Person-centred transitions between mental health inpatient settings and home for young people

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Overview

- Increasing numbers of young people needing to go into psychiatric hospitals
- Admission often happens out of the area they usually live in, separating them from their family, peers and social networks
- This guidance offers practical steps from pre-admission planning through to aftercare
- It is aimed at practitioners supporting young people and those who commission services
- The guidance is for people of all ages; this webinar focuses on the needs of young people

NICE guidance

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

- Transition between inpatient mental health settings and community or care home settings (QS159) – NICE quality standard

- Improving young people's experiences in transition to and from mental health settings – NICE/SCIE quick guide

Guideline structure

- Pre-admission planning
- In-patient stay
- Discharge planning
- Aftercare

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.

1.1.3 Support people in transition in the least restrictive setting available.

1.1.6 Enable the person to maintain links with their home community. This is particularly important if people are admitted to mental health units outside the area in which they live.

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

Response and liaison

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)

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.

Planning admission

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.

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

- Children and young people on the autistic spectrum or with learning disabilities and other additional needs
- Children and young people placed outside the area in which they live.

During admission

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.

1.3.6 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.

1.4.1 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).

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.

Out-of-area admissions cont.

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.

Education

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.

Discharge planning

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.

Discharge planning

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.

NB The evidence for these recommendations specifically related to adults with psychosis

Care planning to support 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
- 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.

Preparing for discharge cont.

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.

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.

Follow-up support cont.

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.

Follow-up support cont.

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.

Quality standard (QS159)

Statement 1 People admitted to an inpatient mental health setting have access to independent advocacy services.

Statement 2 People admitted to specialist inpatient mental health settings outside the area in which they live have a review of their placement at least every 3 months.

Statement 3 People discharged from an inpatient mental health setting have their care plan sent within 24 hours to everyone identified in the plan as involved in their ongoing care.

Statement 4 People who have a risk of suicide identified at preparation for discharge from an inpatient mental health setting are followed up within 48 hours of being discharged

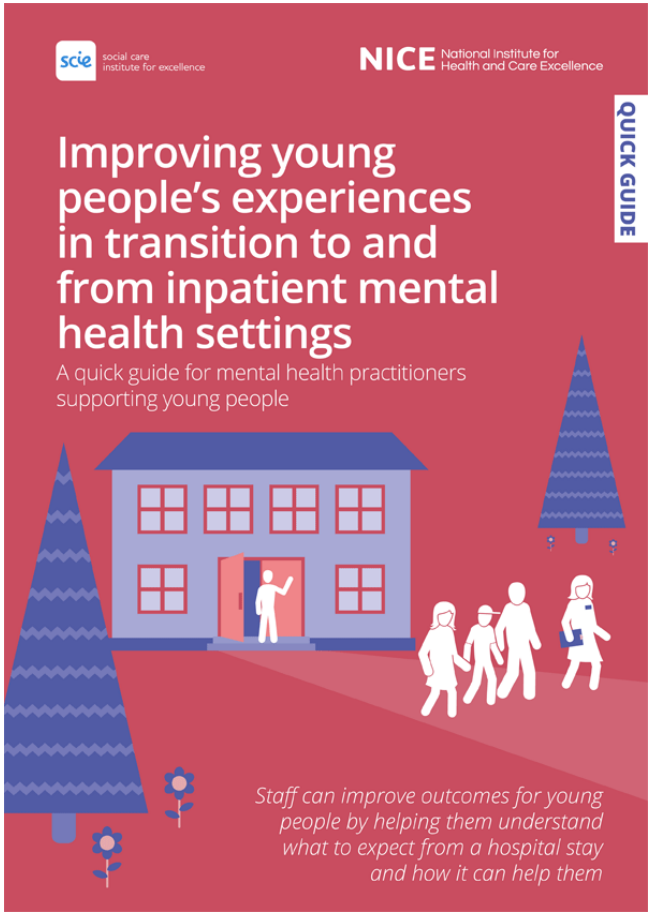
Implementing the guideline

- Guideline tools and resources - https://www.nice.org.uk/guidance/ng53/resources

- Working with young people to plan person-centred care and support for admission to and discharge from inpatient mental health settings – https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245856/chapter/Introduction

- Challenges for implementation - https://www.nice.org.uk/guidance/ng53/chapter/Implementation-getting-started

Implementing the guideline



NICE/SCIE quick guide - https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/improving-young-people-s-experiences-in-transition-to-and-from-inpatient-mental-health-settings

NICE resources

Sign up for the NICE social care newsletter

http://www.nice.org.uk/social-care-newsletter

Access our range of quick guides

https://www.nice.org.uk/about/nice-communities/social-care/quick-guides

Questions?

Thank you