Appendix A: Summary of evidence from surveillance

Exceptional surveillance review (2017) – Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53

Summary of evidence from surveillance

Follow-up support

Q – 01 What is the effectiveness or impact of interventions, components of care packages and approaches designed to improve discharge from inpatient mental health settings?

Recommendations relevant to the new evidence

1.6.7 Follow up a person who has been discharged within 7 days

1.6.8 Follow up a person who has been discharged within 48 hours if a risk of suicide has been identified

Surveillance decision

This review question should not be updated.

Time to follow-up after discharge

2017 exceptional surveillance summary

The National Confidential Inquiry (2016)[1] reported data on suicide rates and priorities for safer services for people with a mental illness. Data was collected from UK countries between 2004 and 2014. The overall rate of suicide in 2014 was found to have risen from previous years in this population. The period after discharge from hospital was identified as a particularly high risk for suicide. The report found that in this period, the risk of suicide is highest within the first 2 weeks after discharge from an inpatient setting with the highest number of suicides occurring on day 3. However, a reduction in the rate of suicide was found to occur in the period between discharge and first service contact. The report concluded that a recognition of the need for early follow-up is required.

Mind (2017)[2] reported data on the numbers of people receiving follow-up contact after discharge from adult mental health inpatient services. Data was derived from freedom of information requests to mental health trusts in England and Wales and from data published by NHS England for 2015/16. However, not all trusts responded to the request and some provided incomplete information. The results found that in England 88% of people received follow-up contact within 7 days of discharge. Sufficient amounts of data were not available for the report to analyse follow-up within 48 hours. Mind also provided data from a survey investigating the experiences of discharge in people with a mental health problem. The survey found that suicide and self harm attempts were more likely to occur in people receiving discharge follow-up after 7 days or not at all compared to people followed-up within 7 days. Mind concluded that everyone discharged from mental health inpatient settings should be followed-up within 48 hours as a suicide prevention measure.

Topic expert feedback

Comments from topic experts agreed that the new evidence is consistent with current recommendations. Experts agreed that the recommendations on follow-up after discharge should not be updated.

Impact statement

Evidence from the 2017 exceptional surveillance suggests that the risk of suicide is high following discharge from mental health inpatient settings. This risk is most prominent during the first 7 days post-discharge and in people not receiving follow-up at all. Data suggests that suicide rates peak on day 3 following discharge. The National Confidential Inquiry and Mind reports both highlight the need to recognise early follow-up as a suicide prevention measure.

These findings are largely consistent with recommendations in NICE guideline NG53 which advises to follow-up all patients within 7 days and to reduce this time to 48 hours if a risk of suicide was identified.

The development of the recommendations was based primarily on consensus from topic experts. The guideline committee discussed the increased risk of suicide in the first week after discharge. They agreed that suicide risk should be assessed prior to discharge. It was agreed that those with an identified risk of suicide should be followed up within 48 hours and those without a risk within 7 days.

Topic experts agreed that the new evidence is consistent with current recommendations which should not be updated.

New evidence is unlikely to change guideline recommendations.

References

1. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review. October 2016. University of Manchester.
2. Freedom of information data on follow-up after hospital. April 2017. Mind.