Consumer Satisfaction with Wisconsin’s Public Mental Health Services

Results from the 2013 and 2014 Mental Health Statistical Improvement Project (MHSIP) Surveys
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This report was written by the Mental Health Services and Performance Management Section of the Bureau of Prevention Treatment and Recovery, Division of Care and Treatment Services, Wisconsin Department of Health Services.
Executive Summary

Wisconsin’s 2013 and 2014 Mental Health Statistical Improvement Project consumer satisfaction surveys were administered in early 2014 and 2015, respectively. There were 342 adult respondents and 262 parents or caregivers of youth consumers who responded to the 2013 surveys, with response rates of 36% and 38%, respectively. The 2014 surveys were completed by 375 adults and 320 youth caregivers, for 40% and 36% response rates. Youth consumers were disproportionately male while adult respondents were more likely to be female, representative of the sex distribution within Wisconsin’s public mental health service system. Blacks and Hispanics were especially under-represented among adult respondents relative to Wisconsin’s population as a whole.

Respondents’ levels of satisfaction with services were in line with responses from previous years (as generally reflected in the trend lines illustrated for each satisfaction domain). Notable variations in these trends included: a two-year decrease in caregivers’ satisfaction with social connectedness among youth (from 82% in 2012 to 79% and 76% in 2013 and 2014, respectively); a marked drop from 66% satisfaction with adults’ treatment outcomes in 2012 to 58% in 2013 (with a partial rebound to 63% in 2014); and a decline in levels of adult satisfaction with improved functioning (from 68% in 2012 to 60% and 62% in 2013 and 2014, respectively).

Adult consumers demonstrated higher levels of satisfaction than youth for many domains, including access to services, treatment outcomes, improved functioning, and overall satisfaction. However, there were notable exceptions (where caregiver satisfaction surpassed adult consumer satisfaction), including participation in their child’s treatment planning and youths’ social connectedness.

Without exception, Wisconsin consumers were less satisfied with the services they received than other consumers across the United States. In both 2013 and 2014, Wisconsin remained below the national average for all domains of satisfaction among both adults and youth. Additional analyses compare Wisconsin’s satisfaction to the national average and to states with a comparable survey methodology. This context analysis also indicated Wisconsin scored below average for that subgroup of peer states.

However, these lower rankings relative to other states mask the fact that most Wisconsin consumers were quite satisfied with the mental health services they received. Across 2013 and 2014 adult respondents reported especially high levels of satisfaction with: access to services (75% in both years), quality and appropriateness of services (78% and 79%, respectively), and overall satisfaction (75% and 78%, respectively). During these same years youth caregivers were most likely to be satisfied with: participation in treatment planning (76% and 78%, respectively), cultural sensitivity of staff (89% and 90%, respectively), and social connectedness (79% and 76%, respectively). On the other hand, there were decidedly lower levels of satisfaction with treatment outcomes (48%) and improved functioning (49% and 48%, respectively) among youth.

Some additional questions branched out beyond satisfaction to learn more about consumers who received public mental health services. Data suggests adults were not only more likely to be obese, have diabetes, and smoke than other Wisconsin residents, but also had a functional impairment (when poor physical or mental health kept them from doing their usual activities) at least 10 days each month.
Youth consumers generally reported little change (before and after services began) in arrest rates or school suspensions and expulsions, although were more likely to report an increase in school attendance after treatment began. While most youth saw a decrease in police encounters with the onset of services, youth who spent more time in services saw increased encounters with police more often than youth with shorter time in services.

Taken together, these results suggest both strengths and some areas for possible improvement in treatment services provided through Wisconsin’s public mental health system.
Introduction

Survey Background

In 1976, the National Institute on Mental Health initiated the Mental Health Statistics Improvement Program (MHSIP) to evolve data standards that reflected current developments in mental health services. The MHSIP satisfaction surveys for adults and youth were developed to provide states a standard method of measuring consumer satisfaction with mental health services. These MHSIP surveys are now recommended by the Center for Mental Health Services, in the U.S. Department of Health and Human Services, as the preferred tool for reporting client perception of care, one of Center for Mental Health Services’ standardized National Outcome Measures required for federal reporting and used by Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA) for state-by-state comparisons.

Survey Methodology

Each year, the Wisconsin Department of Health Services Division of Care and Treatment Services (DCTS) contracts with the University of Wisconsin Survey Center to administer a variation of the standard MHSIP satisfaction surveys to adult and youth consumers of public mental health services across the state. Respondents for Wisconsin’s survey are selected from the DCTS database of public mental health service records, known as the Program Participation System. Random samples are drawn from the Program Participation System of adult consumers with serious mental illness and youth consumers with serious emotional disorder (SED) who had at least six months of service history during the previous calendar year. Sampled consumers receive three waves of mailings (including a letter of explanation about the survey from DCTS; the survey instrument itself; a self-addressed stamped return envelope; and a $2 incentive to complete the survey) and a postcard reminder in order to achieve the highest possible response rate.

Adult consumers age 18 years and older are asked to fill out their own surveys based on their personal experiences with the state’s mental health service system. If an adult is unable to fill out a survey on his or her own, then they are considered ineligible for the survey; no one else is authorized to fill out the survey on their behalf. Caregivers of child and youth consumers age six to 17 years are asked to fill out surveys on behalf of these younger respondents. Throughout this report, the separate surveys are referred to as the “adult” and “youth” surveys.

The survey is intended to gauge satisfaction with services across a number of pre-established domains. Consumers are not directed to answer survey questions with regard to any particular service type (for example, medication management) or program (for example, Comprehensive Community Services). Instead, survey results present a global sense of consumers’ perceptions of Wisconsin’s public mental health system as a whole.

Response Rates

The response rates in 2013 and 2014 for adult consumers (36.1% and 39.7%, respectively) and youth consumers (37.8% and 36.4%, respectively) were comparable to response rates in 2012 when completed surveys were returned by 37.8% of adults and 36.4% of youth, respectively. The number of completed surveys in 2013 and 2014 (342 and 375 adult surveys, 262 and 320 youth
surveys, respectively) were very close or equal to the number of surveys needed to accurately represent the population of mental health consumers across the state.

**Respondent Characteristics**

Information on demographic characteristics (sex, age, race, and ethnicity) was taken from the Program Participation System data for adult and youth consumers who responded to the MHSIP survey in 2013 and 2014.

**Sex**

The sex breakdown of survey respondents was quite different for adults and youth. While 58% of adult survey respondents were female (and 42% male) in both 2013 and 2014, approximately two-thirds of the completed youth surveys (62% and 58% in 2013 and 2014, respectively) were filled out on behalf of male consumers.

**Figure 1: Sex of Adult Respondents, 2013 and 2014**

**Figure 2: Sex of Youth Respondents, 2013 and 2014**
**Race**

The overwhelming majority of both adult and youth consumers were White (generally reflecting the racial composition of Wisconsin as a whole, where Whites were 88% of total residents). The percent of White adults increased slightly between 2013 and 2014 while the percent of White youth decreased slightly. Somewhat greater percentages of youth than adult consumers in 2014 were either Black (8% vs. 2%) or More than One Race (3% vs. 1%), and Blacks were under-represented among adult respondents in 2014 (relative to their 6.6% among Wisconsin residents).

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**Figure 3: Race of Adult Respondents, 2013 and 2014**

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**Figure 4: Race of Youth Respondents, 2013 and 2014**

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1 Based on figures from the U.S. Census Bureau: [http://www.census.gov/quickfacts/table/PST045215/55.00](http://www.census.gov/quickfacts/table/PST045215/55.00)
**Ethnicity**

Only 2% of adult consumers surveyed reported being Hispanic or Latino, while the percent of surveyed youth who were Hispanic was closer to the state’s population as a whole (6.2%).²

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Age

Early intervention is an important component of effective treatment. Figure 3 shows the age distribution of surveyed youth consumers. Less than half (46%) of surveyed youth were between the ages of 5 and 12 years (up slightly from 40% in 2012); about one-third of youth consumers were early teens (13-15 years old); and one-fifth were 16-17 years old (down slightly from 26% in 2012).

Figure 7: Age Distribution of Youth Respondents, 2013 and 2014
Satisfaction Trends for Adults and Youth

Both the adult and youth surveys ask consumers a number of questions about their satisfaction with the mental health services they or their child received, each with a range of response options (from “1”=Strongly Agree to “5”=Strongly Disagree). Summarizing this large number of items would be difficult. Using factor analysis, a statistical technique that identifies groups of related items based on their high correlation (or association) with each other, researchers reduced the number of measures needed to understand consumer responses by combining items together into eight domains. These domains include:

- Access to services (*Access*).
- Participation in treatment planning (*Participation*).
- Social connectedness (*Connected*).
- Treatment outcomes (*Outcomes*).
- Overall satisfaction with services (*Overall*).
- Satisfaction with both the quality and appropriateness of services – adults only (*Quality*).
- Satisfaction with their improved level of functioning as a result of treatment – adults only (*Functioning*).
- Satisfaction with the cultural sensitivity of staff providers – youth only (*Culture*).

The next several sections track these domains for adult and youth consumers who received mental health services and completed the MHSIP survey between 2006 and 2014, both in Wisconsin and across the United States.

**Access to Services**

The *Access* domain describes the perceived ease with which mental health services were obtained. This domain was constructed for both adults and youth for all individuals who responded to both of the following statements:

- “The location of services was convenient for [me, us].”
- “Services were available at times that were convenient for [me, us].”

In addition, the adult survey also asked the following access-related statements:

- “Staff was willing to see me as often as I felt it was necessary.”
- “Staff returned my calls in 24 hours.”
- “I was able to get all the services I thought I needed.”
- “I was able to see a psychiatrist when I wanted to.”
Historically, youth have been less satisfied with access to services than adults. While satisfaction with access increased slightly for adults from 2012, youth satisfaction remained fairly consistent across time.

While the majority of both adults and youth (75% and 63-64%) expressed satisfaction with access to services in 2013 and 2014, both groups of consumers in Wisconsin continued to be less satisfied with access to services than consumers across the United States.

**Figure 8: Satisfaction with Access to Services, Adult Consumers in Wisconsin and United States, 2006-2014**

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3 The differential between adult and youth seems to represent a true difference in satisfaction with access to services, rather than a difference based on the scales themselves. Although the adult survey asks more questions about access than the youth survey, adult responses to those additional questions were even lower than for the shared questions, indicating the difference between the adult and youth level of satisfaction with access would be even greater if the scales were based on only the shared questions.
Figure 9: Satisfaction with Access to Services, Youth Consumers in Wisconsin and United States, 2006-2014
Participation in Treatment Planning

Person-centered planning is a key component of mental health recovery. It has been shown that involving consumers and caregivers directly in the development of their treatment plan improves consumer outcomes. Thus, it is important for consumers to feel that they were actively incorporated into their treatment planning.

The Participation domain relates to how well consumers or consumers’ family members were integrated into treatment planning and was constructed for individuals who responded to at least two of the following statements. One question is comparable on both the adult and youth surveys:

- “I, not staff, decided my treatment goals.” (Adult survey)
- “I helped to choose my child’s treatment goals.” (Youth survey)

The other statements used to build this domain were:

- “I felt comfortable asking questions about my treatment and medication.” (Adult survey)
- “I helped to choose my child’s services.” (Youth survey)
- “I participated in my child’s treatment.” (Youth survey)

The majority of both adults (64% in 2013 and 67% in 2014) and youth (76% in 2013 and 78% in 2014) were satisfied with their degree of participation in treatment planning. However, in contrast with most other satisfaction domains (except social connectedness), youth respondents were more satisfied with their level of participation than adult respondents. Both adult and youth satisfaction appeared to increase slightly in 2014, matching the highest level of satisfaction measured across the period since 2006.

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Figure 10: Satisfaction with Participation in Treatment Planning, Adult Consumers in Wisconsin and United States, 2006-2014

Figure 11: Satisfaction with Participation in Treatment Planning, Youth Consumers in Wisconsin and United States, 2006-2014
Quality and Appropriateness of Services - Adults

The MHSIP adult survey asks about the consumer’s satisfaction with the quality and appropriateness of the mental health services they received. This Quality domain was constructed based on adult surveys with responses to at least six or more of the following nine statements:

- “Staff believed that I could grow, change and recover.”
- “I felt free to complain.”
- “I was given information about my rights.”
- “Staff encouraged me to take responsibility for how I live my life.”
- “Staff told me what side effects to watch out for.”
- “Staff respected my wishes about who is and who is not to be given information about my treatment.”
- “Staff was sensitive to my cultural background (race, religion, language, etc.).”
- “Staff helped me obtain the information I needed so that I could take charge of managing my mental illness.”
- “I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).”

Consistently, at least three-quarters of adult consumers have reported being “satisfied” or “very satisfied” with the quality and appropriateness of the mental health services they have received.

Figure 12: Satisfaction with Quality and Appropriateness of Services, Adult Consumers in Wisconsin and United States, 2006-2014
Cultural Sensitivity of Staff - Youth

The MHSIP youth survey asks about the consumer’s satisfaction with the cultural sensitivity of the staff who provided the mental health services they received. This *Culture* domain was constructed based on youth surveys with responses to at least three of the following four statements:

- “Staff treated me with respect.”
- “Staff respected my family’s religious or spiritual beliefs.”
- “Staff spoke with me in a way that I understood.”
- “Staff was sensitive to my cultural or ethnic background.”

The *Culture* domain is consistently associated with very high levels of satisfaction, with about 90% satisfaction among youth over the past six years. It is also the one domain among Wisconsin respondents that comes closest to matching the level of satisfaction among consumers across the United States.

**Figure 13: Satisfaction with Cultural Sensitivity of Staff, Youth Consumers in Wisconsin and United States, 2006-2014**

![Graph showing satisfaction rates from 2006 to 2014 for Wisconsin and United States. The graph includes data points for each year, with a line for Youth-WI and another for Youth-US, showing consistent satisfaction levels above 80%. The highest point in the graph is 93% for both domains in 2010 for Youth-WI and Youth-US.](image)
Social Connectedness

One important aspect of recovery from mental illness is social support. Research has shown that having “natural supports”—for example, family, friends, supportive coworkers, and acquaintances—in place can help to bolster and sustain recovery over the long term. Decreasing a consumer’s actual and perceived sense of isolation and maximizing their social supports are often treatment goals of person-centered planning.

In contrast to other domains on the youth survey, the social connectedness questions ask the parent or guardian to respond based on their own social connectedness, rather than the connectedness of the youth receiving services. While social connectedness is vital for young people receiving mental health services, it is also imperative for adult caretakers of children with serious emotional disturbance to have social supports to provide high-quality care and participate effectively in the child’s treatment plan.

Therefore, both the adult and youth surveys ask the respondent to report on their own level of social connectedness, although they approach the concept in different ways. Among the four questions included in the Connected domain, there are two statements in common between the adult and youth surveys:

- “I have people with whom I can do enjoyable things.”
- “In a crisis, I would have the support I need from family or friends.”

The adult survey also includes the following:
- “I am happy with the friendships I have.”
- “I feel I belong in my community.”

The other statements on the youth survey are:
- “I know people who will listen and understand me when I need to talk.”
- “I have people that I am comfortable talking with about my child’s problems.”

Neither the adult nor youth respondents are asked to report on these items prior to receiving mental health services, nor are they asked to respond to how much their social connectedness changed as a result of the services they received. Thus, both adult and youth reported levels of social connectedness could reflect a consumer’s relationships and connectedness prior to treatment, changes in connectedness brought about by treatment, or a combination of both.

Satisfaction with their levels of social connectedness among both adults (63% in both 2013 and 2014) and youth respondents (79% in 2013 and 76% in 2014) is slightly lower than in 2012. Also, respondents of the youth survey were generally more satisfied with their social connectedness than adult consumers (a finding opposite from most other domains, except for Participation).

Figure 14: Satisfaction with Social Connectedness, Adult Consumers in Wisconsin and United States, 2006-2014

Figure 15: Satisfaction with Social Connectedness, Youth Consumers in Wisconsin and United States, 2006-2014
Treatment Outcomes

Consumers seek out mental health services with the hope of improving their lives. Both the adult and youth surveys include a series of questions that try to capture the perceived treatment-related improvements in consumers’ lives. The Outcomes domain is made up of surveys that contain responses to at least five of the statements below preceded by, “As a direct result of the mental health services [I, my child] received in the last 12 months,…”

• “I deal more effectively with daily problems.” (Adult survey)
  “My child is better at handling daily life.” (Youth survey)
• “I am better able to deal with a crisis.” (Adult survey)
  “My child is better able to cope when things go wrong.” (Youth survey)
• “I am getting along better with my family.” (Adult survey)
  “My child gets along better with family members.” (Youth survey)
• “I do better in social situations.” (Adult survey)
  “My child gets along better with friends and other people.” (Youth survey)
• “I do better in school and/or work.” (Adult survey)
  “My child is doing better in school and/or work.” (Youth version)

The following additional items appear only on the adult survey:
• “I am better able to control my life.”
• “My housing situation has improved.”
• “My mental illness symptoms are not bothering me as much.”

The following item appears only on the youth survey: “I am satisfied with our family life right now.”

Historically, Outcomes has been the domain with the lowest levels of satisfaction both in Wisconsin and on a national level. Less than two-thirds of adult consumers were satisfied with treatment outcomes (58% and 63% in 2013 and 2014, respectively) and less than half of youth respondents were satisfied with their child’s treatment outcomes (48% in both years).
Figure 16: Satisfaction with Treatment Outcomes, Adult Consumers in Wisconsin and United States, 2006-2014

Figure 17: Satisfaction with Treatment Outcomes, Youth Consumers in Wisconsin and United States, 2006-2014
Improved Functioning

This Functioning scale is conceptually very similar to the Outcomes scale, but is sufficiently distinct to merit its own domain. Responses to the following statements from the adult survey are used to create this domain and are preceded by, “As a direct result of the mental health services I received in the last 12 months,…”:

- “My mental illness symptoms are not bothering me as much.” (also on the “Outcomes” domain)
- “I do things that are more meaningful to me.”
- “I am better able to take care of my needs.”
- “I am better able to handle things when they go wrong.”
- “I am better able to do things that I want to do.”

The Functioning domain includes the following statements from the youth survey and are preceded by, “As a direct result of the mental health services my child received in the last 12 months,…”:

- “My child is better at handling daily life.”
- “My child gets along better with family members.”
- “My child gets along better with friends and other people.”
- “My child is doing better in school and/or work.”
- “My child is better able to cope when things go wrong.”
- “My child is better able to do things he or she wants to do.”

The Functioning domain appeared to show steady improvement among adult consumers in recent years (with the exception of 2009), reaching 68% satisfaction in 2012. However, adult satisfaction dropped in the past two years (down to 60% in 2013, then up slightly to 62% in 2014).

Figure 18: Satisfaction with Improved Functioning, Adult Consumers in Wisconsin and United States, 2006-2014
Among youth respondents, the Functioning domain (which closely mirrors the Outcomes domain) indicates that, consistent with past years, only about half were satisfied with their child’s level of improved functioning.

Figure 19: Satisfaction with Improved Functioning, Youth Consumers in Wisconsin and United States, 2006-2014

Overall Satisfaction

The Overall domain describes the general level of satisfaction that an adult or parent has with the services they or their child received. The domain was constructed for adults who responded to at least two of the following statements and parents who responded to at least four of the youth survey statements below:

One statement is comparable on both the adult and youth surveys:
- “I like the mental health services that I received.” (Adult survey)
- “Overall, I am satisfied with the mental health services my child received.” (Youth survey)

The adult Overall domain also included these two statements:
- “If I had other choices, I would still get services from the same agency.”
- “I would recommend the same agency to a friend or family member.”

The youth Overall domain also included these four statements:
- “The people helping my child stuck with us no matter what.”
- “I felt my child had someone to talk to when he or she was troubled.”
- “The mental health services my child and/or family received were right for us.”
- “My family got the help we wanted for my child.”
- “My family got as much help as we needed for my child.”

Despite the relatively low levels of satisfaction in the Outcomes and Functioning domains, the majority of adult respondents reported being satisfied with their mental health services. Comparable to levels of satisfaction found in the Quality domain, the Overall domain shows that more than three-quarters of adults were either “satisfied” or “very satisfied” with the mental
health services they received (including 75% in 2013 and 78% in 2014). General levels of youth satisfaction were similar to responses seen in recent years.

**Figure 20: Overall Satisfaction with Care, Adult Consumers in Wisconsin and United States, 2006-2014**

![Figure 20: Overall Satisfaction with Care, Adult Consumers in Wisconsin and United States, 2006-2014](chart)

**Figure 21: Overall Satisfaction with Care, Youth Consumers in Wisconsin and United States, 2006-2014**

![Figure 21: Overall Satisfaction with Care, Youth Consumers in Wisconsin and United States, 2006-2014](chart)
Summary of Satisfaction Trends

Overview of Adult Trends

Results of the 2013 and 2014 MHSIP adult survey aligned closely with the results from previous years. Overall satisfaction with mental health services increased to 78% in 2014 (the highest level reported across the time period covered), with over eight in 10 adult consumers saying they liked the mental health services they received.

Respondents felt most positively about the way that staff treated them (the quality of services and their participation in treatment planning) and the ease of access to mental health services. For instance, 84% and 86% of respondents in 2013 and 2014 (up from 81% in 2012) agreed that staff respected their wishes about who was to be given access to their information, and 85% and 81%, respectively, agreed that staff was respectful of their cultural background (race or religion). Also, 89% in both 2013 and 2014 (up from 85% in 2012) reported that staff had given them information about their rights. However, two other items have received lower ratings in recent years: a smaller percentage of adults (72% and 70% in 2013 and 2014) reported that staff told them what side effects to watch out for (up somewhat from 65% in 2012) and even fewer said they were able to participate in their treatment goals (65% and 66% in 2013 and 2014).

With regard to access, most adults (83% in both 2013 and 2014) agreed that the location of mental health services and the times when these services were available were convenient for them. However, only about three-quarters of adult respondents said they were able to get all the services they needed (74% and 78% in 2013 and 2014) and even fewer (66% and 68%) reported that they were able to see a psychiatrist when they wanted. There is an acknowledged shortage of both adult and child psychiatrists in Wisconsin.6

However, adults reported lower levels of social connectedness than in the past. In three of the four items that measured social connectedness, adults reported less satisfaction in 2014 than 2013, agreeing less with the statements that they are happy with the friendships they have (72% in 2013 and 71% in 2014) and that they have people with whom they can do enjoyable things (75% and 73% in 2013 and 2014). Adult consumers were especially dissatisfied with the sentiment of feeling they belong in their community with somewhat over half agreeing (58%) in 2013 and even fewer (53%) in 2014.

Even to a greater extent than in the past, the lowest scoring items in 2013 and 2014 were those questions that asked consumers to discuss their mental health outcomes and changes in functioning as a direct result of the mental health services they had received. Only about half of respondents reported that they have done better in school and/or work (49% in 2013 and 57% in 2014, closer to the 56% in 2012), just over half reported that their symptoms were not bothering them as much (54% and 57%, respectively, down from 62% in 2012), and only 57% and 58% (in 2013 and 2014, respectively) said they do better in social situations as a result of treatment (fewer than the 62% in 2012). Only about two-thirds of respondents (66% and 64%) agreed that they are better able to deal with crises (down from 69% in 2012) and fewer than six in 10

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consumers (56% and 60%, down from 65% in 2012) reported they are better able to handle things when they go wrong. Of those reporting, 62% in 2013 and 63% in 2014 (down from 69%) were better able to do things they want to do, and 63% (down from 68% in 2012) reported that their housing situation had improved. One item that scored significantly higher in 2012 than in 2011 (and remained high in 2013 and 2014) was the question “I am better able to take care of my needs.” In 2011, only 53% of consumers agreed with that statement; satisfaction rose to 75% in 2012 but remained at 71% in 2013 and 2014.

Overview of Youth Trends

As in previous years, parents of children receiving mental health services in 2013 and 2014 gave the highest ratings to statements relating to cultural sensitivity. Most parents felt that staff treated them with respect (85% and 88% in 2013 and 2014); somewhat lower than the 92% seen in 2012. They also thought staff spoke to them in a way they could understand (92% and 91% in 2013 and 2014). Parents also felt that staff was sensitive to the family’s cultural or ethnic background (increasing to 92% in 2013 and back to the previous level of 89% in 2014) and respected the family’s spiritual or religious beliefs (up slightly from 88% in 2012 to 91% and 90% in 2013 and 2014). These items are important for the family’s perception of the adequacy and appropriateness of services and most likely have a bearing on a family’s willingness to continue treatment. Parents who feel that they are being treated with respect and sensitivity are more likely to work with providers and keep their children in treatment than those who feel disrespected.

Caregivers’ participation in their child’s mental health services is also important for the success and continuity of treatment: parents who are actively engaged are generally more willing and able to support a child’s treatment. Most parents reported being involved in their child’s treatment (89% in 2013 and 90% in 2014, up from 87% in 2012) while somewhat fewer (76% in 2013 and 80% in 2014) helped choose their child’s mental health services or treatment goals. Caregivers also were fairly satisfied with access to services: about 70% said services were available at convenient times and somewhat more (75% in 2013 and 80% in 2014) agreed the location of services were convenient.

While caregivers were very satisfied with the cultural sensitivity of staff and their own level of participation in their child’s treatment, they were less than completely satisfied with the services themselves; only about 70% agreed that “overall, [they were] satisfied with the mental health services [their] child received.” While the majority of parents felt their child and/or family received the appropriate services, only two-thirds (66%) agreed that the services they received were “right for us.” Even fewer (63%-65% in 2013 and 2014) felt their family got the help they wanted for their child and only about half (54%-55% in 2013 and 2014) felt their family got as much help as they needed.

Continuing a trend seen in past years, parents reported the lowest level of satisfaction with the outcome of the services their children received and their level of functioning. Similar to results from 2012, just over half of parents in 2013 and 2014 (53%-54%) agreed that their child was

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better at handling daily life or better able to do things he or she wants to do as a result of treatment (dropping from 57% in 2012 to 53% in 2013, increasing to 56% in 2014). Similar percentages of parents felt their children were better at getting along with family members (56% and 57% in 2013 and 2014) or friends and other people (55% in 2013, up to 59% in 2014) while somewhat higher percentages felt their children were doing better in school and/or work (58% and 60% in 2013 and 2014). However, less than half of parents (45% and 47% in 2013 and 2014, comparable to 2012) felt their child was better able to cope when things went wrong and only half of all parents (50% and 51% in 2013 and 2014) were “satisfied with our family life right now.”

A picture emerges from these responses that parents do not believe their children are getting the right type of services, nor enough services to make a significant difference in their lives. There is evidence from other sources as well that caregivers believe their children need more services than they have received. It is also possible that the services being administered are not particularly effective, regardless of quantity. Unfortunately, there are no questions on the survey about the types of services received. Although parents are asked about their perception of the appropriateness of services, there is no way to tell whether youth are actually receiving appropriate and effective services, such as evidence-based practices. Lastly, it is possible that parents have unrealistic expectations about how well (or how quickly) their children will respond to effective treatment. While parents in Wisconsin may be more pessimistic about their children’s outcomes than parents in other states, there is no reason to expect Wisconsin caregivers have less realistic expectations than their peers in other states.

In summary, for most MHSIP domains, both adults and youth respondents demonstrate continuity over time with the occasional rise or fall in satisfaction levels from year to year. The Outcome and Functioning domains have consistently reported relatively low levels of satisfaction among both youth and adult consumers, with only about half of respondents being satisfied in any given year. While it may seem surprising that Overall satisfaction is much higher than satisfaction with Outcomes, this pattern has been noted elsewhere. Research has found that consumers often rate services based on “their emotional experience during [the service] rather than its longer term outcomes.”

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8 Perrault et al., 2012.
Wisconsin Satisfaction in Context

Adults in Context

The data presented thus far in this report tracks the recent trends in Wisconsin’s data. However, it is also instructive to see how Wisconsin fares relative to the national average. Figure 22 below shows this comparison in 2014 for all of the domains reported by SAMHSA’s Center for Mental Health Services.¹⁰

One potential explanation for these results involves sampling methodology. Unlike most states, Wisconsin uses a random sample of adults with serious mental illness. These adults have more serious and ongoing treatment needs and may, as a result, express lower levels of satisfaction than those with short-term, less significant treatment needs.¹¹

¹⁰ The national figures are taken from the Center for Mental Health Services Uniform Reporting System (URS) Output Tables, 2015. While Wisconsin data for 2015 also appears in the table, what is actually reported under 2015 is the 2014 survey data. This is because Wisconsin’s data collection cycle does not align with the federal data collection cycle. To correct for this, this report uses the 2015 data for Wisconsin utilized throughout this report. Thus, there is a discrepancy between the data reported here and those reported in the URS tables. Regardless of which data are used for Wisconsin, the state falls below national averages across all domains.

¹¹ An analysis of the survey data shows a slight but highly statistically significant negative correlation between number of days per month of poor mental health and overall satisfaction with services. In other words, consumers who reported poorer mental health were also less likely to be satisfied with their services. In addition, an analysis of
Treatment Outcomes

The figure below displays levels of satisfaction with outcomes for just those states whose survey methodology compared with the rigor of Wisconsin’s (that is, applied either random or stratified sampling techniques to adults with serious mental illness), and should therefore provide a better basis for comparison. Descriptions of survey methodology were taken from SAMHSA’s Uniform Reporting System tables.12

Figure 23 shows that Wisconsin ranks fifth on levels of satisfaction with treatment outcomes out of the 10 states listed as using a rigorous method to sample adults with serious mental illness. It should be noted that some of the higher-ranking states (Kansas and Vermont) had significantly lower response rates (16% and 31%, respectively) than Wisconsin (49%), which implies that their data may have been more subject to nonresponse bias. That is, when survey response rates are low, survey data is less likely to accurately represent the population being surveyed. For example, only those consumers with very strong opinions may have completed the surveys. While this phenomenon might account for some of the reported differences in consumer satisfactions, not all states listed here had low response rates and thus actual differences in consumer satisfaction are also likely.

Overall Satisfaction

When it comes to overall levels of satisfaction with services, Wisconsin ranks last among states with similar survey methods and samples. As discussed above, some of this difference may be

Canadian youth survey data by Perrault et al. (p. 235) showed that caregivers whose relatives had experienced a hospitalization or visited the emergency room tended to be less satisfied with services (Perrault et al., 2012). Other studies have also confirmed that consumers with more severe mental health problems tend to be less satisfied with services. See e.g., Vecchio, N., Stevens, S., and Cybinski, P. (2008).” Caring for people with a mental disability at home: Australian carers’ perceptions of service provision.” Community Mental Health Journal, 22(2), 125–134.

12 Available by state at: https://www.samhsa.gov/data/us_map.
accounted for by differential response rates, but the results are telling. While the highest-ranking state within this group, Kansas, has 92% satisfaction in this domain, and the U.S. average is 89%, Wisconsin has only 78% satisfaction in this domain.

Figure 24: Levels of Adult Overall Satisfaction with Services for States with Similar Survey Methodologies, 2014

These results do not account for other factors that could affect levels of satisfaction between states such as the:

- Structure of the state mental health system.
- Geographic location of a state.
- The demographic and economic makeup of a state’s population.
- Response rates and representativeness of survey samples.

If there were combined survey data from across all of these states, these would be factors to control for in a formal statistical model. However, just looking at the results available here, Wisconsin falls below other Midwestern states such as Ohio, Kansas, South Dakota, and Minnesota. Future analyses might delve more deeply into the practices of these peer states to see if any lessons can be learned that may be applicable to Wisconsin.
Youth in Context

Figure 25 in the adult section provided comparative data between Wisconsin and national averages, based on data reported to SAMHSA for the 2015 URS (Uniform Reporting System) tables. Figure 25, below, reports the same measures for the youth data.13

![Figure 25: Average Levels of Youth Satisfaction by Domain for Wisconsin vs. United States, 2014](image)

Similar to the adult survey results, Wisconsin youth satisfaction scores below the national average across all domains reported to SAMHSA with overall average of 16% below the national average. The greatest differences are in overall satisfaction and outcomes (24% and 22%, respectively), while the smallest is in the culture domain (3%).

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13 As with the adult data, the youth results are drawn from Wisconsin’s 2014 consumer survey result data contained within 2015 URS output tables.
Treatment Outcomes

As with the adult analysis provided above, the figure below displays levels of satisfaction with outcomes for just those states whose survey methodology was similar to Wisconsin’s, and should therefore provide a better basis for comparison. Comparable states had a rigorous survey methodology (either random sampling or stratified sampling) and sampled youth with serious emotional disturbance. Descriptions of survey methodology were taken from SAMHSA’s URS tables.

Figure 26 shows that Wisconsin has the lowest score among states with similar methodologies when it comes to satisfaction with youth outcomes. Wisconsin scores notably lower than other midwestern states such as Ohio, South Dakota, Kansas, and Minnesota (54%).
**Overall Satisfaction**

The results are similar when it comes to overall satisfaction with services; Wisconsin ranks last when compared to states with similar survey methodology. The next highest scoring states are Minnesota and Massachusetts, both with 70% satisfaction.

![Figure 27: Levels of Youth Overall Satisfaction with Services for States with Similar Survey Methodologies, 2014](image)

As stated in the section on adult satisfaction scores, there are many factors beyond the treatment context that might affect the reported differences in satisfaction levels, and those factors are not controlled for here. However, even with the understanding that other factors might be at play, these initial results should spark a broader conversation of how youth mental health services in Wisconsin might be improved.
Other Wisconsin MHSIP Outcomes

Adult Health Indicators

The MHSIP adult survey includes several questions aimed at gauging the respondent’s physical health. Since people with mental illness are generally more likely to have co-occurring physical health ailments,\textsuperscript{14} attention to physical health is an important aspect of recovery.

Body Mass Index

One aspect of physical health is body mass index (BMI), which was calculated from a respondent’s reported weight (in pounds) and height (in inches) as BMI = 703*(weight / height\(^2\)).\textsuperscript{15} Respondents were then grouped into one of three categories by BMI: not overweight (BMI = below 25.0), overweight (BMI = 25.0-29.9), or obese (BMI = 30.0 or more).\textsuperscript{16}

Overall, a total of 82% of MHSIP adult respondents had elevated BMI (with 56% obese and 26% overweight). The obesity rate among adult respondents was 25% higher in 2013 than for Wisconsin as a whole (31% obese statewide compared with 56% among adult respondents) and 12% higher in 2014 (43% among adult respondents).\textsuperscript{17}

\textsuperscript{14} Ziege, Anne and Tim Connor. “Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey.” Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy, 2009.


\textsuperscript{16} A fourth category, underweight (BMI = below 18.5), was not reported separately here but instead combined with the “not overweight” category to be comparable with the Wisconsin Behavioral Risk Factor Survey, 2014.

\textsuperscript{17} Centers for Disease Control and Prevention, “Prevalence of Self-Reported Obesity among U.S. Adults by State and Territory, BRFSS, 2014.” \textit{http://www.cdc.gov/obesity/data/table-adults.html}.
Differences in BMI are evident for both men and women, as can be seen in the two figures below.\textsuperscript{18}

**Figure 28: BMI Categories for Male Respondents vs. Wisconsin Males, 2013 and 2014**

As in past years, both male and female MHSIP respondents are more likely to be obese than the general adult population of Wisconsin, and this difference was more pronounced for women than for men. In particular, female MHSIP respondents in 2013 were more than twice as likely as the average Wisconsin woman to be obese (61% vs. 28%). The differences between MHSIP respondents (both male and female) and Wisconsin adults in 2014 was smaller but still substantial.

\textsuperscript{18} Statewide data is based on the results of the 2014 Wisconsin Behavioral Risk Factor Survey, Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, [https://www.dhs.wisconsin.gov/wish/index.htm](https://www.dhs.wisconsin.gov/wish/index.htm), BRFS Module.
Physical Health Conditions

Rates of selected physical health conditions (whether a health professional ever said they had one of these conditions) were compared between MHSIP adult respondents and the adult population of Wisconsin as a whole. Similar to 2012, rates of heart disease, heart attack, and stroke among survey respondents were very low and comparable to the statewide population (differing only by 1%-2%) while rates of high blood pressure were much higher (over 30%) but also similar to the rate in the state population. In a reversal from 2012, high cholesterol was less common among adult respondents than in the state overall (31% and 32% in 2013 and 2014, vs. 36% in Wisconsin). Meanwhile, rates of asthma (23% and 19% in 2013 and 2014) were higher than across the state (15%), and the incidence of diabetes (22% and 23%) was particularly elevated among survey respondents compared with adults in the state generally (8%).

Figure 30: Prevalence of Physical Health Conditions among MHSIP Respondents and Wisconsin Population, 2013 and 2014

<table>
<thead>
<tr>
<th>Condition</th>
<th>MHSIP 2013</th>
<th>MHSIP 2014</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>22%</td>
<td>23%</td>
<td>8%</td>
</tr>
<tr>
<td>Asthma</td>
<td>23%</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>Stroke</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>31%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>33%</td>
<td>32%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Smoking

A smoking question was included on the MHSIP adult survey. Comparable to the 42% who reported smoking in 2012, 41% and 43% of adult respondents indicated they currently smoke in 2013 and 2014. However, this is about 25% higher than the rate of smoking of 17% for Wisconsin adults in 2014.

Self-Rated Health

Finally, adult respondents were asked to report the number of days in the past 30 days when: their physical health was not good (due to physical illness or injury); their mental health was not good (from stress, depression, or problems with emotions); and they experienced functional impairment (when poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation). As in 2012, poor mental health was more common than poor physical health or functional impairment among adult MHSIP respondents (with the average respondent saying their mental health was poor on 12.8 and 12.1 of the past 30 days (over 40% of the time) in 2013 and 2014. The average respondent also reported that their physical health was poor over 30% of the time (10.6 days out of 30 in 2013 and 9.4 days in

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2014) and that they felt functionally impaired about one-third of the time (11.0 and 9.5 days out of 30 in 2013 and 2014, respectively).

Figure 31: Average Number of Days in Past Month when Respondents Experienced Poor Physical or Mental Health, 2013 and 2014
Youth Criminal Justice and Education Indicators

The MHSIP youth survey asked respondents to comment on issues beyond satisfaction with services, namely: encounters with police, arrests, school attendance, and suspensions or expulsions. Because contact with the criminal justice system and problems at school can potentially result from the disruptive effects of mental illness, these areas are expected to improve with the provision of effective treatment.

The federal government asks states to assess youth experiences in these areas based on their length of treatment, so youth respondents are split into two groups: those who received services for less than one year at the time of the survey (shorter length: 50 [20%] of the 247 youth respondents in 2013; 87 [28%] of the 309 youth respondents in 2014) versus those who received services for one year or more (longer length: 197 [80%] of the 247 youth respondents in 2013; 222 [72%] of the 309 youth respondents in 2014). The results below are presented for these two groups of youth.

Encounters with Police

The MHSIP youth survey asks the question, “Since your child began receiving these mental health services, have their encounters with police been reduced, stayed the same, or increased?”

The most common response for youth in both service length categories was that encounters with police had decreased since treatment began: in 2013, close to half of youth (46% of those with a shorter length, 49% with a longer length) saw such improvements; and the association in 2014 was even stronger, with well over half reporting fewer encounters with police since receiving services (61% of youth with a shorter length, 54% with a longer length). ²¹

In both 2013 and 2014, about one-quarter of all youth said there had been no change in their frequency of contact with police since services began. Among youth with shorter length (in both 2013 and 2014), even fewer youth said their encounters with police had increased. However, youth with longer service length in 2013 were more likely to see increased police contact than no change (27% vs. 24%); in 2014, these youth were less likely to see increased police encounters than to see no change (21% vs. 25%). Still, in both 2013 and 2014, youth with longer service lengths were more likely to see increased encounters with police than youth with shorter lengths.

²¹ Note that the raw numbers are small because only a subset of children and youth had any contact with police before the onset of treatment.
This pattern of decreasing police encounters with the onset of services is indeed encouraging. At the same time, the lower percentage of decreasing encounters among youth with longer treatment histories is somewhat puzzling. A few explanations are possible. One is that children with longer service histories have more extensive needs and are perhaps less likely to respond as positively to treatment. Another possibility is that children with longer service histories started services earlier, and that the timing of the progression into adolescence makes it more likely that they will engage in risky behaviors, including those that involve police contact. Further evaluation of the differences between service length categories should take into account the youth’s age to determine whether some of this effect may be due to the difference in ages between the two groups.
**Arrests**

Treatment among youth generally corresponds with a decrease in encounters with police, but the same pattern does not seem to hold for arrests, a more severe gauge of contact with the criminal justice system. In 2013, youth who had been receiving services for less than one year were twice as likely to have been arrested prior to treatment than they were since services began (18% and 9%, respectively); in 2014, youth with shorter service lengths were equally likely to have been arrested prior to and since services began (13% and 14%). Among youth with longer service lengths, slightly greater percentages had been arrested in the last 12 months than in the year prior to treatment in both 2013 and 2014.

**Figure 34: Arrest Rates Prior to and Since Services Began Among MHSIP Youth, By Length of Service, 2013**

![Bar chart showing arrest rates for youth receiving services for less than one year vs. one year or more, comparing prior to services and since services began for 2013.]

**Figure 35: Arrest Rates Prior to and Since Services Began Among MHSIP Youth, By Length of Service, 2014**

![Bar chart showing arrest rates for youth receiving services for less than one year vs. one year or more, comparing prior to services and since services began for 2014.]

39
There are a few possible explanations for these findings. One is that the survey question is not specific enough to get at possible improvements in arrests; the question asks only whether a youth was arrested during a given time period, not the number or frequency of arrests or the severity of the offense (all of which may decrease with treatment). As discussed above, youth with longer service lengths might also have more extensive mental health needs, be less likely to respond positively to treatment, or display various risky behaviors often associated with an older adolescent population. Nonetheless, the increased arrest rate for those with an extended service history is contrary to the pattern one would hope to see for this outcome.

School Attendance

School attendance is another important indicator of a child’s mental health. Respondents were asked “have the number of days he/she has been in school been greater, about the same, or less” since services began. Generally, youth were most likely to say their school attendance had not changed with treatment (39% with shorter and 52% with longer service lengths in 2013, and 49% and 43% respectively in 2014). However, many youth reported that their attendance had increased since services began (39% and 30% in 2013, 35% and 40% in 2014). Relatively few youth (among those with either shorter or longer service lengths) saw school attendance drop off during treatment. So, while services appeared to have little impact on school attendance for many youth, among those for whom treatment did make a difference, the change in school attendance tended to be a positive one.

Figure 36: Changes in School Attendance Since Services Began Among MHSIP Youth, By Length of Service, 2013
It should be noted that the question response categories might have influenced the findings in this section (see Appendix 2 “2013 & 2014 Youth Satisfaction Survey,” Question 40). While respondents had the option to indicate that the question “Does not apply” because the “Child did not have a problem with attendance before starting services,” it is possible that some respondents whose child did not have an attendance problem instead selected “About the same” before reading this answer. This may partially explain why school attendance was unchanged for many youth. Of course, it is also possible that treatment often did not result in improved attendance, especially in the short timeframe covered by the MHSIP survey.

Also, there is some support in the literature for the idea that longer times in services are associated with higher caregiver satisfaction, but this association was not apparent in these survey results.

On a more positive note, almost 60% of respondents agreed that “My child is doing better in school and/or work” (Question 19), the highest level of satisfaction of all the youth outcome questions. While this finding appears to contradict the results above, youth improvements in school may have been in areas other than attendance, possibly with improved grades or smoother interactions with teachers.

22 Perrault et al., 2012: 235.
Suspensions and Expulsions

Just as arrests (relative to police encounters) are a more severe measure of youth contact with the criminal justice system, so too are suspensions and expulsions (relative to school attendance) a more severe reflection of problems at school. Also, as with the association between receiving services and arrests, the association between receiving services and suspensions/expulsions was more apparent in 2013 than 2014.

Figure 38: Suspensions and Expulsions Prior to and Since Services Began, Among MHSIP Youth, By Length of Service, 2013

Figure 39: Suspensions and Expulsions Prior to and Since Services Began, Among MHSIP Youth, By Length of Service, 2014
Suspensions and expulsions declined somewhat among all youth in 2013 (but especially among those with shorter service lengths) while the association between suspensions/expulsions and service length was mixed in 2014 (with little change among youth with shorter service lengths and a small increase among youth with longer service lengths). Again, as discussed above with regard to arrests, youth who received services for a longer period of time might have more extensive mental health needs, or may be less likely (or take longer) to respond positively to treatment. Regardless, the smaller impact of treatment on suspensions/expulsions among youth with an extended service history is contrary to the pattern one would hope to see.
Conclusion

The results of this survey help to shed light on current dynamics in Wisconsin’s public mental health system. In general, the majority of adult and youth respondents indicated that they were satisfied with most aspects of their treatment services. Satisfaction with the cultural sensitivity of staff towards youth consumers and their families was particularly rated high. At the same time, both adult and youth scores in Wisconsin were below the national average and tended to be towards the bottom of states that surveyed their population using a similar methodology.

The inclusion of body mass index (BMI) and physical health indicators on the adult survey reveals that Wisconsin’s mental health consumers experience poorer physical health than the population as a whole. While more than half of adult consumers reported they were obese, more than one in five reported having diabetes, over 40% currently smoked (more than twice the state rate), and on average these respondents had physical and/or mental health issues that prevented them from engaging in normal activities approximately one-third of the time. These results should encourage a holistic approach to consumers’ physical and mental health.

There is a particular need to focus on treatment outcomes and functional improvements among youth consumers. Fewer than half of caregivers were satisfied with their child’s treatment outcomes and level of functioning as a result of their services and Wisconsin scored below the national average and results for comparable states. The low levels of satisfaction with outcomes appeared to be backed by more objective outcome measures. Although youth respondents often reported decreased encounters with police and were more likely to increase school attendance after treatment began, improvements were not the norm with regard to the more severe measures of youth arrests or suspensions and expulsions. Alternate explanations for these results cannot be ruled out, but when viewed alongside low reported satisfaction with youth outcomes, they make a case for further exploration of the effectiveness of the youth system.

While survey results are meant to be illustrative, it is also important to keep in mind the limitations of a survey such as this. Because the survey sampled consumers with serious mental health concerns and extended service histories, this report cannot speak to the experiences of individuals who may have low-level needs and short-term experiences with the public mental health system. In addition, this report looks only at the public mental health system; it does not examine whether consumers in the public system are more or less satisfied with their care than those who see private providers. Similarly, only those consumers who actually gained access to the county mental health system were sampled, and only those who completed and returned MHSIP surveys were counted. Therefore, the voices of consumers who attempted to access the system but became discouraged (perhaps due to wait times or restrictions on payment resources) are not represented here. Lastly, additional analyses would need to be conducted to fully determine the meaning of some of the numbers reported here (for example, whether differences in levels of satisfaction over time are statistically significant or likely to represent normal variation).
Appendix 1 – 2013 and 2014 Adult Satisfaction Survey

**CONSUMER SATISFACTION SURVEY**

In order to provide the best possible mental health services, we need to know what you think about the mental health services you received in the last 12 months, the people who provided them, and the results. You may have also received care for physical health issues in the last year, but please respond to this survey only about the mental health care you received in the last 12 months.

Please indicate how much you agree or disagree with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle “N/A” to indicate that this item is not applicable to you.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like the mental health services that I received.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. If I had other choices, I would still get mental health services from the same agency.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I would recommend the same agency to a friend or family member.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. The location of mental health services was convenient (parking, public transportation, distance, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. Staff was willing to see me as often as I felt it was necessary.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. Staff returned my calls in 24 hours.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. Mental health services were available at times that were good for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I was able to get all the mental health services I thought I needed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I was able to see a psychiatrist when I wanted to.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. Staff believed that I could grow, change and recover.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I felt comfortable asking questions about my mental health treatment and medication.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I felt free to complain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I was given information about my rights.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. Staff encouraged me to take responsibility for how I live my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. Staff told me what side effects to watch out for.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. Staff respected my wishes about who is and who is not to be given information about my treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I felt staff decided my mental health treatment goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. Staff was sensitive to my cultural background (race, religion, language, etc.).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Question</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>-----------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
<tr>
<td>19. Staff helped me obtain the information I needed so that I could</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>take charge of managing my mental illness.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I was encouraged to use consumer-run programs (support groups,</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>drop in centers, crisis phone line, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For questions 21-32: As a direct result of the mental health services</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>I received in the last 12 months...</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. I deal more effectively with daily problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. I am better able to control my life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. I am better able to deal with crisis.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. I am getting along better with my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. I do better in social situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. I do better in school and/or work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>27. My housing situation has improved.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>28. My mental illness symptoms are not bothering me as much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>29. I do things that are more meaningful to me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>30. I am better able to take care of my needs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>31. I am better able to handle things when they go wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>32. I am better able to do things that I want to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>For questions 33-36: Please answer about the current relationships you</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>have with persons other than your mental health provider(s).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>33. I am happy with the friendships I have.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I have people with whom I can do enjoyable things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>35. I feel I belong in my community.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>36. In a crisis, I would have the support I need from family or friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
37. Confidential state records show that you were participating in mental health services in [2013, 2014]. When did you begin receiving these mental health services? [ ] [ ] / [ ] (month / day / year)

38. Are you currently receiving mental health services?

[ ] Yes → Go to question 38a

[ ] No → Continue

38a. When did you stop receiving these services? [ ] [ ] / [ ] (month / day / year)

These next two questions are to help determine any possible impact of mental health services on involvement with the police.

39. Have you been arrested for committing any offense(s) in the last two years? Please include both minor and major offenses.

[ ] Yes → Go to question 39a

[ ] No → Continue

39a. Please list the month and year for each arrest that occurred in the last two years.

  Month / Year [ ] [ ]
  Month / Year [ ] [ ]
  Month / Year [ ] [ ]
  Month / Year [ ] [ ]
  Month / Year [ ] [ ]
  Month / Year [ ] [ ]

For each of the following, please tell us whether or not you expected each to happen before you started treatment from your current or most recent mental health provider?

40. Did you expect to deal more effectively with your daily problems? [ ] Yes [ ] No [ ] Not Sure

41. Did you expect to be better able to control your life? [ ] Yes [ ] No [ ] Not Sure

42. Did you expect to be better able to deal with crises? [ ] Yes [ ] No [ ] Not Sure

43. Did you expect to get along better with your family? [ ] Yes [ ] No [ ] Not Sure

44. Did you expect to do better in social situations? [ ] Yes [ ] No [ ] Not Sure

45. Did you expect to do better in school or work? [ ] Yes [ ] No [ ] Not Sure

46. Did you expect that your housing situation would improve? [ ] Yes [ ] No [ ] Not Sure

47. Did you expect that your mental illness symptoms would not bother you as much?

   [ ] Yes [ ] No [ ] Not Sure

If yes, please tell us what outcome you expected on the next page. [ ] Yes [ ] No [ ] Not Sure
48a. If yes, what other outcome did you expect?

The next set of questions is about your overall health.

49. What is your height? _____ feet and _____ inches

50. How much do you weigh? _____ pounds

51. Do you currently smoke cigarettes?
   - Yes
   - No

52. If a doctor, nurse, or other health professional has ever told you that you had any of the following health conditions, place a check in the appropriate box:
   - Diabetes
   - Asthma
   - Angina or coronary artery disease
   - Heart Attack
   - Stroke
   - High cholesterol
   - High Blood Pressure
   - Cancer

53. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? Please enter one number between 0 and 30.
   _____ days

54. Thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good? Please enter one number between 0 and 30.
   _____ days

55. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation? Please enter one number between 0 and 30.
   _____ days

56. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?
   - Yes
   - No

57. The last question below is to help us understand how best to contact people.

   Do you have regular access to the internet at your home?
   - Yes
   - No

Thank you for your time and cooperation in completing this questionnaire! Please return it in the postage paid self addressed envelope provided to the UW Survey Center at:
475 N Charter Street Room B607, Madison, WI 53706-1507
## Youth Services Survey for Families

In order to provide the best possible mental health services, we need to know what you think about the mental health services your child received in the last 12 months, the people who provided them, and the results. The parent or guardian who had the most contact with your child’s mental health service provider(s) in the last 12 months should fill out this survey. Your answers are confidential and will not influence the mental health services your child receives.

Please indicate how much you agree or disagree with each of the following statements by circling the number that best represents your opinion. If the question is about something you or your child have not experienced, circle “N/A” to indicate that this item is not applicable to you.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, I am satisfied with the mental health services my child received.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>2. I helped to choose my child’s mental health services.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>3. I helped to choose my child’s mental health treatment goals.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>4. The people helping my child stuck with us no matter what.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>5. I felt my child had someone to talk to when he or she was troubled.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>6. I participated in my child’s mental health treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>7. The mental health services my child and/or family received were right for us.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>8. The location of mental health services was convenient for us.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>9. Mental health services were available at times that were convenient for us.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>10. My family got the help we wanted for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>11. My family got as much help as we needed for my child.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>12. Staff treated me with respect.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>13. Staff respected my family’s religious or spiritual beliefs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>14. Staff spoke with me in a way that I understood.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>15. Staff was sensitive to my cultural or ethnic background.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

For questions 16-22: As a direct result of the mental health services my child and/or family member received in the last 12 months...

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. My child is better at handling daily life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>17. My child gets along better with family members.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Question</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
<td>N/A</td>
</tr>
<tr>
<td>----------</td>
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<td>-------</td>
<td>-----------</td>
<td>----------</td>
<td>------------------</td>
<td>-----</td>
</tr>
<tr>
<td>18. My child gets along better with friends and other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>19. My child is doing better in school or work.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>20. My child is better able to cope when things go wrong.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>21. I am satisfied with our family life right now.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>22. My child is better able to do things he or she wants to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

For questions 23-26: Please answer about current relationships you have with persons other than your child’s and/or family’s mental health provider(s).

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. I know people who will listen and understand me when I need to talk.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>24. I have people that I am comfortable talking with about my child’s problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>25. In a crisis, I would have the support I need from family or friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>26. I have people with whom I can do enjoyable things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Please answer the following questions to let us know how your child is doing.

27. Is your child currently receiving mental health services?
   - Yes
   - No → Go to question 27a

27a. When did your child stop receiving mental health services?
   - Month / Day / Year

28. Confidential state records show your child was participating in mental health services in [2013, 2014]. Did these mental health services begin more than one year ago or less than one year ago?
   - More than one year ago → Go to question 35 on the next page
   - Less than one year ago

Please answer questions 29 to 34 if your child began receiving mental health services less than one year ago.

29. Has your child been arrested since these mental health services began?
   - Yes
   - No
30. Was your child arrested during the 12 months before these mental health services began?
   - Yes
   - No

31. Since your child began receiving these mental health services, have his/her encounters with the police been reduced, stayed the same, or increased?
   - Been reduced (For example, he/she has not been arrested, hassled by police, taken by police to a shelter or crisis program.)
     - Stayed the same
     - Increased
     - Not applicable (He/she had no police encounters this year or last year.)

32. Has your child been expelled or suspended since these mental health services began?
   - Yes
   - No

33. Was your child expelled or suspended during the 12 months before these mental health services began?
   - Yes
   - No

34. Since your child began receiving these mental health services, has the number of days he/she has been in school been greater, about the same, or less?
   - Greater  
   - About the same  
   - Less  
   - Does not apply  
   - Go to question 41

   Please select why this does not apply:
   - Child did not have a problem with attendance before starting services  
   - Child was expelled from school  
   - Child is home schooled  
   - Child dropped out of school  
   - Other  
   - Go to question 41

35. Was your child arrested during the last 12 months?
   - Yes
   - No

36. Was your child arrested during the 12 months prior to that?
   - Yes
   - No

37. In the last 12 months, have his/her encounters with the police been reduced, stayed the same, or increased?
   - Been reduced (For example, he/she has not been arrested, hassled by police, taken by police to a shelter or crisis program.)
     - Stayed the same
     - Increased
     - Not applicable (He/she had no police encounters this year or last year.)
38. Was your child expelled or suspended during the last 12 months?
   □ Yes
   □ No

39. Was your child expelled or suspended during the 12 months prior to that?
   □ Yes
   □ No

40. In the last 12 months, have the number of days he/she has been in school been greater, about the same, or less?
   □ Greater
   □ About the same
   □ Less
   □ Does not apply → Please select why this does not apply.
      □ Child did not have a problem with attendance before starting services
      □ Child is too young to be in school
      □ Child was expelled from school
      □ Child is home schooled
      □ Child dropped out of school
      □ Other: _______________________

For each of the following, please tell us whether or not you expected each to happen before your child started treatment from their current or most recent mental health provider.

41. Did you expect that your child would be better at handling daily life? □ Yes □ No □ Don’t Know

42. Did you expect that your child would get along better with family members? □ Yes □ No □ Don’t Know

43. Did you expect that your child would get along better with friends and other people? □ Yes □ No □ Don’t Know

44. Did you expect that your child would do better in school and/or work? □ Yes □ No □ Don’t Know

45. Did you expect that your child would be better able to cope when things go wrong? □ Yes □ No □ Don’t Know

46. Did you expect that you would be more satisfied with your family life? □ Yes □ No □ Don’t Know

47. Did you expect that your child would be better able to do things he or she wants to do? □ Yes □ No □ Don’t Know

48. Did you expect some other type of outcome not listed above? □ Yes □ No □ Don’t Know
   If yes, what other outcome did you expect? _______________________

Please provide the following information about yourself.

49. Is your child currently living with you?
   □ Yes
   □ No

50. Do you have regular access to the internet at your home?
   □ Yes
   □ No

Thank you for your time and cooperation in completing this questionnaire!
Please return it in the postage paid self addressed envelope provided to the UW Survey Center at:
475 N Charter Street Room B607, Madison, WI 53706-1507

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