

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

NICE guideline

Published: 30 August 2016

www.nice.org.uk/guidance/ng53

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

Overview	4
Who is it for?	4
Recommendations	5
1.1 Overarching principles	5
1.2 Before hospital admission	7
1.3 Hospital admission	9
1.4 Support for families, parents and carers throughout admission	14
1.5 Hospital discharge	16
1.6 Follow-up support	21
Terms used in this guideline	24
Carers	24
Coping strategies	24
Discharge letter	24
Discharge summary	24
Observation	24
Psychoeducation	17
Recovery	25
Therapeutic relationships	25
Implementation: getting started	26
Challenges for implementation	26
Context	30
More information	31
Recommendations for research	32
1 Care and support for people with dementia	32
2 People with complex needs other than dementia	32
3 Children and young people in transition between settings	33

This guideline is the basis of QS159.

Overview

This guideline covers the period before, during and after a person is admitted to, and discharged from, a mental health hospital. It aims to help people who use mental health services, and their families and carers, to have a better experience of transition by improving the way it's planned and carried out.

The Care Quality Commission uses NICE guidelines as evidence to inform the inspection process.

Who is it for?

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

Recommendations

Although most of the recommendations in this guideline cover both planned and unplanned admissions, some (like those on pre-admission planning) are only applicable to planned admissions. If an admission is unplanned, then these recommendations should be applied at the soonest possible point after admission, if appropriate to the person's individual circumstances.

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

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

1.1 *Overarching principles*

1.1.1 Ensure the aim of care and support of people in transition is person-centred and focused on [recovery](#).

1.1.2 Work with people as active partners in their own care and transition planning. For more information, see the section on [relationships and communication](#) in NICE's guideline on service user experience in adult mental health services.

1.1.3 Support people in transition in the least restrictive setting available (in line with the Mental Health Act [Code of Practice](#)).

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

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

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

- supporting them to maintain relationships with family and friends, for example, by finding ways to help with transport
- helping them to stay in touch with social and recreational contacts

- helping them to keep links with employment, education and their local community.

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

1.1.7 Mental health services should work with primary care, local authorities and third sector organisations to ensure that people with mental health problems in transition have equal access to services. This should be based on need and irrespective of:

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

1.1.8 Give people in transition comprehensive information about treatments and services for their mental health problems at the time they need it. If required, provide information:

- in large-print, braille or Easy Read format
- by audio or video
- in translation.

For more information, see the section on [care and support across all points on the care pathway](#) in NICE's guideline on service user experience in adult mental health.

1.2 *Before hospital admission*

Planning and assessment

1.2.1 Mental health practitioners supporting transition should respond quickly to requests for assessment of mental health from:

- people with mental health problems
- family members
- carers
- primary care practitioners (including GPs)
- specialist community teams (for example, learning disability teams)
- staff such as hostel, housing and community support workers.

Assessments for people in crisis should be prioritised.

1.2.2 If admission is being planned for a treatment episode involve:

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

1.2.3 When planning treatment for people being admitted, take account of the expertise and knowledge of the person's family members, parents or carers.

1.2.4 Allow more time and expert input to support people with complex, multiple or specific support needs to make transitions to and from services, if necessary. This may include:

- children and young people
- people with dementia, cognitive or sensory impairment
- people on the autistic spectrum

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

1.2.5 For planned admissions, offer people an opportunity to visit the inpatient unit before they are admitted. This is particularly important for:

- children and young people
- people with dementia, cognitive or sensory impairment
- people on the autistic spectrum
- people with learning disabilities and other additional needs
- people placed outside the area in which they live.

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

1.2.7 During admission planning, record a full history or update that:

- covers the person's cognitive, physical and mental health needs
- includes details of their current medication
- identifies the services involved in their care.

For more information, see the section on [medicines reconciliation](#) in NICE's guideline on medicines optimisation.

1.2.8 If more than 1 team is involved in a person's transition to, within and from a service, ensure there is ongoing communication between the inpatient team and other relevant teams that include:

- community health or social care providers, such as:
 - the community mental health team
 - the learning disability team
 - teams that work with older people

- child and adolescent mental health services (CAMHS)
- housing support teams
- general hospital or psychiatric liaison teams.

Crisis plans

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

- relapse indicators and plans
- who to contact in a crisis
- [coping strategies](#)
- preferences for treatment and specific interventions
- advance decisions.

For more information, see the section on [community care](#) in NICE's guideline on service user experience in adult mental health services.

1.3 Hospital admission

General principles

1.3.1 Start building [therapeutic relationships](#) as early as possible to:

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

This is particularly important for people who have been admitted in crisis.

1.3.2 Practitioners involved in admission should refer to crisis plans and advance statements when arranging care.

- 1.3.3 Advance decisions must be followed in line with the [Mental Capacity Act 2005](#).
- 1.3.4 At admission, offer all people access to advocacy services that take into account their:
- language and communication needs
 - cultural and social needs
 - protected characteristics (see the GOV.UK page about [discrimination](#)).
- 1.3.5 Health and social care practitioners admitting someone with cognitive difficulties should try to ensure the person understands why they have been admitted.
- 1.3.6 During admission, discuss with the person:
- any strategies for coping that they use
 - how they can continue to use, adapt and develop positive [coping strategies](#) on the ward.
- 1.3.7 Start discharge planning at admission or as early as possible when in crisis (for more information, see section 1.5).
- 1.3.8 For recommendations on assessing and treating people who have been detained under the Mental Health Act, see [section 1.8](#) of NICE's guideline on service user experience in adult mental health services.
- 1.3.9 For recommendations on crisis, including crisis admissions, see [section 1.5](#) in NICE's guideline on service user experience in adult mental health services.

Out-of-area admissions

- 1.3.10 If the person is being admitted outside the area in which they live, identify:
- a named practitioner from the person's home area who has been supporting the person
 - a named practitioner from the ward they are being admitted to.

- 1.3.11 The named practitioners from the person's home area and the ward should work together to ensure that the person's current placement lasts no longer than required. This should include reviewing the person's care plan, current placement, recovery goals and discharge plan at least every 3 months, or more frequently according to the person's needs. This could be done in person or by audio or videoconference.
- 1.3.12 For people admitted to hospital outside the area in which they live, take into account the higher risk of suicide after discharge at all stages of the planning process (see the [National Confidential Inquiry into Suicide and Homicide by People with Mental Illness](#)). This should include:
- assessing the risk
 - discussing with the person how services can help them to stay safe
 - discussing with the person's family members, parents or [carers](#) how they can help the person to stay safe.

Legal status of person being admitted

- 1.3.13 The senior health professional responsible for the admission should tell the person being admitted about their legal status at the point of admission. They should:
- use clear language
 - discuss rights and restrictions with the person
 - provide written and verbal information
 - make the discussion relevant to the ward the person is being admitted to
 - explain whether they are under [observation](#) and what this means (see [observations and restrictions](#)).
- 1.3.14 A senior health professional should ensure that discussions take place with the person being admitted to check that:
- they have understood the information they were given at admission

- they know they have a right to appeal, and that information and advocacy can be provided to support them to do so if they wish
- they understand that any changes to their legal status and treatment plans will be discussed as they occur.

Observations and restrictions

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

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

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

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

Addressing personal concerns

1.3.17 To support the person's transition to the ward the admitting nurse or person responsible should make the following items available if the person needs them:

- a toothbrush
- hygiene products
- nightwear.

This is particularly important for people who have been admitted in crisis.

- 1.3.18 Give the person verbal and written information about ward facilities and routines (see the section on [hospital care](#) in NICE's guideline on service user experience in adult mental health).
- 1.3.19 At admission, a senior healthcare professional should discuss all medication and care needs with the person being admitted. This should include:
- physical healthcare needs
 - pregnancy, breastfeeding or the need for emergency contraception
 - advice about immediate addiction issues, treatment and support
 - mental health treatment.
- 1.3.20 The admitting nurse or person responsible should discuss with the person how to manage domestic and caring arrangements and liaise with the appropriate agencies. This may include:
- people they have a responsibility to care for, such as:
 - children
 - frail or ill relatives
 - domestic arrangements, in particular:
 - home security
 - tenancy
 - benefits
 - home care service

- – pets.

1.3.21 On admission, ensure people (particularly children and young people) know who they can talk to if they are frightened or need support. For more information, see the section on [hospital care](#) in NICE's guideline on service user experience in adult mental health services.

1.3.22 Identify whether the person has any additional need for support, for example, with daily living activities. Work with [carers](#) and community-based services, such as specialist services for people with learning or physical disabilities, to provide support and continuity while the person is in hospital.

1.4 *Support for families, parents and carers throughout admission*

1.4.1 Identify a named practitioner who will make sure that the person's family members, parents or [carers](#) receive support and timely information (see the section on [sharing information with families, parents and carers](#)).

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

- in an empathetic, reassuring and non-judgemental way
- acknowledging that admission to hospital can be particularly traumatic for families and carers, particularly if it is the person's first admission.

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

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

- care planning meetings
- discharge planning meetings
- other meetings concerning the care of the person.

Sharing information with families, parents and carers

- 1.4.5 Respect the rights and needs of carers alongside the person's right to confidentiality. Review the person's consent to share information with family members, carers and other services during the inpatient stay. For more information, see the subsection on [involving families and carers](#) in NICE's guideline on service user experience in adult mental health services.
- 1.4.6 Throughout admission, give families, parents or carers clear, accessible information about:
- the purpose of the admission
 - the person's condition (either general, or specific if the person agrees to this)
 - the treatment, care and support that the person is receiving
 - the inpatient unit, including:
 - the ward and the wider hospital environment
 - the practicalities of being in hospital
 - resources that are available, including accommodation for families
 - visiting arrangements
 - preparing for discharge.
- 1.4.7 Give families, parents and carers information about support services in their area that can address emotional, practical and other needs (this is particularly important if this is the person's first admission).
- 1.4.8 Give young carers (under 18) of people in transition relevant information that they are able to understand.

Carers' assessments

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

- 1.4.10 Identify carers (including young carers) who have recognisable needs. If the carer wishes it, make a referral to the carer's local authority for a carer's assessment (in line with the [Care Act 2014](#)). Ensure a carer's assessment has been offered, or started, before the person is discharged from hospital.

1.5 *Hospital discharge*

- 1.5.1 Health and social care practitioners in the hospital and community should plan discharge with the person and their family, carers or advocate. They should ensure that it is collaborative, person-centred and suitably-paced, so the person does not feel their discharge is sudden or premature. For more information, see NICE's guideline on [service user experience in adult mental health services](#).

Maintaining links with the community

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

- keep links with their life outside the hospital (see recommendation 1.1.6)
- restart any activities before they are discharged.

This is particularly important for people who need a long-term inpatient stay, are placed out-of-area, or who will have restricted access to the community.

- 1.5.3 Before discharge offer:

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

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

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

Education – for people under 18

- 1.5.5 Children and young people under 18 must have continued access to education and learning throughout their hospital stay, in line with the [Education Act 1996](#).
- 1.5.6 Before the child or young person goes back into community-based education or training:
- identify a named worker from the education or training setting to be responsible for the transition
 - arrange a meeting between the named worker and the child or young person to plan their return.

Accommodation

- 1.5.7 Before discharging people with mental health needs, discuss their housing arrangements to ensure they are suitable for them and plan accommodation accordingly. This should take into account any specific accommodation and observation requirements associated with risk of suicide.
- 1.5.8 Give people with serious mental health issues who have recently been homeless, or are at risk of homelessness, intensive, structured support to find and keep accommodation. This should:
- be started before discharge
 - continue after discharge for as long as the person needs support to stay in secure accommodation
 - focus on joint problem-solving, housing and mental health issues.

Helping the person to prepare for discharge

- 1.5.9 Before discharge, offer a series of individualised [psychoeducation](#) sessions for people with psychotic illnesses to promote learning and awareness. Sessions should:
- start while the person is in hospital
 - continue after discharge so the person can test new approaches in the community

- cover:
 - symptoms and their causes
 - what might cause the person to relapse, and how that can be prevented
 - psychological treatment
 - coping strategies to help the person if they become distressed
 - risk factors
 - how the person can be helped to look after themselves
- be conducted by the same practitioner throughout if possible.

1.5.10 Consider psychoeducation sessions for all people with other diagnoses as part of planning discharge and avoiding readmission.

1.5.11 During discharge planning, consider group psychoeducation support for carers. This should include signposting to information on the specific condition of the person they care for.

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

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

Peer support

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

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

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

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

Care planning to support discharge

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

1.5.16 Write the care plan in clear language. Avoid jargon and explain difficult terms.

1.5.17 Ensure the care plan is based on the principles of recovery and describes the support arrangements for the person after they are discharged.

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

1.5.19 Ensure frequent, comprehensive review of the person's care plan and progress toward discharge.

1.5.20 Send a copy of the care plan to everyone involved in providing support to the person at discharge and afterwards. It should include:

- possible relapse signs
- recovery goals
- who to contact
- where to go in a crisis
- budgeting and benefits
- handling personal budgets (if applicable)
- social networks
- educational, work-related and social activities
- details of medication (see the recommendations on [medicines-related communication systems](#) in NICE's guideline on medicines optimisation)
- details of treatment and support plan
- physical health needs including health promotion and information about contraception
- date of review of the care plan.

Preparing for discharge

1.5.21 Mental health practitioners should carry out a thorough assessment of the person's personal, social, safety and practical needs to support discharge. The assessment should include risk of suicide (see recommendations 1.6.6–1.6.8). It should:

- relate directly to the setting the person is being discharged to
- fully involve the person
- be shared with carers (if the person agrees)
- explore the possibility of using a personal health or social care budget and ensure the person understands about charges for social care
- cover aftercare support, in line with [section 117](#) of the Mental Health Act 1983
- cover aspects of the person's life including:

- – daytime activities such as employment, education and leisure
- food, transport, budgeting and benefits
- pre-existing family and social issues and stressors that may have triggered the person's admission
- ways in which the person can manage their own condition
- suitability of accommodation.

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

1.5.23 Before the person is discharged:

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

1.6 *Follow-up support*

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

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

1.6.2 Consider booking a follow-up appointment with the GP to take place within 2 weeks of the person's discharge. Give the person a written record of the appointment details.

1.6.3 At discharge, the hospital psychiatrist should ensure that:

- Within 24 hours, a [discharge letter](#) is emailed to the person's GP. A copy should be given to the person and, if appropriate, the community team and other specialist services.
- Within 24 hours, a copy of the person's latest care plan is sent to everyone involved in their care (see recommendation 1.5.20).
- Within a week, a [discharge summary](#) is sent to the GP and others involved in developing the care plan, subject to the person's agreement. This should include information about why the person was admitted and how their condition has changed during the hospital stay.

1.6.4 If the person has a learning disability, dementia or is on the autistic spectrum, the hospital team should lead communication about discharge planning with the other services that support the person in the community. This could include:

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

1.6.5 If a person is being discharged to a care home, hospital and care home practitioners should exchange information about the person. An example might be a hospital practitioner accompanying a person with cognitive impairment when they return to the care home to help their transition (see also [sharing information about a resident's medicines](#) in NICE's guideline on managing medicines in care homes).

1.6.6 In collaboration with the person, identify any risk of suicide and incorporate into care planning.

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.

1.6.9 Consider contacting adults admitted for self-harm, who are not receiving

treatment in the community after discharge, and providing advice on:

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

Community treatment orders

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

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

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

- the specific benefit for the person
- how to access advocacy (including their entitlement to an Independent Mental Health Advocate), and what this means
- what restrictions the order involves
- when it will be reviewed
- what will happen if the person does not comply with the order, and that this may not automatically lead to readmission.

1.6.12 Ensure that the conditions, purpose, legal basis and intended benefit of the order are explained to families, [carers](#) and others providing support.

Terms used in this guideline

Carers

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

Coping strategies

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

Discharge letter

A short document that includes the details of a person's current prescription, the reasons for any changes in medicines and their immediate medication treatment plan.

Discharge summary

A summary of what happened during a person's admission and hospital stay from a medical perspective. It must include the diagnosis, outcomes of investigations, changes to treatment and the medicines started or stopped, or dosage changes and reasons why.

Observation

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

Psychoeducation

Education sessions for people affected by mental illness and their families and carers. Psychoeducation uses shared learning to empower people to cope better. Sessions can cover areas such as recognising symptoms and triggers, preventing relapses and developing coping strategies.

Carers learn how best to support the person. Sessions should start while the person is in hospital and run beyond discharge so the person can test approaches in their home setting.

Recovery

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

Therapeutic relationships

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

For other social care terms, see the Think Local, Act Personal [Care and Support Jargon Buster](#).

Implementation: getting started

This section highlights 3 areas of the transition between inpatient mental health settings and community and care home settings guideline that could have a big impact on practice and be challenging to implement, along with the reasons why change needs to happen in these areas. We identified these with the help of stakeholders and guideline committee members. For more information, see [developing NICE guidelines: the manual](#). The manual also gives information on [resources to help with implementation](#).

Challenges for implementation

The challenge: Delivering services that are person-centred and focus on recovery

See recommendations [1.1.1-1.1.4](#) and [1.5.1](#).

All practitioners have a role to play in ensuring care and support is provided in a therapeutic environment that is responsive to people's individual needs and choices while being focused on [recovery](#). Creating the right culture needs skilled practitioners who work with people as active partners and have a good understanding of what makes a successful transition. People will benefit because they will experience care and support that is tailored to their needs and supports their recovery.

Transitions for people using acute mental health services can be complex. They often involve more than 1 agency and setting. Workload pressures in hospitals and community settings can lead to competing demands. A poor transition that is not person-centred can be stressful for people using mental health services and their families and [carers](#). This can result in an unsatisfactory experience for all concerned and may impede recovery.

What can commissioners, managers and practitioners do to help?

- Embed principles of person-centred and recovery-focused care in all training, supervision and continuing professional development for practitioners involved in transitions. Publications from the [Improving recovery through organisational change](#) programme may be helpful; in particular those on [supporting recovery in mental health services: quality and outcomes](#), [making recovery a reality in forensic settings](#), [peer support workers: a practical guide to implementation](#) and [recovery: a carer's perspective](#).
- Ensure that mental health and social care practitioners inexperienced in working with people from diverse backgrounds are able to seek advice, training and supervision from colleagues

- who do have this experience (in line with the section on community care in NICE's guideline on [service user experience in adult mental health](#)).
- Ensure that health and social care practitioners have opportunities to learn about the emotional and practical impact of transitions, change and loss. This should include discussion of the particular risks and challenges of transitions.
- Offer training opportunities to all professionals involved in assessments for admission under the [Mental Health Act 2007](#). This includes police, community psychiatric nurses, approved mental health professionals, psychiatrists, GPs, ambulance staff, general hospital staff and psychiatric liaison staff. Training opportunities may include:
 - training delivered by people who use services
 - on-the-job learning
 - training done alongside other involved professionals.

The challenge: Ensuring effective communication between teams, and with people using services and their families and carers

See recommendations [1.1.5](#), [1.1.8](#), [1.2.8](#), [1.3.10–1.3.14](#) and [1.4.1–1.4.8](#).

Good communication is important – both between health and social care practitioners working in multidisciplinary teams and between practitioners and people using mental health services (and their families, parents or carers). Good communication leads to better coordinated care and a better experience for the person.

Practitioners need to work together, across physical and professional boundaries, to ensure that people experience good transition. People need help to stay in touch with their life outside the hospital, including relationships, employment, education and their local community. But this can be particularly hard if they live some distance from the hospital, or if a number of agencies are involved.

What can commissioners and managers do to help?

- Ensure that effective systems are in place to help practitioners communicate effectively.

What can health and social care practitioners do to help?

- Ensure that information about people is shared with colleagues if appropriate (in line with

- information-sharing protocols).
- If people are placed outside the area in which they live, ensure that good communications are maintained, both between practitioners in different services and between practitioners and people using services (and their families and carers).
- Ensure that there is good communication between service providers and people using mental health services (and, if appropriate, their families and carers).
- Offer information on treatment and services to people at the point they need it.
- Think carefully about what information people need and how to make sure they have understood it. This could be checked during a conversation with the person when they are feeling less unwell.

The challenge: Co-producing comprehensive care plans that meet people's changing needs

See recommendations [1.1.2](#), [1.1.4](#), [1.2.2–1.2.3](#), [1.3.15](#) and [1.6.10–1.6.11](#).

Co-producing care plans with people helps them to feel more in control and be active partners in their own care and [recovery](#). Care plans should draw on all forms of documented treatment intentions and preferences relating to the person (including crisis plans, discharge and recovery plans, and Care Programme Approach documentation). Lack of coordination between plans can result in frustration and stress if people are asked for information repeatedly. Plans should be reviewed regularly. Planning early for each stage of admission and discharge can ensure better continuity of care and a better experience for the person as they move between services.

Requiring practitioners to explain to people and their carers why a restriction (involuntary admission, [observation](#) or community treatment order) has been applied is likely to lead to improved communication with people and their carers. It will also support more reflective practice.

Identifying the person's family or carers early on means they can be more involved in the person's care and support from an earlier stage. It can also aid practitioners' understanding of the person and their needs.

Building in the flexibility to pace a transition according to a person's cognitive and communication needs may mean that changes are needed to the way things are usually done.

What can commissioners and managers do to help?

- Ensure that health and social care practitioners involved in transitions to and from mental health hospitals have the skills to:
 - carry out needs assessments
 - develop care and discharge plans in collaboration with the person.

What can health and social care practitioners do to help?

- Ensure that all planning is person-centred and involves the person as an active partner in their care.
- Start all plans at the earliest possible opportunity.
- Focus planning on enabling people to have a seamless transition into and out of hospital.
- Recognise that care plans are 'living documents' that should be regularly reviewed and take account of changed circumstances.

Context

Poor transition between inpatient mental health settings and community or care home settings has negative effects on people using services and their families and [carers](#). A key issue affecting transitions between inpatient mental health settings and the community is a lack of integrated and collaborative working between mental health and social care services, and between practitioners based in hospitals and those in the community. Both can result in inadequate and fragmented support for people using mental health services.

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

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

The consequences of a poor transition can be very serious for the person and their family or carers. For example, the University of Manchester's [National Confidential Inquiry into Suicide and Homicide by People with Mental Illness](#) found that, between 2003 and 2013 in England, 2,368 mental health patients died by suicide in the first 3 months after being discharged from hospital (compared with 1,295 inpatient deaths in the same period).

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

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

People placed in inpatient facilities away from their home communities are particularly vulnerable

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

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

More information

You can also see this guideline in the NICE pathway on [transition between community or care home and inpatient mental health services](#).

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

See also the guideline committee's discussion and the evidence reviews (in the [full guideline](#)), and information about [how the guideline was developed](#), including details of the committee.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Care and support for people with dementia

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

Why this is important

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

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

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

2 People with complex needs other than dementia

What is the effect of specific interventions to support people with complex needs because of multiple diagnoses and resistance to treatment during transition between inpatient mental health settings and community or care home settings? (This includes people with physical or learning disabilities, people with personality disorder, people with complex psychosis, people with long-term severe mental illness and people on the autistic spectrum.)

Why this is important

As the population ages and people live longer, the number of people with severe and complex mental and physical care needs is increasing. They may need ongoing intensive support from

rehabilitation and other mental health services to live in the community after discharge. Although they are a relatively small group, expenditure on care for people in this group accounts for around 25% of the total mental health budget.

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

3 Children and young people in transition between settings

What is the effect of specific interventions to support children and young people during transition between inpatient mental health settings and community or care home settings? Is there any particular benefit for black, Asian and minority ethnic communities?

Why this is important

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

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

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

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

ISBN: 978-1-4731-2023-5

Accreditation

