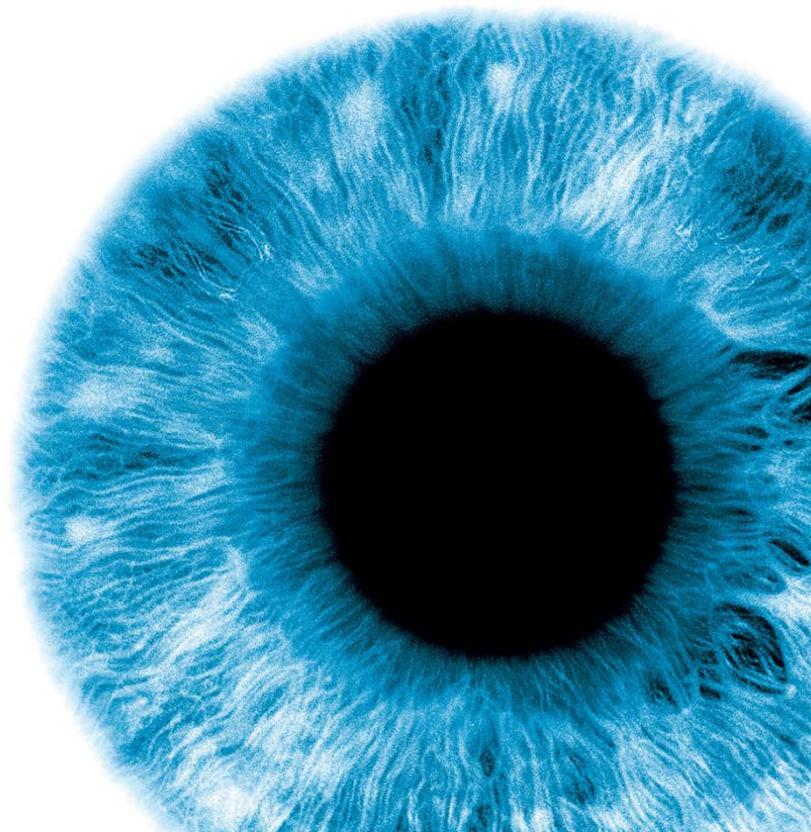


Service user experience in adult mental health

Evidence Update May 2014

A summary of selected new evidence relevant to NICE clinical guideline 136 'Service user experience in adult mental health: improving the experience of care for people using adult mental health services' (2011)

Evidence Update 61



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Introduction

Evidence Updates are intended to increase awareness of new evidence – they do not replace current NICE guidance and do not provide formal practice recommendations.

Evidence Updates reduce the need for individuals, managers and commissioners to search for new evidence. For contextual information, this Evidence Update should be read in conjunction with the relevant clinical guideline.

This Evidence Update provides a summary of selected new evidence published since the literature search was last conducted for the following NICE guidance:

¹  [Service user experience in adult mental health](#). NICE clinical guideline 136 (2011)

A search was conducted for new evidence from 1 April 2011 to 5 November 2013. A total of 3088 pieces of evidence were initially identified. After removal of duplicates, a series of automated and manual sifts were conducted to produce a list of the most relevant references. The remaining 37 references underwent a rapid critical appraisal process and then were reviewed by an [Evidence Update Advisory Group](#), which advised on the final list of 8 items selected for the Evidence Update. See [Appendix A](#) for details of the evidence search and selection process.

Evidence selected for inclusion in this Evidence Update may highlight a potential impact on guidance: that is, a high-quality study, systematic review or meta-analysis with results that suggest a change in practice. Evidence that has no impact on guidance may be a key read, or may substantially strengthen the evidence base underpinning a recommendation in the NICE guidance.

The Evidence Update gives a preliminary assessment of changes in the evidence base and a final decision on whether the guidance should be updated will be made by NICE according to its published processes and methods.

This Evidence Update was developed to help inform the review proposal on whether or not to update NICE clinical guideline 136 ([NICE CG136](#)). The process of updating NICE guidance is separate from both the process of an Evidence Update and the review proposal.

See the [NICE clinical guidelines development methods](#) webpage for further information about updating clinical guidelines.

Other relevant NICE guidance

The focus of the Evidence Update is on the guidance stated above. However, overlap with other NICE guidance has been outlined as part of the Evidence Update process. Where relevant, this Evidence Update therefore makes reference to the following guidance:

¹  [Psychosis and schizophrenia in adults](#). NICE clinical guideline 178 (2014)

¹  [Depression in adults](#). NICE clinical guideline 90 (2009)

- ² [Antenatal and postnatal mental health](#). NICE clinical guideline 45 (2007)

¹ [NICE-accredited guidance](#)

² Guidance published prior to NICE accreditation

NICE Pathways

NICE pathways bring together all related NICE guidance and associated products on the condition in a set of interactive topic-based diagrams. The following NICE Pathways cover advice and recommendations related to this Evidence Update:

- [Service user experience in adult mental health services](#). NICE Pathway
- [Psychosis and schizophrenia](#). NICE Pathway
- [Depression](#). NICE Pathway
- [Antenatal and postnatal mental health](#). NICE Pathway

Quality standards

- [Service user experience in adult mental health](#). NICE quality standard 14

Other relevant NICE Evidence Updates

- [Patient experience in adult NHS services](#). NICE Evidence Update 52 (2014)

Feedback

If you would like to comment on this Evidence Update, please email contactus@evidence.nhs.uk

Key points

The following table summarises the key points for this Evidence Update and indicates whether the new evidence may have a potential impact on [NICE CG136](#). Please see the full commentaries for details of the evidence informing these key points.

The section headings used in the table below are taken from [NICE CG136](#).

Evidence Updates do not replace current NICE guidance and do not provide formal practice recommendations.

Key point	Potential impact on guidance	
	Yes	No
<p>Care and support across all points on the care pathway</p> <ul style="list-style-type: none"> Healthcare professionals' nonverbal communication skills – particularly listening, warmth and avoiding negativity – are associated with improved service user satisfaction. Perceptions of healthcare professionals' lack of compassion or lack of time to deal with postnatal psychological problems may be barriers to seeking help in black Caribbean women. Continuity of care is important for service users to build a trusting relationship with their mental healthcare professionals. Improving service users' knowledge about their illness may help them to actively participate in treatment decisions and maintain their autonomy. In service users with a history of compulsory admissions because of non-adherence to treatment, having a collaborative relationship with healthcare professionals may lead to improved attitudes towards future adherence to treatment. The questionnaire 'Views on Inpatient Care' (VOICE) may be easy for service users to complete and understand, and has good validity and internal and test–retest reliability. 		<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓
<p>Access to care</p> <ul style="list-style-type: none"> Multiprofessional care coordinated by a case manager may result in improvements in symptoms of depression, especially if the case manager is a nurse or is based in the community. 		<ul style="list-style-type: none"> ✓
<p>Assessment</p> <ul style="list-style-type: none"> Adding a quality-of-life assessment to standard psychiatric assessment may increase service users' global satisfaction if treating clinicians are provided with the results and a comparison of the score against population norms. However, assessing quality of life without considering the results clinically against population norms could result in potential harm to the patient. 		<ul style="list-style-type: none"> ✓
<p>Community care</p> <ul style="list-style-type: none"> People seem to prefer psychological treatments to drug treatments for mental health problems, irrespective of whether or not they have experience of mental health problems. 		<ul style="list-style-type: none"> ✓

1 Commentary on new evidence

These commentaries focus on the 'key references' identified through the search process and prioritised by the EUAG for inclusion in the Evidence Update, which are shown in bold text. Section headings are taken from [NICE CG136](#).

1.1 [Care and support across all points on the care pathway](#)

Relationships and communication

[NICE CG136](#) recommends that healthcare professionals should work in partnership with people using mental health services and their families or carers. They should offer help, treatment and care in an atmosphere of hope and optimism. Healthcare professionals should also take time to build trusting, supportive, empathic and non-judgmental relationships as an essential part of care.

Non-verbal communication

A systematic review and meta-analysis by [Henry et al. \(2012\)](#) was previously discussed in '[Patient experience in adult NHS services](#)', NICE Evidence Update 52 (2014), which gives a full overview. Briefly, the review included 26 studies of interactions between patients and any healthcare professionals to address a physical or mental health problem. Most included studies were of general practice (17 studies), and 4 were of inpatient psychiatric facilities; overall, 7 studies reported mental health outcomes. Patient satisfaction was the most commonly assessed outcome (reported in 17 studies) and was the only outcome suitable for meta-analysis.

Increasing healthcare professional warmth was associated with significantly increased patient satisfaction (pooled effect size=0.31, 95% confidence interval [CI] 0.23 to 0.38, $p<0.001$). There was a positive association between healthcare professionals listening and patient satisfaction (pooled effect size=0.25, 95% CI 0.13 to 0.37, $p<0.001$). The greater the negativity of nurses, the less patients were satisfied (pooled effect size=-0.35, 95% CI -0.53 to -0.17, $p<0.001$), but the relationship was not significant for all healthcare professionals considered together or physicians alone.

The study demonstrates the importance of healthcare professionals' non-verbal communication skills – particularly listening, warmth and avoiding negativity – in achieving service user satisfaction. The study reinforces the recommendation in [NICE CG136](#) to build trusting, supportive, empathic and non-judgemental relationships in adult mental health services, and provides insights that could inform healthcare professional skills training.

Key reference

Henry SG, Fuhrel-Forbis A, Rogers MA et al. (2012) [Association between nonverbal communication during clinical interactions and outcomes: a systematic review and meta-analysis](#). *Patient Education and Counseling* 86: 297–315

Black Caribbean women's perceptions of postnatal mental health services

[Edge \(2011\)](#) reported a qualitative study from the northwest of England that explored black Caribbean women's views on factors affecting the under-representation of this group among users of postnatal mental health services. Participants (n=42) were purposefully selected to represent a range of perspectives, and were recruited via posters in the community, local radio or newspapers, NHS organisations and churches with a mainly black congregation. Focus group sessions of 6–10 people lasting 60–90 minutes were conducted using an interview guide. Data were analysed by framework analysis, in which key themes and concepts were identified, coded and refined.

Although the study aimed to examine black women's views about perinatal mental health care, the focus group conversations often broadened to cover healthcare more generally. Most women reported that their maternity care was less than ideal, with some indicating poor experiences with hospital midwives and doctors, but better experiences with community midwives.

If women perceived a lack of compassion from their healthcare professionals, they were less likely to engage with mental health services or with general health services. Trusting relationships with sympathetic healthcare staff were considered necessary for people to feel able to disclose psychological problems. Perceptions that healthcare staff such as midwives or health visitors are too busy to address psychological needs were also barriers to seeking help. Furthermore, women perceived that healthcare staff seemed to focus on the infant at the mother's expense, and that interactions were protocol driven and formulaic.

Women considered an ideal service to be capable of addressing all needs, from support for people with mild emotional distress to treatment for those with diagnosed mental health problems. Women said care should be delivered in mixed ethnic groups, as opposed to either groups of black women only, or individual treatment. They additionally felt that drug treatments were useful for severe symptoms or if psychological treatments failed. However, they suggested that GPs are interested only in prescribing rather than in providing social support, which reinforced their reluctance to consult their GP.

The results from this sample of women may not be generalisable to the rest of the UK outside the area of northwest England in which the study was conducted, or to other ethnic groups. The women's views on an ideal service seem to mirror the stepped-care model of care recommended in '[Antenatal and postnatal mental health](#)' NICE clinical guideline 45, which was published in February 2007 and is [currently being updated](#). However, the interviews in the present study took place between September 2007 and June 2008, so recommended practice may not have been implemented at the time participants used perinatal health services.

Overall, this study suggests that perceptions of healthcare professionals' lack of compassion or lack of time to deal with postnatal psychological problems may be barriers to seeking help in black Caribbean women. These findings support the recommendations in [NICE CG136](#) about building relationships, particularly the need for time and being supportive and empathetic. These characteristics of interactions between people and healthcare professionals may apply not only to the mental health setting, but also to healthcare professionals who may be the first contact for people to raise concerns about their mental health.

Key reference

Edge D (2011) '[It's leaflet, leaflet, leaflet then, "see you later"](#)': black Caribbean women's perceptions of perinatal mental health care. *British Journal of General Practice* 61: 256–62

Experiences of compulsory inpatient treatment

[NICE CG136](#) recommends that when working with people using mental health services, healthcare professionals should:

- aim to foster their autonomy, promote active participation in treatment decisions and support self-management
- maintain continuity of individual therapeutic relationships wherever possible
- offer access to a trained advocate.

Trust, choice and the power balance in treatment

[Laugharne et al. \(2012\)](#) conducted a qualitative study in the UK of the experiences and attitudes towards mental health care in people who had received compulsory inpatient treatment for psychosis. Interviews focused on how service users built trusting relationships with clinicians, how much choice they had in their care and what the balance of power was in their care.

Participants were recruited in a rural setting in Cornwall and in an urban setting in London. People in Cornwall who were registered with an enhanced care programme of mental health services were invited. Invitations were initially sent alphabetically, but the first 9 people were predominantly white men older than 50 years. Subsequently, women and men under 50 years were selectively recruited. In London, people attending a day hospital were asked to participate by hospital staff.

A topic guide was used in the interview, and when interviewees mentioned a topic of interest but did not spontaneously provide information, probing questions were asked to encourage more detailed reflection on the topic. Data were analysed by the lead investigator and 3 other researchers using grounded theory and thematic analysis. A total of 22 interviews were conducted, 2 of which were not analysed. In one case the participant appeared to the interviewer to be intimidated by the interview, which was then stopped. In the other case the participant's speech was inaudible on the recording.

In terms of factors enhancing trust, participants noted that trust depends on both the service user and the clinician. Although service users valued clinicians' professional expertise, they also appreciated clinicians with a caring or kind attitude. Continuity of care was another important theme, which included having a regular or reliable clinician who delivered on promises. Trust was additionally enhanced when clinicians listened to the service user, were honest and positive about the future, or related to the service user by disclosing small details of personal information. Trust was undermined by a history or perception of coercion, perceptions of neglect by services when unwell, clinicians relying only on scientific knowledge, and the nature of the illness itself.

Choice in care was enhanced by service users' knowledge of their illness, time spent with healthcare staff, and having treatments other than medication available. Factors that undermined choice of care were that some service users did not think about choice, or lacked information about choice. The nature of the illness itself, subsequent lack of confidence in decisions, and history or perception of coercion also negatively affected service users' choice.

Service users generally felt that when they had been compulsorily detained, it was necessary, but that consultation with carers and other professionals about compulsory detention may have been worthwhile. Other factors affecting the power balance were service users' knowledge of their mental health and sharing responsibility for their health with the clinician. The power balance was negatively affected by perceptions of neglect by services when unwell, history or perception of coercion, and the nature of the illness itself. Minor factors that undermined services users' power were clinicians straying into areas that service users thought they should not, and perceptions that other service users abused their power.

The findings from this study suggest that continuity of care is important for service users to build a trusting relationship with their mental healthcare professionals. Improving service users' knowledge about their illness may help them to actively participate in treatment decisions and maintain their autonomy, which is consistent with recommendations in [NICE CG136](#).

Key reference

[Laugharne R, Priebe S, McCabe R et al. \(2012\) Trust, choice and power in mental health care: experiences of patients with psychosis. International Journal of Social Psychiatry 58: 496–504](#)

Relationships and treatment adherence

[Gault et al. \(2013\)](#) reported a qualitative study from the UK of perspectives of treatment adherence in people who had experienced compulsory drug treatment after partial or complete non-adherence to drug treatment. Participants had undergone at least 2 compulsory admissions; those who were actively distressed or were currently under a compulsory treatment order were excluded. The population therefore included people who had time to reflect on the process of compulsory treatment. Data were collected from 2008 to 2010.

Grounded theory was used to code data for analysis. Interviews were conducted with service users (n=24), and carers were permitted to be present and contribute if the service user wished. In a second phase to review findings, individual interviews and a focus group were used (n=7).

The pathway of care started when the service user needed mental health care but refused treatment. Several caregivers reported that mental health services were unresponsive to the service user's needs until an emergency admission was necessary. After a compulsory admission, service users felt that they lost their voice and identity and became defined by their mental illness. At that point, if the service user did not yet recognise that their mental function was impaired, they may have recognised that healthcare professionals reward compliant behaviour and the service user may have appeared to be compliant.

One participant reported mimicking behaviour that professionals perceived as 'well', and avoiding talking about her issues. Other service users reported partial adherence because the side effects of drug treatment did not allow them to lead normal lives.

After repeated relapses, service users reluctantly accepted that they had a mental health problem that needed treatment, including medication. Healthcare professionals who had a collaborative attitude to treatment, such as trying different medication to avoid side effects, were appreciated by service users and felt to enable adherence. Conversely, a non-collaborative attitude towards care from healthcare professionals was likely to result in poor adherence. Non-collaborative care included not giving adequate information, reluctance to listen to service users' genuine concerns about side effects or over-medication, or treating service users like a nuisance or problem.

The results of this study suggest that in service users with a history of compulsory admissions because of non-adherence to treatment, having a collaborative relationship with healthcare professionals may lead to improved attitudes towards future adherence to treatment. This evidence is consistent with the recommendation in [NICE CG136](#) that healthcare professionals should work in partnership with people using mental health services and their families or carers.

Key reference

[Gault I, Gallagher A, Chambers M \(2013\) Perspectives on medicine adherence in service users and carers with experience of legally sanctioned detention and medication: a qualitative study. Patient Preference and Adherence 7: 787–99](#)

Engaging service users in improving care

[NICE CG136](#) recommends that service managers should routinely commission reports on the experience of care across non-acute and acute care pathways, including the experience of being treated under the Mental Health Act (1983; amended 1995 and 2007). These reports should:

- include data that allow direct comparisons of the experience of care according to gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and disability

- include analyses of data from multiple sources, particularly data collected by service users monitoring service user experience and complaints
- be routinely communicated to the health and social care providers' board.

[Evans et al. \(2012\)](#) reported a study of a brief self-report measure of service users' experience of inpatient care, 'Views on Inpatient Care (VOICE)'. The study took place in an inner-city NHS trust in London. Participants in the development phase had inpatient treatment in the 2 years before the study. The feasibility phase recruited people from acute and psychiatric intensive care wards. Participants in the psychometric testing phase were recruited from acute wards. Test–retest participants were from acute and forensic units.

Overall, 45% of people who were eligible participated. Participants could provide informed consent and had been on the ward for at least 7 days of the 4-week data collection period. Information on age, gender, ethnicity and employment status were self-reported; data on diagnosis, legal status and admission status were obtained from NHS records.

VOICE was developed in collaboration with service users, including service users as researchers and facilitating focus groups. In this phase, all information was self-reported by the 37 participants. VOICE then underwent psychometric testing for feasibility, acceptability, reliability and validity, involving 360 participants.

Test–retest reliability was assessed by inpatients completing VOICE twice within 6–10 days. Validity was assessed by comparing scores on VOICE with results on the Service Satisfaction Scale, which were expected to have some overlap and some differences. Additionally, some difference in perceptions of care was expected among users from different populations and settings; specifically, poorer ratings were expected in people who were compulsorily admitted and in people from minority ethnic groups.

In both development and psychometric testing phases, about half of participants had a diagnosis of schizophrenia or psychosis. Both phases had groups that consisted of about half white people and about half black or other minority ethnicity. In the development phase, 43% of participants were men and the median age was 45 years (range 20–66 years). In the psychometric testing phase, 60% of participants were men and the mean age was 40 years (range 18–75 years).

In the development phase, the inter-rater reliability for coding of information from the focus groups was 97–99%. In the first set of feasibility tests (n=40), 98% of participants found the measure easy to understand and complete. In the second set of feasibility tests (n=106), 82% of participants found VOICE to be an appropriate length, taking 5–15 minutes to complete. Some questions were upsetting for 6 participants, and 2 disliked completing the tool.

No significant difference between test–retest scores was seen, and Pearson's coefficient showed significant correlation between VOICE scores and scores on the Service Satisfaction Scale ($r=0.82$, $p<0.001$). Participants who had been admitted compulsorily had significantly worse perceptions of care than others ($p<0.001$), which remained significant after multivariate analysis.

This study suggests that the questionnaire 'Views on Inpatient Care (VOICE)' may be easy for service users to complete and understand, and has good validity and internal and test–retest reliability. This questionnaire may be an option for services to use when evaluating service users' experience of services, as recommended in [NICE CG136](#).

Key reference

Evans J, Rose D, Flach C et al. (2012) [VOICE: developing a new measure of service users' perceptions of inpatient care, using a participatory methodology](#). *Journal of Mental Health* 21: 57–71

1.2 [Access to care](#)

Collaborative care

[NICE CG136](#) recommends that mental health services should establish close working relationships with primary care services to ensure:

- agreed processes for referral are in place, and
- primary care professionals can provide information about local mental health and social care services to the people they refer.

[Thota et al. \(2012\)](#) did a systematic review and meta-analysis of collaborative care models for treating depression in primary care. The review aimed to assess the evidence of effectiveness and identify the variables that influence how applicable and generalisable the models of care are to the general population. Primary outcomes of interest were improvement in depression (in terms of symptoms, response to treatment, remission or recovery) and diagnosis, adherence to treatment, health-related quality of life and functional status.

The review included studies of collaborative care with input from at least a case manager, general practitioner and a mental health specialist compared with no or minimum collaborative care. Participants had major depression, minor depression or dysthymia, without comorbid psychosis. A total of 32 studies published in 2004 or later that were rated as good or fair quality were included. Studies were conducted mainly in white or African-American adults, but the number of people in each study was not reported.

Effect sizes were calculated as a corrected standardised mean difference (Hedges g) in which values greater than 0 or odds ratios greater than 1 indicated effects in favour of the intervention.

Overall, the improvement in depression symptoms, compared with no or minimum collaborative care, was considered to be meaningful for improving health (Hedges $g=0.34$, 95% CI 0.25 to 0.43). Collaborative care was also associated with clinically significant improvements in adherence, response, remission, recovery and satisfaction with care (all $p<0.05$). Quality of life including functional status was associated with a small effect.

In terms of the type of organisation conducting the collaborative care, community-based organisations were associated with the largest improvement in symptoms of depression (Hedges $g=0.82$), and US Veterans Affairs organisations had the lowest (Hedges $g=0.11$). Among the different types of healthcare professionals acting as case managers, nurse case managers had the greatest effect on symptoms of depression (Hedges $g=0.37$). Socioeconomic status did not seem to affect results.

The included studies may have had selection bias if they recruited only participants with severe or major depression, because initial severe symptoms increase the potential amount of improvement. Conversely, if participants had only minor symptoms, the chances of remission or recovery may have been increased. No evidence of publication bias was noted.

These results suggest that multiprofessional care coordinated by a case manager may result in improvements in symptoms of depression, especially if the case manager is a nurse or is based in the community. This evidence is consistent with the recommendation in [NICE CG136](#) for mental health services to establish close working relationships with primary care services. '[Depression in adults](#)' NICE clinical guideline 90 (currently being updated) recommends a stepped-care model, in which most people with mild or moderate depression are likely to be treated in primary care. People with severe and complex depression should be referred to specialist mental health services for a programme of coordinated multiprofessional care. The guidance does not specify use of a case manager.

Key reference

Thota AB, Sipe TA, Byard GJ et al. (2012) [Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis](#). *American Journal of Preventive Medicine* 42: 525–38

1.3 Assessment

Assessment of quality of life

[NICE CG136](#) recommends that when carrying out an assessment:

- ensure there is enough time for the service user to describe and discuss their problems
- allow enough time towards the end of the appointment for summarising the conclusions of the assessment and for discussion, with questions and answers
- explain the use and meaning of any clinical terms used
- explain and give written material in an accessible format about any diagnosis given
- give information about different treatment options, including drug and psychological treatments, and their side effects, to promote discussion and shared understanding
- offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed.

[Boyer et al. \(2013\)](#) did a randomised controlled open-label trial in people with schizophrenia to investigate the effect that feedback to clinicians on quality-of-life assessment had on service users' satisfaction with care. Participants (n=124) in a psychiatric outpatient treatment facility in France were assigned to one of 3 groups. The groups were: standard psychiatric assessment (n=42); standard psychiatric assessment plus quality-of-life assessment (n=42); and standard psychiatric assessment plus quality-of-life assessment with feedback to clinicians about the results (n=40).

Participants in the groups having quality-of-life assessments completed self-administered questionnaires before the standard psychiatric assessment was done. In the clinician feedback group, data on current and previous quality-of-life assessments and population norms were provided to clinicians before the standard psychiatric assessment. The primary outcome was service user satisfaction (based on global satisfaction), satisfaction with staff and satisfaction with the care structure. Two-thirds of participants were men with mild schizophrenia, with a mean age of 41.1 years. Participants had a mean score on the Positive and Negative Syndrome Scale of 63.0, which the authors described as mild illness.

At 6 months, the proportion of people who rated their global satisfaction as 'high' was significantly different in the quality-of-life feedback group (72.5%) compared with the quality-of-life assessment group (45.2%) and the standard psychiatric assessment group (67.5%, $p < 0.025$). Similar results were seen for satisfaction with the care structure (77.5%, 50.0% and 70.0% respectively, $p < 0.025$). Results for satisfaction with staff were not significant.

The authors postulated that giving clinicians access to quality-of-life information provided them with useful intelligence and led to better communication between clinicians and service users. However, the study did not measure how the clinicians used the quality-of-life data in consultations with service users. Additionally, the lowest satisfaction was seen in the group that had quality-of-life assessments but no feedback to clinicians. This could mean that completing the quality-of-life assessment may increase service users' expectations of care with regard to quality of life. If clinicians do not then take account of quality of life in subsequent consultations, service users may be more dissatisfied than if they had no quality-of-life assessment.

The evidence suggests that adding a quality-of-life assessment to standard psychiatric assessment may increase service users' global satisfaction if treating clinicians are provided

with the results and a comparison of the score against population norms. However, assessing quality of life without considering the results clinically against population norms could result in potential harm to the service user.

These results are consistent with the recommendation in [NICE CG136](#) to allow enough time towards the end of the appointment for summarising the conclusions of the assessment and for discussion, with questions and answers. The findings are also consistent with '[Psychosis and schizophrenia in adults](#)', NICE clinical guideline 178, which recommends comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care, including quality-of-life assessment.

Key reference

Boyer L, Lançon C, Baumstarck K et al. (2013) [Evaluating the impact of a quality of life assessment with feedback to clinicians in patients with schizophrenia: randomised controlled trial](#). *The British Journal of Psychiatry* 202: 447–53

1.4 [Community care](#)

Types of treatment

[NICE CG136](#) recommends ensuring that service users treated in the community have timely access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problem in NICE guidance. When service users are in hospital they should also have access to treatments recommended in NICE guidance provided by competent health or social care professionals. Psychological and psychosocial treatments may be provided by health and social care professionals who work with the service user in the community.

Preference for psychological treatment

[McHugh et al. \(2013\)](#) conducted a meta-analysis of 34 studies (n=90,483) to investigate people's preferences towards psychological or drug treatment for mental health problems. Studies were selected if they included people with a diagnosed mental health problem who were asked about their preference for psychological or drug treatment before starting or being randomly assigned to one of these treatments. Additionally, papers were included if they asked healthy people whether they would prefer psychological or drug treatment if they were ever diagnosed with a mental health problem. The searches mainly identified studies of depression and post-traumatic stress disorder.

Overall, 75% (95% CI 68% to 80%) of people preferred psychological treatment, which the authors noted was significantly different ($p<0.0001$) from the point of equal preference, that is 50% preferring psychological treatment and 50% preferring drug treatment. The preference for psychological treatment in people having treatment for a mental health problem was lower (69%, 95% CI 61% to 77%) but this was still significantly different to the point of equal preference ($p<0.001$).

A funnel plot indicated possible publication bias from unpublished studies. However, the authors calculated that they would need to have missed 22 studies of 130 people in each preference group to discount their findings and concluded that the results were robust to publication bias.

This evidence suggests that people seem to prefer psychological treatments to drug treatments for mental health problems, irrespective of whether or not they have experience of mental health problems. This finding relates to recommendations in [NICE CG136](#) to ensure access to the appropriate pharmacological, psychological and psychosocial treatments for users of mental health services.

Key reference

McHugh RK, Whitton SW, Peckham AD et al. (2013) [Patient preference for psychological vs pharmacological treatment of psychiatric disorders: a meta-analytic review](#). *Journal of Clinical Psychiatry* 74: 595–602

1.5 [Assessment and referral in a crisis](#)

No new key evidence for this section was selected for inclusion in this Evidence Update.

1.6 [Hospital care](#)

No new key evidence for this section was selected for inclusion in this Evidence Update.

1.7 [Discharge and transfer of care](#)

No new key evidence for this section was selected for inclusion in this Evidence Update.

1.8 [Assessment and treatment under the Mental Health Act](#)

No new key evidence for this section was selected for inclusion in this Evidence Update.

2 New evidence uncertainties

During the development of the Evidence Update, the following evidence uncertainties were identified for the UK Database of Uncertainties about the Effects of Treatments (UK DUETs).

Community care

- [Psychological treatment versus pharmacotherapy: patient preference in the full range of psychiatric illnesses](#)

Further evidence uncertainties for service user experience in adult mental health can be found in the [UK DUETs database](#) and in the [NICE research recommendations database](#).

UK DUETs was established to publish uncertainties about the effects of treatments that cannot currently be answered by referring to reliable up-to-date systematic reviews of existing research evidence.

Appendix A: Methodology

Scope

The scope of this Evidence Update is taken from the scope of the reference guidance:

- [Service user experience in adult mental health](#). NICE clinical guideline 136 (2011)

The literature searches for the guideline and this Evidence Update covered systematic reviews, randomised controlled trials and observational studies. The literature search for this Evidence Update additionally included qualitative studies from the UK.

Searches

The literature was searched to identify studies and reviews relevant to the scope. Searches were conducted of the following databases, covering the dates 1 April 2011 (the end of the search period of NICE clinical guideline 136) to 5 November 2013:

- AMED (Allied and Complementary Medicine Database)
- CDSR (Cochrane Database of Systematic Reviews)
- CENTRAL (Cochrane Central Register of Controlled Trials)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- DARE (Database of Abstracts of Reviews of Effects)
- EMBASE (Excerpta Medica database)
- MEDLINE (Medical Literature Analysis and Retrieval System Online)
- MEDLINE In-Process
- NHS EED (Economic Evaluation Database)
- PsycINFO

The Evidence Update search strategy replicates the strategy used by [NICE CG136](#) (for key words, index terms and combining concepts) as far as possible. Where necessary, the strategy is adapted to take account of changes in search platforms and updated indexing language.

Table 1 provides details of the MEDLINE search strategy used, which was adapted to search the other databases listed above. The search strategy was used in conjunction with validated Scottish Intercollegiate Guidelines Network [search filters for systematic reviews, RCTs and observational studies](#).

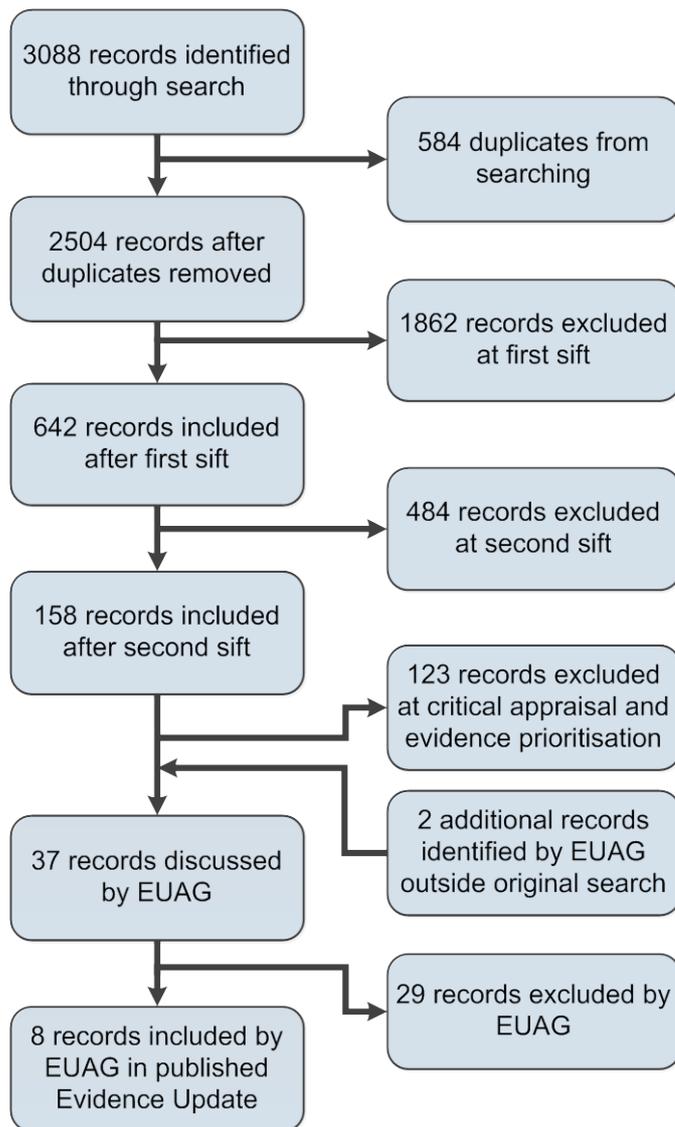
Figure 1 provides details of the evidence selection process. The list of evidence excluded after review by the Chair of the EUAG, and the full search strategies, are available on request from contactus@evidence.nhs.uk

See the [NICE Evidence Services](#) website for more information about [how NICE Evidence Updates are developed](#).

Table 1 MEDLINE search strategy (adapted for individual databases)

1	Consumer advocacy/	16	Mental Health/
2	Patient advocacy/	17	Mentally Ill Persons/
3	exp Patient satisfaction/	18	Psychiatric Department, Hospital/
4	Total quality management/	19	Community Psychiatry/
5	exp physician/ and (choos\$ or choice\$).tw.	20	exp Psychiatry/
6	((consumer\$ or patient\$) adj choice\$) or ((doctor\$ or physician\$ or plan or provider\$) and (choos\$ or choice\$)).ti,ab.	21	exp Psychology/
7	((choice\$ or choos\$ or (public adj5 disclos\$) or (quality adj5 improve\$)) and (performance adj (data or indicator\$ or information or measure\$ or report))) or report card).ti,ab.	22	Affective Symptoms/
8	((consumer\$ or patient\$ or user\$) adj satisfaction) or ((consumer\$ or patient\$ or user\$) adj5 survey\$) or (patient\$ adj (assessment or complaint\$ or evaluation or feedback or report)) or ((health or patient\$) adj advocacy) or pals or complaints system).ti,ab.	23	Delusions/
9	Quality improvement/	24	Depression/
10	Choice behavior/	25	exp Mental Disorders/
11	or/1-10	26	Paranoid Disorders/
12	Alcoholism/	27	exp Self-injurious behavior/
13	Substance-Related Disorders/	28	Hospitals, Psychiatric/
14	Community mental health centers/	29	Psychology, Social/
15	Mental Health Services/	30	exp Somatoform Disorders/
		31	Emergency Services, Psychiatric/
		32	Social Work, Psychiatric/
		33	(cmhs or mental\$ or psychiatric\$ or psychologic\$).tw.
		34	exp Institutionalization/ and psychiatric\$.tw.
		35	or/12-34
		36	11 and 35
		37	limit 36 to yr="2011 - 2013"
		38	limit 37 to english language

Figure 1 Flow chart of the evidence selection process



EUAG – Evidence Update Advisory Group

Appendix B: The Evidence Update Advisory Group and Evidence Update project team

Evidence Update Advisory Group

The Evidence Update Advisory Group is a group of topic experts who reviewed the prioritised evidence from the literature search and advised on the development of the Evidence Update.

Mike Crawford – Chair

Professor of Mental Health, Imperial College London and Central and North West London NHS Foundation Trust

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Reader in User-led Research, Institute of Psychiatry, King's College London

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Representing service user and carer interests

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Evidence Update 61 – Service user experience in adult mental health

(May 2014)

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