National Institute for Health and Care Excellence
Transition between inpatient mental health settings and community and care home settings
Scope Consultation Table

Date of consultation from 30th September – to 28th October 2014

Type	ID	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	001	The Meriden Family Programme	1	4.2.1	What are the particular needs when the transition is into the family home? This may the first time the person has been within their family home for some time.	Thank you for your comment. This is an important issue that will be addressed through this guideline.
SH	001	The Meriden Family Programme	2	4.3.1	What interventions are appropriate to enable family and carers to provide effective support to their loved one through the transition process?	Thank you for your comment. We agree that support for families and unpaid carers is vital for achieving successful transitions. We intend to specifically address this through the proposed review question 4.5.8.
SH	001	The Meriden Family Programme	3	4.3.1	What needs to be considered in order to ensure that the person's family, friends or social network are involved in the whole transition process where appropriate?	Thank you for your comment. Support for carers during transition will be addressed via review question 4.5.8.
SH	001	The Meriden Family Programme	4	General	How are the views of the family, carers or friends sought on the appropriateness of the accommodation, its location and general environment?	Thank you for your comment. The views of family, friends and unpaid carers will be addressed via review question 4.5.8.
SH	002	British Geriatrics Society	1	General	I think the attempt to combine children, younger people and adults into one scoping document is worthy but flawed. Although some	Thank you for your view on this. The scoping group has discussed the subject at length. Having considered all the consultation responses and reflected on the scope of other NICE guidelines (in

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					general principles will apply, I think that in practice the issues with children are likely to be very different from those with older people with dementia, for example. I think you may need to separate the guidelines.	development and forthcoming), the group is satisfied that this guideline is the most appropriate place to address children and young people's transition between inpatient mental health settings and the community. The guideline will therefore adopt a whole population approach. We do appreciate that the issues facing children and young people during transition may be different to those experienced by others such as people with dementia. We will therefore ensure that the Guideline Development Group (GDG) constituency reflects experience and expertise in children and young people's transitions between inpatient mental health settings and the community. We will also include a review question dedicated to children and young people in this context and for all review questions focussed on views and experiences, our search strategies will be will be oriented to seek out material on the views and experiences of children, young people and their carers.
SH	002	British Geriatrics Society	2	General	The document makes almost no mention of older people, though delayed discharges of older people from mental health units are common and expensive.	Thank you for highlighting this. The scope of the guideline includes the whole population, including older people and we have therefore endeavoured not to focus on any specific group. However you make an important point that will be passed on to the GDG. It is also worth noting that as a result of the scope consultation a specific review question has been

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						added to investigate transitions between inpatient mental health settings and the community for people living with dementia. When the review questions are being finalised, the GDG will consider the need for a further question about all older people experiencing these transitions.
SH	002	British Geriatrics Society	3	General	Alongside this, there is almost no mention of physical health issues. These are important for adults across the age range, and crucial in considering the safe transition of older people.	Thank you for raising this. We agree that people with mental health difficulties and comorbidities are an important consideration. As long as they are experiencing a transition between an inpatient mental health setting and the community, that population is within the scope of this guideline.
SH	002	British Geriatrics Society	4	3.1.2	Also worth mentioning that, especially for more specialised placements (e.g. learning disabilities), patients often end up being transferred to facilities far removed from where they belong with consequent adverse consequences for them and for their families trying to keep in touch.	Thank you for your comment. We agree that the issue of out of area placements is important, it is within the scope of this guideline.
SH	002	British Geriatrics Society	5	3.2	The section on Current Practice is almost exclusively about discharges, though this is contrary to bullet point 2 in section 2. I'd like to see mention of the evidence from initiatives such as crisis teams, admission avoidance, intermediate care, social respite	Thank you for your comment. We assume that you are referring to bullet 1 in section 2 ('admission to inpatient mental health settings from community or care home settings') rather than bullet 2. In that case, we would confirm that admission avoidance is outside the scope of the guideline. However, we expect that evidence on intermediate care and crisis teams will be included for their contribution to

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					care, etc.	facilitating discharge from inpatient mental settings and reducing readmissions.
SH	002	British Geriatrics Society	6	3.2.1	This lists some groups of people for whom transitions may be difficult. I think that physical comorbidity is also important here.	Thank you for highlighting this. People with physical comorbidities who experience a transition between inpatient mental health settings and the community are within scope. We have not added them to section 3.2.1 because this is intended to provide examples and not be exhaustive.
SH	002	British Geriatrics Society	7	3.3.1	This refers to policy for children and to the NSF for Mental Health. The latter specifically excludes people over the age of 65, so there is no mention of any policy that refers to the care of older people or people with dementia (NSF for Older People, National Dementia Strategy etc).	Thank you for highlighting this. We have added the National Dementia Strategy since it was published more recently than the NSF for Older People.
SH	002	British Geriatrics Society	8	4.3.1 (e)	Should also mention attention to physical health needs. Let's not forget the increased mortality of people with schizophrenia not just frail older people here.	Thank you for your comment. People moving between inpatient mental health settings and the community who also have physical needs are included within the scope of this guideline. A separate NICE guideline on transitions between (general) inpatient hospital settings and community or care home settings is currently in development. Ultimately the two guidelines will contribute to a NICE pathway that addresses transitions for people with mental and physical health needs.
SH	002	British Geriatrics Society	9	4.3.2 (b)	It seems unfortunate to exclude admission avoidance, as isn't it part of the solution? Services like	Thank you for your comment. You are right that admission avoidance is excluded from the scope of this guideline, which focuses on transitions that

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					dementia outreach and intermediate care teams need to connect both before and after admissions to MH units.	occur (rather than those that are avoided). However we agree that the experience and quality of the admission process is intrinsically linked with the success of transition from the inpatient setting. This aspect is included in scope. In relation to dementia outreach services and intermediate care teams, we anticipate that they will be included in the evidence review for their contribution to facilitating discharge from inpatient mental settings and reducing readmissions.
SH	002	British Geriatrics Society	10	4.4	Among the main outcomes suggested is years of life saved. Unless this is used very carefully, it is frankly discriminatory against older people.	Thank you for your comment. 'Life years gained' is only one among a range of outcomes that NICE uses to evaluate whether an intervention provides 'value for money'. However where an intervention only measures life years saved, NICE does not have a prescribed threshold in social care to determine at which point the intervention is/is not 'worth it'. Therefore the economists' appraisal of the evidence will be constrained to a descriptive statement about the relative benefits and costs, but not a conclusion about value for money. Therefore, stakeholders should not be worried about ageist recommendations.
SH	002	British Geriatrics Society	11	4.5	The review questions should also include: 'What research is required?' I also think that, bearing in mind the PM's Dementia Challenge, there should be a specific question about outcomes	Thank you for these suggestions. Although we will not have a review question asking whether more research is required, this is a question that the GDG will constantly return to throughout the development of the guideline. The guideline itself will contain 'research recommendations' with

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					for people with dementia.	suggestions for further work on the basis of the evidence reviewed. We have added a dementia specific review question to the scope and the GDG will be tasked with agreeing whether this is included in the final set of questions.
SH	002	British Geriatrics Society	12	4.5	Throughout the document, there is not much reflection of the diverse and multicultural nature of society. There is an opportunity here to add a question about how successfully equality works in the case of transitions, or whether any minority groups are particularly ill- (or well-) served.	Thank you for raising this. The reason we do not have a specific review question about minority groups, is that our search strategies will be oriented to seek out material on these and other groups across all review questions. Our approach to addressing equalities issues is set out in our draft Equality Impact Assessment (published with the draft scope). As well as searching for evidence on populations identified in the EIA, the GDG will be asked to consider the impact of recommendations on those groups.
SH	003	Association of Directors of Adult Social Services (ADASS)	1	General	Whilst we welcome the scope to include children, young people and adults to provide a holistic, joined up approach, the standards must consider the financial impacts that the introduction of any new standards may have. This should include the implications for additional staff training and development, as well as changes to systems and processes.	Thank you for your comment. Although funding is a concern, it is not an issue on which NICE social care guidelines make recommendations. However, the Guideline Development Group (GDG) does develop recommendations on the basis of cost-effectiveness evidence.

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					Further, the scoping paper notes that poor transitions are often related to "...a lack of funding for ongoing support and awaiting assessment for support, care home placement and further NHS funding". The issue of adequate funding cannot be overlooked within the scope of this standards.	
SH	004	National Confidential Inquiry into Suicide and homicide by people with Mental Illness	1	GENERAL	We welcome the development of NICE guidance in this area. Clinical transitions, particularly following discharge from in-patient care have been a core part of the remit of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Inquiry) since we started in 1997 and were pleased that our data were quoted in the scoping document. We would be very happy to share other relevant data with the GDG. Suicide deaths following psychiatric in-patient discharge continue to be a major issue. In our most recent Annual Report (July 2014) our data show that there are on average 1,248 patient deaths by suicide in	Thank you for your support for this guideline. Thanks also for the additional data. We have not added it to the figures already in the scope but your annual report will be a key source document for the development of the guideline.

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					England per year, 90% of which occur in community care settings. Approximately 20% of community based deaths occur within 3 months of discharge from hospital - in other words there are currently 221 post-discharge deaths per year in England. In regard to the activities set out in the scoping document that the guidance must cover, the Inquiry's findings support the view that the new guidance should - Encourage a multi-agency approach to care planning prior to discharge to address and try to mitigate factors that the patient may be returning to at home that could impact adversely on their continued recovery, e.g., debt, housing, employment issues - Strengthen existing policy on follow up within 7 days of discharge from in-patient care (our data show that the first week following	Thank you for highlighting these areas of practice that influence transitions between inpatient mental health settings and the community. We anticipate that research relevant to the issues you have raised will be identified via the review questions on the effectiveness of interventions to improve transition from inpatient settings, views about the admission process and the effectiveness of different approaches to reducing re-admissions.

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					discharge continues to be the period of highest risk for suicide; 16% of all suicide within 3 months). Early follow-up is key and within 7-days of discharge should be reinforced in the final guidance. Recognise the role that crisis resolution/ home treatment (CRHT) teams may play in reducing the time patients spend in hospital but highlight for discharge planners that it may not be an appropriate service for patients who have little/ no home support and who may be returning home to face adverse circumstances as mentioned above (our data show that as in-patient suicides have fallen over the last 10 years, suicide by patients under CR/HT have increased and there are now currently twice as many suicides in the CR/HT setting)	
SH	005	DMBC	1	General	As a general comment/observation I would urge greater emphasis be paid to robust aftercare planning which should ideally start at an early stage in the inpatient admission. The need for Social Worker input into the MDT	Thank you for your comment. We recognise that planning for discharge from inpatient settings should ideally begin during the admission process and should include all relevant professionals, the individual and their families. This will be investigated via the review question about care planning and assessment during admission and

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					discussion around discharge/transitional planning is from my experience of working within the local Mental Health Trust (RDASH) something which is not given due attention or resource. I would recommend that all Mental Health Trusts provide inpatient Social Work as a matter of priority and advise that discussion around transition into on-going services and the meeting of social needs including accommodation is not something which can be hurriedly pulled together at the point of discharge or pressured by the need to create bed space.	through questions on service user, carer and professional views on admission and discharge.
SH	005	DMBC	2	4.1.2	"People moving between prison or young offenders' institution and a community or care home setting." More thought needs to be given to this area so that people leaving prisons and requiring residential or community mental health care are covered by this guidance – I appreciate that it is focussed on transition from inpatient to residential or community care but we should not be ignoring the needs of prisoners – how does this	Thank you for raising this, we understand your point, especially in the context of the Care Act. However, NICE is currently developing a separate guideline about the mental health of prisoners in which transition between prison and the community is within the draft scope and which we anticipate will not change when published. To avoid duplication and possible overlap between the two guidelines, the area is excluded from this guideline. If you would like to look at the scope for the 'mental health of prisoners' guideline, please follow this link to the NICE website http://www.nice.org.uk/guidance/indevelopment/gid-

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					marry up with new statutory duties to prisoners outlined in the Care Act?	cgwave0726
SH	006	Association for Real Change (ARC)	1	3.1.1.	Great difficulty in identifying care manager for patient – originally social care but developed mental health problem, discharge delayed and then rushed and inadequate resulting in setback.	Thank you for your comment. Research relevant to delayed discharge from and readmission to inpatient mental health settings will be extensively reviewed during the development of this guideline.
SH	006	Association for Real Change (ARC)	2	3.1.2.	Problem arises when patient transferring back from mental health inpatients to care home placement after a stay of over four weeks. No longer responsibility of local authority funding but not taken up by health authority. Result possible forfeit of place due to independent home not wishing to fill funding gap of five weeks. Place then reallocated. Penalise original patient. This was enhanced by a total lack of any communication between authorities.	Thank you for highlighting this. Research relevant to these issues will be reviewed during the development of this guideline.
SH	006	Association for Real Change (ARC)	3	3.1.5	Difficult to coordinate when admission sudden – therefore general protocol should be in place for any possible admission.	Thank you for your comment. Improving admission to inpatient mental health settings from the community and from residential homes is a specific focus of this guideline.

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SH	006	Association for Real Change (ARC)	4	3.2.3	Definite problem of communication between sectors. Mental health seen as a separate area. A combined service is so essential for patients with mental health problems where consistency and continuity are so important to avoid confusion. Lack of therapeutic opportunities. More OT input needed	We agree that continuity of care and communication between services are important factors in improving transition between inpatient mental health settings and the community. Research on these issues will be reviewed for the development of the guideline and this is set out under 'key areas and issues' in the scope. We will review evidence about the way coordination of care and joint working contributes to improving transitions. This includes joint working between mental health, social care and primary care and where appropriate, housing and education.
SH	006	Association for Real Change (ARC)	5	4.3.e	Not too much emphasis on community input where professional skills and support are required. Volunteers are very useful when patients are more independent.	Thank you for your comment.
SH	006	Association for Real Change (ARC)	6	4.5	As a carer for someone with mental health problems I have to say that it was impossible to understand how to access support and to feel as though you had a right to be involved, especially as you were coping 24 x 7. Mental health facilities in the area very poor. Help in the closed unit in London excellent. Gave me confidence to cope.	Thank you for sharing your experience. The views of people who have made a transition between inpatient mental health services and their carers will make an important contribution to developing recommendations.
SH	006	Association for	7	4.5.2	The practitioners I worked	Thank you. As you can see, we plan a specific

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		Real Change (ARC)			alongside were very frustrated themselves with the lack of coordination and communication between services. Because of this it took longer than it should have.	review question to examine evidence on the views of health, social care and housing professionals.
SH	006	Association for Real Change (ARC)	8	4.5.6.	Frustrating to try and get an adequate support plan in place to avoid readmission. Apparent lack of understanding about the significance of appropriate ongoing support	Thank you for your comment. We will be reviewing evidence on reducing readmissions via a specific review question on effective interventions and also via questions about the views of people, their carers and professionals.
SH	006	Association for Real Change (ARC)	9	4.5.9	Very important to involve care managers from social care, mental health and care home carers and patient in meeting to identify what patient sees as the way forward so that the plan can be proactive and not reactive. Independent care home needs input from mental health – an area that they are not always equipped to manage.	Thank you for your comment. We anticipate that the research that is reviewed for our proposed question on learning and development will cover these issues.
SH	007	South West Yorkshire Partnership NHS Foundation Trust	1	3.2.1	The use of reasonable adjustments may be required.	Thank you for your comment.
SH	008	NHS England	1	General	Thank you for the opportunity to comment on the above guideline. I	Thank you, we note that you have no substantive comments to make about the draft scope.

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					wish to confirm that NHS England has no substantive comments to make regarding this consultation.	
SH	009	Department of Health, Mental Health & Disability Division	1	General	The scope of the guidance should cover the specific arrangements that are required for the transition of 'restricted' patients from hospital into the community to ensure that they are managed effectively and that the NHS and other agencies involved in their care and management observe reporting requirements through the multi-agency public protection arrangements (MAPPA) framework. Including this aspect within the guidelines will further support the requirements mentioned in the scope for better collaboration between services and better outcomes for 'restricted' patients by supporting them to reintegrate into society and helping to avoid reoffending and/or recall to a secure hospital. <u>Background</u> A 'restricted' patient is one who has been made subject to a restriction order by either the Court or the	Thank you for raising this. As you know, transitions between prison and the community for people with mental health difficulties are excluded. The reason is that these transitions are anticipated to be covered by a separate NICE guideline on the mental health of people in prison and are currently included in the draft scope. Transitions between secure psychiatric hospitals and the community are included within the scope of this guideline. As you have highlighted, this should include the small proportion of people who are transferred from high security hospitals to the community. In light of this we have removed 'high security settings' from 4.2.2 'Settings that will not be covered'

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					Secretary of State on the basis that they pose a serious risk of harm to the public. 'Restricted' patients are subject to management by the Justice Secretary.	
SH	010	Royal College of General Practitioners	1	General	I would recommend the involvement of Mental Health Charities particularly Barnardo' South West. Their Helping Young People Engage (HYPE) project recognised the importance of transitions in chapter 4 of their Consultation to explore young people's and parents views and experiences of the eating disorder care pathways in South Gloucestershire and Bristol 2012. Their main areas of focus are: 4.1 Recognition of the impact of transitions on young people and their families 4.2 Timely referral and transition processes at all stages of care pathway 4.3 Preparing families for a transition to anew service 4.4 Consistent support for families throughout the care pathway 4.5 Effective joint working between services	Thank you for your suggestion to involve Barnardo's South West. The deadline for applications to the Guideline Development Group (GDG) has now passed. However, there may be an opportunity for the GDG to invite expert witnesses to provide evidence from projects such as the one you describe. In the meantime, Barnardo's should be encouraged to register as a stakeholder for the development phase of this guideline. Registered stakeholders receive updates about the progress of the guideline and have the opportunity to comment on a draft version prior to publication. Registration can be completed by clicking on 'register as a stakeholder' on the left hand side of the guideline webpage http://www.nice.org.uk/guidance/indevelopment/gid-scwave0711

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					4.6 Support exit/ discharge processes Many parents and young people talked about the fear associated with leaving the supported environment of an inpatient unit and the need for gradual discharges/exits. Families were helped by the reassurance that they could contact the services again after they had left. Young people were less confident about contacting services once they were discharged and often did not think the services were available.	
SH	010	Royal College of General Practitioners	2	4.3.1. g	This refers to support but this should be widened to support and involve carers. The involvement of carers is vital. The triangle of care model used by some inpatient services helps staff to have confidence with involving families and carers in the person's treatment whilst still respecting the person's confidentiality.	Thank you for raising this. We agree that it is important to involve families and unpaid carers during transition between inpatient mental health services and the community. We expect to find research evidence about this via our review questions on the admission process, on improving discharge and on the views of people using services and their carers. To make this more explicit, we have added 'involvement of carers' to 4.3.1 (g), which now reads, "Support for and involvement of carers."
SH	011	The Royal college of Nursing	1	General	This is just to let you know that the feedback I have received from nurses caring for people with	Thank you, we note that you have no substantive comments to make about the draft scope.

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					Transition between inpatient mental health settings and community and care home settings suggests that there are no additional comments to submit in relation to the Stakeholders' comments response table for the above guidelines.	
SH	012	Nottinghamshire NHS trust	1	3.3	Given that at 4.2.1 it is stated that specialist units for people with mental health problems and learning disabilities will be included, the policy and guidance section (3.3) should reference the post-Winterbourne documents e.g. Transforming Care, Positive and Proactive etc.	Thank you for your suggestions. The section on policy and legislation only cites examples and is not intended to be comprehensive. We have not added the documents to which you refer but be assured that all relevant policy and legislation will be included as source documents for the development of the guideline.
SH	013	Royal College of Psychiatrists	1	1	We suggest this guideline includes reference to transition to foster care, as most children and young people will move to foster care rather than a residential setting if they cannot stay with their parents.	Thank you for your suggestion. The inclusion of foster care was implied in the draft scope but we have made this more explicit in the final version, adding 'foster care' to the list of community settings.
SH	013	Royal College of Psychiatrists	2	3.1.2	Delay in discharge for children may also be due to lack of educational provision, time frames for planning educational provision for children with SEN is often longer than the need for inpatient mental health provision.	Thank you for highlighting these issues, which are clearly central to ensuring successful transitions for children moving between inpatient mental health settings and the community. We expect that we will locate and review research evidence on care coordination, communication and out of area placements and to ensure this, have added 'joint

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					In the case of CAMHS inpatient units, delays in discharge may be due to lack of co-ordinated planning between the inpatient and community clinicians, who may be geographically remote from the inpatient unit. This can be particularly relevant for a young person placed in a Psychiatric Intensive Care Unit (PICU) or secure psychiatric bed. Being admitted to a bed a long distance from home will make visits by family and carers more problematic and it will be difficult to arrange periods of home leave, thereby prolonging admission.	working with education' to the key areas of the scope.
SH	013	Royal College of Psychiatrists	3	3.2.2	Institutionalisation is also a significant risk for patients who are unable to move from a mental health setting. The impact of delayed discharge on children and adolescents is of even greater significance where delayed discharge has an effect on attachment relationships, peer relationships and future re-integration into their community. This may in turn, adversely affect prognosis. For providers, bed blocking results	Thank you for highlighting the negative impact of delayed transfers of care for children and adolescents. We expect to locate and review evidence on these issues as part of the guideline development process.

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					in reduced availability of mental health beds	
SH	013	Royal College of Psychiatrists	4	3.2.3	Interagency work needs to include education for children and adolescents. Separation of funding for aftercare support between Health Care and Social Care can be a further factor. Ongoing support needs can be difficult to separate into health and social care needs. There should be a separate process for assessment and application of funding. This does vary from area to area, with some services still having integrated health and social care funding.	Thank you for your comment, we agree that interagency work is crucial to achieving smooth transitions and that in the context of services for children and adolescents, education is an important element. As well as adding 'joint working with education' to the key areas of the scope, we have altered our review question on practitioner views to include the views of all relevant professionals. This would potentially provide data from housing and education as well as health and social care. In relation to your point about funding, although it is a concern, it is not an issue routinely covered by NICE social care guidelines.
SH	013	Royal College of Psychiatrists	5	3.2.4	This is very adult orientated again include educational provision for children and adolescent please.	Thank you for highlighting this. We recognise the importance of ensuring the ongoing provision of education during transition between inpatient mental health settings and the community. We have altered the scope to make more explicit reference to interagency working between health, social care and education. However we have not added anything to the paragraph on guidance because this is intended to provide a general overview, rather than citing particular professional groups.
SH	013	Royal College	6	3.3.1	Which agency has lead	Thank you for your comment.

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		of Psychiatrists			responsibility for the CPA approach will depend on the child/adolescent and which agency is best placed to do this. As NICE applies to England and Wales, please include reference to the Welsh equivalent of CPA. This is the Mental Health (Wales) Measure. This legislation introduced in 2010 applies across the age range. Under the Measure, every adult and child/young person in secondary mental health care has a Care & Treatment Plan (CTP) and designated Care Co-ordinator. A child or young person admitted to an inpatient psychiatric unit should have an allocated designated specialist CAMHS worker to visit, liaise and maintain a therapeutic relationship. This facilitates timely discharge back to the community. Every Welsh child or adult admitted to a psychiatric inpatient bed and requiring on going specialist mental health intervention is expected by law (the Measure) to have a	Thank you for your comment. NICE social care guidance is developed for England only, which explains why there are no references to Welsh legislation or practice issues in the draft scope. However, the recommendations in the final guideline may be applicable to other practice settings, including Wales and the other devolved governments of the UK. Since children and young people are included within scope, it is likely we will locate evidence on this issue.

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					designated care co-ordinator and this clinician or social care worker is expected to visit regularly and attend CPA/CTP meetings. Reference should be made to the Wales Mental Health Strategy, Together for Mental Health, which sets out the requirement for Intensive Outreach /CRHT as an alternative to psychiatric admission, and to reduce length of stay through step down. This policy applies across the age range, including for young people. Specialist adult mental health teams - assertive outreach, early intervention etc are being withdrawn or integrated into community teams, and although these functions should be maintained within integrated teams, There is also a small group of service users, often those with high levels of dependency and vulnerability, who do not always meet the criteria for assertive outreach, or forensic teams, both of watch have smaller case loads and therefore able to provide more	Thank you for your comment. These are all incredibly important issues for improving transitions into and out of inpatient mental health settings and reducing readmissions. We anticipate that we will locate research about the issues you raise via the review questions on effectiveness and those on the views of people moving between settings, their carers and also professionals from health, social care and housing.

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					intensive community support than can be provided by a generic community mental health team. These service users have often spent long periods of time in hospital and therefore the transition is a particularly vulnerable time for them. Community rehabilitation teams (as described in the Joint Commissioning Panel for Mental Health Guidance for commissioners of rehabilitation services for people with complex needs) can provide support for service users making this transition. Such teams also have expertise and experience in working with multiple agencies.	
SH	013	Royal College of Psychiatrists	7	3.2.3	Should there be reference to the Children Act & Safeguarding legislation? Some young people admitted to inpatient settings are subsequently transferred to A secure welfare bed under S.25 of the Children Act. Also, please include relevant Health and Social Care legislation for Wales.	Thank you for highlighting this. We have added the Children Act and to section 3.3.2 of the scope. With regard to Welsh legislation, NICE social care guidance is developed for England only, which explains why there are no references to Welsh legislation or practice issues in the draft scope. However, the recommendations in the final guideline may be applicable to other practice settings, including Wales and the other devolved governments of the UK.
SH	013	Royal College of Psychiatrists	8	4.2.1	Foster care settings should be included here. Care homes should include Residential Children's	Thank you for your comment. Foster care has been added under the list of community settings in 4.2.1. Children's homes have been added to the

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					Homes, including Secure Children's Homes.	examples of care home settings. We have added 'secure units for children and adolescents' to the list of inpatient mental health settings.
SH	013	Royal College of Psychiatrists	9	4.3.1 e	I would expect educational planning to be part of this and communication of risk to be detailed.	We agree that care planning for children and young people during transition should address the provision of ongoing education. This is included in the scope of the guideline but has not been added to the list of examples in 4.3.1 (e) because the list is not intended to be exhaustive.
SH	013	Royal College of Psychiatrists	10	4.4	Please include educational attainment/or access to educational provision as a quality of life measure for children and adolescents.	Thank you for your suggestion. The outcomes listed in the scope are deliberately general and only intended as examples. Educational attainment and access to education will be included as intermediate outcomes because they are proxy indicators of individual outcome.
SH	013	Royal College of Psychiatrists	11	4.5.2	Can you include local authority also in this section, relation to educational planning?	Thank you for your suggestion. We acknowledge the importance of the views and experiences of a range of practitioners in this context and we have altered question 4.5.2 to reflect this.
SH	013	Royal College of Psychiatrists	12	General	It could be argued that the separation between health and social care, particularly for mental health service users, is an artificial division and funding for community support should be from a single budget. This is mentioned in the notes of the stakeholder meeting.	Thank you for highlighting this. We recognise that the organisation of funding can be problematic but commissioning and funding are not routinely covered by NICE social care guidelines.
SH	014	OCD Action	1	General	We welcome the development of this guidance as people with OCD face many challenges moving	Thank you for your support for the scope and for highlighting these issues. Arranging appropriate support for people transitioning between settings

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					between the community and specialist in-patient services including reluctance by local CCGs to fund specialist treatment out of area, an unwillingness or inability for CMHTs to remain responsible for the individual and support them after discharge in ways recommended by the specialist service.	will be covered by the guideline but it is worth noting that NICE social guidance does not cover commissioning and funding.
SH	014	OCD Action	2	3.3.1	As people with a diagnosis of OCD rarely present a risk they are generally not supported through the Care Programme Approach which often leads to CMHTs discharging them rather than stepping their care up in line with NICE guidance.	Thank you for highlighting this.
SH	014	OCD Action	3	4.1.1	We welcome the fact that the scope of this guidance will cover children and young people and adults as OCD can have a hugely detrimental effect on people's lives at any age. We are concerned however that there is currently no specialist inpatient service for children and young people with OCD.	Thank you for your comment, we recognise that people of all ages, experience poor transitions including a lack of appropriate services.
SH	015	Monitor	1	General	**Importance of coordinated services for users of mental health services.** We are pleased to see the references made to the	Thank you for your comment. We recognise that the coordination of care is crucial and it will be covered by this guideline in so far as it contributes to improving transitions between inpatient mental

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					importance of coordinated services for patients with mental health conditions. We consider that this patient group is likely to directly benefit from organisations and care professionals delivering more integrated care. Coordination of care is critical both within the NHS (from primary and community to hospital care at both ends of the care pathway and between services addressing physical to mental health) as well as between health and social care settings. A holistic and coordinated, rather than a health or hospital-centric approach is clearly essential to reduce anxiety and negative patient experience due to poor transitions between care settings and professionals for this cohort of patients.	health settings and the community.
SH	015	Monitor	2	General; 4.3	**Definition of 'transition'.** It may be helpful to define and clarify how a 'transition' should be defined in terms of when it starts and ends and who should be involved from both health and social care perspectives. For example, "when a person's care needs materially	Thank you for this suggestion. Transition is a key issue across a range of NICE guidelines and is defined differently according to the scope of each one. For this guideline, a transition is represented by a physical move *between* an inpatient mental health setting and a community or care home setting. It is described in section 2 of the scope as: - Admission to inpatient mental health

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					change such that the mix of services required must be re-planned".	settings from community or care home settings and - Discharge from inpatient mental health settings to community or care home settings. We do not use a time limit in our working definition although it is accepted that good discharge planning begins at the point of admission to the inpatient setting. If there is evidence to support the inclusion of specific timescales for admission and discharge planning this will be located via the proposed review questions.
SH	015		3	3.1.1; 4.3; 4.5.3	**Importance of care planning.** We agree that care planning is essential, as ineffective transitions can be felt most acutely when the transfer of care is badly planned and lacks continuity and support. The Care Programme Approach (CPA) is therefore crucial during the transition phases. Care planning should be coordinated across settings to ensure a system level approach and cover all aspects, including joint working, communications and	Thank you for highlighting these issues, which will all be covered by our proposed review questions.

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					information sharing. Such an approach can help to ensure that patients do not leave hospital too early and then unnecessarily readmitted as an emergency. In order to provide the most appropriate care for patients when they leave hospital to help avoid emergency readmissions within 30 days, planning may include coordinating with the patient's family and GP regarding medication or arranging post-discharge equipment or care by a community or social care provider.	
SH	015	Monitor	4	3.1.1; 4.3.2	**Care planning for patients' whole care needs.** We do not agree with care and support planning not specifically designed to support timely transition between inpatient mental health settings and community or care home settings being out of scope for this Guideline. This could reinforce a lack of coordination if the transition care plan does not a least take into account a patient's broader care plan. One way to achieve this might be to explore the extent to which the transition care plans may need	Thank you for your comment. The focus of this guideline is on transitions that occur rather than on those that are avoided. The prevention of admission to inpatient mental health settings is a far broader issue that is beyond the scope of this guideline.

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					to link to patient's broader care plans so that there is good "transition away from transition" and back to a patient's broader needs.	
SH	015	Monitor	5	4.3.1	**Information-sharing as an enabler.** Information sharing is a key enabler for person-centred, coordinated care, whether in the care planning process or across the patient's whole experience of care delivery. Ensuring that the right information, particularly clinical information, is collected and effectively disseminated to the right organisations at the right time can play a critical role in ensuring that care is delivered in an integrated way, but is often regarded as a barrier to more integrated care. You may wish to consider in the scope of the Guideline whether the right (and high quality) information is available to support decision-making by providers when planning, procuring and organising care and support. This may include critically sharing clinical information for direct patient care, such as measurements of Haemoglobin	Thank you for raising this issue. We recognise the importance of information sharing and we are sure that research on the subject will be located via our proposed review questions.

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					A1c and blood pressure for mental health patients with diabetes as a co-morbidity.	
SH	015	Monitor	6	3.2.1	**Information-sharing out of area.** Out of Area Treatments (OATs) arise if mental health trusts refer patients to other providers, including those in the private and/or non-statutory sector when essential treatment cannot be supplied locally. Care planning can be poor if information about the client is not shared between the host referring agency and the new provider.	Thank you for your comment. The issue of out of area placements is within scope and will be addressed via our proposed review questions.
SH	015	Monitor	7	3.2.3	**Recognising wider reasons for delayed transfers.** There is evidence that delayed transfers from mental health services is a common problem, with approximately 7% of psychiatric beds for adults and 16% for older adults being lost to delay (NHS Benchmarking, Mental Health Benchmarking Toolkit, 2013). The Guideline scope references a number of reasons cited for delayed discharges (now more commonly referred to as 'delayed transfers of care'). It is worth noting that a number of reasons for such	Thank you for providing this information. We acknowledge that there are a range of interrelated causes of delayed transfers of care from inpatient mental health settings. The ones cited in the scope were the results of two studies, so the reasons given are limited to the study findings. However, the additional information you have provided adds important context and the factors you outline are likely to be covered by our review of the evidence.

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					delays also include those within the control of the inpatient setting and not just due to factors attributable to the community or home setting. These include, for example, interrelated factors such as awaiting completion of assessment, awaiting further non-acute NHS care or limited awareness among clinicians of appropriate community services such as supported accommodation. Additionally, the lack of community facilities available is currently a real challenge for the sector, exacerbating the problem of poor transitions and may be outside the control of the community care providers.	
SH	015	Monitor	8	2; 3.1.2; 3.2.3	**Impact of delayed transfers and inappropriate discharges.** While clearly a reduction in delayed transfers of care is beneficial, this should not be considered successful where patients are consequently readmitted within a short period of time because the discharge was poorly considered or rushed. Considering the effectiveness of hospital transfers	Thank you for pointing this out. The focus of the guideline is on successful transitions, which as you say, does not always mean 'quick transitions'. If a transfer of care from an inpatient mental health setting is made too quickly and without adequate planning and support, this can result in readmission. For this reason we propose a specific research question on reducing readmissions. In relation to carer support, we propose a specific review question to seek evidence on how carers

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					by also understanding, e.g. the volume and causes of failed discharges or readmissions, may therefore be helpful. Reducing delayed transfers of care requires that community, primary, acute and social care bodies work together, as well as recognising the roles played by the voluntary sector and carers. This is particularly so as the majority of adults with mental health problems are more likely to attend general practice than be referred to specialist mental health services or even be admitted to mental health inpatient settings. You may also wish to consider the importance of providing carer support and education in helping to reduce delayed transfers and readmissions post failed discharge.	should be supported during transition between inpatient mental health settings and the community. In addition, where our review questions seek evidence on the effectiveness of interventions and approaches (to improve transitions or reduce readmissions), our strategies will be oriented to seek out material on support for carers.
SH	015	Monitor	9	3.3.1; 4.5.4; 4.5.5	**Effectiveness of early intervention.** Evidence suggests that increasing investment in promotion, prevention and treatment of mental health disorders could improve patient outcomes, and produce net savings to the health sector and to the	Thank you for providing this example, which we will pass on to our economist. It is worth remembering that prevention in its broadest sense is outside the scope of this guideline. Training would be within scope if it is designed to help professionals improve transitions between inpatient mental health settings and the community.

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					welfare system. An example includes GP training in suicide prevention or early detection in psychosis. You may wish to review the *No Health without Mental Health* Supporting Document (DH, 2011) which sets out the economic case for improving efficiency and quality in mental health.	Thanks also for the suggested to add *No Help without Mental Health*. We have added this to the scope, along with the supporting document.
SH	015	Monitor	10	General; 4.3.1; 4.4; 4.6	**Including the patient perspective**. Ensuring that patients (and their carers) are fully empowered in, and included in all aspects of, their own care are important aspects of improving the coordination of care. The National Voices 'I' statements purposefully set out the experience of integrated care from the individual's own perspective and usefully cover areas such as care transitions. Including patients and carers within scope, including the recommendations, will help ensure that patient experience is reflected in the outcome measures and helping to ensure that, e.g. readmissions or unnecessary admissions and GP visits are	Thank you for your comment. We recognise the critical importance of involving patients, carers and families in order to ensure effective transitions - this is reflected in the scope's key areas, outcomes and review questions. It is worth noting that the outcomes we assess and report on during the evidence review will depend on what has been used in the existing research. Of course, we will prioritise outcome measures defined from the perspective of people using services and their carers and studies that have genuinely involved service users.

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					reduced. These 'I' statements have been created with reference to person-centred, coordinated care in general (A common definition for person-centred, co-ordinated care, 2013), and for those with mental health conditions in particular (No Assumptions – A Narrative for Personalised, Coordinated Care and Support in Mental Health, 2014), and may be useful references for the development of this Guideline. Additionally, as part of the personalisation agenda, NHS England plans to develop personal health budgets for users of mental health services from 2015.	
SH	015	Monitor	11	General; 2; 4.6	**Commissioning and funding as enablers.** We recognise that NICE guidelines do not cover how services are commissioned or funded. However, you may wish to consider that jointly or collaborative commissioned mental health services by NHS and local authorities can help enable better care transitions. Integrated care should not be	Thank you for your comment. Although the issue of funding is not covered by NICE social care guidance, we do recognise the importance of coordinated service design and delivery and expect to locate evidence about these factors during the review process.

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					viewed in the context of providers in isolation. The role of (NHS and/or local authority) commissioners, working with local providers, is a vital part of developing and funding better and more integrated patterns of care. Indeed, work on the 'House of Care' sets out an excellent model for coordinated service delivery across the whole system, where responsive commissioning is essential and underpins the involvement of patients and care professionals, care planning and organisational systems and processes. In addition, Monitor is working with NHS England to develop mental health currencies based on outcomes, e.g. for IAPT. Such work may better promote coordinated working across mental health pathways.	
	015	Monitor	12	4.2.2; 4.3.1; 4.5.4	**Suggestion to include mental health patients in acute settings in scope.** While we recognise that the Guideline scope does not cover general inpatient hospital settings, it is important to recognise the	Thank you. It is worth noting that a NICE guideline on transition between general hospital settings and the community is also in development. We will ensure there are good links between the two guidelines and avoid any overlap or contradictions. We do recognise that transitions involving general

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					interrelation between, and complementary nature of, patients' physical and mental health care needs and therefore also the transitions for patients between these settings. People with dementia often have physical co-morbidities (particularly cardiovascular) and, in particular, early onset dementia is poorly diagnosed, which can lead to confusion and can extend lengths of stay for those suffering falls or infections, requiring much more support on discharge. Additionally, liaison psychiatry and dementia consultants in A&E departments play a crucial role in both preventing admissions (through A&E case finding) and facilitating discharges. There is good evidence of cost effectiveness for this service, such as the specialist multi-disciplinary Rapid, Assessment, Interface and Discharge (RAID) model. Of particular importance are those with long-term physical problems that may not have their mental health needs identified and	hospital and those involving inpatient mental health settings are interrelated but opted for two separate guidelines in the interest of adequately covering both areas. In relation to physical co-morbidities, as long as they are experiencing a transition between an inpatient mental health setting and the community, that population is within the scope of this guideline. We have not added 'physical co-morbidities' to section 3.2.1 because this is intended to provide examples and not be exhaustive. Thank you for highlighting evidence on the cost effectiveness of the RAID model, which we will pass to our economist.

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					effectively managed and vice versa. You may wish to consider NHS England's recently introduced policy for mental health staff to provide physical 'MOTs' to mental health patients to help reduce avoidable deaths, and *Lethal Discrimination* (Rethink, September 2013).	
SH	015	Monitor	13	3.3.1	**Additional mental health policy documents you may wish to reference**: - *No health without mental health* (DH, 2011) sets out the long-term ambitions for the transformation of mental health care to improve outcomes for people of all ages. It also references the key policy commitment to achieving parity of esteem between mental and physical health services, that is also reflected in other documents such as the NHS Mandate and, for example, Better Care Fund guidance. - *Closing the gap: Priorities for essential change in mental health* (DH, 2014) is a strategy aimed to improve access to	Thank you for your suggestions. The policy section only cites examples and is not intended to be comprehensive. However we have added *No Help without Mental Health* and the supporting document. We have not added the other documents to which you refer but be assured that all relevant policy and legislation will be included as source documents for the development of the guideline.

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					mental health services and reducing gaps in provision, including through improved transitions. - *Achieving Better Access to Mental Health Services by 2020* (DH, 2014). - *Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis* (DH, 2014).	
SH	015	Monitor	14	2; 5	**Complementary guidelines.** We think that this Guideline will also complement the NICE guidelines on: coordinated transition between health and social care scope; and multi-morbidity.	Thank you. We will ensure the related guidelines complement each other. Transition is a key issue across a range of NICE guidelines and the recommendations from each of them will eventually be drawn together to contribute to a NICE Pathway on transition.
SH	016	College of Occupational Therapists	1	4.3.1	Should the role of commissioning pathways be included here? For example if there is no inpatient CAMHS commissioned locally nor Mother and Baby Unit beds this has a huge resource implication for well planned transitions as it can involve clinicians travelling long distances	Thank you for your comment. Commissioning pathways are outside the scope of this guideline. However, we expect to locate evidence about appropriate service provision and out of area placements through the review of evidence.
SH	017	Durham County Council	1	General	Consideration of transition issues heading both ways, as suggested, is essential.	Thank you, we agree with you about the importance of improving transitions into and out of inpatient mental health settings.

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SH	017	Durham County Council	2	General	Such guidance is really crucial as current practice is very inconsistent.	Thank you for your support for this guideline.
SH	017	Durham County Council	3	General	All work on the guidance will need to consider the work done by all local authority/health areas as part of the MH Crisis Care Concordat initiative, to make sure that emerging best practice is incorporated.	Thank you for highlighting this. We recognise that the Mental Health Crisis Care Concordat initiative is an important aspect of the practice context for this guideline. We are confident that Guideline Development Group (GDG) members will contribute knowledge about the impact the Concordat is having on practice relating to transition between inpatient mental health settings and the community.
SH	017	Durham County Council	4	General	The inclusion of timescales for admission/discharge planning particularly in relation to accommodation in the community would be helpful as this is a key issue for many people with mental health problems.	Thank you for your comment. If there is evidence to support the inclusion of specific timescales for admission and discharge planning this will be located via the proposed review questions.
SH	017	Durham County Council	5	General	There is no mention in the scoping document with regards to the Recovery approach to mental health and how this will be embedded in the transitions guidance. For example reducing the use of nursing and care home placements and access to short term reablement/recovery options.	Thank you for highlighting this. Evidence on components of the Recovery approach, as it is variously defined, is likely to be located via our review questions on improving transfer inpatient settings and reducing re-admissions.
SH	018	Mencap	1	General	It is not clear from the settings whether inpatient learning disability	Thank you for your comment. We can confirm that the transition of a person with a learning disability

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					services will be included. Discharge of people with a learning disability from inpatient mental health or learning disability services is a key area to look at. The Government's Transforming Care agenda is clear that people with a learning disability and behaviour that challenges should not be living in inpatient units. They should be able to get the right support and services in their local communities, and if they do need to go into a unit for assessment and treatment it should be for as short a time as possible. However, we know that people with a learning disability and behaviour that challenges are remaining stuck in inpatient units for many reasons, including failure to develop the right support and services in the local community and disputes over funding. People with a learning disability and behaviour that challenges will often need complex packages of support in the community, and it is	from an inpatient mental health setting to the community is within scope. However transition from inpatient learning disability services are not in scope and may be covered by forthcoming NICE guidance on 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (due to be published in May 2015).

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					crucial that discharge planning begins as soon as someone is admitted to a unit. It is important there are guidelines to ensure people have well-planned, timely discharges from inpatient units and smooth transitions, and the right package of support is in place in the community so that the placement doesn't break down. We think it is important there is a specific focus in the NICE guidance on transition between inpatient units and community and care home settings for people with a learning disability and behaviour that challenges. Mencap and the Challenging Behaviour Foundation's Out of sight report www.mencap.org.uk/outofsight looked at five people with a learning disability who were sent to inpatient units, their experience there and their families' battles to get them out. See pages 38 – 42 'how do they get out?' for some of	Thank you for drawing our attention to this document, which provides invaluable context and may be used as a source document for the development of the guideline.

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					the issues families faced in getting their son or daughter out of a unit.	
SH	019	Rethink Mental Illness	1	General	Rethink Mental Illness is pleased to see this guideline addressing both transitions from community settings to inpatient mental health services, as well as from inpatient settings to the community. We particularly welcome the inclusion of low and medium secure services in this scope as we know there are particular issues around discharge from these services which can lead to delays.	Thank you for your support for the scope.
SH	019	Rethink Mental Illness	2	4.2.1	Currently too many people detained under section 135 and 136 are brought to police cells as a place of safety, pending an assessment under the Mental Health Act. While we welcome the inclusion of police cells in this scope as this is a transition that is often poorly managed, we would urge that any recommendations discourage the use of cells as much as possible.	Thank you for highlighting this important issue. Your comment led the scoping group to reflect on the merits of including police cells as a setting within the scope of this guideline. They concluded that as it is neither an inpatient mental health setting nor a community setting then it should be excluded. Moreover the matter is covered in detail in the Code of Practice for the Mental Health Act. However, we do propose a review question specifically about transition between inpatient mental health settings and the community for people detained under the Mental Health Act. The experience of people detained under sections 135 and 136 is therefore within scope.

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SH	019	Rethink Mental Illness	3	4.2.2	We would ask for clarification that if transitions to and from prison are not covered here, the intention is that they will be explicitly addressed in the 'Mental health of people in prison' guideline currently in development.	Thank you for your question. We can confirm that the draft scope of the 'mental health of people in prison' guideline states it will address transition to and from prison. We don't anticipate this will change in the final version which is due to publish soon. The draft scope for that guideline states that key issues included: • care pathways and transitions through the criminal justice system, in particular from juvenile to young offender services and • the interface with community based services for mental health problems, and between the criminal justice system and primary, secondary and tertiary healthcare provision.
SH	019	Rethink Mental Illness	4	4.3.2	Admission avoidance is listed as one of the areas outside of the scope of this guideline, as the focus is on readmissions. However, it seems that establishing whether a transition is necessary at all is a key part of a good transition. This would include considering community alternatives to the initial admission, such as recovery houses, and therefore covering in the guideline would be helpful. This would potentially impact on the	It is the case that admission avoidance is excluded from the scope of this guideline, which focuses on transitions that occur (rather than those that are avoided). However, we anticipate that evidence about community alternatives would be located via review questions on improving hospital discharge and reducing readmissions.

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					outcomes (4.4) and review questions (4.5)	
SH	019	Rethink Mental Illness	5	4.4	To aid consistency with the areas and issues in scope, we would suggest considering the following additional outcomes in the evidence: - Employment rates - Access to advocacy - Involvement of people in transition in care and crisis planning Involvement in carers in care and crisis planning	Thank you for your suggestions. The outcomes listed in the scope are deliberately general and only intended as examples. Therefore we have not added any more outcomes to section 4.4. All the issues you mention are included within the scope of this guideline.
SH	020	National Collaborating Centre for Mental Health	1	General	We think this is an important topic and very much welcome the scope.	Thank you for your support.
SH	020	National Collaborating Centre for Mental Health	2	General	Many of the areas in this scope have the potential to overlap with parts of many of the mental health guidelines. This may be helpful as the developers can cross refer to the MH guidelines where necessary, and possibly avoid doing some review work that has already been done. Throughout development it will be critical to be aware:	We are grateful that you have highlighted the potential areas of overlap between this guideline and those already produced through the NCCMH. The NCCSC has made contact with the NCCMH and the two centres plan an early meeting to ensure a collaborative approach and avoid duplication and overlap.

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					• of the need to check the MH guidelines to avoid duplicating review work already done • of potentially contradicting existing MH guidelines • that reviews which overlap with ours may cause the need for an update of our guidelines. We have tried in our comments below to highlight the main areas where there is potential overlap.	
SH	020	National Collaborating Centre for Mental Health	3	4.2.1	Some of the settings that will be covered overlap very closely with MH guidelines, for example: • Tier 4 CAMHS inpatient settings - may overlap with several guidelines Care home settings – in particular this may overlap with the Dementia guideline.	Thank you for highlighting the possible overlap with settings included in existing mental health guidelines. It is worth noting that our focus on these settings is where a transition of care occurs into them or out of them.
SH	020	National Collaborating Centre for Mental Health	4	4.3.1 a)	**Referral and Assessment** These are covered in almost all MH guidelines. Once again you need to be aware of potential overlaps. It might be helpful to be more specific, for example, to focus on discharge planning rather than	We are grateful that you have highlighted this potential area of overlap. In light of your comment, we have deleted 'referral and assessment' from the key areas of the scope.

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					assessment.	
SH	020	National Collaborating Centre for Mental Health	5	4.3.1 b)	**Care and support planning** This is covered in many MH guidelines, for people with mental health problems, including the need to provide information, to involve carers in planning.	Thank you for highlighting this. Our emphasis will be specifically on providing appropriate support for carers during the transition process.
SH	020	National Collaborating Centre for Mental Health	6	4.3.1 d)	We found that there was limited evidence in these areas. Despite this there are recommendations in many of the MH guidelines, so there may be times when the developers can cross refer to the relevant guidelines.	We are grateful that you have highlighted this potential challenge. As stated, the NCCSC and NCCMH plan an early meeting about the scope of this guideline to avoid duplication and ensure appropriate cross referencing with existing mental health recommendations.
SH	020	National Collaborating Centre for Mental Health	7	4.3.1 e)	This section includes a vast array of treatment modalities and it will be impossible to fully review the effectiveness of each. There is also the potential to overlap with MH guidelines, especially for CBT, and information for service users and carers.	Thank you, it is useful to be alerted to this. Given the scope of the guideline, we will not be reviewing the effectiveness of each aspect of care planning and provision, instead our emphasis is on their contribution to supporting transitions.
SH	020	National Collaborating Centre for Mental Health	8	4.3.2 d)	**General inpatient hospital settings** Once again there is the potential to overlap with MH guidelines, especially for CBT, and information for service users and carers. You need to look at the psychosis and schizophrenia guideline in	Thank you for highlighting this, it is helpful to be aware of potential overlap.

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					particular as you may need to draw upon parts of it for this section.	
SH	020	National Collaborating Centre for Mental Health	9	4.5.2	Transition is touched upon in several MH guidelines	Thank you for commenting on the proposed review questions. As stated, the NCCSC and NCCMH plan an early meeting about the scope of this guideline to ensure a collaborative approach and avoid duplication and overlap. The review questions will be discussed in depth.
SH	020	National Collaborating Centre for Mental Health	10	4.5.5	This was covered for psychosis and schizophrenia, in the psychosis and schizophrenia guideline.	
SH	020	National Collaborating Centre for Mental Health	11	4.5.8	This is covered in a number of MH guidelines. In particular refer to the 'Service user experience in adult mental health' guideline	

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