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

NICE guideline: short version

Draft for consultation March 2016

This guideline covers admission to inpatient mental health settings from the community or a care home, and discharge from inpatient mental health settings to the community or a care home. It aims to improve outcomes for people using health and social care services and their families and carers by:

- improving the experience of people who are being admitted to or discharged from inpatient mental health settings
- supporting people affected by a mental health condition to build up resilience and reduce the impact of symptoms on their everyday life
- promoting better practice
- encouraging continuity through integrated working between mental health and social care.

Who is it for?

- Providers of care and support in inpatient and community mental health and social care services.
- Front-line practitioners and managers in inpatient and community mental health and social care services.
- People who use inpatient and community mental health services, their families and carers.

Commissioners of mental health services should ensure any service specifications take into account the recommendations in this guideline when it is finalised.

This version of the guideline contains the draft recommendations, information about implementing the guideline, context and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the guideline committee's discussion and the evidence reviews (in the full guideline), the scope, and details of the committee and any declarations of interest.

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

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.

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 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.

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 that 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 that 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, parents or 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 families 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 that health and social care practitioners involved in transitions to and from mental health hospitals have the skills to:
  - carry out needs assessments
  - develop care, and 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.

Context

Poor transition between inpatient mental health settings and community or care home settings has negative effects on people using services and their families and

carers. 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 practitioners based in hospitals and those in the community. Both can result in inadequate and fragmented support for people using mental health services.

People who use inpatient mental health services and their families and carers have reported a number of problem areas:

- delayed assessment and admission, so that the person is not treated until they are in crisis
- inadequate planning for – and support after – discharge, resulting in readmissions
- the person and their carers not being involved in planning admission, treatment and discharge
- people being discharged having no help to manage the mental health symptoms and other problems that contributed to their admission
- failure to give people the information, advocacy and support they need
- failure to arrange support to help the person reintegrate into the life they want to lead in the community (for example, returning to employment, education and social activities).

The consequences of a poor transition can be very serious for the person and their family or carers. For example, the University of Manchester's 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 in the first 3 months after being discharged from hospital (compared with 1,295 inpatient deaths in the same period).

Older people are sometimes discharged to care homes when they might have been able to return to their own homes if extra support, such as home care, had been arranged in advance.

The impact of poor discharge planning on young people who are not supported to reintegrate into education and training can have long-lasting consequences for their life chances.

People placed in inpatient facilities away from their home communities are particularly vulnerable to delayed discharges, because case management is difficult at a distance. Delayed discharge is an unnecessary expense to the NHS, but also has consequences for patients, who may become dependent on inpatient care, lose coping skills that they will need after discharge, and find that personal relationships are damaged, and housing or jobs lost.

This guideline is about everyone who uses mental health inpatient facilities, including children, young people and adults, and people who have other health issues and care needs. It primarily covers transitions – admissions and discharges – and makes recommendations about how they might be handled in order to maximise the benefits of the treatment being offered, and continuity of care. It includes people who are admitted from, or discharged to, care homes and other community settings. The guideline also covers the preparation for discharge that takes place during the inpatient stay.

More information

To find out what NICE has said on topics related to this guideline, see our web page on service transition.

Recommendations for research

The guideline committee has made the following recommendations for research.

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 need 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.

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.

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 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.

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.