Consumer Satisfaction with Wisconsin’s Public Mental Health Services:
Results from the 2012 Mental Health Statistical Improvement Project (MHSIP) Survey

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Executive Summary

Wisconsin’s 2012 Mental Health Statistical Improvement Project (MHSIP) consumer satisfaction survey was administered in 2013. Three hundred and sixty adult consumers and 316 parents or caregivers of youth consumers responded to the surveys, for response rates of 37.8% and 36.4%, respectively. African-Americans were under-represented among youth respondents and Hispanics and Latinos were under-represented among adult respondents. Youth consumers were disproportionately male, which is representative of the gender breakdown in Wisconsin’s public mental health service system.

Respondents’ levels of satisfaction with their services were generally in line with responses from previous years, with adult consumers demonstrating higher levels of satisfaction for most domains than youth. Some notable variations this year included a 6% decrease in levels of adult satisfaction with access to services from 2011 levels (from 77% to 71%); a 6% increase in adult satisfaction with treatment outcomes (from 60% to 66%); and a 5% increase in satisfaction with youth outcomes (from 42% to 46%). Wisconsin remains below the national average for all areas of satisfaction for both adults and youth. An additional comparison between Wisconsin and states with a similar survey sample and methodology also reveals that Wisconsin scores towards the bottom within that subgroup.

These low rankings mask the fact that most Wisconsin consumers were satisfied with their services. Respondents reported highest levels of satisfaction with access to services and quality of services (for adults) and the cultural respectfulness of providers (for youth). They were also generally pleased with services overall. Respondents reported the lowest levels of satisfaction with treatment outcomes. However, the adult satisfaction with treatment outcomes and with improvements in functioning did reach historic highs (66% and 68%, respectively).

Some additional questions branched out beyond satisfaction to learn more about consumers. Survey results confirmed that adults with serious mental illness (SMI) who receive public mental health services report significant functional impairment and have higher than average rates of physical health problems. Youth who undergo treatment generally do not report improvements in school improvement or arrest rates, but do show reduced contact with police once treatment begins. Taken together, these results point to some strengths and some areas for improvement in Wisconsin’s public mental health system.
Introduction: Survey Methodology

Each year the Wisconsin Department of Health Services’ (DHS) Division of Mental Health and Substance Abuse Services (DMHSAS) works with the University of Wisconsin Survey Center (UWSC) to distribute a satisfaction survey to consumers of public mental health services across the state. The survey is a variation of the standardized Mental Health Statistical Improvement Project (MHSIP) survey, which is used by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for state-by-state comparisons. Respondents for Wisconsin’s survey are selected from DMHSAS’s database of public mental health service records, known as the Program Participation System (PPS, formerly HSRS). Random samples are drawn of adult and youth consumers with serious mental health conditions (Serious Mental Illness or SMI for adults and Serious Emotional Disorder or SED for youth) who had at least six months of service history. Sampled consumers receive a mail survey. Initial mail surveys include incentives, and three waves of mail surveys are administered in order to achieve the highest possible response rate.

Adult consumers age 18 and older are asked to fill out their own surveys based on their personal experiences with the 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 an adult’s behalf. Caregivers of children under 18 are asked to fill out surveys on behalf of child and youth consumers; youth do not fill out surveys directly. Throughout this report the separate surveys are referred to as the “adult” and “youth” surveys. Reference to “youth respondents” means respondents who filled out the youth survey (i.e., caregivers), rather than youth themselves.

The survey is intended to gauge satisfaction with services across a number of domains. Consumers are not directed to answer with regard to any particular service type (e.g., medication management) or program (e.g., Comprehensive Community Services). Thus, the survey results present a global and impressionistic sense of consumers’ perceptions of the mental health system as a whole. However, it should be noted that the 2012 MHSIP survey collected data on consumer satisfaction in early 2013, prior to recent investments in community services and other mental health services across Wisconsin.

Response Rates and Respondent Characteristics

The adult response rate was 37.8% and the youth response rate was 36.4%. The response rates for both adults and youth were slightly lower than anticipated, with 360 adult responses (vs. a goal of 381) and 316 completed youth responses (vs. a goal of 347). This slightly increases the margin of error that should be used when interpreting these responses, from a goal of 5% to 5.1% for adults and 5.3% for youth.

The gender breakdown of survey respondents was quite different for adults vs. children and youth. For adults, 55% of respondents were female, whereas approximately two-thirds of the youth surveys were filled out on behalf of male consumers. This mirrors a pattern of heavier male involvement in the youth mental health service system.
The overwhelming majority of both adult and youth consumers were White, with slight variations in the representation of other racial groups. A comparison of the racial breakdown among adult and youth consumers appears in Table 1 below.

**TABLE 1: Racial Composition of Surveyed Consumers, Adults vs. Youth**

<table>
<thead>
<tr>
<th>Race</th>
<th>Adults</th>
<th>Youth</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td>More than One Race</td>
<td>2%</td>
<td>6%</td>
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<tr>
<td>African American</td>
<td>8%</td>
<td>3%</td>
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<tr>
<td>Asian</td>
<td>1%</td>
<td>0%</td>
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<tr>
<td>Native American</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Just over six percent of surveyed child/youth consumers were Hispanic or Latino, which is in proportion to the state’s population as a whole (6.2%). Conversely, less than two percent of adult consumers surveyed were Hispanic or Latino. African-Americans, who make up 6.5% of the population of Wisconsin, were slightly over-represented among adults, but under-represented among youth.\(^1\) However, 6% of youth were multi-racial.

**SATISFACTION TRENDS FOR YOUTH AND ADULTS**

The MHSIP survey asks about consumer satisfaction in a number of specific domains: overall satisfaction with services (“overall”), satisfaction with treatment outcomes (“outcomes”), satisfaction with participation in treatment planning (“participation”), and satisfaction with access to services (“access”).

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\(^1\) Information on race and ethnicity taken from United States Census Bureau, “State and County Quick Facts”, [http://quickfacts.census.gov/qfd/states/55000.html](http://quickfacts.census.gov/qfd/states/55000.html).
Although the adult and youth surveys have slightly different questions, both surveys cover these four domains. In addition, the adult survey also covers satisfaction with the quality/appropriateness of services ("quality") while the youth survey instead covers satisfaction with the cultural sensitivity of providers ("culture"). All of the questions on the survey fall into at least one of these domains.

Below are graphs that track average domain scores for each of the adult and youth surveys across a number of years. The 2009 survey is omitted from the graphs below because a different method was chosen to select the sample in that year, and the data is thus not considered comparable.

The first domain is “access to services.” This includes the following questions for both adults and youth:

- “The location of services was convenient.”
- “Services were available at times that were convenient.”

In addition, the adult survey also includes the following access-related questions:

- “Staff was willing to see me as often as I felt it was necessary.”
- “Staff returned my calls in 24 hours.”
- “Services were available at times that were good for me.”
- “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 respondents have been less satisfied with access to services than adult respondents; a trend which continued in 2012. In 2012, reported satisfaction with access to services declined slightly for both youth and adults from the previous two years’ worth of data, but still remained fairly consistent across years. The most notable drop was for adults, which scored the lowest it has since this survey has been administered (with 73% being the previous record low; results not shown). In both cases however, the majority of consumers (64%-71%) expressed satisfaction with access to services.

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2 This differential seems to represent a true difference in satisfaction with access to services, rather than a difference based on the scales themselves. For instance, although the adult survey asks more questions about access than the youth survey, the adult satisfaction rates for those additional questions are generally lower than for the shared questions. This indicates that the difference between the adult and youth satisfaction scores would be even greater when just looking at the shared questions.
A second domain relates to how well consumers or consumers’ family members (in the case of children and youth) were integrated into 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 in treatment” domain includes one question that is analogous on both the adult and youth versions. It is:

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

The other questions were:

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

In 2012, the majority of both adult (64%) and youth (74%) respondents were satisfied with their degree of participation in treatment. However, as has been the case historically, for this domain youth respondents were more positive than adult respondents. Youth responses were slightly lower than in previous years (74% in 2012 vs. 76%-78% in recent years), but were not at a historic low for Wisconsin (73%). Adults were actually slightly more satisfied with their participation in treatment than they have been in most recent years, but the overall pattern is of relative stasis.

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One important aspect of recovery from mental illness is social support. Research has shown that having “natural supports” in place—i.e., family, friends, and supportive co-workers and acquaintances—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 connectedness are often treatment goals of person-centered planning. Both the adult and youth versions of the MHSIP survey therefore ask about social connectedness, although they approach the concept in different ways. The adult survey asks the adult consumer to report on his/her own level of social connectedness, using the following questions:

- “I am happy with the friendships I have.”
- “I have people with whom I can do enjoyable things.”
- “I feel I belong in my community.”
- “In a crisis, I would have the support I need from family or friends.”

Consumers are not 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 their services. Thus, 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.

The same is true of the youth survey. However, the social connectedness questions differ from other questions on the youth survey in that they ask the parent, guardian, or other adult filling out the survey to reply based on their own social connectedness, rather than on the connectedness of the child receiving services. While social connectedness is vital for children and youth receiving mental health services, it is also imperative for adult caretakers of children with severe emotional disorders (SED) to have social support in order to provide high-quality care and participate effectively in the child’s treatment plan.

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Thus, the questions on the youth survey are as follows:

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

The results in this domain are reversed from those in many of the other areas discussed here, in that results from the youth survey are generally higher than those for the adult survey. However, as described above, the difference here is that the youth survey reflects the social connectedness of adult caretakers (who may or may not have any mental health concerns of their own), while the adult survey reflects the results of adults with Serious Mental Illness (SMI). This is one of the highest-scoring domains on the youth survey, and the results for 2012 (82% satisfaction rate) were slightly higher than in previous years. The same is true of adult respondents (66% satisfaction rate).

Consumers enter mental health services with the hope that such services will help improve their lives. Both the adult and youth surveys include a domain related to treatment outcomes. The survey tries to capture treatment-related improvements through the following questions:

- “I deal more effectively with daily problems.” (Adult version)/“My child is better at handling daily life.” (Youth version)
- “I am better able to deal with crisis.” (Adult version)/“My child is better able to cope when things go wrong.” (Youth version)
- “I am getting along better with my family.” (Adult version)/“My child gets along better with family members.” (Youth version)
- “I do better in social situations.” (Adult version)/“My child gets along better with friends and other people.” (Youth version)
- “I do better in school and/or work.” (Adult version)/“My child is doing better in school and/or work.” (Youth version)
The following additional items appear only on the adult version:

- “I am better able to control my life.”
- “My housing situation has improved.”
- “My mental illness symptoms are not bothering me as much.”

The youth version also includes “My child is better able to do things he or she wants to do.” A version of this question also appears on the adult survey, but is included in the “Functioning” domain rather than the “Outcomes” domain.

Historically, the “outcomes” domain has been the area with the lowest levels of satisfaction in Wisconsin. This is also true on a national level. For youth, fewer than half of all respondents were satisfied with their child’s outcomes. The majority of adults are satisfied with treatment outcomes, although this is still the lowest-ranking domain for adults. In 2012, both adult and youth respondents were slightly more positive with regard to treatment outcomes than they had been in recent years. The adult satisfaction level was actually the highest recorded in Wisconsin to date (previous high was 64%). It remains to be seen whether this marks a sustained improvement in satisfaction with outcomes or just normal variance from this year’s sample. The youth survey did not meet its historic high of 49% (not shown here), but was slightly higher than it has been in recent years.

![Figure 5: Satisfaction with Treatment Outcomes for Adults vs. Youth, 2007-2012 (2009 omitted)](image)

Despite the relatively low levels of satisfaction with treatment outcomes, the majority of both adult and youth consumers do report being satisfied with their services overall. The “Overall Satisfaction with Care” domain includes the following question for both youth and adults: “I like the services that I received” (Adult version); “Overall, I am satisfied with the services my child received (Youth Version).” The adult version includes the following additional questions:

- “If I had other choices, I would still get services from this agency.”
- “I would recommend this agency to a friend or family member.”

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Youth questions include:

- “The people helping my child stuck with us no matter what.”
- “I felt my child had someone to talk to when he/she was troubled.”
- “The 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.”

Over three-quarters of adults were generally satisfied with services, as opposed to slightly less than two-thirds of youth respondents. The level of satisfaction for adults was higher than it has been in recent years, but not at a historic high for Wisconsin (results not shown here). Youth levels of satisfaction were similar to responses in recent years.

While it may seem somewhat surprising that overall satisfaction is so much higher than satisfaction with outcomes for both adults and youth, this is a pattern that has been noted elsewhere. Scholars have noted that consumers often rate services based on “their emotional experience during [the service] rather than its longer term outcomes” (Fitzgerald and Galyer 2007:22).⁶

![Figure 6: Overall Satisfaction with Services for Adults vs. Youth, 2007-2012](image)

To summarize this section, in most domains both adults and youth demonstrate continuity in satisfaction levels from previous years. One of the greatest differences from 2011 occurred for adult satisfaction with access, which decreased by 6% (from 77% to 71%). While low, the outcome domains for both adults and youth did increase over 2011 levels, to a historic high of 6% for adults (from 60% to 66%) and by 5% for youth (from 42% to 47%).

DISCUSSION OF ADULT SURVEY RESULTS

One additional adult scale which has no equivalent in the youth survey measures satisfaction with a consumer’s improvements in functioning as a result of treatment. This scale is conceptually very similar to the “outcome” scale, but is sufficiently distinct to merit its own domain.

The questions on the “improvement in functioning” scale include the following:

“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 I want to do.”

As can be seen in Figure 7 below, this domain has shown steady improvement in recent years, reaching 68% satisfaction in 2012. Responses to this domain are very similar to those in the Outcome domain, albeit slightly higher.

Overview of Adult Trends

Figures 2-6 from the previous section show the results for both adults and youth for each domain over time. This section provides more discussion on the data presented in those graphs. The results of the adult survey aligned closely with the results from previous years. Respondents felt most positively about the way that staff treated them and ease of access to services. For instance, 81% of respondents agreed that

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7 However, in the 2011 MHSIP report, the youth “Outcomes” domain was labeled “Improvement in Functioning.” For the purposes of federal reporting, however, this is considered the “Outcomes” domain.
staff respected their wishes about who was to be given access to their information, and 81% agreed that staff was respectful of their cultural or ethnic background. In addition, 85% reported that staff had given them information about their rights. Conversely, many fewer people agreed that staff told them what side effects to watch out for (65%) or that they were able to participate in their treatment goals (67%). These items have also received low ratings in recent years.

With regard to access, 84% agreed that the location and times of services were convenient for them. However, respondents were much less likely to report that they were able to see a psychiatrist when they wanted to (65%). There is an acknowledged shortage of both adult and child psychiatrists in the state.8

As in years past, the lowest scoring items were those questions that asked consumers to discuss their mental health outcomes and any changes in functioning. For instance, slightly more than half of respondents (56%) reported that they do better in work/school as a result of their mental health treatment. Only 62% reported that their symptoms were not bothering them as much or that they do better in social situations as a result of treatment. Approximately two-thirds of consumers (65%) reported that they are better able to handle things when they go wrong. Sixty-eight percent reported that their housing situation had improved. Nearly 70% of respondents agreed that they are better able to deal with crisis (69%) and better able to do things they want to do (69%) because of their treatment. One item that scored significantly higher in 2012 than in 2011 was the question “I am better able to take care of my needs.” In 2011, only 53% of consumers agreed with that statement; in 2012, the number increased to 75%.

There were some statistically significant differences in consumers’ perceptions of care based on consumers’ own characteristics. For instance, women were slightly less likely to be satisfied with their outcomes and quality of services than men (p>.05), yet there were no significant gender differences for the other domains (i.e., participation in treatment, access, and overall satisfaction). No significant differences existed for any domain by race, although that might also be related to the relative lack of variation in this category (i.e., relatively small numbers of non-white consumers).

Wisconsin 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 8 below shows this comparison in 2012 for all of the domains reported by the Substance Abuse and Mental Health Services Administration (SAMHSA’s) Center for Mental Health Services (CMHS).9

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9 The national figures are taken from the CMHS Uniform Reporting System (URS) Multi-Year Output Tables, 2010-2012. While Wisconsin data for 2012 also appears in the table, what is actually reported under 2012 is the 2011 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 2012 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.
Figure 8 reveals that Wisconsin scores below the national average across all domains reported to SAMHSA. This is consistent with findings from previous years as well. The greatest difference was in Overall Satisfaction (a spread of 14%), followed by Access.

One potential explanation for these results involves sampling methodology. Unlike most states, Wisconsin uses a random sample of adults with Serious Mental Illness (SMI). 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.10

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 were defined as those with a rigorous survey methodology (either random sampling or stratified sampling) which sampled adults with SMI. Descriptions of survey methodology were taken from SAMHSA’s Uniform Reporting System tables.11

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10 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 Canadian youth survey data by Perrault et al (p. 235) showed that caregivers whose relatives had experienced a hospitalized or visited the emergency room tended to be less satisfied with services (Perrault et al, “Predictors of Caregiver Satisfaction with Mental Health Services,” Community Mental Health Journal, 2012 (48) 232-337. 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., & 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.

Figure 9 shows that Wisconsin ranks 7th out of the ten states listed as using a rigorous method to sample SMI adults. It should be noted that some of the higher-ranking states (Minnesota and Kansas) had significantly lower response rates than Wisconsin (20% vs. 33%), which implies that there may have been more skew to their data. That is, when response rates are low, only those with strong opinions (either positive or negative) are likely to respond. This might account for some of the reported differences. However, this trend does not hold across all the states listed here, and Wisconsin’s response rate is still quite low and below the national average of 50%. Therefore, not all of the difference can be accounted for based on differential response rates; at least some of the differences are likely due to actual differences in consumer satisfaction by state.

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 accounted for by differential response rates, but the results are telling. While the highest-ranking state within this group, Mississippi, has 90% satisfaction in this domain, and the U.S. average is 88.7%, Wisconsin has only 77% satisfaction in this domain.
These results do not account for many factors that could affect levels of satisfaction between states, such as:

- How the state mental health system is structured
- Where a state is located geographically
- What a state’s population looks like, both demographically and economically

If there were combined survey data from across all of these states, these would be factors to control for in a more formal way. However, just looking at the results available here, Wisconsin falls below other Midwestern states such as Ohio, Kansas, South Dakota, and—most notably—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.

**Other Outcomes**

The federal government asks states to report on the arrest rates for those receiving public mental health services. In the 2012 survey, 7.8% of respondents indicated that they had been arrested at least once in the last two years. This is slightly higher than the reported arrest rate for the 2011 survey (6.2%). It is also higher than the 2011 Wisconsin general population rate of 6.1%, or 6,142 arrests per 100,000 adults age 18 and over.\(^\text{12}\)

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DISCUSSION OF YOUTH SURVEY RESPONSES

Early intervention is an important component of effective treatment. Figure 11 below shows the age breakdown of surveyed youth consumers.

Seven youth consumers (1.6% of respondents) were under age five: two were three years old at the time of the survey and five were four years old. Those consumers are not displayed in Figure 11 above. Sixty percent of youth consumers were teens, while most of the remaining 40% were between 5-12 years old.

The youth survey includes a domain that does not appear on the adult survey, which is satisfaction with the cultural sensitivity of providers. This domain tends to be associated with high levels of satisfaction, and in 2012 respondents reported 90% satisfaction. While very small numbers of surveyed youth consumers were people of color, it is notable that all of the African American (n=6), Native American (n=4) and consumers marking “Other” as a racial category (n=12) indicated satisfaction with providers’ cultural sensitivity. Conversely, two of the fourteen consumers who were listed as having more than one race (14%) indicated dissatisfaction or neutral reactions to the providers’ cultural sensitivity. Just over 10% of White respondents were unsatisfied with this domain.
Overview of Youth Survey Results

The results discussed in this section refer to the trends displayed in Figures 2 through 6 above. As in previous years, parents of children receiving mental health services gave the highest ratings to questions relating to cultural sensitivity. Most parents felt that staff treated them with respect (92%), spoke in a way they could understand (92%), and respected the family’s cultural or ethnic background (89%) and spiritual or religious beliefs (88%). 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. Thus, such responses are non-trivial. Parents also reported that they were involved in their child’s treatment (87%), which 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. Lastly, parents by and large reported that their children received the appropriate type of service, as indicated by the response to the question “The services my child and/or family received were right for us” (87%). More than four out of five parents (83%) also agreed that the location of services were convenient for them.

Two of the questions had higher satisfaction ratings than the previous year. In 2011, only 41% of parents responded positively to the question “My child gets along better with family members”; in 2012 it was 56%. Similarly, in 2011, 32% of parents responded affirmatively to “My child is better able to cope when things go wrong”; in 2012, that number had risen to 45%. Hopefully these numbers will continue to increase in coming years.

As can be seen from the previous two items, the questions that received the lowest agreement were generally related to outcomes. Just over half of parents agreed that their child was better at handling daily life (54%), at getting along with friends and other people (56%) or with family members (56%), or at doing things he or she wants to do (57%). Less than half of parents agreed that their child was better able

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13 Perrault 2012.
to cope when things went wrong (47%). Relatedly, only slightly over half of parents (53%) indicated that their child had received as much care as they believed they needed.

The picture that emerges from these responses is that parents generally believe that they are getting the right type of services, but not enough to make a significant difference in the lives of their children or family. It is of course not possible from a single survey to determine definitively what is happening with children’s mental health care, but there is evidence from other sources that caregivers believe their children need more services than they received. It is also possible that the services being administered are not particularly effective, regardless of duration. There is also no question on the survey about the type of services received. Although parents are asked about their perception of the appropriateness of the services, there is no way to tell whether or not child consumers are actually receiving appropriate and effective services, such as evidence-based practices. Lastly, it is possible that parents have unrealistic expectations about how well their children will respond to effective treatment. At the same time, parents in Wisconsin are much more pessimistic about their children’s outcomes than parents in other states. Since there is no a priori reason to expect that Wisconsin caregivers have less realistic expectations than their peers in other states, these results imply a need to look more closely at Wisconsin’s system.

In additional analyses, no statistically significant differences in overall satisfaction or in satisfaction with outcomes were found by a child’s age group. Neither were there any significant differences in responses based on a child’s gender or race for any domain. No significant differences were found based on the parent’s gender, either. Similarly, there were no significant differences based on available measures of a child’s severity coming into services—i.e., based on either the prior arrest record or prior school suspension/expulsion record. In theory, one could imagine that parents of children with more disruptive behaviors would have higher expectations for treatment and may therefore express greater disappointment with outcomes. Some studies in fact show this to be the case (see e.g. Perrault 2012). However, the data show no such differences.

*Wisconsin Youth In Context*

Figure 8 in the adult section provided comparative data between Wisconsin and national averages, based on data reported to SAMHSA for the 2012 Uniform Report System (URS) tables. The figures below do the same for the youth data. As with the adult survey, for the youth survey Wisconsin scores below national averages across all domains. The greatest differences are in Overall Satisfaction and Access; the differences between Wisconsin and the national average are smallest in the Culture domain.

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14 Perrault 2012
15 As with the adult data, here the Wisconsin figures are drawn from the 2012 survey results, rather than from the URS tables.
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 SED. Descriptions of survey methodology were taken from SAMHSA’s URS tables.

Figure 14 shows that Wisconsin (47%) is next to last among methodologically comparable states when it comes to satisfaction with youth outcomes, with only Mississippi scoring lower, at 42% satisfaction. Wisconsin scores notably lower than other Midwestern states such as Ohio, South Dakota, Kansas, and most notably Minnesota (79%).
The results are slightly worse when it comes to overall satisfaction with services. Wisconsin (60%) actually ranks last in this category when compared to states which used a similar survey methodology; Mississippi is the highest with 90% satisfaction.\textsuperscript{16}

As stated in the section on adult satisfaction scores, there are many factors beyond the treatment context which 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.

\textit{Other Youth Outcomes}

The youth survey asked respondents to comment on other issues beyond satisfaction with services; namely, changes in the young person’s arrests, contact with police, and school attendance since the onset of mental health services. Contact with the criminal justice system and problems with school attendance can all potentially result from the disruptive effects of mental illness, and therefore these are areas that are expected to improve with the provision of effective treatment. The federal government asks states to break these questions down into two categories based on length of service: those youth who have received services for one year or more vs. those who have received services for less than one year. The results are therefore reported as such below.

\textsuperscript{16} Mississippi had surprisingly high responses to this domain, despite low rates of satisfaction with outcomes and with other domains not reported here.
Figure 16 reveals responses to the question, “Since your child began receiving these mental health services, have his/her encounters with police been reduced, stayed the same, or increased?” The most common response for youth in both service tenure categories (i.e., those with less than one year of services and those with one year or more of services) is that encounters with police did in fact decrease during the course of treatment: 79% of those with the shorter service history (n=15) and 51% of those with the longer service history (n=61) saw such improvements. The second most likely outcome across service tenure categories was for there to be no change in police contact (n=3 for less than one year of service; n=35 for one year or more of service). The least likely outcome across categories was for encounters with police to increase since the onset of treatment (n=1 for less than one year of service; n=23 for one year or more of service).

This pattern of police encounters generally decreasing with the onset of services is indeed encouraging. At the same time, the relatively lower success rates for those 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, at the time of the survey. A more thorough investigation into the differences between service tenure categories would need to control for the youth’s age in order to determine whether some of this effect may be due to differences in ages of the two groups.

While treatment does seem to correspond with general decreases in contact with police, that same pattern does not hold for the most severe cases: that of arrests. Youth who were arrested prior to treatment were equally or more likely to be arrested after the onset of treatment (see Figure 17 below).

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17 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.
There are a few possible explanations for this outcome. One is that the question is not specific enough to get at possible improvements in arrests, at least for those with less than one year of service. The question asks only whether a youth was arrested during a given time period, not the number of arrests or the severity of the offense. Thus, it is possible that the same percent of youth were arrested both before and during treatment, but that the frequency of arrests or severity of the crime decreased with treatment, and that difference is not displayed here. However, at least for those with one year or more of services, there was an absolute increase in the number of youth who were arrested once services began (n=32, vs. n=24 prior to treatment). As discussed above, this could be due in part to higher risk associated with an aging 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 is another important indicator of a child’s mental health. Respondents were asked, “Since your child began receiving these mental health services, have the number of days he/she has been in school been greater, about the same, or less?” The most common response to this question was that school attendance was unchanged with the initiation of treatment (see Figure 18 below). Fifty-six percent of those with less than one year of services (n=20) and 50% of those with one or more year of services (n=74) reported no change in school attendance.

The next most common response was that attendance increased (n=12 for those with less than one year of service; n=60 for those with one year or more of service), while a relatively small percent of respondents saw school attendance drop off during treatment (n=4 for those with less than one year of service; n=15 for those with one year or more of service).
There are a few possible interpretations of these data. One possibility is that the responses to the question are a bit misleading. The question response categories were:

- Greater
- About the same
- Less
- Does not apply: Please select the reason 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

While the question does include the option “child did not have a problem with attendance before starting services,” it is possible that some respondents whose children did not have a problem with attendance may have already selected “about the same” before reading this answer. If that is the case, then it may partially explain why the most common response was that school attendance was unchanged. It is of course also possible that the data are accurate and that in most cases treatment did not result in improved attendance. One thing to note here is that approximately 60% of respondents agreed with the question “My child is doing better in school and/or work.” This was the highest level of satisfaction of all the outcome questions (i.e., getting along with family and friends, coping, handling daily life, doing things he or she wants to do). However, it is possible that the reported improvements in school were in some other area besides attendance, such as improved grades or smoother interactions with teachers.
One interesting thing to note was that no statistically significant differences were detected between the length of service variable (less than one year; one year or more) and levels of satisfaction with either outcomes or services overall. There is some support in the literature for the idea that longer times in services are associated with higher caregiver satisfaction, but that was not evident in this survey. It is possible that such an effect could emerge if the analysis accounted for the exact amount of time a youth was in treatment, rather than relying on two somewhat arbitrary service tenure groupings.

ADULT HEALTH INDICATORS

The adult version of the MHSIP survey includes several questions aimed at gauging the respondent’s physical health. People with mental illness are generally more likely to have co-occurring physical health ailments, and attention to physical health is an important aspect of recovery.

One aspect of physical health is weight, or body mass index (BMI). Respondents were asked to report their height in inches and their weight in pounds. The respondent’s BMI was calculated from those numbers, and respondents were grouped into one of three categories: not overweight, overweight, or obese. Overall, 82% of adult respondents had elevated BMI (50% obese and 32% overweight). The obesity rate among respondents is 20% higher than for the state as a whole (30% statewide; 50% among respondents).

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20 A fourth category, underweight, is not reported here due to lack of comparison data from the Wisconsin Behavioral Risk Factor survey.
Differences in BMI are evident for both men and women, as can be seen in Figures 19 and 20 below.\footnote{22 Statewide data is based on the results of the 2010 Wisconsin Behavioral Risk Factor Survey, Wisconsin Department of Health Services, \texttt{http://www.dhs.wisconsin.gov/wish/main/BRFS/BRFSHome.htm}.}

Figure 19: Weight Categories for Male Survey Respondents vs. Male State Population

While both male and female survey respondents are more likely to be obese than the general adult population of Wisconsin, the difference is more pronounced for women than for men. Female survey respondents were more than twice as likely as the average Wisconsin woman to be obese.

Figure 20: Weight Categories for Female Survey Respondents vs. Female State Population
A smoking question was also included on the survey. Forty-two percent of respondents indicated that they currently smoke, which is nearly 21% higher than the 2011 rate for Wisconsin adults as a whole (not shown here). In general, survey respondents had much higher rates of selected health conditions than the state as a whole (see Figure 21). While rates of heart attacks are identical to the statewide population and heart disease are less than the population, rates of diabetes (24% vs. 7%), asthma (23% vs. 11%), and high blood pressure (37% vs. 27%) are particularly elevated among survey respondents.

Differences in physical health were related to consumers’ levels of satisfaction. For instance, people who rated their physical health higher (“In general, how would you describe your health?”) were also slightly more likely to report that they were satisfied overall with the services that they received (p=.002).

Respondents were also asked how many days in the last 30 days their physical and mental health was not good. The mean response for poor physical health was almost a third of the time (9.75 days out of 30, or 32.5%). By comparison, respondents reported slightly more days of poor mental health during the past month (11.74 days out of 30, or almost 40%). An additional question geared at functional impairment asked how many days poor physical or mental health kept the respondent from engaging in usual activities; the average response for this item was 10.09 days, or 33.6%.

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Despite the fact that respondents as a whole reported suffering from poor health between 32.5%-40% of the time, most respondents (57%) reported that they were in good health (38% “good”; 14% “very good”; 5% “excellent”). Thirty-three percent of respondents reported that their health was “fair”, while only 10% reported that their health was “poor” (results not shown here.)

Conclusions

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. Some areas, such as cultural sensitivity towards youth consumers and their families, were particularly highly rated. At the same time, both adult and youth scores in Wisconsin were below the national averages and tended to be towards the bottom of those states that surveyed a similar population using a similar methodology. This indicates room for improvement in Wisconsin’s system. A particular area in need of improvement is youth treatment outcomes: fewer than half of respondents were satisfied with improvements in their children’s functioning as a result of mental health services, and the results were below the national average and averages for peer states. These low levels of satisfaction with perceived outcomes also appeared to be backed by more objective outcome measures: while most respondents to the youth survey did report decreased encounters with police, such improvements were not the norm with regard to arrest rates or school attendance. While alternate explanations for these results cannot be ruled out, when viewed alongside low reported satisfaction with youth outcomes, they make a case for further exploration of the effectiveness of the youth system.

The inclusion of physical health indicators on the adult survey reveals that Wisconsin’s mental health consumers experience much poorer physical health than the population as a whole. While more than half of respondents nonetheless consider themselves to be in good health, on average they report that their physical and/or mental health prevents 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.
While the 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, and does not examine whether consumers in the public system are more or less satisfied with their care than those who see private providers.\textsuperscript{25} Similarly, it is important to keep in mind that only consumers who actually gained access to the county mental health system are surveyed; thus, the voices of consumers who may have attempted to access the system and become discouraged (either due to wait times or restrictions on payment sources) are not represented here. This is important to note because only a small proportion of youth in particular actually receive services: Wisconsin’s mental health service penetration rate is 4.6% for ages 0-12 (vs. 21.4% for the U.S.) and 17.7% for ages 13-17 (vs. 41.2% for the U.S.).\textsuperscript{26} Lastly, additional analyses would need to be conducted to fully determine the meaning of some of the numbers reported here; e.g., whether differences in levels of satisfaction over time are statistically significant or likely to represent normal variation.

\textsuperscript{25} Some limited data sources do exist from the private sector. See e.g., MHCA, “Client Satisfaction Report 2013” Tallahassee, FL: 2013. \url{http://www.mhca.com/CustSat_Files/Org%20Report%20.pdf}.

\textsuperscript{26} Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. “Wisconsin 2012 National Outcome Measure (NOMs): CMHS Uniform Reporting System” \url{http://www.samhsa.gov/dataoutcomes/urs/2012/Wisconsin.pdf}. 