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EQUALITY IMPACT ASSESSMENT

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NICE guidelines

Equality impact assessment

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

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

1.0 Scope: before consultation (To be completed by the developer and submitted with the draft scope for consultation)

1.1 Have any potential equality issues been identified during the development of the draft scope, before consultation, and, if so, what are they? (Please specify if the issue has been highlighted by a stakeholder)
Focus on all children, young people and adults: Children and young people are included within scope but early scoping identified a relative paucity of evidence on children and young people's transitions.. The number of young people to which this guideline applies may be small but certain groups within this population may be in particularly vulnerable circumstances such as those aged 16-25 years, who are admitted to/ discharged from mental health settings. Similarly, whilst including all adults, there is a risk of marginalising older people in favour of adults of working age. In the wider literature on transitions, older people tend to experience delayed discharges most acutely. However, delayed transfer of care' data are not collated specifically for inpatients in mental health settings so there is no profiling by age and extent of the problem is undocumented and known. **LGBT people:** Studies show that that lesbian, gay and bisexual people show higher

levels of anxiety, depression and suicidal feelings than heterosexual men and women. Services should be sensitive and responsive to LGBT requirements and the difficulties in accessing services that individuals may face.

People of minority ethnic background: According to the Mental Health Foundation, people from black and minority ethnic groups living in the UK experience a number of disadvantages, including being more likely to be diagnosed with mental health difficulties; and being more likely to disengage from mainstream mental health services. Services should be sensitive and responsive to different cultural and religious requirements and the difficulties in accessing services that these groups may face. Recent migrants, including refugees and asylum seekers, and people who do not speak English as their first language are likely to have reduced knowledge of, and hence access to, social care services. They may find it particularly problematic to navigate transitions between hospital and social care services.

Gender: There are issues for both sexes receiving personal care concerning the sex of the worker. A stakeholder relayed that women who are under observation have reported feeling uncomfortable being observed by a male member of staff.

People with cognitive impairment: This includes people with dementia and those who do or may lack capacity. Without appropriate support, people with cognitive impairment are likely to find it incredibly difficult to negotiate the complexities of moving between care settings. Communication strategies, quality of services, choice and control, and safeguarding are important issues for this group.

People with communication difficulties and/or sensory impairment: Communication strategies, quality of services, choice and control, and safeguarding are important issues for people with communication difficulties, whatever their cause. Sensory impairment and communication difficulties, including profound deafness and where people's first language is BSL, may also develop with or be exacerbated by age. This may lead to difficulty in accessing services and negotiating the complicated interface between mental health settings and social care. Communication difficulties may also lead to problems during transition for adults with learning disabilities and among people for whom English is not their first language.

People admitted and discharged under the Mental Health Act: There are important ethical, legal and human rights issues relating to detaining people involuntarily under the Mental Health Act. How a person is discharged and supported in the community depends on whether they have been detained under the MHA. People leaving secure hospitals should be entitled to free after care under section 117 of the MHA, which is normally the responsibility of the local authority. Serious problems have been well documented when these arrangements break down.

People with co-morbidities: Since there is a strong association between mental and physical ill health, people often experience co-morbid conditions. This group of people

may be particularly vulnerable to poor or unnecessary transitions and associated negative outcomes. This category includes those with long-term conditions; people with end of life care needs who may need enhanced care and regular review, for instance; and those who experience drug and alcohol use disorders (see below – dual diagnosis).

Dual diagnosis: People with dual diagnosis can be in particularly vulnerable circumstances when mental health and drugs and alcohol services are not joined up. This group is included in the scope only where a drug and alcohol problem is co-morbid with a mental health difficulty. Some mental health providers do also have drug and alcohol services, so we may identify evidence about this group by setting as much as by condition.

People on the autistic spectrum: Particular attention should be given to the circumstances of people on the autistic spectrum, especially as their care and support needs can often go unaddressed. This includes those living in assessment and treatment units which may be seen as mental health inpatient settings. The experience of people with learning disabilities and those who have been misdiagnosed as being psychotic may be identified through the evidence but others may not.

Socio-economic status: Evidence suggests that lower socio-economic status may be associated with poor access to information about care options.

Location: Ensuring smooth transition from mental health settings and delivering coordinated health and social care support for people in rural environments and individuals placed out of area may be particularly challenging.

People who live alone: Negotiating the transition between settings may be particularly difficult for people who live alone especially if we consider the consequences of a person being discharged from an inpatient mental health setting without adequate planning and support.

People without a home: Mental ill health is closely correlated with homelessness being both a cause and consequence of the loss of accommodation. People who do not have settled accommodation (e.g. homeless people; gypsies and others with traveller lifestyle) are likely to be excluded from services, although searches oriented to their care and support will be undertaken.

Out of area placements: people placed out of area experience particular difficulties, including less contact with family and friends, social exclusion, and reduced opportunities for employment and education (Rethink & Care Services Improvement Partnership, 2007). Furthermore, from an organisational perspective, where the independent sector provide a significant proportion of the mental health beds in England, there are implications in terms of case management and monitoring people

for discharge when placed in specialist beds out of area.

People with a mental illness and have been involved with the police, court or prison: Since forensic mental health settings are included in the remit, this group will be included.

Family carers' gender and ethnicity: There is some evidence of stereotyping that suggests that women and ethnic minority carers are more likely to be expected to provide unpaid care than their male/white counterparts.

Ex- service personnel: The government's strategy document 'No Health without mental health' highlighted its intention to set aside funding from the Department of Health to provide the best treatment possible for Service and ex-Service personnel. This group can often be overlooked. Individuals can experience serious mental health problems following military service, which can in turn lead to other problems such as drug and alcohol misuse and family breakdown. Access to mental health provision and social care can also be problematic and should be recognised as an issue.

Dealing with these aspects: Plans for dealing with these aspects include sensitivity to equality and diversity issues, and search strategies specifically oriented to seek out material on these groups. The guideline addresses the organisations and delivery of services that take account of these issues, including the provision of advice and information to support access to personalized services. The guideline attempts to uncover and address some of the areas where there is well-documented discrimination. The Guideline Committee has made recommendations specifically in relation to particular service users and carers when considering whole population issues.

1.2 What is the preliminary view on the extent to which these potential equality issues need addressing by the Committee? For example, if population groups, treatments or settings are excluded from the scope, are these exclusions justified – that is, are the reasons legitimate and the exclusion proportionate?

The following groups are not included in the scope:

People moving between inpatient mental health settings. A lack of integration is cited as an overarching reason for delayed discharges, specifically; inadequate whole system working across inpatient and community mental health services and a lack of interagency collaboration and coherence between health, social care and housing (CSIP, NIHME, 2007). This is exacerbated by a lack of community facilities and therapeutic opportunities. The priority of this guideline is on transition between

mental health settings and the community, not between inpatient mental health settings.

People moving between prison or a young offenders' institution and an inpatient mental health setting or between prison and the community. The focus of this guideline is health and social care, so would exclude prisons or young offender institutions (this is the subject of another NICE guideline under development). However, in this area community forensic mental health teams (CFMHT) would be included.

Children and young people moving from children's to adult services are excluded unless a transition between an inpatient mental health setting and the community is also involved. This is the subject of a separate NICE guideline: 'Transition from children's to adult services for young people using health or social care services'. We will seek to ensure that relevant evidence is included and both pieces of guidance are aligned.

General inpatient hospital settings
This will be covered in a separate NICE guideline: 'Transition between inpatient hospital settings and community settings or care home settings for adults with social care needs'.

Completed by Developer:
Amanda Edwards and Rebecca Harrington_____

Date_ 15/12/14_____

Approved by NICE quality assurance lead
Nick Baillie_____

Date__15/12/14_____

2.0 Scope: after consultation (To be completed by the developer and submitted with the final scope)

2.1 Have any potential equality issues been identified during consultation, and, if so, what are they?
Stakeholders voiced concern about how well older people were represented in the draft scope, especially in light of the policy section. Stakeholders also identified the need for more specific references to the kinds of

residential settings that children, especially looked-after children, may be transitioning from/to. There was also a request for the Children Act 2004 to be referenced, specifically with regards to section 25 which relates to placing a child in secure accommodation. See 2.2 below for more details.

2.2 Have any changes to the scope been made as a result of consultation to highlight potential equality issues?

Section 3.3.1 of the draft scope referenced policy which was relevant for children and young people; the Care Programme Approach; and the National Service Framework for Mental Health. In light of stakeholder feedback that the National Service Framework specifically excludes people over the age of 65, alongside other concerns from stakeholders that older people were not adequately represented, the final scope now references the national dementia strategy 'Living well with dementia' in the policy section (3.3.1).

In light of stakeholder comments that most children and young people will transition to foster care (rather than a residential setting) if they cannot stay with parents or carers upon discharge, 'Foster care' was added to the list of included community settings. 'Children's homes' has been added to the examples of care home settings and 'secure units for children and adolescents' was added to the list of inpatient mental health settings.

Stakeholders also requested that the scope should reference the Children Act & Safeguarding legislation as some young people admitted to inpatient settings are subsequently transferred to a secure welfare bed under S.25 of the Children Act. The final scope includes a reference to The Children Act 2004 which stipulates that all organisations working with children have a duty to safeguard and promote their welfare. Specific reference is made to section 25 which sets out the provisions under which a child who is being looked after by the local authority can be placed in secure accommodation.

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2.3 Is the primary focus of the guideline a population with a specific disability-related communication need? If so, is an alternative version of the 'Information for the Public' document recommended? If so, which alternative version is recommended? The alternative versions available are: • large font or audio versions for a population with sight loss; • British Sign Language videos for a population who are deaf from birth; • 'Easy read' versions for people with learning disabilities or cognitive impairment.
The primary focus of the guideline is not a population with a specific disability-related communication need, it is a whole population topic for those transitioning to/from inpatient mental health settings. However, the guideline committee made a strong recommendation that the guideline should be made available in 'Easy read' format for people with learning disabilities or cognitive impairment as they are particularly vulnerable to poor transitions.

Updated by Developer _____

Date_____08/01/16_____

Approved by NICE quality assurance lead ___Jane Silvester_____
Date_____30/08/16

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3.0 Guideline development: before consultation (to be completed by the developer before draft guideline consultation)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
One review question specifically addressed interventions to support people with dementia, a sub-group identified alongside those with cognitive impairment as being at risk of poor transitions. Unfortunately the review did not furnish any evidence for this review question, however, an expert witness gave a testimony to the Guideline Committee. The Guideline Committee was able to make recommendations based on this testimony, combined with their own experiences. For example, recommendations 1.2.4, 1.2.5 and 1.6.4 are all specific to people with dementia, learning disabilities, or cognitive or sensory impairments, and reference the specific approaches to care planning and communication which could improve transitions for this vulnerable group. As no studies were identified about transition for people with dementia from or to inpatient mental health settings, and this was one of the groups identified as requiring special attention, the Guideline Committee made a research recommendation for effectiveness studies which looked at the effect of specific interventions to support people with dementia during transition between inpatient mental health settings and community or care home settings (see Research Recommendation 1). There is also a second research recommendation on ‘people with complex needs other than dementia’. This addresses specific interventions to support people with complex needs (including people with long-term severe mental illness, people with a learning disability, people with complex physical care needs and people on the autistic spectrum) during transition between inpatient mental health settings and community or care home settings. Although this represents a relatively small group, expenditure on care for people in this group accounts for around 25% of the total mental health budget. The research recommendation is for evaluations of different approaches and interventions to support people with complex needs during transition, as well as qualitative studies exploring views and experiences of people with complex needs and their families, and staff from the receiving care home. For all other review questions, the search strategy was deliberately designed to capture literature relevant to the whole population, including all the sub groups identified during the scoping process. Particular attention was paid to capturing literature on people who are placed out of area and those subject to the Mental Health Act. While there was considerable evidence about people subject to the Mental Health Act, there was limited evidence on those placed out of area. The evidence found was qualitative, and tended to apply to people with learning disability in addition to mental illness, as specialist units for this population are fewer. Children and young people, and people with eating disorders, are other examples of people who may be placed out of area in order to access specialist treatment. Through consensus decisions and information given by the Expert Witness from Young

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3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
Minds, the Guideline Committee created a section within the recommendations on 'Out-of-area admissions' which contains recommendations .1.3.9 to 1.3.11. The needs and circumstances of specific sub groups were addressed through the recommendations in the following ways: **Children and young people:** some limited evidence was located and an Expert Witness from Young Minds gave a testimony to the Guideline Committee. Recommendations were developed which specifically addressed the needs of children and young people during transitions between inpatient mental health settings and community or care home settings. Examples include recommendations 1.5.5 and 1.5.6 in the 'Education for people under 18' section about ensuring continued access to education and learning throughout hospital stay and beyond, and 1.3.20 about ensuring that children and young people, in particular, know who they can talk to if they are frightened or need support. Recommendations 1.4.7 and 1.4.10 address the needs of young carers. The Guideline Committee identified various gaps in evidence for this review area, including: child protection and safeguarding, voluntary compared with involuntary admission, understanding by children and young people of their status, the experience and support of looked after children admitted to a mental health unit, and how best to support reintegration into education services. As such the committee made a research recommendation for studies measuring the effect of specific interventions to support children and young people in transition between inpatient mental health settings and community or care home settings. **LGBT people:** Recommendation 1.1.7 states that mental health services should work with primary care and third sector organisations to ensure that all people with mental health problems have equal access to services based on clinical need and irrespective of sexual orientation. Aside from this no evidence was located and no further recommendations were specifically agreed in relation to LGBT people. However, recommendations that focus on 'person-centred care' and considering the whole person and their social context are expected to address issues relating to LGBT status. **People of minority ethnic background:** A number of recommendations cover diversity in population. General principles of hospital admission starts with recommendation 1.3.1 about access to advocacy services that takes into account people's language, cultural and social needs and protected characteristics. Recommendation 1.1.7 is about ensuring that all people with mental health problems have equal access to services based on clinical need and irrespective of cultural, ethnic and religious background. 1.3.14 is about making sure that personal, gender and cultural preferences are taken account of when somebody is under observation. A somewhat old cross-sectional study (Commander et al, 1999) suggested that

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
people of black and Asian background were more likely to be formally admitted, to be rated as hostile or aggressive and to be less satisfied with the admission process. A good quality economic evaluation (Barrett et al., 2013) compared joint crisis plans plus usual care to usual care alone. Sub-group analyses from the public sector perspective indicated that the intervention is more cost effective and produced better outcomes (fewer compulsory admissions) for black ethnicity. However, from a societal perspective there is no clear evidence that the intervention is cost effective. The Guideline Committee did make a recommendation about crisis planning for people who have had more than one admission but could not arrive at a recommendation which highlighted the particular cost-effectivness for black (African and Caribbean) people and which met criteria. The research recommendations on 'Peer support' and 'Children and young people in transition between settings' both ask if these interventions show any particular benefit for black, Asian and minority ethnic communities. The Committee regretted the absence of more data on this population, and took the view that person-centred recommendations should apply to all populations without discrimination. **Gender:** Recommendation 1.1.7 states that that all people with mental health problems should have equal access to services based on clinical need and irrespective of gender. 1.3.14 is about making sure that personal, gender and cultural preferences are taken account of when somebody is under observation. Aside from this no evidence was located and no further recommendations were specifically agreed in relation to gender. However, recommendations that focus on 'person-centred care' and considering the whole person and their social context are expected to address issues relating to gender. **People with cognitive impairment:** This particular sub-group included people with dementia, a population which had its own review area. As described above, no studies were identified for this particular question, however through use of expert witness testimony and their own experience the Guideline Committee made recommendation 1.2.4, about allowing more time, consideration and expertise for people with dementia, cognitive or sensory impairment. Recommendation 1.2.5 is about offering people an opportunity to visit the inpatient unit they are being admitted to ahead of their admission, with a particular emphasis on facilitating this for people with dementia and people with learning disabilities, and 1.6.4 is about ensuring hospital teams lead communication about discharge planning with specialist community services for people who have dementia or a learning disability, or who are on the autistic spectrum. Research recommendations 1 (dementia) and 2 (people with complex needs) were made to improve the evidence base for people with cognitive impairment. **People with communication difficulties and/or sensory impairment:**

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3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
Communication needs are addressed throughout the recommendations, from ensuring verbal and written information is in a format that the person finds easy to understand, to offering all people access to advocacy services that take account of their language needs. The GC included several recommendations to follow-up information provision to ensure that the person has understood and retained it (for example, 1.3.12 and 1.3.13) and that their wishes are recorded at all stages (1.1.4). People with mental health disorders may have problems with communication when they are very unwell, so it was felt important that opportunities for dialogue arose throughout admission, inpatient stay and discharge processes. **People admitted and discharged under the Mental Health Act:** The review furnished a number of studies about people who were admitted and discharged under the Mental Health Act. The Guideline Committee felt that many of the findings relating to this particular subgroup should be extrapolated to the whole population, and that, with pressures on beds, a majority of those admitted might be either formally admitted or would be so if they tried to leave. There are two specific sections in the recommendations which are particularly relevant to the Mental Health Act: 'Legal Status ' and 'Community Treatment Orders'. Recommendations 1.3.12 and 1.3.13 make up the 'Legal Status' section ': they are about ensuring senior health professionals clearly explain people's legal status and restrictions at the point of admission and that they have discussions with the person who has been admitted to ensure that they have understood their rights. The section on Community Treatment Orders (recommendations 1.6.8 – 1.6.10)) advises Mental Health professionals to be clear about the purpose, conditions, legal status, and specific benefit to the individual to whom the Community Treatment Order (CTO) has been issued. These orders are likely to be applicable to people with at least one compulsory admission (and the qualitative evidence on CTOs suggests that both are experienced as coercive). **People with co-morbidities:** Physical care needs and co-morbidities are addressed at various points throughout the guideline, from discussing physical health care needs on admission (1.3.18); identifying additional need for support (1.3.21); including physical health needs in the care plan (1.5.20) and considering physical health care needs when arranging follow-up support (1.6.1). **Dual diagnosis:** We found no papers that specifically concerned people with dual diagnosis (substance misuse and mental health disorders. Some studies included people with dual diagnosis alongside psychiatric patients in their samples (eg Swanson et al, (1999) on motivational interviewing aiming to improve attendance at outpatient services), and some excluded them from samples. There was insufficient evidence to make recommendations specific to this group, although the

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

recommendations appear equally relevant to this group.

People on the autistic spectrum: In light of stakeholder responses to the draft recommendations the Guideline Committee added 'people on the autistic spectrum' to the list of potential groups of people for whom more time and expertise may be required to be supported through transitions (1.2.4) and to the list of people that would especially benefit from being offered an opportunity to visit the inpatient unit before they are admitted (1.2.5). 1.6.4 recommends that the hospital team should lead the communication about discharge planning with the various services that support the person in the community if the person has a learning disability, dementia or is on the autistic spectrum. The Guideline Committee made a research recommendation (2) for evaluations of different approaches and interventions for 'people with complex needs other than dementia' - this specifically included people on the autistic spectrum.

Socio-economic status: Recommendation 1.1.76 states that all people with mental health problems should have equal access to services based on clinical need and irrespective of socio-economic status. Aside from this no evidence was located and no further recommendations were specifically agreed in relation to socio-economic status. However, recommendations which focus on 'person-centred care' and the person's social circumstances are expected to address issues pertaining to socio-economic status.

Location: No recommendations were made specifically about people who are placed in rural areas. Some recommendations were made about people who are placed out of area (see below for more information). Ensuring continuity of care and joined up working between services are both themes that runs throughout the recommendations and are expected to minimise adverse outcomes which may arise as a result of people's location.

People who live alone: No recommendations were made specifically about people who live alone. However, recommendations which focus on 'person-centred care' and the person's social circumstances are expected to address issues relating to people who live alone.

People without a home: Recommendation 1.5.7 calls for consideration of the suitability of the accommodation to which the person is being discharged. . This recommendation is designed to avert possible future homelessness, if the home or household composition is unsuitable for the person or their carers. Recommendation 1.5.8 is about giving structured, intensive support to people who are, or are at risk of,

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

being homeless to help them find and keep accommodation.

Out of area placements: Recommendations 1.3.9 ,1.3.10 and 1.3.11 are specific to out of area admissions. They are about identifying a named practitioner from the person's home area and the ward they are being admitted to and ensuring joint working in relation to care planning, recovery plans and maintaining relationships. Recommendation 1.3.11 references the higher risk of suicide for this particular sub-group as highlighted in the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

People with a mental illness and have been involved with the police, court or prison: There were no recommendations which related specifically to people with a mental illness who have been involved with the police, court or prison. People moving between prison or a young offenders' institution and an inpatient mental health setting, or between prison and the community were excluded from the guideline as there is a NICE guideline currently in development: Mental health of adults in contact with the criminal justice system. Community forensic mental health teams (CFMHT) were in scope, however no evidence was found about this particular subgroup so no specific recommendations were made.

Family carers' gender and ethnicity: Although carers' gender and ethnicity are not specifically cited, the recommendations do address the needs and wishes of carers throughout the guideline, and specifically in section 1.4. Need for practical and emotional support for themselves, and desire to participate in care and support planning for the person are the two areas which evidence on carers consistently raised. For example, recommendation 1.4.6 is about signposting local support services to carers which can address their emotional, practical and other needs. Recommendation 1.4.4 is about accommodating carers' working patterns and other responsibilities so they can be involved in care planning and discharge meetings if the person wishes it.

Ex- service personnel: There was one study identified (Rosen, 2013) about telephone monitoring and support for veterans after discharge from residential treatment for post-traumatic stress disorder treatment (PTSD). This challenging disorder is particularly relevant to this population, but the treatment was found to be ineffective and no recommendations were made about it because this single study was not a sound basis for recommendations. For administration and insurance reasons, US health studies may often include veterans (eg Dixon et al, 2009, on a poorly described 'critical time intervention'), but the Guideline Committee felt that the

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3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
general recommendations they were able to make also applied to this population.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?
No additional equality issues were addressed.

3.3 Were the Committee's considerations of equality issues described in the consultation document, and, if so, where?
Where equalities issues were discussed, they are reported in the LETR tables under 'other considerations'.

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
In developing the draft recommendations the Committee took care to ensure that it would not be more difficult for any group of people to access support during transitions.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

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The Guideline Committee were careful when developing recommendations to ensure they would not have an adverse impact on people with disabilities.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 3.1, 3.2 or 3.3, or otherwise fulfil NICE's obligation to advance equality?
The Guideline Committee agreed a range of recommendations to address difficulties with access to services encountered during transition from inpatient mental health settings. See section 3.1 for examples.

Completed by Developer: Deborah Rutter

Date 02 February 2016

Approved by NICE quality assurance lead: Jane Silvester
Date 22 February 2016

4.0 Final guideline (to be completed by the Developer before GE consideration of final guideline)

4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
Stakeholders voiced concern that some of the recommendations were not appropriate for the children and young people population and suggested that, in some cases, a distinction should be made between the adult and CYP population. The Committee addressed these issues by amending the wording of certain recommendations to clarify whether or not they apply to children and young people and/ or just adults. For example, in light of a stakeholder comment that children who are admitted for self-harm should never be discharged without a robust community

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4.1 Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed them?
support package, 1.6.7 was reworded to 'For adults admitted for self-harm, who are not receiving treatment in the community post-discharge […]' in order to clarify that children and young people who are admitted for self-harm should always be receiving treatment in the community post-discharge. Similarly, 'people' was replaced with 'adults' in 1.5.12 on group-based psychological interventions for people with bipolar disorder to show that condition-specific psychoeducation interventions are unfeasible for a children and young people population. Stakeholders also commented that a few of the recommendations were particularly relevant to people on the autistic spectrum. The Committee considered the relevance of these recommendations for this particular group and added 'people on the autistic spectrum' to 1.2.4 and 1.2.5. One stakeholder commented that women have reported how important it is to them to not be under observation by male staff. The Committee considered this comment and felt that it would be too prescriptive to stipulate that women should never be observed by a male member of staff. However, the Committee understood the point to be about making an effort to uphold personal preferences and upholding people's dignity and safety during the process. 1.3.14 about observations now includes the following amended point: 'explain how they will be observed and how often (taking account of personal, gender and cultural preferences).' Another stakeholder commented that it would be helpful if the guideline advocated a more proactive approach to BME groups through initiatives such as tailored advocacy and tailored peer support. The Committee have added a question to the 'Peer support' research recommendation which asks if there is any particular benefit of peer support interventions to support transitions for black, Asian and minority ethnic communities**.**

4.2 If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
All changes to the recommendations were made with the intention of improving access to services for specific groups which were highlighted through the stakeholder responses.

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4.3 If the recommendations have changed after consultation, is there potential for the recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?
The Guideline Committee were careful when developing recommendations both before and after consultation to ensure they would not have an adverse impact on people with disabilities.

4.4 If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in questions 4.2, 4.3 and 4.4, or otherwise fulfil NICE's obligations to advance equality?
The Guideline Committee agreed a range of amendments to recommendations to address difficulties with access to services encountered during transition from inpatient mental health settings on account of stakeholder responses to the draft guideline. See 4.1 for more information.

4.5 Have the Committee's considerations of equality issues been described in the final guideline document, and, if so, where?
Where equalities issues were discussed, they are reported in the LETR tables under 'other considerations'.

Updated by Developer _____Sarah Lester

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Date____02/06/16_____

Approved by NICE quality assurance lead _____Jane Silvester_____

Date_____30/8/2016

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5.0 After Guidance Executive amendments – if applicable (To be completed by appropriate NICE staff member after Guidance Executive)

5.1 Outline amendments agreed by Guidance Executive below, if applicable:

Approved by Developer _____

Date_____

Approved by NICE quality assurance lead _____
Date_____