Commitment Orders may have positive effects on psychotic patients readmission rates, but only if they are supplemented by intensive outpatient treatment. This then confuses the effective intervention.
RR9	There is evidence of moderate quality from a Danish RCT (Kessing et al. 2013 +/+), that people with bipolar affective disorder who have had at least 1 admission to a general psychiatric unit have significantly fewer readmissions if they are treated in a specialised mood disorder clinic, offering pharmacological treatment plus group psychoeducation. (Specialist treatment may benefit patient populations with other specific disorders, but we found no studies exploring this point.)
RR10	There is evidence of moderate quality from a US RCT (Sledge et al. 2011 +/+), that people who have undergone at least 2 prior hospitalisations may benefit, and reduce their likelihood of rehospitalisation, from peer support from people who have experience of mental illness, and have been trained to provide such support.
RR11	There is evidence of low quality from a small UK survey study (with very low response rates) (Fahy et al. 2013 -/+) that people who are put on Community Treatment Orders (CTOs) often do not feel consulted or informed about them, but are likely to think that agreeing and conforming to them is the only way they can secure discharge from hospital. There was little understanding that use of the CTO to recall a patient into an acute unit would be linked to assessment of the risk to a patient, rather than to outright refusal to conform to conditions set. There were mixed views on the extent to which people felt their liberty was restricted.
RR12	There is evidence of a poor to moderate UK study (Papageorgiou et al. 2004 -/+) that people who have advance directives express preferences for about reduced coercion or enhanced human rights, the increased availability of alternative therapies, counselling, psychotherapy, better hospital facilities (e.g. ‘my own room’) and staff contact with their families. Some 40% reported that they would want to use the directives again, but a similar number did not find them useful because the professionals involved in their care did not refer to, or acknowledge, them in subsequent care. This latter conclusion was reinforced by consultant psychiatrists, 71% of those responding saying they did not recollect the patient having an advance directive.
RR13	There is evidence of moderate quality from 2 UK qualitative studies (Stroud 2015 +/+ and Canvin 2014 +/+) that understanding of how Community Treatment Orders (CTOs) work in practice varies considerably. While Canvin revealed that service users, carers and professionals saw CTO’s legal clout as the main facilitator for achieving their purpose (especially medication adherence), all groups showed uncertainty over the exact criteria for recall to hospital. Both the studies raised ethical concerns because they revealed that professionals were not incentivised to ensure that people were fully informed about the extent of the legal standing of CTOs for fear that it would lessen respect for their perceived ‘power’. Service users often believed, mistakenly, that to break a condition would automatically result in recall. This lack of clarity in service users’ understanding produced a sense of unease among professionals (particularly AMHPs) that legal powers were weaker in reality than presented (Stroud 2015).

RR14	There is evidence of moderate quality from 1 UK study (Stroud 2015 +/+) that some, but not all service users, practitioners, and nearest relatives value Community Treatment Orders (CTOs) as a 'safety net'. In particular, nearest relatives and housing service providers who otherwise felt unsupported by mental health services were reassured by the perceived legal authority and enforceability of CTOs. Carers responded positively to CTOs and particularly appreciated having clear contacts to call, and that an emergency appointment could be triggered quickly without the need for a new mental health assessment. Similarly, another moderate quality UK qualitative study (Canvin 2014 +/+) found that carers' knowledge that the person they cared for could be returned to hospital without fully relapsing allayed their fears about patient wellbeing, and in some cases, their own safety.
RR15	There is evidence of moderate quality from 2 UK qualitative studies (Stroud 2015 +/+ and Canvin 2014 +/+) that there is considerable variability in effectiveness of Community Treatment Orders (CTOs). Some service users described enjoying greater stability since being on a CTO, and others found the close monitoring of medication intrusive and disempowering; not many service users thought the CTO had reduced time spent in hospital or reduced readmissions. Psychiatrists were able to give examples where they thought a CTO had produced a beneficial effect, but this was very dependent on the type of patient. CTOs were viewed as useful for a restricted group of 'revolving door' patients for whom other options had been unsuccessful. CTOs were considered to be more successful when they were carefully planned, as opposed to being made as a matter of course.
RR16	There is moderate quality evidence from 1 UK qualitative study (Canvin 2014 +/+) that psychiatrists, patients and carers all perceive the main purpose of the Community Treatment Order (CTO) to be enforcement of medication. The strong emphasis on medication adherence – and the failure to address lack of motivation or desire to engage socially – was considered a major flaw by carers and services users alike. Overemphasis on medication adherence was seen to impede recovery and prevent patients from having a normal social life or being able to work. However, in contrast, psychiatrists emphasised that people under CTOs did not receive preferential treatment and tended to focus narrowly on enforceability and achievability when designing conditions.
RR17	We found no evidence on the role of crisis resolution and/or home treatment teams in reducing readmissions to inpatient mental health settings through interventions delivered before, after or during transitions (scope 4.3.1 (e)). The guideline committee discussed this issue and agreed that it was likely that these teams were effectively gatekeeping beds, and that services would already have considered and rejected the option of treating people who are admitted in a community setting.
Ec RR 1	There is high quality evidence from 1 UK study (Barrett et al 2013 +/++) comparing joint crisis plans plus usual care vs usual care alone. They focus on individuals aged 16+ with a history of previous psychiatric hospitalisations. This study is applicable to the guideline and it has very minor limitations. The results of the analysis for the whole sample (over an 18-month period) indicate that, from the public sector perspective (2009/10 prices), joint crisis planning has an 80% probability of being cost effective for a 1% reduction in compulsory admissions. The public sector perspective included service use from the NHS, personal social services, housing and criminal justice services. However, from a societal perspective, there is no clear evidence that it is cost effective – there is a 44% chance of being cost effective if the decision-maker does not want to pay any additional cost, however, this rises to a probability

	of 55% if the decision-maker is willing to pay at least £9,000 per 1% percent reduced in compulsory admissions. Sub-group analyses from the public sector perspective indicate that the intervention is more cost effective for black ethnicity (90% probability of being cost effective across all values that a decision maker is willing to pay per 1% in reduced compulsory admission). For black ethnicity, individuals had better outcomes (fewer compulsory admissions) and lower costs; this is compared to white ethnicity that had no difference in compulsory admissions but higher costs (the intervention had a 25–35% probability of being cost effective). The intervention was not cost effective for Asian ethnicity, with a 20% chance that the intervention is cost effective if decision-makers were willing to pay between £0 and £10,000 and likelihood decreases at higher values (worse outcomes, higher proportions with compulsory admissions and higher costs). From societal perspective, sub-group results were similar.
Ec RR 2	There is 1 moderate quality non-UK study (Kessing 2013 +/+) comparing a multi-staged psychological intervention over a 24-month period in addition to group psychoeducation for their carers compared to treatment as usual. The study focused on individuals in the early stages of bipolar I disorder, defined as having between 1 to 3 hospital admissions. Individuals were allowed in the study even if they had substance misuse. This study has limited applicability to the guideline due to issues of generalising non-UK results to a UK context (institutional factors and unit cost differences). Additional analysis is required in order to understand the extent to which results are likely to be transferrable to the UK. The study also has potentially serious limitations because the analysis took a very limited perspective and only included direct treatment costs plus use of acute care services. It did not measure changes that may have arisen in other health or social services or impact on carers. In spite of these limitations, the results show that the costs of the intervention are offset by lower inpatient stay (measured over a 30-month period). There were no differences in symptoms, either depressive or manic but results may be flawed due to low response rates.

Included studies for the reducing readmissions review question (full citation, alphabetical order)

Bach P, Hayes SC (2002) The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients: a randomized controlled trial. Journal of Consulting and Clinical Psychology 70: 1129–39

Barrett B, Waheed W, Farrelly S, et al. (2013) Randomised controlled trial of joint crisis plans to reduce compulsory treatment for people with psychosis: Economic outcomes. PloS One 8: 11. e74210

Burns T, Rugkasa J, Molodynski A, et al. (2013) Community treatment orders for patients with psychosis (OCTET): A randomised controlled trial. The Lancet 381: 1627–33

Canvin K, Rugkåsa J, Sinclair J, Burns T (2014) Patient, psychiatrist and family carer experiences of community treatment orders: qualitative study. Social Psychiatry and Psychiatric Epidemiology 49: 1873–82

Dush DM, Ayres SY, Curtis C, et al. (2001) Reducing psychiatric hospital use of the rural poor through intensive transitional acute care. Psychiatric Rehabilitation Journal 25: 28–34

Fahy GM, Javaid S, Best J (2013) Supervised community treatment: patient perspectives in two Merseyside mental health teams. Mental Health Review Journal 18: 157–64

Kessing LV, Hansen HV, Hvenegaard A, et al. (2013) Treatment in a specialised out-patient mood disorder clinic v. standard out-patient treatment in the early course of bipolar disorder: Randomised clinical trial. The British Journal of Psychiatry 202: 212–19

Lay B, Blank C, Lengler S et al. (2015) Preventing compulsory admission to psychiatric inpatient care using psychoeducation and monitoring: feasibility and outcomes after 12 months. European Archives of Psychiatry and Clinical Neuroscience 265: 209–17

Papageorgiou A, King M, Janmohamed A, et al. (2002) Advance directives for patients compulsorily admitted to hospital with serious mental illness. Randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science 181: 513–9

Papageorgiou A, Janmohamed A, King M, et al. (2004) Advance directives for patients compulsorily admitted to hospital with serious mental disorders: directive content and feedback from patients and professionals. Journal of Mental Health 13: 379–88

Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52

Sledge WH, Lawless M, Sells D, et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatric Services 62: 541–4

Steadman HJ, Gounis K, Dennis D, et al. (2001) Assessing the New York City involuntary outpatient commitment pilot program. Psychiatric Services 52: 330–6

Stroud J, Banks L, Doughty K (2015) Community treatment orders: learning from experiences of service users, practitioners and nearest relatives. Journal of Mental Health 24: 88–92

Swartz MS, Swanson JW, Wagner HR, et al. (1999) Can involuntary outpatient commitment reduce hospital recidivism?: Findings from a randomized trial with severely mentally ill individuals. The American Journal of Psychiatry 156: 1968–75

Thornicroft G, Farrelly S, Szmukler G, et al. (2013) Clinical outcomes of Joint Crisis Plans to reduce compulsory treatment for people with psychosis: A randomised controlled trial. The Lancet 381 (9878): 1634–41

2.4 Transitions from inpatient mental health settings to community or care home settings for people with dementia

Introduction to the review questions

The main aim of the review question was to evaluate the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings. The main focus for this question was specialist dementia units within adult mental health inpatient settings.

After the first screening of search outputs, we identified 20 studies which appeared relevant on the basis of information included in their titles and abstracts. After reviewing these, we excluded those that were clearly not on topic and ordered 6 full texts as they appeared relevant. We then read the full texts of these 6 papers to consider them for inclusion. We established that there were no studies relevant to transitions for people with dementia in or out of inpatient units providing mental healthcare. All screening decisions were verified and checked for consistency between different individuals within the review team.

Below is a summary of the key reviewing stages.

Review question for evidence of effectiveness

7. What is the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify the impact and effectiveness of the different ways (including specific interventions and services to aid integration into community settings and specialist and general services, including those supporting social participation) in which adults living with dementia are supported through safe and timely admission to inpatient mental health settings from community or care home settings

- identify the impact and effectiveness of the different ways (including specific interventions) in which adults living with dementia are supported through safe and timely transfers of care from inpatient mental health settings to community or care home settings
- assess the cost-effectiveness of interventions designed to improve transitions between inpatient mental health settings and community or care home settings, for people living with dementia
- identify and evaluate variation and opportunities for improvement in approaches to reducing readmission and time spent in inpatient mental health settings for people subject to the provisions of the Mental Health Act, Deprivation of Liberty restrictions or the Mental Capacity Act
- consider the impact of out-of-area placements (placement in specialist services or in services with available beds) on admissions into, and discharge from, inpatient mental health settings for people living with dementia.

Population

Adults living with dementia who are in transition between inpatient mental health settings and community or care home settings and their families, partners and carers, including self-funders and people who organise their own care or whose families organise their care.

This topic is relevant to the whole population. Protected characteristics under the Equality Act 2010 were considered throughout the development of the scope. In addition, it is recognised that the needs and experience of particular service users and carers may raise issues specific to that population. These include people without stable accommodation; people of minority ethnic background; people with co-morbidities including substance misuse; people with communication difficulties, sensory impairment or learning difficulties; people treated under a section of the Mental Health Act (and/or people under Ministry of Justice restrictions and people treated under Mental Capacity Act); and people placed out-of-area. The review process included and sought evidence of any considerations specific to these groups of people. The full list of people considered in this respect is outlined in the Equality Impact Statement published on NICE website (Equality impact assessment).

Intervention

Personalised and integrated assessment, discharge planning and care and support specifically for people living with dementia. Usual treatment compared to the effectiveness of an innovative intervention.

Setting

Service users' own home, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes, and all inpatient mental health settings for adults and older people (including specialist dementia units in mental health inpatient settings).

Outcomes

User- and carer-related outcomes (such as user and carer satisfaction; quality of life; quality and continuity of care; independence, choice and control; involvement in decision-making.) Also suicide rates and years of life saved. Service outcomes such as use of mental health and social care services, unplanned or inappropriate admissions, length of hospital stay, readmissions and need for unpaid care and support.

The study designs relevant to this question were:

- systematic reviews of studies of different models of assessment (on admission and discharge), care planning and support for people living with dementia
- RCTs of different approaches to assessment, care planning and support (on admission and discharge) for people living with dementia
- economic evaluations
- quantitative and qualitative evaluations of different approaches to supporting the transition of people living with dementia

- observational and descriptive studies of process
- cohort studies, case control and before and after studies
- mixed methods studies.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units’ or hospitalised patients with mental disorders, and b) the process of ‘transition’, discharge, admission, to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept is used to focus the search on particular study designs to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups, and economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also undertaken.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transition between community and care home to inpatient hospital settings for adults with social care needs. The search was restricted to studies published from 1999 onwards. This is on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken in January 2015 will be updated in March 2016 to identify new studies that might meet the inclusion criteria and may alter the recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder)
- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions)
- setting (inpatient mental health acute hospital setting, community setting or care home)

- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. We identified 20 studies which had appeared relevant by title and abstract at the first screening of search outputs. These 20 papers were independently screened by at least 2 reviewers. We ordered 6 full texts from the set that we felt might be relevant, and reviewed these for relevance to the review question and research design, coding our decisions in EPPI Reviewer 4.

Results

We reviewed all 20 studies which had appeared relevant by title and abstract at the first screening of search outputs. We ordered 6 full texts from the set of 20 that we felt might be relevant, and read these full texts to consider if these papers should be included. We concluded that none of these 6 studies met our review question criteria. These are listed below with the reasons for exclusion inserted in the list.

Anderson K, Bird M, Blair A, MacPherson S (2014) Development and effectiveness of an integrated inpatient and community service for challenging behaviour in late life: from confused and disturbed elderly to transitional behavioural assessment and intervention service. Dementia

Excluded, out of scope: this is a small Australian feasibility evaluation using structured measures, but was felt very unlikely to apply to the UK setting. It was unclear what treatment or intervention was made available, but ‘challenging behaviour’ – i.e. a possible symptom of dementia rather than an aspect of general mental health – was the key eligibility criterion for inclusion.

Bloomer M, Digby R, Tan H, Crawford K, Williams A (2014) The experience of family carers of people with dementia who are hospitalised. Dementia

Excluded, out of scope: participants were from a general hospital setting. Sixty-bed geriatric evaluation and management facility forms part of a health service network in Melbourne, Victoria. The facility focused on the rehabilitation of older people with multiple physical health problems.

Chene B (2006) Dementia and residential placement: a view from the carers' perspective. Qualitative Social Work 5: 187–215

Excluded, out of scope: transition here is about moving from being cared for at home to residential care.

Pashby P, Hann J, Sunico M (2009) Dementia care planning: shared experience and collaboration. Journal of Gerontological Social Work 52(8): 837–48

Excluded, out of scope: this paper is about staff and carer experience on an inpatient assessment ward, with no transition.

Spencer K, Foster P, Whittamore KH, Goldberg SE, Harwood RH (2013) Delivering dementia care differently – evaluating the differences and similarities between a specialist medical and mental health unit and standard acute care wards: a qualitative study of family carers' perceptions of quality of care. BMJ Open 3

Excluded, out of scope: as a qualitative complement to the Goldberg study below, this paper was about the inpatient experience of a dedicated ward in a general hospital, not about transitions.

Wismayer FS, Sipos A (1999) Neuroleptics in dementia: two consecutive surveys of prescribing practice at the interface of hospital and primary care. Psychiatric Bulletin 23: 409–12

Excluded, out of scope: the surveys do not measure the effectiveness of an intervention against another or care as usual. They compare results over 2 years, from a sample of 18 people discharged on neuroleptics in 1995, and 24 discharged in 1996. This is a clinical study and certainly not generalisable to current practice.

We also noted that we had included a paper linked to the Spencer et al. (2013) paper above in the admissions review question. This paper was:

Goldberg SE, Bradshaw LE, Kearney FC et al. (2013) Care in specialist medical and mental health unit compared with standard care for older people with cognitive impairment admitted to general hospital: randomised controlled trial. BMJ 347: f4132

This appears to be incorrectly included in the admissions section (above), as it is not about admissions but about the inpatient ward environment of a dementia-specific ward within a general hospital, where the care offered was for acute physical (not mental health) problems.

The team revisited the output from the searches to see whether any of the material not retrieved in full text previously might be relevant – for example qualitative studies from outside the UK – but this process did not identify any further relevant papers.

In conclusion therefore, we found no evidence on effectiveness or cost-effectiveness of interventions designed to improve transitions between inpatient mental health settings and community or care home settings for people living with dementia. Furthermore:

- We found no research identifying and evaluating variation and opportunities for improvement in approaches to reducing readmission and time spent in inpatient mental health settings for people living with dementia.
- We found no evidence on the impact of out of area placements (placement in specialist services or in services with available beds) on admissions into, and discharge from, inpatient mental health settings for people living with dementia.
- We also found no evidence that people living with dementia had access to inpatient support with other mental health problems (where dementia may be masking other treatable mental health issues). Liaison and support

between practitioners in inpatient mental health and in care home settings were of particular interest for this topic.

Because no papers were identified for the dementia review question, we have not presented a narrative summary. We presented our findings to the guideline committee and agreed that we would invite an expert witness to address this gap, drawing on their practice experience.

Expert witness testimony

The need for expert testimony

In light of the limitations of the evidence in this review area, the guideline committee agreed to try and address this gap through inviting an expert witness. Members sought expert witness testimony about the effectiveness or impact of specific interventions designed to support people living with dementia and their carers during transition between inpatient mental health settings and community or care home settings. These might include aspects of support, including innovative models or approaches, specific interventions, tools and other components of care that helped to facilitate admission to and discharge from inpatient mental health settings for people with dementia.

Testimony

The full testimony from the expert can be found in Appendix D. In brief, the witness, who was a consultant practitioner in a large mental health trust, discussed the issues that can cause delays or problems during transition from community or care homes to inpatient mental health settings, and discharge from inpatient settings back to the community. The focus of the evidence was on promoting good practice in discharging people with dementia to care homes. Issues identified include:

- poor communication between practitioners, the person with dementia and their carers
- poor communication between inpatient practitioners and the staff at the care home that the individual is being discharged to

- lack of clarity about what information is required to help facilitate smoother transitions
- lack of adequate planning for discharge.

Good practice therefore includes extensive communication with staff at the new home. This should specifically support consideration of whether the care home to which the person is being discharged has the resources and expertise to adequately care for the person. Communication to record and plan care going forward is also essential, and the practitioner presented a checklist which had been designed as a key tool to cover a range of potentially very complex needs. This written record could then be shared and discussed with the practitioners to which the person was to be discharged. Planning the move is also critical to help facilitate a smooth transition and includes drawing up an individual timetable and holding a discharge meeting which includes key staff from the ward and care home staff as well as the person with dementia. The person with dementia and their carer(s) should have the opportunity to visit the new care setting, and where this is not possible, photos or videos could be provided. Discharge should take place at a time when care home staff would be available to support the person, and should be postponed if the person is not well on the designated day. Ideally, a member of staff would accompany the person to liaise with care home staff. In all cases, ongoing contact with the ward would be offered, and inpatient staff would make a phone call after 48 hours to check that the individual is settling in. A member of the inpatient team would make a follow-up visit after a week has elapsed to make sure that there are no problems for the person in the new care setting.

2.5 Transitions from inpatient mental health settings to community or care home settings for children and young people

Introduction to the review questions

The purpose of the review questions was to examine research about the effectiveness and cost-effectiveness of specific interventions or approaches to support children and young people during transitions from mental health inpatient settings to home or care home settings. The questions also aimed to consider research which systematically collected the views and experiences of children and young people using services, as well as those of their families and carers and those of care and support staff involved in transitions. (In line with the scope, transitions involving inpatient general healthcare settings are not addressed by this review question.)

Review question for evidence of effectiveness

8. What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?

Review questions for evidence of views and experiences

The review questions considered in relation to views and experience of discharge were:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify the impact and effectiveness of the different ways (including specific interventions and services aimed at maintaining participation in education) in which children and young people are supported through safe and timely admission to inpatient mental health settings from community or care home settings
- identify the impact and effectiveness of the different ways (including specific interventions and specific services that support children and young people to participate in mainstream education, employment and social and leisure activities) in which children and young people are supported through safe and timely transfers of care from inpatient mental health settings to community or care home settings
- assess the cost-effectiveness of interventions designed to improve transitions between inpatient mental health settings and community or care home settings, for children and young people
- consider the impact of out of area placements (placement in specialist services or in services with available beds) on admissions into, and discharge from, inpatient mental health settings for children and young people.

For the views and experiences review questions, the protocol sought to identify studies specifically relating to transitions between inpatient mental health settings to community or care homes settings for children and young people that would:

- describe the self-reported views and lived experiences of people using services about the care and support they receive during a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings
- consider specifically whether people using services think that their care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and, where appropriate, housing, education and employment services
- consider what service users, families and carers think supports good care during transition, and what needs to change
- describe the self-reported views and lived experiences of families and carers of people using services about the care and support provided for people using services at a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings
- consider specifically whether families and carers of people using services think that care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and, where appropriate, housing, education and employment services
- consider what families and carers think supports good care during transition, and what needs to change
- to describe the views and experiences of people delivering, organising and commissioning mental and general healthcare, social care and other relevant services such as housing, employment and education about the care and support provided during transition from inpatient mental health settings to community or care home settings
- to collect evidence on key practice and workforce issues which may impact on transitions and should be considered within the guideline

- to highlight aspects of the transition from inpatient mental health settings to community or care home settings which work well, and are i) personalised and ii) integrated, as perceived by practitioners, managers and commissioners.

Population

Children and young people who are in transition between inpatient mental health settings and community or care home settings and their families, parents and carers, including self-funders and people who organise their own care, or whose families organise their care.

Social care practitioners (providers, workers, managers, social workers) and health and social care commissioners involved in delivering care and support to children and young people during transition between inpatient mental health settings and community or care home settings; approved mental health professionals; advocates; personal assistants engaged by children and young people with mental health problems and their families. General practice and other community-based healthcare and mental health practitioners: GPs and community psychiatric nurses, occupational therapists, psychologists, psychotherapists and other therapeutic professionals; psychiatrists and ward staff in inpatient mental health settings for children and young people (especially those with a role in admission and discharge procedures). Where relevant, the views of housing, employment and education practitioners and police and ambulance personnel involved in supporting children and young people during transition into or from inpatient mental health settings will be considered.

Intervention

Personalised and integrated assessment, admission, discharge planning and care and support specifically for children and young people. Usual treatment compared to the effectiveness of an innovative intervention. Specific services that support children and young people to participate in mainstream education, and social and leisure activities.

Setting

Service users' own homes, including temporary accommodation; supported housing; sheltered housing; foster care and care homes for children. All children's inpatient mental health settings, including tier 4 CAMHS, secure mental health settings for children and young people and specialist autism units.

Outcomes

User- and carer-related outcomes, such as user and carer satisfaction; quality of life; quality and continuity of care; independence, choice and control; involvement in decision-making. Also suicide rates and years of life saved. Service outcomes such as use of mental health and social care services, unplanned or inappropriate admissions, length of hospital stay, readmissions and need for unpaid care and support.

The study designs included for the effectiveness question on admission to and discharge from inpatient mental health settings were:

- systematic reviews of studies of different models of assessment, care planning and support at discharge
- RCTs of different approaches to discharge, assessment and care planning and support
- economic evaluations
- quantitative and qualitative evaluations of different approaches
- cohort studies, case control and before and after studies
- mixed methods studies.

The study designs relevant to the views and experiences questions were expected to include:

- systematic reviews of qualitative studies on this topic

- qualitative studies of user, carer and practitioner views of social, mental health and integrated care
- qualitative components of effectiveness and mixed methods studies
- observational, cohort and cross-sectional survey studies of user, carer and practitioner experience.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care, and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units’ or hospitalised patients with mental disorders, and b) the process of ‘transition‘, discharge, admission to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept used focused the search on particular study designs (see above) to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups; economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also carried out.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The search was restricted to studies published from 1999 onwards, on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken will be updated in March 2016 to identify new publications which meet inclusion criteria and may alter recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder)
- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions)

- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, randomised controlled studies, and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions. In some cases it was decided that the search output was too large to review in full text, and that we should select according to relevance and methodological quality (for example by prioritising UK views studies if there was a good quantity of views studies).

When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

Results

From 51 papers which appeared relevant to the review question upon first screening on title and abstract, we ordered 22 full text papers for full text review. Within this fairly narrow evidence base, most of the papers retrieved reported views and we therefore decided to consider views papers not only from the UK but also those which were about views of care in the EU, US, Canada, Australia and New Zealand.

Similarly, we anticipated that there were unlikely to be RCTs on this subject, particularly given some of the ethical problems of setting up RCTs in this area, and, indeed, we found this to be the case. We therefore decided to include comparative studies which used secondary data analysis and non-experimental methods design. It is important to note that all questions to evaluate effectiveness must be comparative and have a comparison group.

We were able to retrieve full texts for 19 of the 22 papers which we ordered. Reviewing the papers on full text we identified 9 papers which matched all of our criteria and were within scope. Seven papers were categorised as views and experience studies (n=7), with the remaining 2 papers falling under ‘effectiveness studies’ (n=2).

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=2)

1. Fontanella CA et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents

Outline: Fontanella et al. (2010) (+/+) is a US-based study that concludes that stabilisation strategies focused on medication management and discharge planning can decrease early readmission. The paper aims to understand the medication and discharge planning strategies employed by psychiatrists and social workers in inpatient hospitals for adolescents, and to describe their impact on preventing early readmission. For the purposes of this narrative, only the discharge planning specific data has been extracted as medication management is out of scope of this guideline.

The study uses secondary data selected from young people on the Medicaid register consecutively admitted to 3 private psychiatric hospitals in Maryland over a 1-year period between 1 July 1997 and 30 June 1998. From an initial number of 1595 patients various inclusion/exclusion criteria were applied resulting in a final sample of 517 adolescents with a mean age at admission of 14.3 years.

The authors acknowledge that discharge planning and timely and appropriate aftercare has an impact on the effectiveness of inpatient care.

‘Three variables were used to measure discharge planning practices and aftercare: placement at discharge (i.e. family home, foster care, group home respite program/transitional care and residential treatment); change in living situation; and referral to a partial hospitalization program’ (p121).

Results: the study found that discharge planning practices are strongly correlated with early readmission. The findings showed that a change in living arrangement at discharge reduced the risk of readmission by 82%. For example, a quarter of the sample was placed in a different living arrangement at discharge, commonly to a more restrictive one, such as a residential treatment centre. The researchers conclude that social work intervention that helps to facilitate the provision of a more stable living arrangement (such as remaining in the family home) or provide a more appropriate level of care, can help to reduce early readmission.

Type of aftercare arrangement was also strongly linked with readmission; the rate of readmission was 3.45 times more for young people placed in group homes at discharge compared to those placed with their families. The authors point out that it is likely that provision in group homes may not adequately meet the complex needs of young people in inpatient mental health settings, whose conditions are usually characterised by severe and enduring emotional and behavioural disturbances, past abuse and neglect, multiple previous placements and higher levels of psychotropic medication than young people not placed in group homes.

The findings also suggest that partial hospitalisation after care is linked to higher readmission rates. Again, it is important for us to note that this study does not have a comparison group that would allow us to assess intervention effectiveness and therefore is limited in terms of the extent to which it can answer our research question.

The authors note some limitations in their study. For example, the sample of adolescents included were covered by Medicaid and admitted to 3 private psychiatric hospitals, which may mean that findings may not be generalisable to general hospitals or other non-Medicaid populations. Second, the use of secondary data from medical records provides little understanding of actual decision-making processes.

2. Kyriakopoulos M et al. (2015) Emergency mental health admissions for children: a naturalistic study

Outline: Kyriakopoulos et al. (2015) (-/+) is a comparative study (emergency admission versus planned admission) based on secondary data. Emergency mental health admissions (EAs) for children under 13 years are not routinely offered in the UK, and the authors suggest this may be related to misconceived ideas about their safety, suitability and acceptability, as well as a severe shortage of beds. Consequently, children with severe mental health needs and their families experience delays in accessing appropriate inpatient CAMHS services and are often inappropriately admitted in paediatric beds or remain in the community waiting for an assessment.

This study examined the first UK sample of children (up to the age of 13) routinely admitted as emergencies in a national mental health unit, compared to children admitted after a pre-admission assessment. EAs are defined in this study in the context of the unit’s decision to continue to the admission on the basis of the information provided in the referral letter with no need for a pre-admission assessment. Planned admissions (PAs) were defined as such if there was an accompanying pre-admission assessment. Authors used a combination of retrospective data analysis of records of 82 admissions to the inpatient mental health unit (over a 3-year period from October 2009 and October 2012) and a 9-item questionnaire aimed at parents and children. EA and PA were compared on demographic and clinical characteristics, outcome measures, length of stay (LOS), significant risk-related incidents and children and parent satisfaction.

Results: the findings showed that EA children (n=47) did not differ from PA children (n=35) in age, length of admission, medication treatment, functioning at discharge, access to education at discharge and satisfaction levels. Furthermore, there was no difference in significant risk related incidents between the 2 groups.

Significantly, EAs showed a greater change than PAs in the main outcome measure Children's Global Assessment Scale (CGAS) – a measure of social and psychiatric functioning for children ages 4–16 years where the scores range from 1, very worst to 100, which is the very best. This was reflected as follows (mean CGAS change in EA: 36, mean CGAS change in PA: 25; t=2.595, df=80, p=0.011).

The authors acknowledge that for EA, the effect of mental health difficulties on CGAS scores at the point of admission seems to be greater in comparison with children admitted in a more planned way, and this could feasibly indicate the fact that these admissions are more likely to happen at a point of crisis. They also acknowledge that the lower EAs mean CGAS scores on admission (EAs: 23, PA: 30; t=-2.296, df=80, p=0.024) also determined to a degree the mean CGAS change (above) following inpatient interventions. However, the CGAS scores at discharge were not significantly different between the 2 groups, indicating that EA and PA children were equally affected by their difficulties at discharge. A total of 91% of parents (number not stated) completed a short 9-item satisfaction questionnaire designed to elicit both parent and children's views. A total of 70% of children (n=82) completed the relevant children's section. Satisfaction data suggests that parents favoured EAs and were happy with the fast response from the unit. The authors suggest that previous comprehensive discussion with the clinician making the referral, phone contact with the unit, access to information from the unit's detailed website, and the choice to stay in the unit's family flat for the first days of their child's admission, may have encouraged families to feel positive about the suitability of the inpatient unit for their child. In terms of children's responses, generally, satisfaction levels did not differ between EAs and PAs.

In summary, results indicate that EAs for children included in this study were not linked with increased numbers of inappropriate admissions, were safe, and were more acceptable to families than PAs. In other words, emergency admissions can be appropriate, clinically indicated, a safe substitute to planned admissions, and are favoured by parents. The findings also challenge the beliefs around the necessity of pre-admission assessments for children in need of inpatient treatment for safety reasons. The authors stress that wider take-up of this model is likely to benefit children and their families most in need of an intensive CAMHS care package due to their complexity and clinical need.

The authors note that the main limitation of the study is its use of retrospective data and lack of randomisation and stress that a randomised trial would provide more robust evidence in relation to EAs. However, they also point out that in a period of EAs being treated as potentially unsafe and undesirable for children and their families, a randomised trial would not be seen as ethical. Another limitation, not alluded to by the authors, was the absence of information indicating how many parents were consulted through the questionnaire. The researchers identified a limitation in terms of using a suitable definition of what represents an 'emergency'. They addressed this issue by considering referral requests for an immediate admission to the unit that had been accepted on the basis of information included in the referral letter – the main point being that the study aim was to the review the unit's response to these emergency admissions and compare this group with those admitted in a planned way. This study does not contain a comparison group that would allow us to assess intervention effectiveness and therefore is limited in terms of the extent to which it can answer our research question.

Studies reporting views and experience data (n=7)

1. Bobier C et al. (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients

Outline: Bobier (2009) (+/-) is a non-UK survey study (7 multiple choice and 3 open-ended questions) which aimed to assess the usefulness of a narrative discharge letter written to adolescent psychiatric inpatients as rated by the adolescents, family members and professionals who received them. Narrative letters contained an overview of the admission, progress, difficulties and achievements of the adolescent and aimed to be supportive and reflective as well as objective. Narrative discharge letters were introduced to the youth inpatient unit in 2006 as an alternative to issuing a copy of the professional discharge letter. Open-ended feedback showed that, on the whole, family members appreciated that the letters were written using language which was free of medical jargon and easy to understand. Family members' responses indicated that mental illness was isolating and 'scary' (p185), so the reassurance provided by clear communication was particularly appreciated.

Results: respondents (both parents and young people) stated that the map of the youth's journey (from pre-admission to post-discharge) gave them insight. Conceptualising the young person's experience made them feel empowered and more prepared for the future. In particular, parents said the information made them more aware of warning signs to look out for, and adolescents gained awareness of themselves and their situation. Outpatient professionals appreciated the opportunity provided by the narrative letter to support working in partnership with the young person, and across services. Some of the feedback was negative, with 1 adolescent responding that the letter barely correlated with his experience, and a health professional suggesting the letter would be improved by an increased emphasis on the whole family.

The survey scored low (-) on external validity, not only on account of its small sample size (n=38), but because the sample was derived from just 1 adolescent inpatient unit in New Zealand. However, as the study assessed the views of the children, families and professionals on the value of the discharge letter in supporting transition out of the hospital, the reviewers assessed it as being relevant for inclusion.

2. Clemens EV et al. (2011) Elements of successful school re-entry after psychiatric hospitalization

Outline: Clemens (2011) is a non-UK qualitative study of moderate quality (+) which aimed to assess mental health professionals' (n=14) views on the barriers and facilitators to adolescents' successful school reintegration after psychiatric hospitalisation. The sample comprised health professionals working in inpatient (n=4), outpatient (n=4) and school settings (n=6).

Results: communication and coordination with teachers about arranging extensions, accessing notes and appointing an adult support person for the student within the school were cited as facilitators of successful school re-entry. Equally, an initial planning meeting with teachers, including a time to follow-up, and encouraging the returning student to complete daily self-assessments were seen as important factors. Flexible re-entry plans which allow for a part-time return to education were seen as useful alternatives to immediate full school reintegration in certain cases.

Consistent parental investment in recovery was seen to be an important facilitator, along with direct and honest parental responses to students and the school about the recent hospitalisation. Planning for potential challenges and ensuring that the student has support from both the school and mental health services was another asset to re-entry. Across all categories the importance of communication came up as a recurring theme.

While the study took place in the US and did not take account of the views of students undergoing school re-entry transition or those of their parents, efforts were made to maximise the representativeness of the sample. The sample was taken from across 4 different psychiatric hospitals and 4 different schools, across 3 states. Interviewees were also required to have had recent experience of working with adolescents who were undergoing hospital to school transition.

3. Geraghty K et al. (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit

Outline: Geraghty K (2011) was a secondary data non-UK study of low quality (-) which used consultant records to investigate how families used a peer support service provided in an inpatient unit of a child and youth mental health service. Consultants all had personal experience of being parents and carers of children with mental health problems which they freely shared with users of the service.

A minority of all families of children who were admitted to the unit during the study period opted to make use of the service, so evidently the findings only represent views of the parents and siblings who used the service rather than those of the whole unit.

Results: parents expressed distress when talking about their experience of having their child admitted to a mental health unit. Over a third of parents experienced feelings of guilt and blame (appeared in 36% of the records). Feelings of guilt were associated with concern that they were responsible for the child’s illness or that they had failed them in some way.

Blame was not so much about personal culpability than concern that others – staff or other family members – would hold them accountable for their child’s illness. More general concern about how mental illness is perceived by the wider community was coded as ‘stigma and shame’ (p257) (which appeared in 18% of the records). Some parents described feelings of loss and grief (in 15% of records) and, in particular, some parents described having to deal with the ‘irrevocable’ change that had taken place in their child, and feeling pain at having to leave their child in hospital when they were clearly in a state of emotional distress. Hospital admission was seen as disruptive and over a third of parents (35%) voiced concern about the family challenges this presented, for example, the effect that the disruption may have on other children in the family. Need for information was detected in 36% of the records; within this theme, the most common requirement was for information on the child’s mental illness, followed by information on treatment options and information on support and resources.

The study has severe limitations not only because the data was analysed retrospectively, but also because the consultant records were only summaries (meaning specific context and surrounding details may have been lost). Parents were not asked specific questions, so the views presented here are only those that happened to feature in the selected files. Other issues surrounding selectivity and potential bias arise from the fact that 2 members of the consumer consultant service undertook the data analysis, although risk of bias was mitigated by the use of 2 outside auditors who verified their work. Bearing these limitations in mind, the study revealed that appreciation of the support service was signalled in over half (53%) of the themes; families made direct references to the value of being able to discuss their concerns with non-clinical people who had been through similar experiences.

4. Hepper F et al. (2005) Children's understanding of a psychiatric inpatient admission

Outline: Hepper (2005) is a qualitative study of moderate quality (+) which used semi-structured in-depth interviews with children aged 8 to 13 years (n=18) who were consecutively admitted to a specialist unit in West London. The children were interviewed at 2 phases; phase I – within 2 weeks of admission and phase II – shortly prior to discharge.

The aims of the study which are relevant to our review question are: 'to describe how children saw the nature of "the problem" that led to their admission'; and 'to obtain children's views about the potential social and personal costs of inpatient admission' (p559). The authors state that the therapeutic approach of the unit 'follows a behavioural model that encourages the children to become active collaborators in their treatment' (p560), and that the children attend pre-admission planning sessions. The single unit approach restricts the generalisability of the findings to the wider UK context.

Results: all 18 participants saw admission as being for the purpose of getting help for emotional or behavioural problems which were beyond their control and which ran the risk of them being excluded from school or home. Eleven of the children described their difficulty as having 'temper problems' (p563) which led them to do things they didn't want to do.

Interestingly, none of the children felt that admission was punitive and the children referred to the sense of containment which was created by staff as a key benefit. However, the constant surveillance and supervision by staff was also seen as a problem by others and the loss of independence interfered with coping strategies which were used at home. In 1 case, a child described increasing self-harming behaviour because she had been ‘so annoyed’ (p568) by the situation.

Regarding ‘personal and social costs of inpatient admission’ (p568) children described how they protected their social identity by way of strategies which legitimised their illness and reinvented psychiatric treatment as ‘cool’. Children controlled how others perceived the unit by normalising it, either by describing it as a school, or glamorising it by describing it as a ‘big brother’- type institution (p570).

The study’s external validity was marked as ‘somewhat relevant’ to the guideline. The study only maps onto our review question in part, as the children’s views on admission are addressed as part of a wider question about children’s perception of their involvement in their treatment.

5. Offord A et al. (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults’ retrospective views of treatment and discharge

Outline: Offord (2006) is a qualitative UK study of moderate quality (+) which aimed to find out the views of young adults on the treatment they had received for anorexia nervosa while admitted to a general adolescent psychiatric unit. The study was included because it focused specifically on views on admission and discharge, in addition to treatment. Seven white British females aged 16–23 opted into the study (out of a possible 50 participants). They were interviewed retrospectively (i.e. all participants had been discharged 2–5 years prior to the study).

Results: several participants described the initial taking away of control over their eating habits on admission as relieving and helpful. However, the majority of participants experienced a pervasive sense of being removed from the outside world upon admission. Loss of contact with the outside world made participants feel that their development was being suspended; caused problems relating to their emotional wellbeing; and posed a challenge to subsequent readjustment to the ‘real world’ (p379) following discharge. Many participants felt they were actively discouraged from taking part in ‘real world activities’ (p379), even those not linked to their eating disorder or to exercise.

Several participants felt that taking part in everyday activities outside of the unit would have helped with their transition following discharge. Incentives such as a new college course, new friends or a job were given as examples of key factors which helped with successful readjustment to the community.

Participants commented frequently that the contrast between high levels of structure and support in the unit and the lack of structure and support in the community led to high levels of dependency and painful feelings on discharge. Abrupt transitions were experienced as scary, while planned ones which adopted a gradual and collaborative approach were experienced much more positively.

Without this structured reclaiming of control, the sudden availability of freedom following discharge was seen to be unmanageable.

With hindsight, many participants agreed that it was important for them to receive a relatively high level of support following discharge, even though they may not have wanted continued contact at the time. Superficial and infrequent support after discharge was cited as a possible reason for relapse in 1 case. Participants said it was important that the level of support reflected the individual’s stage of recovery.

The reviewers felt that the sampling technique was inadequately reported, and the resulting sample was small and homogenous. The retrospective nature of the study – i.e. participants were interviewed 2 to 5 years after hospital discharge – ran the risk that participants would report misremembered details. At the same time it allowed time for the interviewees to reflect on their experiences. The authors reported that this was in keeping with the interpretative phenomenological analysis (IPA) approach which espouses that the important reality is that which people perceive it to be.

6. Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units

Outline: Scharer (2000) is a US qualitative study of moderate quality (+) which uses both interviews and observation to describe and analyse the relationships that develop between parents and nursing staff in inpatient and day hospital settings, during short-term hospital stays of up to 10 days. One explicit aim was to describe the critical points in the evolving relationship between parents and staff.

The admission period was recognised as 1 such critical point that shaped this relationship between parents and child psychiatric nurses. This research adds insight into an area where evidence is very poor.

This study is based on a sample of 12 parents whose children were hospitalised in 2 child psychiatry inpatient units, where the focus was their (parents') interactions with 13 nursing staff connected through a total of 21 relationships. The researcher employed to undertake this study had extensive work experience in child psychiatry units and also regularly visited the units during the research to develop an understanding of the culture and build trust with the research participants.

Results: all parents found the process of admitting their child a harrowing one, filled with fear and exasperation as well as a sense of their own failure – 1 parent described having to leave their distressed child on the ward as 'a major trauma' (p731). The research demonstrated that admission was a critical time in relationship-building between parents and nursing staff. The factors that shaped this admission phase were identified as 2-fold: firstly, the expectations of the participants in the relationship, and secondly the routines and norms of the unit.

In terms of expectations and perceptions, for example, some parents with former experience of psychiatric care anticipated that they would be judged or blamed and this made them feel nervous, thus consequently having a negative impact on their relationships with staff. One mother said: ‘I think it is important for the staff to understand what parents are going through. You know they’re going through the guilt and feel like everything they have done and are doing is being put under a microscope. That’s the initial feeling’ (p736). However, a non-judgemental, reassuring attitude from the admitting nurse can help allay these fears and concerns about being blamed for their child’s mental health problem. One parent was pleasantly surprised and felt greatly supported by the staff’s reassuring and supportive attitude in helping her deal with guilt.

When routines or norms were disrupted for some reason, the admission became more difficult, from the staff member’s perspective. Each nursing staff member had a set of expectations for the parents’ behaviour, 1 individual commenting: ‘I think ideally to expect the parents to be involved, be on the unit, and working with the care team. And learning how, you know, watching nurses interact with their children if they need help with that and learning from us’ (p737). Nurses described situations where they had heard reports about parents from other nurses, and – especially when they were negative as a result of a difficult admission – this influenced all staff and their interactions with the parent, while a properly orchestrated admission encouraged the development of a positive nurse–parent relationship.

All of the nurses and many of the parents expressed that the admission process was a pivotal part of relationship-building and the way this was experienced could ‘set the tone’ (p730) for the whole hospital stay. Within the context of current short-term hospital stays, the admission becomes a strategic time for information-sharing from the nurses’ viewpoint. For parents, most of whom bring their child to the unit during a crisis, admission is equally significant. While parents were inclined to talk about the stressful aspects of admission, the nurses typically described admission as an important time for assessment and data-gathering, as well as building relationships.

7. Turrell SL et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness

Outline: Turrell (2005) is a qualitative non-UK study (+) which used open-ended questionnaires to elicit views of adolescents with anorexia nervosa (n=14), their parents (n=14) and nursing staff (n=14) on conditions necessary for discharge readiness. Registered nurses (RNs) and parents completed questionnaires during the adolescent's first weekend pass (when they were allowed home), and adolescents (all female, and all experiencing first-time admission to the inpatient eating disorders unit for treatment for anorexia nervosa) completed the questionnaire after returning to hospital.

Results: adolescents described wanting to be educated on how to manage their meals if they were more active upon returning home. Parents and nurses both thought it was important for adolescents to have a clear understanding of meal plans.

Parents, nurses and adolescents all noted that psychological changes (encompassing cognitive, emotional and behavioural changes) would have to take place to ensure a successful transition. For example, adolescents stated they would have to eat without being supervised, and parents said that their daughters would need to have less anxiety about food.

One of the main findings of the study was that while nurses suggested these psychological changes would be necessary for both adolescents and parents, parents only identified a need for this change in their daughters. Similarly, nurses were the only group which described the need for parents to agree on the severity of the illness and to become active members of the treatment team. This discrepancy suggests that nurses thought that parents would still need to be involved with their child's recovery in the period after discharge, while parents may have assumed their child would be 'cured': nurses stated that parents would still need to supervise mealtimes and help with their child's eating problems. The authors, perhaps unfairly, make inferences about 'parental denial' throughout study.

All groups identified a need for community resource planning – follow-up care beyond meal and exercise plans. Adolescents stated that they would need as much warning as possible so that they could prepare for discharge, and that they would like individual counselling near their home. Parents sought coordination and follow-up with a local doctor, continued counselling and a hotline for urgent problems. Nurses identified the need for planned community involvement, such as social activities and/or peer support networks.

The limitations of study – small, homogenous sample from 1 unit in Canada– restrict its generalisability to the UK context. The study adopts a family systems approach, which assumes connectedness of the family and the healthcare team and allows little room for variation within family dynamics.

Evidence statements

CYP1	There is some evidence from 1 moderate quality qualitative UK study (Hepper et al. 2005, +) that children and young people who are treated as active collaborators in their care and attend pre-admission planning sessions do not see the reason for their admission as punitive, and understand it in terms of getting help for emotional or behavioural problems which are beyond their control and which have the potential to escalate to school or home exclusion.
CYP2	There is evidence from 1 qualitative UK study (Hepper et al. 2005 +) that some children and young people feel that the sense of containment created by staff is a key benefit of hospitalisation. For other children and young people the loss of independence and constant surveillance is distressing and can negatively interfere with coping strategies used at home.
CYP3	There is good evidence from 1 non-UK qualitative study of moderate quality (Scharer 2000 +) and 1 low quality secondary data non-UK study (Geraghty et al. 2011 -) that parents of children who are admitted to psychiatric units experience feelings of guilt and blame. Guilt manifests itself as a feeling that the parent is in some way responsible for the child's illness. Blame is less about personal accountability and materialises from the feeling that others – namely hospital staff, neighbours, family members – will hold them responsible for the child's illness. There was also evidence (Scharer 2000 +) that parents' concerns about being blamed arose from experiences with hospital staff on previous admissions. A non-judgemental, reassuring attitude from admitting staff can help to mitigate parents' fears that they are to blame for their child's illness
CYP4	There is some evidence from 1 non-UK qualitative study of moderate quality (Scharer 2000 +) to suggest that the admission process is a critical period in terms of forming and building relationships between parents and staff and this could positively or negatively impact the entire experience of the hospital stay.

CYP5	There is some evidence from 1 UK mixed methods study of moderate quality (Kyriakopoulos et al. 2015 -/+) that parents are in support of emergency admissions to inpatient mental health settings. Emergency admissions can be appropriate, 'clinically indicated' and a safe alternative to planned admissions.
CYP6	There is moderate evidence from 1 UK qualitative study (Offord et al. 2006 +) and 1 non-UK qualitative study (Turrell et al. 2005 +) that incentives and contact with the 'outside world' help to facilitate successful discharge for adolescents treated for anorexia nervosa. Nurses identified the need for planned community involvement, such as social activities and/or peer support networks as a factor of discharge readiness (Turrell et al. 2005 +). Adolescents treated for anorexia nervosa in a general psychiatric adolescent unit (Offord et al. 2006 +) described incentives such as a college course, new friends or a new job as key factors to ensure successful transition to the community. Upon admission adolescents felt actively discouraged from taking part in 'real world' activities, even those that were not linked to eating or exercise; this suspension of contact with the 'real world' was experienced as damaging to their emotional wellbeing and sense of development, and was seen as likely to exacerbate issues with readjustment after discharge.
CYP7	There is moderately good evidence from 2 qualitative studies – 1 UK (Offord et al. 2006 +) and 1 non-UK (Turrell et al. 2005 +) – that adolescents treated for anorexia nervosa value planned discharges which allow advance warning, and which are structured to give back control in small increments (e.g., allowing them to make their own meals and encouraging them to make their own decisions) in the run up to discharge. Hospital discharge which adopts a gradual and collaborative approach helps to moderate the stark contrast between the high levels of structure in the unit and the lack of structure in the outside world – the sudden availability of freedom being perceived by some as overwhelming and potentially problematic.
CYP8	A non-UK qualitative study (Turrell et al. 2005 +) provided moderate quality evidence that RNs, parents and adolescents all identify community resource planning as a key part of successful discharge after hospital treatment for anorexia nervosa – this involves follow-up care beyond meal and exercise plans. Adolescents wanted individual counselling to be available near their home upon discharge; similarly parents sought coordination and follow-up with a local doctor, continued counselling as well as a hotline for urgent problems. There is also moderately good evidence from 1 UK qualitative study (Offord et al. 2006 +) that adolescents rated a relatively high level of support following discharge from hospital as an important factor of successful transition to the community. As the interviews were conducted retrospectively (2 to 5 years after discharge) participants reflected that continued support after discharge was important even though they did not necessarily want that contact at the time; superficial or infrequent support after discharge was cited as a possible reason for relapse. It is therefore critical that the level of follow-up support reflects the individual's stage of recovery.

CYP9	There is some evidence from 1 moderate quality study (Fontanella et al. 2010 +/+) that discharge planning has a significant impact on readmission. This is enhanced through social work intervention that helps to facilitate the provision of a more stable living arrangement or care that is tailored at an appropriate level. Type of aftercare arrangement is also significantly linked with readmission; the rate of readmission being 3.45 times more for youths placed in group homes at discharge compared to those placed with their families.
CYP10	There is moderate evidence from 1 non-UK survey study (Bobier et al. 2009 +/-) that a narrative discharge letter which maps the adolescent inpatient's journey from pre-admission to post-discharge using easy to understand language is reassuring to parents and, to a lesser extent, adolescents who receive them. Parents of adolescents with mental illness appreciate clear communication which is free from medical jargon. Families reported feeling well-informed about their child's illness and aware of any 'warning signs' they should look out for in the future. The majority of adolescents who received the narrative discharge letter reported gaining insight and empowerment with respect to their own situation. There is less directly relevant evidence (Bobier et al. 2009 +/-) that outpatient professionals appreciated the narrative discharge letter's ability to galvanise collaborative working and partnerships, both with adolescents and across other mental health support services.
CYP11	There is evidence of moderate quality and indirect relevance from 1 non-UK study (Clemens et al. 2011 +) that mental health professionals view coordination and communication with teachers as a major factor of successful school re-entry for adolescents transitioning from hospital. An initial planning meeting with the school which includes a time to follow-up, and appointing an adult support person for the student within the school are key facilitators of re-entry. Communication and planning across both mental health and school services are crucial elements of successful school reintegration for adolescents transitioning from psychiatric hospital.

Included studies for children and young people review question (full citation, alphabetical order)

Bobier C, Dowell J, Craig B (2009) Youth-, family-, and professional-rated utility of a narrative discharge letter written to older adolescent psychiatric inpatients. Journal of Child and Adolescent Psychiatric Nursing 22: 182–8

Clemens EV, Welfare LE, Williams AM (2011) Elements of successful school re-entry after psychiatric hospitalization. Preventing School Failure 55: 202–13

Fontanella CA, Pottick KJ, Warner LA, et al. (2010) Effects of medication management and discharge planning on early readmission of psychiatrically hospitalized adolescents. Social Work in Mental Health 8: 117–33

Geraghty K, McCann K, King R (2011) Sharing the load: parents and carers talk to consumer consultants at a child and youth mental health inpatient unit. International Journal of Mental Health Nursing 20: 253–62

Hepper F, Weaver T, Rose G (2005) Children's understanding of a psychiatric inpatient admission. Clinical Child Psychology & Psychiatry 10: 557–73

Kyriakopoulos M, Ougrin D, Fraser C, et al. (2015) Emergency mental health admissions for children: A naturalistic study. Clinical Child Psychology and Psychiatry 20: 8–19

Offord A, Turner H, Cooper M (2006) Adolescent inpatient treatment for anorexia nervosa: a qualitative study exploring young adults' retrospective views of treatment and discharge. European Eating Disorders Review 14: 377–87

Scharer K (2000) Admission: a crucial point in relationship building between parents and staff in child psychiatric units. Issues in Mental Health Nursing 21: 723–44

Turrell SL, Davis R, Graham H, et al. (2005) Adolescents with anorexia nervosa: multiple perspectives of discharge readiness. Journal of Child and Adolescent Psychiatric Nursing 18: 116–26.

2.6 Supporting carers of people in transition

Introduction to the review questions

The purpose of the review questions was to examine research about the effectiveness and cost-effectiveness of specific interventions or approaches to support carers of people with mental health problems during transitions between mental health inpatient settings and home or care home. The questions also aimed to consider research which systematically collected the views and experiences of carers of people using services, as well as those of care and support staff involved in transition who may be working with or supporting carers. (In line with the scope, transitions involving inpatient general healthcare settings are not addressed by this review question.)

We agreed with the guideline committee (GC 10) that the following definition of carer would be used: ‘A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally or through a voluntary organisation.’ This is based on the legal definition of carer given in the Care Act 2014.

In considering this topic, we were mindful of the crucial role that carers may have in supporting a person before, during and after admission to an inpatient mental health unit. This underpins the need for evidence that offers specific support – emotional, practical and educational – to carers, and the need for practitioners involved in transitions and in supporting the person during an inpatient stay to involve and consult carers. We were also aware that carers may be a valuable source of understanding of the patient’s needs, especially if the person has cognitive or communication difficulties, but that it should never be assumed that the person with mental health problems would consent for the carer to be involved in information-sharing and care planning.

From 27 papers accessed in full text, fully reviewed and critically appraised, we found 3 papers that evaluated interventions using a control group, and 5 papers that systematically collected data on the views and experiences of carers at and about transitions. Seven were judged to be of moderate quality, while 1 views paper was rated poor as it used a sample of only 4 carers. Those papers that were discarded at full text review were predominantly discarded because they were not about carers’ experience of transitions (being primarily focused on the inpatient episode).

In November 2015 the review team carried out forward citation searching and presented relevant findings to the guideline committee at GC 11. Forward citation searching of all included studies in the review furnished 5 new papers from 4 distinct studies. On title and abstract 1 of these studies related to the ‘Support for carers of people in transition’ review area. Sin and Norman (2014) was a systematic review of psychoeducational interventions for family members of people with schizophrenia. Unfortunately, despite contacting the publishers directly we were unable to obtain this study in order to assess its suitability for inclusion in any more detail.

Review question for evidence of effectiveness

9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

Review questions for evidence of views and experiences

The review questions considered in relation to views and experience of carers around transitions were:

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. b) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- identify approaches in care planning and delivery which enable carers, partners and families to participate in care planning and delivery, both in inpatient mental health settings and community or care home settings

- identify and evaluate interventions and approaches (including information and education) which can be integrated into care planning, admission and discharge processes to support carers in the tasks of caring

- consider how providers of mental health and social care services can work in partnership and support families and unpaid carers of people during a) admission to inpatient mental health settings from community or care home settings and b) transition from inpatient mental health settings to community or care home settings.

For the views and experiences review questions, the protocol sought to identify studies specifically relating to transitions between mental health inpatient settings and community settings that would:

- describe the self-reported views and lived experiences of families and carers of people using services about the care and support provided for people using services at a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings

- consider specifically whether families and carers of people using services think that care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and, where appropriate, housing, education and employment services

- consider what families and carers think supports good care during transition, and what needs to change

- describe the views and experiences of people delivering, organising and commissioning mental and general healthcare, social care (and other relevant services such as housing, employment and education) about the care and support provided to carers during a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings.

Population

Families, partners and unpaid carers of children, young people and adults during admission to inpatient mental health settings from community or care home settings and during a transfer of care from inpatient mental health settings to community or care home settings. Families, partners and unpaid carers of self-funders experiencing a transfer of care to inpatient mental health settings from community or care home settings and vice versa are included. Young carers are included.

Health and social care commissioners and practitioners involved in delivering care and support to people during transition between inpatient mental health settings and community or care home settings; approved mental health professionals; advocates; personal assistants engaged by people with mental health problems and their families.

This is a whole population topic. The population of interest included those with protected characteristics, and people without stable accommodation; people of minority ethnic background; people with co-morbidities including substance misuse; people with communication difficulties, sensory impairment or learning difficulties; people treated under a section of the Mental Health Act (and/or people under Ministry of Justice restrictions and people treated under

Mental Capacity Act), and people placed out-of-area (see Equality impact assessment).

Intervention

‘Support to care’. Involvement, with the patient’s consent, in planning and delivery; specific support such as needs assessment and respite; education and training in skills such as psychological support and physical tasks such as lifting; support to enable social participation and reduce isolation of carers.

Setting

Service users’ own homes, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes, care homes for children, and all inpatient mental health settings for adults, older people, children and young people and specialist inpatient units for people with mental health problems and additional needs.

Outcomes

Carer outcomes (such as carer satisfaction; quality and continuity of care; quality of life, perception of carer burden; choice and control for users and carers; involvement in decision-making; dignity and independence; health status of carer; safety and safeguarding; ability to carry on caring). Service outcomes (including hospital readmissions, unplanned admissions, length of stay in hospital and need for unpaid care and support).

The study designs included for the questions on carer interventions and support were:

- systematic reviews of qualitative studies on this topic
- qualitative studies of carer views and experience
- systematic reviews utilising measures of carer burden and satisfaction
- RCTs and cluster randomised trials of interventions to support carers to care (for example education).

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units‘ or hospitalised patients with mental disorders, and b) the process of ‘transition’, discharge, admission to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept used focused the search on particular study designs (see above) to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups; economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also carried out.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The search was restricted to studies published from 1999 onwards, on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken (January 2015) will be updated in March 2016 to identify new publications which meet inclusion criteria and may alter recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder or be a carer of someone with a mental health disorder)
- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting carers through transitions)
- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)

- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, randomised controlled studies, and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions.

When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

Results

At first screening of title and abstract from the search outputs, we found 60 texts that appeared to be relevant to 1 or more of the carer review questions set out above. At second screening on title and abstract, 7 of these appeared to concern active interventions to support carers (though not necessarily at transition points), 8 appeared to be UK studies concerning carers’ views and experience of transitions, and 12 were non-UK studies of carers’ views and experiences. We initially ordered full texts of those 7 papers which might be interventions and the 8 UK views studies. As there were further exclusions from both sets when full text articles were found to be irrelevant to the review question, it was decided by the team that it would be helpful to access non-UK studies if their findings appeared relevant to the review question, and generalisable to England. We ordered full texts for these remaining 12 studies of views and experience from outside the UK.

A total of 27 full texts were reviewed for this topic. Three papers on interventions for carers, 5 on views (3 from UK and 1 each from Canada and USA) were included in the final review. The guideline committee approved this approach.

The included studies (see below) were critically appraised using NICE tools for appraising different study types, and the results tabulated. Further information on critical appraisal is given in the introduction at the beginning of Section 3. Study findings were extracted into findings tables.

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=3)

None of the 3 studies of interventions to support carers were necessarily provided at patient discharge or admission, although we have taken the view that they could be, and each of the 3 appears to offer some preparation to family carers to support the person outside the inpatient setting.

1. Cassidy E et al. (2001) Efficacy of a psychoeducational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation

Outline: this study, from the Irish Republic (rated +/+), is a relatively old paper (data from 1995–8) about a psychoeducational 'Carers' Education Programme' delivered over 7 2-hour sessions to 101 relatives (almost all of whom were parents) caring for people with schizophrenia. The aim of the intervention was to improve carer understanding of the course and management of schizophrenia, and to establish what if any impact the course had on a) carer knowledge; b) on rates of readmission; and c) on time to readmission. The study measured apparent gain in knowledge of 101 relatives (using a before/after multiple choice questionnaire), and followed up the hospitalisation records of the person cared for over 24 months. As only 28 people whose parent(s) had had the intervention could be included, they were matched by case to the records of a case control group of 28 people whose relatives had not attended the course. Matching was done on age, gender, diagnosis, point of last admission and same consultant.

Results: the 101 carers on the course made significant (p<0.0001) gains in knowledge about schizophrenia in all the areas tested (aetiology, demography, course, symptoms, treatment, coping) with a mean total knowledge gain of 22.4%, SD 13.6; 95% CI. The greatest gains in knowledge were about treatment: 27.8%, SD 19.1; 95% CI: 22.6, 33; p<0.0001. ‘After the intervention, controls (17/28) were significantly more likely to be readmitted than cases (8/28) at 2-year follow-up (OR = 3.86, 95% CI: 1.3, 11.8; P = 0.03). The median survival time (with readmission as the terminal event) was longer for cases (730 days) than controls (593 days) at 2 years after the intervention (Wilcoxon-Gehan statistic 4.813; P < 0.05)’ (p448). However, analysing the data by year showed that ‘while cases spent significantly (p<0.01) fewer days in hospital (6 days, SE 2) than controls (31 days, SE 10) in the first 12 months following the intervention, the effect was not statistically significant at 24 months (cases 16 days, SE 6; controls 39 days, SE 9)’ (p448). The paper indicates that the significant advantage of the intervention group (in time to, and numbers of, readmissions) fell away after 12 months.

2. Macdonald P et al. (2014) Carers’ assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients

Outline: this UK prospective comparison study (+/+) used qualitative data to assess a caregiver self-help skills training intervention delivered as part of an RCT. The Experienced Caregivers Helping Others (ECHO) intervention aimed to alleviate distress and provide skills training to carers/parents of people admitted to inpatient care with severe or chronic anorexia nervosa. The intervention is not well described: it is ‘a skills training, guided self-help intervention (ECHO)’ (p431). Carers were encouraged to reflect on their personal response to the illness, engage in self-care adaptive coping and build awareness of how they could change their behaviour to have a more positive effect. The main focus of this aspect of the study was to explore how patients perceived their relationship and involvement with their caregiver/parent in the year following discharge, and whether caregivers observed any impact on the people they cared for. Researchers analysing data were blind to group allocation.

Results: the study analysed feedback from 101 patients and 115 primary caregivers sampled from 15 inpatient or day-patient hospital centres across the UK. Data was collected by self-report assessment at hospital admission, discharge, and 6 and 12 months post-discharge.

Patients in the ECHO group reported a higher number of positive changes in caregiver styles; more than twice as many reported reduced criticism, overprotection and anxiety (ECHO n=16; TAU n=6), and exactly twice as many noted improved relationship and communication with their caregiver (ECHO n=24; TAU n=12). Almost half the caregivers reported aspects of acceptable functioning in the person with anorexia, meaning an engagement with life beyond the eating disorder, for example, with relationships, jobs and improved social life and independence. This theme occurred more often in the ECHO group (ECHO n= 33; TAU n=22).

The authors conclude that caregiver-guided self-help interventions can be a useful tool that can improve communication and relationships between people with anorexia and their primary caregiver and enhance the wellbeing of both carers and patients. However, TAU is not described, and – owing to the 15 different treatment sites – was likely to be heterogeneous. Moreover, the skills training book is available for the general public to buy and a few members of the TAU group seemed to have implied within their responses that they had also accessed this or similar material, thus affecting the reliability of the TAU group as a reliable comparator. The sample of patients was taken from those admitted for both intensive inpatient and day-patient treatment (day-patient treatment is out of scope).

3. Pitschel-Walz G et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study

Outline: Pitschel-Walz et al. (2006) is a German RCT of moderate quality and generalisability (+/+) which aimed to examine the long-term outcome and benefits of the Psychoeducation Information Project (PIP). Patients with schizophrenia and their relatives were encouraged to attend 8 psychoeducational sessions over a period of 4 to 5 months. Sessions were separate for patients and carers. Sessions 1 to 4 took place weekly, mostly during the patient’s inpatient stay (after reduction of acute symptoms) and the last 4 sessions took place monthly, predominantly after discharge. During these sessions information was given to caregivers that covered relapse prevention, psychological treatment, adequate coping strategies, as well as advice on how they could better help the person with schizophrenia and how they could obtain support and emotional relief for themselves. The study describes the effects of the psychoeducational groups (intervention) in comparison with routine care (control) from a sample of 236 patients taken from 3 different German psychiatric hospitals.

Results: the main outcome reported in this study is rehospitalisation rates (so it is also relevant to review question 6 on reducing readmissions). Rehospitalisation rates were significantly reduced in the intervention group after 12 and 24 months ($p<0.5$). After 1 and 2 years, patients in the control group had on average nearly twice as many hospitalisations as those in the intervention group: 0.6 (SD 1.1) vs 1.1 (1.4), $p=.031$. In addition, those in the control group spent almost twice the number of days in hospital compared to the intervention group: 39 days (SD90.4) vs 78(127.2), $p=.034$. This paper does not report on all recorded outcomes: some outcome criteria – such as satisfaction with treatment, families’ expressed emotion – were reported elsewhere but we are unable to obtain these findings in English. Limitations of the study include the fact that patients in the intervention group also received psychoeducation sessions, so it is not possible to attribute all positive effects to the caregiver intervention alone. In addition, the intervention group had a greater amount of patients who were experiencing their first admission (intervention n=28; control n=18) with the control group experiencing more previous admissions than the intervention group (previous admissions, mean: intervention n=3, control n=4). This study was conducted between1990 and 1994.

Studies reporting views and experiences data (n=5)

1. Clarke D, Winsor J (2010) Perceptions and needs of parents during a young adult's first psychiatric hospitalization: 'we're all on this little island and we're going to drown real soon'

Outline: Clarke and Winsor (2010) is a small Canadian qualitative interview study of 10 parent carers' experience of their adult child's first admission to an inpatient mental health unit (rated + for quality and relevance, although it has a small sample and the data was collected in 2004). It is implied in the data that this admission is also the point at which the parents realise that their child has a serious mental illness (i.e. first admission for severe mental illness).

Results: the study reports on carers' feelings of relief, disbelief and shock, and feeling alone and stigmatised. Carers reported that inpatient staff tended to ignore them during visits, exacerbating feelings of guilt, stigma and isolation. The shock of leaving a child (albeit adult) on a locked ward, and the hopelessness of their (uninformed) perception of the child's future, added to the need for support.

All respondents felt excluded from discharge processes, even when they were (sometimes with no notice) invited to attend. Decision to discharge was made by the hospital with no warning: 'Like it was a place to air concerns but it wasn't a place that decisions were going to be changed' (parent, p245). Parents often had little warning of imminent discharge, no support and did not know what to do next. They wanted the inpatient staff to acknowledge parental anxieties and feelings, and connect with the parents; offer coping mechanisms and recommend a support group; provide comprehensive involvement in discharge planning and instil hope.

2. Donner B et al. (2010) Mainstream inpatient mental health care for people with intellectual disabilities: service user, carer and provider experiences

Outline: Donner et al. (2010) (+), is a UK-based study about how people with intellectual disabilities experience mainstream mental health services. The study aimed to firstly examine how service users with intellectual disabilities, their carers and service providers perceive mainstream inpatient mental health services, and secondly, to what extent their accounts are in line with key policy objectives (promoting the use of mainstream healthcare by people with intellectual disabilities and the requirement for mental health and intellectual disability services to work together proactively). The views and experiences of 9 carers from 5 different mainstream mental health units were obtained through semi-structured interviews either with the service user present or independently of them, depending on the wishes of the cared-for person. Service users were aged between 30 and 55 years and some lived alone, with their families, or in supported accommodation prior to the admission.

Results: a key theme from the interviews was that the admission provided carers with much needed respite. Even when carers were sceptical about the benefits of admission, they were nevertheless thankful that their relative was in hospital. Carers who were put in touch with other services during the admission felt that this vastly improved their situation on discharge.

However, gaining access to inpatient settings in the first place was described by carers as often being fraught and difficult, because psychiatric practitioners were often seen as reluctant to assess someone with an intellectual disability. Carers described the situation as ‘fighting a constant battle’: sometimes they felt they had no alternative but to phone the police or threaten to abandon the person to secure an admission. Significant delays in receiving help created anger and frustration with services and forced carers to ‘hold’ the crisis alone. At times carers also felt devalued and judged by the people they were seeking help from. Carers found it difficult to know who to liaise with and often felt excluded. ‘I really had to find out what was happening through X. No one would tell me anything there and again I found that hard to comprehend' (p219). Participants emphasised repeatedly that success stories were 'down to individual relationships that may have developed over time. It's about who you know' (p222).

Overall, the carer experience on inpatient admissions for a relative with intellectual disabilities to mainstream mental health services was negative. The study reported little on carer experience of discharge except to point out that some carers felt that the person they cared for was discharged without a proper assessment and inadequate attention was given to their needs.

3. Gerson R et al. (2009) Families' experience with seeking treatment for recent-onset psychosis

Outline: Gerson et al. (2012) is a small-scale US qualitative study (+) reporting interviews with 14 family members of 12 young adults who had been admitted in the past year for first-episode psychosis. The paper reports family experience, but much of it is discursive and calls for change. Recruitment of the small sample was through inpatients, and it is not clear how they were selected although they are of mixed ethnic backgrounds. Reported themes are very similar to those identified in Clarke and Winsor (2010) above.

Results: carers found it difficult to access treatment when their children (aged 16–24, mean 20.7 years) became ill – if they tried to set up appointments with outpatient providers, they might find it hard to get the patient to attend (and get no definitive answer). Most patients were involuntarily admitted, described by most as 'traumatic but necessary' (author, p3). Two of the 3 Afro-American patients had police involvement in admission – 1 teenage girl locked herself in the bathroom and the family's 911 call was answered by SWAT team who handcuffed her.

After the trauma of involuntary admission, stigma of psychotic illness was strongly felt by carers (described as 'shame' and guilt). 'This [schizophrenia] is a dirty word ... I'm going to be dealing with it for the rest of my life' (family member, p4). The attitudes and statements of staff and social workers confirmed feelings of hopelessness: the illness would have a very negative impact on the person and would be lifelong. Parents felt excluded from any meaningful involvement in treatment. One mother waited weeks before the psychiatrist even spoke with her, and that was at the point of discharge. Help and advice at and after discharge, including advice on how to manage a psychotic episode, was rarely forthcoming. ‘Three months into the process, is it reasonable for them to have some kind of conversation, provide some kind of information and education? Some therapy, something?’ (family carer, p4). Family carers also thought ‘patient confidentiality’ was used as a shield to avoid having conversations with them. Authors suggested that the fear and distrust arising from these early encounters between people and their families would taint future relationships with mental health services.

Carers’ commentary on their experience showed they needed:

- less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic
- greater recognition from staff on inpatient wards that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning
- information, education and dialogue about how to manage and support the person after discharge
- support to find providers for ongoing care post-discharge that insurance would cover
- less negativity and more encouragement to contemplate a positive future for their child.

4. Jankovic J et al. (2011) Family caregivers’ experiences of involuntary psychiatric hospital admissions of their relatives – a qualitative study

Outline: Jankovic et al. (2011) is a qualitative study (+) which used in-depth interviews to explore how family caregivers of people who were involuntarily admitted to psychiatric hospital experienced their admission. Efforts were made to maximise representativeness of the sample: 31 family caregivers with a range of relationships to the patient (parent, partner, sibling, child, grandparent) were recruited from across 12 NHS hospitals across England. Fifteen out of 29 patients who the caregivers were providing care for had been admitted previously, and 12 patients were experiencing their first admission (data was missing for 2 patients).

Results: 1 of the main themes which emerged was frustration experienced by carers in trying to get help from services (n=18). Caregivers did not know who to contact for help and believed that delays in receiving help from services contributed to the deterioration in their relative’s condition and, in turn, made their involuntary admission inevitable. Services were reactive rather than proactive, and only responded when situations reached crisis point. Caregivers of people who had not previously experienced an admission felt most handicapped in accessing mental health services.

More than a quarter of caregivers (n=8) felt they were given too much responsibility for their relative’s care. Despite feeling that they were not sufficiently involved in decisions about their relative’s treatment, they felt that they were implicitly expected to take responsibility for their continuing care after discharge. A related theme was around difficulties surrounding confidentiality (n=7). Caregivers acknowledged rights to patient confidentiality, but some felt that practitioners’ adherence to protocol around patient confidentiality risked compromising their own safety. ‘... When I’m the one that’s at risk, I expect a bit of a say in it. That’s fine if you’ve got him in a safe place and he’s being looked after, but when he’s out in the community with me, then I expect a bit of a say in what goes on’ (caregiver to a son, not first admission, p4).

Only 50% of all eligible patients who had been involuntarily admitted to the participating hospitals agreed to take part in the study, and of those that did participate the majority lived alone and did not have a caregiver. Caregivers of patients who did not give consent may have had more strained relationships with their family, or at least, a different set of experiences.

5. Wilkinson C, McAndrew S (2008) ‘I’m not an outsider, I’m his mother!’ A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings

Outline: Wilkinson et al. (2008) is a very small UK study, rated low on methods (-) because only 4 carers of people admitted formally to acute inpatient settings within the preceding 2 years took part, although the data is rich. Four main themes emerged from the research, which focused on carer involvement: powerlessness; feeling isolated; needing to be recognised and valued; and a desire for partnership. The findings mirror the views articulated by carers in other studies, reporting that, while carers want to work in partnership with healthcare professionals, they often feel excluded. This experience of exclusion supports findings from the non-UK Gerson and Clarke papers.

The 4 themes are summarised below.

- Powerlessness: all of the carers interviewed spoke of a sense of powerlessness once the person that they cared for was admitted to hospital. ‘I just felt that as soon as she was sectioned, I handed over her care … I felt inferior, I didn’t know what was going on, I didn’t know how to make things right. The doctors and nurses were the experts and I had to trust them.’ (carer, p395). While carers acknowledged that they attended ward meetings, for example, the overriding sense was that they were passive rather than active in the care of the person they habitually cared for.

  Feeling isolated: during the admission of the person they cared for to hospital, carers experienced confusion and anguish when they needed support to understand and cope with what was happening. They felt ignored by healthcare staff, which in turn fostered a sense of isolation. ‘I cried when I came home from the hospital that first night. I felt so alone … I had wanted to speak to someone about what was happening, but when I tried I was told by the nurse that she couldn’t speak to me, I should visit my doctor’ (carer Mary, p396). Carer Rebecca added: ‘As soon as he was admitted to the ward I became a nobody, an outsider, but I’m not an outsider, I'm his mother!' (p396). Carers had no opportunity to learn more about the illness of the person they cared for, and felt ignored. Jean stated: 'Nobody ever spoke to me about the illness and nobody ever explained anything to me. I didn't understand what was going on' (p396). James added that: 'It got to a point where I just gave up trying to speak with the nurses. They were always too busy to talk to me and I just couldn't see the point in pushing it. It wouldn't have done any good anyway' (p396). Carers found it difficult to build a relationship with healthcare professionals, particularly nursing staff, and felt that the staff used confidentiality as a means of avoiding engagement with them (p396). Carers felt that a great deal more non-confidential information concerning the safety and wellbeing of the person they cared for could and should be shared with them, during general phone enquires. Often decisions made during the hospital admission affected the whole family, and consequently, carers felt that family should be involved at the decision-making level. Rebecca said: 'I wasn't involved, I was an afterthought … no one told us anything, no one rang to keep us up to date with the plan of care. I only found out that he [son] had been started on an injection when he rang to tell me that he'd had a needle in his bum … How can I look after him at home if I don't know what I'm supposed to be doing?' (p397).

- A need to be recognised and valued: all of the carers said they needed to be recognised, valued and involved by healthcare staff. When they (carers) expressed their point of view, they felt they were not valued as a source of knowledge. Mary said: 'They [professionals] should appreciate me for who I am. I'm his wife. I've lived with him for 30 years. I know him better than anybody. I'm not questioning what they do, I'm not complaining, I'm just trying to help make it easier for everybody' (p397). Carers also felt that they themselves had suffered shock and trauma at the compulsory admission. 'As a family, we went through a really traumatic experience leading up to the crisis and afterwards and nobody ever acknowledged this' (p397). James explained: 'The turning point for me was when 'M' [community psychiatric nurse] visited the ward. He spent ages with me and it gave me the chance to ask all the questions I'd wanted to ask since my wife first went into hospital … It was like a dam had been building inside me and M had knocked it down. It was such a relief. I had so many fears and they just came flooding out, but it felt good and I felt so much better afterwards' (p397).

- A desire for partnership: despite feeling a sense of powerlessness and isolation, all of the carers expressed a wish to work in partnership with healthcare professionals. They felt that this would improve the carer experience of acute psychiatric hospitals and increase their sense of involvement in the care package. Jean explained: 'It's about working together, the team knowing that I have valuable things to contribute and vice versa, because we all want the same at the end of the day' (p397). Rebecca stated: 'I'd like to be valued as someone who can contribute to my son's care. For that to happen, the attitude of the nurses and doctors has to change from "they know best". I have so much to contribute, but it's as though by asking me what I think it's challenging their knowledge and know-how and it's just silly. They're professionals in mental health. I'm a professional about my son. It needs to be about working together. It shouldn't be about us and them' (p398).

Evidence statements

C1	There is moderate evidence from 3 studies using control groups – Cassidy et al. (2001), Macdonald et al. (2014) and Pitschel-Walz et al. (2006), all rated (+/+) – that carers are willing to participate in, and do derive knowledge from, psychoeducational groups which enable them to find out more about the meaning and management of the illness of the person they care for, whether schizophrenia or anorexia, and to learn coping strategies.
C2	There is moderate evidence from 2 studies using control groups – Cassidy et al. (2001) and Pitschel-Walz et al. (2006), both rated (+/+) – that giving carers the opportunity to attend educational sessions on the meaning, development and management of schizophrenia, including relapse prevention and coping skills, may cause fewer readmissions to take place within 12 months and increase the length of time before readmission (Cassidy et al. 2001); and may reduce readmissions within 24 months of delivering the sessions (Pischel-Walz et al. 2006).
C3	There is evidence from a small UK study, Wilkinson and McAndrew 2008 (rated - because only 4 carers participated), from a Canadian qualitative interview study – Clarke and Winsor (2010) (+) and from a small US qualitative study, Gerson et al. (2012) (+), that admission of the person they cared for to an inpatient acute ward may be traumatic for the carer(s). Reported feelings include shock, guilt, relief, feeling alone, powerless and isolated, and highly stigmatised by the event and/or the label of mental illness or schizophrenia.
C4	There is evidence from a small Canadian qualitative interview study (Clarke and Winsor

	2010 +) and a small US qualitative study (Gerson et al. 2012 +), that first admission of an adult child to an inpatient acute ward may be traumatic for the carer(s). In addition to the feelings reported in CS3 (above), carers were less likely to have knowledge of psychiatric disorders, and assumed their child's future would be dominated by the condition.
C5	There is evidence from a small Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study (Gerson et al. 2012 +) and a very small UK qualitative study (Wilkinson and McAndrew 2008) that carers' feelings and anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress – often requests were declined with reference to 'patient confidentiality' (a point also flagged in Jankovic et al. 2011, see below). Family carers often had little notice of discharge, and no idea how to support the patient, or find support for themselves, after discharge. Family carers wanted greater involvement and information, and a sense of sharing care with professionals.
C6	There is evidence from a UK qualitative interview study (Jankovic et al. 2011 +) that family carers of people formally admitted felt unable to get help until the person's illness led to sectioning, which was an undesirable outcome. More than a quarter of caregivers felt that, although they were not involved by staff in decision-making or treatment review, they were unfairly expected to take full responsibility for the person after discharge.
C7	There is evidence from a small US qualitative study (Gerson et al. 2012 +) and from a very small UK qualitative study (Wilkinson and McAndrew 2008, rated - for its small sample), that family carers want the following at first and subsequent admissions: • less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic • greater recognition from staff on inpatient wards that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning • greater recognition from staff that they had valuable knowledge of the person to offer • information, education and dialogue about the mental health condition, and how to manage and support the person after discharge • partnership with professionals • support to find providers for ongoing care that insurance would cover (from the US paper) • less negativity and more encouragement to contemplate a positive future for their child.
C8	There is moderate evidence from a small UK qualitative interview study (Donner et al. 2010 +) that carers found it very difficult to access support from mainstream mental health services, staff of which were reluctant to assess someone with intellectual disability (although it is policy that mainstream services should support this group). Inability to access timely support and admission could exacerbate a crisis: carers might initiate police involvement to bring about admission.
C9	There is evidence from a small UK qualitative interview study (Donner et al. 2010 +) that carers of people with intellectual disability felt that their anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress or discharge arrangements. Any 'success' in finding out anything depended on making an 'individual relationship' with a staff member. Family carers felt the people they cared for were discharged without proper assessment. They themselves benefited if they were put in touch with other sources of support during the

	admission.

Included studies for the supporting carers in transition review question (full citation, alphabetical order)

Cassidy E, Hill S, O'Callaghan E (2001) Efficacy of a psychoeducational intervention in improving relatives' knowledge about schizophrenia and reducing rehospitalisation. European Psychiatry 16: 446–50

Clarke D, Winsor J (2010) Perceptions and needs of parents during a young adult's first psychiatric hospitalization: 'we're all on this little island and we're going to drown real soon'. Issues in Mental Health Nursing 31: 242–47

Donner B, Mutter R, Scior K (2010) Mainstream inpatient mental health care for people with intellectual disabilities: service user, carer and provider experiences. Journal of Applied Research in Intellectual Disabilities 23: 214–25

Gerson R, Davidson L, Booty A, et al. (2009) Families' experience with seeking treatment for recent-onset psychosis. Psychiatric Services 60: 812–16

Jankovic J, Yeeles K, Katsakou C, et al. (2011) Family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives - a qualitative study. PloS One 6:10, e25425

Macdonald P, Rhind C, Hibbs R, et al. (2014) Carers' assessment, skills and information sharing (CASIS) trial: a qualitative study of the experiential perspective of caregivers and patients. European Eating Disorder Review 22: 430–8

Pitschel-Walz G, Bäuml J, Bender W, et al. (2006) Psychoeducation and compliance in the treatment of schizophrenia: results of the Munich Psychosis Information Project Study. The Journal of Clinical Psychiatry 67: 443–52

Wilkinson C, McAndrew S (2008) 'I'm not an outsider, I'm his mother!' A phenomenological enquiry into carer experiences of exclusion from acute psychiatric settings. International Journal of Mental Health Nursing 17: 392–401

2.7 Learning, development and training

Introduction to the review questions

The purpose of the review question was to examine the impact of learning development and training for mental health and social care staff and others who may be involved in transitions between inpatient mental health settings and community or care home settings. The questions also aimed to consider research which collected the views of care and support staff and people using services and their carers in relation to learning, development and training for those involved in transitions.

Overall, a small amount of evidence on learning, development and training was located and reviewed. There was no evidence about a direct causal link between training and outcomes of transitions at the individual or service level. However, a medium quality study evaluating the impact of training on police officers' knowledge, perception and attitudes towards mental illness, and a low quality evaluation of a UK-based peer support training and support intervention were located. The review team also located a Canadian study reporting on the barriers and facilitators to successful implementation of a transitional relationship model (where the hospital clinical staff member who has developed a therapeutic relationship with the patient remains involved following hospital discharge until the client has established 1 or more therapeutic relationships with community care providers), and a low quality UK research note reporting the views of various professional groups involved in admission under the Mental Health Act on their training and support.

Review question for evidence of effectiveness

10. What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings?

Review questions for evidence of views and experiences

The review questions considered in relation to views and experience of discharge were:

1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings?

2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?

3. (a) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?

3. (b) What are the views and experiences of health, social care and other practitioners (for example in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?

Summary of review protocol

The protocol sought to identify studies that would:

- Identify the impact and effectiveness of approaches to existing induction, training and continuing personal development delivered to health and social care staff working in inpatient mental health settings and the community, especially those involved in admission and discharge processes. Population of interest includes advocates, including volunteers and peer support workers and (unregulated) personal assistants, housing and support staff.

- Identify the potential for improvement in this area.
- Identify possible barriers and facilitators to the implementation of training and support for health and social care staff involved in supporting transitions between inpatient mental health settings and community or care home settings.
- Consider whether and how integrated working fosters shared learning between health and social care staff in relation to improving transitions between inpatient mental health settings and community or care home settings.

For the views and experiences review questions, the protocol sought to identify studies, specifically relating to training, learning and development that would:

- describe the self-reported views and lived experiences of people using services about the care and support they receive during a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings
- consider specifically whether people using services think that their care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and, where appropriate, housing, education and employment services
- consider what service users, families and carers think supports good care during transition, and what needs to change
- describe the self-reported views and lived experiences of families and carers of people using services about the care and support provided for people using services at a) admission to inpatient mental health settings and b) transition from inpatient mental health settings to community or care home settings
- consider specifically whether families and carers of people using services think that care is i) personalised and ii) coordinated across inpatient and community mental health, social care, primary care and, where appropriate, housing, education and employment services

- consider what families and carers think supports good care during transition, and what needs to change
- describe the views and experiences of people delivering, organising and commissioning mental and general healthcare, social care (and other relevant services such as housing, employment and education) about the care and support provided during transition from inpatient mental health settings to community or care home settings
- collect evidence on key practice and workforce issues which may impact on transitions and should be considered within the guideline;
- highlight aspects of the transition from inpatient mental health settings to community or care home settings which work well, and are i) personalised and ii) integrated, as perceived by practitioners, managers and commissioners.

Population

Social care practitioners (providers, workers, managers, social workers), and health and social care commissioners involved in delivering care and support to people during transition between inpatient mental health settings and community or care home settings; approved mental health professionals; advocates; personal assistants engaged by people with mental health problems and their families. General practice and other community-based healthcare and mental health practitioners: GPs and community psychiatric nurses, occupational therapists, psychologists, psychotherapists and other therapeutic professionals; psychiatrists and ward staff in inpatient mental health settings (especially those with a role in admission and discharge procedures). Where relevant, housing and education practitioners involved in supporting people during transition into or from inpatient mental health settings.

Intervention

Organisational skills support; models of integration and cross-agency work and training; personalised services which respond to the needs of the individual, promote understanding of recovery and identify and respond to existing or evolving problem conditions. Staff support, supervision, training and assessment. Development of and use of protocols.

Setting

Service users' own homes, including temporary accommodation; supported housing; sheltered housing; care (residential and nursing) homes, care homes for children and all inpatient mental health settings for adults, older people, children and young people and specialist units for people with mental health problems and additional needs.

Outcomes

Effectiveness studies of 'training' with follow-up; outcomes relating to safeguarding and safety; reduction in suicide rates; reduction in hospital bed days; reduction in hospital readmissions: implementation of CQC regulations and contract monitoring.

The study designs relevant to this question are likely to include:

- systematic reviews of qualitative and quantitative studies on relevant interventions
- qualitative studies of service user and carer views of training and competencies of staff and themselves (drawing on question 1)
- standardised scales measuring satisfaction and wellbeing
- RCTs and cluster RCTs on training
- other comparative studies
- pre- post-test evaluations of training
- observational and descriptive studies of implementation and process.

Full protocols can be found in Appendix A.

How the literature was searched

Electronic databases in the research fields of health (which includes mental health), social care and social science, education and economics were searched using a range of controlled indexing and free-text search terms based on a) the setting ‘mental health inpatient units’ or hospitalised patients with mental disorders, and b) the process of ‘transition‘, discharge, admission to capture the setting. Research literature on the process of transition between inpatient mental health settings and the community uses a wide range of terminology, so terms on leaving or returning to home or community settings are used to capture setting transitions for individuals. Terms combining secondary care, hospitalisation and inpatients with terms for social services and primary care are used to capture literature about system-level transitions. A third concept used focused the search on particular study designs (see above) to capture items that are qualitative studies, or studies on people’s views and experiences; controlled trials or studies with comparison groups; economic evaluations and systematic reviews and meta-analyses.

The search aimed to capture both journal articles and other publications of empirical research. Additional searches of websites of relevant organisations were also carried out.

The search for material on this topic was carried out within a single broad search strategy (search undertaken January 2015) to identify material which addressed all the agreed review questions on transitions between inpatient hospital settings and community or care home settings for adults with social care needs. The search was restricted to studies published from 1999 onwards, on the basis that it was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare. Generic and specially developed search filters were used to identify particular study designs, such as systematic reviews, RCTs, economic evaluations, cohort studies, mixed method studies and personal narratives. The database searches were not restricted by country. The search undertaken will be updated in March 2016 to identify new publications which meet inclusion criteria and may alter recommendations. Forward citation searches of included studies were conducted in November 2015 using Google Scholar in order to identify additional potentially relevant studies.

Full details of the search can be found in Appendix A.

How studies were selected

Search outputs (title and abstract only) were stored in EPPI Reviewer 4 – a software program developed for systematic review of large search outputs – and screened against an exclusion tool informed by the parameters of the scope. The search was restricted to studies published from 1999 onwards, on the basis that 1999 was the year of publication for the National Service Framework for Mental Health which set new standards and a 10-year agenda for improving mental healthcare.

Formal exclusion criteria were developed and applied to each item in the search output, as follows:

- date (not published before 1999)
- language (must be in English)
- population (must have a mental health disorder)
- transition (transition into or out of an inpatient mental health hospital setting must have occurred or be in the planning stage)
- intervention (must be involved in supporting transitions)
- setting (inpatient mental health acute hospital setting, community setting or care home)
- country (must be UK, European Union, Denmark, Norway, Sweden, Canada, USA, Australia or New Zealand)
- type of evidence (must be research)
- relevance to (1 or more) review questions.

Title and abstract of all research outputs were screened against these exclusion criteria. Those included at this stage were re-screened for study types (in order to prioritise systematic reviews, RCTs and other controlled studies) and marked as relevant to particular review questions. Screening on title and abstracts led us to identify queries, and these were discussed by at least 2 of the systematic review team.

The total material for each question was reviewed to ascertain whether the material appeared consistent with the study types and topic(s) relevant to the review questions. When accessed, full texts were again reviewed for relevance to the review question and research design. If still included, critical appraisal (against NICE tools) and data extraction (against a coding set developed to reflect the review questions) was carried out. (Where evidence was very sparse, which did not apply to the discharge topic, the team revisited the set to see whether any of the material not retrieved in full text might be relevant – for example qualitative studies from outside the UK.) The coding was all conducted within EPPI Reviewer 4, and formed the basis of the analysis and evidence tables (see Appendix B). All processes were quality assured by double coding of queries, and of a random sample of 10%.

Results

From 51 papers which appeared relevant to the review question upon first screening on title and abstract, we ordered 22 full text papers for full text review. Within this fairly narrow evidence base, most of the papers retrieved reported views and we therefore decided to consider views papers not only from the UK but also those which were about views of care in the EU, US, Canada, Australia and New Zealand.

Similarly, we anticipated that there were unlikely to be any RCTs on this subject, particularly given some of the ethical problems of setting up RCTs in this area, and, indeed, we found this to be the case. We therefore decided to include comparative studies which used secondary data analysis and non-experimental methods design. It is important to note that all questions to evaluate effectiveness must be comparative and have a comparison group.

We were able to retrieve full texts for 19 of the 22 papers which we ordered. Reviewing the papers on full text we identified 4 papers which matched all of our criteria and were within scope. One paper was categorised as a views and experience study, with the remaining 3 papers falling under ‘effectiveness studies’.

For full critical appraisal and findings tables, see Appendix B.

Narrative summaries of the included evidence

Studies reporting effectiveness data (n=1)

1. Ellis HA (2014) Effects of a crisis intervention team (CIT) training program upon police officers before and after crisis intervention team training

Outline: Ellis (2014) is a moderate quality (+/+) before/after US study that evaluates the effectiveness of a crisis intervention team (CIT) training programme on police officers’ knowledge, perception and attitudes towards mental illness. Twenty-eight police officers from 3 municipalities in Florida received a 40-hour, 1-week training intervention. Training aimed to teach officers to use specialised skills as a systematic response to calls involving people with mental illness. It covered how to assess for the likely presence of mental illness, how to use communication and de-escalation techniques and how to communicate with mental health providers. The behavioural health crisis management techniques taught in CIT are a core training requirement of psychiatric nurses. Participants used a series of questionnaires before and after the training intervention to assess their scores.

Results: knowledge about mental illness, perception and attitude scores all showed statistically significant improvements after the training intervention (improvements in scores of knowledge p=.009; perception p=.001; attitude p=.002). A cluster analysis using a sub-scale to divide knowledge scores into sub-sets of personal knowledge, inconsistent knowledge, external knowledge and biological knowledge indicated improvements in each area. However, none of these sub-scores reached statistical significance. Results indicated that a larger sample size may have resulted in a significant effect. Furthermore, a more nuanced knowledge-measurement tool rather than the 4-point Likert scale format may have resulted in a more precise measure of officers' knowledge. Likert relies on levels of endorsement rather than a definitive right or wrong response to each question, so this scale may not capture the full extent of changes in outcomes.

Studies reporting views data (n=3)

1. Bowers L et al. (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists

Outline: Bowers et al. (2003) is a low quality (-) UK research note which used semi-structured interviews to elicit multidisciplinary reflections on assessment for compulsory admission. Although the study covers a range of aspects on assessment for admission under the Mental Health Act, 1 section of the research note focused on skills and training. Thirty-one professionals comprising doctors, community psychiatric nurses, ambulance personnel, police, psychiatrists and approved social workers (ASWs) were interviewed about their experiences.

Results: all groups were able to clearly identify the skills required to successfully manage assessment for compulsory admission; however, formal training was seen to be absent or rated as poor by nearly all respondents.

Medical school training on assessment skills was seen as unhelpful, and communication skills workshops were dismissed by doctors: 'Teaching on communication courses was very helpful – in how not to do it!' (p966).

Doctors and ASWs both referred to learning through watching and observation. The majority of ASWs felt that they learned by experience: 'On the job, no question' (p966). Observing how others managed assessment and sharing stories with other staff were seen as a successful way of learning techniques. A member of the ambulance crew also commented that their learning was mostly experiential.

Community psychiatric nurses (CPNs) also felt that training had not prepared them well for real situations. Three CPNs admitted that training could never prepare you completely, but the suggestion was made that observing compulsory admissions would be a useful part of training.

Police officers similarly reported they had received almost no formal training in dealing with mentally ill people. One officer said he learned a lot from talking to doctors and nurses, and knew to turn his radio off and take his hat off when dealing with someone with mental health problems.

Inter-professional training and observing others with more experience were suggested modes of learning about the process of assessment for compulsory admission during training. But in terms of ‘shadowing’ consideration should be given to the issue of overcrowding. As 1 doctor commented in the study, he used common-sense techniques such as talking in a calm voice and avoiding overcrowding of small rooms during the assessment process.

The paper has severe limitations in terms of its generalisability. The study used a convenience sample made up of volunteers, a sampling technique which introduces a risk of bias. The research was conducted in 2003 when ASWs were responsible for organising assessments. Since 2007 this role has been superseded by the approved mental health professional (AMHP) role.

2. Forchuk C et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model

Outline: Forchuk (2013) is a moderate quality Canadian study (+) which used a ‘delayed implementation control group design’ to examine best practice facilitators and barriers to implementing the transitional relationship model (TRM) intervention.

The 3 basic assumptions of TRM are:

- people heal in relationships (including staff and peer relationships)

- transitions in care are vulnerable periods for individuals with mental illness
- a network of relationships provided during transitional periods assists in recovery (p585).

The model suggests that the hospital clinical staff member who has developed a therapeutic relationship with the client remains involved following hospital discharge until the client has established 1 or more therapeutic relationship with community care providers.

A range of qualitative data (derived from field notes, monthly summaries of significant events and changes, ward minutes of meetings, progress summaries and focus groups comprising around 200 staff and patients) was collected to inform a ‘research as process’ study involving wards from across 6 psychiatric sites. Twenty-four A-wards were involved in the study (which had already implemented the TRM during previous studies) alongside 12 B-wards (which implemented the intervention in year 1 following suggestion put forward by A-wards), and 10 C-wards (which implemented the intervention last, using the suggestion put forward by both A- and B-wards). Two C-wards dropped out of the intervention.

Results

Facilitators

Educational modules: all wards valued having specific education and interactive workshops on TRM prior to implementation. The content evolved with each set of wards and the methods of delivery became focused on faster implementation with successive sets of wards. Hospital staff training topics cover:

- introduction to transitional relationship model and best practices
- therapeutic relationships
- bridging and peer support specialists
- therapeutic boundaries
- transitional discharge planning
- telephone practice

- bridging safely bridging and crisis intervention
- partners and resources.

Best practices and telephone practices were suggested by A-wards. Crisis intervention was added as a result of feedback from the B-wards.

As a result of findings from A- and B-wards full-day workshops and online modules were recommended to the C-wards. At 1 C-ward hospital staff complained of 14 annual online modules which they deemed too much. Modes of learning can become unfeasible or unwarranted depending on other circumstances.

On-ward champions

A-wards recommended having on-ward champions – designated people to whom staff could go with questions or concerns.

Consistent factors of focus groups

- Importance of developing and maintaining multiple relationships.
- Ensuring meaningful participation throughout the process.
- Working with consumer groups about how to find sources for the peer support–workload and work environment issues.

Focus groups data revealed that the strategies which each of the wards found useful varied depending on the specific ward environment.

Barriers

Overwhelmed staff described being on ‘educational overload’ with the number of mandatory educational programmes and the introduction of new projects which were introduced in addition to the study. They felt overwhelmed by the amount of paperwork and described feeling ‘burnt-out’ (p590).

Group dynamics

Close working between different members of the group and inter-professional relationships were important to the successful implementation of the model. Context greatly influences a team’s ability to implement the intervention so any issues need to be addressed prior to implementation.

The study is compromised because it does not reveal the impact of training on patient outcomes in the community. Findings are not clearly attributed to either staff or service users, even though the authors state services users were involved in the focus groups.

3. Simpson A et al. (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom

Outline: Simpson (2014) is a low (- /+) quality before/after UK study which reports the findings of a peer support workers' training and support intervention. Thirteen people with lived experience of mental illness/distress and mental health service use, who had been officially recruited, received peer support training over 12 weekly 1-day sessions (8 went on to offer support). The aim of the training was to prepare individuals to support people being discharged from hospital with their recovery through providing practical and emotional support and promoting hope during the transitional period from psychiatric hospital to home.

Peer support was provided alongside conventional aftercare services; contact was initiated while the service user was still an inpatient and then they were offered 4 weeks of support following discharge. Training was divided into 2 clear objectives: emphasis on participants drawing from their own unique experiences; personal development – developing key skills and preparation for peer support role including communication training, and active, attentive listening. Each session began and ended with a brief check-in to establish how the participants were feeling (relating to the training or otherwise). From week 3 onwards, participants went on to receive fortnightly individual support from the peer support coordinator (PSC). Those who went on to become peer support workers attended regular supervision while they were providing support. These measures helped to develop a sense of containment and safety.

The study used the Nottingham Peer Support Training Evaluation Tool (NPSTET) which requires respondents to reflect on their own qualities and assess their ability to perform many of the skills required for effective peer support.

Results: NPSTET scores – pre-training scores on the adapted NPSTET were high, with an average of 6 (of a possible 7) across all questions, indicating that, even before the training, trainees tended to ‘agree’ with most statements. There was no change post-training; the average score remained 6 of 7, indicating that trainees still tended to ‘agree’ with most statements.

Qualitative findings

What works well

The PSWs reported very positive experiences, with the combination of training and working boosting their self-esteem and confidence. The quality of relationships with their service user peers varied but most experienced productive, rewarding peer support interactions. Numerous examples of supportive emotional and practical therapeutic relationships emerged alongside evidence of constructive developments on the part of their peers.

PSWs described an increased understanding of their own recovery processes and positive effects on their wellbeing. However, many expressed their frustration that the 6-week training period was too short.

Various aspects of the training were mentioned and recalled positively and many people spoke of it providing them with confidence. Role-plays in particular were seen as one of the most useful parts of training.

PSWs were positive about the support they received from the PSC, and the importance of a supportive, proactive PSC was recognised by all. Many PSWs reported feeling that the PSC created a safe environment.

What can be improved

Many of the PSWs did not believe they had been adequately prepared for the strong emotions they would experience generally, and particularly in relation to the ending of the peer support relationship after 6 weeks.

This study has significant limitations in that there was a very small sample (8 PSWs ultimately provided support). Recruitment for peer support worker positions occurring concurrently to data collection introduced a strong risk of bias. The high pre-test scores are likely to be influenced by the participants' desire to show their suitability for the role.

Evidence statements

T1	There is evidence from 1 old, low quality UK qualitative research note (Bowers et al. 2003 -) that professionals involved in assessment for admission under the Mental Health Act consider formal training to be either absent or poor. All groups of professionals involved in the process of assessment for compulsory admission explained that they learned 'on the job', through experience, but also suggested that observing others with more experience and inter-professional training would be valuable learning techniques.
T2	There is evidence from 1 moderate quality before/after US study (Ellis 2014 +/+) that a 40-hour training course containing health crisis management techniques required of psychiatric nurses improved police officers' perception, knowledge and attitude towards mental illness. Qualitative data from a low quality UK study (Bowers et al. 2003 -) revealed anecdotal evidence that despite receiving little formal mental health training, police found contact with doctors and nurses useful in terms of knowing how to interact with a person who is undergoing a mental health crisis (for example turning off their radio and removing their hat). The importance of joint working and developing and maintaining multiple inter-professional relationships in order to successfully implement a transitional hospital discharge intervention was highlighted in a moderate quality qualitative Canadian study (Forchuk et al. 2013 +).
T3	There is evidence from 1 moderate quality Canadian study (Forchuk et al. 2013 +) that hospital staff value having specific educational modules and workshops before the implementation of transitional hospital discharge interventions. On-ward learning, online modules and full-day interactive workshops were all appreciated: however, preferences for modes of training varied across wards and were dependent on other circumstances (for example, a growing number of concurrent online educational modules decreased staff enthusiasm for online learning). Some staff regarded 'on-ward champions' – designated individuals to go to with questions or concerns – as a key factor to help facilitate the successful implementation of the transitional intervention.
T4	One low quality before/after UK study (Simpson et al. 2014 - /+) demonstrated some evidence that PSWs who are suitably recruited and who attend subsequent training sessions in a safe and contained environment feel they are able to use their past experience of mental health illness and services use to assist people being discharged from hospital with their recovery. With the right guidance PSWs can develop mutually beneficial supportive, emotional and practical therapeutic relationships. PSWs saw role-playing as a particularly useful part of training, a mode of learning which bestowed confidence and insight into the kinds of situations and challenges which lay ahead. PSWs regarded proactive and continued support from an understanding PSC as an essential part of the process. Preparation for the emotional ramifications of peer support work, in particular the ending of the peer support relationship period, was seen as insufficient.

Included studies for learning training and development question (full citation, alphabetical order)

Bowers L, Clark N, Callaghan P (2003) Multidisciplinary reflections on assessment for compulsory admission: the views of approved social workers, general practitioners, ambulance crews, police, community psychiatric nurses and psychiatrists. British Journal of Social Work 33: 961–8

Ellis HA (2014) Effects of a Crisis Intervention Team (CIT) Training Program Upon Police Officers Before and After Crisis Intervention Team Training. Archives of Psychiatric Nursing 28: 10–6

Forchuk C, Martin ML, Jensen, et al. (2013) Integrating an evidence-based intervention into clinical practice: transitional relationship model. Journal of Psychiatric and Mental Health Nursing 20: 584–94

Simpson A, Quigley J, Henry SJ, et al. (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. The Journal of Psychosocial Nursing & Mental Health Services 52: 31–40

2.8 Evidence to recommendations

This section of the guideline details the links between the guideline recommendations, the evidence reviews, expert witness testimony and the guideline committee discussions. Section 3.8.1 (see below) provides a summary of the evidence source(s) for each recommendation. Section 3.8.2 provides substantive detail on the evidence for each recommendation, presented in a series of linking evidence to recommendations (LETR) tables.

3.8.1 Summary map of recommendations to source(s) of evidence

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
1.1 Overarching principles	

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
Person-centred care	
1.1.1 Ensure the care and support of people in transition is person-centred and focused on their recovery.	HA3, expert witnesses (Young Minds, dementia), GC consensus
1.1.2 Work with people as active partners in their own care and transition planning. Refer to the section on relationships and communication in NICE's guideline on service user experience in adult mental health services.	HA6, HA9, HA14,DC16, CYP1, NICE guideline CG136
1.1.3 Record the needs and wishes of the person at each stage of transition planning and review.	DC15
Maintaining community links	
1.1.4 Identify the person's support networks. Work with the person to explore ways in which the people who support them can be involved throughout their admission and discharge.	CYP6, C9
1.1.5 Enable the person to maintain links with their home community by: • supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport costs • helping them to keep links with employment, education and their local community. This is particularly important if people are admitted to mental health units outside the area they live-in.	HA10, GC consensus
Access and information	
1.1.6 Mental health services should work with primary care and local third sector (including voluntary) organisations to ensure that people with mental health problems in transition have equal access to services. This should be based on clinical need and irrespective of: • gender • sexual orientation • socioeconomic status • age • disability • cultural, ethnic and religious background • whether or not they are receiving support through the Care Programme Approach • whether or not they are subject to mental health legislation.	Adapted from rec 1.2.5, Service user experience in adult mental health services guideline (CG136). HA13, HA10

Recommendation	**Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)**
1.1.7 Give people using mental health services who are in transition comprehensive information, at the time they need it, on the nature of, and treatments and services for, their mental health problems. If needed, provide: • information in large-print, braille or Easy Read format • information on audio or video • translated material. See the sections on relationships and communication and providing information in NICE's guideline on service user experience in adult mental health.	Adapted from rec 1.1.5 from related guideline, Service user experience in adult mental health services guideline (CG136), and from 1.1.5 of the related guideline, Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27) GC consensus
1.2 Before admission to hospital	
Planning and assessment	
1.2.1 Mental health and primary care practitioners (including GPs) and specialist community teams supporting people during transition should respond quickly to requests for mental health assessment from: • people with mental health problems • family members • carers • staff such as hostel, housing and community support workers.	C6, HA12, C8 GC consensus
1.2.2 Allow more time and expertise to support people with more complex needs to make transitions to and from services, if necessary. This may include: • children and young people • people with dementia, or cognitive and sensory impairment • people placed outside the area they live in.	Expert witnesses (Young Minds, dementia) GC consensus
1.2.3 When admission is being planned for a specific treatment episode involve: • the person who is being admitted • their family members, parents or carers • community accommodation and support providers.	HA6, HA9, HA12, HA14, CYP1
1.2.4 When planning the treatment the person will have, take account of the expertise and knowledge of the person's family members, parents or carers.	C7, C9, HA12
1.2.5 Offer people an opportunity to visit the inpatient unit before they are admitted. This is particularly important for:	Expert witnesses (Young Minds, dementia) GC consensus

Recommendation	**Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)**
• young people • people with dementia • people with learning disabilities and other additional needs • those placed outside the area they live in.	
1.2.6 If it is not possible for the person to visit the inpatient unit they will be admitted to in advance, consider using online and printed information to support discussion about their admission.	Expert witnesses (Young Minds, dementia) GC consensus
1.2.7 During admission planning, record a full history or update that covers the person's cognitive, physical and mental health needs and identifies the services involved in their care.	Expert witness, dementia
1.2.8 If more than 1 team is involved in a person's transition to, within and from a service, ensure there is ongoing communication between those teams, which may include: • the community mental health team • the learning disability team • the team that works with older people • child and adolescent mental health services (CAMHS) • the inpatient hospital team.	HA10, HA12, C8, C9 Expert witness (Young Minds)
1.2.9 Support people who have had more than 1 admission to develop a crisis plan as part of their care planning process. This should include the following: • relapse indicators and plans • coping strategies • preferences for treatment and specific interventions • advance decisions. • See the section on community care in NICE's guideline on service user experience in adult mental health services.	EcRR1 RR6, RR11, RR12, Ec RR1, HA14 NICE guideline CG136, GC consensus
1.3 Hospital admission	
General principles	
1.3. At admission offer all people access to advocacy services that take into account their: • language needs • cultural and social needs	HA13 Care Act 2014

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
• protected characteristics (see the Gov.UK page about discrimination).	
1.3.2 Health and social care practitioners admitting someone with cognitive difficulties should try to ensure the person understands why they have been admitted.	HA11
1.3.3 Start building therapeutic relationships as early as possible to: • lessen the person's sense of being coerced • encourage the person to engage with treatment and recovery programmes and collaborative decision-making • create a safe, contained environment • reduce the risk of suicide, which is high during the first 7 days after admission.	HA1, HA3, HA4, HA6, HA15
1.3.4 During admission, discuss with the person: • any strategies for coping that they use • how they can continue to use, adapt and develop positive coping strategies on the ward.	HA9, HA14 GC consensus
1.3.5 Practitioners involved in admission should refer to crisis plans and advance statements when planning care. In line with the Mental Capacity Act 2005, advance decisions must be taken into account.	RR5, RR6, EcRR1, GC consensus
1.3.6 Start discharge planning at admission.	GC consensus
1.3.7 For recommendations on assessing and treating people who have been detained under the Mental Health Act, see NICE's guideline on service user experience in adult mental health services.	NICE advice
Out-of-area admissions	
1.3.8 If the person is being admitted outside the area they live in, identify: • a named practitioner from the person's home area who has been supporting the person • a named practitioner from the ward they are being admitted to.	HA10 Expert witness (Young Minds) GC consensus
1.3.9 The named practitioners from the person's home area and the ward should work together to ensure that care planning, recovery goals and discharge plans are regularly reviewed as the person's needs change.	HA10 Expert witness (Young Minds) GC consensus
1.3.10 At all stages of planning treatment, take into account the higher risk of suicide after discharge for people admitted to hospital outside the area they live in (see the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness). This should	HA10 Expert witness (Young Minds) GC consensus

Recommendation	**Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)**
include: • assessing the risk • discussing with the person how services can help to keep them safe.	
Legal status and restrictions	
1.3.11 The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should: • use clear language • discuss rights and restrictions with the person • provide written and verbal information • make the discussion relevant to the ward the person is being admitted to • explain whether they are under observation and what this means (see recommendation 1.3.16).	HA1, HA5, HA6 GC consensus
1.3.12 A senior health professional should arrange follow-up with the person being admitted to ensure: • they have understood the information they were given at admission • they know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish • they understand that any changes to their legal status and treatment plans will be discussed as they occur.	HA1, HA6 GC consensus
Addressing personal concerns	
1.3.13 At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include: • physical healthcare needs • advice about immediate addiction issues, treatment and support • mental health treatment.	GC consensus

1.3.14 The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements. This may include:
• people they have a responsibility to care for, such as:
    • children
    • frail or ill relatives.
• domestic arrangements, in particular:
    • home security
	HA6
	GC consensus

Recommendation	**Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)**
- tenancy - benefits - home care service - pets.	
1.3.15 Ensure that the ward to which the person is admitted is a safe and therapeutic environment. People, particularly children and young people, should know who they can talk to if they are frightened or need support. See also the section on hospital care in NICE's guideline on service user experience in adult mental health services.	HA12, NICE guideline CG136 GC consensus
Observation	
1.3.16 The admitting nurse or person responsible should tell the person what level of observation they are under and: - explain what being under observation means - explain clearly the reasons why the person is under observation and when, or under what circumstances, this will be reviewed - explain how they will be observed and how often - explain how their rights to privacy and dignity will be protected - explain how observation will support their recovery and treatment - offer the person an opportunity to ask questions.	HA1, HA6, CYP2

1.3.17 Ensure that restrictions, including restrictions on access to personal possessions:
- are relevant and reasonable in relation to the person concerned
- take into consideration the safety of the person and others on the ward
- are explained clearly to ensure the person understands:
  - why the restrictions are in place and
  - under what circumstances they would be changed.
	HA6, expert witness (Young Minds)

1.4 Support for families, **parents** and **carers throughout transitions**	
Support for families and carers – at admission	
1.4.1 Identify a named practitioner who will make sure that the person's family members, parents or carers receive support and timely information including:	C5, C7

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
- the purpose of the admission - information (either general, or specific if the person agrees) about the person's condition - the practicalities of being in hospital - preparing for discharge - other sources of support for carers.	
1.4.2 Practitioners should start to build relationships with the person's family members, parents or carers during admission. This should be done: - in an empathetic, reassuring and non-judgemental way - acknowledging that a first admission can be particularly traumatic for families and carers.	C3, C4, CYP4, C5, C7
1.4.3 Arrange for parents to have protected time at an early point in the process of admitting their child to discuss the process with the relevant practitioners.	CYP3
Support for carers and families – involving them during treatment phase	
- 1.4.4 Give families, parents or carers clear information about the inpatient unit in a format they will be able to understand. This should include information about:the ward and the wider hospital environment - resources that are available, including accommodation for families - visiting arrangements - the treatment, care and support the person is receiving.	CYP3, expert witness (Young Minds), CG136
1.4.5 Give young carers (under 18) of people in transition relevant information that they are able to understand.	C3, GC consensus
1.4.6 Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay. See the section on involving families and carers in NICE's guideline on service user experience in adult mental health services.	C5, C6
1.4.7 At the point of admission, give carers information about carers' support services in their area that can address emotional, practical and other needs. This is particularly important if this is the person's first admission.	C1, C7
1.4.8 Try to accommodate parents' or carers' working patterns and other responsibilities so that they can	GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
attend meetings (if the person they care for wants this). This should include: - Care Programme Approach meetings - discharge planning meetings - other meetings concerning the care of the person.	
Carers' assessments	
1.4.9 Practitioners involved in admission and discharge should always take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge.	GC consensus
1.4.10 Identify carers (including young carers) who have recognisable needs. Make a referral to the carer's local authority for a carer's assessment, if the carer wishes it (Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.	C5, Care Act 2014 GC consensus
1.5 During hospital stay	
Planning support	
1.5.1 Ensure regular review of the person's care plan and progress toward discharge.	NICE suggestion, adopted by GC at GC11

1.5.2 Work with the person throughout their hospital stay to help them:
- keep links with their life outside the hospital, including:
  - family and friends
  - social and recreational contacts
  - education, training or work
- restart any activities before they are discharged.
This is particularly important for people who need a long-term inpatient stay and people who will have restricted access to the community.
	DC14

1.5.3 Identify whether the person has any additional need for support, for example with daily living activities. Work with carers and community-based services, such as specialist learning or physical disability services, to provide support and continuity while the person is in hospital.	C7, HA12
Education – for people under 18	
1.5.4 Children and young people under 18 must have continued access to education and learning throughout their hospital stay, in line with the Education Act 1996.	CYP11
1.5.5 Before the child or young person goes back into	CYP11

<table>
<tr><th>Recommendation</th><th>Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)</th></tr>
<tr><td>community-based education or training:
identify a named worker from the education or training setting to be responsible for the transition
arrange a meeting between the named worker and the child or young person to plan their return.</td><td></td></tr>
<tr><td colspan="2">1.6 Discharge from hospital</td></tr>
<tr><td colspan="2">Helping the person prepare for discharge – accommodation</td></tr>
<tr><td>1.6.1 Before discharging people with mental health needs to their home or care home, ensure it is suitable for them. Discuss and plan housing needs with the person and their family or carers.</td><td>CYP9</td></tr>
<tr><td>1.6.2 Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation. This should:
be started before discharge
continue after discharge for as long as the person needs support to stay in secure accommodation
focus on joint problem-solving, housing and mental health issues.</td><td>DC12, DC13
GC consensus</td></tr>
<tr><td colspan="2">Helping the person prepare for discharge – psychoeducation</td></tr>
<tr><td>1.6.3 Offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness before discharge. Sessions should:
start while the person is in hospital
continue after discharge so the person can test new approaches in the community
cover:
symptoms and their causes
what might cause the person to relapse, and how that can be prevented
psychological treatment
coping strategies to help the person if they become distressed
risk factors
ways in which the person can be helped to look after themselves.
be conducted by the same practitioner throughout if possible.</td><td>RR2, RR3, RR4</td></tr>
</table>

Recommendation	**Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)**

1.6.4 Consider a staged, group-based psychological intervention for people with bipolar disorder who have had at least 1 hospital admission and are being discharged from hospital. This should include:
• evaluation by a psychiatrist within 2 weeks of discharge
• 3 sequential sets of group sessions led by trained practitioners that focus on, respectively:
    • people's current mental health and recent experiences in hospital
    • psychoeducation or cognitive behavioural therapy
    • early warning signs and coping strategies
• group-based psychoeducation sessions for families and carers.
	EcRR2, RR9

1.6.5 Consider psychoeducation sessions (see recommendation 1.6.3) for all people with other diagnoses as part of planning discharge and avoiding readmission.	RR2, RR3, RR4, C1, C2, EcRR2, RR9 GC consensus
1.6.6 During discharge planning, offer carers group psychoeducation support. Ensure this is tailored to the specific condition of the person they care for.	C1, C2, EcRR2
Discharge from hospital – recovery plan to support discharge	
1.6.7 Ensure that there is a designated person responsible for writing the recovery plan in collaboration with the person being discharged (and their carers if the person agrees).	GC consensus
1.6.8 Ensure the recovery plan describes the support arrangements for the person after they are discharged. Send a copy to everyone involved in providing support to the person at discharge and afterwards. It should include: • possible relapse signs • where to go in a crisis • budgeting and benefits • handling personal budgets (if applicable) • social networks • educational, work-related and social activities • points of contact • details of medication • details of treatment and support plan • physical health needs	DC4 GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
- recovery goals - date of review of the recovery plan.	
1.6.9 Write the recovery plan in clear language. Avoid jargon and explain difficult terms.	CYP10
Discharge from hospital – peer support	

1.6.10 For people being discharged from hospital, consider a group-based, peer-delivered self-management training programme as part of recovery planning. Sessions should:
- continue for up to 12 weeks
- be delivered in groups of up to 12 members
- provide an opportunity for social support
- cover:
  - self-help, early warning signs and coping strategies
  - independent living skills
  - making choices and setting goals.
	EcDC1, economic modelling (Fuhr 2014)
	GC consensus

1.6.11 Consider providing peer support to people with more than 1 previous hospital admission. People giving peer support should: - have experience of using mental health services - be formally recruited, trained and supervised.	RR10, EcDC1, economic modelling (Fuhr 2014) GC consensus
Discharge planning	
1.6.12 Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For detailed recommendations on discharge and transfer of care, see NICE's guideline on service user experience in adult mental health services.	CYP7, DC14, CG136
1.6.13 Before discharge arrange: - phased leave (the person can have trial periods out of hospital before discharge) - phased return to employment or education (the person can gradually build up hours spent in employment or education). This is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community.	CYP7, DC14
1.6.14 Before discharging a person who is in education or training, arrange a planning meeting between them and a named person from the education setting to plan	CYP11 GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
their return to learning.	
1.6.15 If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning.	C7, expert witness, dementia

1.6.16 Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should:
• relate directly to the setting the person is being discharged to
• fully involve the person
• be shared with carers (if the person agrees)
• explore the possibility of using a personal health or social care budget
• cover aspects of the person's life including:
  ◦ daytime activities such as employment, education and leisure
  ◦ food, transport, budgeting and benefits
  ◦ pre-existing family and social issues and stressors that may have triggered the person's admission
  ◦ ways in which the person can manage their own condition.
(See also information about psychoeducation sessions in recommendations 1.6.3–1.6.5.)
	DC15, DC16
	GC consensus

1.6.17 Recognise that carers' circumstances may have changed since admission, and take any changes into account when planning discharge.	C9, CYP9 GC consensus
1.6.18 Before the person is discharged: • inform their carers of the plans for discharge • discuss with carers the person's progress during their hospital stay and how ready they are for discharge • ensure that carers know the likely date of discharge well in advance.	C9, CYP9 GC consensus
Follow-up support	

1.6.19 Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:
• contact details, for example of:
  ◦ a community psychiatric nurse or social worker
  ◦ the out-of-hours service
• support and plans for the first week
	DC1, DC2, DC3

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
- practical help if needed - employment support.	
1.6.20 On discharge: - the hospital psychiatrist should ensure that a discharge summary is emailed to the person's GP on the day of discharge and a copy given to the person - include information in the discharge summary about why the person was admitted and how their condition has changed during the hospital stay - consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.	DC4, DC5
1.6.21 If the person has a learning disability or dementia, the hospital team should lead the communication about discharge planning with the various services that support the person in the community. These agencies could include: - older people's services - learning disability services - the home care service.	HA12, expert witness, dementia
1.6.22 When a person is being discharged to a care home, look for opportunities for hospital and care home practitioners to exchange information about the person. An example might be a hospital practitioner accompanying the person when they return to the care home.	HA12, expert witness, dementia
1.6.23 In collaboration with the person, identify any risk of suicide as part of the needs and safety assessment. Incorporate this into the discharge planning and follow up within 7 days. Follow up earlier if the safety assessment indicates a risk of suicide.	DC16
1.6.24 Consider contacting people admitted for self-harm after discharge, who are not receiving treatment in the community. Give them advice on: - services in the community that may be able to offer support or reassurance - how to get in touch if they want to.	DC9, DC17
Community Treatment Orders (CTOs)	
1.6.25 Decide whether a community treatment order (CTO) or guardianship order is needed (see the Mental Health Code of Practice), based on:	RR7, RR8, RR15, RR16 GC consensus

Recommendation	Evidence statement(s) and other supporting evidence (expert witness testimony guideline committee – GC – consensus)
- the benefit to the person (for example, it may be helpful for people who have had repeated admissions) - the purpose (for example, to support the person to follow their treatment plan) - the conditions and legal basis.	
1.6.26 Ensure that the person who will be subject to the order has the opportunity to discuss why it is being imposed. Explain: - the specific benefit for the person - what restrictions it involves - when it will be reviewed - what will happen if the person does not comply with the order, and that this may not automatically lead to readmission.	RR7, RR13, RR15, RR16, DC18 GC consensus
1.6.27 Ensure that the conditions, purpose, legal basis and intended benefit are explained to families, carers and others providing support.	RR14

3.8.2 Linking evidence to recommendations (LETR) tables

Topic/section heading	Overarching principles – person-centred care
Recommendations	1.1.1 Ensure the care and support of people in transition is person-centred and focused on their recovery. 1.1.2 Work with people as active partners in their own care and transition planning. Refer to the section on relationships and communication in NICE's guideline on service user experience in adult mental health services. 1.1.3 Record the needs and wishes of the person at each stage of transition planning and review.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 7. What is the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings?

	8. What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings? 10. What is the impact of learning, development and training for mental health and social care staff and others involved in transitions between inpatient mental health settings and community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings? 3. (b) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on person-centred care were based on evidence from hospital admission, hospital discharge, people living with dementia, and children and young people review areas. Although we found no effectiveness studies to support these recommendations, there was a wide range of good quality qualitative research which underpinned these recommendations.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence	HA3 There is moderately good evidence from 1 cross-sectional study (Sheehan and Burns 2011 +/+) that the relationship between involuntary admission and therapeutic relationships with

statements from which the recommendation(s) were developed	staff is not necessarily causal – i.e. that sectioning a person need not damage relationships. This means that fostering therapeutic relationships may mitigate perceived coercion (rec 1.1.1). HA6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by improved: involvement in, information about, and explanation of decisions and treatment; being listened to; having some concessions to freedom of movement and activity; staff showing respect to people and listening and responding to patients' concerns; sense of safety, being protected and being cared for by staff (rec 1.1.2). HA9 There is evidence from 1 moderately good qualitative study (Smith et al. 2014+) that people admitted for treatment for anorexia nervosa experienced admission as a 'handing over of control' which could be experienced as threatening to existing coping strategies. This raised conflicts and could be felt as threatening to personal safety and integrity. The patient experience of involvement in decision making may be different from that in other mental health settings (rec 1.1.2). HA14 There is good evidence from a high quality qualitative sub-study (Farrelly et al. 2014 ++) of the content of joint crisis plans that service users who become unwell want: to be treated with respect, with all their needs considered; staff to be able to distinguish between behaviour and attributes that relate to mental illness, and that which does not. Familiarity is a factor. To have continuity of staff, and consistency and clarity, e.g. in the treatment plan; to be involved and in control as far as possible. This is more likely if the person is admitted voluntarily; other alternatives to hospital admission to be considered, as well as non-clinical interventions that might help (e.g. yoga), possibly delivered during the hospital episode to alleviate boredom (rec 1.1.2). DC16 There is good evidence from a qualitative study (Owen-Smith et al. 2014 ++) that the challenges faced by people leaving hospital after a psychiatric admission are concerning, and that the high incidence of suicide after discharge could be explained in those terms. Four of the 10 interviewed did not agree with the decision to discharge, and had had thoughts of self-harming. Most of the sample cited the need to return to problems which had existed prior to admission – social isolation, financial difficulties, challenging familial relationships, childcare responsibilities, and dealing with everyday household responsibilities. They felt that social networks and families had disintegrated, and the sudden absence of care and support would be particularly difficult to deal with. Although 9 of the 10 had support plans, there was some cynicism about whether support would materialise or be adequate (rec 1.1.2 and 1.1.3). CYP1 There is some evidence from 1 moderate quality qualitative UK study (Hepper et al. 2005 +) that children and young people who are treated as active collaborators in their

	care and attend pre-admission planning sessions do not see the reason for their admission as punitive, and understand it in terms of getting help for emotional or behavioural problems which are beyond their control and which have the potential to escalate to school or home exclusion (rec 1.1.2). DC15 There is good evidence from a relatively large assessment by interview study conducted 6 weeks after discharge (Simons and Petch 2006 ++/+) that people discharged from a psychiatric unit have unmet needs (ranked) for help with psychological distress (including psychotic symptoms); daytime activities and company; information about condition and treatment; food and transport; budgeting and benefits. People with a non-psychotic illness expressed higher unmet need than those with a psychotic illness. Staff ranked the most common unmet need among patients as need for daytime activities; help with psychological distress; company; psychotic symptoms; and obtaining and preparing food. Staff considered that 97% of need for information about condition and treatment had been met (rec 1.1.3).
Other considerations	Expert witness from Young Minds (building on research with young people and their families) described poor levels of participation by both parents and young person in decisions about admission, within care planning once admitted, and at discharge; insufficient information and communication from practitioners; and discharges which were rushed and unplanned or unnecessarily delayed. The young person's views and individual needs were not taken into account. The expert witness on dementia also highlighted the importance of thorough planning around the individual needs of the person, and the need for comprehensive assessment and recording to facilitate continuity of care between inpatient and care home settings (rec 1.1.1, 1.1.2, 1.1.3). The GC were mindful of the need for the person to be supported to be fully involved in their own recovery. The recovery focus (see terms) was important in order to promote the person's quality of life, build resilience and focus on the individual's own goals. Co-produced wellness recovery action plans are 1 means of recording the person's wishes, although there was no research evidence on their use in transitions (rec 1.1.1, 1.1.2 and 1.1.3 – see also recs 1.6.7–1.6.9). The shortcomings identified by the expert witness from Young Minds would be addressed by treating people as active partners in their own care (rec 1.1.2). GC members commented that people are often told what is available, rather than considering their needs and what is best for them. Recording of a person's views and wishes was felt to be essential if they were to influence the process, but these records should be changed and updated as the person's needs and views changed (rec 1.1.3).

Topic/section heading	**Overarching principles – maintaining community links**
Recommendations	1.1.4 Identify the person's support networks. Work with the person to explore ways in which the people who support them

	can be involved throughout their admission and discharge. 1.1.5 Enable the person to maintain links with their home community by: • supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport costs • helping them to keep links with employment, education and their local community. This is particularly important if people are admitted to mental health units outside the area they live in.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 8. What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings? 9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings? 3. (b) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on maintaining community links were based on evidence from hospital admission and hospital

	discharge, children and young people and carer support review areas. Although we found no effectiveness studies to support these recommendations, there was moderately good qualitative research which underpinned these recommendations.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	CYP6 There is moderate evidence from 1 UK qualitative study (Offord 2006 +) and 1 non-UK qualitative study (Turrell 2005 +) that incentives and contact with the 'outside world' help to facilitate successful discharge for adolescents treated for anorexia nervosa. Nurses identified the need for planned community involvement, such as social activities and/or peer support networks as a factor of discharge readiness (Turrell 2005 +). Adolescents treated for anorexia nervosa in a general psychiatric adolescent unit (Offord 2006 +) described incentives such as a college course, new friends, or a new job as key factors to ensure successful transition to the community. Upon admission adolescents felt actively discouraged from taking part in 'real world' activities, even those that were not linked to eating or exercise; this suspension of contact with the 'real world' was experienced as damaging to their emotional wellbeing and sense of development, and was seen as likely to exacerbate issues with readjustment after discharge (rec 1.1.4). C9 There is evidence from a small UK qualitative interview study, (Donner et al 2010 +), that carers of people with intellectual disability felt that their anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress or discharge arrangements. Any 'success' in finding out anything depended on making an 'individual relationship' with a staff member. Family carers felt the people they cared for were discharged without proper assessment. They themselves benefited if they were put in touch with other sources of support during the admission (rec 1.1.4). HA10 There is evidence from 1 small qualitative study (Chinn et al 2011 +) that people placed in specialist units for people with intellectual disabilities (IDs) with mental health problems were probably more likely than those without IDs to be placed at a distance from their homes. This made contact with families, community resources and minority language speakers more difficult, and increased dependency on staff. People detained might experience the detention as punishment, and some residents felt belittled and intimidated by staff (rec 1.1.5).
Other	The GC were mindful of the need to identify, in collaboration with

considerations	the person, who should be involved as ‘carer’. The definition of carer was discussed and agreed (see terms). However, ‘support networks’ has a wider definition than ‘carers’ and could include people and services with whom the person had social, emotional, employment and educational links (rec 1.1.4 and 1.1.5). The GC discussed the evidence on people feeling cut off from their ‘normal’ life, in an artificial environment, and finding it difficult to reintegrate on discharge. People placed out-of-area were particularly disadvantaged, as they might have limited or no access to friends and activities that were important to them. Hospital practitioners should therefore be more proactive in welcoming visitors to the ward and working with the person to engage people and services that will support them after discharge (rec 1.1.5)).

Topic/section heading	**Overarching principles – access and information**
Recommendations	1.1.6 Mental health services should work with primary care and local third sector (including voluntary) organisations to ensure that people with mental health problems in transition have equal access to services. This should be based on clinical need and irrespective of: • gender • sexual orientation • socioeconomic status • age • disability • cultural, ethnic and religious background • whether or not they are receiving support through the Care Programme Approach • whether or not they are subject to mental health legislation. 1.1.7 Give people using mental health services who are in transition comprehensive information, at the time they need it, on the nature of, and treatments and services for, their mental health problems. If needed, provide: • information in large-print, braille or Easy Read format • information on audio or video • translated material. See the sections on relationships and communication and providing information in NICE’s guideline on service user experience in adult mental health.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or

	care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings? 3. (b) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on access and information were based on evidence from the hospital admission review area, and on related NICE guidelines. There was limited qualitative evidence on the disadvantages faced by people from different cultural backgrounds, but good qualitative evidence on the need for people and their families to be informed to support active collaboration.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA10 There is evidence from 1 small qualitative study (Chinn et al. 2011 +) that people placed in specialist units for people with intellectual disabilities (IDs) with mental health problems were probably more likely than those without IDs to be placed at a distance from their homes. This made contact with families, community resources and minority language speakers more difficult, and increased dependency on staff. People detained might experience the detention as punishment, and some residents felt belittled and intimidated by staff (rec 1.1.6). HA13 There is moderate quality evidence from a small cross-

	sectional study in Birmingham (Commander et al. 1999 +/-), that black and Asian patients are more likely than white counterparts to be compulsorily admitted, are viewed by service providers as more likely to display negative behaviour such as hostility, were more likely to be admitted with police involvement, and were less satisfied with the admission process (rec 1.1.6).
Other considerations	Although there was limited available evidence on cultural and language diversity, and the disadvantages faced by particular groups, the GC felt it was important to promote equal access to all services. Some of the evidence had highlighted difficulty in accessing assessment for mental health problems. The GC adapted recommendation 1.2.5 from the NICE Service user experience in adult mental health guideline, CG136 (rec 1.1.6; see also 1.2.1). The GC felt that information on treatment and services should be available to people using services at the point that they need it. While there are statutory obligations in this area (e.g. for local authorities under the Care Act 2014), the GC wanted to make recommendations for practitioners to consider what information people need, when they need it, and how understanding can be reinforced, e.g. by checking that they have understood, perhaps when the person is less unwell. People also needed information about voluntary and community organisations that might support them, as well as about statutory services. The GC adapted recommendation 1.1.5 from the NICE Service user experience in adult mental health guideline, CG136 (rec 1.1.7). Different formats (e.g. videos, easy read and pictorial information) should be made available, to take account of different cognitive, communication and language issues. The GC was mindful of recommendation 1.1.5 of the related transition between inpatient hospital settings and community or care home settings for adults with social care needs guideline, NG27 (rec 1.1.7).

Topic/section heading	**Before hospital admission – planning and assessment (1)**
Recommendations	1.2.1 Mental health and primary care practitioners (including GPs) and specialist community teams supporting people during transition should respond quickly to requests for mental health assessment from: • people with mental health problems • family members • carers • staff such as hostel, housing and community support workers. 1.2.2 Allow more time and expertise to support people with more complex needs to make transitions to and from services, if necessary. This may include: • children and young people • people with dementia, or cognitive and sensory

	impairment • people placed outside the area they live in. 1.2.3 When admission is being planned for a specific treatment episode involve: • the person who is being admitted • their family members, parents or carers • community accommodation and support providers. 1.2.4 When planning the treatment the person will have, take account of the expertise and knowledge of the person's family members, parents or carers. 1.2.5 Offer people an opportunity to visit the inpatient unit before they are admitted. This is particularly important for: • young people • people with dementia • people with learning disabilities and other additional needs • those placed outside the area they live in. 1.2.6 If it is not possible for the person to visit the inpatient unit they will be admitted to in advance, consider using online and printed information to support discussion about their admission.
Research recommendations	The GC did not prioritise planning and assessment for admission as an area on which to make research recommendations. However, this area may be included within research recommendations concerned with transitions for children and young people (research rec 4); people with dementia (research rec 1) and people with complex needs (research rec 2).
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 7. What is the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings? 8. What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings? 9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings? 1 (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2 (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3 (a) What are the views and experiences of health, social care

	and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on planning admission were based on evidence from the hospital admission and carer review areas. There were no effectiveness studies. The evidence used comprises moderate to good qualitative studies on views and experience.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. The GC, based on their own experience, did not consider the recommendations to have significant resource implications. Where these might arise (1.2.5, 1.2.6) the GC provided options for targeting the support to particular vulnerable groups.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	C6 There is evidence from a UK qualitative interview study (Jankovic 2011 +) that family carers of people formally admitted felt unable to get help until the person's illness lead to sectioning, which was an undesirable outcome. More than a quarter of caregivers felt that, although they were not involved by staff in decision-making or treatment review, they were unfairly expected to take full responsibility for the person after discharge (rec 1.2.1). HA12 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that carers of people with intellectual disability (ID) eventually admitted to mainstream mental health inpatient units: • had experienced great difficulty in accessing mental health assessment and care • viewed the mainstream wards as 'depressing', 'intimidating' or 'frightening' • did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care • thought staff did not properly distinguish mental health and ID issues • did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and intellectual disability services, and lack of understanding among mental health staff of person-centred care for people with ID were echoed by ID service providers (Donner et al. 2010) (recs 1.2.1, 1.2.3, 1.2.4). HA 6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and

	from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by: • improved involvement in, information about, and explanation of decisions and treatment • being listened to • having some concessions to freedom of movement and activity • staff showing respect to people and listening and responding to patients' concerns • a sense of safety, being protected and being cared for by staff (rec 1.2.3). HA9 There is evidence from 1 moderately good qualitative study (Smith et al. 2014+) that people admitted for treatment for anorexia nervosa experienced admission as a 'handing over of control' which could be experienced as threatening to existing coping strategies. This raised conflicts and could be felt as threatening to personal safety and integrity. The patient experience of involvement in decision-making may be different from that in other mental health settings (rec 1.2.3). HA14 There is good evidence from a high quality qualitative sub-study (Farrelly et al. 2014 ++) of the content of joint crisis plans that service users who become unwell want: • to be treated with respect, with all their needs considered • staff to be able to distinguish between behaviour and attributes that relate to mental illness, and those which do not – familiarity is a factor • to have continuity of staff, and consistency and clarity, e.g. in the treatment plan • to be involved and in control as far as possible; this is more likely if the person is admitted voluntarily. Other alternatives to hospital admission to be considered, as well as non-clinical interventions that might help (e.g. yoga), possibly delivered during the hospital episode to alleviate boredom (rec 1.2.3). C7 There is evidence from a small US qualitative study (Gerson 2012 +) and from a very small UK qualitative study (Wilkinson 2008, rated - for its small sample), that family carers want the following at first and subsequent admissions: • less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic • greater recognition from staff on inpatient wards that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning • greater recognition from staff that they had valuable knowledge of the person to offer

	- information, education and dialogue about the mental health condition, and how to manage and support the person after discharge - partnership with professionals - support to find providers for ongoing care that insurance would cover (from the US paper) - less negativity and more encouragement to contemplate a positive future for their child (rec 1.2.4). C8 There is moderate evidence from a small UK qualitative interview study (Donner et al, 2010 +) that carers found it very difficult to access support from mainstream mental health services, staff of which were reluctant to assess someone with intellectual disability (ID) (although it is policy that mainstream services should support this group). Inability to access timely support and admission could exacerbate a crisis: carers might initiate police involvement to bring about admission (rec 1.2.1). C9 There is evidence from a small UK qualitative interview study (Donner et al, 2010 +) that carers of people with ID felt that their anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress or discharge arrangements. Any 'success' in finding out anything depended on making an 'individual relationship' with a staff member. Family carers felt the people they cared for were discharged without proper assessment. They themselves benefited if they were put in touch with other sources of support during the admission (rec 1.2.4). CYP1 There is some evidence from 1 moderate quality qualitative UK study (Hepper et al. 2005 +) that children and young people who are treated as active collaborators in their care and attend pre-admission planning sessions do not see the reason for their admission as punitive, and understand it in terms of getting help for emotional or behavioural problems which are beyond their control and which have the potential to escalate to school or home exclusion (rec 1.2.3).
Other considerations	The GC highlighted concerns expressed by carers that they were unable to arrange mental health assessments (rec 1.2.1), particularly where the person had complex needs (rec 1.2.2), as this made it more likely that the person would reach crisis point and have to be admitted (perhaps involuntarily). The expert witness from Young Minds reported that young people sometimes feel they could have been cared for in the community without admission if services had carried out earlier assessment (rec 1.2.1 and 1.2.2). The expert witness on dementia was clear about the additional time and expertise that was required in planning and implementing transitions if the person had complex needs and cognitive difficulties (rec 1.2.2). It was felt to be desirable that where admission was being considered as the preferred treatment or assessment option, preparation and planning should include the person, carer and provider from the earliest opportunity. The GC noted, given the potential disruption for the person, the importance of clarity considering the purpose of the admission (and it is not adequate

	to be admitted on account of lack of services in community) (rec 1.2.3). People should be able to visit the inpatient setting as part of preparation, and should be able to access online and printed information about what to expect (ideally as part of a discussion) (recs 1.2.5 and 1.2.6). With the person's permission, planning admission and treatment should involve carers and parents (rec 1.2.4). This may be especially important if the person is very unwell or unable to understand their situation and communicate their wishes. The expert witness on dementia suggested that a very comprehensive account of the person's history, problems, abilities and preferences should be collated before admission or by the time of discharge so that the receiving practitioners are adequately informed.

Topic/section heading	**Before hospital admission – planning and assessment (2)**
Recommendations	1.2.7 During admission planning, record a full history or update that covers the person's cognitive, physical and mental health needs and identifies the services involved in their care. 1.2.8 If more than 1 team is involved in a person's transition to, within and from a service, ensure there is ongoing communication between those teams, which may include: • the community mental health team • the learning disability team • the team that works with older people • child and adolescent mental health services (CAMHS) • the inpatient hospital team. 1.2.9 Support people who have had more than 1 admission to develop a crisis plan as part of their care planning process. This should include the following: • relapse indicators and plans • coping strategies • preferences for treatment and specific interventions • advance decisions. See the section on community care in NICE's guideline on service user experience in adult mental health services.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 7. What is the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings? 8. What is the effectiveness or impact of specific interventions to

	support children and young people during transition between inpatient mental health settings and community or care home settings? 9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings? 1 (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2 (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3 (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations in this section on planning admission were based on evidence from the hospital admission and reducing recommendations review areas. There was 1 effectiveness study and 1 cost-effectiveness study (rec 1.2.9). The rest of the evidence used comprises moderate to good qualitative studies on views and experience.
Relative value of different outcomes	It was not possible from available evidence to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	It was not possible from available evidence to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	EcRR1 There is high quality evidence from 1 UK study (Barrett et al. 2013 +/++) comparing joint crisis plans plus usual care vs usual care alone. They focus on individuals aged 16+ with a history of previous psychiatric hospitalisations. This study is applicable to the guideline and it has very minor limitations. The results of the analysis for the whole sample (over an 18-month period) indicate that, from the public sector perspective (2009/10 prices), joint crisis planning has an 80% probability of being cost effective for a 1% reduction in compulsory admissions. The public sector perspective included service use from the NHS, personal social services, housing, and criminal justice services. However, from a societal perspective, there is no clear evidence that it is cost effective – there is a 44% chance of being cost effective if the decision-maker does not want to pay any additional cost, however, this rises to a probability of 55% if the decision-maker is willing to pay at least £9,000 per 1% percent reduced in compulsory admissions. Sub-group analyses from the public sector perspective indicate that the intervention is more cost effective for black ethnicity (90% probability of being cost effective across all values that a

	decision-maker is willing to pay per 1% in reduced compulsory admission). For black ethnicity, individuals had better outcomes (fewer compulsory admissions) and lower costs; this is compared to white ethnicity that had no difference in compulsory admissions but higher costs (the intervention had a 25–35% probability of being cost effective). The intervention was not cost effective for Asian ethnicity, with a 20% chance that the intervention is cost effective if decision-makers were willing to pay between £0 and £10,000 and likelihood decreases at higher values (worse outcomes – higher proportions with compulsory admissions – and higher costs). From societal perspective, subgroup results were similar (rec 1.2.9).
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA10 There is evidence from 1 small qualitative study (Chinn et al. 2011 +) that people placed in specialist units for people with intellectual disabilities (IDs) with mental health problems were probably more likely than those without IDs to be placed at a distance from their homes. This made contact with families, community resources and minority language speakers more difficult, and increased dependency on staff. People detained might experience the detention as punishment, and some residents felt belittled and intimidated by staff (rec 1.2.8). HA12 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that carers of people with ID eventually admitted to mainstream mental health inpatient units: • had experienced great difficulty in accessing mental health assessment and care • viewed the mainstream wards as ‘depressing’, ‘intimidating’ or ‘frightening’ • did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care • thought staff did not properly distinguish mental health and ID issues • did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and ID services and lack of understanding among mental health staff of person-centred care for people with ID, were echoed by ID service providers (Donner et al. 2010) (rec 1.2.8). C8 There is moderate evidence from a small UK qualitative interview study (Donner et al, 2010 +) that carers found it very difficult to access support from mainstream mental health services, staff of which were reluctant to assess someone with ID (although it is policy that mainstream services should support this group). Inability to access timely support and admission could exacerbate a crisis: carers might initiate police involvement to bring about admission (rec 1.2.8). C9 There is evidence from a small UK qualitative interview study (Donner et al, 2010 +) that carers of people with ID felt that their anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient’s treatment or

	progress or discharge arrangements. Any ‘success’ in finding out anything depended on making an ‘individual relationship’ with a staff member. Family carers felt the people they cared for were discharged without proper assessment. They themselves benefited if they were put in touch with other sources of support during the admission (rec 1.2.8). RR 6 There is good evidence from a study of moderate quality (Papageorgiou et al. 2002 +/-), and from a high quality UK RCT (Thornicroft et al. 2013 +/++) that the legal status of advance directives and joint crisis plans (JCPs) as an influence over how people are treated in the event of a crisis is unclear to all parties, and that many (but not all) practitioners do not consider them to be an important aspect of co-production, and do not refer to them or implement them when a person comes into psychiatric care. Evidence of a small improvement in the secondary outcome of therapeutic relationships with nurse facilitators of the JCP (from Thornicroft 2013) may arise from the collaborative approach to drawing up JCPs which some facilitators adopted (rec 1.2.9). RR12 There is evidence from a poor to moderate UK study (Papageorgiou et al. 2004 -/+) that people who have advance directives express preferences about reduced coercion or enhanced human rights, the increased availability of alternative therapies, counselling, psychotherapy, better hospital facilities (e.g. ‘my own room’) and staff contact with their families. Total 40% reported that they would want to use the directives again, but a similar number did not find them useful because the professionals involved in their care did not refer to, or acknowledge, them in subsequent care. This latter conclusion was reinforced by consultant psychiatrists, 71% of those responding saying they did not recollect the patient having an advance directive. (rec 1.2.9).
Other considerations	The expert witness on dementia suggested that a very comprehensive account of the person’s history, problems, abilities and preferences should be collated before admission or by the time of discharge so that the receiving practitioners are adequately informed (rec 1.2.7). This should include risks. A GC member commented that having to repeat your whole history to several practitioners is potentially stressful and unsettling – as though no one was paying attention. It might then be that an ‘update’ would be more suitable than a full history (rec 1.2.7). The GC reviewed evidence on the difficulties faced by people with more than 1 condition, and in pursuit of collaborative working and continuity of care between inpatient and community settings it was considered important for admission planning to involve all the care teams a person might be engaged with, or might need during or after admission (rec 1.2.8). This might address some of the difficulties encountered by people in mainstream mental health units who have complex needs or need help with daily activities, and would potentially support inpatient practitioners to care for the person. A specific case might be that of a young person needing access to educational support.

	The GC carefully considered the effectiveness and cost-effectiveness of crisis plans for people with at least 1 admission (rec 1.2.9). Although they did not appear to reduce readmissions, the GC was persuaded that JCPs (i.e. drawn up in collaboration with practitioners) were a worthwhile approach if they could be implemented properly and used when the person was admitted. It was felt that they represented a valuable aspect of co-production of treatment plans, and there was potential for them to improve therapeutic relationships with practitioners. It was felt they should be considered part of admission planning. The GC noted that JCPs should not be available only to people on enhanced CPA (rec 1.2.9). There was also a desire within the GC to highlight their likely increased cost-effectiveness for black (African and Caribbean) people (a group widely thought to be disadvantaged at admission and more likely to be formally admitted). However, the GC could not arrive at a recommendation which met criteria.

Topic/section heading	**Hospital admission – general principles**
Recommendations	1.3.1 At admission offer all people access to advocacy services that take into account their: • language needs • cultural and social needs • protected characteristics (see the Gov.UK page about discrimination). 1.3.2 Health and social care practitioners admitting someone with cognitive difficulties should ensure the person understands why they have been admitted. 1.3.3 Start building therapeutic relationships as early as possible to: • lessen the person's sense of being coerced • encourage the person to engage with treatment and recovery programmes and collaborative decision-making • create a safe, contained environment • reduce the risk of suicide, which is high during the first 7 days after admission. 1.3.4 During admission, discuss with the person: • any strategies for coping that they use • how they can continue to use, adapt and develop positive coping strategies on the ward. 1.3.5 Practitioners involved in admission should refer to crisis plans and advance statements when care planning. In line with the Mental Capacity Act 2005, advance decisions must be taken into account. 1.3.6 Start discharge planning at admission. 1.3.7 For recommendations on assessing and treating people who have been detained under the Mental Health Act, see NICE's guideline on service user experience in adult mental

	health services.
Research recommendations	The GC did not prioritise this as an area to make research recommendations on. However, this area (including advocacy) may be included within research recommendations concerned with transitions for children and young people (rec 4), people with dementia (rec 1) and people with complex needs (rec 2).
Review questions	4 How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on general principles of admissions were based on evidence from hospital admission and reducing readmissions review areas. There was little evidence on effectiveness of admissions and approaches to admissions, except for 1 good RCT and cost-effectiveness study on the use and impact of crisis plans. There was moderate quality evidence from 1 old cross-sectional study on the experience of people from black and Asian backgrounds at admission; and a range of good qualitative evidence on the experience of coercion at admission (whether or not the person was formally admitted), and the potential for mitigating coercion through empathetic approaches and therapeutic relationships. Good evidence from qualitative accounts of the experience of people with intellectual disability. One good cross-sectional study on the correlates of suicide within 7 days of admission.
Relative value of different outcomes	The absence of relevant effectiveness studies (except on JCPs) meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies (except on JCPs) meant that it was not possible to ascertain and compare trade-off between benefits and harms (but see economic considerations below).
Economic considerations	EcRR1 There is high quality evidence from 1 UK study (Barrett et al. 2013 +/++) comparing JCPs plus usual care vs usual care alone. They focus on individuals aged 16+ with a history of previous psychiatric hospitalisations. This study is applicable to the guideline and it has very minor limitations. The results of the analysis for the whole sample (over an 18-

	month period) indicate that, from the public sector perspective (2009/10 prices), joint crisis planning has an 80% probability of being cost effective for a 1% reduction in compulsory admissions. The public sector perspective included service use from the NHS, personal social services, housing and criminal justice services. However, from a societal perspective, there is no clear evidence that it is cost effective – there is a 44% chance of being cost effective if the decision-maker does not want to pay any additional cost, however, this rises to a probability of 55% if the decision-maker is willing to pay at least £9,000 per 1% reduction in compulsory admissions. Sub-group analyses from the public sector perspective indicate that the intervention is more cost effective for black ethnicity (90% probability of being cost effective across all values that a decision-maker is willing to pay per 1% in reduced compulsory admission). For black ethnicity, individuals had better outcomes (fewer compulsory admissions) and lower costs; this is compared to white ethnicity that had no difference in compulsory admissions but higher costs (the intervention had a 25–35% probability of being cost-effective). The intervention was not cost effective for Asian ethnicity, with a 20% chance that the intervention is cost effective if decision-makers were willing to pay between £0 and £10,000 and likelihood decreases at higher values (worse outcomes – higher proportions with compulsory admissions – and higher costs). From societal perspective, sub-group results were similar. While this is the only cost-effectiveness study, the GC were aware that the implementation of all these recommendations involved staff taking time to communicate and make relationships with people, and inform them about the process. Against the background of the distress apparent from qualitative studies of user experience at admission, they felt justified in making these recommendations. The extension of the offer of advocacy to all people at admission may be costly (rec 1.3.5).
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA13 There is moderate quality evidence from a small cross-sectional study in Birmingham (Commander et al. 1999 +/-) that black and Asian patients are more likely than white counterparts to be compulsorily admitted, are viewed by service providers as more likely to display negative behaviour such as hostility, are more likely to be admitted with police involvement, and are less satisfied with the admission process (recs 1.3.1, 1.3.4). HA11 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that people with ID admitted to mainstream mental health inpatient units: • sometimes viewed the admission as motivated by respite for their carer(s) • did not always know why they were being admitted • felt disempowered and vulnerable, especially in inpatient units not designed for people with ID. On the other hand, some people enjoyed the wider range of

	social contact on the generic wards (rec 1.3.2). HA15 There is good quality evidence from a case control study (Hunt et al. 2013 ++/+) that people admitted to psychiatric hospitals are at high risk of suicide within the first 7 days of admission (40% of the sample within 3 days). Factors associated with predictable risk of suicide are: • being off the ward (on leave or having absconded) • having a history of self-harm • having experienced adverse life events in preceding 3 months • having had a mental illness for less than 12 months • being male (rec 1.3.3). HA1 There is good evidence from 1 mixed methods study (Katsakou 2011 ++/++) and 1 cross-sectional study (Bindman 2005 +/+) that people admitted to mental health units may feel coerced into accepting admission, whether or not they are formally admitted under the Mental Health Act. There is also evidence (Bindman 2005 +/+) that people do not necessarily know whether they are voluntary or involuntary patients, and may suspect they will be sectioned if they do not cooperate. Although most felt they needed help, they held alternative treatment to be preferable and less restrictive, and did not feel respected or cared for. Those not reporting a sense of coercion felt included in the admission and treatment process, respected and cared for (rec 1.3.3). HA3 There is moderately good evidence from 1 cross-sectional study (Sheehan and Burns 2011 +/+) that the relationship between involuntary admission and therapeutic relationships with staff is not necessarily causal – i.e. that sectioning a person need not damage relationships. This means that fostering therapeutic relationships may mitigate perceived coercion (rec 1.3.3). HA4 There is moderate quality evidence (Nolan et al. 2011 +) from a qualitative study that admission is experienced by some people with mental health problems as positive, if their experience of services is connected with good, empathetic and kind mental health staff, contact with other patients experiencing similar issues and recognition that admission would provide the best opportunity to rest and recover. For other patients, a negative perception of services, staff and the value of past treatment will impact on their view of admission (rec 1.3.3). HA6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by improved: • involvement in, information about, and explanation of decisions and treatment • being listened to • having some concessions to freedom of movement and activity

	- staff showing respect to people and listening and responding to patients' concerns - sense of safety, being protected and being cared for by staff (rec 1.3.3). HA9 There is evidence from 1 moderately good qualitative study (Smith et al. 2014 +) that people admitted for treatment for anorexia nervosa experienced admission as a 'handing over of control' which could be experienced as threatening to existing coping strategies. This raised conflicts and could be felt as threatening to personal safety and integrity. The patient experience of involvement in decision-making may be different from that in other mental health settings (rec 1.3.4). HA14 There is good evidence from a high quality qualitative sub-study (Farrelly et al. 2014 ++) of the content of JCPs that service users who become unwell want: - to be treated with respect, with all their needs considered - staff to be able to distinguish between behaviour and attributes that relate to mental illness, and that which does not – familiarity is a factor - to have continuity of staff, and consistency and clarity, e.g. in the treatment plan - to be involved and in control as far as possible; this is more likely if the person is admitted voluntarily. Other alternatives to hospital admission to be considered, as well as non-clinical interventions that might help (e.g. yoga), possibly delivered during the hospital episode to alleviate boredom (rec 1.3.4). RR 5 There is moderate evidence from a UK RCT (Papageorgiou et al. 2002 +/-) and good evidence from a high quality UK RCT (Thornicroft et al. 2013 +/++) that advance directives and JCPs drawn up while a person is able to consider their preferences for care do not reduce the number and length of compulsory admissions for patients with psychotic illness (rec 1.3.5). RR 6 There is good evidence from a study of moderate quality (Papageorgiou et al. 2002 +/-) and from a high quality UK RCT (Thornicroft et al. 2013 +/++) that the legal status of advance directives and JCPs as an influence over how people are treated in the event of a crisis is unclear to all parties, and that many (but not all) practitioners do not consider them to be an important aspect of co-production, and do not refer to them or implement them when a person comes into psychiatric care. Evidence of a small improvement in the secondary outcome of therapeutic relationships with nurse facilitators of the JCP (from Thornicroft 2013) may arise from the collaborative approach to drawing up JCPs which some facilitators adopted (rec 1.3.5).
Other considerations	Advocacy services must be provided under the Care Act 2014 section 67 of part 1, BUT it only has to be done if the authority judges that the person is unlikely to be able to understand, retain, weigh up information or communicate their wishes. The

	GC wished to extend this offer to the whole population, and stressed the need for independence in advocacy services (rec 1.3.1). The GC were also aware of the particular issues around culture, language and the poor experience of people from minority ethnic backgrounds; and the need for better communication and support for people with ID, so that they can understand the reason for admission. People with ID may be admitted to specialist or mainstream mental health services, so all staff need good communication skills and the ability to distinguish between ID and mental health issues (rec 1.3.2). The GC considered evidence that all, whether formally admitted or not, might feel coerced at admission. The level of mental distress (supported by qualitative accounts) requires a highly skilled, thoughtful and empathetic approach which mitigates coercion and enhances the therapeutic relationship. The high risk of suicide within 7 days of admission may possibly be mitigated by therapeutic relationships with staff. ‘Therapeutic relationships’ incorporate the values which matter to people at this stressful time (see HA6), including respect and being listened to (rec 1.3.3). Limited material on admissions for people with an eating disorder supports the view that loss of control over one’s life – a common aspect of admission for all – is particularly difficult, as ‘coping strategies’ (such as not eating; self-harming; apparent ‘aggression’; substance use) may be unacceptable in the inpatient context. The GC felt that coping strategies – and the person’s inherent strengths – should be explicitly discussed and that the therapeutic relationship is a foundation for this (rec 1.3.4). The GC felt that, despite the lack of impact on readmissions and length of stay, crisis plans and advance decisions or directives should be used at admissions if they have been drawn up (although Mental Health Act provisions could overrule the person’s wishes). Lack of proven effectiveness and cost-effectiveness was compounded by evidence from the studies on joint crisis planning (RR5, RR6 and EcRR1) that practitioners did not always promote their use, did not cooperate with the process of co-producing them, and did not refer to them. There was also interest in the finding (EcRR1) that JCPs were more likely to be cost effective (reducing readmissions length of stay) for people of black (African and Caribbean) ethnicity (who experience more formal admissions). There was GC consensus that development and use of JCPs should be encouraged, as they could enhance the person’s sense of control and ‘being listened to’ (rec 1.3.5). NICE colleagues identified the section on people admitted under the Mental Health Act in the service user experience in adult mental health guideline, and it was agreed that it complemented this section (rec 1.3.7). Discharge planning should begin early, ideally at admission (GC consensus). This should ensure that the person’s admission is seen as a stage in their recovery, and because care arrangements in the community may take time to arrange (rec

	1.3.6).

Topic/section heading	**Hospital admission – out-of-area admissions**
Recommendations	1.3.8 If the person is being admitted outside the area they live in, identify: - a named practitioner from the person’s home area who has been supporting the person - a named practitioner from the ward they are being admitted to. 1.3.9 The named practitioners from the person’s home area and the ward should work together to ensure that care planning, recovery goals and discharge plans are regularly reviewed as the person’s needs change. 1.3.10 At all stages of planning treatment, take into account the higher risk of suicide after discharge for people admitted to hospital outside the area they live in (see the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness). This should include: - assessing the risk - discussing with the person how services can help to keep them safe.
Research recommendations	The GC did not prioritise this as an area to make research recommendations on. However, because they may be more likely to be placed in specialist units out-of-area, research recommendations concerned with transitions for children and young people (rec 4), people with dementia (rec 1) and people with complex needs (rec 2) may be relevant.
Review questions	4 How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on out-of-area admissions were based on evidence from the hospital admission review area. There were no effectiveness or cost-effectiveness studies on out-of-area placements. Indirect qualitative evidence was derived from particular populations (people with intellectual disabilities; children and young people).

Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies (except on JCPs) meant that it was not possible to ascertain and compare trade-off between benefits and harms for people placed out-of-area, but the potential loss of support from carers, friends and family; the cost (including time) of transport for visitors; and the effects of not being able to engage in social, educational and employment activities were all considered as potential harms. The increased risk of suicide for people placed out-of-area is of particular concern.
Economic considerations	There was no direct evidence on the cost of out-of-area admissions, but the GC was aware that specialist units (e.g. for people with mental disorders and intellectual disability; people with eating disorders) may have a wide catchment area, resulting in people being placed at a distance from family, community and mainstream service support, and increased risk of suicide. These units may be more costly than mainstream services, and there is the danger that the individual may be overlooked – so there should be regular review of specialist, out-of-area and long placements. The GC decided that regular review of all inpatients - including those out of area - should be recommended as all admissions are costly (see rec 1.5.1).
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA10 There is evidence from 1 small qualitative study (Chinn et al. 2011 +) that people placed in specialist units for people with ID with mental health problems were probably more likely than those without ID to be placed at a distance from their homes. This made contact with families, community resources and minority language speakers more difficult, and increased dependency on staff. People detained might experience the detention as punishment, and some residents felt belittled and intimidated by staff (rec 1.3.8–1.3.10).
Other considerations	The GC also considered that children and young people were more likely to be placed out of area, because of the distribution of CAMHS beds. In the absence of research evidence, expert witness testimony was commissioned from Young Minds. Based on their own qualitative research with young people and their families, this testimony suggested that issues around admission for young people were exacerbated when young person placed further away from home. Difficulties included: • insufficient information was available to them before admission about the service they/their child would be admitted to • lack of participation (by both parents and the young person) in decisions about admission and within care planning once admitted – including lack of involvement in setting outcomes for the hospital stay • poor communication from staff at inpatient CAMHS with parents – lack of information and dismissive tone • some families found the process rushed and parents reported young people being discharged with insufficient

	planning and support set up in the community. Other families found the discharge unnecessarily delayed by the prioritisation of process over the needs of the individual young person, e.g. delaying discharge because a place could not be found in a step-down service, even when young person and parents didn't believe or understand why such a process was needed (rec 1.3.8, 1.3.9). The GC discussed the importance of communication between community teams responsible for community support of the person liaising with diverse inpatient teams in specialist units at all stages of admission and discharge. This was felt to be essential to continuity of care (rec 1.3.8). The GC acknowledged the elevated risk of suicide on discharge for the out-of-area population, as documented in The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2015 (referenced by GC member) (rec 1.3.10).

Topic/section heading	**Hospital admission – legal status and restrictions**
Recommendations	1.3.11 The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should: • use clear language • discuss rights and restrictions with the person • provide written and verbal information • make the discussion relevant to the ward the person is being admitted to • explain whether they are under observation and what this means (see recommendation 1.3.16). 1.3.12 A senior health professional should arrange follow-up with the person being admitted to ensure: • they have understood the information they were given at admission • they know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish • they understand that any changes to their legal status and treatment plans will be discussed as they occur.
Research recommendations	The GC did not prioritise this as an area to make research recommendations on.
Review questions	4 How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings?

	2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on legal status and restrictions were based on evidence from the hospital admission review area. There were no effectiveness or cost-effectiveness studies on formal or involuntary vs informal or voluntary admissions (or use of community support as an alternative). Four qualitative studies of very good/moderately good quality were found.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare trade-off between benefits and harms for people admitted under different legal provisions.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA 1 There is good evidence from 1 mixed methods study (Katsakou 2011 ++/++) and 1 cross-sectional study (Bindman 2005 +/+) that people admitted to mental health units may feel coerced into accepting admission, whether or not they are formally admitted under the Mental Health Act. There is also evidence (Bindman 2005 +/+) that people do not necessarily know whether they are voluntary or involuntary patients, and may suspect they will be sectioned if they do not cooperate. Although most felt they needed help, they held alternative treatment to be preferable and less restrictive, and did not feel respected or cared for. Those not reporting a sense of coercion felt included in the admission and treatment process, respected and cared for (rec 1.3.11, 1.3.12). HA 5 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++) that most people admitted under the Mental Health Act recognised that they were unwell (10 of the total 59 did not feel this), and 63% of the total sample felt the need for a safe haven. However, 92% (54 people) experienced involuntary admission as a loss of personal autonomy similar to 'imprisonment' and some recalled coercion, restraint and forced medication. People felt that less coercive treatment given in the community would be less 'unjust', and less disruptive of work and other commitments (rec 1.3.11, 1.3.12). HA 6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be

	supported by improved: - involvement in, information about, and explanation of decisions and treatment - being listened to - having some concessions to freedom of movement and activity - staff showing respect to people and listening and responding to patients' concerns - sense of safety, being protected and being cared for by staff (rec 1.3.11, 1.3.12
Other considerations	The GC took into account the fact that people did not necessarily know whether they had been admitted as a formal or informal patient – and that the distinction may be misleading if people felt they would be 'sectioned' if they did not cooperate. Information about legal status and rights was felt to be important, but the GC recognised that the person may not be able to take it in at admission, and hence needed reiteration and follow up. This needed to be overseen or delivered by a practitioner ('senior health professional') who was competent to explain the Mental Health Act (as not all staff may have adequate knowledge). Ideally, this discussion might take place within the context of a developing 'therapeutic relationship'. Accessible written information – possibly a video - might also be useful (recs 1.3.11, 1.3.12).

Topic/section heading	**Hospital admission –** addressing personal concerns

Recommendations	1.3.13 At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:
	- physical healthcare needs
	- advice about immediate addiction issues, treatment and support
	- mental health treatment.
	1.3.14 The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements. This may include:
	- people they have a responsibility to care for, such as:
	    - children
	    - frail or ill relatives
	- domestic arrangements, in particular:
	    - home security
	    - tenancy
	    - benefits
	    - home care service
	    - pets.
	1.3.15 Ensure that the ward to which the person is admitted is a safe and therapeutic environment. People, particularly children and young people, should know who they can talk to if they are

	frightened or need support. See also the section on hospital care in NICE’s guideline on service user experience in adult mental health services.
Research recommendations	The GC did not prioritise this as an area to make research recommendations on.
Review questions	4 How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services) in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on creating a safe and welcoming environment were based on evidence from the hospital admission review area. The evidence for these recommendations came from 5 high - good quality studies concerning the experience and views of people admitted and their carers.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare any trade-off between benefits and harms for people admitted under these recommendations. However, the GC considered that these provisions were based on universal standards of residential care.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +) that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by improved: • involvement in, information about, and explanation of decisions and treatment • being listened to • having some concessions to freedom of movement and activity • staff showing respect to people and listening and

	responding to patients' concerns - sense of safety, being protected and being cared for by staff (rec 1.3.14, 1.3.15). HA12 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that carers of people with intellectual disability eventually admitted to mainstream mental health inpatient units: - had experienced great difficulty in accessing mental health assessment and care - viewed the mainstream wards as 'depressing', 'intimidating' or 'frightening' - did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care - thought staff did not properly distinguish mental health and ID issues - did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and intellectual disability services, and lack of understanding among mental health staff of person-centred care for people with ID were echoed by ID service providers (Donner et al. 2010) (rec 1.3.14, 1.3.15). As the research studies cited as evidence concerned only those admitted involuntarily or people with intellectual disability, the GC explicitly decided that these recommendations should apply to all people admitted, whatever their status. GC consensus on these recommendations was guided by the experience of service users and carers within the GC.
Other considerations	The GC recognised that an individual may have a number of physical health needs involving medication and diet, and interaction of medicines, especially if they are not expecting admission. They would need an early assessment with a senior healthcare professional to consider their holistic health needs (rec 1.3.13). (Medication itself is outside the scope of this guideline.) The GC recognised that a person suddenly admitted may well be anxious and distressed about their dependants, home security and other everyday responsibilities. While approved mental health professionals (AMHPs) are legally responsible for ensuring these things are looked after for formally admitted people, it is unclear how thorough their remit is, and who takes responsibility for people informally admitted. People who are anxious about these matters may not benefit from treatment unless they are reassured that these issues are attended to. It may be that liaison with friends or family may be all that is required to 'manage' the situation (rec 1.3.14). The GC agreed that a therapeutic environment should not be one in which there was violence, aggression or intimidation, but this might be difficult to guarantee. Feeling safe and cared for was important (HA6), and feeling frightened (HA12) might be a

	common experience, especially at a first admission. Although it was acknowledged that staff rotas would mean that a source of support would be impractical, people should know who to approach if distressed or frightened (rec 1.3.15).

Topic/section heading	**Hospital admission – observation**

Recommendations	1.3.16 The admitting nurse or person responsible should tell the person what level of observation they are under and:
	• explain what being under observation means
	• explain clearly the reasons why the person is under observation and when, or under what circumstances, this will be reviewed
	• explain how they will be observed and how often
	• explain how their rights to privacy and dignity will be protected
	• explain how observation will support their recovery and treatment
	• offer the person an opportunity to ask questions.
	1.3.17 Ensure that restrictions, including restrictions on access to personal possessions:
	• are relevant and reasonable in relation to the person concerned
	• take into consideration the safety of the person and others on the ward
	• are explained clearly to ensure the person understands:
	  • why the restrictions are in place and
	  • under what circumstances they would be changed.

Research recommendations	The GC did not prioritise this as an area to make research recommendations on.
Review questions	4 How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 8 What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 3. (a) What are the views and experiences of health, social care and other practitioners (e.g. in housing and education services)

	in relation to admissions to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on observation were based on evidence from hospital admission and children and young people review areas. The evidence for these recommendations came from 5 high/good quality studies concerning the experience and views of people admitted and their carers.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare any trade-off between benefits and harms for people admitted under these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	HA1 There is good evidence from 1 mixed methods study (Katsakou 2011 ++/++) and 1 cross-sectional study (Bindman 2005 +/+) that people admitted to mental health units may feel coerced into accepting admission, whether or not they are formally admitted under the Mental Health Act. There is also evidence (Bindman 2005 +/+) that people do not necessarily know whether they are voluntary or involuntary patients, and may suspect they will be sectioned if they do not cooperate. Although most felt they needed help, they held alternative treatment to be preferable and less restrictive, and did not feel respected or cared for. Those not reporting a sense of coercion felt included in the admission and treatment process, respected and cared for (rec 1.3.16). HA6 There is good quality evidence from 2 good qualitative studies (Katsakou et al. 2011 ++; Valenti et al. 2014 ++), and from 1 literature review (Van Den Hooff 2014 +), that people who are involuntarily admitted under the Mental Health Act value freedom, safety and respect from staff. These values could be supported by improved: • involvement in, information about, and explanation of, decisions and treatment • being listened to • having some concessions to freedom of movement and activity • staff showing respect to people and listening and responding to patients' concerns • sense of safety, being protected and being cared for by staff (rec 1.3.16, 1.3.17). CYP2 There is evidence from 1 qualitative UK study (Hepper et al. 2005 +) that some children and young people feel that the sense of containment created by staff is a key benefit of hospitalisation. For other children and young people the loss of independence and constant surveillance is distressing and can

	negatively interfere with coping strategies used at home (rec 1.3.16).
Other considerations	The GC considered that by definition people admitted to a psychiatric ward would all be subject to observation at some level. This need not be seen in a negative light – having someone address you by name and ask after your welfare could be reassuring. Observation should be conducted in a manner which is beneficial to the treatment plan, and respects the need for privacy and dignity. The post-admission phase is a vulnerable time for potential suicide, but the monitoring should be therapeutic and caring (not just looking to check if the person is still breathing!). The person being observed should be fully informed about the reasons behind the observation, and when the level of observation will be reviewed (rec 1.3.16). The expert witness from Young Minds referred to the fact that young people find it difficult to be parted from possessions which they use frequently to alleviate boredom. The GC alluded to the problem of expensive items being stolen on the wards (as staff cannot be expected to protect them), and the possibility that some items might be dangerous. The GC phrased recommendations so that the person would at least know and understand the reasons for restrictions (in where they can go; in what possessions they can have on the ward) (rec 1.3.17).

Topic/section heading	**Support for carers and families – at admission**
Recommendations	1.4.1 Identify a named practitioner who will make sure that the person's family members, parents or carers receive support and timely information including: • the purpose of the admission • information (either general or specific if the person agrees) about the person's condition • the practicalities of being in hospital • preparing for discharge • other sources of support for carers. 1.4.2 Practitioners should start to build relationships with the person's family members, parents or carers during admission. This should be done: • in an empathetic, reassuring and non-judgemental way • acknowledging that a first admission can be particularly traumatic for families and carers. 1.4.3 Arrange for parents to have protected time at an early point in the process of admitting their child to discuss the process with the relevant practitioners.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings?

	2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on planning admission were based on evidence from the carer and children and young people review areas. There were 3 controlled studies of moderate quality that evaluated carer education groups. The rest of the evidence for this area is qualitative in nature. Although some studies are small, there is consistency in the findings.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	C3 There is evidence from a small UK study, Wilkinson (2008, rated - because only 4 carers participated), from a Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study, Gerson (2012 +) that admission of the person they cared for to an inpatient acute ward may be traumatic for the carer(s). Reported feelings include shock, guilt, relief, feeling alone, powerless and isolated and highly stigmatised by the event and/or the label of mental illness or schizophrenia (rec 1.4.2). C4 There is evidence from a small Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study, Gerson (2012 +), that first admission of an adult child to an inpatient acute ward may be traumatic for the carer(s). In addition to the feelings reported in CS3 (above), carers were less likely to have knowledge of psychiatric disorders, and assumed their child's future would be dominated by the condition (rec 1.4.2). C5 There is evidence from a small Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study, Gerson (2012 +) and a very small UK qualitative study (Wilkinson 2008) that carers' feelings and anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress – often requests were declined with reference to 'patient confidentiality' (a point also flagged in Jankovic 2011, see below). Family carers often had little notice of discharge, and no idea how to support the patient, or find support for themselves, after discharge. Family carers wanted greater involvement and information, and a sense of sharing care with professionals (recs 1.4.1, 1.4.2).

	C7 There is evidence from a small US qualitative study, Gerson (2012 +) and from a very small UK qualitative study, Wilkinson (2008 rated - for its small sample), that family carers want the following at first and subsequent admissions: • less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic • greater recognition from staff on inpatient ward that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning • greater recognition from staff that they had valuable knowledge of the person to offer • information, education and dialogue about the mental health condition, and how to manage and support the person after discharge • partnership with professionals • support to find providers for ongoing care that insurance would cover (from the us paper) • less negativity and more encouragement to contemplate a positive future for their child. (recs 1.4.1, 1.4.2). CYP3 There is good evidence from 1 non-UK qualitative study of moderate quality (Scharer 2000 +) and 1 low quality secondary data non-UK study (Geraghty 2011 -) that parents of children who are admitted to psychiatric units experience feelings of guilt and blame. Guilt manifests itself as a feeling that the parent is in some way responsible for the child’s illness. Blame is less about personal accountability, and materialises from the feeling that others – namely hospital staff, neighbours, family members – will hold them responsible for the child’s illness. There was also evidence (Scharer 2000 +) that parents’ concerns about being blamed arose from experiences with hospital staff on previous admissions. A non-judgemental, reassuring attitude from admitting staff can help to mitigate parents’ fears that they are to blame for their child’s illness (rec 1.4.3). CYP4 There is some evidence from 1 non-UK qualitative study of moderate quality (Scharer 2000 +) to suggest that the admission process is a critical period in terms of forming and building relationships between parents and staff and this could positively or negatively impact the entire experience of the hospital stay (rec 1.4.2).
Other considerations	The GC discussed what support and information it was possible and desirable to give to parents and carers at admission. Controlled studies concerned helping the carer through educating them about meaning and management of illness of person cared for and coping strategies – this approach might need to be condition-specific (see rec 1.6.2–1.6.6). The additional areas of practical and emotional support were considered, but it was felt that practitioners would be unable to deliver such support directly, but could signpost sources of

	support for carers (rec 1.4.1). The GC acknowledged the evidence which said that practitioners did not appear to recognise or address the potential trauma of admission for carers, parents (of young and adult children) and families. The emotional impact on parents (guilt, anxiety, stress) was felt to be particularly difficult, and the negative and unsupportive responses from staff, and prevailing tone of negativity in terms of their child’s future described in the evidence exacerbated trauma. The GC talked about the importance of ‘therapeutic optimism’ and hope. Practitioners could address the needs of families and carers by employing empathetic and reassuring attitudes and behaviours (see rec 1.4.2). The GC also considered that building relationships between practitioners and carers or family members would be beneficial to all parties, including the person in hospital. Parents should expect to be involved in the care of their children even when children may not necessarily want their involvement (see rec 1.4.6 and 1.4.8). Giving them guaranteed time at beginning of the treatment process was felt to require recommendation, as qualitative evidence suggested that parents were sometimes overlooked (rec 1.4.3).

Topic/section heading	**Support for carers and families – involving them during treatment phase**
Recommendations	1.4.4 Give families, parents or carers clear information about the inpatient unit in a format they will be able to understand. This should include information about: • the ward and the wider hospital environment • resources that are available, including accommodation for families • visiting arrangements • the treatment, care and support the person is receiving. 1.4.5 Give young carers (under 18) of people in transition relevant information that they find easy to understand. 1.4.6 Respect the rights and needs of carers alongside the person’s right to confidentiality. Review the person’s consent to share information with family members, carers and other services during the inpatient stay. See the section on involving families and carers in NICE’s guideline on service user experience in adult mental health services. 1.4.7 At the point of admission, give carers information about carers’ support services in their area that can address emotional, practical and other needs. This is particularly important if this is the person's first admission. 1.4.8 Try to accommodate parents’ and carers’ working patterns and other responsibilities so that they can attend meetings (if the person they care for wants this). This should include: • Care Programme Approach meetings

	• discharge planning meetings • other meetings concerning the care of the person.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on involving families and carers in treatment were based on evidence from the carer and children and young people review areas. The evidence for this area is qualitative and of moderately good quality. Although some studies are small, there is consistency in the findings.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	CYP3 There is good evidence from 1 non-UK qualitative study of moderate quality (Scharer 2000 +) and 1 low quality secondary data non-UK study (Geraghty 2011 -) that parents of children who are admitted to psychiatric units experience feelings of guilt and blame. Guilt manifests itself as a feeling that the parent is in some way responsible for the child's illness. Blame is less about personal accountability, and materialises from the feeling that others – namely hospital staff, neighbours, family members – will hold them responsible for the child's illness. There was also evidence (Scharer 2000 +) that parents' concerns about being blamed arose from experiences with hospital staff on previous admissions. A non-judgemental, reassuring attitude from admitting staff can help to mitigate parents' fears that they are to blame for their child's illness (rec 1.4.4). C3 There is evidence from a small UK study (Wilkinson 2008, rated - because only 4 carers participated), from a Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study (Gerson 2012 +) that admission of the person they cared for to an inpatient acute ward may be traumatic for the carer(s). Reported feelings include shock, guilt, relief, feeling alone, powerless and isolated and highly stigmatised by the event and/or the label of mental illness or schizophrenia (rec 1.4.5).

	C5 There is evidence from a small Canadian qualitative interview study (Clarke & Winsor 2010 +), a small US qualitative study (Gerson 2012 +) and a very small UK qualitative study (Wilkinson 2008) that carers' feelings and anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress – often requests were declined with reference to 'patient confidentiality' (a point also flagged in Jankovic 2011, see below). Family carers often had little notice of discharge, and no idea how to support the patient, or find support for themselves, after discharge. Family carers wanted greater involvement and information, and a sense of sharing care with professionals (rec 1.4.6). C6 There is evidence from a UK qualitative interview study – (Jankovic 2011 +) that family carers of people formally admitted felt unable to get help until the person's illness lead to sectioning, which was an undesirable outcome. More than a quarter of caregivers felt that, although they were not involved by staff in decision-making or treatment review, they were unfairly expected to take full responsibility for the person after discharge (rec 1.4.6). C7 There is evidence from a small US qualitative study (Gerson 2012 +) and from a very small UK qualitative study (Wilkinson 2008, rated - for its small sample), that family carers want the following at first and subsequent admissions: • less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic • greater recognition from staff on inpatient ward that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning • greater recognition from staff that they had valuable knowledge of the person to offer • information, education and dialogue about the mental health condition, and how to manage and support the person after discharge • partnership with professionals • support to find providers for ongoing care that insurance would cover (from the US paper); • less negativity and more encouragement to contemplate a positive future for their child (rec 1.4.7).
Other considerations	The GC were mindful of the traumatic nature of admission for carers and families, especially if this was the person's first admission. Practical information about the ward and hospital, visiting times, etc. were felt to be important to promote contact, and families and carers would need general information about the condition and treatment (rec 1.4.8). The expert witness from Young Minds reiterated these points. Although the guideline was limited in the attention it might give to child carers or relatives, the GC felt they needed particular support and information (rec 1.4.5).

	The GC were aware that evidence suggested that carers were sometimes excluded from discussion by practitioners on the grounds of confidentiality. While – whatever the age of the person in hospital – their rights to confidentiality should be respected, this did not preclude more general information (on conditions, treatments and ward routines) being shared (rec 1.4.6). The person's consent to share information with carers might well change as their recovery progressed: this should be reviewed (rec 1.4.6). Parents and carers should be encouraged to attend CPA and discharge meetings if the person wished it, and practitioners needed to be mindful of their other responsibilities when setting them up (rec 1.4.8).

Topic/section heading	**Support for carers and families – carers' assessments**
Recommendations	1.4.9 Practitioners involved in admission and discharge should always take account of carers' needs, especially if the carer is likely to be a vital part of the person's support after discharge. 1.4.10 Identify carers (including young carers) who have recognisable needs. Make a referral to the carer's local authority for a carer's assessment, if the carer wishes it (Care Act 2014). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	9. What is effective in supporting carers of people in transition between inpatient mental health settings and community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings?
Quality of evidence	The recommendations on carer's assessments were based on evidence from the carer review area. The evidence for this area is qualitative and of moderately good quality. Although some studies are small, there is consistency in the findings.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements –	C5 There is evidence from a small Canadian qualitative interview study (Clarke and Winsor 2010 +), a small US qualitative study

numbered evidence statements from which the recommendation(s) were developed	(Gerson 2012 +) and a very small UK qualitative study (Wilkinson 2008) that carers' feelings and anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress – often requests were declined with reference to 'patient confidentiality' (a point also flagged in Jankovic 2011). Family carers often had little notice of discharge, and no idea how to support the patient, or find support for themselves, after discharge. Family carers wanted greater involvement and information, and a sense of sharing care with professionals (recs 1.4.10).
Other considerations	The recommendations in this section were arrived at through GC consensus. The GC were mindful that the Care Act 2014 entitles carers to an assessment of their need, but that carers – and inpatient practitioners – might not know about this right, as it is a local authority responsibility. The GC considered that practitioners managing admission or discharge – and discharge planning – should always consider carers' needs, especially if they are an important part of post-discharge support (rec 1.4.9). Admitting practitioners were in a good position to identify carers needing support and signpost them to the assessment if they wished it (rec 1.4.10). This should take account of the fact that the admission may be out of area, so the local authority of the hospital may not be the one with responsibility for that carer. Practitioners planning discharge should check that the person has been offered an assessment, and whether they have critical needs (which may have changed since admission) which have not been addressed and may have a negative impact on ability to care (rec 1.4.9, 1.4.10). The GC considered making a stronger recommendation about linking the assessment with discharge, but felt that the carers' rights to decline the assessment, and the short length of stay (average 11 days suggested) would not take account of the time local authorities need to deliver a carer's assessment.

Topic/section heading	**During hospital stay – maintaining relationships**

Recommendations	1.5.1 Ensure regular review of the person's care plan and progress toward discharge.
	1.5.2 Work with the person throughout their hospital stay to help them:
	• keep links with their life outside the hospital, including:
	  ◦ family and friends
	  ◦ social and recreational contacts
	  ◦ education, training or work
	• restart any activities before they are discharged.
	This is particularly important for people who need a long-term inpatient stay and people who will have restricted access to the community.
	1.5.3 Identify whether the person has any additional need for support, for example, with daily living activities. Work with carers and community-based services, such as specialist learning or

	physical disability services, to provide support and continuity while the person is in hospital.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations. However, the research recommendation on supporting people with complex needs may well be relevant to this area. The proposed research question is 'What is the effect of specific interventions to support people with complex needs (including people with long-term severe mental illness, people with a learning disability and people on the autistic spectrum) during transition between inpatient mental health settings and community or care home settings?' (rec 2).
Review questions	4. How do different approaches to assessment, care planning and support (including joint working) affect the process of admission to inpatient mental health settings from community or care home settings? 5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 1. (a) What are the views and experiences of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (a) What are the views and experiences of families and carers of people using services in relation to their admission to inpatient mental health settings from community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on maintaining relationships were based on evidence from the hospital admission, discharge and carer review areas. There were no effectiveness studies. The evidence used comprises moderate to good qualitative studies on views and experience.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements –	DC14 There is moderately good evidence from a qualitative study (Offord et al. 2006 +) that people discharged from a

numbered evidence statements from which the recommendation(s) were developed	general adolescent unit after treatment for anorexia nervosa experience are concerned and dismayed about the huge differences in everyday life and activities, sense of control and self-efficacy and available support between the hospital and the home environment. They may also feel they have lost touch with their peer group and fallen behind in education. Respondents suggested that discharge should be graduated and personalised according to individual need, and that introducing more ‘normal’ activities on the ward, and handing back ‘control’ gradually during discharge, would be helpful. These findings may be generalisable to other adolescents, and other inpatients, who are facing discharge (rec 1.5.2). C7 There is evidence from a small US qualitative study (Gerson 2012 +) and from a very small UK qualitative study (Wilkinson 2008, rated - for its small sample) that family carers want the following at first and subsequent admissions: • less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic • greater recognition from staff on inpatient ward that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning • greater recognition from staff that they had valuable knowledge of the person to offer • information, education and dialogue about the mental health condition, and how to manage and support the person after discharge • partnership with professionals • support to find providers for ongoing care that insurance would cover (from the US paper) • less negativity and more encouragement to contemplate a positive future for their child (recs 1.5.3). HA12 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005 +) that carers of people with intellectual disability eventually admitted to mainstream mental health inpatient units: • had experienced great difficulty in accessing mental health assessment and care • viewed the mainstream wards as ‘depressing’, ‘intimidating’ or ‘frightening’ • did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care • thought staff did not properly distinguish mental health and ID issues • did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and intellectual

	disability services, and lack of understanding among mental health staff of person-centred care for people with ID, were echoed by ID service providers (Donner et al. 2010) (rec 1.5.3).
Other considerations	The GC decided (at GC11) that a new recommendation should be made by consensus to review the care plans of people and ensure that they were not being unnecessarily kept in hospital. ‘Progress toward discharge’ was agreed as a means of reviewing progress against treatment. Long stays in hospital are costly and potentially damaging for the person (rec 1.5.1). Although some of the evidence for these recommendations is specific to people with eating disorders and people with intellectual disabilities, the GC felt the principles of maintaining links with people and with ‘life outside’ were important to all. Hospital admission can be associated with loss of work, education and social and emotional support. People may lose confidence and social skills. Reintegration back into ‘normal’ life can be very difficult, especially for those who have had a long admission or who are place out-of-area or confined to the hospital for any reason (rec 1.5.2). Encouraging and welcoming family and carer visits to the ward (if the person wishes it) was a recommendation that linked to a range of others about the carer being seen as a partner, fully involved, in the person’s care and care planning (see evidence statement C7 above). Rec 1.5.3 also responds to evidence that carers can feel marginalised by hospital practitioners. Research concerning carers of people with intellectual disabilities suggests that they are disadvantaged if in a specialist unit because it is likely to be some distance from ‘home’; and are disadvantaged if in a mainstream mental health unit because practitioners may not know how to support them in everyday activities (e.g. washing, doing things they enjoy). Although there was no evidence, a person with mobility or physical challenges might also need support from outside the hospital, whether from a carer or family member or a specialist community service. Inpatient staff would need to recognise these needs and work with carers and service practitioners to address them during the hospital stay (rec 1.5.3).

Topic/section heading	**During hospital stay – education for people under 18**
Recommendations	1.5.4 Children and young people under 18 must have continued access to education and learning throughout their hospital stay, in line with the Education Act 1996. 1.5.5 Before the child or young person goes back into community-based education or training: • identify a named worker from the education or training setting to be responsible for the transition • arrange a meeting between the named worker and the child or young person to plan their return.
Research	The GC considered that research on transitions for children and young people was inadequate. There was a particular lack of

recommendations	evidence on admissions and community reintegration for children in specific circumstances, such as being looked-after, or subject to safeguarding proceedings. They therefore made a research recommendation to address the question: 'What is the effect of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?' (rec 4).
Review questions	8. What is the effectiveness or impact of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings?
Quality of evidence	The evidence used derives from a study identified for the children and young people review area. This is a qualitative study.
Relative value of different outcomes	The recommendations on maintaining relationships were based on evidence from the hospital admission, discharge and carer review areas. There were no effectiveness studies. The evidence used comprises a moderate qualitative studies of mental health practitioner views and experience.
Trade-off between benefits and harms	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	CYP11 There is evidence of moderate quality and indirect relevance from 1 non-UK study (Clemens 2011 +) that mental health professionals view coordination and communication with teachers as a major factor of successful school re-entry for adolescents transitioning from hospital. An initial planning meeting with the school which includes a time to follow-up, and appointing an adult support person for the student within the school are key facilitators of re-entry. Communication and planning across both mental health and school services are crucial elements of successful school reintegration for adolescents transitioning from psychiatric hospital (rec 1.5.4, 1.5.5).
Other considerations	There was discussion in the GC as to whether it was necessary to make a recommendation which is obligatory by law (rec 1.5.4). It was felt to be helpful because some people under 18 will be admitted to adult wards, and practitioners may lack awareness of these principles. The GC discussed who would need to be involved in planning re-entry into education or training, and decided it would probably be undertaken by a named worker from the education facility who could support the student on return. The role of the mental health practitioner might be restricted to identifying and contacting the person and facilitating meetings with the young person (rec 1.5.5). GC members gave examples of young people returning to education gradually, building up hours on a daily or weekly basis.

Topic/section heading	**Discharge from hospital – helping the person prepare for discharge, accommodation**
Recommendations	1.6.1 Before discharging people with mental health needs to their home or care home, ensure it is suitable for them. Discuss and plan housing needs with the person and their family or carers. 1.6.2 Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation. This should: • be started before discharge • continue after discharge for as long as the person needs support to stay in secure accommodation • focus on joint problem-solving, housing and mental health issues.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?
Quality of evidence	The recommendations on accommodation were based on evidence from the children and young people and hospital discharge review areas. The focus is on discharge to suitable accommodation: only 1 study addressed this as a possible means of reducing readmissions among children and young people. There was 1 analysis of old US data on outcomes for children, a very small pilot of a housing intervention, and an RCT of a critical time intervention (the content of which is not clear). None of the evidence was ideal for our question and the studies are not from a UK setting (US, Canada, Germany).
Relative value of different outcomes	The absence of relevant, large and well conducted effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications. However, the GC did not recommend that specific housing or housing support components be implemented.
Evidence statements – numbered evidence statements from	CYP9 There is some evidence from 1 moderate quality study (Fontanella et al. 2010 +/+) that discharge planning has a significant impact on readmission. This is enhanced through social work intervention that helps to facilitate the provision of a

which the recommendation(s) were developed	more stable living arrangement or care that is tailored at an appropriate level. Type of aftercare arrangement is also significantly linked with readmission; the rate of readmission being 3.45 times more for youths placed in group homes at discharge compared to those placed with their families (rec 1.6.1). DC12 There is (methodologically) poor evidence from a very small Canadian pilot RCT (Forchuk et al. 2013 +/-) with an initial sample of 14 that people discharged from hospital to hostels or no fixed address can be housed quickly after discharge with the support of a housing advocate and that they can maintain their tenancies at 3 and 6 months after discharge. This study was curtailed when it was decided that all participants should be offered the intervention (rec 1.6.2). DC13 There is a good evidence (Herman et al. 2013 ++/+) that a critical time intervention to combat homelessness among people recently discharged (to a variety of shelters and transitional settings) can achieve significant results. The comparative number of homeless nights in 18 months of follow-up in the intervention group was 1812 vs 2403 in the control group (p<0.001). Although there was difficulty in contacting people in the later stages of follow-up, among those with complete follow-up data, 3 out of 58 (5%) of subjects assigned to the CTI group experienced homelessness during the final 3 follow-up intervals, and 11 out of 59 (19%) of subjects assigned to the control group experienced homelessness during this period (rec 1.6.2).
Other considerations	The GC was unsure about the details within the studies – for example, what was a US 'group home' (Fontanella 2010), and what did the critical time intervention (Herman 2013) include that specifically supported housing? The GC felt the evidence for this topic was underdeveloped (but did not make a research recommendation). It also failed to cover supported housing contexts (which may be because they are not evaluated for ethical reasons – as in the Forchuk study where the intervention was eventually offered to all). There were also queries raised about whether people with a psychotic disorder (Herman) or an indeterminate 'serious mental illness' (Forchuk) were generalisable to UK populations of people discharged from inpatient units. The GC was aware that people on the CPA were likely to have housing and tenancy support, but many were not on CPA. However, there was GC consensus about the importance of housing for people with severe mental health problems, and the need to consider it as a crucial aspect of discharge and recovery. The study linked to outcomes for children and young people (Fontanella 2010) suggests that household composition may also be a critical aspect of suitable accommodation: i.e. that the 'suitability' of housing reflected family dynamics and should therefore be discussed with the person and their carers (rec 1.6.1). The GC also felt that people who are homeless or at risk of homelessness are unlikely to continue with recovery or treatment, and people should be supported to find and keep accommodation. This might well mean that support should begin before discharge (so the person was not discharged to no fixed

	address), and continue long enough to ensure the person was managing housing responsibilities (rec 1.6.2).

Topic/section heading	**Discharge from hospital – helping the person prepare, psychoeducation**

Recommendations	1.6.3 Offer a series of individualised psychoeducation sessions for people with psychotic illnesses to promote learning and awareness before discharge. Sessions should:
	• start while the person is in hospital
	• continue after discharge so the person can test new approaches in the community
	• cover:
	  • symptoms and their causes
	  • what might cause the person to relapse, and how that can be prevented
	  • psychological treatment
	  • coping strategies to help the person if they become distressed
	  • risk factors
	  • ways in which the person can be helped to look after themselves.
	• be conducted by the same practitioner throughout if possible.
	1.6.4 Consider a staged, group-based psychological intervention for people with bipolar disorder who have had at least 1 hospital admission and are being discharged from hospital. This should include:
	• evaluation by a psychiatrist within 2 weeks of discharge
	• 3 sequential sets of group sessions led by trained practitioners that focus on, respectively:
	  • people’s current mental health and recent experiences in hospital
	  • psychoeducation or cognitive behavioural therapy
	  • early warning signs and coping strategies
	• group-based psychoeducation sessions for families and carers.
	1.6.5 Consider psychoeducation sessions (see recommendation 1.6.3) for all people with other diagnoses as part of planning discharge and avoiding readmission.
	1.6.6 During discharge planning, offer carers group psychoeducation support. Ensure this is tailored to the specific condition of the person they care for.

Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?

	1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on psychoeducation were based on evidence from the reducing readmissions and carer review areas, and on economic analysis. The quality of the evidence for this topic is good, with 6 controlled studies that demonstrate either the effectiveness and/or acceptability of psychoeducation sessions to support people with severe mental health problems and their carers. All the studies have some limitations – size, restriction to specific mental health disorders, generalisability to the UK context, complexity of intervention confusing effectiveness – but the findings are consistent in supporting this approach.
Relative value of different outcomes	Much of the evidence for this topic was derived from studies which used the primary outcome of reducing (number and/or length of) readmissions. This is because inpatient admissions are costly, disruptive and sometimes traumatic for the individual, as they are strongly associated with decline in mental health. There is therefore no demonstrable weighting against other outcomes.
Trade-off between benefits and harms	There was no evidence found of any harms arising from psychoeducation sessions.
Economic considerations	Ec RR2 There is 1 moderate quality non-UK study (Kessing 2013 +/+) comparing a multi-staged psychological intervention over a 24-month period in addition to group psychoeducation for their carers compared to treatment as usual. The study focused on individuals in the early stages of bipolar I disorder, defined as having between 1 to 3 hospital admissions. Individuals were allowed in the study even if they had substance misuse. This study has limited applicability to the guideline due to issues of generalising non-UK results to a UK context (institutional factors and unit cost differences). Additional analysis is required in order to understand the extent to which results are likely to be transferrable to the UK. The study also has potentially serious limitations because the analysis took a very limited perspective and only included direct treatment costs plus use of acute care services. It did not measure changes that may have arisen in other health or social services or impact on carers. In spite of these limitations, the results show that the costs of the intervention are offset by lower inpatient stay (measured over a 30-month period). There were no differences in symptoms, either depressive or manic but results may be flawed due to low response rates (rec 1.6.4, 1.6.5, 1.6.6). Additional economic analyses were undertaken on this study in the form of a cost-utility analysis. The report is located in Appendix C. The GC considered that these recommendations could have cost implications so made stronger recommendations where there is

	evidence of both effectiveness and cost effectiveness, and weaker recommendations where the evidence is less clear.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	RR2 There is moderate evidence from 1 small RCT with a short (4 month) follow-up period (Bach and Hayes 2002 +/+) that rehospitalisation, and the time to readmission, may be reduced through the use of psychological treatment, delivered in pre-discharge sessions, which impacts on psychotic delusions and auditory hallucinations (or voices). The therapy aims to equip the person to contextualise the symptoms (e.g. by identifying events which bring them on), distinguish them from reality, promote coping strategies to reduce the distress caused and to encourage 'acceptance' of the symptoms, so that they do not lead to hospital readmission (recs 1.6.3, 1.6.5). RR3 There is moderate evidence from 1 small RCT (Lay et al. 2015 +/+) that a mixed individualised intervention beginning in hospital and including needs and strengths assessment, relapse prevention, triggers of rehospitalisation, crisis card production and telephone monitoring (monthly for 2 years after discharge) may reduce the number and length of formal (involuntary) psychiatric readmissions in patients with a history of such admissions (recs 1.6.3, 1.6.5). RR4 There is moderate evidence from a German RCT (Pitschel-Walz et al. 2006 +/+) that a programme for people with schizophrenia of (8) psychoeducational sessions (some delivered before and some after discharge) focusing on symptoms, aetiology, acute treatment, relapse prevention and psychological treatment of schizophrenia may help to reduce readmission rates. Adequate coping strategies were discussed; and individual crisis plans were drawn up. The study sample suffered high attrition rates, and the inclusion of carers in the programme may have affected outcomes (in either direction) for individual patients (recs 1.6.3, 1.6.5). RR9 There is evidence of moderate quality from a Danish RCT (Kessing et al. 2013 rated +/+), that people with bipolar affective disorder who have had at least 1 admission to a general psychiatric unit have significantly fewer readmissions if they are treated in a specialised mood disorder clinic, offering pharmacological treatment plus group psychoeducation (recs 1.6.4, 1.6.5). C1 There is moderate evidence from 3 studies using control groups – Cassidy (2001); Macdonald (2014) and Pitschel-Walz (2006), all rated +/+, that carers are willing to participate in, and do derive knowledge from, psychoeducational groups which enable them to find out more about the meaning and management of the illness of the person they cared for, whether schizophrenia or anorexia, and to learn coping strategies (recs 1.6.5, 1.6.6). C2 There is moderate evidence from 2 studies using control groups – Cassidy (2001) and Pitschel-Walz (2006), both rated +/+, that giving carers the opportunity to attend educational sessions on the meaning, development and management of schizophrenia, including relapse prevention and coping skills, may cause fewer readmissions to take place within 12 months and increase the length of time before readmission (Cassidy 2001); and may reduce

	readmissions within 24 months of delivering the sessions (Pischel-Walz 2006) (recs 1.6.5, 1.6.6).
Other considerations	Although the GC discussed differences in the diagnoses of the populations involved in each study, they agreed that there was considerable overlap in interventions tested in the studies (Bach, Lay, Kessing and Pitschel-Walz), and sought to extract the common features in making recommendations. The recommendations are focused on 2 groups: those with a psychotic illness, including bipolar disorder, and carers. The success of these interventions suggest they might be considered for people with other disorders (such as depression: GC members knew of such interventions) (recs 1.6.3, 1.6.4, 1.6.5, 1.6.6). There was general support for the content of sessions – information about the disorder (so should ideally be disorder-specific), symptoms and individual triggers and warning signs of relapse, coping strategies and risks (recs 1.6.3, 1.6.4, 1.6.5, 1.6.6). There was GC consensus that psychoeducation for people and carers should ideally commence in hospital and continue after discharge, so that people felt prepared for the challenges of discharge, and had the opportunity to 'test' the strategies developed in the sessions, and develop others if necessary (recs 1.6.3, 1.6.4). There was some lack of clarity in the evidence about whether individual or group-based sessions might be more cost effective but the GC were guided by the evidence, and felt that different options might suit different individuals, and resources would also influence this point. The suggestion of offering carers group psychoeducation reflects a concern with costs, but also the possibility that carers of people with similar disorders might value the social context (as might some people with the disorder). Rec 1.6.3 suggests individualised sessions for people with psychosis; rec 1.6.4 a mixture of individual and group sessions; rec 1.6.6 group sessions for carers. The GC were persuaded that giving people and their carers a means to combat relapse was likely to be empowering. The GC felt that the term 'psychoeducation' might be 'jargon', but no suitable alternative was identified.

Topic/section heading	**Discharge from hospital – recovery plan to support discharge**
Recommendations	1.6.7 Ensure that there is a designated person responsible for writing the recovery plan in collaboration with the person being discharged (and their carers if the person agrees). 1.6.8 Ensure the recovery plan describes the support arrangements for the person after they are discharged. Send a copy to everyone involved in providing support to the person at discharge and afterwards. It should include: • possible relapse signs • where to go in a crisis • budgeting and benefits

	• handling personal budgets (if applicable) • social networks • educational, work-related and social activities • points of contact • details of medication • details of treatment and support plan • physical health needs • recovery goals • date of review of the recovery plan. 1.6.9 Write the recovery plan in clear language. Avoid jargon and explain difficult terms.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?
Quality of evidence	There was no research evidence on recovery plans used during transitions, and recommendations were made by GC consensus (see below). The 2 evidence statements cited (from discharge and children and young people review areas) are only indirectly relevant: the first offers support for motivational interviewing, which relates to rec 1.6.7 on being supported to write the personal plan; the second highlights the importance of using jargon-free language (in all communications) so that people are informed and empowered by explanatory texts rather than perplexed by medical jargon.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications. However, if this is a substantial change to current practice in some places, there are options, such as peer support to write the plan, which may reduce costs. Ideally recovery planning is a lay-led activity.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	DC4 There is moderately good evidence from a US RCT (Swanson et al. 1999 +/+) that 2 sessions of motivational interviewing (a technique widely used with people with problem substance misuse) pre-discharge can significantly increase the proportion of patients – a mixed population of those with psychiatric problems only, and those with psychiatric and substance misuse problems – who attend their first outpatient appointment. The difference between those with the additional intervention and the controls was particularly evident for subjects

	with a dual diagnosis (rec 1.6.7, 1.6.8). CYP10 There is moderate evidence from 1 non-UK survey study (Bobier 2009 +/-) that a narrative discharge letter which maps the adolescent inpatient's journey from pre-admission to post-discharge using easy to understand language is reassuring to parents and, to a lesser extent, adolescents who receive them. Parents of adolescents with mental illness appreciate clear communication which is free from medical jargon. Families reported feeling well-informed about their child's illness and aware of any 'warning signs' they should look out for in the future. The majority of adolescents who received the narrative discharge letter reported gaining insight and empowerment with respect to their own situation. There is less directly relevant evidence (Bobier 2009 +/-) that outpatient professionals appreciated the narrative discharge letter's ability to galvanise collaborative working and partnerships, both with adolescents and across other mental health support services (rec 1.6.9).
Other considerations	There was no evidence found directly on the effectiveness of recovery plans produced during transitions (although there is a US literature, e.g. on wellness recovery action plans). However, this concept was familiar to the GC, and it was GC consensus to recommend it. A recovery plan (see terms) is distinct from a discharge plan as it is always produced by the person (with support if necessary), owned by the person and includes strategies and goals which are important to the person (which may have little to do with clinical outcomes). The GC agreed on the suggested content of the plan (rec 1.6.8), that copies should be sent to anyone providing support at and after discharge (rec 1.6.8), and that people were likely to need support to write it, especially if unfamiliar with it (rec 1.6.7). A peer support person could be considered for this role. The use of clear and jargon-free language was supported by 1 evidence statement (rec 1.6.9).

Topic/section heading	**Discharge from hospital – peer support**

Recommendations	1.6.10 For people being discharged from hospital, consider a group-based, peer-delivered self-management training programme as part of recovery planning. Sessions should:
	• continue for up to 12 weeks
	• be delivered in groups of up to 12 members
	• provide an opportunity for social support
	• cover:
	  ◦ self-help, early warning signs and coping strategies
	  ◦ independent living skills
	  ◦ making choices and setting goals.
	1.6.11 Consider providing peer support to people with more than 1 previous hospital admission. People giving peer support

	should: • have experience of using mental health services • be formally recruited, trained and supervised.
Research recommendations	Although the GC were aware of a forthcoming (reporting 2019+) study on peer support, they decided to make a research recommendation to address the question 'Is peer support that is provided during and after discharge from mental health inpatient settings effective and cost effective in reducing rates of readmission?' (research rec 3).
Review questions	5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 6. What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?
Quality of evidence	The evidence for these recommendations derived from evidence review in the areas of improving discharge and reducing readmissions. There was 1 poor quality pilot study (Simpson et al. 2014) and a systematic review (Fuhr 2014) which was reviewed as the basis for an economic model on the impact of peer-delivered interventions (see Appendix C). The studies in the meta-analysis did not directly measure impact on health and social care resource use (i.e. whether they reduced readmissions). The use of 'consider' within these recommendations reflects the poor quality of available evidence.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	It was recognised by individual members of the GC that peer support could have adverse outcomes. Peer supporters (whether formally employed or not) might experience a decline in their own mental health due to the additional responsibility; they might also have an adverse impact on the person being supported. Recruitment, training and supervision might mitigate the likelihood of such outcomes. The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations. Research evidence is not sufficiently well developed to address this potential.
Economic considerations	Ec DC1 There is low quality UK evidence regarding the cost-effectiveness study on of peer support workers in addition to usual care services to assist in discharge from inpatient stay (compared to usual care services). The study focuses on for all inpatients discharged from hospital (excluding those with dual diagnosis of substance misuse, serious personality disorder, pregnant or caring for children, and those at risk to others). This study has limited applicability to the guideline because findings are based on a single poor quality UK pilot study (Simpson et al. 2014 -/+), which is severely limited by its small sample size (n=15). Results are based on findings from 3-months follow-up

	from randomisation. The analysis was conducted from using the perspective of the public sector perspective (NHS, social services, and criminal justice sector) using 2010 prices. Results indicates that peer support workers have a 40% probability of being cost effective for the Beck Hopelessness Scale (BHS) if the decision-maker's willingness to pay is £0. The maximum likelihood that peer support is cost effective if the decision-maker is willing to pay any additional cost is 55% (increasing willingness to pay does not change the probability). The incremental cost-effectiveness ratio was £12,555 for 1 unit of improvement in BHS. For the outcome of quality of life using the EQ-5D, the probability that the intervention is cost effective is 33% for any value that the decision-maker is willing to pay (higher or lower values of willingness to pay do not alter the probability of cost-effectiveness) (rec 1.6.10, 1.6.11). The results of the cost-effectiveness analysis need to be considered with caution due to the study's serious limitations (noted above). Generalisability is unclear and further research is needed with larger sample sizes and longer follow-up periods. Additional economic analysis was carried out on group-based peer-delivered self-management. The analysis was based on a meta-analysis (Fuhr et al. 2014) which showed small improvements in quality of life for individuals (3 studies on people with severe mental illness), hope (2 studies) and equivalence on clinical symptoms in 2 equivalence trials in the same population.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	See above.
Other considerations	These recommendations were made by GC consensus, and the first recommendation is linked to recommendations 1.6.3–1.6.6. The evidence for peer support interventions was not strong enough to make specific recommendations about using peer workers to deliver psychoeducation groups and/or for individual support (befriending in nature) (rec 1.6.10). Peer support was known to be variable in terms of quality, training, etc. However, if delivered well, the GC highlighted the potential importance of peer support to give carers respite (rec 1.6.11). The GC was also mindful that the NICE guideline, Psychosis and schizophrenia in adults: treatment and management guideline (CG178) recommends peer support. The GC agreed that these 2 recommendations as worded was justified. Involvement of peer support workers in delivering psychoeducation related to the principle of co-production; individual support delivered by peer support who were recruited, trained and supervised was likely to have beneficial outcomes. The recommendations are based on a conservative analysis of the data (see economic model).

Topic/section heading	**Discharge from hospital – discharge planning (1)**

Recommendations	1.6.12 Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For detailed recommendations on discharge and transfer of care, see NICE's guideline on service user experience in adult mental health services.
	1.6.13 Before discharge arrange:
	• phased leave (the person can have trial periods out of hospital before discharge)
	• phased return to employment or education (the person can gradually build up hours spent in employment or education).
	This is particularly important for people who have been in hospital for an extended period and people who have had restricted access to the community.
	1.6.14 Before discharging a person who is in education or training, arrange a planning meeting between them and a named person from the education setting to plan their return to learning.
	1.6.15 If a person is being discharged to a care home, involve care home managers and practitioners in care planning and discharge planning.
	1.6.16 Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should:
	• relate directly to the setting the person is being discharged to
	• fully involve the person
	• be shared with carers (if the person agrees)
	• explore the possibility of using a personal health or social care budget
	• cover aspects of the person's life including:
	  ◦ daytime activities such as employment, education and leisure
	  ◦ food, transport, budgeting and benefits
	  ◦ pre-existing family and social issues and stressors that may have triggered the person's admission
	  ◦ ways in which the person can manage their own condition.
	(See also information about psychoeducation sessions in recommendations 1.6.3–1.6.5.)

Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

	1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The recommendations on discharge planning were based on evidence for the discharge, admissions, children and young people and carers review areas. The evidence considered comprised moderate to high quality qualitative studies and a good structured interview study.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	DC14 There is moderately good evidence from a qualitative study (Offord et al. 2006 +) that people discharged from a general adolescent unit after treatment for anorexia nervosa experience are concerned and dismayed about the huge differences in everyday life and activities, sense of control and self-efficacy and available support between the hospital and the home environment. They may also feel they have lost touch with their peer group and fallen behind in education. Respondents suggested that discharge should be graduated and personalised according to individual need, and that introducing more ‘normal’ activities on the ward, and handing back ‘control’ gradually during discharge, would be helpful. These findings may be generalizable to other adolescents, and other inpatients, who are facing discharge (rec 1.6.12, 1.6.13). DC15 There is good evidence from a relatively large assessment by interview study conducted 6 weeks after discharge (Simons and Petch 2006 ++/+) that people discharged from a psychiatric unit have unmet needs (ranked) for help with psychological distress (including psychotic symptoms); daytime activities and company; information about condition and treatment; food and transport; budgeting and benefits. People with a non-psychotic illness expressed higher unmet need than those with a psychotic illness. Staff ranked the most common unmet need among patients as need for daytime activities; help with psychological distress; company; psychotic symptoms and obtaining and preparing food. Staff considered that 97% of need for information about condition and treatment had been met (rec 1.6.16). DC16 There is good evidence from a qualitative study (Owen-

Smith et al. 2014 ++) that the challenges faced by people leaving hospital after a psychiatric admission are concerning, and that the high incidence of suicide after discharge could be explained in those terms. Four of the 10 interviewed did not agree with the decision to discharge, and had had thoughts of self-harming. Most of the sample cited the need to return to problems which had existed prior to admission – social isolation, financial difficulties, challenging familial relationships, childcare responsibilities and dealing with everyday household responsibilities. They felt that social networks and families had disintegrated, and the sudden absence of care and support would be particularly difficult to deal with. Although 9 of the 10 had support plans, there was some cynicism about whether support would materialise or be adequate (rec 1.6.16).

CYP7 There is moderately good evidence from 2 qualitative studies – 1 UK (Offord 2006 +) and 1 non-UK (Turrell, 2005 +) – that adolescents treated for anorexia nervosa value planned discharges which allow advance warning, and which are structured to give back control in small increments (e.g., allowing them to make their own meals and encouraging them to make their own decisions) in the run-up to discharge. Hospital discharge which adopts a gradual and collaborative approach helps to moderate the stark contrast between the high levels of structure in the unit and the lack of structure in the outside world – the sudden availability of freedom being perceived by some as overwhelming and potentially problematic (rec 1.6.12, 1.6.13).

CYP11 There is evidence of moderate quality and indirect relevance from 1 non-UK study (Clemens 2011 +) that mental health professionals view coordination and communication with teachers as a major factor of successful school re-entry for adolescents transitioning from hospital. An initial planning meeting with the school which includes a time to follow-up, and appointing an adult support person for the student within the school are key facilitators of re-entry. Communication and planning across both mental health and school services are crucial elements of successful school reintegration for adolescents transitioning from psychiatric hospital (rec 1.6.14).

C7 There is evidence from a small US qualitative study (Gerson 2012 +) and from a very small UK qualitative study (Wilkinson 2008, rated - for its small sample), that family carers want the following at first and subsequent admissions:

- less traumatic ways of seeking treatment (i.e. before the first onset of psychosis accelerated into a crisis), bearing in mind that the person might not want to attend a psychiatric clinic
- greater recognition from staff on inpatient wards that they were under great stress, and needed both support and reassurance as well as information and involvement in assessment, treatment and discharge planning
- greater recognition from staff that they had valuable knowledge of the person to offer
- information, education and dialogue about the mental health condition, and how to manage and support the

	person after discharge - partnership with professionals - support to find providers for ongoing care that insurance would cover (from the US paper) - less negativity and more encouragement to contemplate a positive future for their child (rec 1.6.12, 1.6.15).
Other considerations	There were several qualitative papers suggesting that discharge was associated with sudden (and probably unplanned) discharge, in which carers were not involved. Various people (carers, children and young people) experienced discharge as sudden: moving from a very structured routine and environment was difficult, and carers found they had little time for preparation if they were not involved in discharge planning. The GC recognised that not everyone wanted a gradual discharge, but thought that the implementation of the process should be appropriate to the needs of the individual person and of their carer(s). Expert testimony on discharging people with dementia supported this approach (rec 1.6.12). The GC supported the use of leave, and a phased return to usual activities such as work and training, as a means of gradually returning to community life. Gradual and flexible discharge was evidently more important for people who had been inpatients, and/or away from home communities, for some time (rec 1.6.13). There was no direct evidence on a phased return to work, although the GC unanimously supported this: work is an area which may be a potential stressor, and evidence showed that discharge planning is needed to confront and manage potential stressors during the post-discharge phase, when people are vulnerable to suicide (rec 1.16.13, 1.6.16). A planning meeting for those in education and training is also recommended (recognising that people over 18, see rec 1.5.5, may also be in education and training) (rec 1.6.14). The expert witness on dementia highlighted the importance of inpatient practitioners liaising closely with staff from the receiving care home to ensure that they knew as much as possible about the person, and had given active consideration to whether and how they could meet the person's needs. This point may apply to anyone living in a supported community environment (rec 1.6.15). The GC also noted that a thorough assessment would be needed to identify and manage the considerable needs the person and their carer might have after discharge (rec 1.6.16).

Topic/section heading	**Discharge from hospital – discharge planning (2)**
Recommendations	1.6.17 Recognise that carers' circumstances may have changed since admission, and take any changes into account when planning discharge. 1.6.18 Before the person is discharged: - inform their carers of the plans for discharge - discuss with carers the person's progress during their

	hospital stay and how ready they are for discharge - ensure that carers know the likely date of discharge well in advance.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The evidence for these recommendations was taken from the discharge, carer and children and young people review areas. The evidence consisted moderately good qualitative and a good structured interview study.
Relative value of different outcomes	The absence of relevant effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. Based on their own experience the GC did not consider the recommendations likely to have significant resource implications.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	C9 There is evidence from a small UK qualitative interview study (Donner et al, 2010 +) that carers of people with intellectual disability (ID) felt that their anxieties were not acknowledged by inpatient staff, and that they were excluded from any discussion of the patient's treatment or progress or discharge arrangements. Any 'success' in finding out anything depended on making an 'individual relationship' with a staff member. Family carers felt the people they cared for were discharged without proper assessment. They themselves benefited if they were put in touch with other sources of support during the admission (rec 1.6.17, 1.6.18).
Other considerations	Material on carers consistently highlighted issues around lack of involvement in planning, and in the discharge context this might mean that carers never had the opportunity to discuss timing of discharge, the subsequent needs of the person and whether they could be met by the carer. Assumptions that carers could continue to provide the level of care they had provided were unquestioned. Carers were often concerned that the difficulties they had faced in supporting the person before admission might be unresolved, and had little idea what assessment (including of

	risk) had taken place. The GC therefore arrived by consensus at the recommendations involving and consulting carers before discharge (rec 1.6.17, 1.6.18).

Topic/section heading	**Discharge – follow-up support**

Recommendations	1.6.19 Discuss follow-up support with the person before discharge. Arrange support according to their mental and physical health needs. This could include:
	• contact details, for example of:
	    • a community psychiatric nurse or social worker
	    • the out-of-hours service
	• support and plans for the first week
	• practical help if needed
	• employment support.
	1.6.20 On discharge:
	• the hospital psychiatrist should ensure that a discharge summary is emailed to the person’s GP on the day of discharge and a copy given to the person
	• include information in the discharge summary about why the person was admitted and how their condition has changed during the hospital stay
	• consider booking a follow-up appointment with the GP to take place within 2 weeks of the person’s discharge; give the person a written record of the appointment details.
	1.6.21 If the person has a learning disability or dementia, the hospital team should lead the communication about discharge planning with the various services that support the person in the community. These agencies could include:
	• older people’s services
	• learning disability services
	• the home care service.
	1.6.22 When a person is being discharged to a care home, look for opportunities for hospital and care home practitioners to exchange information about the person. An example might be a hospital practitioner accompanying the person when they return to the care home.
	1.6.23 In collaboration with the person, identify any risk of suicide as part of the needs and safety assessment. Incorporate this into the discharge planning and follow up within 7 days. Follow up earlier if the safety assessment indicates a risk of suicide.
	1.6.24 Consider contacting people admitted for self-harm after discharge, who are not receiving treatment in the community. Give them advice on:
	• services in the community that may be able to offer support or reassurance
	• how to get in touch if they want to.

Research recommendations	The GC did not in general prioritise this as an area on which to make research recommendations. However, they did make a recommendation on transitions for people with dementia, as there is no research evidence on transitions for people with dementia (although an expert witness was called to testify). The research recommendation relates to the question 'What is the effect of specific interventions to support people with dementia during transition between inpatient mental health settings and community or care home settings?' (research rec 1). Recognising that a person with dementia is likely to be 1 group of many with complex problems, a further research recommendation was made: 'What is the effect of specific interventions to support people with complex needs (including people with long-term severe mental illness, people with a learning disability and people on the autistic spectrum) during transition between inpatient mental health settings and community or care home settings?' (research rec 2).
Review questions	5. What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings? 7. What is the effectiveness or impact of specific interventions to support people living with dementia during transition between inpatient mental health settings and community or care home settings? 1. (b) What are the views and experiences of people using services in relation to their discharge from inpatient mental health settings into community or care home settings? 2. (b) What are the views and experiences of families and carers of people using services in relation to their discharge from inpatient mental health settings to community or care home settings?
Quality of evidence	The evidence for these recommendations was found in the discharge and admissions review areas. There were 3 small US RCTs (2 rated moderate quality, and 1 rated poor) that looked at the outcomes (reducing readmissions and time to follow-up appointments) of transitional case management over the discharge period. One UK RCT involving psychiatrist liaison with GPs showed improved levels of GP follow-up. Two studies (1 an old US RCT) and a later pilot study suggested that 'letters of concern' might be effective in reducing suicide. One qualitative study of good quality was included.
Relative value of different outcomes	The absence of relevant, high quality recent effectiveness studies meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant, high quality recent effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	Chiverton et al. (1999 +/+) was considered as a source for economic evaluation. However, it was concluded that lack of

	statistical analysis limited the value of any conclusions about the intervention’s cost-effectiveness. Economic analysis was very limited to the perspective of hospital-related costs (A&E and inpatient admissions), and costs of the intervention were likely underestimated. The strength of recommendations with possible resource implications (for example on post discharge contact) reflects this.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	DC1 There is moderate quality evidence from 1 US RCT (Chiverton et al. 1999 +/+) that transitional case management by nurses based in the inpatient setting can be cost effective by reducing readmissions and the use of the emergency department in the 10 weeks after discharge. (Patient and carer satisfaction and improvements in clinical symptoms of depression were not measured in the comparison group, so conclusions cannot be drawn on the effect of the model on the intervention group.) (Rec 1.6.19.) DC2 There is moderate evidence from 1 small US RCT (Dixon et al. 2009 +/+) that a brief (3-month) critical time intervention to promote continuity of care across hospital and community health services (systems level), and to engage patients in community health services (individual level), can increase the individual’s use of community services. Service use recorded showed that the intervention group had significantly earlier first post-discharge appointments to discuss mental health, and twice as many appointments of this nature during 180 days post-discharge. They also reported having more help to make and attend health appointments, and attended more medical appointments for physical healthcare (rec 1.6.19). DC3 There is poor to moderate evidence from 1 small (n=40) US pilot RCT (Hanrahan et al. 2014 -/+) that a brief (3-month) transitional care intervention for people with severe mental illness (involving a pre-discharge session, a post-discharge home visit and access to a support line), which focused on managing risk of decline, problem behaviours, assessing and managing physical symptoms and preventing functional decline/promoting adherence to therapy, doubled readmissions in the IG compared to control group during the 12 weeks following discharge. Around half of these admissions were for physical health problems. The study is too small to be conclusive, and, being delivered by a single nurse practitioner, the intervention may be understaffed and the focus on purely clinical aspects may have been too narrow to address patients’ needs (rec 1.6.19). DC4 There is moderately good evidence from a US RCT (Swanson et al. 1999 +/+) that 2 sessions of motivational interviewing (a technique widely used with people with problem substance misuse) pre-discharge can significantly increase the proportion of patients – a mixed population of those with psychiatric problems only, and those with psychiatric and substance misuse problems – who attend their first outpatient appointment. The difference between those with the additional intervention and the controls was particularly evident for subjects with a dual diagnosis (rec 1.6.20)

	DC5 There is moderately good evidence from a UK RCT (Naji et al. 1999 +/+) that a protocol requiring psychiatrists to routinely speak with the GP of a person approaching discharge, make the first follow-up appointment within a week of discharge and post a discharge summary to the GP, can significantly increase the number of GP appointments for mental health-related matters within the 6 months following discharge. This intervention was designed to engage and inform GPs, and encourage patients to use general practice services for mental health problems, and showed near significant reductions in readmissions. However, the practice was not observed by all study practitioners, and feedback suggested it was too time-consuming and not always thought necessary (rec 1.6.20). DC9 There is good evidence from a US RCT (Motto and Bostrom 2001 ++/+) that regular, personalised letters of concern, restating how to contact the service for further support if desired, reduce death by suicide. The effect (comparing those in treatment, those in the intervention group, and those not in neither) appears most pronounced in the first 2 years following the admission for suicide or self-harm (rec 1.6.24). DC16 There is good evidence from a qualitative study (Owen-Smith et al. 2014 ++) that the challenges faced by people leaving hospital after a psychiatric admission are concerning, and that the high incidence of suicide after discharge could be explained in those terms. Four of the 10 interviewed did not agree with the decision to discharge, and had had thoughts of self-harming. Most of the sample cited the need to return to problems which had existed prior to admission – social isolation, financial difficulties, challenging familial relationships, childcare responsibilities and dealing with everyday household responsibilities. They felt that social networks and families had disintegrated, and the sudden absence of care and support would be particularly difficult to deal with. Although 9 of the 10 had support plans, there was some cynicism about whether support would materialise or be adequate (rec 1.6.23). DC17 There is a moderate quality pilot study (Bennewith et al. 2014 +/+) which used a modified intervention developed by Motto and Bostrom (2001). Letters of concern were developed including reminders of contact details and follow-up arrangements (in first 3 letters) and enclosing a leaflet detailing local sources of support and advice. Generally, recipients were long-term service users (unlike the recipients in the original study), who know who to approach in a crisis situation, so much of the information was redundant. Some thought they were more useful to 'first timers' after a first admission. It was also noted that there was no invitation (unlike the earlier prototype) to contact the sender of the letter. The letters were generally felt to add little to post-discharge support and were felt by some to be impersonal, and/or a negative reminder of hospitalisation (rec 1.6.24). HA12 There is good quality evidence from 2 qualitative studies (Donner et al. 2010 ++; Scior and Longo 2005,+) that carers of people with intellectual disability eventually admitted to

	mainstream mental health inpatient units: - had experienced great difficulty in accessing mental health assessment and care - viewed the mainstream wards as ‘depressing’, ‘intimidating’ or ‘frightening’ - did not trust staff to understand and help the patient as needed, e.g. in relation to personal daily care - thought staff did not properly distinguish mental health and ID issues; - did not welcome carer visiting and involvement (as was the case in specialist units). Concerns about poor communication between staff and patients, confusion of roles between mental health and ID, and lack of understanding among mental health staff of person-centred care for people with ID, were echoed by ID service providers (Donner et al. 2010) (rec 1.6.21, 1.6.22).
Other considerations	The GC noted that much of the evidence for these recommendations concerned small RCTs, some based on old data, and coming from the US (where, e.g., the ‘treatment as usual’ comparison is unclear). The GC agreed that the person approaching discharge should discuss need for support and have as a minimum a contact who could support them if their mental health deteriorated, and support and plans that would cover the first week. These could form part of a discharge plan or a recovery plan (rec 1.6.19). It was felt that the ‘transitional case management' or 'critical time interventions' referred to in evidence were generally not clear about the ‘active’ ingredients that might make a difference to outcomes, and that the evidence did not support a particular model. The GC noted that there was national guidance that discharge letters should be sent to the GP within the first week, especially as the person might only have a week’s medication to take away – but whether to recommend that hospital practitioners should book an appointment with the GP was uncertain (as this could be time-consuming and would not then be adhered to). While the outcome of achieving a transition between hospital and primary-based care was agreed as important (for both mental and physical health disorders), the GC did not think that motivational interviewing was sufficiently distinct to recommend it as a means to achieving this transfer (rec 1.6.20). The GC recognised the particular complexities in managing transitions for people with a learning disability or dementia (among other populations) and agreed that discharge planning must be supported by community-based agencies with particular specialisms (rec 1.6.21). Likewise, as informed by the expert witness on dementia, the GC were persuaded that care home staff should be involved in discharge planning, but that opportunities to liaise might need to be ‘creative’, and should not be left until discharge (rec 1.6.22). The risk of suicide in the first week after discharge was discussed as an area where practitioners might have limited

	awareness. The GC agreed that a direct conversation with the person was needed to identify risk of suicide, and that the person should have follow-up, if only a phone call, within 7 days, or earlier if the person seemed to need it (rec 1.6.23). The GC were mindful of the studies concerning proactive follow-up by letter (see statements DC9 and DC17). Although the earlier US high quality study (Motto and Bostrom 2001 ++/+) appeared to deliver good outcomes, the more recent study (Bennewith et al. 2014) had not met with similar success or acceptance. The GC thought it could be considered for people admitted for self-harm who were not otherwise engaged with services (as people who had long service experience thought it was not helpful except perhaps for people new to services) (rec 1.6.24).

Topic/section heading	**Discharge – Community Treatment Orders (CTOs)**
Recommendations	1.6.25 Decide whether a community treatment order (CTO) or guardianship order is needed (see the Mental Health Code of Practice), based on: • the benefit to the person (for example, it may be helpful for people who have had repeated admissions) • the purpose (for example, to support the person to follow their treatment plan) • the conditions and legal basis. 1.6.26 Ensure that the person who will be subject to the order has the opportunity to discuss why it is being imposed. Explain: • the specific benefit for the person • what restrictions it involves • when it will be reviewed • what will happen if the person does not comply with the order, and that this may not automatically lead to readmission. 1.6.27 Ensure that the conditions, purpose, legal basis and intended benefit are explained to families, carers and others providing support.
Research recommendations	The GC did not prioritise this as an area on which to make research recommendations.
Review questions	6. What is the effectiveness or impact of interventions and approaches delivered as part of discharge and admission processes in reducing or preventing readmissions to inpatient mental health settings?
Quality of evidence	The evidence for this set of recommendations is from the reducing readmissions and discharge review areas. There was 1 high quality UK RCT, and 2 smaller US RCTs of lesser quality. There were a number of mostly moderately good qualitative studies which looked at the impact of CTOs on people at and after discharge.
Relative value of different outcomes	The single relevant, large and well conducted effectiveness study did not identify any significant differences in outcomes (reduced

	readmissions) for the CTO group. This meant that it was not possible to ascertain and compare the relative values of outcomes from implementing these recommendations.
Trade-off between benefits and harms	The absence of relevant effectiveness studies in arriving at these principles of care meant that it was not possible to ascertain and compare trade-off between benefits and harms for people in implementing these recommendations.
Economic considerations	No economic evidence was available to inform these guideline recommendations. In considering the effectiveness evidence (see other considerations below), and mindful of potential cost and risk of overuse the GC developed recommendations focused on establishing clear benefit in each individual case.
Evidence statements – numbered evidence statements from which the recommendation(s) were developed	RR7 There is high quality evidence from a UK RCT (Burns et al. 2013 ++/++) that CTOs for patients with psychosis offer no advantages to those on them, and no significant differences in number and length of admissions. A lesser quality pilot study (Steadman et al. 2001 +/+) of US Involuntary Commitment Orders also found no differences in outcomes (despite enhanced and more intensive outpatient services being made available to the intervention group (rec 1.6.25, 1.6.26). RR8 There is evidence of a smaller, poorer quality US RCT (Swartz et al. 1999 +/-) to suggest that Involuntary Commitment Orders may have positive effects on psychotic patients' readmission rates, but only if they are supplemented by intensive outpatient treatment. This then confuses the effective intervention (rec 1.6.25). RR13 There is evidence of moderate quality from 2 UK qualitative studies (Canvin 2014 +/+; Stroud 2015 +/+) that understanding of how CTOs work in practice varies considerably. While Canvin revealed that service users, carers and professionals saw CTO's legal clout as the main facilitator for achieving their purpose (especially medication adherence), all groups showed uncertainty over the exact criteria for recall to hospital. Both the studies raised ethical concerns because they revealed that professionals were not incentivised to ensure that people were fully informed about the extent of the legal standing of CTOs for fear that it would lessen respect for their perceived 'power'. Service users often believed, mistakenly, that to break a condition would automatically result in recall. This lack of clarity in service users' understanding produced a sense of unease among professionals (particularly AMHPs) that legal powers were weaker in reality than presented (Stroud 2015) (rec 1.6.26). RR14 There is evidence of moderate quality from 1 UK study (Stroud 2015 +/+) that some, but not all, service users, practitioners and nearest relatives value CTOs as a 'safety net'. In particular, nearest relatives and housing service providers who otherwise felt unsupported by mental health services were reassured by the perceived legal authority and enforceability of CTOs. Carers responded positively to CTOs and particularly appreciated having clear contacts to call, and that an emergency appointment could be triggered quickly without the need for a new mental health assessment. Similarly, another moderate quality UK qualitative study (Canvin 2014 +/+) found that carers'

	knowledge that the person they cared for could be returned to hospital without fully relapsing allayed their fears about patient wellbeing, and in some cases their own safety (rec 1.6.27). RR15 There is evidence of moderate quality from 2 UK qualitative studies (Canvin 2014 +/+; Stroud 2015 +/+) that there is considerable variability in effectiveness of CTOs. Some service users described enjoying greater stability since being on a CTO, and others found the close monitoring of medication intrusive and disempowering; not many service users thought the CTO had reduced time spent in hospital or reduced readmissions. Psychiatrists were able to give examples where they thought a CTO had produced a beneficial effect, but this was very dependent on the type of patient. CTOs were viewed as useful for a restricted group of ‘revolving door’ patients for whom other options had been unsuccessful. CTOs were considered to be more successful when they were carefully planned, as opposed to being made as a matter of course (rec 1.6.25, 1.6.26, 1.6.27). RR16 There is moderate quality evidence from 1 UK qualitative study (Canvin 2014 +/+) that psychiatrists, patients and carers all perceive the main purpose of the CTO to be enforcement of medication. The strong emphasis on medication adherence – and the failure to address lack of motivation or desire to engage socially – was considered a major flaw by carers and service users alike. Overemphasis on medication adherence was seen to impede recovery and prevent patients from having a normal social life or being able to work. However, in contrast, psychiatrists emphasised that people under CTOs did not receive preferential treatment and tended to focus narrowly on enforceability and achievability when designing conditions (rec 1.6.25, 1.6.26, 1.6.27). DC18 There is a (methodologically) poor study (Fahy et al. 2013 -/+) which researched the views of 17 people who had experience of having a CTO. Although some saw CTOs positively because they were a ‘ticket’ to early discharge from hospital, others felt they were restrictive and hung over them as a threat of recall to hospital. Only 6 agreed that they were involved in the decision to initiate a CTO, and most felt the key decisions were made by the responsible clinician (rec 1.6.26).
Other considerations	The GC were mindful, despite the well-conducted UK trial (Burns et al. 2013 ++/+), that they could not recommend that CTOs were not used in any circumstances. It was possible that they might have benefits for a sub-section of the general population of people being discharged on a CTO (or being placed on a CTO instead of being readmitted). There was also evidence that carers found CTOs reassuring, as they apparently fast-tracked the person into hospital (without further assessment). Given the qualitative evidence on what the CTOs ‘meant’ to particular stakeholders, and the unfortunately coercive nature of the approach, they considered that there was a case for reflection and justification of their use by the psychiatrists who imposed them (rec 1.6.25). Similar views were expressed on the role of guardianship orders.

	The GC agreed by consensus that the use of CTOs should be considered within the principle of personalised care, and at all times the person made subject to the order should be aware of the reasons and potential benefits of the approach. The GC felt that there were negative ethical consequences if psychiatrists were using CTOs without proper explanation (see qualitative evidence). They appeared to see some benefit in people being uncertain about what might constitute a breach. People put on CTOs or guardianship orders and their carers should be enabled to understand why the order was imposed, what would happen if it was contravened, and when it would be reviewed (rec 1.6.26). This should also be explained to carers and families providing support (rec 1.6.27).

Implementation: getting started

NICE has worked with the guideline committee to identify 3 areas in this draft guideline that may have a big impact on practice and could be challenging to implement.

During the consultation we want stakeholders to let us know whether you agree with the 3 areas identified below. Or do you think other areas in this guideline will have a bigger impact, or be more difficult to implement?

To help us complete this section please give us your views on these questions:

- Which areas will have the biggest impact on practice?
- Which areas will be the most challenging to implement?
- Who will these areas be most challenging for, and why? What would help users to overcome any challenges? (For example, existing practical resources, national initiatives or examples of good practice.)

Please use the stakeholder comments form to send us your comments and suggestions.

Challenges for implementation

The challenge: Delivering services that are person-centred and focus on recovery

See recommendations 1.1.1–1.1.3 and 1.6.12.

All practitioners have a role to play in ensuring care and support is provided in a therapeutic environment that is responsive to people's individual needs and choices while being focused on recovery. Creating the right culture needs skilled practitioners who work with people as active partners and have a good understanding of what makes a successful transition. People will benefit because they will experience care and support that is tailored to their needs and supports their recovery.

Transitions for people using acute mental health services can be complex. They often involve more than 1 agency and setting. Workload pressures in hospitals and community settings can lead to competing demands. A poor transition that is not person-centred can be stressful for people using mental health services and their families and carers. This can result in an unsatisfactory experience for all concerned and may impede recovery.

What can commissioners, managers and practitioners do to help?

- Embed principles of person-centred and recovery-focused care in all training, supervision and continuing professional development for practitioners involved in transitions.
- Ensure that mental health and social care practitioners inexperienced in working with people from diverse backgrounds are able to seek advice, training and supervision from colleagues who do have this experience (in line with the section on community care in NICE's guideline on service user experience in adult mental health).
- Ensure health and social care practitioners have opportunities to learn about the emotional and practical impact of transitions, change and loss. This should include discussion of the particular risks and challenges of transitions.
- Ensure all professionals involved in assessments for admission under the Mental Health Act 2007, such as police, community psychiatric nurses, approved mental health professionals, psychiatrists, GPs and ambulance staff, have opportunities for training. These may include:
    - training delivered by people who use services
    - on-the-job learning
    - training done alongside other involved professionals.

The challenge: Ensuring effective communication between teams, and with people using services and their families and carers

See recommendations 1.1.4, 1.1.7, 1.2.8, 1.3.8–1.3.9, 1.4.1–1.4.5.

Good communication is important – both between health and social care practitioners working in multidisciplinary teams and between practitioners and people using mental health services (and their families and carers). Good communication leads to better coordinated care and a better experience for the person.

Practitioners need to work together, across physical and professional boundaries, to ensure that people experience good transition. People need help to stay in touch with their life outside the hospital, including relationships, employment, education and their local community. But this can be particularly hard if they live some distance from the hospital, or if a number of agencies are involved.

What can commissioners and managers do to help?

- Ensure that effective systems are in place to help practitioners communicate effectively.

What can health and social care practitioners do to help?

- Ensure that information about people is shared with colleagues if appropriate (in line with information-sharing protocols).
- When people are placed outside the area they live in, ensure that good communications are maintained, both between practitioners in different services and between practitioners and people using services (and their families and carers).
- Ensure that there is good communication between service providers and people using mental health services (and, if appropriate, their family and carers).
- Offer information on treatment and services to people at the point they need it.
- Think carefully about what information people need and how to make sure they have understood it. This could be checked during a conversation with the person when they are feeling less unwell.

The challenge: Co-producing comprehensive care plans that meet people’s changing needs

See recommendations 1.1.2–1.1.3, 1.2.2, 1.6.7.

Co-producing care plans with people helps them to feel more in control and be active partners in their own care and recovery. Care plans should draw on all forms of documented treatment intentions and preferences relating to the person (including crisis plans, discharge and recovery plans and Care Programme Approach documentation). Lack of coordination between plans can result in frustration and stress when people are asked for information repeatedly. Plans should be reviewed regularly. Planning early for each stage of admission and discharge can ensure better continuity of care and a better experience for the person as they move between services. Requiring practitioners to explain to people and their carers why a restriction (involuntary admission, observation or community treatment order) has been applied is likely to lead to improved communication with people and their carers. It will also support more reflective practice.

Identifying the person's family or carers early on means they can be more involved in the person's care and support from an earlier stage. It can also aid practitioners' understanding of the person and their needs.

Building in time to pace a transition according to a person's cognitive and communication needs may need changes to the way things are routinely done.

What can commissioners and managers do to help?

- Ensure health and social care practitioners involved in transitions to and from mental health hospitals have the skills to:
  - carry out needs assessments
  - develop care, discharge and recovery plans in collaboration with the person.

What can health and social care practitioners do to help?

- Ensure that all planning is person-centred and involves the person as an active partner in their care.
- Start all plans at the earliest possible opportunity.
- Focus planning on enabling people to have a seamless transition into and out of hospital.

- Recognise that care plans are ‘living documents’ that should be regularly reviewed and take account of changed circumstances.

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4 Related NICE guidance

Details of related guidance are correct at the time of consultation (January 2016).

Published

- Transitions from children’s to adults services NICE guideline NG43 (2016)
- Home care NICE guideline NG21 (2015)

- Medicines optimisation NICE guideline NG5 (2015)
- Older people: independence and mental wellbeing NICE guideline NG32 (2015)
- Social care of older people with multiple long-term conditions NICE guideline NG22 (2015)
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline NG27 (2015)
- Violence and aggression: short-term management in mental health, health and community settings NICE guideline NG10 (2015)
- Bipolar disorder: assessment and management NICE guideline CG185 (2014)
- Managing medicines in care homes NICE guideline SG1 (2014)
- Mental well-being of people in care homes NICE quality standard QS50 (2013)
- Psychosis and schizophrenia in children and young people NICE guideline CG155 (2013)
- Patient experience in adult NHS services NICE guideline CG138 (2012)
- Improving the experience of care for people using adult NHS mental health services NICE guideline CG136 (2011)
- Medicines adherence NICE guideline CG136 (2011)
- Psychosis with substance misuse NICE guideline CG120 (2011)
- Self-harm: longer term management NICE guideline CG133 (2011)
- Service user experience in adult mental health NICE guideline CG136 (2011)
- Borderline personality disorder: treatment and management. NICE guideline CG78 (2009)
- Rehabilitation after critical illness NICE guideline CG83 (2009)
- Mental wellbeing in older people NICE guideline PH16 (2008)
- Dementia NICE guideline CG42 (2006)

In development

NICE is developing the following guidance:

- Suicide prevention NICE guideline, publication expected April 2018
- Mental health of adults in contact with the criminal justice system NICE guideline, publication expected November 2016
- Mental health problems in people with learning disabilities NICE guideline, publication expected September 2016

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Declarations of interests

The following members of the guideline committee made declarations of interest. All other members of the Group stated that they had no interests to declare.

Committee member	Interest declared	Decision taken
Mary Birken	It is possible that I may author or co-author published papers or other documents that could be submitted as evidence during the period of membership of guideline committee.	None
Rebecca Harrington	Non-executive director of Barnet, Enfield and Haringey MH NHS Trust. Chair of The Maya Centre, counselling charity. Partner is academic psychiatrist with research interests in this area. All non-financial	None
Catherine King	I am a member of Mind and receive treatment through Cambridge and Peterborough Trust. As far as I know, there are no conflicts of interest.	None
Karen Morse	Member of staff, Skills for Care.	None
Anna Stratford	Director – Recovery Partners We provide a not for profit user- led peer support service for people with mental health issues across East Sussex.	None

	Associate Tutor – Sussex University I have been a part time tutor at Sussex since October 2007. Independent Practice Educator From Jan – June last 2013, I had students on placement at Off the Fence, Brighton Housing Trust and Riverside English Churches Housing Group – all in Brighton and Hove, East Sussex. I currently have a student on placement with the Crisis Resolution and Home Treatment Team, Hove, Sussex Partnership NHS Foundation Trust. Respite Foster Carer Brighton and Hove City Council. Professional Affiliations: Registered with the HCPC (Health and Care Professional Council) as a Social Worker Associate Fellow of the Higher Education Academy since 2012. Member of the College of Social Work. Off the Fence Involved with this organisation but does not feels it constituents a conflict.	

6 Abbreviations

Abbreviations

Abbreviations – terms from included studies.

Abbreviation	Term
ACT	Acceptance and commitment therapy
ADHD	Attention deficit and hyperactivity disorder
AMHP	Approved mental health professional
ASW	Approved social workers
B-CTI	Brief critical time intervention

BDI	Beck Depression Inventory
CAN	Camberwell Assessment of Need
CCG	Clinical commissioning group
CI	Confidence interval
CIT	Crisis intervention team
CMHT	Community mental health team
CPA	Care Programme Approach
CPN	Community psychiatric nurse
CTI	Critical time intervention
CTO	Community treatment order
ECHO	Experienced caregivers helping others
EHC	Education, health and care plan
GP	General practitioner
HRQOL	Health-related quality of life
IA	Involuntary admission
ICM	Intensive case management
ID	Intellectual disability
IG	Intervention
IOC	Involuntary outpatient commitment
JCP	Joint crisis plans
LD	Learning disability
MHA	Mental Health Act
MHCT Act	Mental Health (Care & Treatment) (Scotland) Act 2003
MHRT	Mental health review tribunal
MI	Motivational interviewing
MMSE	Mini-mental status examination
n	Number of participants
NH	Nursing home
NHS	National Health Service
NI	Northern Ireland
NICE	National Institute for Health and Care Excellence
NP	Nurse practitioner
NPSTET	Nottingham Peer Support Training Evaluation Tool
OCTET	Oxford Community Treatment Order Evaluation Trial
OR	Odds ratio
OT	Occupational therapy
p	p-value: a measure that indicates whether the change in outcome was due to chance; a p-value of less than 0.05 suggests that the change was not

	due to chance (statistically significant)
PIP	Psychoeducation information project
PSC	Peer support coordinator
PSW	Peer support worker
PTSD	Post-traumatic stress disorder
QALY	Quality adjusted life years
QOLI	Quality of life interview
RCT	Randomised controlled trial
RR	Relative risk
SD	Standard deviation
ST	Standard treatment
SWAT	Special weapons and tactics
TAU	Treatment as usual
TIMT	Trans-diagnostic internet-based maintenance treatment
TRM	Transitional relationship model
URICA	University of Rhode Island Change Assessment
VA	Veteran affairs

About this guideline

What does this guideline cover?

The Department of Health (DH) asked the National Institute for Health and Care Excellence (NICE) to produce this guideline on transition between inpatient mental health settings and community or care home settings (see the scope).

The recommendations are based on the best available evidence. They were developed by the guideline committee (GC) – for membership see Section 7.

For information on how NICE social care guidelines are developed, see Developing NICE guidelines: the Manual.

Other information

We will develop a pathway and information for the public and tools to help organisations put this guideline into practice. Details will be available on our website after the guideline has been issued.

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