



**NHS patient survey programme**

# **2017 Community Mental Health Survey Statistical release**

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Independent data analysis

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# Summary of findings

The 2017 Community Mental Health Survey received feedback from 12,139 people and had a response rate of 26%. Results for all questions in the 2017 survey are published in the open data section on CQC's website, [www.cqc.org.uk/cmhsurvey](http://www.cqc.org.uk/cmhsurvey).

The 2016 survey showed that many people who use services were experiencing poor quality care. We have found that there has been little or no improvement across many of the areas covered by this survey.

## Positive results

Despite this, around two-thirds of respondents reported a positive experience of overall care. When asked to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'), 64% rated their overall experience with a score of seven or above. A fifth of respondents (20%) gave a score of 10, which is up 2% since 2014 (18%).

In addition, the vast majority of respondents (97%) said that they knew how to contact the person in charge of their care if they had concerns. A higher proportion of respondents this year (71%, up from 68% in 2015) also knew who to contact out of hours if they were experiencing a crisis.

## Key areas for improvement

The survey highlighted some areas where performance has declined over time, particularly around crisis care, the coordination of care, communication and access.

### Crisis care

National policy states that mental health crises should be treated with the same urgency as physical health crises. The proportion of respondents (29%) who said that they do **not** know who to contact out of office hours if they had a crisis has declined in 2017. However, survey results show that a higher proportion of respondents are not getting the help they need when they are experiencing a crisis. Of those respondents who knew who to contact and tried to do so within the last 12 months, 39% said they 'definitely' got the help they needed (45% in 2014). Over a quarter (26%) of respondents said no, they did not get the help they needed.

### Access and coordination of care

When accessing more general mental health services, a quarter of all respondents reported that they had not seen mental health services often enough to meet their needs in the previous 12 months. This proportion has been rising since 2014, from 21% to 25% in 2017.

Furthermore, 42% of people have experienced changes in which mental health professionals they are seeing. Looking at the respondents who had experienced a change (excluding respondents that requested a change or moved home) in which people they see for their care or services in the previous 12 months:

- Less than half (47%) said that the reasons for this change were ‘completely’ explained to them at the time.
- Just under a quarter (23%) said that their care got better following the change. Thirty-one per cent said that their care ‘got worse’.
- Over half (53%) said that they knew who was in charge of organising their care while this change was taking place, leaving 47% who did not.

Respondents also identified areas of concern in how care is organised and planned. Less than half of all respondents said they ‘definitely’ agreed with someone from NHS mental health services about what care they would receive (42% in 2017 and 43% in 2014). Almost a quarter said they had not agreed what care they would receive (24% in 2017 and 22% in 2014). Also, less than three-quarters (74%) of all respondents said they were told who was in charge of organising their care and services, a fall of three percentage points since 2014 (77%). Twenty-six per cent of respondents said they had not been told (23% in 2014).

## Involvement

People are also reporting feeling less involved in their care. While 68% of respondents said they felt listened to by their health or social workers, this is a fall of five percentage points since 2014 (63%). Results also show that there has been a reduction in the proportion of people reporting that they had enough time to discuss their needs and treatment (65% of respondents said ‘yes definitely’ in 2014, compared with 61% in 2017).

## Medicines

Nearly a quarter of respondents (23%) who have been receiving medicines for 12 months or longer reported that an NHS mental health worker had **not** checked with them about how they were getting on with their medicines. Additionally, 28% of all respondents said that in the last 12 months they had **not** had a formal meeting with someone from NHS mental health services to discuss how their care was working.

## Additional support

People using specialist mental health services sometimes have wider needs and NHS mental health trusts need to help them to find support from other sources. Overall, survey results show that only a low proportion of respondents feel supported in other areas of their life and many that would have liked help or advice did not get it.

- 36% of respondents did not get help or advice to find support with their physical health needs, but would have liked it.
- 45% of respondents would have liked help or advice in finding financial advice or benefits, but did not get it.
- 43% of respondents would have liked help or advice in getting support for finding and keeping work, but did not get it.
- 43% of respondents would have liked support to take part in an activity locally, but did not get it.
- 49% of respondents would have liked support from people who have experience of the same mental health needs as them, but did not get it.

## How experience varies for different service user groups

There were marked differences in experience between different population groups across a number of themes, including age, religion, sexual orientation, Care Programme Approach (CPA) status, diagnosis and length of contact. This shows that different service users experienced varying levels of care. This was noticeable in themes around overall care, respect and dignity, involvement, respect for patient-centred values, access to services, crisis care and communication.

As with other surveys in the NHS patient survey programme, we saw a general trend that older respondents (aged 50+) reported more positive experiences. There was also a marked trend that the longer a person is in contact with mental health services, the worse the experience reported. Those with less than a year, or one to five years of contact had significantly better experiences than long-term service users.

There were large differences in experiences of care for people with different diagnoses (care clusters). In general, respondents with non-psychotic disorders and respondents with cognitive impairments or dementia reported worse than average experiences. Respondents with psychotic disorders generally reported better than average experiences.

Those respondents on the new CPA programme reported better outcomes compared with the average for crisis care and access to services.

# Introduction

Community mental health services provide care and treatment for people who require mental health care over and above the services provided by primary care. Most community mental health care is provided by staff who visit people in their own homes, though some specialist outpatient clinics may involve people visiting clinics based in community mental health centres or on a hospital site. Mental health services in England care for people with a wide range of conditions.

The most common mental health conditions that people seek treatment for are depression, anxiety disorders, phobias, obsessive-compulsive disorder and panic attacks.<sup>1</sup> One adult in six has a common mental health disorder: about one woman in five and one man in eight.<sup>a</sup> Since 2000, overall rates of common mental health disorders in England have steadily increased in women and remained largely stable in men. The proportion of people with severe common mental health disorder symptoms did not change significantly between 2007 and 2014. However, the longer-term trend has been one of steady increase. The more severe a person's current symptoms of common mental health disorders, the more likely it is that they are using treatment.<sup>2</sup>

Other disorders are rarer, for example, psychotic disorders and autism each affect about one adult in 100. Mood disorder traits are identified in about one adult in 50. Signs of drug dependence are evident in one adult in 30, with a similar level found for probable alcohol dependence.<sup>3</sup>

Certain groups of people are more likely to experience mental health issues, for example:

- The gender gap in mental illness has become pronounced in young people, and there is evidence that this gap has widened in recent years with young women being a key high-risk group.
- Rates of mental illness increased in men and women aged 55 to 64 since 2007.
- People from certain minority ethnic groups, transgender people and people in prison are at higher risk.
- Male suicide rates are higher than female rates.
- Social factors such as living alone, living in socioeconomic adversity, being unemployed and having poor physical health also puts some groups of people at higher risk.<sup>4,5,6</sup>

Everybody's experience of a mental health condition is different. Some people may have a single, one-off episode of a mental health issue and have short contact with mental health services. Others may have multiple or long-term

<sup>a</sup> According to [National Institute for Health and Care Excellence \(NICE\)](#), common mental health problems include depression, generalised anxiety disorder, social anxiety disorder, panic disorder, obsessive compulsive disorder, and post-traumatic stress disorder.

experiences of varying severity throughout their lives, which may involve either on-going or intermittent contact with mental health services.

Mental illness often goes untreated, and historically, treatment options for mental health problems are less effective than for physical conditions. A third of people with common mental health disorders receive psychotropic medication or counselling or other psychological therapy. Reported treatment use was strongly associated with severity of mental health symptoms, ranging from one person in 20 (5.6%) among those with few or no current symptoms to nearly half (45.8%) of those with severe symptoms. Treatment rates are higher for some disorders than others. The majority of people identified with psychotic disorders are receiving treatment, as are around half of those with depression, obsessive-compulsive disorder, phobias, generalised anxiety disorder, post-traumatic stress disorder, or signs of dependence on drugs other than cannabis. Very few people with autism were receiving mental health treatment, despite high levels of psychiatric comorbidity in this group.<sup>7</sup>

Across mental health services, there is evidence of demographic inequalities in who is receiving treatment that remains after controlling for differences in levels of mental illness between groups. The most pronounced inequalities in use of treatment is related to age, sex and ethnic group. People with common mental health disorders who were Black, Asian, non-British White, or of mixed or other ethnicity were less likely to obtain treatment than those in the white British group. In terms of age, those in midlife are three times more likely to be treated than the youngest. Younger people with common mental health disorders were less likely to get psychotropic medication than other age groups, and were the most likely to have their treatment requests unmet. Older people with common mental health disorder had the lowest rates of psychological therapy, but also the lowest rates of unmet treatment requests – suggesting that they may not be asking for what they need, or may not even be aware of what is available. It may also be the case that men with common mental health disorders are less likely than women to be using treatment, in part due to longstanding stigma or reluctance to talk about mental health or to seek help from health professionals.<sup>8</sup>

## About the Community Mental Health Survey

This survey is part of a wider programme of NHS surveys, which covers a range of topics including acute inpatient, children's inpatient and day-case services, A&E (emergency department) and maternity services. To find out more about the survey programme and to see the results from previous surveys, please see website links in the further information section ([Appendix F](#)).

The 2017 survey of people who use community mental health services involved 56<sup>b</sup> providers of NHS mental health services in England (including combined mental health and social care trusts, foundation trusts and community healthcare social enterprises that provide mental health services). People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the trust between 1 September

<sup>b</sup> One trust was excluded as a high proportion of its service users opted out of the survey.

and 30 November 2016, and were not a current inpatient. Fieldwork took place between February and June 2017. We received responses from more than 12,000 people, a response rate of 26%.<sup>c</sup> In total, 47,600 people were sent questionnaires.<sup>d</sup>

For more information on the survey methodology, see [Appendix A](#). This covers the development of the survey, the analysis of results, and comparability with previous surveys. More detailed information on the limitations of the data is provided in the Quality and Methodology Report (see link in [Appendix E](#)).

The survey collected basic demographic information from all people who took part, and this is available in the 'About the respondents' section within the [Open data published on the CQC website](#). The basic demographic characteristics of respondents in 2017 remain similar to the 2014, 2015 and 2016 surveys for age, gender and ethnicity.

In 2017, 19% of respondents had been in contact with mental health services for less than a year, a decrease from 20% in 2016, but increase from 2014 and 2015 (18%). Forty-one per cent had been in contact for between one and five years (a decrease from 42% in 2014). The remainder had been in contact for between six and 10 years (13%), or more than 10 years (27%).

<sup>c</sup> Please note that we report the 'adjusted' response rate. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

<sup>d</sup> This compares with more than 13,000 respondents in 2016 (28%), from a total sample of 49,300 (58 trusts).

# Background to the Community Mental Health Survey

It is important to note the climate in which the survey took place. This section summarises the main policies, standards and guidelines.

## The importance of people's experiences

Understanding what community mental health care is like for people who receive it provides key information about the quality of services across England. This information is used to encourage improvements both in England as a whole, and locally among providers and commissioners of services.

The importance of positive patient experience is increasingly recognised both within the NHS and in government health policy. The [NHS Constitution](#), published in 2012 and updated in 2015, commits the NHS to encourage people to give feedback of their experiences and to use this to improve services.<sup>9</sup> The [NHS Patient Experience Framework](#), published by the NHS National Quality Board in 2012, outlines elements that are important to people's experiences of NHS services with the intention to help NHS trusts improve.<sup>10</sup> It states that "information, communication, and education on clinical status, progress, prognosis, and processes of care" are necessary "in order to facilitate autonomy, self-care and health promotion."

The Department of Health's [NHS Mandate for 2016/17](#) includes a goal to reduce inequalities in people's experience of the health system.<sup>11</sup> Domain 4 of the [NHS outcomes framework](#) also highlights the need to ensure that people have a positive experience of care.<sup>12</sup>

Shared decision-making is seen as [key to improving patient experience](#) and is now enshrined in law. The [Health and Social Care Act 2012](#) states that those who commission services must promote and facilitate the involvement of patients and carers in decisions about their care and treatment.<sup>13</sup>

Recent research, including that carried out in the development work for the NHS Patient Survey Programme, has identified many aspects of care that are important to people using services. These include being informed and offered options, staff listening to and spending enough time with them, and being involved in their own care.<sup>14</sup>

Evidence from academic research suggests that when people are involved in their care, decisions are made more effectively and health outcomes improve.<sup>15</sup> Studies in this area also suggest that patient experience is positively associated with patient safety and clinical effectiveness.<sup>16</sup> All questionnaires used in the NHS Patient Survey Programme are designed to reflect these themes.

## Mental health policy

The following key areas show some of the main challenges for community mental health care within current policy and practice.

There have been various national policy documents, reports and quality standards relating to mental health published by different governments and by different organisations. However, central themes underlining these include:

- an aspiration to achieve equality between physical and mental health services (sometimes known as ‘parity of esteem’)
- the importance of people’s experiences of using services, and the need to improve this
- the need to actively involve people as partners in their own care
- the importance of multi-agency working to achieve better outcomes (integrated care).

## Increased activity

Mental health services are operating under increasing pressure. According to CQC’s [The State of Care in Mental Health Services 2014 to 2017](#), an estimated 1.8 million people were in contact with adult mental health and learning disability services at some point in 2015/16, and the total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16. In many parts of the country, people with suspected dementia or with an eating disorder have to wait many weeks, and sometimes months, for specialist assessment.<sup>17</sup> There are particularly long waiting times for NHS eating disorder services, with 27% of people waiting 11 weeks or more, and for NHS memory services, 42% of people are waiting for 11 weeks or more.

## Funding

In its [Five Year Forward View for Mental Health](#), NHS England stated that there was a need for CCGs to spend an additional £1billion by 2020/21. It also required CCGs to increase their spend on mental health services in line with budget increases.<sup>18</sup> However, analysis by the [King’s Fund](#) (2016) of mental health trust annual accounts demonstrates that 40% of trusts have in fact seen reductions to their income.<sup>19</sup>

## The mental health strategy for England

[No Health Without Mental Health](#) (published in 2011) is a wide-ranging document that set out the Government’s intentions to promote mental health and wellbeing in the general population and how different organisations (such as schools and employers) need to work together to achieve this.<sup>20</sup> It also sets out the Government’s intention to improve mental health services for those who need them through the provision of high-quality services that are equally accessible to

all. It sets out six key objectives for improved mental health in England, some of which the survey can help to measure. The six key objectives are:

- more people will have good mental health
- more people with mental health problems will recover
- more people with mental health problems will have good physical health
- more people will have a positive experience of care and support
- fewer people will suffer avoidable harm
- fewer people will experience stigma and discrimination.

## Equality between physical and mental health services

Giving mental health equal priority to physical health is often referred to as parity of esteem. It was enshrined in law in the [Health and Social Care Act 2012](#), and has become a central objective for all recent government policy.

[No Health Without Mental Health](#) made explicit the government's objective to give equal priority to mental and physical health, stating "...we are clear that we expect parity of esteem between mental and physical health services".

The Government's [Mandate to NHS England](#) (first published in 2012 and refreshed annually) sets the government's objectives for the NHS. The Mandate includes specific requirements to achieve parity of esteem, to ensure that mental and physical health conditions are given equal priority. The [NHS Constitution](#) was updated in July 2015 to reflect the government's commitment to parity of esteem, stating "...the [NHS] service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard".

This ambition to achieve parity of esteem continues to be reinforced in more recent policy publications, such as [Closing the Gap](#) (published 2014)<sup>21</sup> and the [Five Year Forward View for Mental Health](#) (published 2016).<sup>22</sup>

## Accessing services

In 1999, the [National Service Framework for Mental Health](#)<sup>23</sup> set out the then government's quality standards for mental health. It set out a 10-year agenda that aimed to improve quality and remove variation in care. The framework included seven standards, including the aim that people must be able to access effective treatments and services. Subsequent policy documents have built on and clarified ambitions contained in this document.

Recent policy publications have called for immediate improvements in access to mental health services. [Closing the Gap](#) identifies 25 areas where immediate change and improvement is required from providers in order to meet the objectives set out in the government's strategy [No Health Without Mental Health](#). These are grouped under four key themes: increasing access to mental health services, integrating physical and mental health care, early promotion of mental

health wellbeing to prevent mental health problems, and improving the quality of life for people with mental health problems. Standards on access and waiting times for mental health services, and the allocation of more money for service provision, are both pledged within [Achieving better access to mental health services by 2020](#) (published 2016).<sup>24</sup>

The [Five Year Forward View for Mental Health](#) is a wide-ranging strategy and sets out a number of priority areas for action. This includes that people facing a crisis should have access to mental health care seven days a week and 24 hours a day, in the same way that they are able to get access to urgent physical health care. [Implementing the Five Year Forward Plan for Mental Health](#) (published 2016)<sup>25</sup> provides further details on key commitments to greater funding for mental health services pledged in the [Five Year Forward View for Mental Health](#) and how funding will be made available and delivered.

## People's experiences

Recent mental health policy continues to reinforce the importance of involving people in their care and treatment. [No Health Without Mental Health](#) includes an objective that 'more people will have a positive experience of care and support'. It also recognises that people using services must be involved in planning and decision-making about their care.

The National Institute for Health and Care Excellence ([NICE](#)) has developed a series of quality statements, indicators and accompanying clinical guidelines to help commissioners and providers improve quality of care. While quality standards are not mandatory, they are available for use in the planning and delivery of services to achieve the best possible care. Their Quality Standard for [service user experience in adult mental health services](#) (published 2011) outlines the level of service that people using NHS mental health services should expect to receive.<sup>26</sup> The [Community Mental Health survey questionnaire](#) reflects many of the issues covered in those statements.

## Coordinated care

Coordinated care is a key priority to ensuring that services are well placed to provide effective care. The [Five Year Forward View for Mental Health](#) highlights the importance of coordinated care. It recommends eight principles to underpin reform, one of which is that care must be coordinated across health and social care spanning people's physical, mental and social needs.

## The Care Programme Approach (CPA)

The [Care Programme Approach](#) (CPA) is the framework that organises mental health care. People that have more complex needs and need ongoing support are put on the CPA. Although the [policy](#) has been revised over time, the CPA remains the central approach for coordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.<sup>27</sup>

Twenty-seven per cent of people who responded to the 2017 survey had their care coordinated on the CPA in comparison to 33% in 2014, 30% in 2015 and 29% in 2016. However, it is worth noting that there is a large variation in the proportion of people on the CPA between trusts, which suggests that there are systematic differences in how trusts individually interpret and apply the CPA policy.

# Results from the survey

This section presents the results from the 2017 Community Mental Health Survey. It highlights statistically significant differences between the results from the most recent survey (2017) and the results from previous surveys in 2014, 2015 and 2016.

We carried out statistical tests on the data to determine whether there had been any statistically significant changes in the results for 2017 compared with the previous surveys in 2014, 2015 and 2016.<sup>e,f</sup> Comparisons with the results of these previous surveys appear alongside the result for 2017 only where any difference between the results is statistically significant. Where we do not provide results for 2014, 2015 or 2016, there has been no statistically significant change. Please note that results from four surveys may not necessarily indicate the emergence of a longer-term trend, and therefore do not necessarily indicate a deterioration in people's experiences of services.

Because of the relatively large number of respondents, small changes in results may show to be statistically significant. However, in other cases, there may be an apparent change in the results between survey years that is not significant. There are a number of reasons for this, such as:

- Rounding figures to a whole number can make differences between results appear larger or smaller than they actually are.
- For larger sample sizes, smaller changes to statistics are statistically significant, and confidence intervals are smaller – that is, we can be more confident that the true value is very close to the value we have calculated from the sample. In simpler terms, larger sample sizes mean we can be more confident in the result. Conversely, the fewer people that answer a question, the greater a difference has to be for it to be described as statistically significant.
- Variance also influences whether a change in survey results can be said to be statistically significant. Variance measures how much individual responses to a question vary across the whole group of respondents. The greater the variance, the more a figure has to change for this change to be deemed statistically significant.

The figures shown are the evaluative responses to a question. Responses such as "don't know / can't remember" are not included in the percentages. These responses are included within the set of question responses to allow someone to respond to the question when they cannot remember, or do not have an opinion,

<sup>e</sup> The weighting strategy for the England level results has changed from the 2014 and 2015 survey. The revised weighting takes account of changes in the demographic profile over the comparable years of the survey, and means that if this has changed, we can compare results more fairly. For more detailed information please see [Appendix A](#).

<sup>f</sup> We used a 'z-test' set to 95% significance to compare data between survey years. For more information on statistical significance, please see [Appendix A](#).

to distinguish those reasons from all others and to avoid people making a 'best guess'.

For some questions, we also excluded other responses that indicate that a question is not relevant to a respondent. For example, Q33 asks: "In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?" We did not include responses from people in the results for that question if they said that they 'do not have physical health needs'; that they 'already have support in place and did not need help/advice to find it'; or that they 'did not need support for this,' as the question is not directly relevant to those people.

Results for all questions in the 2017 survey are published in the Open data section on our website, [www.cqc.org.uk/cmhsurvey](http://www.cqc.org.uk/cmhsurvey).

Survey results are organised under the following key themes:

- 1. Care and treatment**
- 2. Health and social care workers**
- 3. Organising care**
- 4. Planning care**
- 5. Reviewing care**
- 6. Changes in who people see**
- 7. Crisis care**
- 8. Treatments**
- 9. Support and well being**
- 10. Overall.**

We also compared the experience of different subgroups across a number of themes. The scores for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a linear mixed effects model.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report. See [Appendix G](#) for the charts.

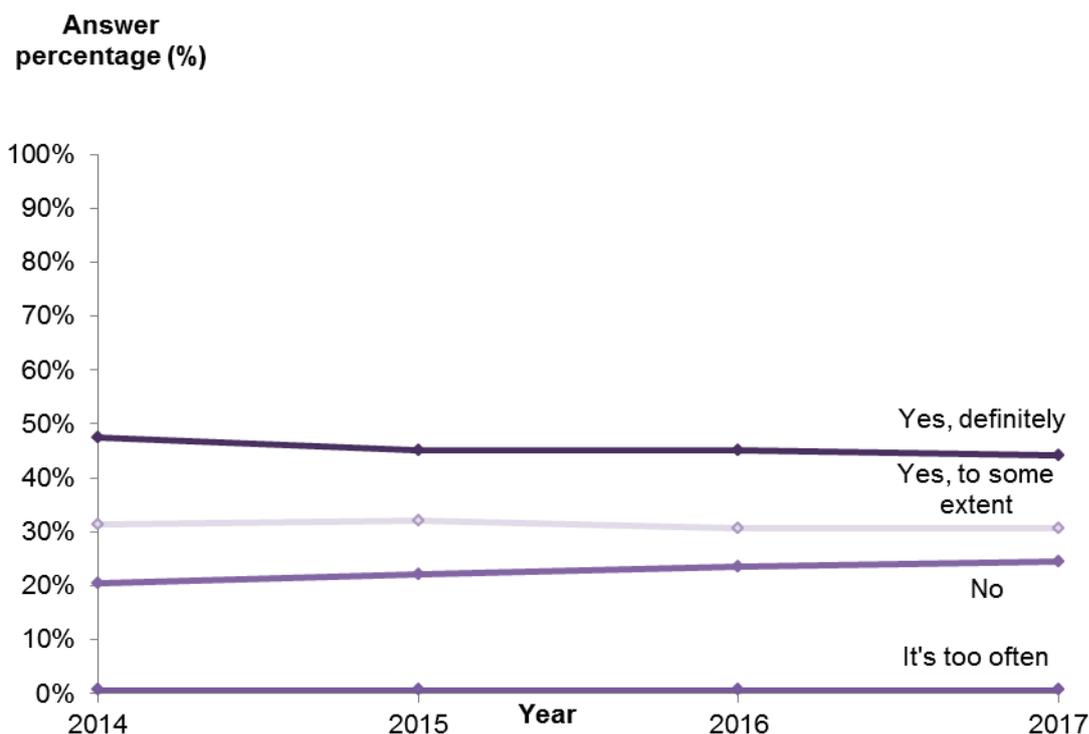
# 1: Care and treatment

The right to access effective mental health care has been set out in various governmental policy documents over the years, and [NICE quality statement 6](#) includes a recommendation that people should be able to access mental health services when they need them.

Policy publications such as [Closing the Gap, Achieving better access to mental health services by 2020](#) and the [Five Year Forward View for Mental Health](#) have all called for immediate improvements in access to mental health services.

Despite this, a quarter (25% in 2017 and 21% in 2014) of respondents to the survey said that they had **not** seen someone from NHS mental health services often enough for their needs.

### Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?



Answered by all

Number of respondents: 2014 (13,061), 2015 (11,072), 2016 (12,587) and 2017 (11,474)

**Note:** those who answered 'Don't know' were excluded from the analysis.

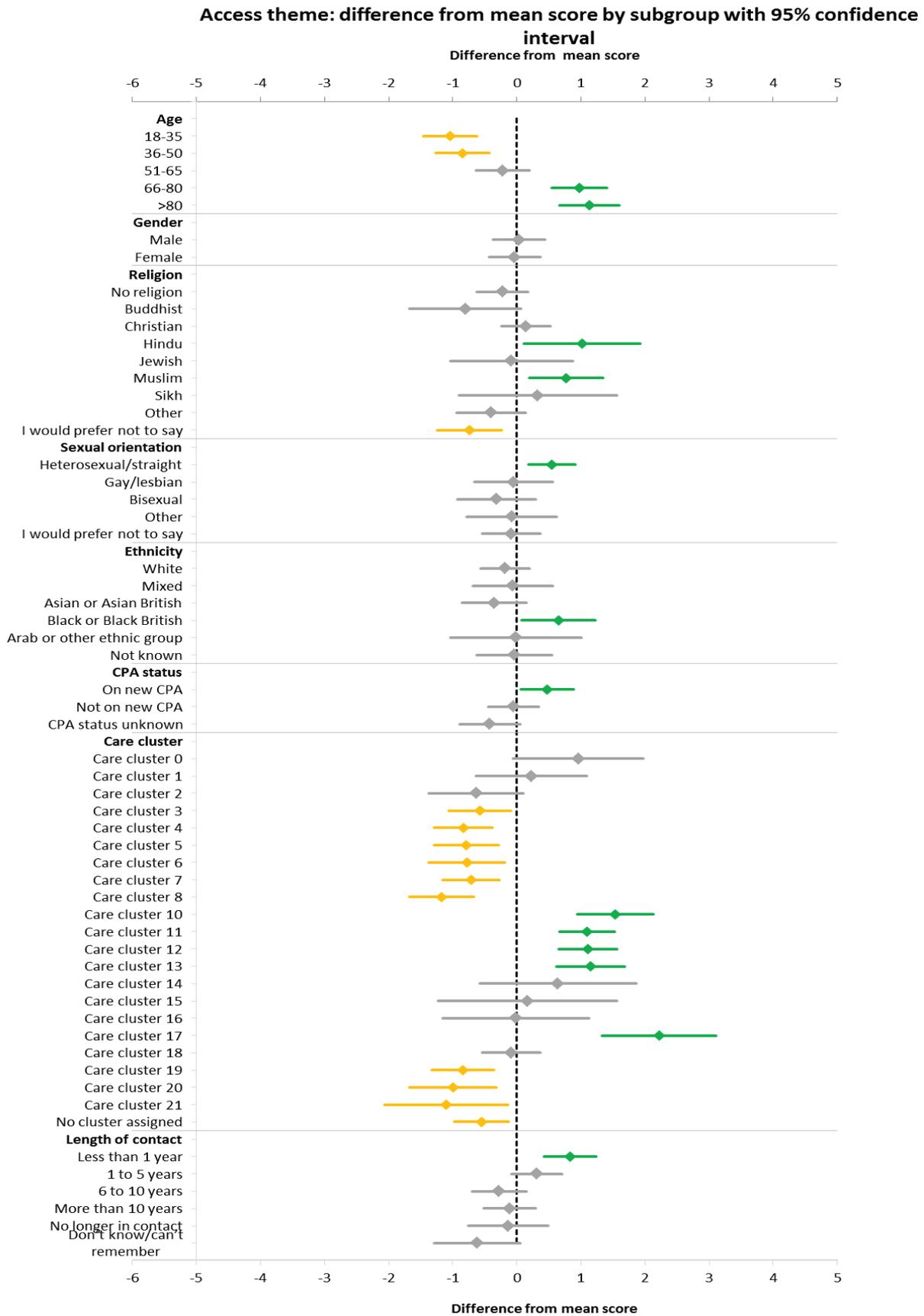
Though the questionnaire does not ask directly about waiting times, there is more information on recent policy in this area in [Appendix B](#).

When looking at the experiences of different service user groups around access to services, groups that reported better than average experience were: service users on a new CPA, those diagnosed as having a psychotic disorder, and those

with less than one year's contact with NHS mental health services. However, those diagnosed as having a non-psychotic disorder or cognitive impairment/dementia had worse than average experiences. There is considerable variation, as shown in the following figure. You can find a full breakdown of scores in the [Multivariate analysis summary](#) section.

In the charts, each question was centred by subtracting its overall mean from each respondent's score before the questions were combined into themed composites. The amber represents worse than average scores (more than 0.1 standard deviations lower than the mean) and the green represents better than average scores (0.1 standard deviations above the mean), with confidence intervals. Full breakdown of care clusters can be found in [Appendix H](#).

# Multivariate chart, Access theme



## 2: Health and social care workers

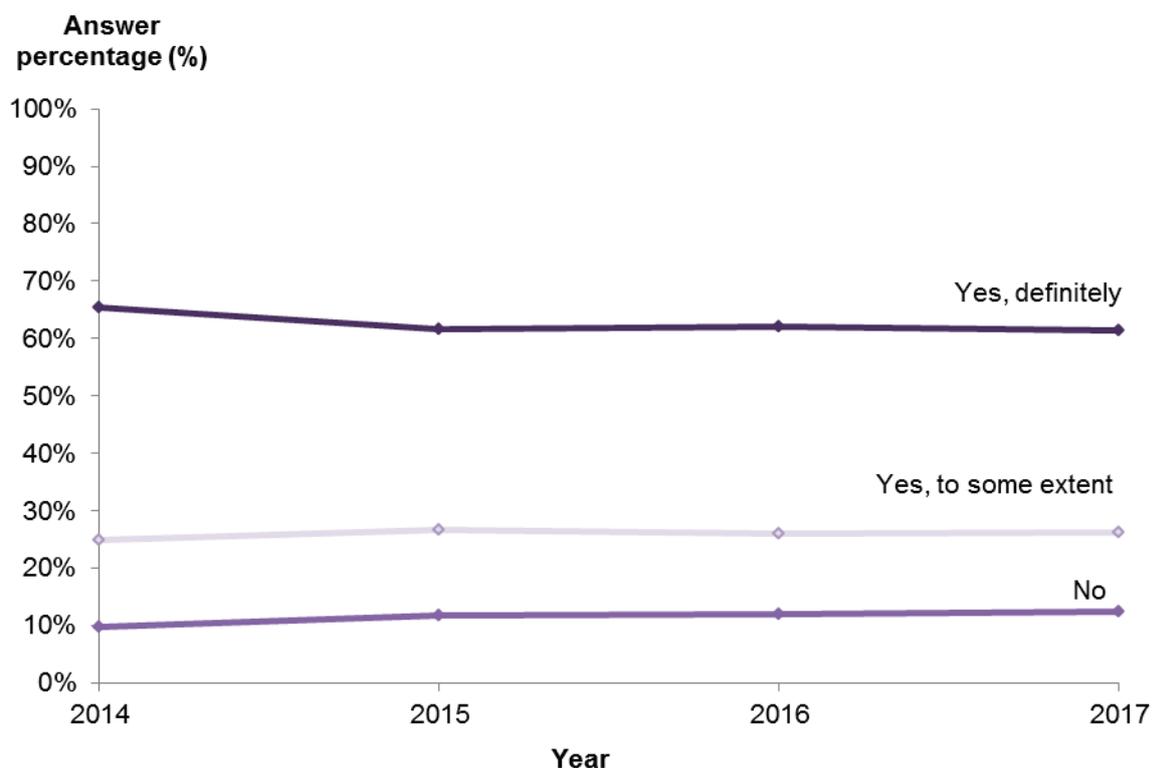
Questions in this section asked respondents about the health and social care workers they saw for their most recent appointment. People's experiences are influenced by their interactions with the staff providing their care, and it is expected that a good relationship with staff will be important.

The majority of respondents gave positive answers to questions asking about contact with staff, but there have been declines since 2014.

Respondents were asked whether the person or people they saw most recently had listened carefully to them. Sixty-eight per cent said they 'definitely' did, a decline of five percentage points since 2014 (73%).

Sixty-one per cent said they were 'definitely' given enough time to discuss their needs and treatment (65% in 2014). Thirteen per cent of respondents were not given enough time (10% in 2014).

### Q5: Were you given enough time to discuss your needs and treatment?



Answered by all

Number of respondents: 2014 (13,085), 2015 (10,925), 2016 (12,507) and 2017 (11,454)

**Note:** those who answered 'Don't know'/'Can't remember' were excluded from the analysis.

Fifty-five per cent of respondents said that the person or people they saw 'definitely' understood how their mental health needs affect other areas of their life. Fourteen per cent of respondents reported that the person or people they saw did not understand it. This is an increase of two percentage points from 2014 (12%).

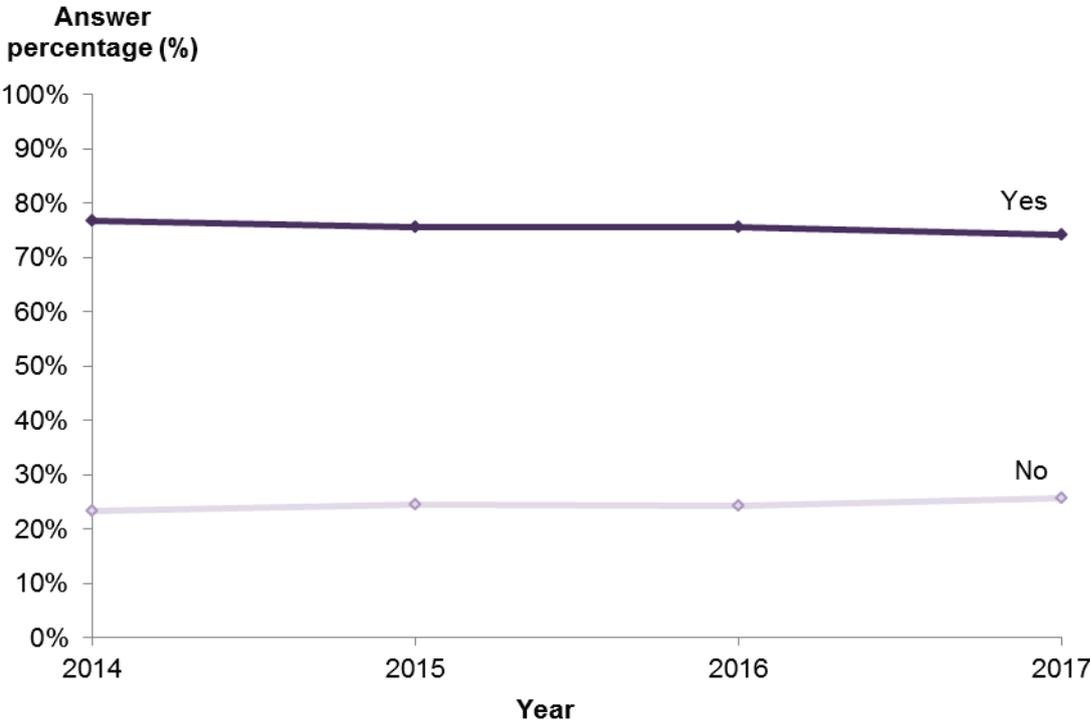
Our analysis showed that, in general, respondents diagnosed as having a psychotic disorder, or respondents that had less than a year or one to five years contact with NHS mental health services reported better than average experiences when asked about communication. Again, respondents diagnosed as having a non-psychotic disorder (moderate severity and non-psychotic chaotic and challenging) or cognitive impairment/dementia (high physical/engagement needs) had worse than average experiences.

### 3: Organising care

[Research suggests](#) that a positive relationship between people who use services and mental health staff can improve outcomes.<sup>28</sup> As the care coordinator will oversee people's care and keep in contact with them, it is important that people using services know who this person is, and that the person does their job effectively. [NICE quality statement 4](#) also recommends that people using community mental health services are supported by staff from a single multidisciplinary community team that is familiar to them, and with whom they have a continuous relationship.

Just under three-quarters (74%) of all respondents said they were told who was in charge of organising their care and services, a fall of three percentage points since 2014 (77%). Twenty-six per cent of respondents said they had not been told this information (23% in 2014).

**Q7. Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”.)**



Answered by all who were told who was in charge of their care and services  
 Number of respondents: 2014 (11,314), 2015 (9,589), 2016 (10,838) and 2017 (9,863)  
**Note:** those who answered 'Not sure' were excluded from the analysis.

Respondents who had been told who was in charge or organising their care and services had positive things to say about that person:<sup>9</sup>

- The vast majority knew how to contact that person if they had a concern about their care (97%).
- Most said that the person who organised their care and services did this ‘very well’ (61%). The remainder responded ‘quite well’ (29%), ‘not very well’ (6%) or ‘not at all well’ (3%).

Positive feedback around service users’ involvement in the organisation of care was particularly evident for service users on a new CPA programme, and those diagnosed with psychotic disorders.

<sup>9</sup> Respondents who told us (at Q8 in the questionnaire) that their GP is in charge of organising their care and services have been removed from the analysis for these questions. This is because results will not be attributable to the mental health trust.

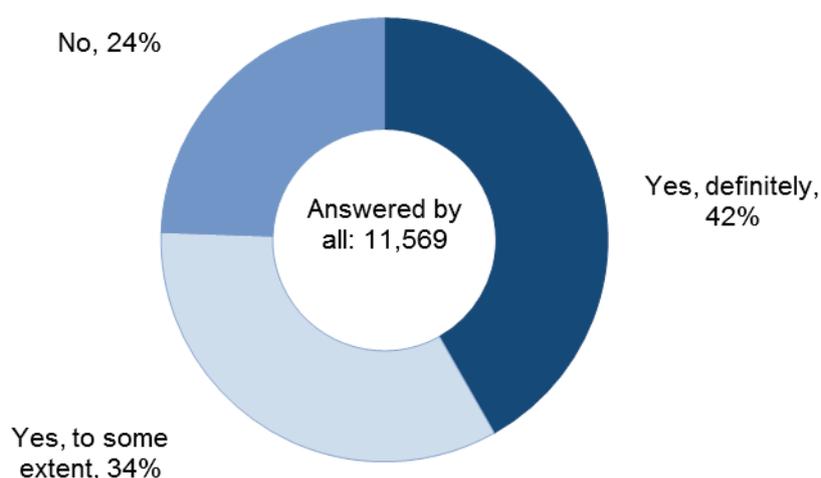
## 4: Planning care

**Guidance** from the Department of Health on coordinating care recommends that everyone receiving care from specialist mental health services should agree what care they will receive. This may be known as a 'care plan' or a 'recovery plan' and should have been developed jointly with mental health and social care professionals. This plan should set out their individual mental health needs, plans and goals for their care and treatment.<sup>29</sup>

A collaborative approach to agreeing care plans is also emphasised in **NICE quality statement 8**, which recommends that people using mental health services jointly develop a care plan with mental health and social care professionals, and that a copy of the plan is given to people with an agreed date to review it.

However, this is not reflected in the 2017 survey results. When asked whether they had agreed with someone from NHS mental health services what care they will receive, less than half of all respondents (42%) said they 'definitely' had. Just over a third (34%) said they had 'to some extent'. This leaves almost a quarter (24%) who said they had not agreed with someone from NHS mental health services what care they will receive.

### **Q11: Have you agreed with someone from NHS mental health services what care you will receive?**



Answered by all  
Number of respondents: 2017 (11,569)

We asked about the experiences of respondents who said they had agreed with someone from NHS mental health services what care they will receive:

- 56% said they were 'definitely' involved as much as they wanted to be in agreeing what care they will receive.
- 59% said their personal circumstances were 'definitely' taken into account.

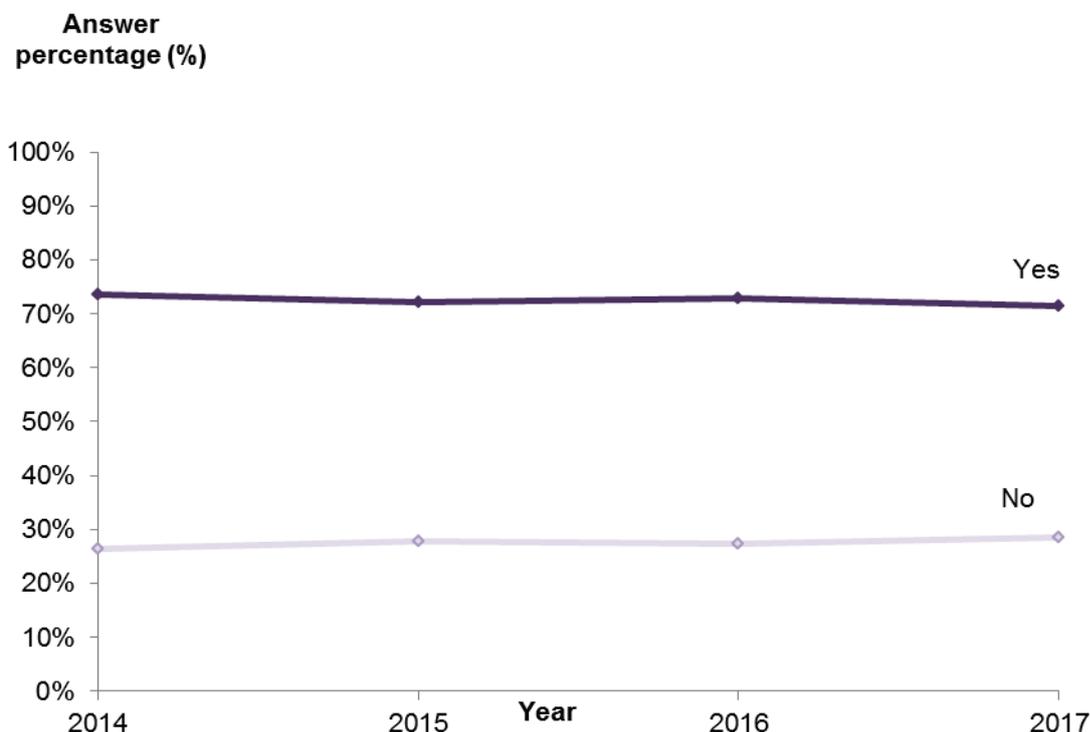
## 5: Reviewing care

These questions were included in the survey to understand whether respondents' care had been reviewed in the previous 12 months and how involved they were in this process.

Involving people in their own care is important as research suggests it can lead to more effective decision-making and better health outcomes. This is also reflected in [NICE quality statement 3](#), which emphasises a collaborative approach to decision-making.

Seventy-two per cent of all respondents said that in the previous 12 months, they had had a formal meeting with someone from NHS mental health services to discuss how their care was working. Twenty-eight per cent said they had not. There has been no significant difference since 2014.

### Q14. In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?



Answered by all

Number of respondents: 2014 (10,255), 2015 (8,798), 2016 (9,735) and 2017 (8,963)

**Note:** those who answered 'Don't know / can't remember' and those who had been in contact with NHS mental health services for less than a year were excluded from the analysis.

We asked about the experiences of the respondents who said they did have a formal meeting in the previous 12 months:

- 60% said that they were 'definitely' involved as much as they wanted to be in discussing how their care was working. The remainder responded 'yes, to some extent' (32%) or 'no, but I wanted to be' (8%).
- 60% said that decisions were 'definitely' made together by them and the person they saw during the discussion on their care. The remainder responded 'yes, to some extent' (30%). One in 10 said 'no' (10%).

## 6: Changes in the staff who people see

There is evidence that continuity of care positively affects people's experiences.<sup>30,31</sup> [NICE quality statement 4](#) recommends that people using community mental health services are supported by staff from a single, multidisciplinary community team, familiar to them and with whom they have a continuous relationship.

However, 42% said that in the last 12 months, the people they see for their care and services had changed (excluding respondents that requested change or moved home).

Looking at the respondents<sup>h</sup> who had experienced a change in the people they see for their care or services in the previous 12 months:

- Less than half (47%) said that the reasons for this change were 'completely' explained to them at the time.
- Just under a quarter (23%) said that their care 'got better' following the change, but 31% said their care 'got worse'.
- Over half (53%) said that they knew who was in charge of organising their care while this change was taking place, leaving 47% who did not.

<sup>h</sup> These questions are only answered by respondents who selected the first response option 'Yes' at Q17.

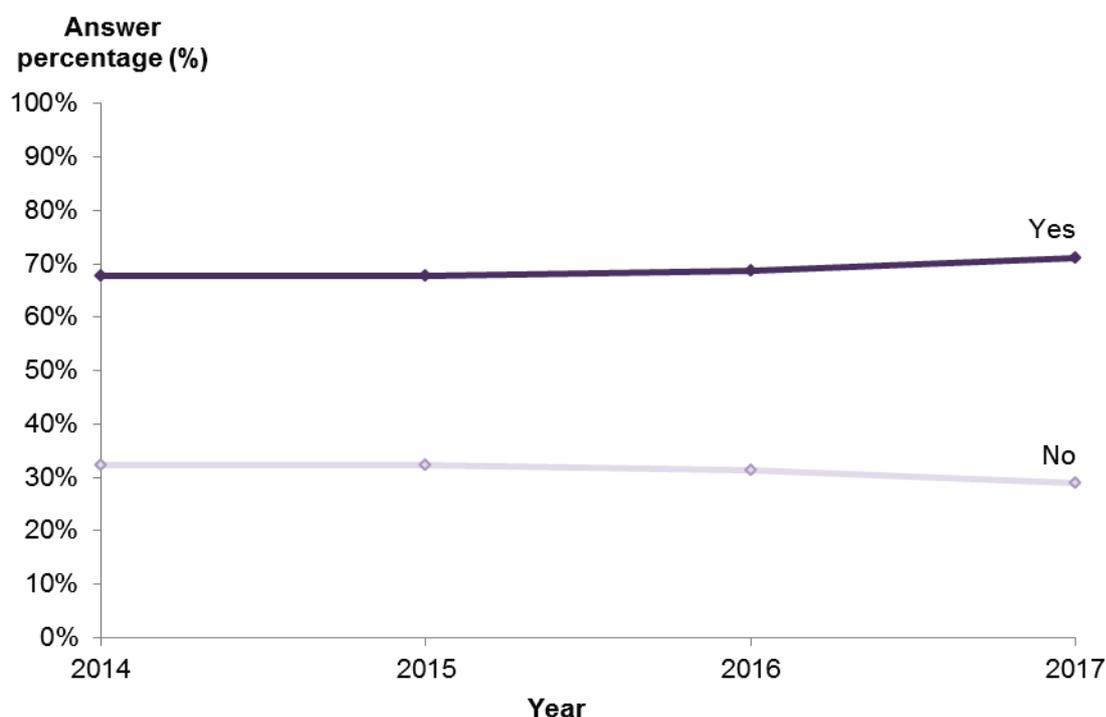
## 7: Crisis care

A mental health crisis is an emergency and it is important that people know who to contact to receive effective care.

Recent policy has included a focus on improving services for people who experience a mental health crisis. The [Five Year Forward View for Mental Health](#) includes a priority that people facing a crisis should have access to mental health care seven days a week and 24 hours a day, in the same way that they are able to get access to urgent physical health care.

Seventy-one per cent of all respondents said that they knew who to contact out of office hours if they had a crisis, leaving almost a third (29%) who did not. This is an improvement from 2014 where 68% of respondents knew who to contact in a crisis out of office hours and 32% did not.

### Q21 Do you know who to contact out of office hours if you have a crisis?



Answered by all

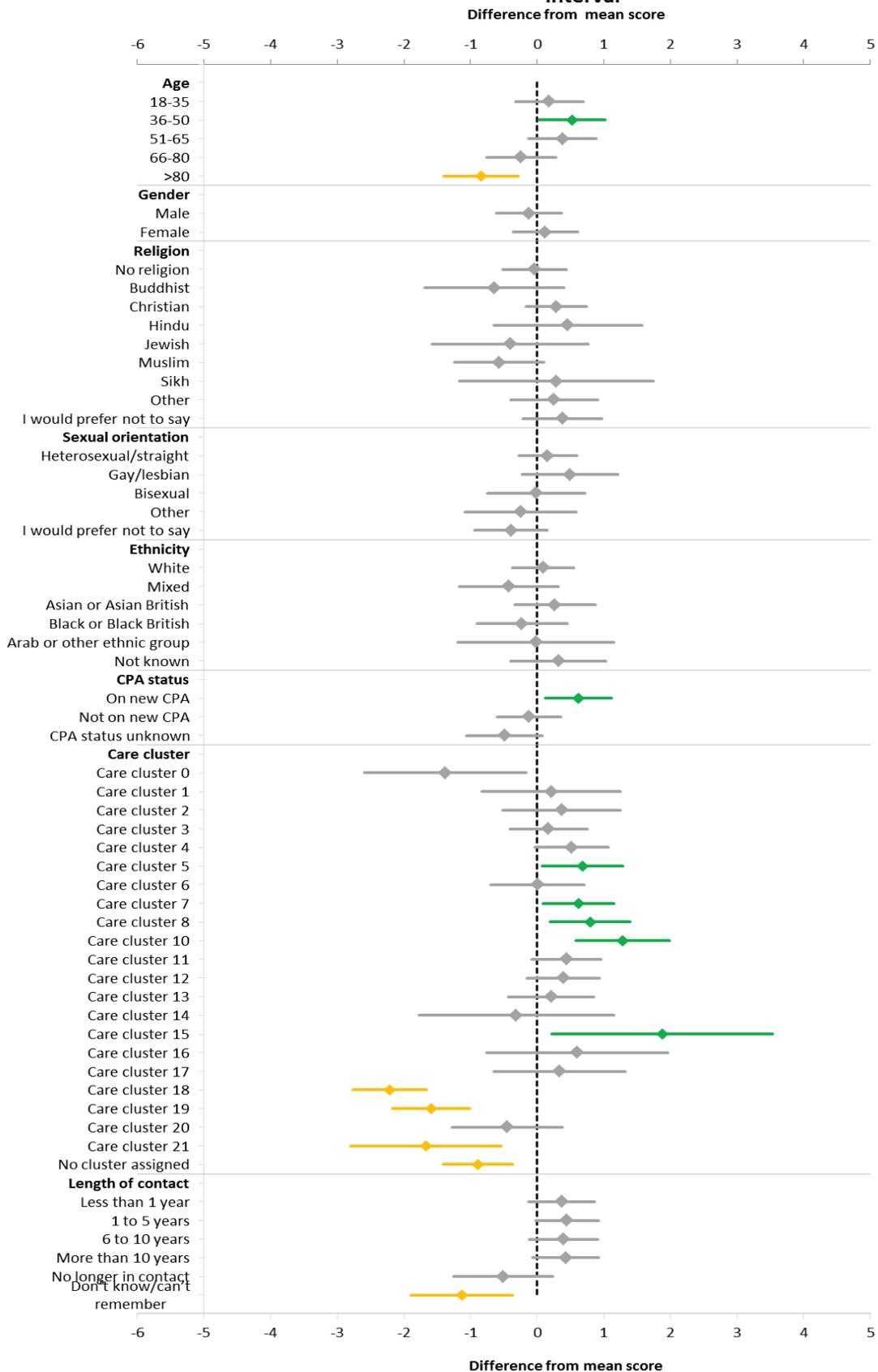
Number of respondents: 2014 (11,868), 2015 (10,155), 2016 (11,417) and 2017 (10,469)

**Note:** those who answered 'Not sure' were excluded from the analysis.

However, there were marked differences in experience of crisis care for different groups shown in the following figure. Respondents in the 36-50 age group or respondents on a new CPA reported better than average experiences when asked about accessing crisis care. In general, respondents from both psychotic and non-psychotic disorder sub-groups also reported better than average experiences in this area. Service users in the 80+ age group or cognitive impairment/dementia service user groups had worse than average experiences.

# Multivariate chart, Crisis Care theme

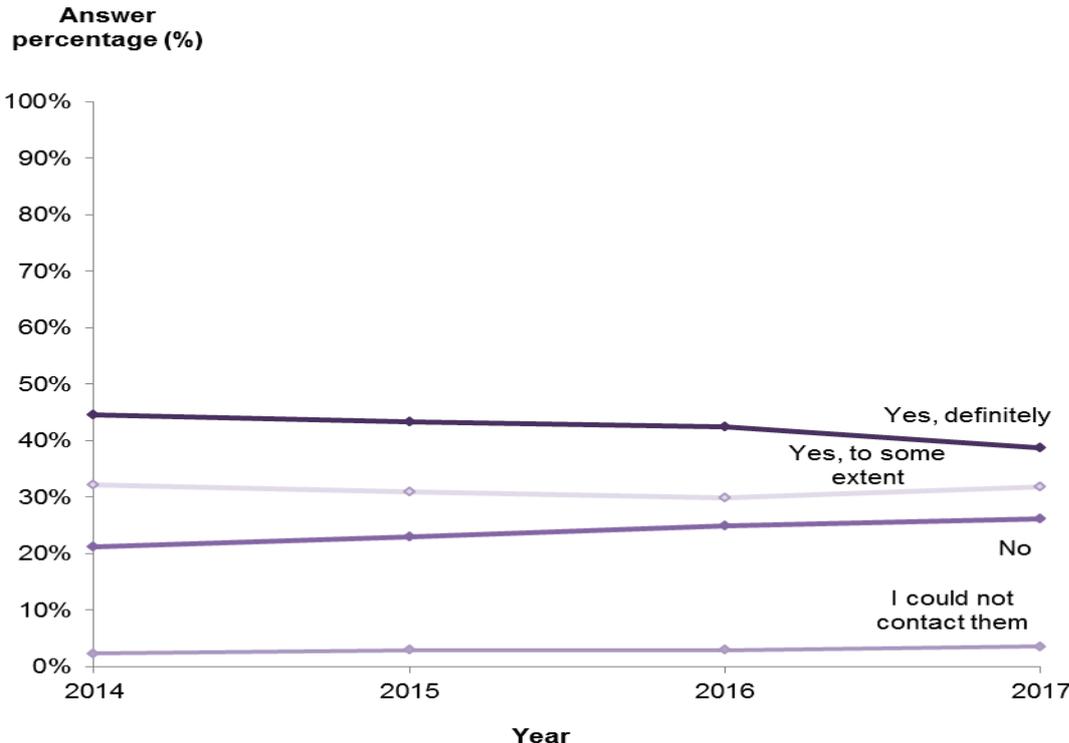
Crisis theme: difference from mean score by subgroup with 95% confidence interval



As well as knowing how to access crisis care, it is important that people also receive effective care. Survey results suggest that some people are still not getting the help they need in a crisis, and the proportion has been steadily growing since 2014.

Thirty-nine per cent of respondents said they ‘definitely’ got the help they needed, a decline of six percentage points since 2014 (45%). Thirty-two per cent said they did ‘to some extent’. Over a quarter (26%) said that they did not get the help that they needed, representing a rise of five percentage points since 2014 (21%).

**Q23. When you tried to contact them, did you get the help you needed?**



Answered by all respondents who had tried in the previous 12 months to make contact with this person/team  
 Number of respondents: 2014 (3,053), 2015 (2,667), 2016 (2,966) and 2017 (2,918)

This is consistent with the findings of CQC’s report [Right here, right now](#), which looked at people’s experiences of crisis care. Many people experienced problems getting help when they needed it, and some healthcare professionals sometimes lacked compassion and warmth when caring for people who are having a crisis.

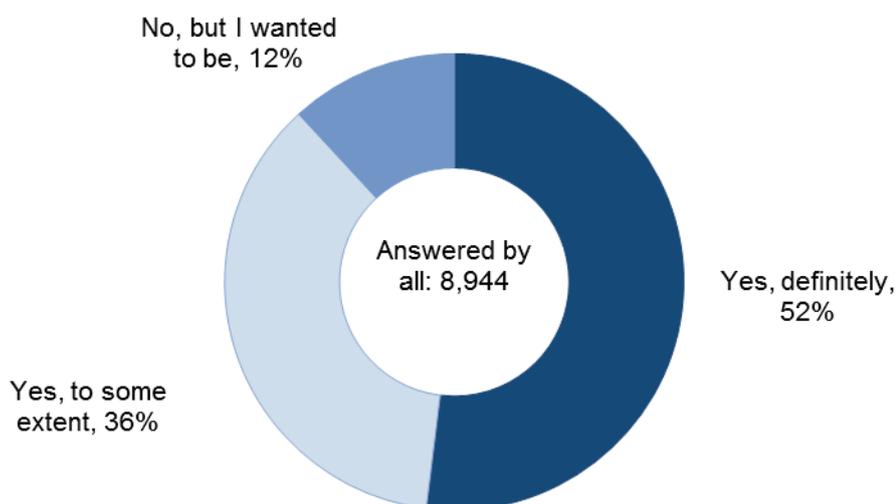
## 8: Treatments

### Medicines

Guidance from [NICE](#) on [adherence to medication](#) recommends involving people in decisions around which medicines to take, which can help improve compliance with taking medicines. <sup>32</sup>

Of those respondents who wanted to be involved in decisions about which medicines they receive for their mental health needs, only 52% said that they 'definitely' were involved.

#### Q25: Were you involved as much as you wanted to be in decisions about which medicines you receive?



Answered by all who received medicines in the previous 12 months  
Number of respondents: 2017 (8,944)

**Note:** respondents who stated that they did not know / could not remember or who did not want to be involved have been excluded.

People who are receiving treatment (medicines or therapies) should be given information about that treatment, including any side effects. The [NICE quality statement 7](#) says that people should be given information and explanations on their assessment, diagnosis and treatment options in a way in which they can understand.

Of respondents that received new medicines in 2017, only 54% said that they were 'definitely' given information about them in a way they could understand.

The [NICE](#) guidance on [adherence to medication](#) states that people on long-term medicines should have them reviewed at regular intervals. The majority (86%) of respondents had been taking medicines for their mental health needs for 12 months or longer.

Of these people, 77% said that in the last 12 months an NHS mental health worker had checked with them about how they were getting on with their medicines leaving just over a fifth (23%) who said this had not happened.

## Other treatments and therapies

Effective care for mental health conditions may involve providing a range of different treatments or therapies.

All respondents were asked if they had received any treatments or therapies for their mental health needs that did not involve medicines in the last 12 months. Less than half (47%) said that they had. Over a quarter (27%) said 'no, but I would have liked this', leaving 26% who responded 'no but I did not mind'.<sup>i</sup>

Looking at the experiences of respondents who, in the previous 12 months, had received other treatments or therapies for their mental health needs:

- 68% said that the treatments or therapies were 'completely' explained to them in a way they could understand.
- Only 55% were 'definitely' involved as much as they wanted to be in deciding which treatments or therapies to use.

## 9: Support and wellbeing

People using specialist mental health services sometimes have wider needs, such as with their finances, housing or employment. While NHS mental health services do not necessarily provide support for this directly, they should help people to find support from other sources, such as sign-posting them to other services.

### Physical health needs

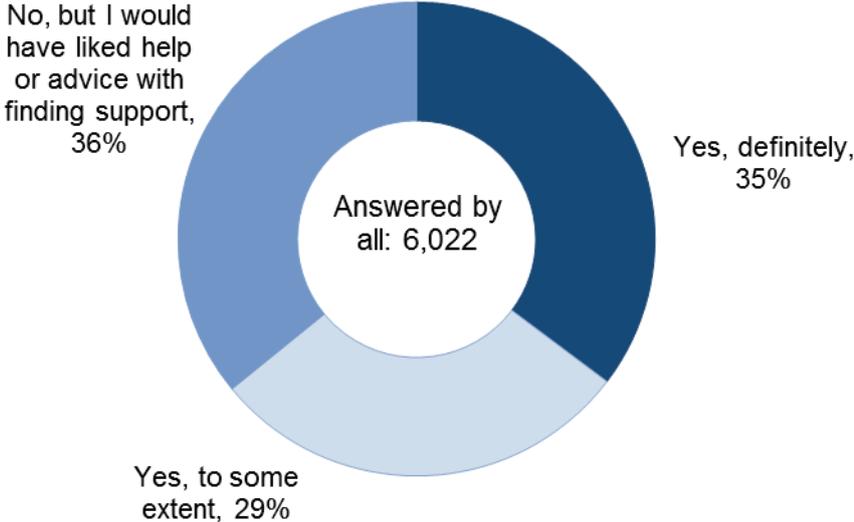
There are strong links between physical and mental health problems. [The King's Fund](#) reported that people with long-term health problems are more likely to also have a mental health problem and almost half of people with a mental health problem also have a long-term physical health problem.<sup>33</sup>

People with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that go unrecognised. NHS England's objective is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.<sup>34,35</sup>

<sup>i</sup> Please note that people who responded 'this was not appropriate for me' were excluded from the analysis for this question.

We asked respondents whether, in the last 12 months, NHS mental health services gave them help or advice with finding support for physical health needs. Of those who needed or wanted this type of support, only 35% said that they 'definitely' received this. Thirty-six per cent responded 'no, but I would have liked help or advice with finding support'.<sup>j</sup>

**Q33. In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?**



Answered by all  
 Number of respondents: 2017 (6,022)  
**Note:** those who answered 'I have support and did not need help/advice to find it', 'I do not need support for this' and 'I do not have physical health needs' were excluded from the analysis.

**Financial advice or benefits and employment**

According to the Mental Health Foundation’s [Surviving or thriving: the state of the UK’s mental health](#) report, household income and economic activity are the most notable demographic difference for determining mental health problems.<sup>36</sup>

According to the Mental Health Taskforce’s [Five year forward view for mental health](#) (2016), psychological therapies and Individual Placement and Support (IPS) services have proved highly effective in helping people into work – with around 30% moving into jobs through IPS – but these are not being commissioned at scale.<sup>37</sup>

<sup>j</sup> We excluded respondents who said that they 'have support in place and did not need help or advice with finding support', or that they 'did not need support' or that they 'do not have any physical health needs'.

We asked respondents whether, in the last 12 months, NHS Mental Health Services gave them any help or advice with finding support for financial advice and benefits, and finding and keeping work.<sup>k</sup> Of those respondents who wanted or needed help or advice with finding support:

- Only 32% said that in the previous 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for financial advice and benefits.
- Only 27% said that in the previous 12 months, NHS mental health services 'definitely' gave them help or advice with finding support for finding or keeping work.

## Community / social activities

Promoting the social inclusion of people with mental health problems has been set out in various governmental policy documents over the years. It is a particular theme in recent publications such as [No Health Without Mental Health](#). [NICE quality statement 8](#) states that care plans should include activities that promote social inclusion such as employment, volunteering, and other aspects such as leisure activities.

The [Promoting Mental Health and Well-being in later life](#) report published by the Mental Health Foundation and Age Concern found that being active and involved in community activities is associated with good mental health and well-being.<sup>38</sup>

Respondents were asked whether someone from NHS mental health services supported them in taking part in an activity locally. Of those respondents who needed or wanted it, 43% answered 'No, but I would have liked it'.

## Peer support

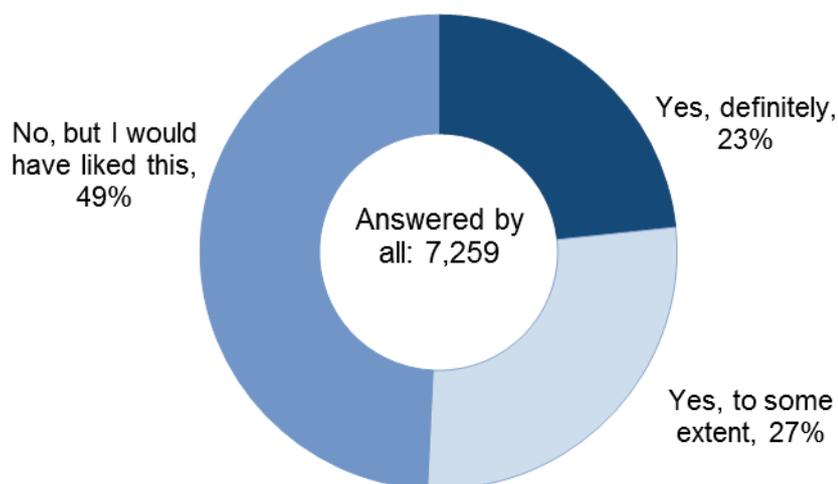
[NICE guidance](#) includes a number of statements relating to people's wider lives, including that people using services should be informed of appropriate local user-led support organisations or options for peer support.

[Research](#) conducted by Repper and Carter (2011) highlighted the benefits of peer support for improving mental health.<sup>39</sup>

Respondents were asked whether they had been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as them. Of the respondents who wanted this, nearly half (49%) responded 'no, but I would have liked this'.

<sup>k</sup> We excluded respondents who said that they 'have support in place and did not need help or advice with finding support' or that they 'did not need support'.

**Q38. Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?**



Answered by all  
Number of respondents: 2017 (7,259)

**Note:** those who answered 'I did not want this' were excluded from the analysis.

### Involving family or friends

The involvement of a person's family (or someone else close to them), when wanted, is an essential part of providing good care. [People in Control of their own health and care: The state of Involvement](#) report produced by the King's Fund suggests such involvement can increase people's knowledge, confidence and understanding in dealing with health issues.

[NICE guidance](#) states that NHS mental health services should welcome the involvement of friends or family in the care of those using services, if this is what they want.

We asked respondents whether NHS mental health services involved a member of their family or someone else close to them as much as they would have liked them to. Of those who wanted friends or family involved, only 54% said that a member of their family or someone else close to them had 'definitely' been involved as much as they would have liked them to be.<sup>1</sup>

### Understanding of wider life

[NICE quality statement 1](#) says that people using mental health services should feel optimistic that care will be effective. This was reflected in findings from the [development work](#) for the survey in 2014, which revealed that an important aspect of the relationship between service users and staff was the staff's

<sup>1</sup> We excluded people who said that 'my friends or family did not want to be involved', that they 'did not want my friends or family to be involved' or that 'this does not apply to me'.

understanding of their lives as a whole, with the interaction between their mental health and the rest of their life clearly understood.

We asked respondents if the people they saw through NHS mental health services helped them with what is important to them. Less than half (45%) said they 'always' did.

Service users diagnosed as having a psychotic disorder, and those who had less than a year or one to five years in contact with NHS mental health services reported better than average experiences when asked about respect for patient-centred values. Service users diagnosed as having a non-psychotic chaotic and challenging disorder or cognitive impairment/dementia (moderate need and high physical/engagement needs) had worse than average experiences.

## 10: Overall

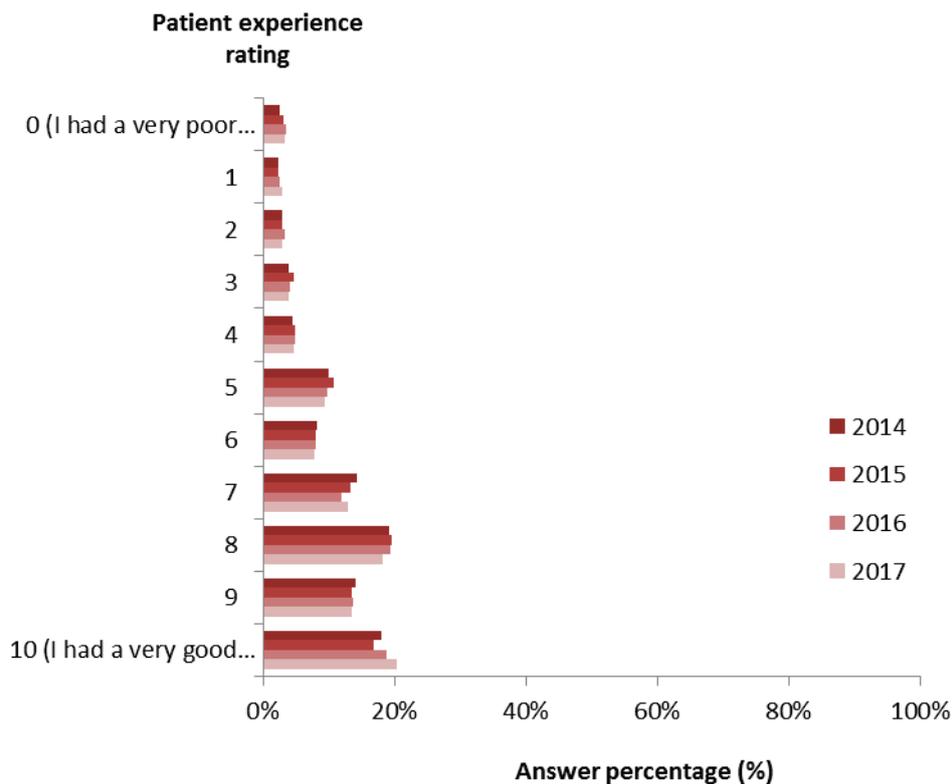
### Overall experience

We asked all respondents to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'). Just under two-thirds rated their overall experience with a score of seven or above out of 10 in 2017 (64%).<sup>m</sup>

Analysis showed that, in general, respondents in the psychotic disorders service user group, and in the less than a year or one to five years contact with NHS mental health services group reported better than average overall experiences. Respondents diagnosed as having a non-psychotic chaotic and challenging disorder or cognitive impairment/dementia (moderate need and high physical/engagement needs) had worse than average experiences.

<sup>m</sup> Calculated using rounded numbers

## Q40. Overall...



Answered by all

Number of respondents: 2014 (12,698), 2015 (10,703), 2016 (12,273) and 2017 (11,202)

**Note:** Respondents were asked to rate their overall experience on a 0-10 scale where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'.

## Overall respect and dignity

The [NHS Constitution](#) states that patients have the right to be treated with respect and dignity. This is also reflected in [NICE quality statement 2](#), which states that people using mental health services, and their families or carers, should feel they are treated with empathy, dignity and respect.

Almost three-quarters (72%) of respondents said that overall, in the last 12 months, they felt that they were 'always' treated with respect and dignity by NHS mental health services.

In general, respondents diagnosed as having a psychotic disorder (with the exception of psychosis and affective disorder), or those that had less than a year or one to five years contact with NHS mental health services reported better than average experiences when asked about respect and dignity. Service users diagnosed as having a non-psychotic chaotic and challenging disorder had worse than average experiences.

# Multivariate analysis summary: how experience varies for different service user groups

## Background

We have included additional analysis to compare how different subgroups of service users rated their experience by using a multilevel model analysis. The multivariate analysis compares the mean scores for a subset of questions by different groups.

In previous surveys, additional analyses (usually at the national level) were broken down by subgroups of respondents using cross tabulations. These cross tabulations were two-dimensional, breaking down a single target (dependent) variable by patient subgroups. This is a very simplified way of showing variation between groups as it does not take account of interdependencies between patient variables. This year, with a multilevel model, we could more effectively explore the relationships between patient characteristics and their experiences.

## Results

The analysis modelled the mean scores of different subgroups: age, gender, religion, sexual orientation, ethnicity, CPA status, diagnosis (care cluster codes) and length of contact for a set of composites.

### 1. Overall

Q40. Overall...

### 2. Respect and dignity

Q41. Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

### 3. Involvement

Q7. Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a “care coordinator” or “lead professional”).

Q37. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?)

### 4. Respect for patient-centred values

Q6. Did the person or people you saw understand how your mental health needs affect other areas of your life?

Q39. Do the people you see through NHS mental health services help you with what is important to you?

### 5. Access

Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?

## 6. Crisis care

Q21. Do you know who to contact out of office hours if you have a crisis?

## 7. Communication

Q4. Did the person or people you saw listen carefully to you?

Q5. Were you given enough time to discuss your needs and treatment?

Differences that are equivalent to at least **0.1** standard deviations from the overall mean of the target variable are treated as being noteworthy in this report.

For more information about how the analysis was completed or about the methodology of the subgroup analysis, see the [Survey methodology](#) section.

## Age

Our analysis found that respondents in the age groups 18-35 and 36-50 reported a worse than average experience for the **overall** (0.23 and 0.14 standard deviations lower than the mean)<sup>n</sup>, **respect and dignity** (0.25 and 0.18), **involvement** (0.13 and 0.16), **access** (0.26 and 0.21) and **communication** (0.23 and 0.16) composites. **respect for patient-centred values** showed a negative experience for the 18-35 age group (0.15). For the **crisis care** composite, we found that 36-50 year olds had a better than average experience in this area (0.11 standard deviations higher than the mean).

We also found that respondents in the age groups 66-80 and 80+ reported a better than average experience for the **overall** (0.20 and 0.17), **respect and dignity** (0.19 and 0.21), **involvement** (0.13 and 0.20), **access** (0.24 and 0.28) and **communication** (0.19 and 0.21) composites. **Respect for patient-centred values** (0.14) showed a better than average experience for the 66-80 age group. The **crisis care** (0.18) composite for the 80+ age group had a worse than average experience.

## Gender

There were no significant differences in the experience of males and females for any of the composites.

## Religion

Christians reported a better than average experience for the **involvement** (0.12), **respect for patient-centred values** (0.11), **respect and dignity** (0.13) and **communication** (0.1) composites.

Buddhists experienced **involvement** (0.26) worse than average.

<sup>n</sup> Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report. See [Appendix G](#) for the charts.

Muslims reported a positive experience for the **access** (0.19) and **communication** (0.21).

For the **access** composite, those respondents that identified themselves as Hindu had a better than average experience (0.25).

## Sexual orientation

Our analysis into sexual orientation found that heterosexual/straight respondents reported a better than average experience for the **overall** (0.14), **respect for patient-centred values** (0.1), **involvement** (0.14), **access** (0.14), **respect and dignity** (0.11) and **communication** (0.1) composites.

## Ethnicity

There were no noteworthy differences in the experience of the ethnicity groups contained in the analysis.

## CPA status

For the **involvement** (0.17), **access** (0.12) and **crisis care** (0.14) composites, respondents on a new CPA had a better than average experience.

## Diagnosis/care clusters

### Non-psychotic disorders:

Respondents with non-psychotic disorders had worse than average experiences for all of the non-psychotic care clusters under the **access** (varying from 0.14 to 0.29 across all non-psychotic disorders that were experienced as significantly negative) theme. Respondents that received a diagnosis of non-psychotic chaotic and challenging disorders (Care Cluster 8) reported having a worse than average experience in all the composites except for the **involvement** and **crisis** composites.

The **crisis** composite is the exception to the trend. Respondents diagnosed with non-psychotic disorders (varying from 0.11 to 0.17 across all non-psychotic disorders that were experienced as significantly positive) experienced crisis care better than the average respondent.

### Psychotic disorders:

Better than average experiences were identified for respondents with psychotic disorders in nearly all of the composites.

### Cognitive impairments and dementia:

Respondents with cognitive impairments or dementia reported worse than average experiences across all the composites, except for the **involvement** and **respect and dignity** composites.

## Length of contact

Respondents that have been in contact with NHS mental health services for less than a year and between one to five years reported better than average experiences across most the composites in this analysis.

See [Appendix G: Multivariate chart analysis charts](#) for detailed charts and [Appendix H: Care cluster codes](#) for more information.

# Appendix A: Survey methodology

## Questionnaire design

The same questions are included to enable year-on-year comparisons where possible. However, questions are reviewed before each survey to determine whether any new questions are needed, to ensure the questionnaire is up to date and in line with current policy and practice. The ongoing work to develop the questionnaire has shown that all survey questions are important to people who use services and to other stakeholders who use the survey data in their work. There is more information on survey stakeholders and how they use the data in [Appendix D](#).

No new questions were added to the 2017 questionnaire, which means that most questions included in the 2017 questionnaire can be compared with results from the 2014, 2015 and 2016 surveys.

For more detailed information please see:

- the 'Development Report for the Community Mental Health Survey 2017': <http://nhssurveys.org/surveys/1024>
- the final questionnaire for the 2017 survey: <http://nhssurveys.org/surveys/1026>

The questionnaire was substantially redeveloped in 2014 and the development report is available here: [www.nhssurveys.org/surveys/750](http://www.nhssurveys.org/surveys/750).

## Survey method

As with most surveys in the NHS Patient Survey Programme, the Community Mental Health Survey used a postal methodology. However, to ensure the questionnaire was as accessible as possible, people were able to complete the questionnaire over the phone in a language other than English.

We sent up to two reminders to people who did not respond.

## Sampling

People aged 18 and over were eligible for the survey if they received specialist care or treatment for a mental health condition and had been seen by a trust between 1 September and 30 November 2016. Trusts drew a random sample from their records of 850 people who had been seen at the trust during the sampling period. The sample size is sufficient to allow analysis of results at individual trust level. Full details of the sampling are available in the instruction manual for the survey (see links in [Appendix F](#)).

All providers of community mental health services were eligible to take part in the survey.

Certain groups of people were excluded from the survey before providers drew their samples, including:

- anyone who was a current inpatient
- anyone seen only once for an assessment
- anyone seen for assessment only through a liaison service
- anyone primarily receiving the following services: drug and alcohol, learning disability, forensic, psychological treatments from Improving Access to Psychological Therapies (IAPT), chronic fatigue/ME, psychosexual medicine (sexual dysfunction) and gender identity
- people who have only been in contact by telephone or email, and have not been seen in person at all.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2017.

For more detailed information on the sampling instructions, and inclusion and exclusion criteria, please see the [instruction manual](#) for the survey.<sup>40</sup>

## Analysis methodology

### Weighting

The weighting strategy for the England level results has changed from the 2014, 2015 and 2016 survey analysis to include population weights as well as trust weights.

### Trust weights

Some trusts have a higher response rate than others and would therefore have a greater influence over the England average if a simple mean was calculated across all respondents. To avoid this, weights are applied to the data. By applying these weights, the responses from each trust have an equal influence over the England average, regardless of differences in response rates between trusts.

Trust weights are useful for calculating the figures for England because they describe the results of the hypothetical 'average trust' for a given year. A similar approach has been used in other surveys including the NHS acute inpatient survey.

### Population weights

A 'population weight' was also applied, which aims to weight the results for each individual trust to that trust's eligible sample profile, with the intention of making each trust's results representative of their own population.

The data for each survey year are separately weighted to the population for the relevant survey period. This weighting strategy has been applied to the 2014, 2015, 2016 and 2017 data published in this report. There are eight unique weights per trust per year, one for each of the age/sex groups.

Both sets of weights are then multiplied together to produce a single combined weight for the data tables that underpin the analysis.

This weighting has been applied to all questions that assess patient experience in any way. Some questions that have been weighted are also 'scored' questions, as seen in the scored questionnaire available [here](#).

The demographic questions in the 'About You' section (Q42-Q47) are not weighted, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than adjust figures.

Please note that where we analyse questions by CPA, this data is also unweighted. CPA is interpreted and applied very differently between trusts: for respondents to the 2017 survey the proportion on the CPA ranged substantially. It is therefore not appropriate to apply weights.

For more detailed information, please see the Quality and Methodology report published on the [CQC website](#).

## Rounding

The results present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%. Please note that rounding up or down may make differences between survey years appear bigger or smaller than they actually are.

## Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2017 compared with the last time the survey was conducted in 2016, and likewise in 2014 and 2015.

A 'z-test' set to 95% significance was used to compare data between survey years and between different groups. A statistically significant difference means it is unlikely we would have obtained this result, if there was no real difference.

Due to the relatively large number of respondents, small changes in results may show to be statistically significant. Such small changes do not necessarily indicate a longer-term trend.

However, in other cases there may be a visible change in the results between survey years but this is not significant. There are a number of reasons for this, such as:

- Rounding figures up or down makes a difference appear larger than it actually is.
- Generally speaking, the larger the sample size, the more likely that findings will be statistically significant, and we can be more confident in the result. Conversely, the fewer people that answer a question, the greater the difference has to be in order to be statistically significant.
- The amount of ‘variance’ also affects whether the difference is significant. Variance means the differences in the way people respond to the question. If there is a lot of variance then differences are less likely to be statistically significant.

## Notes on specific questions

Table A1 below provides information about the analysis of particular questions.

**Table A1: analysis applied to particular questions**

Question	Analysis applied
<p><b>Q8:<sup>o</sup></b> Is the person in charge of organising your care and services?</p>	<p>Respondents may have ticked more than one option to this question. Results are presented as percentages for each option, out of all those eligible to answer that question, because some respondents will have selected more than one category. This means that the results may add up to over 100%. Though this question is not included in this report, you can find the results to this question in the <a href="#">Open data</a> available on the CQC website.</p>
<p><b>Q9 and Q10:</b> Q9 Do you know how to contact this person if you have a concern about your care?  Q10 How well does this person organise the care and services you need?</p>	<p>Respondents who stated at Q8 that their GP is in charge of organising their care and services have been removed from the analysis for these questions. This is because results will not be attributable to the mental health trust.</p>

<sup>o</sup> The questionnaire did not instruct respondents to ‘tick all that apply,’ however, as a large number of respondents did this, data has been treated as multiple response.

<p><b>Q14:</b> In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?</p>	<p>As the question specifies a time period of ‘the last 12 months’ we have removed people who said they have been in contact with mental health services for less than a year (based on their responses to Q2)<sup>p</sup> from the data set, and they are therefore not included in the analysis for this question. This is because they have not been in contact with services long enough to reasonably expect them to have had a care review.</p>
<p><b>Q15 and Q16:</b> Q15 Were you involved as much as you wanted to be in discussing how your care is working?  Q16 Did you feel that decisions were made together by you and the person you saw during this discussion?</p>	<p>We have revised the analysis rules for Q15 and Q16, to be consistent with that applied to Q14.</p> <p>This approach removes respondents who stated at Q2 they had been in contact with mental health services for less than a year from the data set and they are therefore not included in the results for Q15 and Q16 (as well as for Q14) because we cannot be certain that respondents were referring to a care review.</p> <p>The results from the 2015 survey for these questions have been rerun to match the revised approach.</p>

## Comparability with previous years

The results for most questions from the 2017 survey are comparable with the 2014, 2015 and 2016 survey. The following questions are **not comparable** for the reasons outlined below:

**Table A2: comparability with previous years**

Question	Reason not comparable with 2015 and 2014
<p><b>Q17:</b> In the last 12 months, have the people you see for your care or services changed?</p>	<p>A new response option (<i>yes, but this was because I requested this change</i>) has been added to this question in 2016. It is therefore not possible to compare the results for this question with 2014 or 2015.</p>
<p><b>Q18:</b> Were the reasons for this change explained to you at the time?</p>	<p>This was a new question for 2016, and it is therefore not possible to compare the result for this question with 2014 or 2015.</p>

<sup>p</sup> Respondents who selected option one (*‘less than a year’*) at Q2 (*Overall, how long have you been in touch with NHS mental health services?*) were removed from the analysis of Q14, Q15 and Q16 as reported in this section.

<p><b>Q19:</b> What impact has this had on the care you receive?</p> <p><b>Q20:</b> Did you know who was in charge of organising your care while this change was taking place?</p>	<p>Only people who answer 'yes' to Q17 answer these questions, with all other responses being routed past (to Q21). A new response option has been added to Q17 (<i>yes, but this was because I requested the change</i>) in 2016, which will have changed the number of people who go on to answer Q19 and Q20, meaning results are no longer comparable with 2014 or 2015.</p>
<p><b>Q31:</b> Were these treatments or therapies explained to you in a way you could understand?</p>	<p>This was a new question for 2016, and it is therefore not possible to compare the result for this question with 2014 or 2015.</p>
<p><b>Q39:</b> Do the people you see through NHS mental health services help you with what is important to you?</p>	<p>Two questions that came before and after this question were removed for 2016. As it cannot be known if any change in the result for this question in 2016 was caused by a change in the ordering of the questions, this question is not comparable with 2014 or 2015.</p>

Over time, there have been a number of changes made to the survey, including revisions to the eligible age range and major developments to revise the methodology and the questionnaire content, which affect historical comparability:

- The 2004 and 2005 surveys included people aged 16-65 years. In 2006, the age range for the survey was extended to include people aged over 65. This means that to compare results with earlier surveys older respondents must be excluded from the analyses.
- The survey has undergone two major redevelopments ahead of the 2010 and 2014 surveys to reflect changes in policy, best practice and patterns of service. This means that the 2015 survey is only comparable with the 2014 survey. Surveys carried out between 2010 and 2013 are comparable with each other but not with any previous surveys, due to the re-development in 2010.

## Multivariate analysis

Results for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a linear mixed effects model. These means were compared on composites of questions, illustrated in the charts. This kind of model takes into account trust clustering, as trusts are likely to have a big impact on reported patient experience at a national level.

To assess whether experience differs by demographic factors, statistical significance tests were carried out. F tests were performed on each factor (fixed effect) as a predictor of the target variable. P-values were also generated which showed how likely it is that the differences between groups observed in the

results could have arisen from a population where there were no actual differences. They relate to the demographic factor as a whole rather than to compare between specific categories within the factor. Variables were also checked for multicollinearity to ensure co-efficient estimates were not being influenced by additional factors.

In the charts, each question was centred by subtracting its overall mean from each respondent's score before the questions were combined into themed composites. This was a development of the approach used in previous surveys and is intended to remove any difference in composite scores that might potentially arise through different patterns of item non-response.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report. See [Appendix G](#) for the charts.

# Appendix B: Other sources of information related to survey results

The following are links to other sources of data related to mental health services. Please note that they do not measure patient experience and are therefore not directly comparable with findings presented in this report.

## NHS Outcome Framework Indicators

The indicators in the NHS Outcomes Framework have been designed to provide national-level accountability for the outcomes that the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS. They do not set out how these outcomes should be delivered; it is for NHS England to determine how best to deliver improvements by working with clinical commissioning groups (CCGs) to make use of the tools available.

For more information about the NHS Outcome Framework, please visit NHS Digital (formerly the Health and Social Care Information Centre) and GOV.UK websites:

<http://content.digital.nhs.uk/m/nhsdf>

<https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017>

<http://content.digital.nhs.uk/mhldsmonthly?tabid=2>

## Staffing

Statistics on staffing numbers are provided in NHS Digital's statistical release on NHS Workforce Statistics. Please note this data covers all trust types, such as acute and community trusts, as well as mental health providers. For more information, please see: <http://digital.nhs.uk/workforce>.

## Statistics on the use of mental health services

The Mental Health and Learning Disabilities Data Set (MHLDS) is released monthly and contains record-level data about the care of people using secondary mental health services, including people with learning disabilities. It includes data on topics asked about in the survey including:

- data for people on the CPA who had a 12 month review
- data for people with a crisis plan in place
- data on the demographics of people who use services.

Please note that this data set is **not directly comparable** with survey results because:

- It is a different type of data: the survey data is about people's experiences of services whereas the MHLDS data set contains factual data submitted from trusts records.
- The survey covers only community mental health services whereas MHLDS also cover mental health inpatient and learning disability services.
- The sample for the survey has certain exclusions, for example, we exclude people with learning disabilities, certain specialities such as forensic services, and people under the age of 18. For full details of the survey inclusion and exclusion criteria, please see the instruction manual available at <http://www.nhssurveys.org/surveys/1030>.

For more information on MHLDS, please see:  
<http://content.digital.nhs.uk/mhldsmonthly>.

## Waiting times

The government has committed to introducing access and waiting time standards for mental health services. For more information, please see:  
[www.england.nhs.uk/mentalhealth/resources/access-waiting-time/](http://www.england.nhs.uk/mentalhealth/resources/access-waiting-time/).

# Appendix C: Comparisons with other surveys

This is the only survey of community mental health services currently conducted in the UK. Therefore, findings cannot be compared with data from Scotland, Wales or Northern Ireland.

There are very few surveys related to community mental health services. The surveys that are carried out tend to establish prevalence of mental health issues rather than focus on experiences of care received.

However, there are many other surveys carried out in the UK by various organisations. While results are not directly comparable due to different methodologies, these other surveys may be of interest as they provide further information on mental health. Some of the larger surveys are summarised below.

## The Health Survey for England

This is a series of annual surveys designed to measure health and health-related behaviours in adults and children. It covers a wide variety of topics that vary from year to year. In 2016, the 2014 report was updated with mental health data. The 2014 is the most recent iteration of the survey. The survey included questions on the prevalence of mental health issues in England, and found around a quarter (26%) of adults reported having ever been diagnosed with at least one mental illness.

For more information, please see:

- [National Centre for Social Research](#)
- [NHS Digital](#)

## National Audit of Schizophrenia

This is an initiative of the Royal College of Psychiatrists' Centre for Quality Improvement. Its aim is to find out about the quality of care and support for people with schizophrenia and their carers from NHS community mental health services.

The most recent round (second round) of the audit was published in 2014. The audit obtained a final database of 5,608 records (an 88% response rate). Each trust was asked to submit data on a random sample of 100 adults under their care, with diagnoses of either schizophrenia or schizoaffective disorder, who had been under the care of mental health teams in the community for at least 12 months. Trusts also distributed a survey to service users who, in turn, distributed a carer survey form to the individual they considered to be their closest carer.

Although there are some questions that are similar across the two methods of data collection, results are not directly comparable with the Community Mental

Health Survey because the National Audit of Schizophrenia focuses only on people who have schizophrenia, whereas this survey includes a much wider range of conditions. The audit also uses a different questionnaire and sampling strategy. The comparisons listed below are for descriptive purposes only, and have not been tested for statistically significant differences due to the limitations in comparability:

- The audit asked about overall experience of care, and 88% of all service users said they were 'very' or 'fairly' satisfied with their care and 4% were reportedly 'not satisfied at all'. This survey uses a different format of question, and found that 64% of people rated their care as seven or above, out of 10 (Q40).
- In terms of help with looking for work, the audit results show that of those who were interested in looking for work, just over half reported that they did not receive any help towards this (52%). Forty-three per cent of respondents to this survey reported a similar answer, saying they did not receive help or advice but would have liked to (44% in 2014). Note: the survey results exclude those who said they already have support and did not need help, those who did not need any support, and those currently not seeking work.

The National Audit of Schizophrenia was contracted for two rounds and no further updates are expected.

For more information, please see:

[www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/scizophrenia/nationalschizophreniaaudit.aspx](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/scizophrenia/nationalschizophreniaaudit.aspx).

## Adult Psychiatric Morbidity Survey

This provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population (aged 16 and over). The survey is carried out every seven years.

The most recent (2014) survey found demographic inequalities in those who received treatment, with people from Black and minority ethnic groups (BME) having particularly low treatment rates. Socio-economic inequalities were less evident.

Results are not directly comparable with the Community Mental Health Survey because the Adult Psychiatric Morbidity Survey uses a different questionnaire, sampling strategy and methodology (interview survey). The surveys also have different purposes: the Adult Psychiatric Morbidity Survey aims to estimate prevalence of mental health disorders, whereas the Community Mental Health Survey aims to understand people's experiences of using services.

For more information, please see:

<http://natcen.ac.uk/our-research/research/adult-psychiatric-morbidity-survey/>.

## Mental Health of Children and Young People in Britain

This survey was first carried out in 2004, and was repeated in 2016. It aims to check the prevalence of three main childhood mental disorders: conduct disorder, hyperactivity and emotional disorders. The sample is drawn from child benefit records and used an interview methodology. Data was collected from adults and teachers, or children aged 11-16.

Results are not directly comparable with the Community Mental Health Survey due to the different sample, methodology and question content.

For more information, please see:

<https://www.gov.uk/government/publications/improving-the-mental-health-of-children-and-young-people>.

# Appendix D: Main users of the survey data

This appendix lists known users of data from the Community Mental Health Survey and how they use the data.

## Care Quality Commission (CQC)

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC Insight, an intelligence tool that indicates potential changes in quality of care to support decision-making about our regulatory response. Survey data will also form a key source of evidence to support the judgements and inspection ratings published for trusts.

## Department of Health

The government's strategy sets out a commitment to measure progress on improving people's experiences through Domain 4 of the NHS Outcomes Framework 'ensuring people have a positive experience of care', which includes results from the Community Mental Health Survey, among other data sources.

The Framework sets out the outcomes and corresponding indicators that the Department of Health uses to hold NHS England to account for improvements in health outcomes, as part of the government's [Mandate](#) to NHS England. The Outcomes Framework survey indicators are based on the standardised, scored trust level data from the survey (similar to that included in the CQC benchmark reports), rather than the England level percentage of respondents data that is contained within this report.

For more information, see the following link:

[www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017](http://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017).

## NHS England

NHS England uses questions from the NHS Patient Survey Programme (specifically the Inpatient, Community Mental Health and Emergency Department surveys) to produce a separate index measure called [the Overall Patient Experience Score](#). The score forms part of a regular statistical series, which is updated alongside the publication of each respective survey.

The scores are calculated in the same way each year, so that the experience of people who use the NHS can be compared over time. As part of the supporting documentation, NHS England also produce and publish a [diagnostic tool](#) to help NHS managers and the general public understand what feeds in to the overall scores and to see how scores vary across individual NHS provider organisations.

More information is available here:

[www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/](http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/).

## **NHS Improvement**

NHS Improvement oversees NHS trusts and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high-quality, compassionate care within local health systems. NHS Improvement will use the results of the Community Mental Health survey to inform quality and governance activities as part of its Oversight Model for NHS Trusts.

For more Information about NHS Improvement, please see:

<https://improvement.nhs.uk/>.

## **NHS trusts and commissioners**

Trusts, and those who commission services, use the results to identify and make the improvements they need to improve the experience of people who use their services.

## **Patients, their supporters and representative groups**

The survey data is available on CQC's website for each participating NHS trust, under the organisation search tool. The data is presented in an accessible format to enable the public to examine how services are performing, alongside the trust's inspection results. The search tool is available from the CQC home page: [www.cqc.org.uk/](http://www.cqc.org.uk/).

# Appendix E: Quality and methodology

All detail on data limitations can be found in the Quality and methodology document, available at [www.cqc.org.uk/cmhsurvey](http://www.cqc.org.uk/cmhsurvey).

## Revisions and corrections

CQC publishes a [Revisions and Corrections Policy](#) relating to these statistics. The NHS Patient Survey Programme data is not subject to any scheduled revision as they capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised.

This policy sets out how CQC will respond if an error is identified within this and it becomes necessary to correct published data or reports.

# Appendix F: Further information and feedback

## Further information

This report, together with the trust level results, is available CQC's website. You can also find a 'technical document' here, which describes the methodology for analysing the trust level results, and a 'quality and methodology' document, which provides information about the survey development and methodology: [www.cqc.org.uk/cmhsurvey](http://www.cqc.org.uk/cmhsurvey).

The results from previous community mental health surveys that took place between 2004 and 2008,<sup>q</sup> and between 2010 and 2013, are available at the link below. Please note that due to redevelopment work, results from the 2017 survey are only comparable with 2014, 2015 and 2016<sup>r</sup>: [www.nhssurveys.org/surveys/290](http://www.nhssurveys.org/surveys/290).

Full details of the methodology for the survey, including questionnaires, letters sent to people who use services, instructions on how to carry out the survey and the survey development report, are available at: <http://www.nhssurveys.org/surveys/1014>.

There is more information on the NHS Patient Survey Programme, including results from other surveys and a programme of current and forthcoming surveys at: [www.cqc.org.uk/content/surveys](http://www.cqc.org.uk/content/surveys).

## Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the Community Mental Health Survey 2017. The guidance above should help answer any questions you have about the programme. However, if you wish to contact the Team directly, please contact Paul Williamson, User Voice Development Manager, at [Patient.Survey@cqc.org.uk](mailto:Patient.Survey@cqc.org.uk).

## Feedback

We welcome all feedback on the survey findings and the approach we have used to reporting the results, particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how we can improve this publication, please contact Paul Williamson, User Voice Development Manager, at [Patient.Survey@cqc.org.uk](mailto:Patient.Survey@cqc.org.uk).

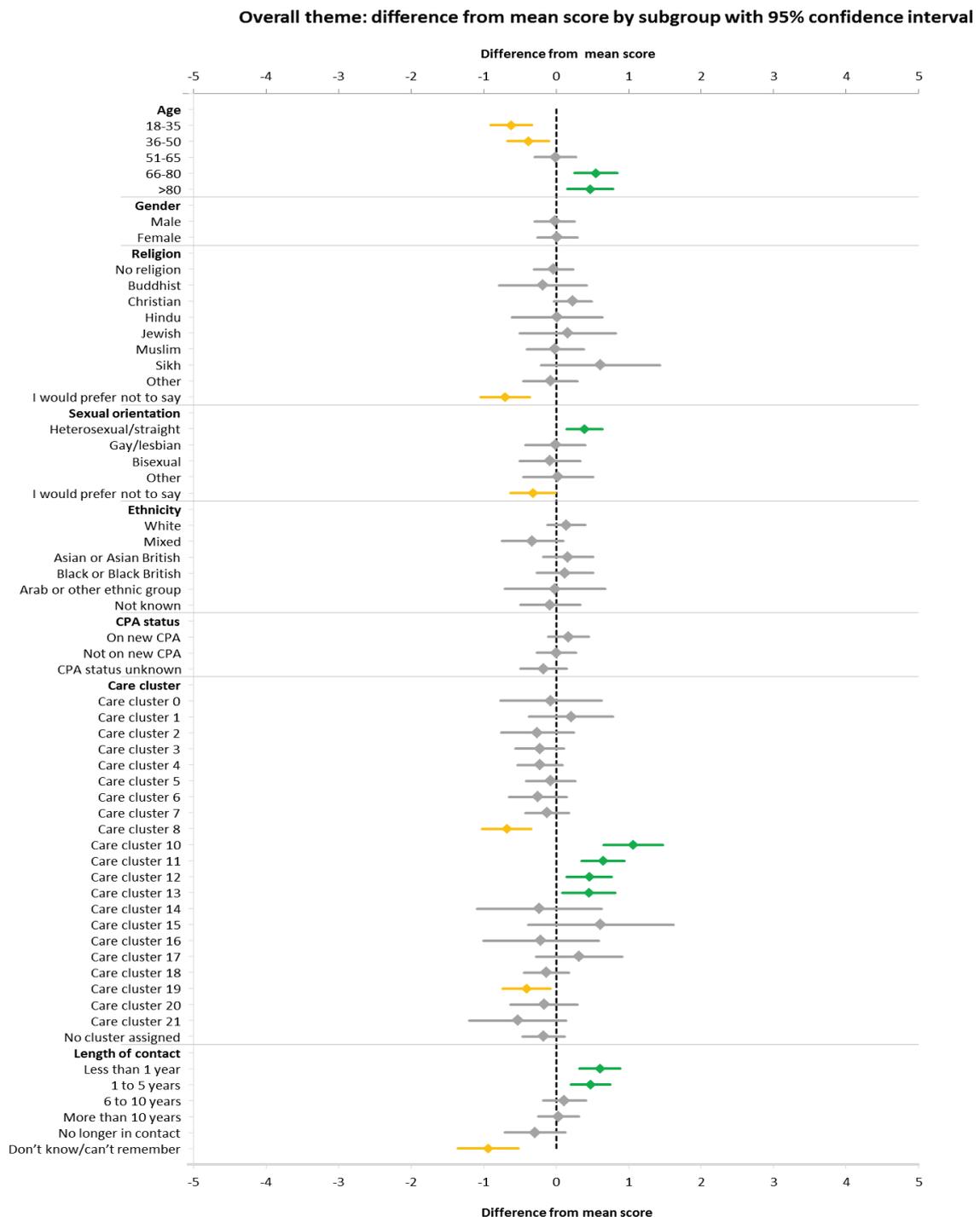
We will review your information and use it, as appropriate, to improve the statistics that we publish across the NHS Patient Survey Programme.

<sup>q</sup> In 2009 there was a survey of mental health inpatient services.

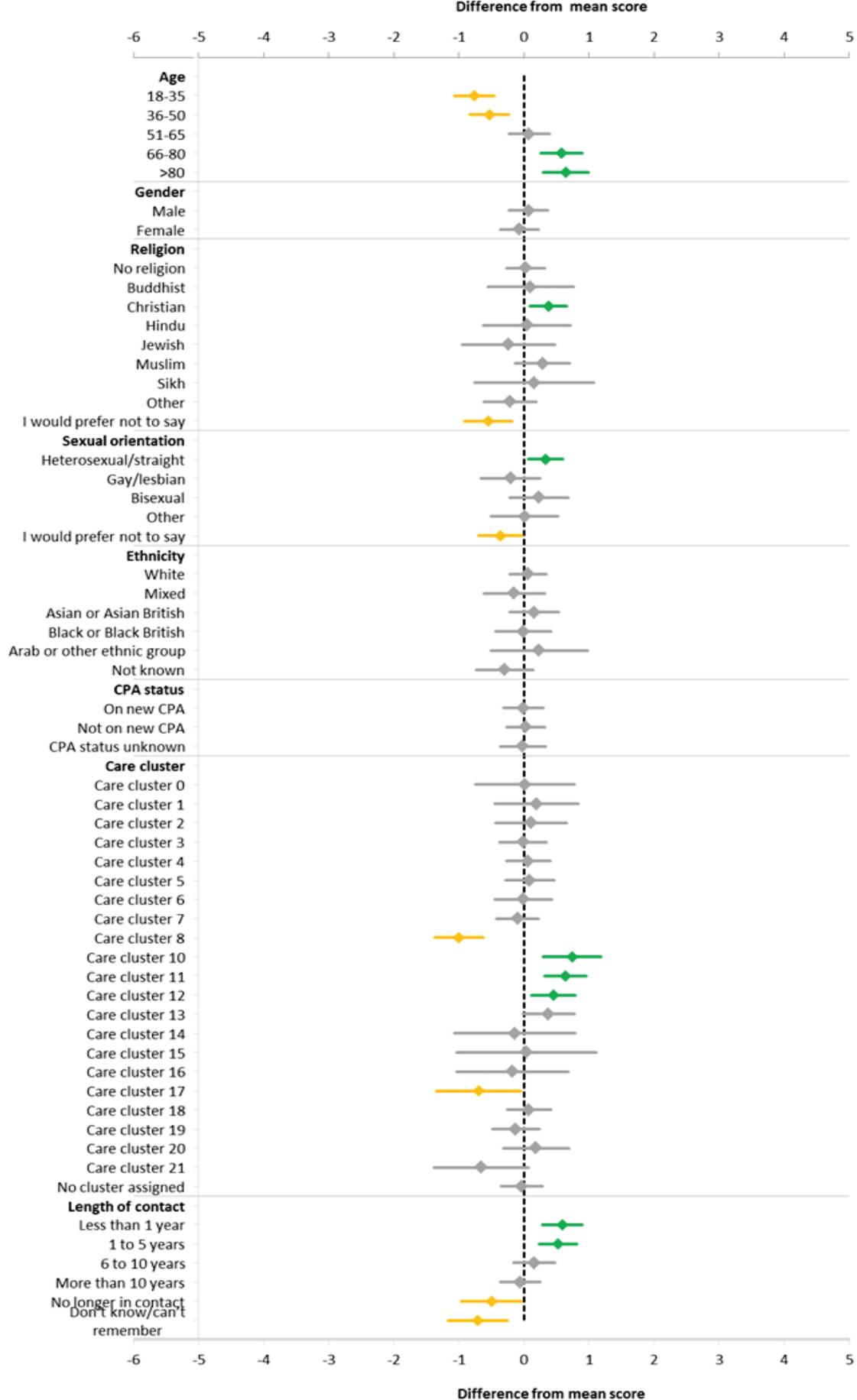
<sup>r</sup> Please note that the survey was also substantially redeveloped in 2010. This means that surveys carried out between 2010 and 2013 are comparable with each other, but not with any other surveys.

# Appendix G: Multivariate chart analysis charts

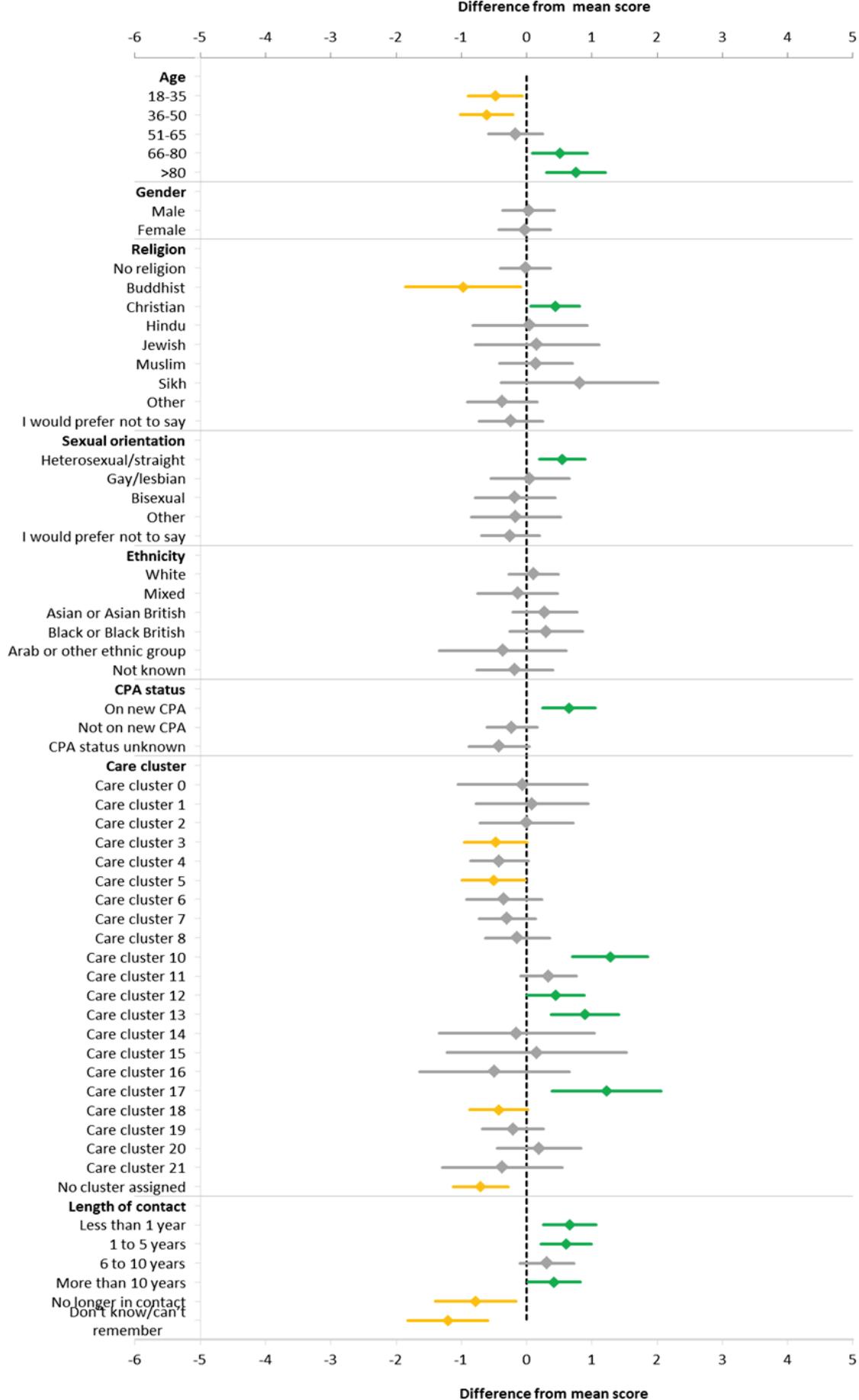
In this section, we have used green to highlight better than average experiences that are statistically significant. Statistically significant worse than average experiences are highlighted in orange for all charts. The cluster code definitions are in [Appendix H](#).



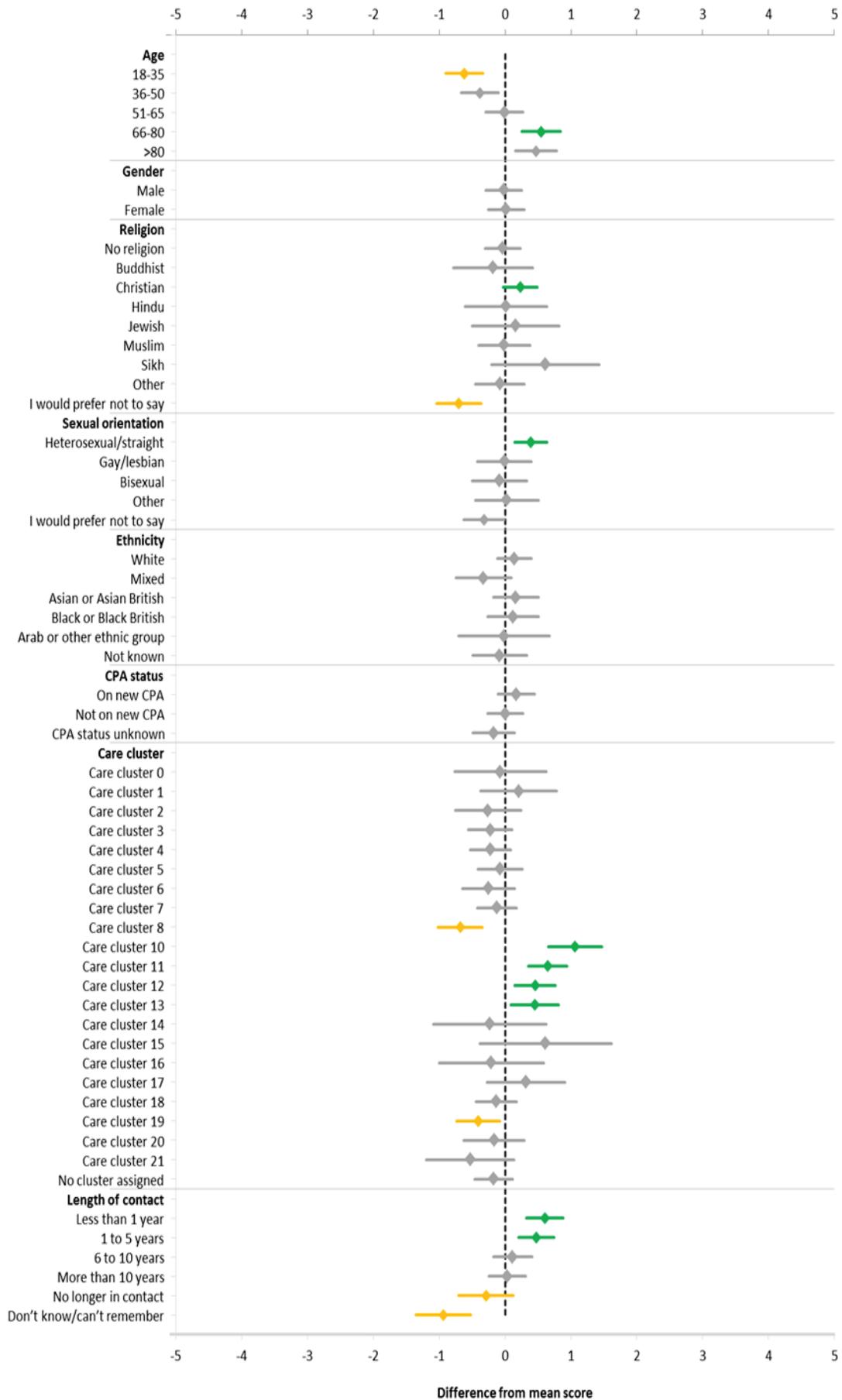
Dignity theme: difference from mean score by subgroup with 95% confidence interval



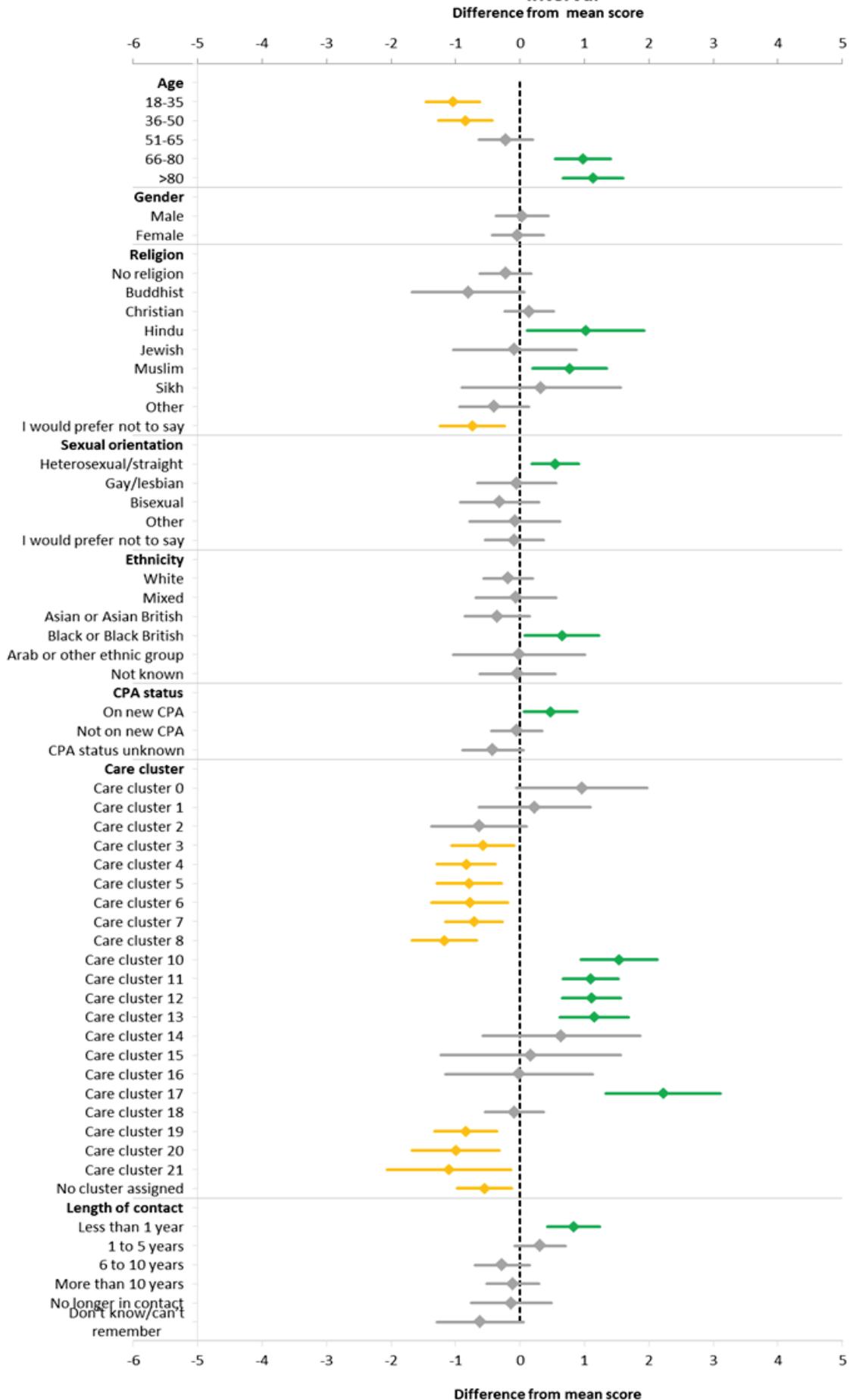
**Involvement theme: difference from mean score by subgroup with 95% confidence interval**



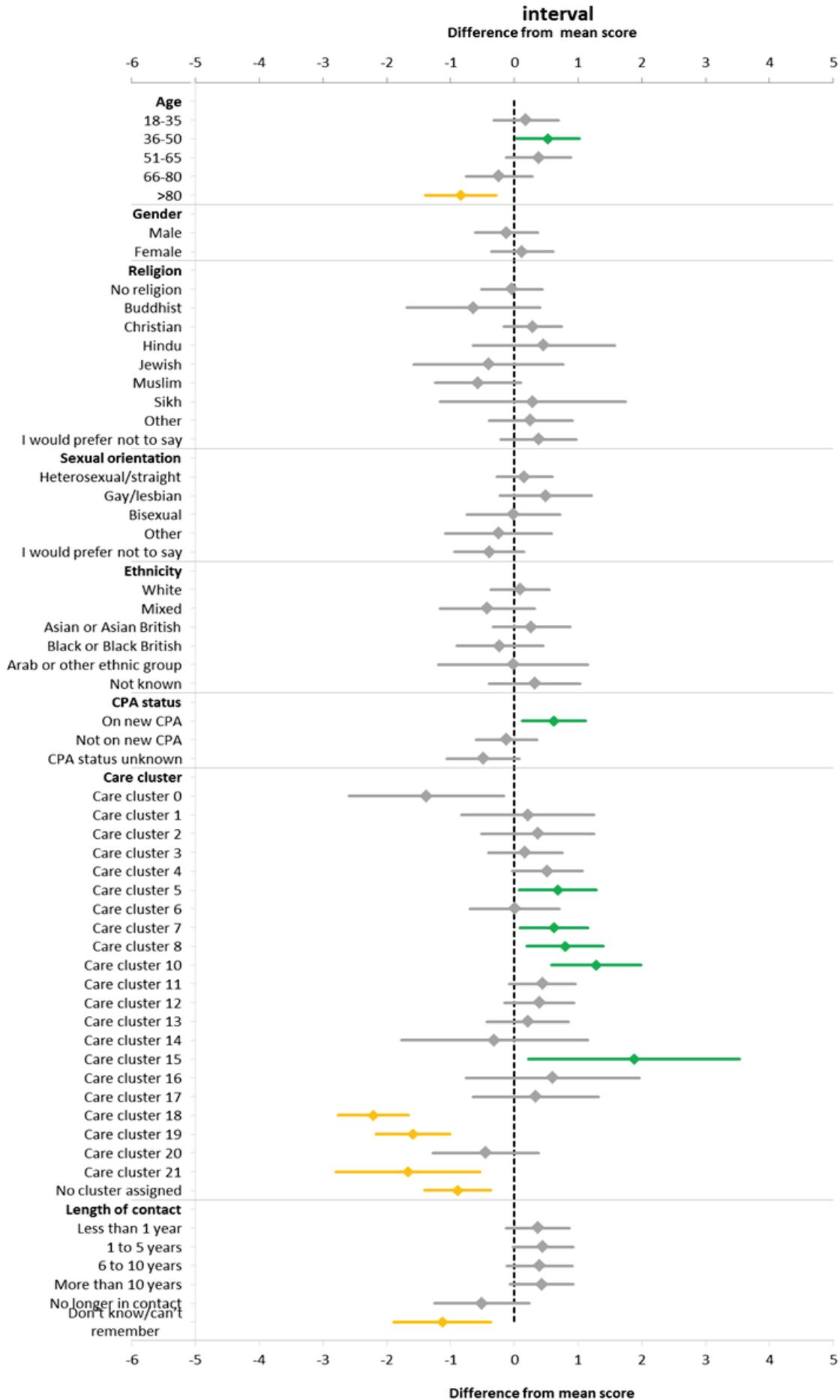
Respect for patient centered values theme: difference from mean score by subgroup with 95% confidence interval



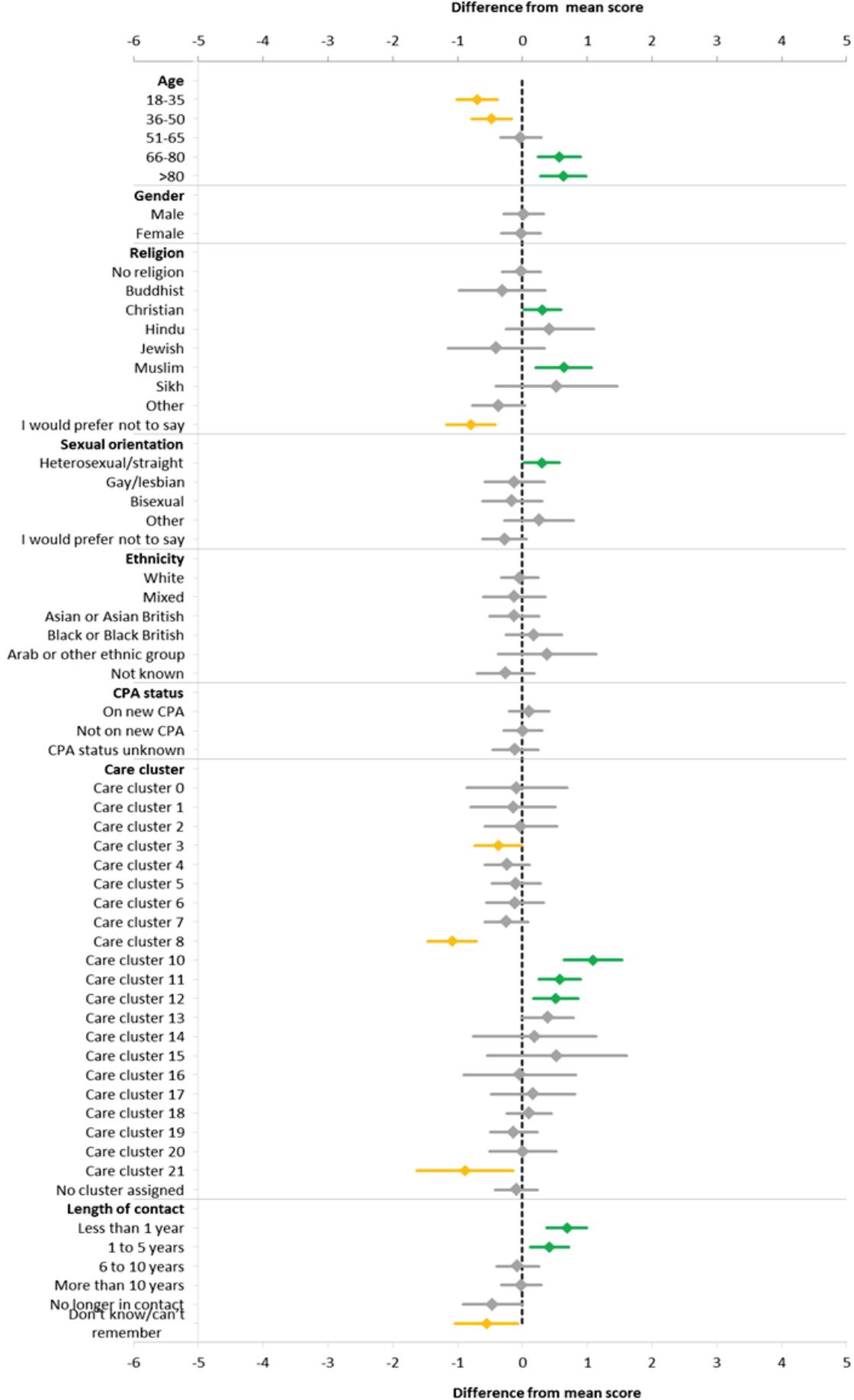
Access theme: difference from mean score by subgroup with 95% confidence interval



**Crisis theme: difference from mean score by subgroup with 95% confidence interval**



Communication theme: difference from mean score by subgroup with 95% confidence interval



## Appendix H: Care cluster codes

- 00 Care Cluster 0: Variance (unable to assign [ADULT MENTAL HEALTH CARE CLUSTER CODE](#))
- 01 Care Cluster 1: Common Mental Health Problems (Low Severity)
- 02 Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need)
- 03 Care Cluster 3: Non-Psychotic (Moderate Severity)
- 04 Care Cluster 4: Non-Psychotic (Severe)
- 05 Care Cluster 5: Non-Psychotic Disorders (Very Severe)
- 06 Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas
- 07 Care Cluster 7: Enduring Non-Psychotic Disorders (High Disability)
- 08 Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders
- 09 Care Cluster 9: Cluster Under Review - Note: This [CARE CLUSTER](#) is under review and should not be used
- 10 Care Cluster 10: First Episode Psychosis
- 11 Care Cluster 11: Ongoing Recurrent Psychosis (Low Symptoms)
- 12 Care Cluster 12: Ongoing or Recurrent Psychosis (High Disability)
- 13 Care Cluster 13: Ongoing or Recurrent Psychosis (High Symptoms and Disability)
- 14 Care Cluster 14: Psychotic Crisis
- 15 Care Cluster 15: Severe Psychotic Depression
- 16 Care Cluster 16: Dual Diagnosis
- 17 Care Cluster 17: Psychosis and Affective Disorder (Difficult to Engage)
- 18 Care Cluster 18: Cognitive Impairment (Low Need)
- 19 Care Cluster 19: Cognitive Impairment or Dementia Complicated (Moderate Need)
- 20 Care Cluster 20: Cognitive Impairment or Dementia Complicated (High Need)
- 21 Care Cluster 21: Cognitive Impairment or Dementia Complicated (High Physical or Engagement)

For more information, visit the [NHS Data model and dictionary](#).

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