State of Oregon
Department of Human Services
Office of Mental Health & Addiction Services

Report on the 2002 Adult Survey
for
Oregon Health Plan
Mental Health Organizations

Prepared
12/24/02
by
Planning Analysis and Evaluation Unit
Department of Human Services
Office of Mental Health & Addiction Services

Executive Summary 2002 Adult Survey

Overall the results of the 2002 Adult Survey should be taken as encouraging.

- Indicators related to access were rated very high with most respondents indicating that services were available at good times (91%) and were easy to get to (92%).
- The quality of services has improved over the year with many of the indicators related to quality showing improvement. Most of consumers surveyed indicated they would still use the same program if they were given other choices (86%).
- A large majority (90-96%) of respondents indicated that their interactions with mental health programs were positive and emphasized strengths in coming up with treatment solutions.
- Consumers were involved in the treatment planning process, as indicated by the 74% of respondents who felt they were involved in creating their treatment plan and 80% who knew the components of their treatment plan
- About 25% of the respondents indicated that they currently held a job or did volunteer work. Of those not working only 3.5% indicated they were not interested in working.
- The survey demonstrated that approximately 43% of the respondents were familiar with the term psychiatric advanced directive.

In an effort to continually improve service, three target areas for improvements in community mental health settings were discussed and noted in the summary section:

- Treatment planning involvement,
- Increased use of advanced directives, and
- The promotion of employment as part of the recovery process**.**

State of Oregon
Department of Human Services
Office of Mental Health & Addiction Services
Report on the 2002 Adult Survey

Introduction

Each year Oregon's Office of Mental Health & Addiction Services (OMHAS) conducts a survey to gather information from adults 18 and over who have received outpatient mental health services through Mental Health Organizations (MHO) under the Oregon Health Plan. The information gathered is part of the overall evaluation of Oregon's mental health system and is used with other data to assist in monitoring and improving the mental health service delivery system.

Results at the level of individual MHOs will not be reported for this year's survey as in the past. This year's survey focused on statewide results. Individual MHOs are encouraged to use the results from this year's statewide survey for comparison purposes.

The Survey

The survey was developed with consumer and stakeholder input and includes items that were adapted from the national work of the Mental Health Statistics Improvement Project. In its current form, it was first used for the 2001 Adult Survey. For the 2002 survey, there were some additions and deletions of items to improve the interpretability of the survey. The impact of the changes is discussed in the "Results and Discussion" section.

Procedure

The Adult Mental Health Services Survey was administered via mail in July 2002. A random sample of 1,906 adults (age 18 or older) was selected to receive the survey from a group of 27,120 adults (age 18 or older) who received an outpatient Medicaid service through an MHO between 7/2001 and 12/2001.

The survey packet included a cover letter detailing the purpose of the survey, what would be done with the data collected, and contact information so the consumer could have any concerns or questions directly answer by staff at OMHAS. Consumers were asked

to fill out the survey based on the past 12 months of service, which includes the time period from which the sample was drawn. Finally, the consumers were ask to return the survey by September 1, 2002 in the stamped addressed enveloped that was included in the survey packet. Surveys returned after this date were not included in analyses.

Consumers were told that information collected through the survey was defined as confidential not anonymous. The surveys were mailed out with a survey ID that could be linked back to the consumers Prime ID (Medicaid ID). This was done to track responses and supply OMHAS with information about each respondent in terms of demographics and service usage. Assurance of the confidentiality of responses was given. Recipients of the survey were informed of the location, the use of the Survey ID, and given the option of returning the survey without the ID making it anonymous. It was assumed that consumers were giving consent to analyze results if their survey was returned with the Survey ID still affixed. The 5% of surveys returned without a Survey ID were not used in the analysis of the results.

Results and Discussion

Sample and Response Rate

The response rate for the survey was 22.1%. The response rate achieves a 95% confidence level and an item confidence interval of +/- 5%. This means, for example, that if 80% of the respondents indicated services had helped them, there is a confidence level of 95% that the true percentage for the population is between 75% and 85% (or 80% +/- 5).

Table 1. Demographic Information

Demographic	Service Population	Respondents
White	89.3%	89.0%
Female	63.9%	64.4%
Age 21-64	91.3%	93.6%
Psychotic Disorders	20.4%	26.7%
Mood Disorders	43.7%	46.9%
Avg. Units of Service*	52.5	79.7

*Units of service 7-12/2001 per individual.

The confidence level and interval is based on the assumption that our survey respondents are representative of the service population. The respondents were compared to the original service population along a number of demographics and found to be similar (see Table 1). So for the purpose of analysis and interpretation, our respondent set is assumed to be representative of

the population from which it was drawn. Even with this interpretation, it is still important to remember that the respondents to the survey are self-selected. Meaning they voluntarily returned the survey. The fact that they did return the survey means that they are in some aspect different from those that did not return the survey, however the differences outside of demographic information are impossible to know.

Factor Analysis

A factor analysis of the items on the survey was conducted. A factor is an underlying construct that assists in summarizing results. For the adult survey, the factor analysis was done to reveal constructs that are interpretable in terms of performance, such as access or quality.

The analysis of the 2001 survey indicated that two strong factors representing Quality and Outcomes were present. A new analysis was conducted on the revised 2002 survey to examine whether or not these factors remained consistent after the addition and deletion of several items from the 2001 survey.

Table 2. Factor Items for 2002 Survey

Quality Factor Items	Outcome Factor Items
Services available at good times	During emergency can talk to staff right away
Same case manager/therapist each visit	Deal better w/daily problems
Treated with respect & dignity	Deal better w/crises
Case manager/therapist listens	Doing better in school and/or work
Staff believe in growth, change, & recovery	Getting along better with family
Sensitive to culture & ethnicity	Improving ability to get a job I like
Useful information for handling problems	Symptoms not bothering me as much
Confident in staff	Housing situation has improved
Agreement on how to deal with problems	Doing more fun activities
Case manager/therapist is warm/ supportive	Feel better about myself
Staff promotes strengths	I'm more in control of my life
Services have helped	
Given choice would still use same program	
I know what is in my treatment plan	
I feel I can disagree with staff	

Items were abbreviated.

The result of analysis yielded two definite groupings of items. This tells us that two sets of questions seem to be closely associated with each other. The groupings generally fit into the categories of Quality and Outcomes, similar to the 2001 results. Two additional factors were

revealed by the analysis, but the groupings were not interpretable in terms of any performance domain, so they were not used in subsequent analyses.

The items found within the quality factor vary to some degree but all seem to have something to do with the way the consumer is interacted with by the providers. The interactions range from making sure services are available at convenient times to treating the consumer based on strengths rather than deficits. The items under the outcome factor all for the most part have to do with what are often called functional outcomes, such as improvement in school/work, housing, or dealing with daily problems.

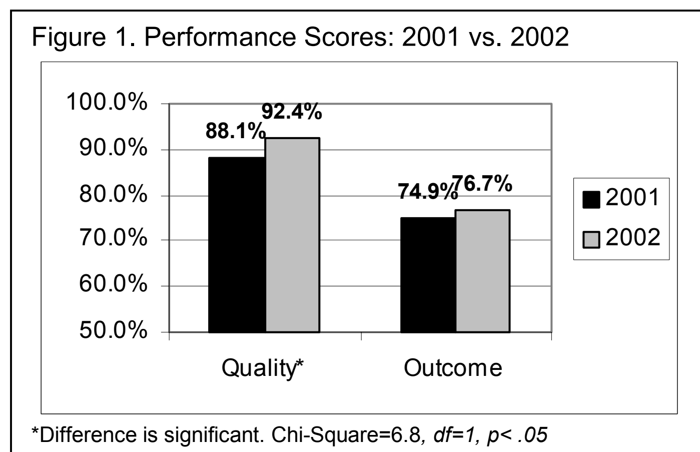
Both the outcome factor and the quality factor for the 2002 survey were fairly consistent with the 2001 survey in terms of item composition. So, scores and analyses for the two factors were compared between 2001 and 2002.

<u>Performance Score</u>

Items within each factor were averaged to produce a factor score for quality and outcome. The score ranges from -1 (low score) to +1 (high score). Scores greater than 0 indicated a positive response to the items of the factor.

The performance score for each factor is the percentage of factor scores greater than 0. Figure 1 compares the performance scores from the 2001 and 2002 survey for the quality and outcome factors. The increase in quality from 2001 to 2002 is significant (Chi-Square=6.8*, df=1, p<.05*). There was a small non-significant increase in the percentage for the outcome factor from 74.9% to 76.7%.

Figure 1. Performance Scores: 2001 vs. 2002



Difference is significant. Chi-Square=6.8, df=1, p< .05*

Based on this year's survey, comparisons on quality and outcomes were made with other demographic variables such age, gender, diagnosis, current status of service, taking medications, receiving alcohol and drug service, and others. Below is a list of the highlights of this set of analyses.

- Consumers who were still receiving service when they received the survey rated the quality of services higher, 94.1% versus 85.1% (Chi-Square=7.9, *df=1, p<.01*).
- Consumers who were employed or held voluntary jobs rated the quality of services higher, 97.2% versus 90.7% (Chi-Square=4.5, *df=1, p<.05*).
- Consumers who indicated they were taking medications for their mental health symptoms rated the quality of services higher, 94.0% versus 86.4% (Chi-Square=5.8, *df=1, p<.05*).
- The only difference for outcome performance was with consumers who received service within 2 weeks of first contact. They rated the outcome of services higher, 82.8% versus 62.1% (Chi-Square=12.2, *df=1, p<.01*).
- No differences on quality or outcomes were found for gender, diagnosis, or urban/rural comparisons

<u>Response to Survey Items</u>

Statewide the percent of respondents who indicated "yes" to a particular item is listed in Table 4 for the 2002 and 2001 survey. All percentages have a confidence interval of +/- 5 with a 95% confidence level.

Comparisons between 2002 and 2001 data were done using the Chi-Square statistic. Four significant differences were found for the individual survey items.

- A smaller percentage of consumers felt they could talk to a therapist or case manager right away during an emergency, 68.5% versus 73.4% (Chi-Square=4.9, *df=1, p<.05*).
- A greater percentage of consumers felt they could complain about services, 84.5% versus 77.5% (Chi-Square=11.5, *df=1, p<.01*).
- A greater percentage of consumers felt they were forced to accept treatment they didn't want, 20.2% versus 15.5% (Chi-Square=6.8, *df=1, p<.01*).
- A smaller percentage of consumers felt their housing situation had improved, 64.9% versus 69.9% (Chi-Square=4.1, *df=1, p<.05*).

Table 3. Survey Items: 2001 vs. 2002

Adult survey items (abbreviated)	2001	2002
Services available at good times	91.0	91.0
Place is easy to get to	91.6	92.2
Receive services outside of clinic	-	35.5
During emergency or urgent need, I get to talk to my case manager or therapist right away	73.4	68.5*
Get appointment when I need one	84.8	82.3
See same case manager or therapist each visit	93.3	92.4
Am treated with respect and dignity	94.1	95.6
Therapist or case manager listens to my questions or concerns	94.3	94.6
Staff believe I can grow, change, and recover	89.0	89.9
I'm encouraged to use consumer-run programs	-	67.8
Therapist or case manager sensitive to cultural or ethnic background	89.6	89.3
Get useful information to handle the problems in my life	85.6	86.9
Confident that staff can provide care I need	85.8	85.8
I agree with case manager or therapist about how to deal with my problems	84.4	83.3
Case manager or therapist is warm and supportive	92.7	92.1
Staff promotes strengths	-	89.6
Services have helped me	90.7	88.7
If I had other choices, I would still get services from this program	86.4	85.5
Were you asked if you had a history of abuse	-	61.1
Did you seek healthcare for a physical illness	-	87.3
I take prescription medication for a psychiatric disorder	-	78.4
Staff help me understand possible side effects	-	85.3
Psychiatric medications help me	-	92.4
I'm involved in my psychiatric medication decisions	-	84.1
I helped create my treatment plan	-	73.6
I know what is in my treatment plan	-	79.3
My treatment plan fits with what I want	82.3	82.4
I was given information about my rights	-	87.3
I feel I can complain about my services	77.5	84.6*
I feel I am forced to accept treatment that I don't want	15.5	20.2*
I feel I can disagree with my therapist or case manager	80.8	84.4
I know what a mental health advance directive is	-	42.8
I deal better with daily problems	83.1	83.8
I am better able to deal with crises	76.6	77.0
I am doing better in school and/or work	59.4	61.9
I am getting along better with my family	77.9	77.4
I am improving my ability to get a job I like	51.3	54.5
My symptoms are not bothering me as much	69.5	69.6
I received alcohol & drug services within the past 12 months	-	15.2
My housing situation has improved	69.9	64.9*
I am doing more fun activities	62.8	61.2
I feel better about myself	77.5	79.2
I am more in control of my life	77.2	80.3

*Difference is significant using Chi-Square, at least $p < .05$
"-" Not collected in 2001.

Timeliness of Service

An item on the survey asked the respondent "How long did you have to wait before your first appointment at your mental health program?" It is expected that consumers will not have to wait long than two weeks for non-urgent or emergent care.

- Of the 61% of consumers who remembered the wait time, 25.7% indicated that it took longer than two weeks for their first appointment, compared to 21% on the 2001 survey.

It is difficult to gauge the accuracy of this particular statistic, because it does rely on the memory of an event that may have taken place a long time ago. Regardless of whether or not the actual percentage is higher or lower; the statistic will need to be monitored to insure an upward trend does not form.

The fact that the only difference for outcome performance was among consumers who received service within 2 weeks of first contact definitely highlights the importance of timely service They rated the outcome of services higher, 82.8% versus 62.1% (Chi-Square=12.2, $df=1$, $p<.01$).

Housing

Housing is a very important functional outcome for system performance, but it is difficult to measure. The survey acts as one data source for consumer housing issues. On the 2002 survey, respondents were asked about improvement in housing and where they currently resided.

As indicated earlier, the 2002 survey found that a smaller percentage of consumers felt their housing situation had improved, 64.9% versus 69.9% (Chi-Square=4.1, $df=1$, $p<.05$). The importance of improved housing can be seen when this item is examined in terms of the outcome performance factor. Of consumers rating outcomes as improved, 77.1% indicated that housing had improved.

Table 4 demonstrates where the consumers indicated they lived. It should be remembered that the survey was sent to consumers receiving outpatient Medicaid services through an

Table 4. Living Situation

	%
Independent Housing	71.5%
Housing w/Supports	20.4%
Homeless or temp Housing	4.8%
Other	3.3%

MHO and did not include fee-for-service consumers or those receiving services in the state hospital. Housing with supports includes supported housing, group homes, adult foster homes, room & board, and nursing homes. A similarly worded question on the 2001 survey indicated about the same percentage of consumers living in independent housing, 71.9%.

Independent housing is often considered a desired outcome, but in our survey we found that:

- Consumers living in housing with supports were the most positive about outcomes and quality with 90.7% perceiving outcomes to be positive and 96.5% perceiving quality to be positive.

What is not known from our results is which type of housing with supports was associated with positive perceptions of quality and outcomes. Nor is it possible to demonstrate why the perceptions were so much more positive than those who indicated living in independent housing (outcomes, 75.4%, and quality, 92%).

Employment

Employment is another outcome considered important but difficult to measure. On the 2002 survey, respondents indicated whether or not they currently worked or volunteered, and how much they worked.

On this year's survey, 25.2% of the respondents indicated that they do paid or volunteer work, which is slightly down from 29.2% on the 2001 survey. The decrease is not statistically significant. Most of the respondents who indicated that they were working had part time employment, 45.9%. A greater percentage of respondents did indicate that they are improving their ability to get a job, 54.5% vs. 51.3% a year ago. Once again, the change was not statistically significant, but it is particularly encouraging given the recent economic downturn.

Of greater interest may be the reasons many consumers indicated for not working on a paid or volunteer basis. Some indicated they were retired (4.5%), some were homemakers or students (6.2%), but

- The majority, 69.6%, of respondents indicated they were unable to work due to disability.

Only 3.5% of the respondents indicated that they were not interested in working. Although this survey was not constructed to give more detailed explanations about what employment does or does not mean to mental health consumers, it is interesting to note the large percentage who perceive they cannot work due to disability. A good question would be what has contributed to that perception. The literature around supported employment indicates that the services should be available to everyone who wishes to use them and that services can be tailored to successfully support the goal of employment regardless of the consumer's level of functioning.

Summary

Overall the results of the 2002 Adult Survey should be taken as encouraging.

Indicators related to access were rated very high with most respondents indicating that services were available at good times (91%) and were easy to get to (92%). The importance of maintaining access and timely services cannot be under emphasized. It has a great bearing on outcomes. Respondents who received services within two weeks of contact with the mental health programs rated outcomes 20% higher than those who had to wait over two weeks.

The quality of services has improved over the year with many of the indicators related to quality showing improvement. Most of consumers surveyed indicated they would still use the same program if they were given other choices (86%). A large majority (90-96%) of respondents indicated that their interactions with mental health programs were positive and emphasized strengths in coming up with treatment solutions. As a key component of quality services, the new adult rule emphasizes recovery oriented assessments and treatment planning. These approaches are starting to be used in some CMHPs as a way to involve consumers in the treatment planning process, as indicated by the 74% of respondents who felt they were involved in creating their treatment plan and 80% who knew the components of their treatment plan. OMHAS would like to observe an increase in those percentages over time, as services evolve under the new adult rule. Movement towards nontraditional assessments will help

consumers become engaged in the assessment and treatment planning process.

Indicators related to outcomes also showed improvement from the previous survey. A greater percentage of respondents felt that they were able to deal effectively with crises, daily problem, and work/school. A particularly positive outcome was the increased percentage of respondents who felt that they were improving their ability to get a job that they liked. As described earlier, about 25% of the respondents indicated that they currently held a job or did volunteer work. Of those not working only 3.5% indicated they were not interested in working. Work has been demonstrated to be beneficial for consumers in their recovery process by helping them reintegrate into the community. OMHAS is promoting employment as part of treatment through the adult rule and is emphasizing the use of evidence-based practices, such as supported employment. As a result, it is expected that employment will become a more common outcome for adults receiving mental health treatment.

In another area of interest, the survey demonstrated that approximately 43% of the respondents were familiar with the term psychiatric advanced directive. Advanced directives allow for consumers to plan how they would like their psychiatric condition to be treated if there is a crisis. This includes writing what types of medication they will take and type of setting they would choose. CMHPs are required to inform all consumers of their right to use an advanced directive. This includes helping consumers diagnosed with severe mental illnesses. Some CMHPs have a variety of settings in which they inform consumers about the directive, for example during the assessment process and/or at intervals throughout treatment. Advanced directives are geared toward recovery in helping consumers shape what tomorrow’s crisis might look like. OMHAS is working with the CMHPs to increase the use of this important tool.

Conclusion

The adult survey gives OMHAS indicators of progress towards changing services to a recovery base, which is a reflection of the recent changes to the adult rule. Many positive results were indicated by the findings of the survey. In an effort to continually improve service, three target areas for improvements in community mental

health settings were discussed and noted in the summary of the "Results and Discussion" section:

- Treatment planning involvement,
- Increased use of advanced directives, and
- The promotion employment as part of the recovery process.

It is expected that over the next year many of these indicators will continue to show improvement as more programs across the state learn to operate under the current adult rule.