

**Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services**

**NICE guidance**

**Draft for consultation, June 2011**

If you wish to comment on this version of the guidance, please be aware that all the supporting information and evidence is contained in the full version.

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## Introduction

Over the past few years several documents and initiatives have highlighted the importance of the service user's experience and the need to focus on improving these experiences where possible.

- Lord Darzi's report 'High quality care for all' (2008) highlighted the importance of the entire service user experience within the NHS, ensuring people are treated with compassion, dignity and respect within a clean, safe and well-managed environment.
- The development of the NHS Constitution (2009–2010) was one of several recommendations from Lord Darzi's report. The Constitution describes the purpose, principles and values of the NHS and illustrates what staff, service users and the public can expect from the service. Since the Health Act came into force in January 2010, service providers and commissioners of NHS care have had a legal obligation to take the Constitution into account in all their decisions and actions.
- The King's Fund charitable foundation has developed a comprehensive policy resource – 'Seeing the person in the patient: the point of care review paper' (2008). Some of the topics explored in the paper are used in the development of this guidance and quality standard.

National initiatives aimed at improving service users' experience of healthcare include NHS Choices, a comprehensive information service that helps people to manage their healthcare and provides service users and carers with information and choice about their care. Local initiatives, such as patient advice and liaison services (PALS), have also been introduced.

Despite these initiatives, there is evidence to suggest that further work is needed to deliver the best possible experience for users of NHS services. The Government signalled in its White Paper, 'Equity and excellence: liberating the NHS' (July 2010) that more emphasis needs to be placed on improving service users' experience of NHS care. This guidance on service user experience in adult mental health services is a direct referral from the National Quality Board.

In 2005 the Department of Health published 'Delivering race equality in mental health care: an action plan for reform inside and outside services and the government's response to the independent inquiry into the death of David Bennett'. The report contained recommendations about the delivery of mental healthcare to service users, in particular those from black and minority ethnic communities. The recommendations also address wider issues in mental health settings, such as the safe use of physical interventions.

High-quality care should be clinically effective, safe and be provided in a way that ensures the service user has the best possible experience of care. This guidance on service user experience, and the quality standard developed from it, aims to ensure that users of mental health services have the best possible experience of care from the NHS.

## **Person-centred care**

This guidance offers best practice advice on improving the experience of people who use adult NHS mental health services. This guidance aims to promote person-centred care that takes into account service users' needs, preferences and strengths. People who use mental health services should have the opportunity to make informed decisions about their care and treatment, in partnership with their health and social care practitioners. If service users do not have the capacity to make decisions, healthcare professionals should follow the Department of Health's advice on consent (available from [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent)) and the code of practice that accompanies the Mental Capacity Act (summary available from [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)). In Wales, healthcare professionals should follow advice on consent from the Welsh Assembly Government (available from [www.wales.nhs.uk/consent](http://www.wales.nhs.uk/consent)).

In this guidance, families and carers include relatives, friends, non-professional advocates and significant others who play a supporting role for the person using mental health services. If the service user agrees, families and carers should have the opportunity to be involved in decisions about treatment and care. Families and carers should also be given the information and support they need.

## Draft quality statements

No.	Draft quality statements
1	People using mental health services and their families or carers are supported to feel optimistic about their care by mental health and social care professionals who are empathetic and non-judgemental.
2	People using mental health services are supported by mental health and social care professionals who have received cultural awareness training from a programme that has input from local voluntary organisations who work with the black and minority ethnic communities.
3	People using mental health services are actively involved in treatment decisions and shared decision-making, and engaged in self-management.
4	People using mental health services are supported by staff from a single, multidisciplinary team, who they know and with whom they have a continuous relationship.
5	People using mental health services can be assured that the views of service users are used to help monitor the performance of services.
6	People have timely and efficient access to mental health services.
7	People using mental health services are given explanations and information about the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8	People working in mental health services are trained in person-centred care and/or customer care by service users.
9	People using mental health services are given a written copy of a care plan that includes details of activities to promote social inclusion such as education, employment, volunteering and other specified occupations such as leisure activities and caring for dependants.
10	People using mental health services who are at risk of hospitalisation have a crisis plan that includes preferences for admission and treatment; treatment refusals; possible early warning signs; and the practical needs of the service user.
11	People in crisis have an assessment undertaken by a competent professional that includes their relationships, their social and living circumstances and level of functioning, their symptoms, behaviour, diagnosis and current treatment.
12	People admitted to hospital for mental health treatment and care are addressed using the name and title they prefer and have their psychological and emotional needs and preferences taken into account.
13	People admitted to hospital for mental health treatment and care are formally assessed within 2 hours of arrival.

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14	People admitted to hospital for mental health treatment and care are introduced to the health and social care team as soon as possible.
15	People in hospital for mental health treatment and care, including service users subject to the Mental Health Act, are routinely involved in shared decision-making with healthcare professionals.
16	People in hospital for mental health treatment and care see, on a one-to-one basis, their named healthcare professional every day for at least 1 hour and their consultant at least once a week for at least 20 minutes.
17	People in hospital for mental health treatment and care have access to meaningful activities, including creative and leisure activities, exercise and self-care 7 days a week during and outside normal working hours.
18	People in hospital for mental health treatment and care are involved in their discharge planning and have at least 2 days' notice of their discharge date.
19	Professionals using control and restraint, and compulsory treatment including rapid tranquillisation, are trained and competent to undertake them safely and use them as a last resort with minimum force.
20	People using mental health services who are subject to control and restraint or compulsory treatment including rapid tranquillisation have the reasons for it explained immediately afterwards and at discharge, and are given the opportunity to document their experience of it in their care record.
21	People using mental health services are asked if and how they want their family and/or carers to be involved in their care.
22	People using mental health services can be assured that services are working with other local organisations to combat the stigma associated with mental health problems, mental illness and mental health services in the local community and the NHS.

# 1 Guidance

The following guidance is based on the best available evidence. The full guidance ([[hyperlink to be added for final publication](#)]) gives details of the methods and the evidence used to develop the guidance.

Recommendations, or parts of recommendations, that underpin the development of the quality statements and associated measures are denoted **[QS]**.

## 1.1 *Care and support across all points on the care pathway*

1.1.1 Work in partnership with people using mental health services and their families or carers. Offer help, treatment and care in an atmosphere of hope and optimism. Take time to build supportive, empathic and non-judgemental relationships as an essential part of care. **[QS1]**

1.1.2 When working with people using mental health services:

- aim to foster their autonomy, promote active participation in treatment decisions and support self-management **[QS3]**
- maintain continuity of individual therapeutic relationships wherever possible
- ensure that comprehensive written information about the nature of, and treatments and services for, their mental health problems is available in an appropriate language or format including any relevant 'Understanding NICE guidance' booklets
- offer access to an advocate.

1.1.3 When working with people using mental health services and their family or carers:

- ensure that you are easily identifiable (for example, by wearing appropriate identification) and approachable
- address service users using the name and title they prefer

- clearly explain any clinical language and check that the service user understands what is being said
- take into account communication needs, including those of people with learning disabilities, sight or hearing problems or language difficulties and provide independent interpreters (that is, someone who does not have a relationship with the service user) or communication aids if required.

1.1.4 Ensure that you are:

- familiar with local and national sources (organisations and websites) of information and/or support for people using mental health services
- able to discuss and advise how to access these resources.

### **Avoiding stigma and promoting social inclusion**

1.1.5 When working with people using mental health services:

- take into account that stigma and discrimination are often associated with using mental health services
- make sure that discussions take place in settings in which confidentiality, privacy and dignity are respected
- be clear with service users about limits of confidentiality. **[QS2, QS22]**

1.1.6 When working with people using mental health services

- be respectful of, and sensitive to, diverse cultural, ethnic and religious backgrounds
- be aware of possible variations in the presentation of mental health problems according to cultural, ethnic or religious background. **[QS2, QS22]**

1.1.7 Health and social care professionals working with people using mental health services should have competence in:

- assessment skills and using explanatory models of illness for people from diverse cultural, ethnic and religious backgrounds
- explaining the causes of different mental health problems, if possible, and treatment options
- addressing cultural and ethnic differences in treatment expectations and adherence
- addressing cultural and ethnic beliefs about biological, social and familial influences on the causes of mental health problems
- negotiating skills for working with service users' families and carers
- conflict management and conflict resolution. **[QS2, QS22]**

1.1.8 Trust boards should work **with** all other local organisations with an interest in mental health (including social services, other hospitals, voluntary organisations, local press and media) to develop a strategy to combat the stigma in the community and in the NHS associated with mental health problems and using mental health services.

### **Consent, capacity and treatment decisions**

1.1.9 Health and social care professionals should ensure that they:

- understand and can apply the principles of the Mental Capacity Act (2005) appropriately
- are aware that mental capacity needs to be assessed for each decision separately
- can assess mental capacity using the test in the Mental Capacity Act (2005)
- understand how the Mental Health Act (1983; amended 1995 and 2007) and the Mental Capacity Act (2005) relate to each other in practice.

1.1.10 Develop advance statements and advance decisions with the person using mental health services, especially if their illness is severe and they have been previously treated under the Mental

Health Act (1983; amended 1995 and 2007). Document these in their care plans and ensure copies are held by the service user and in primary and secondary care records. **[QS10]**

**1.1.11** When a service user has impaired capacity, check their care record for advance decisions and advance statements before offering or starting treatment. **[QS11]**

### **Involving families and carers**

**1.1.12** Discuss with the person using mental health services if and how they want their family or carers to be involved in their care. **[QS21]**

**1.1.13** If the person using mental health services wants their family or carers to be involved, encourage this involvement and:

- negotiate between the service user and their family or carers about confidentiality and sharing of information on an ongoing basis
- explain how families or carers can help support the service user and help with treatment plans
- make sure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the service user and their family or carers.

**1.1.14** If the person using mental health services wants their family or carers to be involved, give the family or carers verbal and written information about:

- the mental health problem(s) experienced by the service user and its treatment, including relevant 'Understanding NICE guidance' booklets
- statutory and voluntary local support groups and services specifically for families and carers, and about how to access these
- their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.

- 1.1.15 If the service user does not want their family or carers to be involved in their care:
- seek consent from the service user and if they agree give the family or carers verbal and written information on the mental health problem(s) experienced by the service user and its treatments, including relevant 'Understanding NICE guidance'
  - give the family or carers information about statutory and voluntary local support groups and services specifically for families or carers, and how to access these
  - tell the family or carers about their right to a formal carer's assessment of their own physical and mental health needs, and how to access this.
- 1.1.16 Ensure that service users who are parents with caring responsibilities receive support to access the full range of mental health and social care services, including:
- childcare to enable them to attend appointments, groups and therapy sessions
  - supported accommodation for families
  - hospital care in local mother and baby units for women in the late stages of pregnancy and within a year of childbirth.

### **Engaging service users in improving care**

- 1.1.17 When providing training about any aspect of mental health and social care:
- involve people using mental health services in the planning and delivery of training
  - ensure that all training aims to improve the quality and experience of care for people using mental health services; evaluate training with this as an outcome.
- 1.1.18 Trusts should consider employing service users to train teams of health and social care professionals and supporting staff who may

come into contact with service users such as receptionists, administrators, secretaries and housekeeping staff, in 'person-centred care' or 'customer care'. Such training should be tailored to the needs of people who attend mental health services and should be evaluated using experience of care as an outcome. **[QS5, QS8]**

1.1.19 Trust managers should employ service users to monitor the experience of using mental health services, especially inpatient services, for example by paying them to undertake exit interviews with service users who have recently left a service. Offer service users training to do this. **[QS5]**

1.1.20 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 be routinely communicated to the trust board. Data should be collected to allow direct comparison of the experience of care for all genders, for different ethnic groups and for other minority groups. **[QS5]**

## **1.2 Access to care**

1.2.1 When people are referred to mental health services, ensure that:

- they are given or sent a copy of the referral letter when this is sent to mental health services
- they are offered an appointment with mental health services within 2 weeks of referral and are informed that they can change the date and time of the appointment if they wish
- any change in appointment does not result in a delay of more than 2 weeks. **[QS6]**

1.2.2 When people are sent an appointment letter for mental health services it should:

- give the name and professional designation of the person who will assess them
- include information about the service including a website address, and different options about how to get to there
- explain the process of assessment using plain language
- specify all the information needed for the assessment, including about current medication
- address the likely anxiety and concern often experienced by people attending mental health services for assessment
- explain that although they can be accompanied by a family member, carer or advocate if they wish for all or part of the time, it is preferable to see the person alone for some of the assessment
- ask if they will need an interpreter, or have any hearing, sight or speech problems, a learning disability or any disability access requirements
- give a number to ring if they have problems getting to the appointment or wish to change it.

1.2.3 Mental health services should establish close working relationships with primary care services to ensure:

- agreed processes for referral, consistent with 1.2.1, are in place, and
- primary care professionals can provide information about local mental health and social care services to the people they refer.

**[QS6]**

1.2.4 Local mental health services should work with primary care and local voluntary organisations to ensure that:

- people with mental health problems from black and minority ethnic groups have the same access to services as other service users based on clinical need
- services are culturally appropriate. **[QS2]**

- 1.2.5 Take into account the requirements of the Equality Act 2010 and make sure services are equally accessible to, and supportive of, all people using mental health services.

### **1.3 Assessment**

- 1.3.1 On arrival at mental health services for assessment, service users should be greeted and engaged by reception and other staff in a warm, friendly, empathic, respectful and professional manner, anticipating possible distress.

- 1.3.2 Before the assessment begins, the health or social care professional undertaking the assessment should ensure that the service user understands:

- the process of assessment and how long the appointment will last
- that the assessment will cover all aspects of their experiences and life
- confidentiality and data protection as this applies to them
- the basic approach of shared decision-making
- that although they can be accompanied by a family member, carer or advocate for all or part of the time, it is preferable to see the person alone for some of the assessment
- that they can refuse permission for any other member of staff, such as a student, to be present.

- 1.3.3 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 about any diagnosis given

- outline different treatment options and give information about these to promote discussion and shared understanding
- offer support after the assessment, particularly if sensitive issues, such as childhood trauma, have been discussed. **[QS7]**

1.3.4 If a service user is unhappy about the assessment and diagnosis, give them time to discuss this and offer them the opportunity for a second opinion.

1.3.5 Copy all written communications with other health or social care professionals to the service user at the address of their choice, unless the service user declines this.

1.3.6 Ensure that if a service user needs to wait before an assessment, this is for no longer than 10 minutes after the agreed appointment time. **[QS6]**

1.3.7 Ensure that waiting rooms are comfortable, clean and warm, and have areas of privacy, especially for those who are distressed or who request this, or are accompanied by children.

1.3.8 Inform service users of their right to a formal community care assessment, and how to access this.

## **1.4 Community care**

1.4.1 When communicating with service users use diverse media, including letters, phone calls, emails or text messages, according to the service user's preference.

1.4.2 Develop care plans jointly with the service user, and include activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependants. Give the service user an up-to-date written copy of the care plan. **[QS9]**

- 1.4.3 Support service users to develop strategies, including risk- and self-management plans, to promote and maintain independence and self-efficacy, wherever possible. Incorporate these strategies into the care plan.
- 1.4.4 If they are eligible, give service users the option to have a personal budget or direct payment so they can choose and control their social care and support, with appropriate professional and peer support as needed.
- 1.4.5 For people at risk of hospitalisation, a crisis plan should be developed by the service user and their care coordinator, which should be respected and implemented, and incorporated into the care plan. The crisis plan should include:
- where the person would like to be admitted
  - possible early warning signs of a crisis,
  - the practical needs of the service user if they are admitted to hospital (childcare or the care of other dependants, including pets). **[QS10]**
- 1.4.6 Ensure that service users routinely have access to their care plan and care record, including electronic versions. Care records should contain a section in which the service user can document their views and preferences, and any differences of opinion with health and social care professionals.
- 1.4.7 Trusts should ensure that service users:
- can routinely receive care and treatment from a single multidisciplinary community team
  - are not passed from one team to another
  - do not undergo multiple assessments. **[QS4]**

- 1.4.8 Ensure that service users have access to the psychological, psychosocial and pharmacological interventions recommended for their mental health problem in NICE guidance.
- 1.4.9 Mental health services should work with local voluntary black and minority ethnic and other minority groups to jointly ensure that culturally appropriate psychological and psychosocial treatments, consistent with NICE guidance and delivered by competent practitioners, are provided to service users from all ethnic and cultural backgrounds.
- 1.4.10 Mental health and social care professionals inexperienced in working with service users from diverse ethnic and cultural backgrounds should seek advice, training and supervision from health and social care professionals who are experienced in working with people from different cultures.

## **1.5 *Assessment and referral in a crisis***

- 1.5.1 Immediately before assessing a service user who has been referred in crisis, find out if they have had experience of acute or non-acute mental health services, and consult their crisis plan if they have one.
- 1.5.2 When undertaking a crisis assessment:
- address and engage service users in a supportive and respectful way
  - provide clear information about the process and its possible outcomes, addressing the individual needs of the service user, as set out in 1.3
  - take extra care to understand and emotionally support the service user in crisis, considering their level of distress and associated fear, especially if they have never been in contact with services before, or if their prior experience of services has

been difficult and/or they have had compulsory treatment under the Mental Health Act (1983; amended 1995 and 2007).

1.5.3 Assessment in crisis should be undertaken by experienced health and social care professionals competent in crisis working, and should include an assessment of the service user's relationships, social and living circumstances and level of functioning, as well as their symptoms, behaviour, diagnosis and current treatment.

**[QS11]**

1.5.4 If assessment in the service user's home environment is not possible, or if they do not want an assessment at home, take full consideration of their preferences when selecting a place for assessment.

1.5.5 When a person is referred in crisis they should be seen by specialist mental health secondary care services within 4 hours of referral. **[QS6]**

1.5.6 Trusts should ensure that service users have access to 24-hour helplines, staffed by trained health and social care professionals, and that all GPs in the area know the telephone number. **[QS6]**

1.5.7 Trusts should ensure that crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, and that they are the first service to assess and provide treatment for service users in crisis regardless of their diagnosis. **[QS6]**

1.5.8 To avoid admission, aim to:

- support a service user in crisis in their home environment
- make early plans to help the service user maintain their day-to-day activities, including work, education, voluntary work, and other occupations such as caring for dependants and leisure activities, wherever possible.

1.5.9 At the end of a crisis assessment, ensure that the decision to start home treatment depends not on the diagnosis but on:

- the level of distress
- the severity of the problems
- the vulnerability of the service user
- issues of safety and support at home
- the reliability of access to, and the person's cooperation with, treatment.

1.5.10 Consider the support and care needs of families or carers of service users in crisis. Where needs are identified, ensure they are met when it is safe and practicable to do so.

1.5.11 Trusts should support direct self-referral to mental health services as an alternative to accessing urgent assessment via the emergency department.

## **1.6 *Hospital care***

1.6.1 When a service user enters hospital, greet them using the name and title they prefer, in an atmosphere of hope and optimism, with a clear focus on their emotional and psychological needs, and their preferences. **[QS12]**

1.6.2 Give verbal and written information to service users, and their families or carers where agreed by the service user, about:

- the hospital and the ward in which the service user will stay
- treatments, activities and services available
- expected contact from health and social care professionals
- rules of the ward (including substance misuse policy)
- service users' rights, responsibilities and freedom to move around the ward and outside
- meal times
- visiting arrangements.

Make sure there is enough time for the service user to ask questions.

- 1.6.3 Undertake shared decision-making routinely with service users in hospital, including, whenever possible, service users who are subject to the Mental Health Act (1983; amended 1995 and 2007). **[QS15]**
- 1.6.4 Undertake formal assessment and admission processes within 2 hours of arrival. **[QS13]**
- 1.6.5 Shortly after service users arrive in hospital, show them around the ward and introduce them to the health and social care team as soon as possible and within the first 12 hours if the admission is at night. This should include the named healthcare professional who will be involved throughout the person's stay. **[QS14]**
- 1.6.6 Offer service users in hospital:
- daily one-to-one sessions lasting at least 1 hour with their named healthcare professional
  - regular (at least weekly) one-to-one sessions lasting at least 20 minutes with their consultant. **[QS16]**
- 1.6.7 Ensure that the overall coordination and management of care takes place at a regular multidisciplinary meeting led by the consultant and team manager with full access to the service user's electronic record. These meetings should not be used to see service users or carers, unless the service user specifically requests this in addition to their daily meeting with their named healthcare professional and their weekly one-to-one meeting with their consultant. **[QS16]**
- 1.6.8 Trusts should ensure that service users in hospital have access to the pharmacological, psychological and psychosocial 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.

1.6.9 Ensure that service users in hospital have access to a wide range of meaningful and culturally-appropriate occupations and activities 7 days per week, and not restricted to 9am to 5pm. These should include creative and leisure activities, exercise, self-care and community access activities (where appropriate). Activities should be facilitated by appropriately trained health or social care professionals. **[QS17]**

1.6.10 Ensure that service users have access to the internet during their stay in hospital.

1.6.11 All health and social care professionals who work in a hospital setting should be trained as a group to use the same patient-centred approach to treatment and care, including 'customer care'. **[QS8]**

1.6.12 Service users receiving community care before hospital admission should be routinely visited while in hospital by the health and social care professionals responsible for their community care.

1.6.13 Ensure that all service users in hospital have access to former inpatients who can act as advocates and regularly feed back to ward professionals any problems experienced by current service users on that ward.

1.6.14 Ensure that hospital menus include a choice of foods, and that these are acceptable to service users from a range of ethnic, cultural and religious backgrounds. Consider including service users in planning menus.

## **1.7 *Discharge and transfer of care***

1.7.1 Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong

emotions and reactions in people using mental health services.

Ensure that:

- such changes are discussed carefully beforehand with the service user (and their family or carers if appropriate) and are structured and phased
- the care plan supports effective collaboration with social care and other care providers during endings and transitions, and includes details of how to access services in times of crisis
- when referring a service user for an assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.

1.7.2 Agree discharge plans with the service user and include contingency plans in the event of problems arising after discharge. Ensure that a 24-hour helpline is available to service users so that they can discuss any problems arising after discharge. **[QS18]**

1.7.3 Before discharge or transfer of care, ensure that any involved family or carers are informed.

1.7.4 Assess the home situation of the service user before they are discharged from inpatient care.

1.7.5 Give service users clear information about all possible support options available to them after discharge or transfer of care.

1.7.6 Give service users at least 48 hours' notice of the date of their discharge from a ward. **[QS18]**

1.7.7 When preparing a service user for discharge, consider encouraging them to contact the local patient advocacy and liaison service (PALS) to enquire about being trained as an advocate or becoming involved in monitoring services.

## **1.8      *Assessment and treatment under the Mental Health Act***

- 1.8.1      Carry out an assessment for possible detention under the Mental Health Act (1983; amended 1995 and 2007) in a calm and considered way, whenever possible, respond to the service user's needs and treat them with dignity and respect.
- 1.8.2      Explain to service users, no matter how distressed, why the compulsory detention or treatment is being used. Repeat the explanation if the service user appears not to have understood or is pre-occupied or confused.
- 1.8.3      When detaining a service user under the Mental Health Act (1983; amended 1995 and 2007) inform the receiving mental health service about the service user so they are expecting them and ready to welcome them to the service.
- 1.8.4      When detaining a service user under the Mental Health Act (1983; amended 1995 and 2007):
- give them verbal and written information appropriate to the section of the Act used, including 'patient rights leaflets' detailing what is happening to them and why, and what their rights are
  - repeat this information if they appear not to have understood or are pre-occupied or confused
  - give them, and their families or carers if they agree, information about the legal framework of the Mental Health Act.
- 1.8.5      Inform service users detained under the Mental Health Act (1983; amended 1995 and 2007) of their right to appeal to a mental health tribunal and support them if they appeal.
- 1.8.6      Tell the service user that if they are dissatisfied with their care and wish to make a complaint while under the Mental Health Act (1983;

amended 1995 and 2007) they can do so to the Care Quality Commission.

1.8.7 Detain service users under the Mental Health Act (1983; amended 1995 and 2007) only after all alternatives have been fully considered in conjunction with the service user if possible, and with the family or carer if the service user agrees. Alternatives may include:

- crisis houses
- home treatment
- acute day facilities
- respite care
- medicines review.

1.8.8 When a service user is admitted to a 'place of safety' ensure they are assessed for the Mental Health Act (1983; amended 1995 and 2007) as soon as possible, and certainly within 4 hours. **[QS6]**

1.8.9 After application of the Mental Health Act (1983; amended 1995 and 2007) ensure that:

- transition to the inpatient unit is smooth, efficient and comfortable
- family and carers can travel with the service user if safe to do so
- the police are involved only if the safety of the service user, family, carers, dependent children or health and social care professionals is an important consideration and cannot be managed by other means, such as involving more professionals.

### **Control and restraint, and compulsory treatment**

1.8.10 Control and restraint, and compulsory treatment including rapid tranquillisation, should be used as a last resort and only by healthcare professionals trained and competent to do this. Document the reasons for such actions. **[QS19]**

1.8.11 When a service user is subject to control and restraint, or receives compulsory treatment including rapid tranquillisation under the Mental Health Act (1983; amended 1995 and 2007):

- recognise that they may consider it a violation of their rights
- use minimum force
- try to involve healthcare professionals whom the service user trusts
- make sure the service user is physically safe
- explain reasons for the episode of compulsory treatment to the service user and involved family members or carers
- discuss episodes of compulsory treatment with the service user at the time of discharge in a calm and simple manner. **[QS20]**

1.8.12 After any episode of control and restraint, or compulsory treatment including rapid tranquillisation, explain the reasons for such action to the service user and offer them the opportunity to document their experience of it in their care record, and any disagreement with healthcare professionals. **[QS20]**

## 2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover. The scope of this guidance is available from [www.nice.org.uk/\[NICE to add details\]](http://www.nice.org.uk/[NICE to add details]).

### How this guidance was developed

NICE commissioned the National Collaborating Centre for Mental Health to develop this guidance. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations.

There is more information about how NICE clinical guidelines are developed on the NICE website ([www.nice.org.uk/HowWeWork](http://www.nice.org.uk/HowWeWork)). A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' (fourth edition, published 2009), is available from NICE publications (phone 0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) and quote reference N1739).

## 3 Implementation

NICE has developed tools to help organisations implement this guidance (see [www.nice.org.uk/guidance/CG\[XX\]](http://www.nice.org.uk/guidance/CG[XX])).

## 4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

### ***4.1 Training in the use of the national quality standard and guidance on service-user experience of care***

For people using adult mental health services, what is the effect of training community mental health teams (CMHTs) and inpatient ward staff in the use

of the national quality standard and underpinning guidance on service user experience, when compared to no training, on service users' experience of care?

### **Why this is important**

The primary purpose of NICE quality standards is to make it clear what quality care is by providing patients and the public, health and social care professionals, commissioners and service providers with definitions of high-quality health and social care<sup>1</sup>. However, little is known about the impact of training health and social care professionals in the use of quality standards.

This question should be answered using a cluster randomised trial of community mental health teams (CMHTs) and inpatient ward staff to evaluate the impact of training them in the use of the national quality standard and underpinning guidance on service service-user experience of care. Three types of intervention should be included in the design:

- CMHTs and wards with no training
- CMHTs and wards where training is delivered by a professional trainer
- CMHTs and wards where training is delivered by a professional trainer and service user(s).

Satisfaction with care and other aspects of service user experience should be surveyed. Qualitative interviews with service users and providers should be used to increase the explanatory power of the study.

## **4.2 *Late access to services and compulsory and intensive treatment***

For people using adult mental health services, what are the personal and demographic factors associated with late access to services and an increased likelihood of compulsory and intensive treatment, and what are the key themes that are associated with poor engagement?

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<sup>1</sup> <http://www.nice.org.uk/guidance/qualitystandards/moreinfoaboutnicequalitystandards.jsp>  
Service user experience in adult mental health: NICE guidance DRAFT  
(June 2011)

### **Why this is important**

Qualitative research and experience surveys suggest that service users experience many problems relating to compulsory treatment. However, little is known about the factors associated with accessing services late and the need for compulsory and intensive treatment.

This question should be answered by a case-control study to identify service users from different ethnic groups who use inpatient and intensive treatment services in order to identify the personal and demographic factors associated with late access to services and an increased likelihood of compulsory and intensive treatment. In-depth interviews with service users should be undertaken to identify key themes that are associated with poor engagement.

### **4.3 Shared decision making**

For people using adult mental health services, what are the key aspects of 'shared decision making' that they prefer, and does a training programme for health and social care professionals designed around these key aspects, when compared to no training, improve service users' experience of care?

### **Why this is important**

In healthcare, 'shared decision making' is the sharing of preferences and decisions by both the professional and the service user to reach a consensus regarding the preferred treatment options. However, the key aspects of shared decision making are unknown, although the principle of shared decision making is an important element of a person-centred care approach.

This question should be answered by a pilot qualitative study of shared decision making to determine what, if any, key aspects of shared decision making are preferred by service users. The pilot should be followed by a randomised controlled trial on shared decision making in community mental health teams (CMHTs) compared with standard decision making, which would be carefully characterised by in-depth qualitative interview. Evaluation would quantify the impact on service-user knowledge, the experience of care, rates of side effects and perceived benefits from treatment. Purposive-selected service users would undertake in-depth interviews to identify themes related

to an improved experience of care associated with the shared decision making and the standard approach.

#### **4.4        *Activities and occupations on inpatient wards***

For people receiving adult mental health hospital care, what activities and occupations do service users want when staying on inpatient wards?

##### **Why this is important**

Qualitative research and experience surveys suggest that many service users find there are insufficient activities and occupations available to them when staying on an inpatient ward. However, little is known about what service users want and how to improve the experience of care.

This question should be answered by a qualitative study to identify what activities and occupations service users want on inpatient wards. This would include service users currently on inpatient wards as well as those who have left. This would allow a future cluster randomised trial evaluating the inclusion of occupations and activities preferred by the service users compared with standard care.

#### **4.5        *Compulsion, control and restraint***

For people using adult mental health services, how is compulsory treatment and 'control and restraint' used in different settings and what is the impact on the service user?

##### **Why this is important**

Qualitative research and experience surveys suggest that service users experience many problems relating to compulsory treatment and the use of control and restraint. However, information is needed about current practice, which can then be used to help improve the experience of care.

This question should be answered by a quantitative audit and an ethnographic study of the use of compulsion and control and restraint and its impact on the service user in a variety of locations. The audit would aim to quantify the:

- frequency of compulsion, control and restraint

- frequency of de-escalation
- record- keeping
- debriefing (individual, staff, and witnesses)
- writing own account in notes.

The ethnographic study, undertaken on the same wards, would be partly by participant observation and partly by in-depth interview, both after compulsory treatment or restraint has been used, and after discharge and at 1-year follow-up. The ethnographic study would aim to capture the impact of compulsory treatment and restraint on service service-user experience, and its longer longer-term impact.

## **5 Other versions of this guidance**

### **5.1 Full guidance**

The full guidance, Service user experience in adult mental health: improving the experience of care for people using adult mental health services' contains details of the methods and evidence used to develop the guidance. It is published by the National Collaborating Centre for Mental Health, and is available from our website ([www.nice.org.uk/guidance/CG\[XX\]/Guidance](http://www.nice.org.uk/guidance/CG[XX]/Guidance)). Note: these details will apply to the published full guidance.

### **5.2 NICE pathway**

The recommendations from this guidance have been incorporated into a pathway, which is available from [http://pathways.nice.org.uk/pathways/\[xxx\]](http://pathways.nice.org.uk/pathways/[xxx])

Note: these details will apply when the guidance is published.

### **5.3 'Understanding NICE guidance'**

A summary for patients and carers ('Understanding NICE guidance') is available from [www.nice.org.uk/guidance/CG\[XX\]/PublicInfo](http://www.nice.org.uk/guidance/CG[XX]/PublicInfo)

For printed copies, phone NICE publications on 0845 003 7783 or email [publications@nice.org.uk](mailto:publications@nice.org.uk) (quote reference number N[XXXX]). Note: these details will apply when the guidance is published.

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about improving the experience of care for people using mental health services.

## 6 Related NICE guidance

### Published

- Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE clinical guideline 115 (2011). Available from: [www.nice.org.uk/guidance/CG115](http://www.nice.org.uk/guidance/CG115)
- Common mental health disorders. NICE clinical guideline 123 (2011). Available from [www.nice.org.uk/guidance/CG123](http://www.nice.org.uk/guidance/CG123)
- Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. NICE clinical guideline 113 (2011). Available from [www.nice.org.uk/CG113](http://www.nice.org.uk/CG113)
- Psychosis with coexisting substance misuse. NICE clinical guideline 120 (2011). Available from [www.nice.org.uk/CG120](http://www.nice.org.uk/CG120)
- Antisocial personality disorder. NICE clinical guideline 77 (2009). Available from [www.nice.org.uk/CG77](http://www.nice.org.uk/CG77)
- Borderline personality disorder. NICE clinical guideline 78 (2009). Available from [www.nice.org.uk/CG78](http://www.nice.org.uk/CG78)
- Depression. NICE clinical guideline 90 (2009). Available from [www.nice.org.uk/CG90](http://www.nice.org.uk/CG90)
- Depression in adults with a chronic physical health problem. NICE clinical guideline 91 (2009). Available from [www.nice.org.uk/CG91](http://www.nice.org.uk/CG91)
- Schizophrenia. NICE clinical guideline 82 (2009). Available from [www.nice.org.uk/guidance/CG82](http://www.nice.org.uk/guidance/CG82)
- Attention deficit hyperactivity disorder (ADHD). NICE clinical guideline 72 (2008). London: NICE. Available from <http://guidance.nice.org.uk/CG72>
- Antenatal and postnatal mental health. NICE clinical guideline 45 (2007). Available from <http://guidance.nice.org.uk/CG45>
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007). Available from [www.nice.org.uk/guidance/CG52](http://www.nice.org.uk/guidance/CG52)

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- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007). Available from [www.nice.org.uk/guidance/CG51](http://www.nice.org.uk/guidance/CG51)
- Bipolar disorder. NICE clinical guideline 38 (2006). Available from [www.nice.org.uk/guidance/CG38](http://www.nice.org.uk/guidance/CG38)
- Dementia. NICE clinical guideline 42 (2006). Available from [www.nice.org.uk/guidance/CG42](http://www.nice.org.uk/guidance/CG42)
- Obsessive-compulsive disorder (OCD). NICE clinical guideline 31 (2005). Available from [www.nice.org.uk/guidance/CG31](http://www.nice.org.uk/guidance/CG31)
- Post-traumatic stress disorder (PTSD). NICE clinical guideline 26 (2005). Available from [www.nice.org.uk/guidance/CG26](http://www.nice.org.uk/guidance/CG26)
- Violence. NICE clinical guideline 25 (2005). Available from [www.nice.org.uk/guidance/CG25](http://www.nice.org.uk/guidance/CG25)
- Self-harm: short-term physical and psychological management. NICE clinical guideline 16 (2004). Available from [www.nice.org.uk/guidance/CG16](http://www.nice.org.uk/guidance/CG16)
- Eating disorders. NICE clinical guideline 9 (2004). Available from [www.nice.org.uk/guidance/CG9](http://www.nice.org.uk/guidance/CG9)

### **Under development**

NICE is developing the following guidance (details available from [www.nice.org.uk](http://www.nice.org.uk)):

- Patient experience in adult NHS services. NICE clinical guideline. Publication expected October 2011.
- Self-harm: longer term management. NICE clinical guideline. Publication expected November 2011
- Autism spectrum conditions in adults. NICE clinical guideline. Publication expected June 2012.
- Social anxiety disorder. NICE clinical guideline. Publication expected July 2013.

## **Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team**

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