NICE National Institute for Health and Care Excellence

NICE Pathways

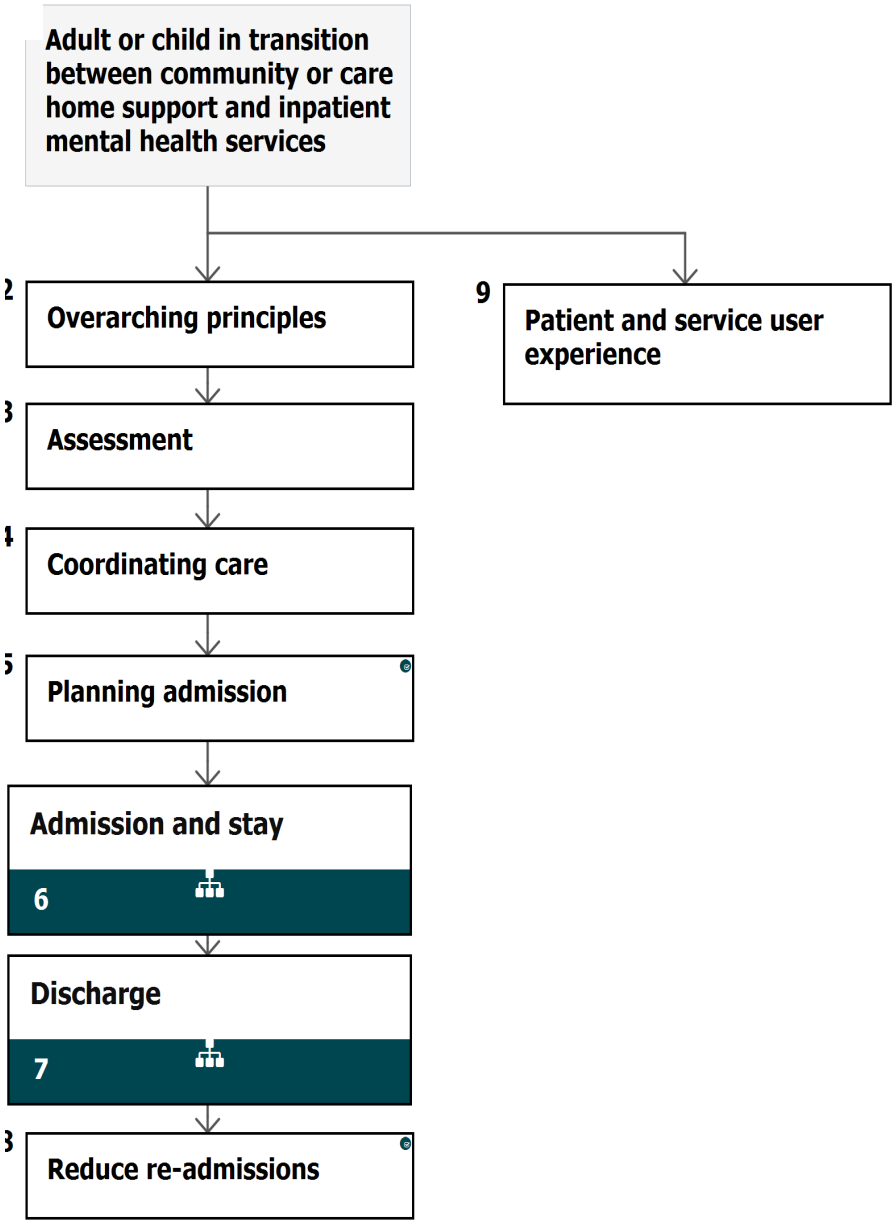
Transition between community or care home and inpatient mental health settings overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/transition-between-community-or-care-home-and-inpatient-mental-health-settings
Pathway last updated: 11 September 2017

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 Adult or child in transition between community or care home support and inpatient mental health services

No additional information

2 Overarching principles

Ensure the aim of care and support of people in transition is person-centred and focused on recovery [See page 9].

Work with people as active partners in their own care and transition planning.

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

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

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.

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.

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.

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:

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

See also what NICE says on relationships and communication and providing information in its recommendations on service user experience.

3 Assessment

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.

Assessment for people in crisis should be prioritised.

4 Coordinating care

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.

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

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.

See also what NICE says on autism spectrum disorder, dementia and mental health problems in people with learning disabilities.

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.

5 Planning admission

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.

See also what NICE says on autism spectrum disorder, dementia and mental health problems in people with learning disabilities.

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.

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 medicines reconciliation for medicines optimisation, and NICE's recommendations on managing medicines in care homes.

Out-of-area admissions

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.

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 [See page 9] 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.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

2. Out-of-area admissions

6 Admission and stay

See Transition between community or care home and inpatient mental health settings / Admission and stay in an inpatient mental health service

7 Discharge

See Transition between community or care home and inpatient mental health settings / Discharge from inpatient mental health services to community or care home support

8 Reduce re-admissions

Suicide and self-harm risk

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

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

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.

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 2015). 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.

See also longer term management of self-harm: assessment and treatment for self-harm.

Crisis plans

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.

See also community care in NICE's recommendations on service user experience.

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

Discharge vulnerable people from health or social care settings to a warm home

See discharge vulnerable people from health or social care settings to a warm home in NICE's recommendations on excess winter death and illnesses associated with cold homes.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

4. Suicide risk

9 Patient and service user experience

See what NICE says on:

- patient experience
- service user experience.

There is no single definition of recovery for people with mental health problems, the guiding principle is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness. In this interactive flowchart 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.

Glossary

carers

carers are people 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

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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 interactive flowchart to refer to ways that people cope with their mental illness or related symptoms, some coping strategies can have negative consequences for a person using them or for the people around them

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

therapeutic relationships

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

Sources

Transition between inpatient mental health settings and community or care home settings (2016) NICE guideline NG53

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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