

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

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Contents

Introduction	4
Person-centred care	6
Quality statements	7
1 Guidance	9
1.1 Care and support across all points on the care pathway	9
1.2 Access to care	15
1.3 Assessment	17
1.4 Community care	18
1.5 Assessment and referral in a crisis	20
1.6 Hospital care	22
1.7 Discharge and transfer of care	25
1.8 Assessment and treatment under the Mental Health Act	26
2 Notes on the scope of the guidance	29
3 Implementation	30
4 Research recommendations	31
4.1 Training in the use of the national quality standard and guidance on service user experience of care	31
4.2 Late access to services and compulsory and intensive treatment	32
4.3 Shared decision-making	32
4.4 Activities and occupations on inpatient wards	33
4.5 Compulsion, control and restraint	33
5 Other versions of this guidance	35
5.1 Full guidance	35
5.2 NICE pathway	35
5.3 Information for the public	35
6 Related NICE guidance	36

Published.....	36
Under development.....	37
Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team.....	38
Guideline Development Group.....	38
Special advisors.....	40
NICE project team.....	40
About this guidance.....	41

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 this experience 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. 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 Department of Health.

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 aims to ensure that users of mental health services have the best possible experience of care from the NHS.

A [NICE quality standard](#) for service user experience in adult mental health has been developed alongside this guidance. NICE quality standards are a set of specific, concise statements and associated measures. They set out aspirational, but achievable, markers of high-quality, cost-effective care. Quality standards are derived from the best available evidence and address three dimensions of quality: clinical effectiveness, service user safety and service user experience. The quality statements for service user experience in adult mental health are listed in the next section.

NICE clinical guidelines are usually shaped around both clinical and economic evidence, and include recommendations concerned with ensuring a good service user experience, with the recognition that such advice should sit alongside evidence of clinical and cost effectiveness. The recommendations in the current guidance have been informed by research evidence, recommendations in previously published NICE clinical guidelines, national survey data and consensus processes that have identified the key elements that are important to service users and how these can be improved to ensure a good experience of care. The guidance draws on multiple evidence and data sources in developing the recommendations, which are further distilled into commissioning guidance in the quality standard.

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](#) and the [code of practice that accompanies the Mental Capacity Act](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

The [Equality Act 2010](#) replaces all previous anti-discrimination legislation and includes a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework which should improve the experience of all mental health service users, particularly those from black and minority ethnic communities.

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.

Quality statements

These quality statements are from the [NICE quality standard](#) on service user experience in adult mental health in the NHS in England, which was developed from the recommendations in this guidance. Recommendations, or parts of recommendations, that underpin the development of the quality statements and associated measures are denoted **[QS]**.

No.	Quality statements
1	People using mental health services, and their families or carers, feel optimistic that care will be effective.
2	People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect.
3	People using mental health services are actively involved in shared decision-making and supported in self-management.
4	People using community mental health services are normally supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.
5	People using mental health services feel confident that the views of service users are used to monitor and improve the performance of services.
6	People can access mental health services when they need them.
7	People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.
8	People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.
9	People using mental health services who may be at risk of crisis are offered a crisis plan.
10	People accessing crisis support have a comprehensive assessment, undertaken by a professional competent in crisis working.
11	People in hospital for mental health care, including service users formally detained under the Mental Health Act, are routinely involved in shared decision-making.

12	People in hospital for mental health care have daily one-to-one contact with mental healthcare professionals known to the service user and regularly see other members of the multidisciplinary mental healthcare team.
13	People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.
14	People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquillisation, will be used competently, safely and only as a last resort with minimum force.
15	People using mental health services feel less stigmatised in the community and NHS, including within mental health services.

1 Guidance

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

1.1 Care and support across all points on the care pathway

Relationships and communication

- 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 trusting, supportive, empathic and non-judgemental relationships as an essential part of care. **[QS]**
- 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 **[QS]**
 - maintain continuity of individual therapeutic relationships wherever possible
 - offer access to a trained 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 (such as using pictures, symbols, large print, Braille, different languages or sign language) if required.

1.1.4 When working with people 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 (that is, which health and social care professionals have access to information about their diagnosis and its treatment and in what circumstances this may be shared with others).

Providing information

1.1.5 When working with people using mental health services:

- 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 text from NICE's [information for the public](#)
- ensure that comprehensive information about other support groups, such as third sector, including voluntary organisations, is made available.

1.1.6 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
- able to discuss and actively support service users to engage with these resources.

Avoiding stigma and promoting social inclusion

1.1.7 When working with people using mental health services:

- take into account that stigma and discrimination are often associated with using mental health services **[QS]**

- be respectful of and sensitive to service users' gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability
- be aware of possible variations in the presentation of mental health problems in service users of different genders, ages, cultural, ethnic, religious or other diverse backgrounds.

1.1.8 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 different cultural, ethnic, religious or other diverse backgrounds
- explaining the possible causes of different mental health problems, and care, treatment and support options
- addressing cultural, ethnic, religious or other differences in treatment expectations and adherence
- addressing cultural, ethnic, religious or other beliefs about biological, social and familial influences on the possible causes of mental health problems
- conflict management and conflict resolution.

1.1.9 Health and social care providers' boards should work with local authorities and all other local organisations with an interest in mental health (including social services, other hospitals, third sector, including voluntary, organisations, local press and media groups, and local employer organisations) 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. **[QS]**

Decisions, capacity and safeguarding

1.1.10 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.

1.1.11 Develop advance statements and advance decisions with the person using mental health services if they wish to do so, 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. **[QS]**

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

1.1.13 Consider service users for assessment according to local safeguarding procedures for vulnerable adults if there are concerns regarding exploitation or self-care, or if they have been in contact with the criminal justice system.

Involving families and carers

1.1.14 Discuss with the person using mental health services if and how they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once. As the involvement of families and carers can be quite complex, staff should receive training in the skills needed to negotiate and work with families and carers, and also in managing issues relating to information sharing and confidentiality.

1.1.15 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
- ensure 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.

1.1.16 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 text from NICE's [information for the public](#)
- statutory and third sector, including voluntary, local support groups and services specifically for families and carers, and 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.

1.1.17 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 text from NICE's [information for the public](#)
- give the family or carers information about statutory and third sector, including 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
- bear in mind that service users may be ambivalent or negative towards their family for many different reasons, including as a result of the mental health problem or as a result of prior experience of violence or abuse.

1.1.18 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:

- information about childcare to enable them to attend appointments, groups and therapy sessions
- hospital care in local mother and baby units for women in the late stages of pregnancy and within a year of childbirth
- a family room or space in inpatient units where their children can visit them.

Engaging service users in improving care

1.1.19 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.

1.1.20 Health and social care providers should consider employing service users to be involved in training teams of health and social care professionals and supporting staff (such as receptionists, administrators, secretaries and housekeeping staff) in 'person-centred 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. **[QS]** Service users themselves should be provided with training and supervision to undertake this role.

1.1.21 Managers of health and social care providers should consider employing 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. **[QS]**

1.1.22 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. **[QS]**

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 a face-to-face appointment with a professional in mental health services taking place within 3 weeks of referral
- they 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. **[QS]**

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 where available, and different options about how to get 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 require anything to support their attendance (for example, an interpreter, hearing loop, wider access)
- 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. **[QS]**

1.2.4 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.

1.2.5 Local mental health services should work with primary care and local third sector, including voluntary, organisations to ensure that:

- all people with mental health problems have equal access to services based on clinical need and irrespective of gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability
- services are culturally appropriate. **[QS]**

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 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. **[QS]**

- 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 20 minutes after the agreed appointment time; explain the reasons for any delay. **[QS]**
- 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](#) (delivered through local authority social services), and how to access this.
- 1.3.9 Inform service users how to make complaints and how to do this safely without fear of retribution.

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
 - provide support to help the service user realise the plan

- give the service user an up-to-date written copy of the care plan, and agree a suitable time to review it. **[QS]**

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 who may be at risk of crisis, 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:

- possible early warning signs of a crisis and coping strategies
- support available to help prevent hospitalisation
- where the person would like to be admitted in the event of hospitalisation
- the practical needs of the service user if they are admitted to hospital (for example, childcare or the care of other dependants, including pets) **[QS]**
- details of advance statements and advance decisions (see [1.1.11](#))
- whether and the degree to which families or carers are involved
- information about 24-hour access to services
- named contacts.

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 Health and social care providers 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 unnecessarily
- do not undergo multiple assessments unnecessarily. **[QS]**

1.4.8 Ensure that service users have timely 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 third sector, including 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 these groups.

1.4.10 Mental health and social care professionals inexperienced in working with service users from different cultural, ethnic, religious and other diverse backgrounds should seek advice, training and supervision from health and social care professionals who are experienced in working with these groups.

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 and advance statements or advance decisions if they have made them. Find out if they have an advocate and contact them if the service user wishes. Ask if the service user has a preference for a male or female health or social care professional to conduct the assessment, and comply with their wishes wherever possible.

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. **[QS]**

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. **[QS]**

1.5.6 Health and social care providers should provide local 24-hour helplines, staffed by mental health and social care professionals, and ensure that all GPs in the area know the telephone number. **[QS]**

1.5.7 Health and social care providers should ensure that crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, and available to service users in crisis regardless of their diagnosis. **[QS]**

1.5.8 To avoid admission, aim to:

- explore with the service user what support systems they have, including family, carers and friends
- 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 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 Health and social care providers 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. Ensure that the service user feels safe and address any concerns about their safety.
- 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). **[QS]**
- 1.6.4 Commence formal assessment and admission processes within 2 hours of arrival.
- 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. If possible, this should include the named healthcare professional who will be involved throughout the person's stay.
- 1.6.6 Offer service users in hospital:
- daily one-to-one sessions lasting at least 1 hour with a healthcare professional known to the service user
 - regular (at least weekly) one-to-one sessions lasting at least 20 minutes with their consultant
 - an opportunity to meet with a specialist mental health pharmacist to discuss medication choices and any associated risks and benefits. **[QS]**
- 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 paper and/or electronic record. Service users and their advocates should be encouraged to participate in discussions about their care and treatment, especially those relating to the use of the Mental

Health Act (1983; amended 1995 and 2007). However, these meetings should not be used to see service users or carers as an alternative to their daily meeting with a known healthcare professional or their weekly one-to-one meeting with their consultant.

- 1.6.8 Health and social care providers 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. **[QS]**
- 1.6.10 Ensure that service users have access to the internet and telephone 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 team to use the same patient-centred approach to treatment and care.
- 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 advocates who can regularly feed back to ward professionals any problems experienced by current service users on that ward. Advocates may be formal Independent Mental Health Advocate (IMHAs), or former inpatients who have been trained to be advocates for other service users not detained under the Mental Health Act (1983; amended 1995 and 2007).

- 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 and with specific physical health problems. 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, especially discharge, are discussed and planned carefully beforehand with the service user 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.
- 1.7.3 Before discharge or transfer of care, discuss arrangements with any involved family or carers. Assess the service user's financial and home situation, including housing, before they are discharged from inpatient care.
- 1.7.4 Give service users clear information about all possible support options available to them after discharge or transfer of care.
- 1.7.5 When plans for discharge are initiated by the service, give service users at least 48 hours' notice of the date of their discharge from a ward.

- 1.7.6 When preparing a service user for discharge, give them information about the local patient advice and liaison service (PALS) and inform them they can be trained as an advocate or become involved in monitoring services if they choose.

1.8 Assessment and treatment under the Mental Health Act

- 1.8.1 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:

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

- 1.8.2 Carry out an assessment for possible detention under the Mental Health Act (1983; amended 1995 and 2007) in a calm and considered way. Respond to the service user's needs and treat them with dignity and, whenever possible, respect their wishes.

- 1.8.3 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. Ask if the service user would like a family member, carer or advocate with them.

- 1.8.4 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.

- 1.8.5 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 (1983; amended 1995 and 2007)
 - ensure they have access to an Independent Mental Health Advocate (IMHA).
- 1.8.6 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; provide information about the structure and likely speed of the appeals process.
- 1.8.7 Inform 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 should, in the first instance, direct their complaint to the service detaining them. If they are dissatisfied with the service's response to their complaint, inform them they can complain to the Care Quality Commission and explain how to do this.
- 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. **[QS]**
- 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, only after all means of negotiation and persuasion have been tried, and only by healthcare professionals trained and competent to do this. Document the reasons for such actions. **[QS]**

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
- offer to discuss episodes of compulsory treatment with the service user at the time of discharge and do so in a calm and simple manner
- ensure training in restraint involves service users.

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
- ensure that other service users on the ward who are distressed by these events are offered support and time to discuss their experience.

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.

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). 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 and quote reference N1739).

3 Implementation

NICE has developed [tools](#) to help organisations implement this guidance.

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 with 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. 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 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? This should include an examination of factors that impact on access to services among younger people and older adults.

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 with no training, improve service users' experience of care? A study should be undertaken to evaluate the impact on treatment choice, the experience of care and treatment effectiveness of training service users to deal with health and social care professionals assertively.

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 user experience, and its 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 www.nccmh.org.uk and [our website](#).

5.2 NICE pathway

The recommendations from this guidance will be incorporated into a [NICE pathway](#)

5.3 Information for the public

NICE has produced [information for the public](#) explaining this guideline.

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

6 Related NICE guidance

Published

- [Self-harm: longer term management](#). NICE clinical guideline 133 (2011).
- [Common mental health disorders](#). NICE clinical guideline 123 (2011).
- [Psychosis with coexisting substance misuse](#). NICE clinical guideline 120 (2011).
- [Alcohol use disorders](#). NICE clinical guideline 115 (2011).
- [Generalised anxiety disorder and panic disorder \(with or without agoraphobia\) in adults](#). NICE clinical guideline 113 (2011).
- [Depression in adults with a chronic physical health problem](#). NICE clinical guideline 91 (2009).
- [Depression](#). NICE clinical guideline 90 (2009).
- [Schizophrenia](#). NICE clinical guideline 82 (2009).
- [Borderline personality disorder](#). NICE clinical guideline 78 (2009).
- [Antisocial personality disorder](#). NICE clinical guideline 77 (2009).
- [Medicines adherence](#). NICE clinical guideline 76 (2009).
- [Attention deficit hyperactivity disorder \(ADHD\)](#). NICE clinical guideline 72 (2008).
- [Drug misuse: opioid detoxification](#). NICE clinical guideline 52 (2007).
- [Drug misuse: psychosocial interventions](#). NICE clinical guideline 51 (2007).
- [Antenatal and postnatal mental health](#). NICE clinical guideline 45 (2007).
- [Dementia](#). NICE clinical guideline 42 (2006).
- [Bipolar disorder](#). NICE clinical guideline 38 (2006).
- [Obsessive-compulsive disorder \(OCD\)](#). NICE clinical guideline 31 (2005).

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- [Post-traumatic stress disorder \(PTSD\)](#). NICE clinical guideline 26 (2005).
 - [Violence](#). NICE clinical guideline 25 (2005).
 - [Self-harm: short-term physical and psychological management](#). NICE clinical guideline 16 (2004).
 - [Eating disorders](#). NICE clinical guideline 9 (2004).

Under development

NICE is developing the following guidance (details available from [our website](#)):

- Patient experience in adult NHS services. NICE clinical guidance. Publication expected 2012.
- 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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About this guidance

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guidance was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), service users and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The recommendations from this guidance will be incorporated into a [NICE pathway](#). We have produced [information for the public](#) explaining this guideline. Tools to help you put the guidance into practice and information about the evidence it is based on are also [available](#).

Changes after publication

June 2012: minor maintenance

October 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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