Contra Costa
Health Services

CONTRA COSTA COUNTY
MENTAL HEALTH
COMMISSION

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MISSION STATEMENT: To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect

QUALITY OF CARE Committee Meeting

November 16, 2017 ♦ 3:15 pm-5pm

2425 Bisso Lane, in Concord

Second floor conference room

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner's comments**

IV. **Chair announcements**

V. **APPROVE minutes from October 19, 2017 meeting**

VI. **DISCUSS Contra Costa Regional Medical Center (CCRMC) consumer advocacy, empowerment and grievance resolution program- Lynnette Watts, MSOD- Health Services Administrator, Patient-Family Advisory Council/Patient Experience @CCRMC**

VII. **RECEIVE updates from Psych Emergency Services (PES) with PES Program Chief, -Victor Montoya**

VIII. **REVIEW and DISCUSS Quality of Care Committee 2017 activities for purposes of drafting the Committee's 2017 Yearend Report**

IX. **REVIEW and DISCUSS Committee's mission statement**

X. **DISCUSS potential Quality of Care Committee goals for 2018 as follows:**
   1. **Goals not completed or addressed in 2017**
   2. **Potential new goals**

XI. **Adjourn**

In accordance with the Brown Act, if a member of the public addresses an item not on the agenda, no response, discussion or action on the item may occur. In the interest of time and equal opportunity, speakers are requested to observe a 3-minute time limit. If special accommodations are required to attend any meeting, due to a disability, please contact the Executive Assistant of the Mental Health Commission, at: (925) 957-5140

Mental Health Commission
Quality of Care Committee Minutes
October 19, 2017- DRAFT

	Agenda Item / Discussion	Action / Follow-up
I.	**Call to Order / Introductions @3:31pm** **Members Present**: Chair- Barbara Serwin, District II (arrived @3:26pm) Gina Swirsding, District I (arrived @3:30pm) **Members Absent**: Meghan Cullen, District V **Others Present**: Sam Yoshioka, District IV Doug Dunn, District III Lauren Retagliatta, District II Victor Montoya, Program Chief for PES Erika Raulston, *submitted application, pending appointment Leslie May *submitted application, pending appointment Jill Ray, Field Rep for District II Supervisor Andersen Priscilla Aguirre, MPP, Quality Management Program Coordinator Dr. Ann Isbell, HS Planner/Evaluator Adam Down-MH Project Manager Liza A. Molina-Huntley, Executive Assistant (EA) for MHC	**Executive Assistant:** • **Transfer recording to computer.** • **Update Committee attendance** • **Update MHC Database**
II.	**Public Comment** • None	
III.	**Commissioner Comments** • Statement regarding concerns with youth having mental breakdowns, how law enforcement assists in the process, what happens before, during and after Juvenile Hall- what services are available to youth, after detention, especially for Foster Care youth.	
IV.	**Chair announcements/comments:** • None	
V.	**APPROVE Minutes from September 21, 2017 meeting** • **Gina Swirsding moved to motion to approve the minutes, without corrections, Barbara Serwin seconded the motion** • **VOTE: 2-0-0** • **YAYS: Gina and Barbara** • **NAYS: 0 ABSTAIN: 0 ABSENT: Meghan Cullen** • Concerns were made regarding certain commission members attending the Family and Human Services meetings. It was clarified that the meetings are closed sessions, by invitation only, and do not violate the Brown Act because only three members attended the meeting, there were not enough members to create a quorum of the commission.	• **Executive Assistant will correct the minutes, finalize and post the minutes on the Mental Health County website.**
VI.	**DISCUSSION regarding an overview and summary of External Quality Review Organization (EQRO) with Priscilla Aguirre, MPP- Quality Management Program Coordinator and Dr. Ann Isbell, Health Services Planner/Evaluator** • EQRO is a federal mandate, required by the United States Department of Health and Human Services, centers for Medicare and Medicaid services (CMS). The review is conducted on an annual basis, to have an independent external evaluation of State Medicaid managed care programs. The state contracts with an agency called "Behavioral Health Concepts". This agency makes annual site visits to review all 56 counties in the state of California. EQRO is an external review and evaluation of access to our services, timeliness of services, and client outcomes. The agency is interested in know whether or not clients are getting better, based on the services that we provide. The agency conducts both staff interviews, as well as focus groups with clients. EQRO is primarily focused on evaluating how the service is being provided to the beneficiaries	• **Include handout from meeting discussion- EQRO report summary** • **EA will ask the Quality Manager- Priscilla Aguirre in JULY/AUGUST for the EQRO report to schedule a presentation at the following meeting**

Agenda Item / Discussion	Action / Follow-up
under the Mental Health Plan (MHP) • The Behavioral Health Administration serves MHP and other clients that are not specific to the MHP • There are 20 components that Behavioral Health Services Division (BHS) is evaluated on. (provided handout listing components that are evaluated) Three areas are focused on the access to services, some are focused on timeliness and the final section is related to quality. Within each of the three components, there is an abundant amount of requirements • The document is divided in two columns: EQRO FISCAL YEAR 2015-16 and EQRO FISCAL YEAR 2016-17. The abbreviations are defined as: "FC" for FULLY COMPLIANT, "PC" means PARTIALLY COMPLIANT and "NC" means NON-COMPLIANT. BHS did not receive any "NC's" during the evaluation. In all 20 components, BHS was either fully or partially compliant, in both years. • The document shows that year to year, that there is a trend, for the two years, of being FULLY COMPLIANT in 10 out of 20 components. • The document demonstrates improvements some components went from partially compliant to fully compliant, in six areas. • Comparing from 2015-16 to 2016-17, the BHS went from being fully compliant in ten areas in 2015-16 to being fully compliant in 16 areas in 2016-17, leaving four areas in partially compliant, out of 20 total. The Behavioral Health Services Division has made strides in a lot of areas. • Regarding the four areas that are partially compliant areas, were affected by previous paper billing and charting. Now that BHS is in the process of implementing the Electronic Health Record System (EHR) the areas will should see improvement that were in the partially compliant category • Questions- • What is EQRO actually looking at for evidence of effective communication from BHS and Mental Health Plan (MHP) – this is different from the Mental Health Administration, correct? RESPONSE: Yes, the Mental Health Plan is specific to the beneficiaries of the Mental Health Plan • Will EHR affect Continuum of Care Reform (CCR) and how? RESPONSE: At this moment, it is unknown, due to the fact that the process of the implementation is still in its initial phase of being launched. Cannot answer the question at this time. • Is there a master plan, created by BHS, in what steps will be taken to improve? RESPONSE: This is the initial data of measurement that will best answered in the following year. There might be different requirements in the future. EQRO is all about improvement, identifying other ways to improve our system to provide better outcomes for the clients • Besides the Electronic Record, was there anything else that BHS was working on to assure that we attain full compliance on the things that we are now partially in compliance? RESPONSE: The question that comes up often is: how do we really now that our clients are getting better? We/BHS are in the planning stages of implementation of other items; for example: CANAS tool, known as the Children's and Adolescents Needs Assessment tool. The tool has the ability to be used for different levels of care and for treatment planning • When a component is identified as FC, PC or NC- does the process include, a piece that requires BHS to identify what it plans to do? Or does it end there and picks back up again the next year? RESPONSE: It is not linear- one of the things that EQRO does is that they include recommendations based on what was observed during their evaluation. BHS is required to respond to the recommendations. • Will SHARE CARE help out in any of the issues, or solely EHR? RESPONSE: For EQRO, the primary focus and improvement will be coming from EPIC (EHR). SHARE CARE is primarily focused on billing. EPIC is focused primarily on documenting, based on the care • Are the numbers representatives of just the youth in the county or all the population?	

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RESPONSE: the EQRO addresses the entire system of care • There are five key areas of the EQRO report: the first is the performance measurements, (pages 13-20), followed by the performance improvement projects (PIP- two are required to be completed, annually, pages 22-29), the third is Consumer and Family Member focus groups (pages 45-47) , fourth is the Information Systems Review (pages 45-53) and the last section is the RECOMMENDATIONS (on page 56) • In the first section: PERFORMANCE measurements, areas that the state has indicated to measure across counties. There are eight specific areas. (see page 13) • The PERFORMANCE IMPROVEMENT projects (PIPs- see page 22) Two are mandated to be conducted per year, one clinical and one non-clinical. These are projects designed to assess and improve processes. It is up to the county to identify the needs by analyzing internal data. For the clinical performance improvement project it was "Coaching to Wellness," it is a MHSA funded project. The project consists of a peer provider, working with a nurse, to assist those individuals with chronic health conditions. The assistance is provided both, one-on-one and group work, to help the client identify goals, educate, link the person to resources so that the individual can do better self-management to improve both their health and mental needs. For the non-clinical PIP an appointment adherence was conducted. The county does have a slightly higher than average "no-show" rate, particularly with Psychiatry appointments. It was addressed in multiple ways: it was identified, from feedback provided by a focus group, that a handbook would be helpful to assist in navigating through the system. The county is currently working, with a workgroup, to provide a handbook. The second project is a transportation project to address transportation issues. Some consumers find it difficult to get to their appointments. Approximately one-third of the individuals miss their appointments due to no available free transportation. A report was submitted, identifying nine different steps to address, including: forming a committee, define problems, why was the project chosen, research questions, develop indicators to measure impact outcomes data. Coaching to Wellness was rated in both years. For the clinical PIP the overall rate received was 88%, which is considered a high rate, meeting client's needs. For the non-clinical, no-show PIP, at the time of the evaluation, the project had just initiated and was in the launching phase, therefore there was not enough data for the evaluation and received a lower score of 75%. • QUESTIONS- • How long ago was the no-show rate evaluation done and how was the data obtained? • Response: The data was obtained by conducting focus groups and distributing and collecting surveys from consumers. • Is there a summary of the information? • Response: Yes, there is a finding reports from the improvement surveys • Is there a way to help consumers prioritize their appointments? If consumers have health problems and mental health issues, they can become overwhelmed with appointments and focus on just the health issues and not show up to their psychiatrists or therapists appointments. • Response: we are trying different ways to identify the optimum time to send out reminder calls- one day, two days, same day especially when considering transportation barriers and or other appointments • Where and when were the PIPS done? • Response: The EQRO evaluation is conducted in annually in February, so it does not capture the full fiscal year. The data submitted was from November 2016. The sites, where the PIPS were conducted at, are the East and Central adult's clinics. • The results of the focus groups, that were conducted by Behavioral Health Concepts, during the site visit in February of 2017. One focus group is done with adult consumers and the other focus group is done with parents and caregivers of children and youth. A multiple series of questions are asked, themes are noted and recommendations are provided. For adults, consumers seemed aware of how to best access crisis services, if needed. Many noted that staffs were increasingly stressed. The staff involved in "wellness recovery, wraparound services, or action planning groups and in our welcome	

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centers found them very useful and supportive of their treatment. While consumers felt recovery was possible, welcomed more input. The recommendation that came from that particular focus group was to increase opportunities for focus groups to provide feedback, which BHS started to do in 2016 including more survey opportunities. • Where are the welcome centers located? Did they visit all three locations? • We believe that the group was referring to RI International welcome centers. We did ask for clarification and that was what was stated. It was not disclosed if all three locations were visited. • The other recommendation was to have more licensed board and cares facilities in the community and services for the mentally ill, that are homeless, seem limited. It was encouraged to embrace and promote family support as essential for recovery. • Regarding the focus group with parents and caregivers, those who had a longer history of service indicated that consumer progress was made and had improved. And that service provisions were adequately offered in our patient services. Many noted that they had negative experiences with hospital discharge procedures and the parents/caregivers felt that youth were prematurely discharged and follow up support was not provided. Those that were in the educated and support, as well as First Hope, along with those receiving school based wrap around services found the services to be very helpful. Participants felt supported by each provider, but noted that more staff is needed. Services were available in the preferred language and transportation was available to appointments, including bus vouchers. • Where were the participants talking about being discharged from? PES? Do we know? Most of our youth are not discharged from our county hospital, that are in mental health treatment, that's why I ask the question, because they are discharged from different locations. • Response: details of location were not provided. We conduct our focus groups differently and request more information. The evaluators protocol is different and do not ask the participants to elaborate or to specify, that is their process. We do not get any information in advance to support the focus groups, so the responses are whatever it is, from the clients who chose to participate and their experience that is what is represented in the EQRO summary. • Another recommendation was a more productive transfer of services for transition aged youth (TAY- see pages 46). Additional recommendations were updated communications, using bulletin boards more effectively, having a bilingual person at the front desk, more prompt follow up calls when a request for service is made and consider appointing a benefits support staff for those who need insurance. • The five recommendations were based on what was observed for our county (on page 56) is: standardizing processes and cross-regional referrals for access to care and subsequent services to enhance the seamless and consistent delivery of services. BHS is working on all aspects, including the launch to EPIC, which started on 9/26/17, developing the referral system, by utilizing CCLINK. BHS is making progress in developing this mechanism for referrals cross-regionally. • The other is requesting timeliness matrix request quarterly reports and analyzes for adherence to standards as component of the contractor provider performance measures. An area that we have started to work on, with our new Chief of Operations, Helen Kearns. • The third is utilizing existing equipment to provide tele-psychiatry services in the regions showing the greatest need. BHS is currently piloting tele-psychiatry, tentatively launching on October 31, working with the EPIC team to effectively utilize the system, using a video monitor to communicate with the client and doctor. It will allow a doctor to be at one location and have appointments with patients at various locations. Psychiatry is the area that BHS is currently focused on for the pilot project. There will be a lot to learn, other counties are utilizing the system, which are show success. • Review services designed for TAY and increase for this target population. BHS is working on exploring to partner with an agency to provide a TAY residential program at Oak Grove.	

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• The final recommendation is to develop a communication plan that includes contract providers and a planning and implementation of an electronic inter-operability of EHR data, between systems. At the time of the evaluation, BHS had not started the implementation of the EHR/EPIC, since then, it has launched, internally, and there will be a second phase to include the providers and that will be informed, after it has launched. The new system has only been operating for three weeks and will continue to improve communication and standards, it will take time. • The information provided is summarized in the EQRO Summary document provided * see attached • The state has requested all counties to provide support to the victims of the fire and Contra Costa is doing their best providing support by sending staff to assist. • Approximately 15 Contra Costa County clinicians have done over 25 shifts at the Napa shelter and Sonoma to help the fire victims, individuals and families	
VII. DISCUSS updates from Psych Emergency Services (PES) with PES Program Chief, Victor Montoya • One of the focuses is looking at the services for minors at PES and currently in the process of obtaining clinical data • There is a Health Educator that has initiated the data and refining the data collection system specifically for children • There currently is not an inpatient children/adolescent minor facility in the county and the follow up care is provided and developed at John Muir facilities or send children as far as Sacramento • The ongoing focus might be on the minors that really need hospitalization, that facilities are unwilling or unable to do, due to the minor's acuity status, and will sit at PES for over the allowed 23 hours and the county does not obtain reimbursement, from MediCal, after 23 hours and the county is absorbing the additional costs • With the changes in foster care youth, in providing mental health services, and the reduction of long term group homes being eliminated, there will be greater challenges in providing residential treatment and increase minors homelessness and increase minor ending up in juvenile hall • A lot of foster care parents are unaware of the various court requirements for fostering youth, especially youth receiving medications and the court documentation required to provide medications • Question: Do you think because of the reduction of group homes, more difficult children will now be placed in foster care homes and the foster care parents will need training on how to handles these children- will there be an increase in children in PES? • More than likely, there will be an increase of children in PES. It currently is phasing in. There is a reason why children in long term group homes do not improve. Children need a more family environment. The higher acuity children wind up getting placed out of state, because there is no place for them to go or the facilities refuse them, further from any family contacts.	***Invite PES for the next meeting**
VIII. DISCUSS and REVIEW the committee activities for 2017	***Forward to the November 16 meeting**
IX. DISCUSS potential committee goals for 2018 as follows: **1. Goals not completed or addressed in 2017** **2. Potential new goals for 2018**	***Forward to the November meeting**
X. Adjourned at 4:49 pm	

Submitted by
Liza Molina-Huntley
ASA II- Executive Assistant for MHC
CCHS- Behavioral Health Administration

TABLE 1. Overall Results of the External Quality Review (EQR) FY 16-17 including trends from FY 15-16 (see pp. 30-45)								
			Compliant (FC/PC/NC)		Trends			
20 EQRO Key Components Evaluated in Mental Health Plan (MHP)			EQRO FY 15-16	EQRO FY 16-17	FC (10)	PC (4)	(+) YR to YR (6)	
Access	1A	Service accessibility and availability are reflective of cultural competence principles and practices	FC	FC	✓			
	1B	Manages and adapts its capacity to meet beneficiary service needs	**PC**	**FC**			✓	
	1C	Integration and/or collaboration with community based services to improve access	FC	FC	✓			
Timeliness	2A	Tracks and trends access data from initial contact to first appointment	**PC**	**FC**			✓	
	2B	Tracks and trends access data from initial contact to first psychiatric appointment	**PC**	**FC**			✓	
	2C	Tracks and trends access data for timely appointments for urgent conditions	PC	PC		✓		
	2D	Tracks and trends timely access to follow up appointments after hospitalization	FC	FC	✓			
	2E	Tracks and trends data on re-hospitalizations	FC	FC	✓			
	2F	Tracks and trends no-shows	FC	FC	✓			
Quality	3A	Quality management and performance improvement are organizational priorities	FC	FC	✓			
	3B	Data are used to inform management and guide decisions	**PC**	**FC**			✓	
	3C	Evidence of effective communication from MHP administration	PC	PC		✓		
	3D	Evidence of stakeholder input and involvement in system planning and implementation	**PC**	**FC**			✓	
	3E	Evidence of strong collaborative partnerships with other agencies and community based services	FC	FC	✓			
	3F	Evidence of a systematic clinical Continuum of Care	--	PC		✓		
	3G	Evidence of individualized, consumer-driven treatment and recovery	--	**FC**			✓	
	3H	Evidence of consumer and family member employment in key roles throughout the system	FC	FC	✓			
	3I	Consumer run and/or consumer driven programs exist to enhance wellness and recovery	FC	FC	✓			
	3J	Measures clinical and/or functional outcomes of consumers served	PC	PC		✓		
	3K	Utilizes information from Consumer Satisfaction Surveys	FC	FC	✓			

-- New category introduced in FY 16-17
FY 17-18 Standard changes: 3C and D combined; and 3E and G deleted

TABLE 2. Performance Improvement Projects EQRO FY 16-17 (pp. 22-30)		
Summary Totals for PIP Validation	**Clinical PIP (1)** ***Coaching to Wellness***	**Non-Clinical PIP (2)** ***No Show***
Number Met	17	9
Number Partially Met	3	6
Number Not Met	1	1
Number Applicable (AP)	21	16
Overall PIP Rating (#Met*2) + (#Partially Met))/(AP*2)	88%	75%

Table 3. Focus Group with 14 Adults EQRO 16-17 (pp. 45-47)	
General comments regarding service delivery:	**Recommendations for improving care:**
• Consumers were aware of how to best access crisis service if needed. • Many noted provider staff were increasingly stressed; most noted the front desk reception can be impolite. • Those involved with WRAP and the Welcome Centers found these to be useful and supportive to treatment. • Overall, consumers felt recovery possible and welcome more venues for input.	• Increase opportunities for focus groups to provide feedback. • Provide licensed Board and Care facilities in the community. • Services to the mentally ill homeless seem limited. • Continue to embrace and promote family support, seen as essential to recovery.

Table 4. Focus Group with 11 Parents/Caregivers of Children/Youth EQRO 16-17 (pp. 46-47)	
General comments regarding service delivery:	**Recommendations for improving care:**
• Those with a longer history of services indicated consumer progress was made and had improved. Service provisions were adequately offered in outpatient. • Many participants had a negative experience with hospital discharge procedures. Most felt youth were prematurely discharged and follow-up support was not provided. • The Educate, Equip, and Support materials, First Hope project, school-based services and wraparound services were found to be helpful. • Participants felt support by each provider, yet expressed more staff are needed. • Services were available in the preferred language. • Transportation is available to appointments as well as bus vouchers.	• Increase productive transfer of services for Transition Age Youth (TAY). • Provide updated communications such as postings on bulletin boards in lobbies. • Translation needed at the front desk. • Return a follow-up call from a request for access. • Consider appointing a benefits support staffer for those who need insurance.

TABLE 5. EQRO Recommendations FY 1516 (pp. 8-10)
Engage in a stakeholder process to select an Electronic Health Records (EHR) system. Include subject matter expert stakeholders from the MHP management and clinical programs, quality improvement, fiscal and billing, and information technology to identify and prioritize functional requirements. Assign sufficient staff resources to complete functional requirements, EHR selection, and contract negotiations timely. ☒ **Fully addressed** ☺
Engage in a stakeholder process with the MHP contract provider agencies which have operational EHR system. Research what other MHPs have implemented for data interoperability solutions. Implement electronic data interchange (EDI) standards for the exchange of healthcare data between systems. ☒ **Partially addressed** 😐
Investigate the feasibility to expand tele-psychiatry service system wide to support staffing gaps, expedite screening, provide targeted expertise (e.g. Spanish speaking child psychiatry) and decrease time to service. ☒ **Not addressed** ☹
Review and analyze high cost beneficiaries' service patterns as both percentages of consumer counts and billed MediCal services are significantly higher than statewide experience. Implement strategies to create stepdown program or alternative services for these beneficiaries where and when appropriate. ☒ **Partially addressed** 😐
Create a welcome packet for consumers with system navigation information; consider rosters of community resources, the mental health newsletter and how to access the Behavioral Health website. ☒ **Fully addressed** ☺

TABLE 6. New EQRO Recommendations FY 16-17 (p. 56)
1. Consider standardized processes and cross-regional referrals for access to care and subsequent services to enhance the seamless and consistent delivery of service.
2. Include timeliness metrics, request quarterly reports, and analyze for adherence to standards as a component of the contract provider performance measures.
3. Utilize existing equipment to provide tele-psychiatry services in the regions showing the greatest need.
4. Review services designed for transition age youth (TAY) and increase as warranted for this target population.
5. Develop a communication plan that includes contract providers in the planning and implementation of electronic interoperability of EHR data between disparate systems.

May 2017 MHSIP Consumer Satisfaction Report

Contra Costa Behavioral Health Services

Research & Evaluation Unit

May 2017

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Executive Summary

From May 15th to May 19th, 2017, consumers who accessed services at Contra Costa County outpatient mental health clinics completed consumer satisfaction surveys. The California Department of Health Care Services selected four different Mental Health Statistics Improvement Project (MHSIP) surveys to assess consumer satisfaction: Adult Survey (consumers 18-59 years); Older Adult Survey (consumers 60+ years); Youth Survey (consumers 13-17 years); and Parent-Caregiver Survey (caregivers of consumers 0-17 years). The survey instruments included closed-ended and open-ended questions; collecting demographic information, service history, health status, and consumer satisfaction across several domains, including:

- General Satisfaction
- Access
- Participation in Treatment
- Quality and Appropriateness
- Outcomes
- Functioning
- Social Connectedness.

Data from the four surveys were aggregated into two groups for analysis: Adults (Adult and Older Adult surveys) and Youth (Youth and Parent-Caregiver surveys). A total of 1,233 surveys (332 Adult and Older Adult Surveys and 901 Youth and Parent-Caregiver Surveys) were completed.[1] The demographic profile of the sample can be summarized in the following way:

- A small majority of the respondents were male (51%), while 48% of the respondents were females and 1% of respondents selected "other" when identifying their gender[2];
- Most of the surveys completed (59%) were about children ages 15 and younger receiving mental health services; 22% of surveys were about transitional age youths (16-25 years old); 16% of surveys were about adults ages 26 to 59; and 5% of surveys were about older adults ages 60 and older.
- Approximately two out of every five respondents (41%) identified as Hispanic/Latino; the remaining 59% of respondents included: 21.5% Black/African-American; 17% White/Caucasian; 11% Multi-Racial (non-Hispanic); 6% 'Other Race;' 2% Asian-Pacific Islander; and 1.5% Native American/Alaskan Native.
- The majority of surveys were completed in English (85.5%), with 14.5% being completed in Spanish;
- Parents/Caregivers of youth (ages 0-17) completed a majority of surveys (40%); a third of the respondents completed the Youth survey; 23% completed the Adult survey; and just 4% completed the Older Adult survey (ages 60 and older).
- More than half (56%) of all respondents reported that they had been receiving mental services at Contra Costa Behavioral Health Services for one year or less.

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[1] This is a convenience sample. The results are not necessarily representative of the entire population of consumers accessing mental health services at Contra Costa County Behavioral Health Services and affiliated clinics.

[2] MHSIP questionnaires, which are designed by a national consortium and approved by the California Department of Health Care Services, ask respondents: "What is your gender?" and offer three options as responses: "Female," "Male," or "Other." Clients utilizing behavioral health services at Contra Costa County outpatient mental health clinics complete registration paperwork that includes gender, with two response options offered: female and male.

Survey results show high satisfaction scores consistent with results from the past several years. The average domain scores for **all** respondents were 4.3 overall; including 4.5 for *Quality and Appropriateness*, 4.4 for *General Satisfaction*, 4.4 for *Access*, 4.3 for *Participation in Treatment Planning*, 4.2 for *Social Connectedness*, 4.0 for *Functioning*, and 4.0 for *Outcomes*. Comparing average domain scores by the different survey types, children and youth (or their parents/caregivers) ages 17 and younger generally rated satisfaction higher in all domains except for *Participation*, *Outcomes*, and *Functioning* which had equivalent composite scores from adults ages 18 and older. Specifically, average domain scores for children/youth/parents ranged from a high of 4.6 for *Quality and Appropriateness*, to 4.5 for *Access*, to 4.4 for *General Satisfaction*, to 4.3 for both *Social Connectedness* and *Participation in Treatment*, and 4.0 for both *Outcomes* and *Functioning*. Average domain scores for adult clients ages 18 and older went from a high of 4.3 for two different domains: *General Satisfaction* and *Participation in Treatment*, to 4.2 for both *Quality and Appropriateness* and *Access*, to 4.0 for *Functioning* and *Outcomes*, and 3.9 for Social Connectedness.

Tests of statistical significance were performed where appropriate. This report also includes an analysis of the open-ended responses (qualitative data).

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Background

Contra Costa Behavioral Health Services (CCBHS) uses the Mental Health Statistics Improvement Project (MHSIP) consumer satisfaction surveys adopted by the California Department of Health Care Services (DHCS) to assess consumer satisfaction with and perceptions about county outpatient mental health services. Administering these surveys to consumers is one way in which Contra Costa County Behavioral Health Services seeks client feedback and suggestions about its services. The results of these surveys are reviewed by a variety of stakeholders to identify service gaps and to inform quality improvement and policy efforts.

Methodology

Surveys

The California Department of Health Care Services selected four MHSIP consumer satisfaction surveys, which are nationally recognized for their reliability and validity:

- Adult Survey (ages 18-59)
- Older Adult Survey (ages 60+)
- Youth Survey (ages 13-17)
- Parent-Caregiver Survey (parents/caregivers of youth, ages 0-17)

All of the surveys collected demographic and service information from respondents.

The Adult and Older Adult Surveys included one open-ended item for consumers to provide feedback about services received. The Adult and Older Adult Surveys also asked about recent arrests and encounters with police. Surveys included 36 items that assessed consumer perceptions of satisfaction across the following seven domains:

- General Satisfaction (services were overall satisfactory and preferable to other choices);
- Access (staff availability, service options, and timeliness and convenience of services);
- Participation in Treatment (consumer participation in treatment planning);
- Quality and Appropriateness (cultural/linguistic access, individual respect and care);
- Outcomes (services led to positive change in treatment goals);
- Functioning (services aided independent community living and decreased symptom distress);
- Social Connectedness (services contributed to improving family and friend support systems).

The Youth and Parent-Caregiver Surveys included three open-ended questions asking consumers about: (1) the most helpful aspects of the services received, (2) how to improve services, and (3) any other feedback about these services. These surveys also asked about recent arrests and encounters with police, and expulsions or suspensions from school. The Youth and Parent-Caregiver Surveys included 26 items that assessed consumer perceptions across the following seven domains:

- General Satisfaction
- Access
- Participation in Treatment
- Quality and Appropriateness
- Outcomes
- Functioning
- Social Connectedness.

In addition, the May 2017 survey included several county specific questions related to:

- Modes of Transportation for mental health appointments;
- Travel time from home to mental health clinic; and
- Cultural competence.

The items for both the Adult and Older Adult Surveys were identical, while the items in the Youth and Parent-Caregiver Surveys were very similar, but the Parent-Caregiver surveys indicated satisfaction with services for their children. High scores on a domain correspond to high levels of consumer satisfaction for that particular category or domain, whereas low scores on a domain represent low levels of consumer satisfaction for that specific domain. See the Appendix for the survey items associated with each domain.

Procedure

In compliance with the mandate from DHCS, CCBHS administered the semi-annual MHSIP surveys for their consumers during the week of May 15th – 19th, 2017.

CCBHS provided paper surveys in English and Spanish to County child and adult mental health clinics, and PDF versions of the surveys to affiliated community-based organizations throughout the county. County parent partners and volunteers provided support for survey completion to consumers in County clinics during the week of survey administration. To encourage consumer participation in the survey, incentives were provided for completing the survey. Respondents at the county mental health clinics were also offered refreshments. Upon completion of the survey, each respondent at a county clinic also had the option to be entered into a raffle contest to win one of two $10 Safeway gift cards. Contracted providers in community-based organizations were encouraged to provide incentives to their own consumers to encourage survey participation. Drop-boxes were made available at each survey collection site to ensure confidentiality.

Survey data were uploaded, retrieved, summarized and analyzed using Teleform, SQL, Excel, Access, and SPSS statistical software. CCBHS scanned and entered data locally using Teleform software, which captures handwritten survey data and uploads them into a SQL database. Surveys were validated for accuracy and data were submitted to the State. A Microsoft Access database was developed to enter and analyze (together with Excel) qualitative data. All other data were analyzed using Excel and SPSS.

Sample

The survey sample is a convenience (i.e., non-random) sample. As such, the results are not necessarily representative of the entire population of mental health consumers in the county. Some subgroups may have been under sampled or over sampled in the survey.

Results

Data from the four surveys were aggregated into two groups for analysis: Adults (Adult and Older Adult surveys) and Youth (Youth and Parent-Caregiver surveys). Additional analyses were completed comparing youth to parents/caregivers and adults to older adults. Regarding the youth/parent surveys, in some cases, a parent/caregiver may have completed a survey for a youth who also completed a survey.

Surveys Completed

A total of 1,233 surveys were returned by early June, including:

- 332 (27%) Adult and Older Adult Surveys
- 901 (73%) Youth and Parent-Caregiver Surveys

The total number of surveys collected in May 2017 was comparable to the number collected in November 2016 (1,283) and 5% more than the number of surveys collected in May 2016 (1,178).

Table 1: MHSIP Surveys Completed 2016-2017

Age Group	May 2017 Surveys Completed		November 2016 Surveys Completed		May 2016 Surveys Completed	
	Count	*Percentage*	*Count*	*Percentage*	*Count*	*Percentage*
Adults	332	27%	522	41%	406	34%
Youth	901	73%	761	59%	772	66%
Total	1,233	100%	1,283	100%	1,178	100%

Table 2: MHSIP Adult Surveys May 2017 by Survey Type

Surveys	Adults Ages 18 – 59		Older Adults Ages 60+		Total
	Count	*Percent*	*Count*	*Percent*	
Surveys	278	84%	54	16%	332

Note: This table describes the number of participants who completed an adult or older adult survey. A separate analysis of age by survey type revealed that some older adults completed an adult survey.

Table 3: MHSIP Child & Youth Surveys May 2017 by Survey Type

Surveys	Parents of Children & Youth Ages 0-17*		Youth Ages 13 – 17*		Total
	Count	*Percent*	*Count*	*Percent*	
Surveys	487	54%	414	46%	901

Note: This table describes the number of participants who completed a parent/caregiver survey form or a youth survey form. *An analysis of age by survey type revealed that, in some cases, both youth (ages 13-17) and parents of youth completed a survey about the same young person receiving services. Additionally, a total of 21 clients aged 18 – 21 were represented among the youth/parent surveys (although those surveys were meant for clients aged 17 and younger).

Demographics

Gender

Slightly more youth respondents were Male (53%). Conversely, among adult respondents more were Female (53%). Less than one percent of youth respondents and about two percent of adults selected "Other" as their gender identity.[1]

Figure 1: Gender - Youth Ages 0-17

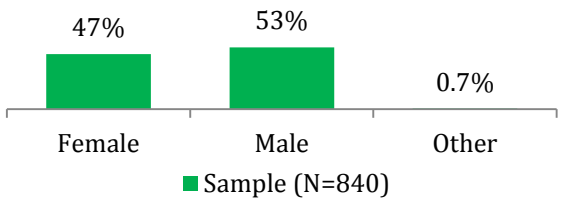
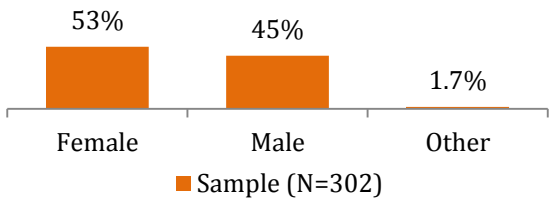


Figure 2: Gender - Adult Ages 18+

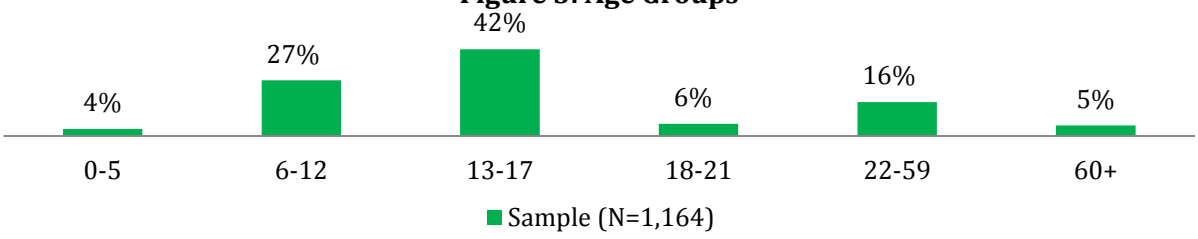


Note. Respondents who chose not to provide their gender were excluded from reported results.

Age

The majority of surveys completed were about respondents aged 13 to 17 (42%), followed by respondents aged 6 to 12 (27%), followed by adult respondents aged 22 to 59 (16%). The remaining sample was distributed as follows: Five and under (4%), ages 18 to 21 (6%), and ages 60 and older (5%).[2]

Figure 3: Age Groups



Note. Respondents with missing or invalid birthdates were excluded. Age categories were aligned to correspond to the CCBHS demographic reports (of Medi-Cal consumers utilizing County behavioral health services in CY 2016).

Ethnicity and Race

Hispanic/Latino clients were over represented in the May 2017 MHSIP survey sample. In this sample approximately two out of every five respondents (41%) identified as Hispanic/Latino, whereas 24% of Contra Costa Behavioral Health Services' Medi-Cal consumers identified as

[1] MHSIP surveys (approved and distributed by the California Department of Health Care Services) ask clients to select one of three options for gender: male, female or other.

[2] Each respondent's age (at the time of the survey) was derived using a function in Microsoft Excel that calculates the number of years between the date of birth and the survey date.

Hispanic/Latino based on county penetration data.[3] The MHSIP survey sample included 55% of clients aged 0-17 and 24% of clients aged 18 and older who self-identified as being of Hispanic, Latino, Mexican or other Latino nationality.

Figure 4:
Mexican/Hispanic/Latino Origin - Youth Ages 0-17

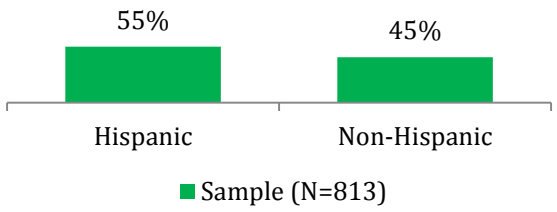
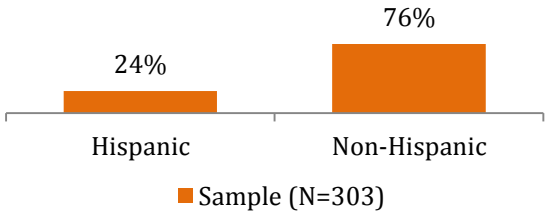


Figure 5:
Mexican/Hispanic/Latino Origin - Adult Ages 18+

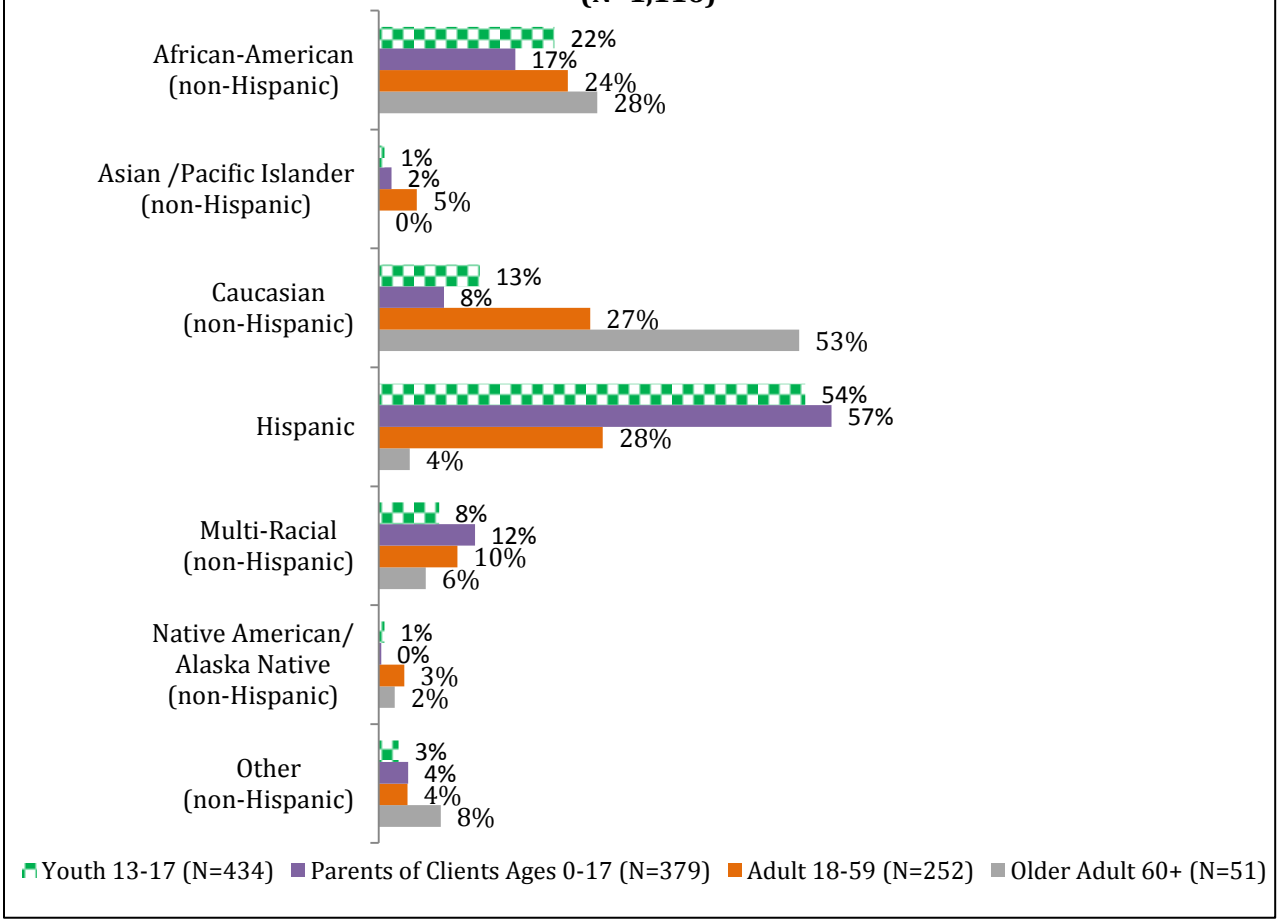


Note: Respondents who did not answer the question about Hispanic ethnicity were excluded.

Ethnicity and Race: Figure 6 on the next page details the distribution of race and ethnicity categories across the four survey populations: 1) Youth ages 13 to 17, 2) Parents of children and youth ages 0-17, 3) Adults ages 18 to 59, and 4) Older Adults ages 60 and older. The graph shows that parents of children/youth had the highest proportion of Hispanic respondents (57%) followed by youth themselves (54%), whereas the highest proportion of non-Hispanic respondents was among Caucasian adult clients ages 60 and older (53%).

[3] A total of 24% of consumers with Medi-Cal who utilized Contra Costa Behavior Health Services in CY 2016 identified as Hispanic. (Report titled: PSP3294, MH-EQRO Audit – Penetration Report, accessed using iSite on March 9th, 2017.)

Figure 6: Race/Ethnicity Comparison: Youth and Adults in Survey Sample (N=1,116)

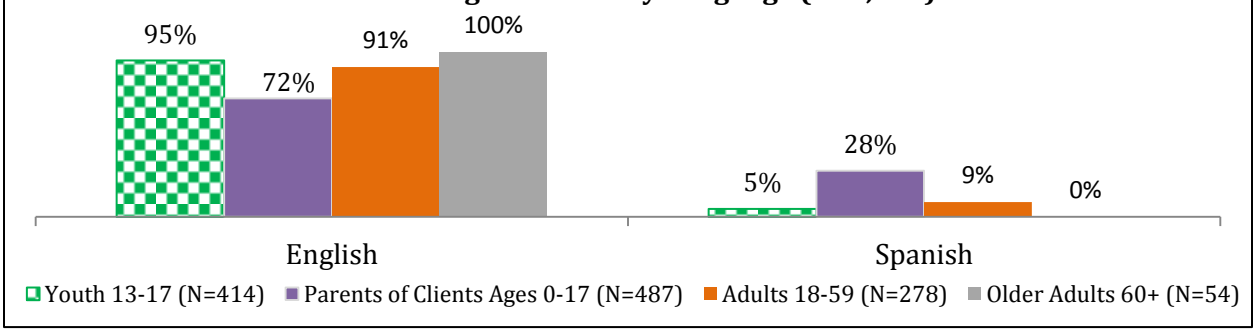


Note: Respondents with missing responses were excluded.

Language

The survey was offered in English and Spanish. The majority of respondents completed the survey in English, with the largest proportion of English speaking respondents being older adults ages 60 and older (100%). Over a quarter (28%) of parents (of clients aged 0-17) completed a survey in Spanish.

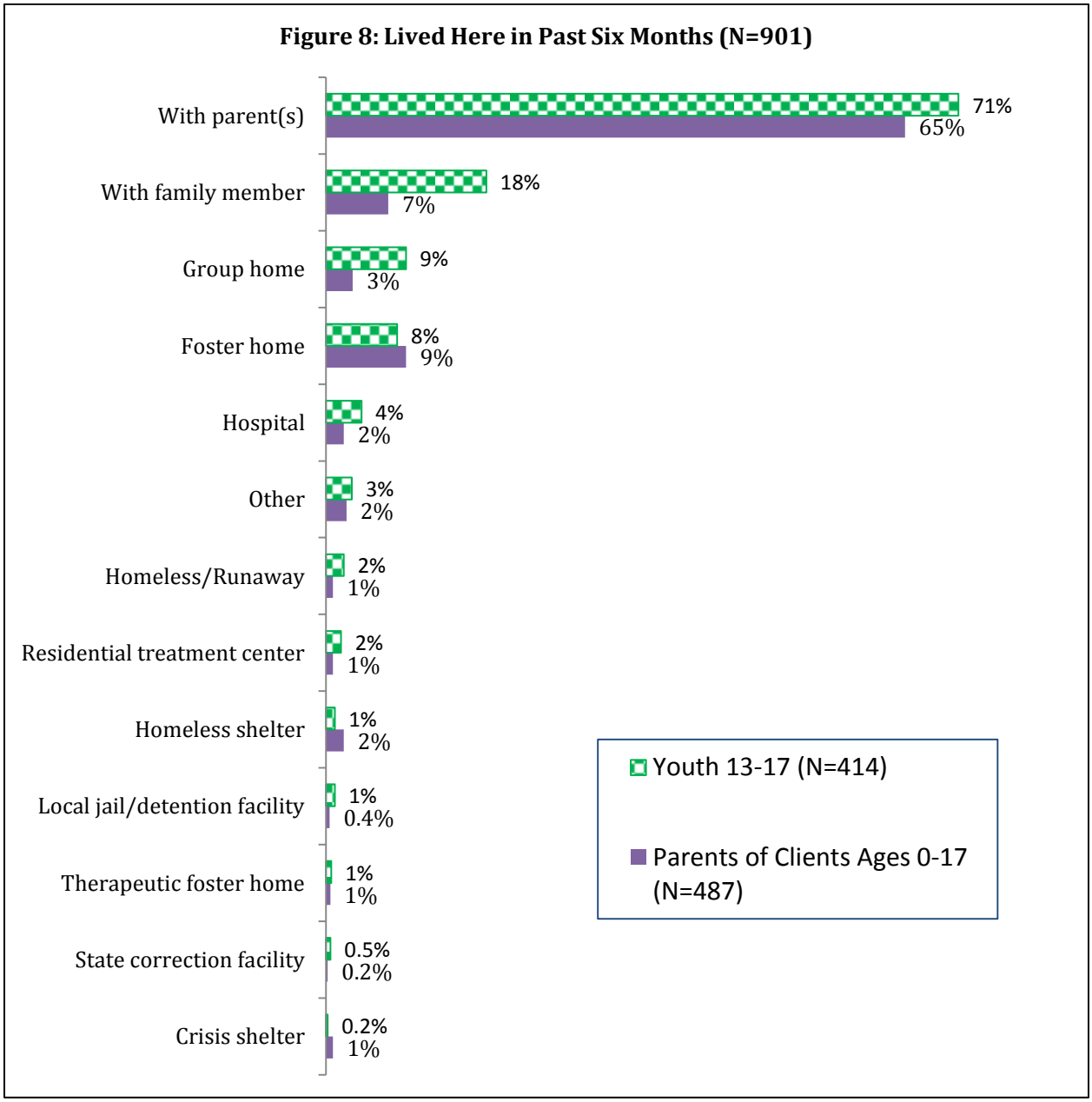
Figure 7: Survey Language (N=1,233)



Living Arrangement (children/youth/parents only)

Most parents of children/youth (65%) and youth respondents (71%) reported living with a parent within the past six months, followed by living with another family member (reported by 18% of youth and 7% of parents of children/youth). Residency in a group home (reported by 9% of youth and 3% of parents of children/youth), foster home (reported by 8% of youth and 9% of parents of children/youth), or hospital (reported by 4% of youth and 2% of parents of children/youth) rounded out the top five living arrangments. Three percent of youth reported "other" living arrangements in the past six months, while smaller percentages cited various living arrangements, including: crisis shelter, jail/detention, foster home, residential treatment center, homeless shelter, homeless/runaway, and/or state correctional facility. Multiple responses were possible.

Figure 8: Lived Here in Past Six Months (N=901)



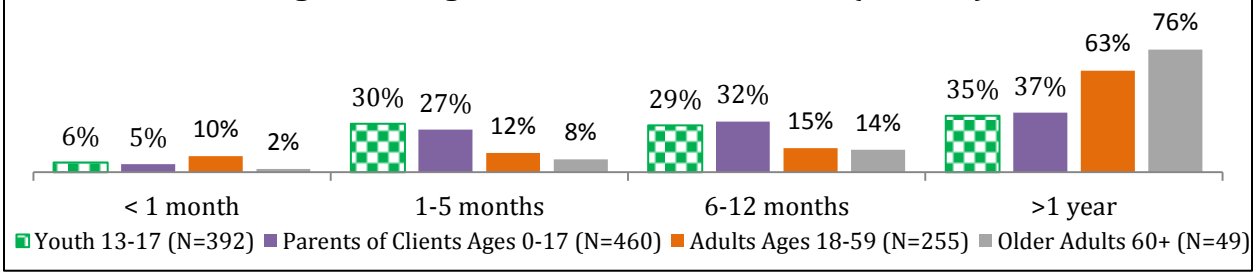
Note: Multiple response question.

Service History

Length of Time Receiving Mental Health Services

Most respondents (56% overall) reported that they had been receiving mental health services for one year or less. When broken down into smaller time periods and comparing survey populations, the results suggest a different pattern, with the highest relative length of time being more than a year (including 76% of older adults, 63% of adults, 37% of parents, and 35% of youth), followed by respondents who had been receiving services for six months to 1 year (32% of parents, 29% of youth, 15% of adults, and 14% of older adults). Figure 9 below depicts the length of service patterns for each surveyed population.

Figure 9: Length of Time Services Received (N=1,156)



Note: Respondents with missing responses were excluded.

Cultural Competence

Almost all respondents reported receiving services in their preferred language (100% of older adults, 98% of parents, 97% of youth, and 94% of adults); as well as written information in their preferred language (97% of parents, 96% of youth, 94% of older adults, and 93% of adults). See Figures 10 and 11 below.

Figure 10: Services in Preferred Language (1,072)

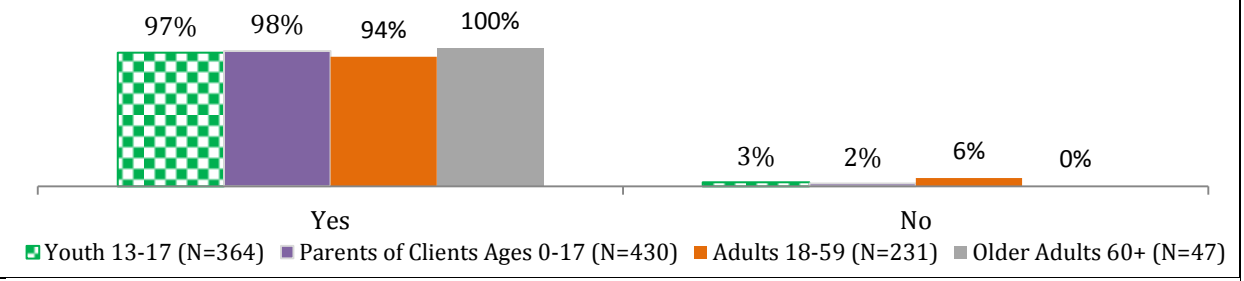
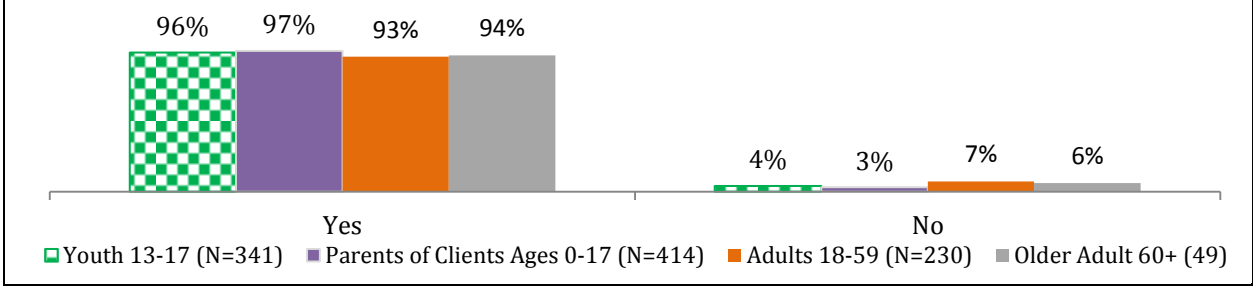


Figure 11: Written Materials in Preferred Language (N=1,034)



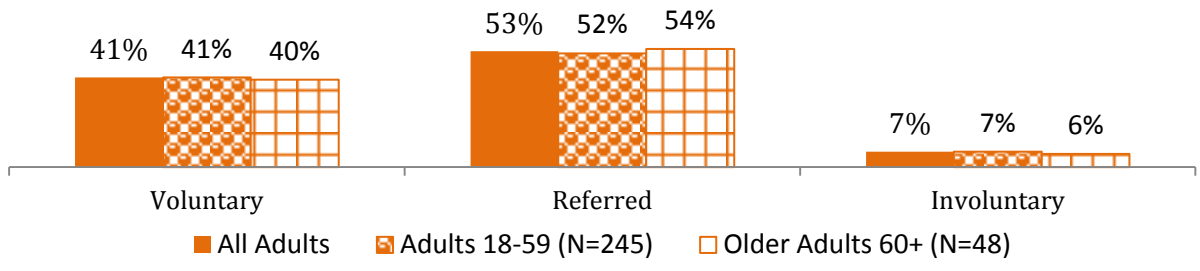
Note: Respondents with missing responses were excluded.

In addition, 92% of survey respondents agreed or strongly agreed that their provider was, as the survey asked: "respectful and supportive of my culture, values, beliefs, life ways and lifestyle (this includes race, religion, language, gender/gender expression, sexual orientation, or disability)."

Reason Services Sought (adults/older adults only)

Two of every five adult respondents age 18 and older (41%) reported that they voluntarily participated in mental health services ("I decided to come in on my own"), with a higher percentage (53%) reporting that they were referred to County mental health services. Only 7% of all adults reported involuntary participation in mental health services ("I came in against my will"). Comparing adult respondents (N=245) to older adult respondents (N=48), both populations were referred at similar rates, 54% for older adults compared to 52% for adults. See Figure 12 below.

Figure 12: Primary Reason Involved in Program (N=293)



Note: Respondents with missing responses were excluded.

Medi-Cal Insurance (children/youth/parents only)

A total of 94% of surveys from children, youth and parents (N=823) indicated that clients had Medicaid coverage (Medi-Cal). Comparing responses by population, parents/caregivers of children and youth ages 17 and younger (N=443) reported somewhat higher rates of Medi-Cal coverage (97%) compared to youth ages 13-17 (91% of 380 youth).

Medical Doctor Visit (children/youth/parents only)

Nearly four out of five surveys (79%) from children, youth and parents (N=857) indicated that clients had seen a physician or nurse for a health check-up or because they were sick in the prior year, either in a clinic/office (66%) or in a hospital/emergency room (13%). The others either did not see a doctor or nurse (13%) or did not remember (8%). Comparing responses by population, parents (N=458) reported somewhat higher rates of medical visits (85%) compared to youth (72% of 399 youth).

Medication (children/youth/parents only)

Over a quarter (27%) of surveys from children, youth and parents (N=809) indicated that clients were taking medications for emotional/behavioral problems. The proportion of yes responses from parents (28% of 429) was slightly higher than the proportion of yes responses from youth (25% of 380). Of those children and youth on medication(s) (N=188), 87% reported that a doctor or nurse had informed them about side effects. The proportion of clients who had been informed about side effects varied by type of survey, with significantly more parents (89% of 104 parents) than youth (83% of 84 youth) reporting that they had been informed about medication side effects.

Transportation Modes and Travel Time

In the May 2017 MHSIP Survey, consumers were asked about their modes of transportation and travel times from home to their mental health clinic for appointments. The most frequent modes of transportation for adults and older adults surveyed (N=332) was to drive to their appointments ("Drive Myself," 27%), followed by receiving a ride from family members/caregivers (26%). The least frequent modes of transportation were using Taxi, Uber/Lyft, or Paratransit services (3%).

Similar results were recorded among youth and parents of children/youth who participated in the survey when it came to primary modes of transportation. The leading modes of transportation identified were driving myself to appointments (35%) and family member/caregiver drives (32%).[4] In contrast, youth and parents did not rely on Paratransit services (0%) to get to the mental health clinics and were also less inclined to use BART (1%), Uber/Lyft (1%), or pay someone (1%) for transportation.

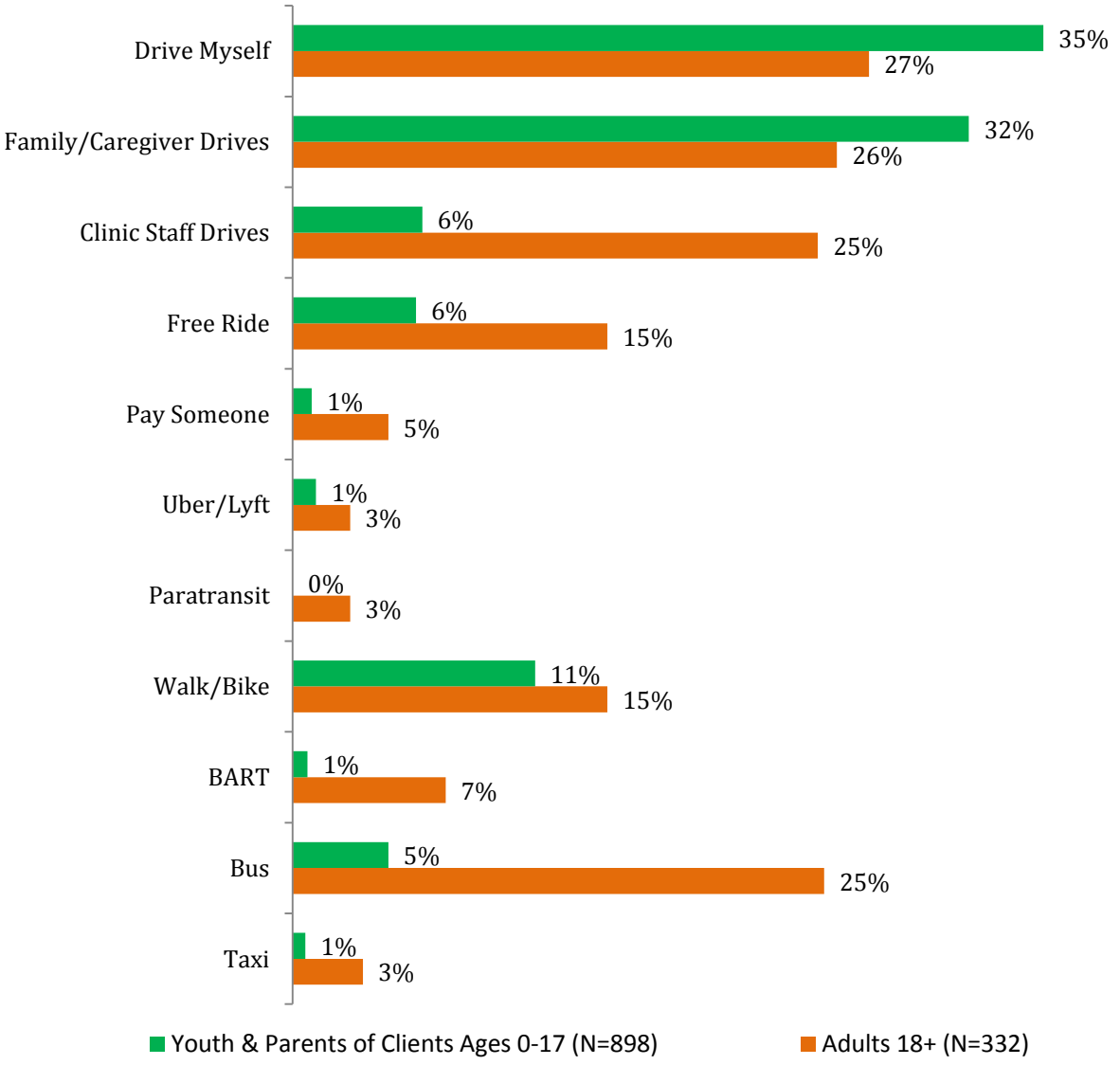
Among adult respondents almost three quarters (72%) of those surveyed (N=293) indicated that their travel time for appointments is 30 minutes or less. Of the remaining responses, 19% have travel times of 31 minutes to 1 hour, 6% have travel times of 1 hour to 2 hours, and 3% indicated more than 2 hours to get from home to their mental health appointments.

The majority (85%) of youth and parents of children/youth surveyed (N=730) responded that they travel 30 minutes or less to get to their mental health clinic for appointments. 12% have travel times of 31 minutes to 1 hour, 3% take between 1 hour to 2 hours in travel time. Only 1 respondent (0.1%) indicated that it takes more than 2 hours for them to get from home to their mental health clinic for appointments.

See Figures 13 and 14 on the following page.

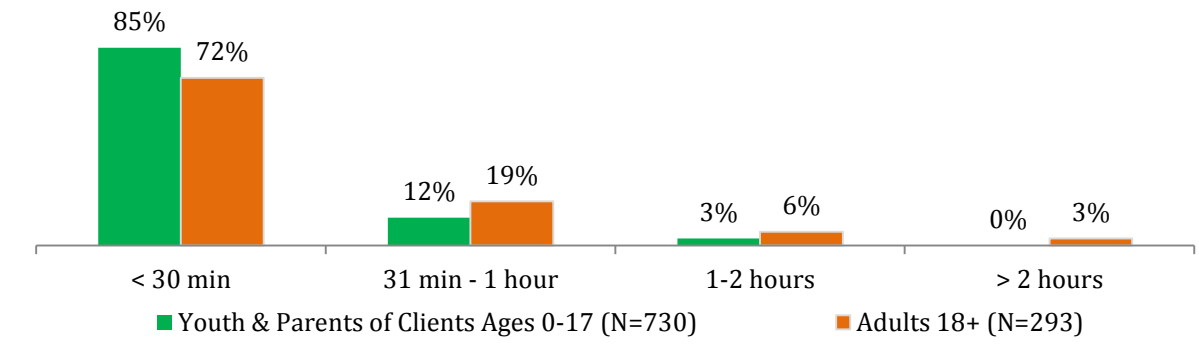
[4] When viewed independently, Youth (13-17) were more likely to identify a family member/caregiver as their primary mode of transportation, whereas Parents of Children & Youth 0-17 responded that they "Drive Myself [Child/Youth]" to mental health clinic appointments.

Figure 13: Mode of Transportation (N=1,230)



Note: Multiple response question.

Figure 14: Travel Time, Home to Mental Health Appointment (N=1023)



Encounters with the Police and School Issues

Police Encounters

Respondents receiving services were asked to indicate any change in the frequency of encounters with police since starting mental health services. **Of adult respondents, age 18 and older, who had been receiving mental health services for one year or less**, three out of every five (60%) of them did not have police encounters. Of the 68 who did have a police encounter, more than half (62%) reported a reduction in those encounters since initiating mental health services, followed by 31% of adult respondents who experienced no change in the number of encounters with the police, and 7% who reported an increase in police encounters.

Only 87 (16%) of youth and parents of children/youth who had been receiving mental health services for one year or less reported any encounters with police since initiating mental health services.[5] Of these, 51% reported reduced numbers of encounters, while 33% reported no change, and 16% reported increased encounters with police.

Findings were similar for respondents who had been receiving mental health services for more than one year, 71% did not report any police encounters. Of the 64 adults who did report polic encounters, slightly less than half (45%) reported a reduced number of police encounters, followed by reports of no change (39%). 16% reported an increase in their encoutners with the police.

Here again, **the majority (85%) of youth and parents of children/youth receiving mental health services for more than one year reported no police encounters.** Of the 56 individuals who reported encounters with the police since beginning mental health services, 48% reported reduced numbers of encounters, while 45% reported no change, and 7% reported increased encounters.

See Figures 15 and 16 on the following page.

[5] Youth and parents of children/youth receiving mental health services for one year or less who selected the option "not applicable" selected that option based on this language: "you had no police encounters this year or last year."

Figure 15: Police Encounters Since Beginning Mental Health Services - Received Services for One Year or Less (N=155)

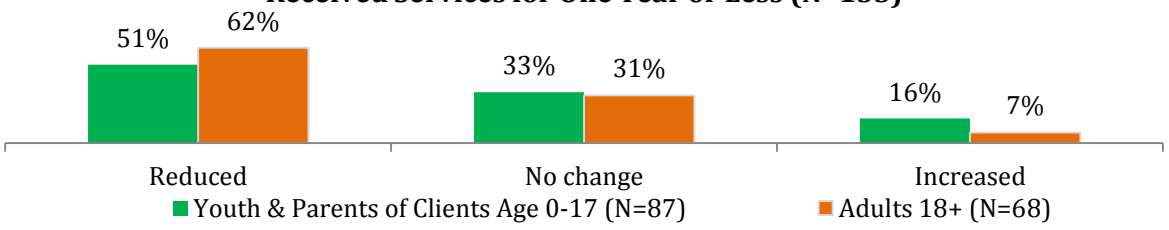
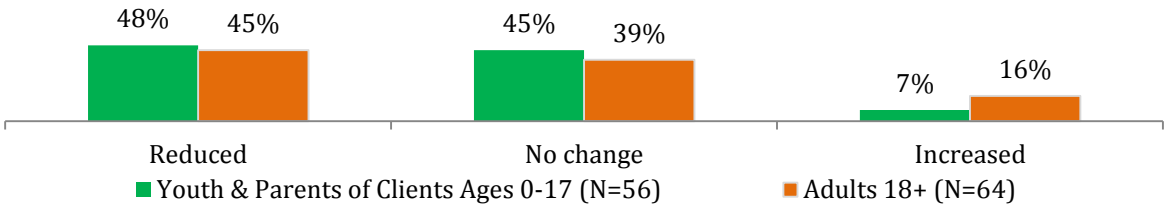


Figure 16: Police Encounters Since Beginning Mental Health Services - Received Services for More than One Year (N=120)



Note: Respondents with missing responses were excluded.

School Attendance (children/youth/parents only)

Of those children and youth attending school and receiving mental health services for one year or less (N=405), 36% reported attending more days of school since initiating mental health services; 53% reported about the same attendance; and 11% reported less school attendance since beginning mental health services. Of those youth respondents attending school while receiving services for more than one year (N=258), 38% reported greater attendance; 47% reported that attendance was about the same; and 15% reported less school attendance since beginning mental health services. See Figures 17 and 18 below.

Figure 17: School Attendance Since Beginning Mental Health Services - Received Services for One Year or Less (N=405)

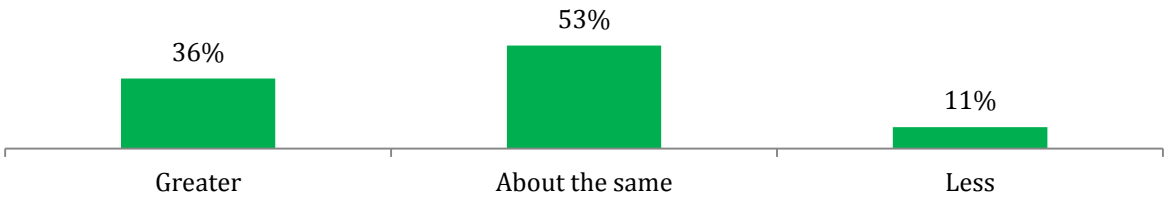
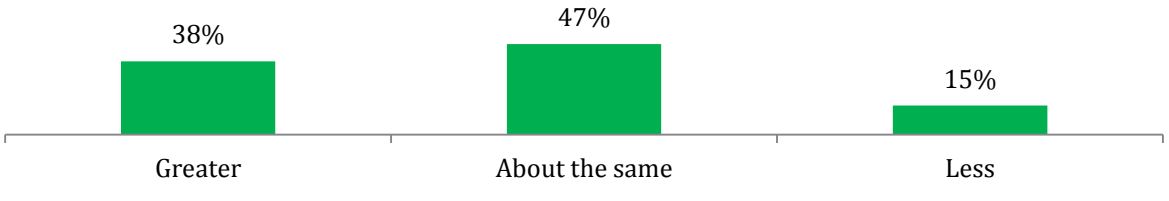


Figure 18: School Attendance Since Beginning Mental Health Services - Received Services for More than One Year (N=258)



Note. Respondents with missing responses were excluded.

School Discipline (children/youth/parents only)

Youth reported being expelled or suspended from school in fairly consistent proportions, with a slight decrease in reported school disciplinary actions for those who had been receiving services for more than a year. Of youth receiving mental health services for one year or less (N=599), 19% reported being expelled or suspended in the current year and 21% (of 588 responses) reported being expelled or suspended in the prior year. Of youth receiving services for more than a year (N=411), 18% reported being expelled or suspended in the current year, and 18% (of 402 responses) reported being expelled or suspended in the prior year. See Figures 19 and 20 below.

Figure 19: School Discipline Current and Year Prior - Received Services for One Year or Less

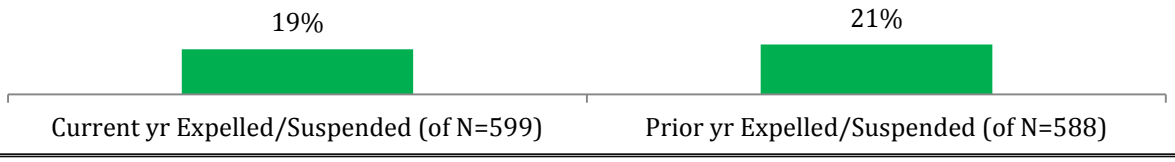
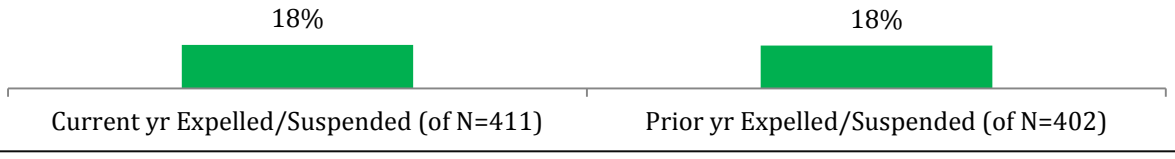


Figure 20: School Discipline Current and Year Prior - Received Services for More than One Year



Note: Respondents with missing responses were excluded.

Domain Scores

Calculating Domain Scores

A mean (i.e., average) score for each domain was calculated from all responses. To prevent "Not Applicable" responses from skewing the average, these responses were excluded from the calculation of a mean domain score. In addition, consistent with best practices in MHSIP survey scoring, only respondents who completed at least two-thirds of the questions for any given domain were included in the calculation of the mean score for that domain. Scores were based on responses to a five point Likert scale as follows: (1) Strongly Disagree, (2) Disagree, (3) I am Neutral, (4) Agree, and (5) Strongly Agree.[6] High mean domain scores indicate high levels of satisfaction with services received.

Domain Scores: Youth & Parents of Children and Youth

As a group, youth and parents of children and youth (age 0-17) generally reported high satisfaction with services received, as evidenced by the overall mean score of 4.3 and the fact that all domain average scores were rated 4.0 or higher. *Quality and Appropriateness* of treatment was the highest ranked domain [*M*=4.6]. The lowest average domain scores among youth and parents were *Outcomes* and *Functioning* [*M*=4.0]. See Table 4 below.

Table 4: Summary MHSIP Domain Scores – Youth/Parents (Combined)

Domain	N	Mean	% 4.0+
Overall	899	4.3	75.0%
General Satisfaction	891	4.4	82.7%
Access	881	4.5	88.8%
Participation in Treatment	879	4.3	81.9%
Quality & Appropriateness	890	4.6	92.0%
Outcomes	874	4.0	58.1%
Functioning	877	4.0	59.7%
Social Connectedness	870	4.3	83.6%

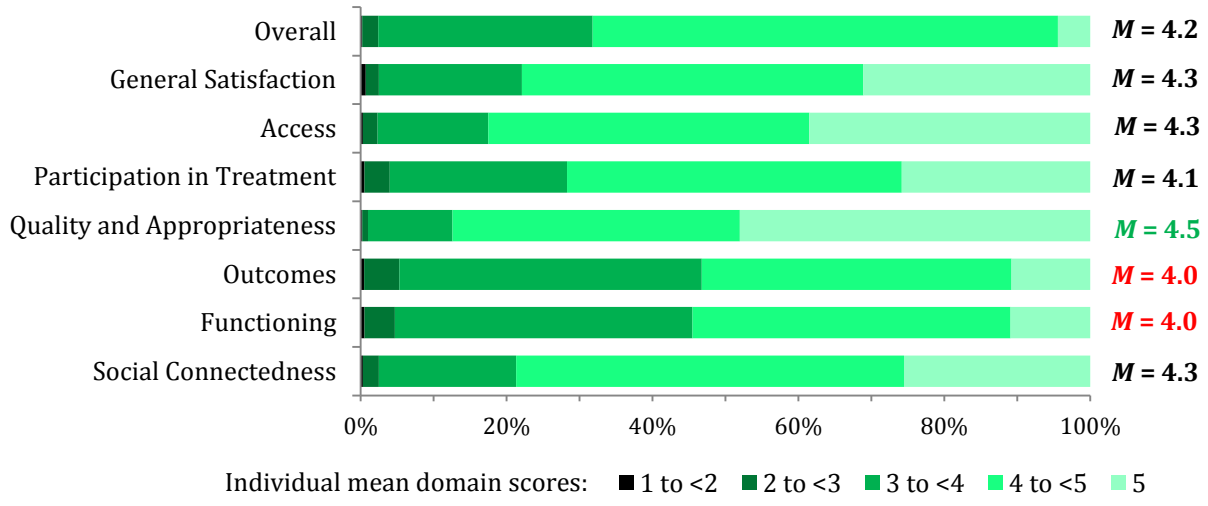
Comparing youth and parents, average domain scores were higher for parents. **The differences in mean scores were statistically significant[7] for all domains except *Outcomes* and *Functioning***. See Figure 21 for average domain scores of youth ages 13-17 and Figure 22 (on page 16) for average domain scores of parents of children and youth ages 17 and under.

[6] One survey instrument – the Parent/Caregiver Survey (for Child/Youth ages 0-17) had one different word in the Likert Scale ("Undecided" instead of "I am Neutral") for the middle option.

[7] Differences in mean scores were statistically significant at the $p<.05$ level using the independent samples *t-test* in SPSS analytical software.

Domain Scores: Youth Ages 13-17[8]

Figure 21: Youth MHSIP Surveys Domain Scores (N=400 to 412)



Green = highest average score. Red = lowest average score.

***General Satisfaction*:** A total of **78%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher for the General Satisfaction domain.

***Access*:** A total of **83%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher for the Access domain.

***Participation in Treatment*:** A total of **72%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

***Quality and Appropriateness*:** A total of **87%** of respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

***Outcomes*:** A total of **53%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

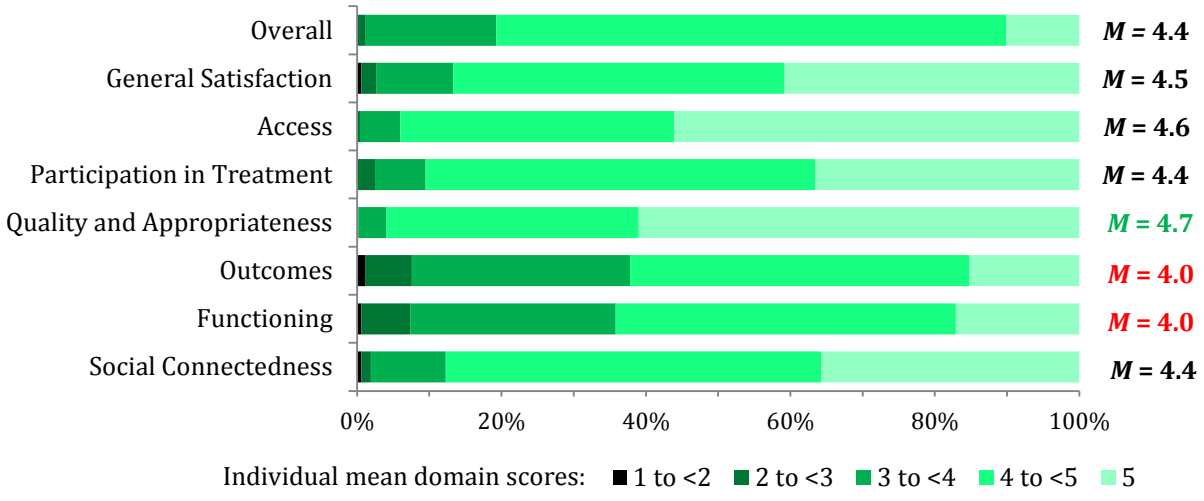
***Functioning*:** A total of **55%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Functioning domain.

***Social Connectedness*:** A total of **79%** of youth respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

[8] Some youth and parents of children/youth ages 18-21 completed surveys that were designed for clients ages 17 and younger. These surveys comprised a small percentage of the total (21 out of 901 or 2%) and are included in the data presented for youth and parents.

Domain Scores: Parents of Children and Youth, Ages 0-17[9]:

Figure 22: Parent MHSIP Surveys Domain Scores (N=470 to 487)



Green = highest average score. Red = lowest average score.

***General Satisfaction*:** A total of **87%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher for the General Satisfaction domain.

***Access*:** A total of **94%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher for the Access domain.

***Participation in Treatment*:** A total of **91%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

***Quality and Appropriateness*:** A total of **96%** of respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

***Outcomes*:** A total of **62%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

***Functioning*:** A total of **64%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Functioning domain.

***Social Connectedness*:** A total of **88%** of parent respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

[9] Some youth and parents of children/youth ages 18-21 completed surveys that were designed for clients ages 17 and younger. These surveys comprised a small percentage of the total (21 out of 901 or 2%) and are included in the data presented for youth and parents.

Comparing Satisfaction Scores: Youth vs. Parent of Children and Youth (Ages 0-17)

Comparing mean domain scores of Youth (ages 13-17) and Parents of Children and Youth (ages 0-17), it is evident that, as a group, parents/caregivers reported higher satisfaction levels than youth. Parents/caregivers had an overall combined satisfaction score of 4.4 compared to the overall combined satisfaction score of 4.2 for youth. Domain satisfaction scores were significantly[10] higher for parents/caregivers compared to youth in all categories except *Outcomes* and *Functioning*. Parents/caregivers scored a high of 4.7 for *Quality & Appropriateness* and a low of 4.0 for *Outcomes and Functioning*, with *Access* [*M*=4.6], *General Satisfaction* [*M*=4.5], *Participation in Treatment* [*M*=4.4] and *Social Connectedness* [*M*=4.4] scores falling in between. Youth satisfaction rankings were similar, but with lower average domain scores compared to parents/caregivers. Specifically, Youth scored a high of 4.5 for *Quality & Appropriateness* and a low of 4.0 for *Outcomes* and *Functioning*, with *General Satisfaction* [*M*=4.3], *Access* [*M*=4.3], *Social Connectedness* [*M*=4.3] and *Participation in Treatment* [*M*=4.1] scores falling in between. The factors associated with higher satisfaction are listed in Table 5 below. The most common factor associated with higher satisfaction for several domains within each group was Spanish speaking, with other factors listed in Table 5 below.

Table 5: Summary MHSIP Domain Scores – Youth vs Parents: Mean Scores and Statistically Significant Factors Associated with Higher Satisfaction

	Youth (N=400-412)		Parents/Caregivers (N=470-487)	
Domain	**Mean Domain Score**	**Reported Factors Associated w/Higher Satisfaction**	**Mean Domain Score**	**Reported Factors Associated w/Higher Satisfaction**
General Satisfaction	**4.3**	Female Gender, Hispanic, Spanish Speaking	**4.5**	Spanish Speaking, Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)
Access	**4.3**	Female Gender	**4.6**	Parents with child 0-12 years old
Participation in Treatment	**4.1**	Female Gender, Spanish Speaking	**4.4**	Parents with child 0-12 years old
Quality & Appropriateness	**4.5**	Female Gender, Hispanic, Spanish Speaking, Length of Service <1yr	**4.7**	Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)
Outcomes	**4.0**	Spanish Speaking, Greater School Attendance (LOS<1yr), Length of Service <1yr	**4.0**	Spanish Speaking, Parents with child 0-12 years old
Functioning	**4.0**	Spanish Speaking, Greater School Attendance (LOS<1yr), Length of Service <1yr	**4.0**	Spanish Speaking, Parents with child 0-12 years old, Greater School Attendance (LOS<1yr)

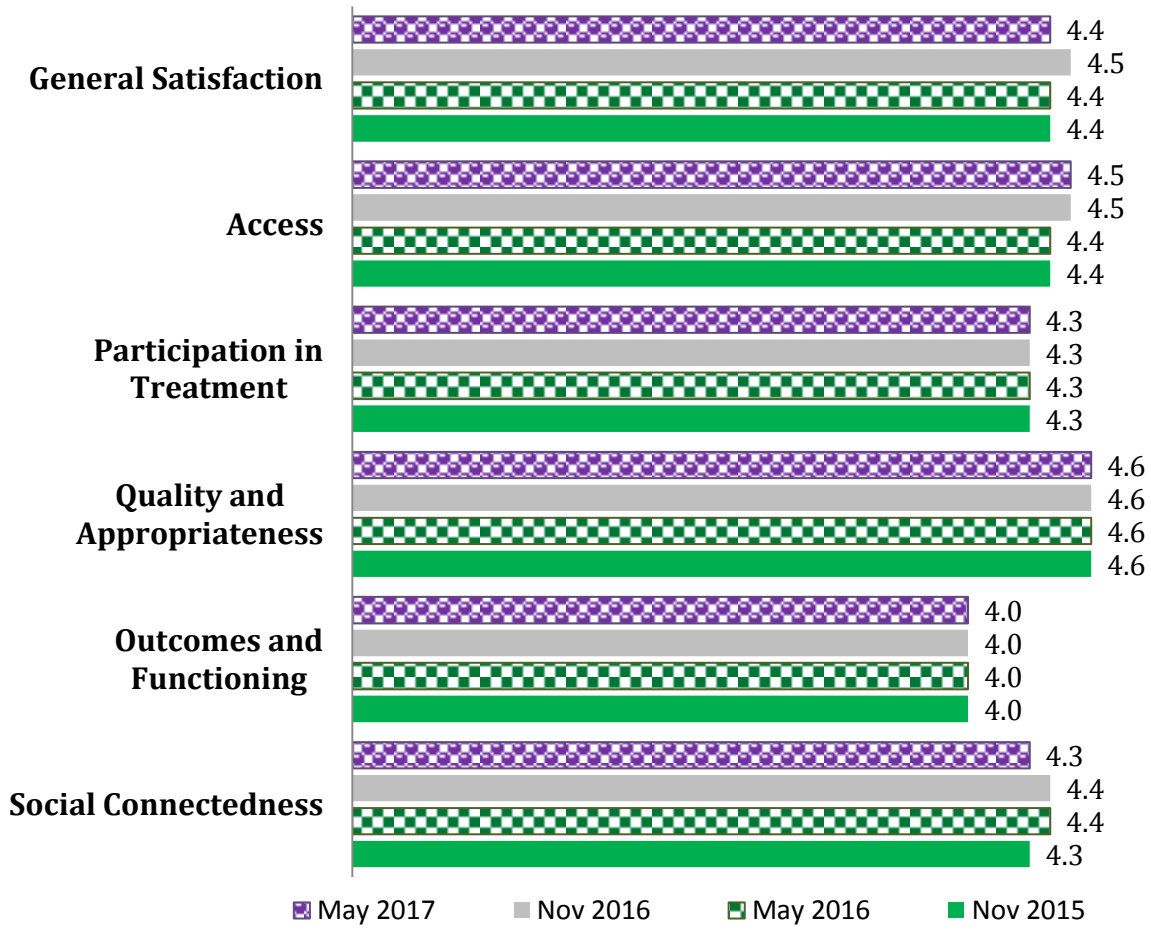
[10] Statistically significant differences in mean scores were established at the level p<.05 using independent sample *t-tests* in SPSS.

Social Connectedness	**4.3**	Length of Service <1yr	**4.4**	Parents with child 0-12 years old, Greater School Attendance

Comparison to Previous Years: Youth/Parent Surveys (Combined)

Average domain scores for youth/parents have remained consistent or improved in the past four years. Figure 23 compares the mean domain scores for Youth and Parent MHSIP surveys administered from November 2015 to May 2017. Sample sizes for combined youth/parent surveys in the past few years ranged from 712 to 901. Average domain scores are almost identical to those of the past two surveys (administered in November 2016 and May 2016); with the exception of a slight decrease in *General Satisfaction* (from 4.5 to 4.4) and *Social Connectedness* (from 4.4 to 4.3).

Figure 23: Youth/Parent MHSIP Mean Domain Scores 2015 to 2017 (N=712 to 901)



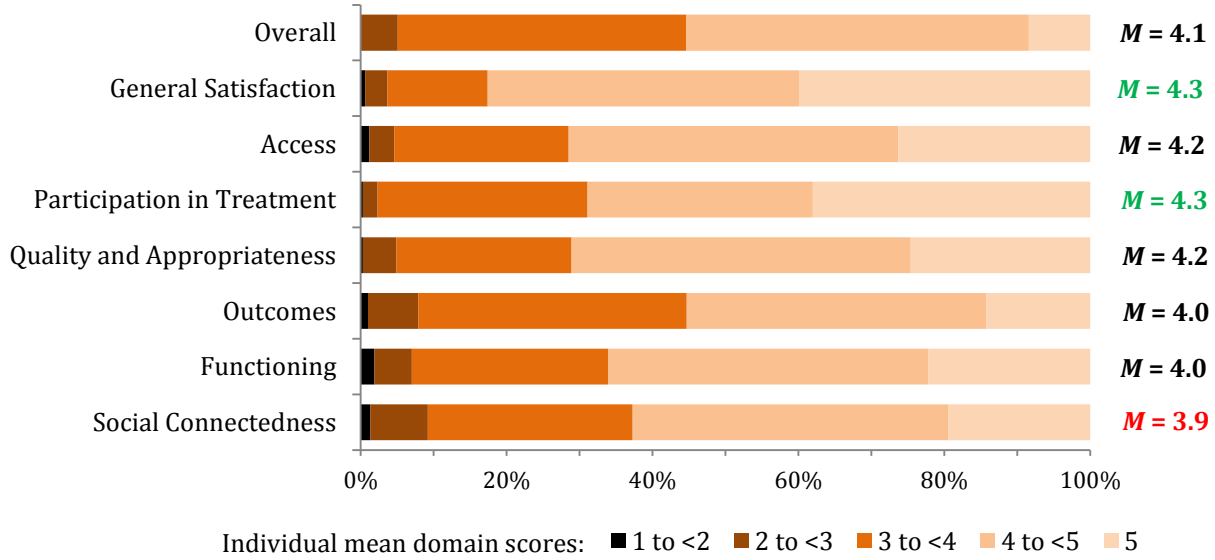
Domain Scores: Adults & Older Adults

Adult respondents (including older adults) were satisfied with services, as demonstrated by the overall average satisfaction rating of 4.1; however, this overall rating is down from 4.3 at the time of last MHSIP administration in November 2016.The highest domain scores for adults were *General Satisfaction* [*M*=4.3] and *Participation in Treatment* [*M*=4.3], while the lowest average domain scores were in *Social Connectedness* [*M*=3.9]. See Table 6 and Figure 24 below.

Table 6: Summary MHSIP Domain Scores – Adult/Older Adults (Combined)

Domain	N	Mean	% 4.0+
Overall	**332**	**4.1**	**60.8%**
General Satisfaction	**328**	**4.3**	**82.6%**
Access	**323**	**4.2**	**71.5%**
Participation in Treatment	**308**	**4.3**	**78.9%**
Quality & Appropriateness	**325**	**4.2**	**71.1%**
Outcomes	**302**	**4.0**	**55.3%**
Functioning	**316**	**4.0**	**66.1%**
Social Connectedness	**314**	**3.9**	**62.7%**

Figure 24: Range of Adult MHSIP Surveys Domain Scores (N=302 to 332)



Green = highest average score. Red = lowest average score.

***General Satisfaction*:** A total of **83%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the General Satisfaction domain.

***Access*:** A total of **72%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Access domain.

***Participation in Treatment*:** A total of **69%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Participation in Treatment domain.

Quality and Appropriateness: A total of **71%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Quality and Appropriateness domain.

Outcomes**:** A total of **55%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Functioning**:** A total of **66%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Outcomes domain.

Social Connectedness**:** A total of **63%** of adult respondents were highly satisfied, with an average rating of 4.0 or higher on the Social Connectedness domain.

Comparing Satisfaction Scores: Adults vs. Older Adults

Comparing mean domain scores of adults (ages 18-59) and older adults (ages 60+), it is evident that, as a group, older adults reported higher satisfaction levels than adults. While both populations had overall combined satisfaction scores of 4.1, domain satisfaction scores were higher for older adults compared to adults in all categories except for *Access* and *Participation in Treatment*. Older adults scored a high of 4.4 for *General Satisfaction*, and a low of 4.0 for *Social Connectedness, with Participation in Treatment* [*M*=4.2], *Quality & Appropriateness* [*M*=4.2], *Access* [*M*=4.1], *Outcomes* [*M*=4.1] and *Functioning* [*M*=4.1] scores falling in between. Adult satisfaction rankings were similar, with slightly lower average domain scores compared to older adults. Specifically, adults scored a high of 4.3 for both *General Satisfaction* and *Participation in Treatment* and a low of 3.9 for both *Outcomes* and *Social Connectedness*; with *Access* [*M*=4.2], *Quality & Appropriateness* [*M*=4.2], and *Functioning* [*M*=4.0] scores falling in between. The most common factor associated with higher satisfaction for several domains within each group was Spanish speaking, with other factors listed in Table 7 below.[11]

Table 7: Summary MHSIP Domain Scores – Adults vs Older Adults: Mean Scores and Statistically Significant Factors Associated with Higher Satisfaction

	Adults (N=256-278)		Older Adults (N=44-54)	
Domain	**Mean Domain Score**	**Reported Factors Associated w/Higher Satisfaction**	**Mean Domain Score**	**Reported Factors Associated w/Higher Satisfaction**
General Satisfaction	**4.3**	Spanish Speaking	**4.4**	No Statistically Significant Factors among those analyzed
Access	**4.2**	Hispanic, Spanish Speaking	**4.1**	No Statistically Significant Factors among those analyzed
Participation in Treatment	**4.3**	Spanish Speaking	**4.2**	No Statistically Significant Factors among those analyzed

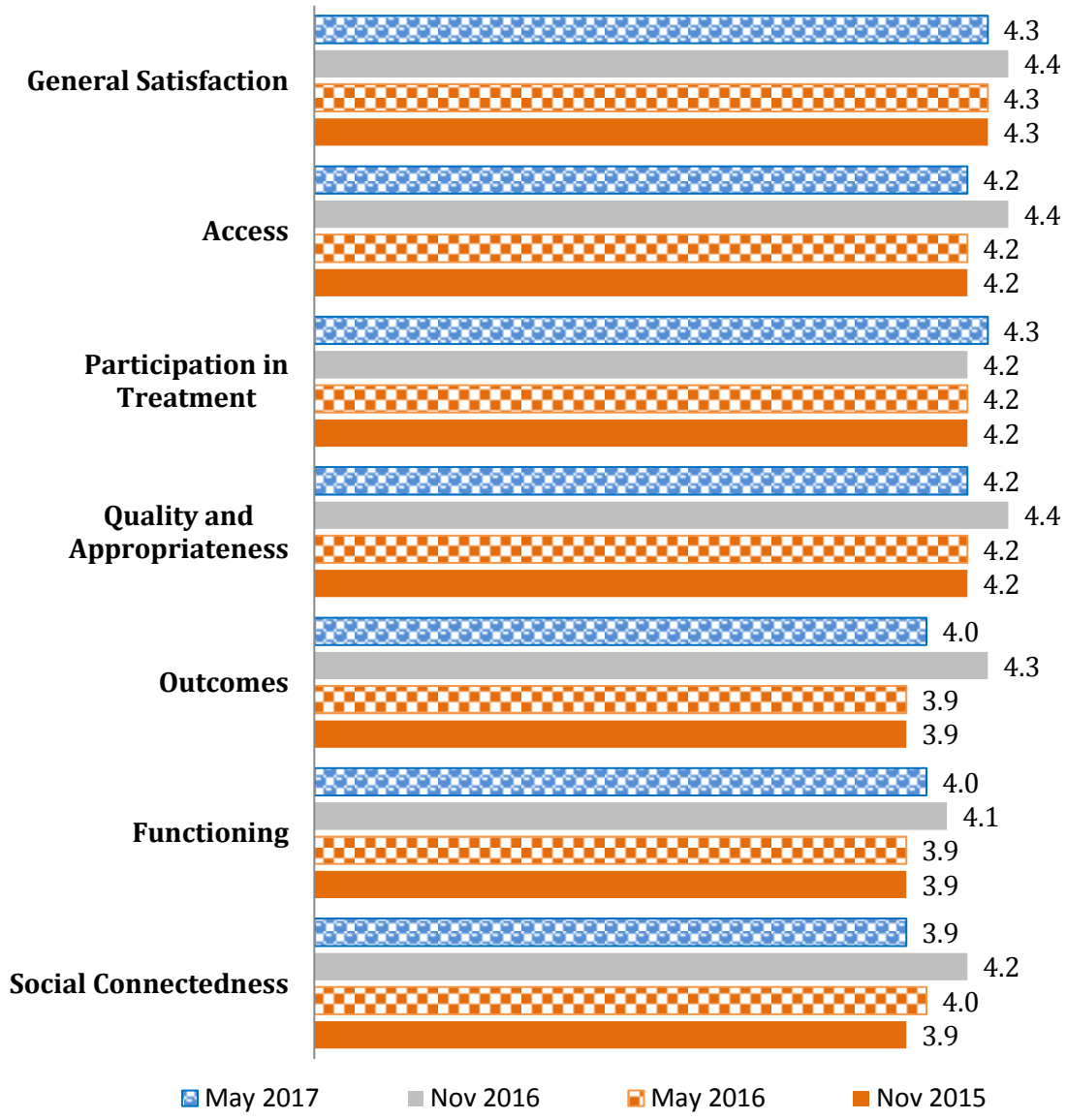
[11] Due to the small size of the Older Adult population (N=54) analyses for statistical significance were based on a limited set of grouping variables (gender and Hispanic ethnicity).

Quality & Appropriateness	**4.2**	Hispanic, Spanish Speaking, Reduced Interactions with Police (LOS<1yr)	**4.2**	No Statistically Significant Factors among those analyzed
Outcomes	**3.9**	Older Adults (compared to 16-25 year olds)	**4.1**	No Statistically Significant Factors among those analyzed
Functioning	**4.0**	Older Adults (compared to 16-25 year olds)	**4.1**	No Statistically Significant Factors among those analyzed
Social Connectedness	**3.9**	Hispanic	**4.0**	Female Gender

Comparison to Previous Years: Adult (including Older Adult) Surveys

Mean domain scores for adults have remained fairly consistent with slight fluctuations in the past few years. Figure 25 on the following page shows the mean domain scores for adult (including older adult) MHSIP surveys administered between November 2015 and May 2017, with survey sample sizes that ranged from 332 to 522. The May 2017 results show increases in the mean composite score for *Participation in Treatment* (4.2 to 4.3), while all other domains show mean composite score decreases ranging from .10 to .30 compared to November 2016 results. The largest declines in mean composite score were in the domains of *Social Connectedness* (3.9 from 4.2) and *Outcomes* (4.0 from 4.3).

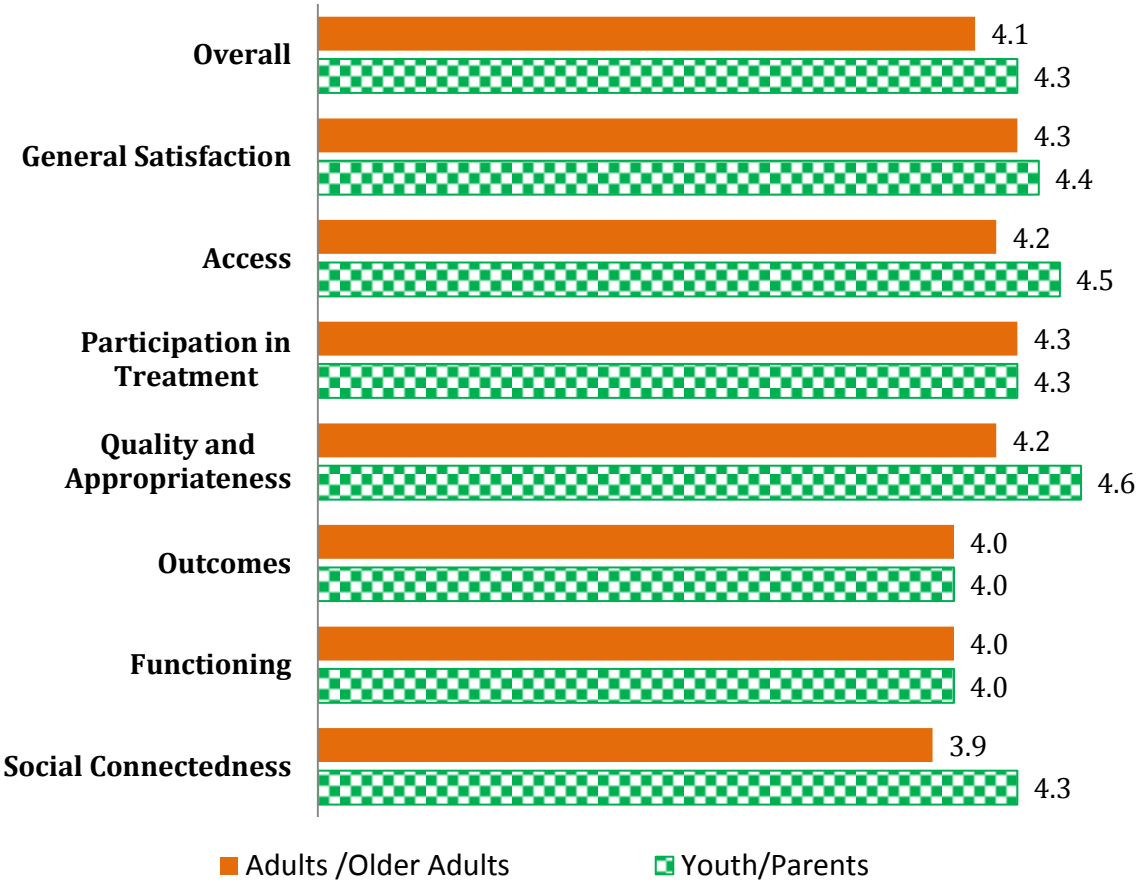
Figure 25: Adult Average MHSIP Surveys Domain Scores 2015 to 2017 (N= 332 to 522)



Comparing Adult and Youth/Parent Domain Scores

In five of the seven domains the average scores for Youth/Parents were higher than those for all Adults. The highest satisfaction category for Youth/Parents was *Quality and Appropriateness* [*M*=4.6] whereas for adults both *General Satisfaction* and *Participation in Treatment* [*M*=4.3] were equally rated. The lowest categories of satisfaction were *Outcomes* and *Functioning* for youth/parents [*M*=4.0] and *Social Connectedness* [*M*=3.9] for adults. See Figure 26 below.

Figure 26: Youth & Adult Mean Domain Scores
MHSIP May 2017 (N= 302 to 899)



Open-Ended Survey Comments

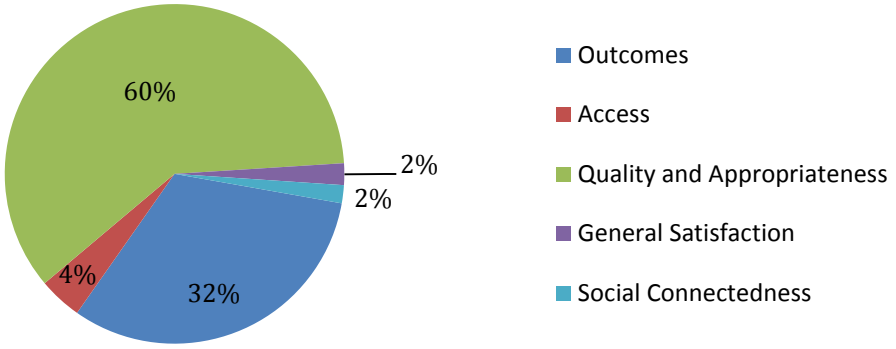
Methodology for Analyzing Comments

Each open-ended response was reviewed and coded according to emerging themes, particularly themes aligned with survey domains.[14] The comments were coded by two different evaluators to increase the reliability and objectivity of the coding. Only valid responses to the open-ended items are included in the results, such that responses that were missing, incomprehensible, or unrelated to the question were considered invalid and thus were excluded from the analysis. Responses that did not seem to pertain to any particular domain were also excluded from this analysis.

Youth

Most helpful: The first open-ended item on the youth survey asked respondents to describe "*What has been the most helpful thing about the services received over the last six months*?" A total of 314 youth respondents completed this open-ended item, of which 291 responses (representing 89% of all surveyed youth) were deemed valid and thematically relevant to the pre-determined domains. The majority (60%) of comments pertained to the domain *Quality and Appropriateness*, while 32% of responses were related to the *Outcome* domain.

Figure 27: Domains for Youth Responses to "Most Helpful" (N=291)



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

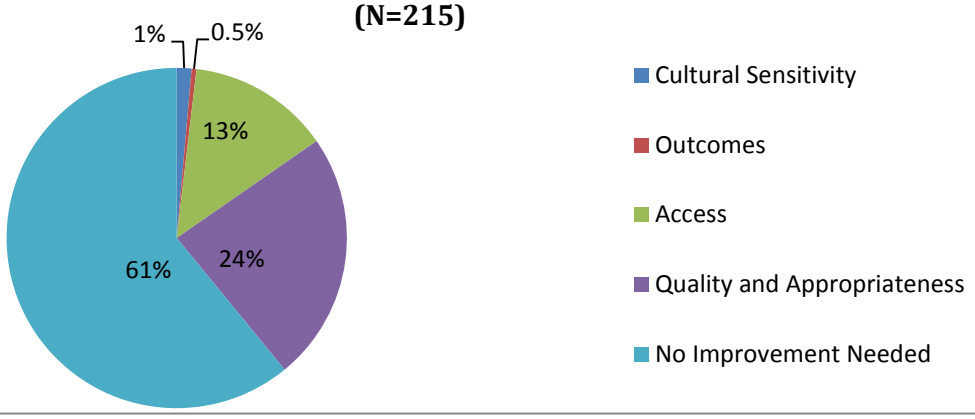
Among the 175 comments related to *Quality and Appropriateness*, 57% of responses mentioned the value of being able to talk and/or have someone to listen. Many youth responded that the most helpful thing about services were being able to "talk to someone without being judged," "being heard," and "having someone who will listen."

Youth also mentioned specific aspects of the services they were receiving, including groups, one-on-one therapy, and some activities such as art and games. Many youth highlighted getting advice and coping skills, such as "breathing techniques," "ways to calm down," and "communication skill building."

[14] Open-Ended responses include the analysis of comments that centered around "Cultural Sensitivity" as a theme; this theme correspondd to the *Quality and Appropriateness* domain outlined in the quantitative analysis section. Additionally, comments identified as relating to the "Functioning" theme have been incorporated into the *Outcomes* domain in this section.

Improving services: The second open-ended item on the youth survey asked *"What would improve services*?" A total of 246 youth respondents completed this open-ended item and 215 responses (representing 66% of all surveyed youth) were deemed relevant to the pre-determined domains. The majority of responses (61%) – which represented 40% of all surveyed youth – indicated that no improvements were needed. A majority of comments fell within the domains of *Quality and Appropriateness* (24%) and/or *Access* (13%).

Figure 28: Domains for Youth Responses to "Improving Services" (N=215)



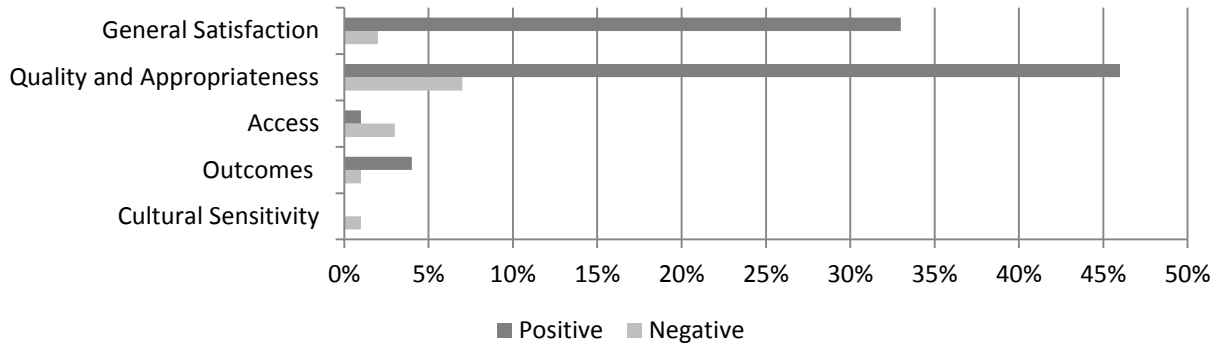
Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

A total of 84 respondents provided comments within the predetermined domains that indicated that improvement was needed. These comments primarily centered around the following themes:

- Activities: About 27% of the comments in coded as pertaining to the topic Quality and Appropriateness related to improved or increased activities. This included specific therapeutic support shuch as more strategies and skills, daily check-ins andrequests for more active activities, games, field trips, etc. One youth wanted "more independent activities" and "help with jobs."
- Staff: About 35% of comments related to staff. Some youth respondents had complaints about the staff or suggestions for staff behavior change ("Staff to stop using bad language" and "better support and less mean staff.") Youth also wanted more sensitivity from staff such as "more understanding comments" and "being left alone more often." A couple youth expressed gratitude or satisfaction with their counselors.
- Other: Several youth wanted amenities such as food, better rooms, relaxing music and less paperwork.

Other feedback: The third open-ended item on the youth survey asked respondents to provide "*both positive and negative feedback*." A total of 97 respondents completed this open-ended item, and 72 of these responses (representing 22% of all surveyed youth) were considered valid and related to the domains. Of these valid responses, 85% contained positive feedback.

Figure 29: Domains for Other Feedback Provided by Youth (N=72)



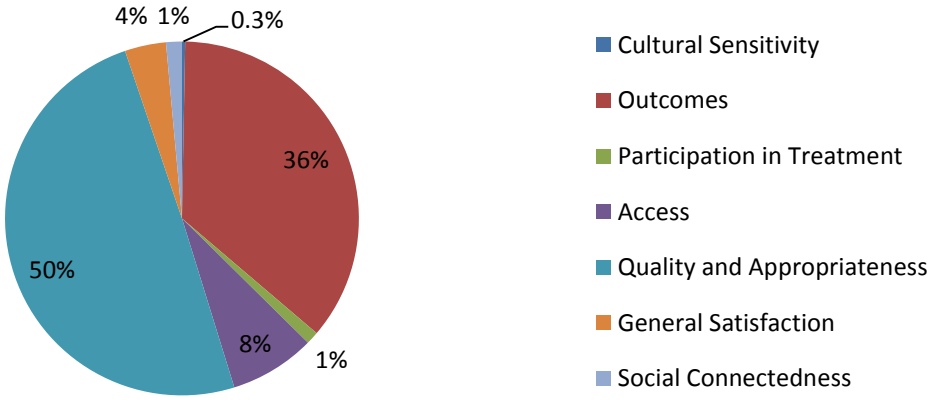
Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

The 61 positive responses were predominantly related to two domains: *General Satisfaction* and *Quality and Appropriateness*. Respondents expressed contentment with the services and people at the clinics, especially service providers. Respondents expressed appreciation for the services and for the positive impact the services had on their lives. In general, comments and themes were similar to the responses to the first two questions.

Parents and Caregivers

Most helpful: Parents and caregivers received a survey with the same open-ended questions as the youth surveys. The first open-ended item on the parent and caregiver survey asked respondents to describe "*What has been the most helpful thing about the services you and your child received over the last six months*?" Of the 368 responses received for this question, 345 responses (comprising 89% of all surveyed parents and caregivers) were deemed valid and relevant to the identified thematic domains. The majority of the responses (50%) were related to the domain *Quality and Appropriateness*, while 36% related to *Outcomes*.

Figure 30: Domains for Parent/Caregiver Responses to "Most Helpful" (N=345)



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

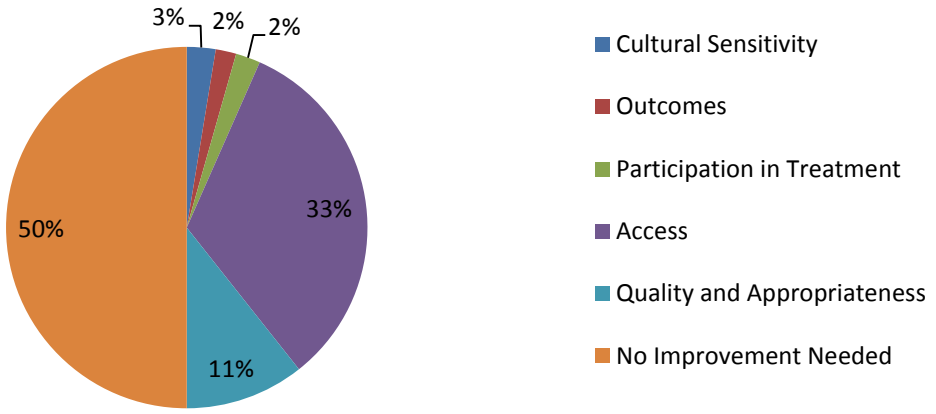
Among the comments related to the domain *Quality and Appropriateness*, respondents were most likely to mention one of two topics: Support and Talking/Listening. Parents/caregivers spoke about

the support that they and their families have received. One wrote, "I like the support that they gave from the first day my service started. They came in being concerned of my child's needs and mine." Respondents praised the ability of staff to communicate well with both youth consumers and their parents/caregivers. One person wrote, "Counselor helped me navigate and open up conversation with my son at home and gave him someone to talk to at school." One wrote that the most helpful thing about services was, "Being able to confide in staff without judgement, having my child feel they're being protected and heard."

Among the 124 comments related to *Outcomes*, parents/caregivers were most likely to speak about improvements in the individual youth's communication, as well as behavioral improvements. One respondent wrote, "That my son now talks with the other people who come to my house and expresses what he feels and talks better with everyone."

Improving Services: The second open-ended item on the parent/caregiver survey asked, *"What would improve the services here?"* Of the 293 parents/caregivers who responded to this question, 272 responses were deemed valid and related to the predetermined domains. Of the valid responses, half (50%) indicated that no improvement was needed. Of the 136 individuals (representing 35% of all surveyed parents/caregivers) who indicated that improvement was needed, most mentioned *Access* (33%) and/or *Quality and Appropriateness* (11%).

Figure 31: Domains for Parent/Caregiver Responses to "Improving Services" (N=272)



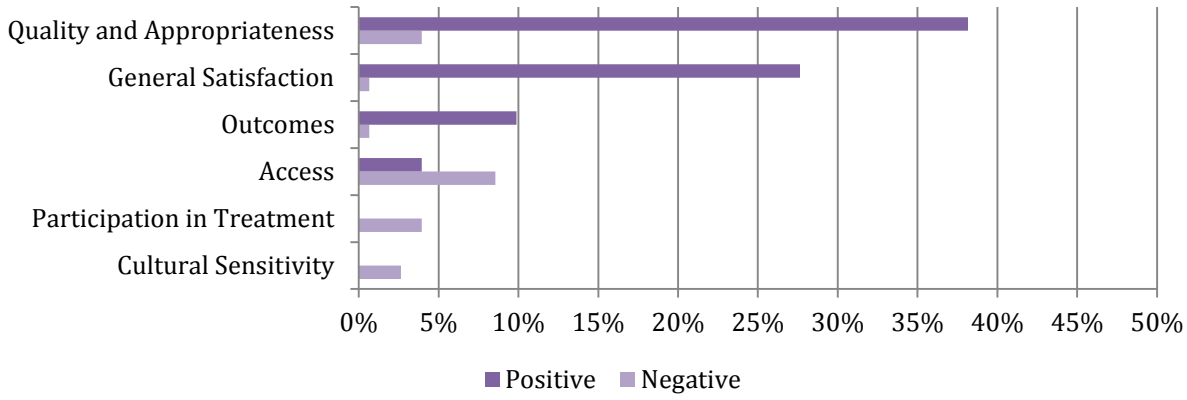
Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

Among the 89 responses that were categorized in the *Access* domain, the most common theme was wanting more frequent sessions and desiring expanded clinic hours (weekends and evenings). One parent/caregiver wrote, "If there were more available days and not only one session per week..." Multiple respondents also mentioned the need for more resources, such as more staff ("More counselors, one is not enough for a student body of 700+"), and for an improved referral system. Other respondents wished for expanded services at school, in the classroom or with the entire family.

Other Feedback: The third open-ended item on the parent/caregiver survey asked respondents to provide "*both positive and negative feedback*." A total of 180 respondents completed this open-ended item, and 152 of these responses (representing 39% of all surveyed parents/caregivers)

were considered valid and related to the domains. Of these valid responses, 80% contained positive feedback.

Figure 32: Domains for Other Feedback Provided by Parents/Caregivers (N=152)



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

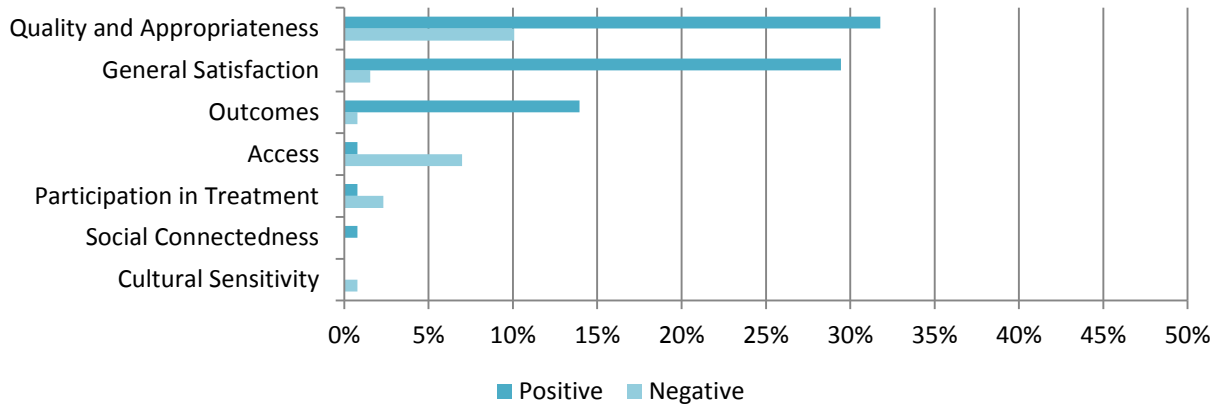
Among the valid comments, 38% were related to the domain *Quality and Appropriateness* (positive). Within this domain, most responses commented on the helpfulness and pleasantness of program staff. One parent/caregiver wrote, "Staff is very friendly, available, ready to listen and offers support whenever needed." The positive comments in categorized in the domain *General Satisfaction* were similar, frequently commenting on their gratitude for services and specific staff members.

The 31 negative comments mentioned desiring extended or additional services. One person wrote, "We feel so attached to our clinician, and it will be difficult to adjust to someone else." Some respondents commented on their need for more consistency in staff and in appointments, as well as the need for better communication from staff about updates.

Adults and Older Adults

The one open-ended item on the adult survey asked respondents to provide "*both positive and negative feedback*." A total of 108 older adult and adult respondents completed this open-ended item. A total of 129 distinct comments (from 88 unique individuals, or 27% of all surveyed adults and older adults) were deemed valid and pertaining to the identified domains. Some individuals contributed more than one comment. The majority of the domain comments were considered positive (78%) while the remainder (22%) were classified as negative. Of the positive comments, most fell into two domains: *Quality and Appropriateness* and *General Satisfaction*. The negative comments were predominantly related to *Quality and Appropriateness* and *Access.*

Figure 33: Themes on Feedback Provided on Adult MHSIP (N=129)



Note. Responses that were missing, incomprehensible, irrelevant, or not pertaining to a domain were excluded.

The negative comments were likely to mention barriers to issues pertaining to service quality and accessing services. Several felt staff needed more training, experience, or cultural sensitivity, with a few stating that they disliked their doctors or thought they were rude. Some talked about staff having communication issues or not being able to access needed services due to scheduling issues, providers turning them away, or lack of response from staff. A couple wanted more services such as grief counseling, support for hearing voices, and food.

The positive responses related to the domain of *General Satisfaction* (30%) generally expressed satisfaction with the services received and gratitude for the programs. The positive responses in *Quality and Appropriateness* (32%) were more specific about the positive aspects of services. Several mentioned specific staff members by name or by roles (therapists, doctors, peer providers, receptionists, etc.) or specific organizations. One older adult consumer wrote, "I like my psychiatrist. He understands me. Explains things very well, i.e. my treatment…the who, what, when, where, why, etc. He's respectful, patient, professional, caring. The first time I saw with him, felt like the biggest weights were lifted off my shoulders within the first 5 minutes. I need the help this facility provides and I'm blessed it's available for those who need it." Comments described the services received as life-changing and even life-saving.

Discussion

MHSIP surveys that were administered for a week during May 2017showed continued high levels of satisfaction with outpatient mental health services at Contra Costa County Behavioral Health Services (CCBHS). As has been the pattern for the past several years, ratings by youth/parents of children were higher than ratings by adults in most domains (except for *Outcomes* and *Functioning*). The highest satisfaction category was *Quality and Appropriateness* for youth and parents [*M*=4.6] followed by *Access* [*M*=4.5] and *General Satisfaction* [*M*=4.4] for youth and parents. The lowest categories of satisfaction were *Outcomes* and *Functioning* for both adults and youth/parents [*M*=4.0]. Due to the large sample sizes more than to big differences in the mean domain scores, most differences in mean composite scores were statistically significant (except for *Outcomes* and *Functioning*).

The relationships between demographic traits/service histories, health status and satisfaction domains were analyzed[15] to answer the following questions:

Is consumer age associated with consumer satisfaction?

Age was significantly associated with mean scores for parents of children/youth in all domains, except for *Outcomes* and *Functioning.* Alternatively for adults, age was not a discernably significant factor between higher satisfaction for older adults (aged 60 and older) versus adults (ages 18-59).

Is consumer gender identity associated with consumer satisfaction?

Gender identity was significantly correlated with higher satisfaction in only a few domains among youth respondents. Female youth had higher satisfaction with *General Satisfaction*, *Access*, *Participation in Treatment*, and *Quality and Appropriateness* compared to male youth.There were no other statistically significant findings related gender among the other surveyed populations (parents/caregivers, adults, or older adults).

Is Mexican/Latino/Hispanic origin associated with consumer satisfaction?

Mexican/Latino/Hispanic origin (here referred to as Hispanic) was significantly correlated with satisfaction scores among youth in two domains – *General Satisfaction* and *Quality and Appropriateness*. Among adults, ethnicity was significantly correlated with *Access*, *Quality and Appropriateness*, and *Social Connectedness*. There were no significant differences in mean satisfaction scores among parents/caregivers who identified as Hispianic compared to those who did not.

Is consumer race associated with consumer satisfaction?

Race was not associated with significant differences in satisfaction for any domains among adults, youth or parents.

[15] Statistically significant differences in mean scores by grouping variables (e.g. demographic or service variables) were tested in these survey populations: youth (ages 13-17), parents/caregivers (of clients ages 0-17), adults/older adults (ages 18+) and adults ages 18-59, and older adults (ages 60+). Statistically significant differences in mean scores were also tested (without associated factors) in youth/parents combined compared to adults/older adults.

Is survey language associated with consumer satisfaction?

In many domains, respondents who completed the MHSIP surveys in Spanish were more satisfied than individuals who completed surveys in English.[16] Among youth, Spanish language respondents had higher levels of satisfaction compared to English language respondents in all domains excluding *Access* and *Social Connectedness*. Among parents, Spanish language speakers had higher mean domain scores in *General Satisfaction*, *Outcomes,* and *Functioning* compared to English speakers. Adult Spanish language respondents also had higher levels of satisfaction compared to English language respondents in *General Satisfaction*, *Access*, *Participation in Treatment*, and *Quality and Appropriateness*.

Is the length of time receiving mental health services associated with consumer satisfaction?

The length of time that respondents had been receiving mental health services was significantly correlated with four domains among youth (ages 13-17): Q*uality and Appropriateness*, *Outcomes*, *Functioning*, and *Social Connectedness*. Youth receiving services for less than one year were more satisfied than youth receiving services for a year or more.

Is a change in school attendance associated with youth consumer satisfaction?

Better school attendance was significantly associated with greater satisfaction among youth and parents of child/youth clients who have been receiving services for less than one year. Specifically, youth who reported higher school attendance since starting mental health services were more satisfied in the following domains: *Outcomes* and *Functioning*. Parents who reported higher school attendance among their children reported higher satisfaction in three domains: *General Satisfaction*, *Quality and Appropriateness*, and *Functioning.*

Additionally, qualitative findings revealed high response rates among youth, significant proportions of positive comments, and some suggestions for improvement related to access and quality of services. The majority (70%) of surveyed youth described services that had been helpful; most of which had to do with quality of services and improved functioning. A total of 20% of surveyed youth had suggestions for improvements that focused mainly on *Quality and Appropriateness* and *Access.* A total of 17% of youth provided additional feedback, the vast majority (85%) of it positive. Response rates among parents/caregivers were also quite high. The majority (71%) of parents/caregivers described services that had been helpful to their children, particularly in the areas of *Quality and Appropriateness* and *Outcomes*. A total of 28% of parents/caregivers had suggestions for improvements, which pertained mainly to *Quality and Appropriateness* and *Access*. Roughly a third (31%) of parents/guardians offered additional feedback, 79% of it positive. In contrast, only about a third (33%) of surveyed adults and older adults completed the open-ended question on the survey. Just over three-quarters of their comments were positive, with most comments relating to *General Satisfaction* and *Quality and Appropriateness*. The negative comments related primarily to *Quality and Appropriateness as well as Access*.

The primary limitation of the surveys is that they only represent the perspectives of active clients who agreed to complete a survey. As a result, input is not included from consumers who:

- Chose not to participate;
- Are active consumers but did not have an appointment during the week the survey was administered;

[16] When comparing this finding to differences related to reported Hispanic ethnicity, one would expect to find more significant differences for Hispanic ethnicity reported above. The discrepancy may be due to a number of respondents in each survey group who did not report race or ethnicity.

- Discontinued services or were unable to access services;
- Are not active clients/successfully completed services.
- Children and their parents both filled out surveys for the same service, thus doublecounting one service experience. In addition, some parents filled out multiple surveys for different children while others only filled out a single survey. Therefore, some families perspectives may have been weighed heavier than others.

Although the MHSIP surveys have some limitations, they provide feedback from a diverse spectrum of mental health consumers regarding satisfaction with services.

Recommendations

The MHSIP survey results from May 2017 provided a wealth of information allowing Contra Costa County Behavioral Health Services to better understand the strengths of its programs and to identify areas for improvement. Overall, the results demonstrate continued high levels of consumer satisfaction. Findings suggest some opportunities for improvement, particularly regarding service quality, access, outcomes/functioning and participation in treatment planning. Recommendations are summarized below:

Survey Administration:

- To achieve a more representative sample with respect to race and ethnicity, promote greater survey participation by Community-Based Organizations that do not have large numbers of Spanish-speaking clients.
- To ensure more support for Spanish speaking survey participants at County clinics, arrange for Spanish-speaking volunteers to assist in the administration of surveys.
- Provide ongoing training to volunteers who administer the surveys regarding the different survey forms and who should fill out which form.

Service Quality and Appropriateness and Access to Services:

- Continue to provide culturally competent services. Higher levels of satisfaction displayed by Hispanic and Spanish-language responders, coupled with high levels of agreement that providers are respectful and supportive of consumer culture, values, etc., indicate that services are perceived as culturally appropriate for Hispanic consumers. At the same time, some Spanish-speaking consumers have expressed the desire for more services in Spanish. This may indicate a need to explore staffing and competencies locally and regionally to ensure the best fit with consumer needs.

Outcomes, Functioning, Participation in Treatment Planning, and Social Connectedness:

- *Outcomes* and *Functioning:* These continue to be the categories with the lowest consumer satisfaction. Implementing more Evidence-based practices in the adult system of care may help to improve these scores. For Participation in Treatment Planning, consider how expectations are set and communicated regarding service access, treatment, and follow-up as well as other factors related to participation in treatment, adherence and support for recovery.
- Further explore opportunities to enhance experiences of social connectedness, mainly among adult consumers.

Involving Consumers, Family Members, Staff and Providers in Using MHSIP Survey Data for Improvements:

- Encourage provider/clinician as well as management participation in reviewing the survey reports and addressing weak areas/opportunities for improvement in their clinical sites. Identify meaningful forums where issues identified in the MHSIP surveys can be shared, action plans or projects developed, and progress celebrated.
- Involve the Office of Consumer Empowerment in exploring ways to involve consumers and family members as volunteers in survey administration but also in sharing results and working on improvement efforts related to the results.

Appendix: Domain Items

Youth and Parent/Caregiver Surveys

General Satisfaction
Overall, I am satisfied with the services I [my child] received.
The people helping me [my child] stuck with me [us] no matter what.
I felt I [my child] had someone to talk to when I [he / she] was troubled.
I received services that [The services my child and / or family received] were right for me [us].
I [My family] got the help I [we] wanted [for my child].
I [My family] got as much help as I [we] needed [for my child].
Access
The location of services was convenient for me [us].
Services were available at times that were convenient for me [us].
Quality & Appropriateness
Staff treated me with respect.
Staff respected my [family's] religious / spiritual beliefs.
Staff spoke with me in a way that I understood.
Staff were sensitive to my cultural / ethnic background.
Participation in Treatment
I helped choose my [child's] services.
I helped to choose my [child's] treatment goals.
I participated in my own [child's] treatment.
Outcomes & Functioning
I am [My child is] better at handling daily life.
I [My child] get along better with family members.
I [My child] get along better with friends and other people.
I am [My child is] doing better in school and / or work.
I am [My child is] better able to cope when things go wrong.
I am satisfied with my family life right now.
I am [My child is] better able to do things I [he or she] want to do.
Social Connectedness
I know people who will listen and understand me when I need to talk.
I have people that I am comfortable talking with abut my [my child's] problem(s).
In a crisis, I would have the support I need from family or friends.
I have people with whom I can do enjoyable things.

Adult and Older Adult Surveys

General Satisfaction
I like the services that I received here.
If I had other choices, I would still get services from this agency.
I would recommend this agency to a friend or family member.
Access
The location of services was convenient (parking, public transportation, distance, etc.).
Staff were willing to see me as often as I felt it was necessary.
Staff returned my calls within 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.
Quality & Appropriateness
Staff here believe that I can 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 were 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 illness.
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).
Participation in Treatment
I felt comfortable asking questions about my treatment and medication.
I, not staff, decided my treatment goals.
Outcomes
I deal more effectively with daily problems.
I am better able to control my life.
I am better able to deal with crisis.
I am getting along better with my family.
I do better in social situations.
I do better in school and / or work.
My housing situation has improved.
My symptoms are not bothering me as much.
Functioning
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 go wrong.
I am better able to do things that I want to do.
Social Connectedness
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.

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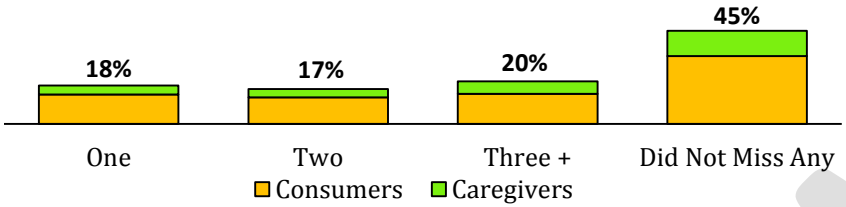
2016 Service Improvement Survey

Individuals receiving services at a County mental health clinic and their caregivers had the opportunity to complete a Service Improvement Survey between November 14 and December 15, 2016. Surveys were available at 6 County-operated clinics during this timeframe. In addition, the survey was available for a limited time at several consumer-centered venues. The purpose of the survey is to inform efforts to improve appointment adherence. There were 448 (421 English, 27 Spanish) consumer and 153 (128 English, 25 Spanish) caregiver surveys submitted resulting in **a total of 601 surveys**.[i]

APPOINTMENT ADHERENCE

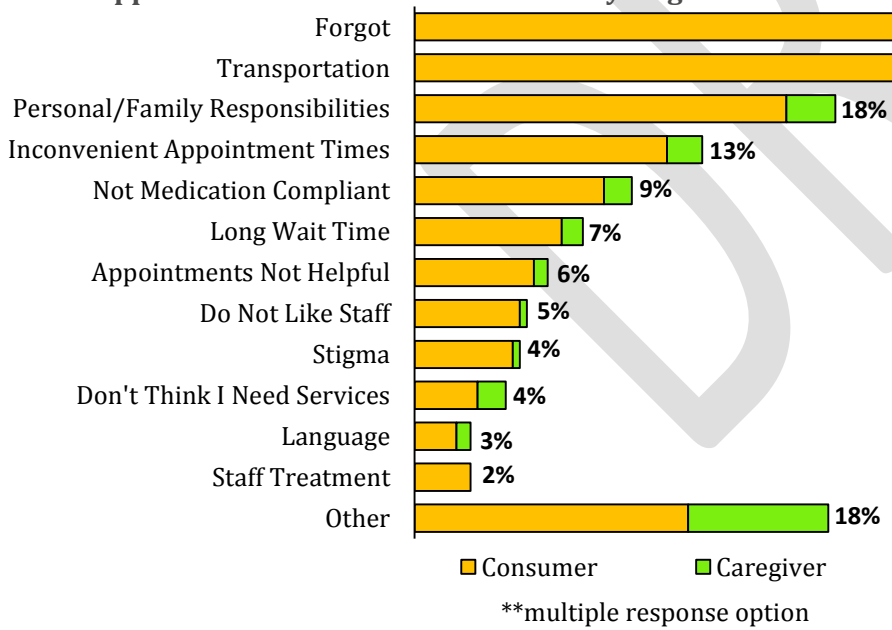
More than half of consumers missed at least one appointment



Appointments Missed (*n*=560)
When asked how many times an appointment was missed at a mental health clinic over the past year, 45% of individuals reported not missing any of their mental health appointments in the past year, 18% missed one appointment, 17% missed two appointments, and **20% missed three or more appointments**. **Adult clinic respondents were more likely than children's clinic respondents to report that they missed an appointment.**

Barriers to Appointment Adherence (*n*=330)
A total of 54% of respondents "forgot I had an appointment." Appointments were also often missed because of a lack of transportation (32%), conflicting personal or family responsibilities (18%), and inconvenient appointment time (13%). Respondents had the option to list other barriers, which 18% of respondents did. These responses included: Illness, conflicting appointments, arrived late, did not want to come, and hospitalized.

Half of appointments are missed because they forgot



**multiple response option

Statistically significant differences in reported barriers included:

- Regionally, **fewer Central County respondents marked transportation as a barrier** to attending appointments compared to other regions.
- **Adult clinic respondents were more likely to report they missed an appointment because they forgot** or were not medication compliant than children's clinic respondents.
- **Consumers were more likely than parents/caregivers to report missing an appointment because of forgetting, transportation**, not medication compliant, inconvenient appointment time, stigma, do not like staff, and personal/family responsibilities.
- **English survey respondents were more likely than Spanish survey respondents to report they missed an appointment because they forgot**, not medication compliant, stigma, do not find appointments helpful, and do not think services are needed.
- **Those who reported missing multiple appointments were more likely to marked transportation**, medication compliance, and language as issues.

Appointment Adherence Support (*n*=222)

Asked what can be done differently to help individuals attend their appointments, responses included:

- Phone Reminder, including multiple phone reminders and a reminder one day before appointment
- Text Reminder
- Email Reminder
- Reminders in General
- Transportation Support
- Provide Bus Tickets/Fare
- Improve Rapport with Consumers
- Greater Appointment Availability
- Better Scheduling System
- Improve Wait Time
- Decrease Lobby Wait
- Have More Types of Services

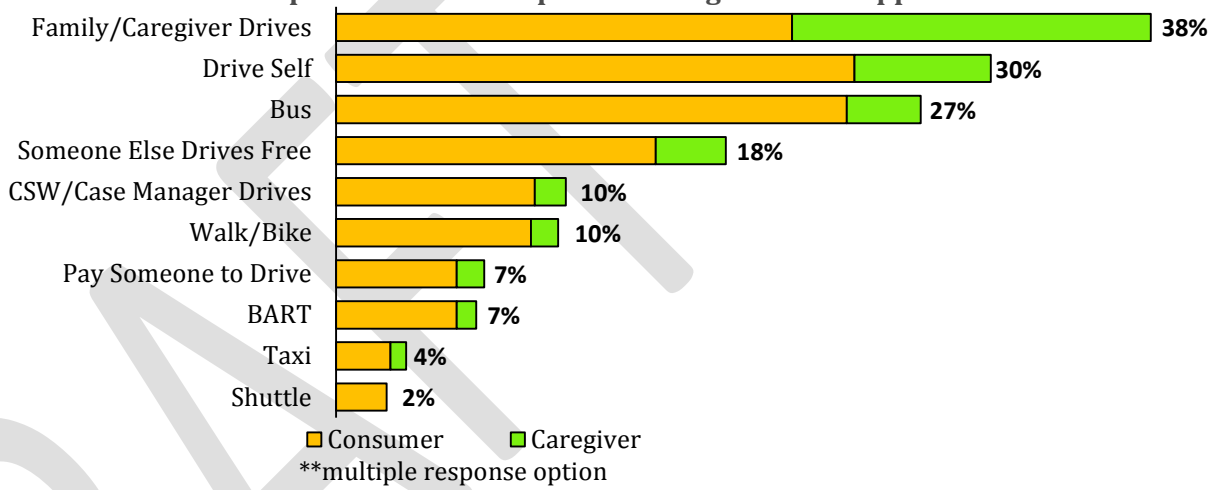
Transportation Modes (*n*=577)

When asked how consumers get to their mental health appointments, the most common modes were: **family/caregiver drives (38%), consumers drive themselves (30%), and use bus (27%)**. More than one-fifth (22%) of consumers rely on multiple modes of transportation to make it to their appointments.

There were several statistically significant group differences found.

- Compared to other regions, fewer respondents from West County reported that family/ caregivers drive or someone was paid to drive them to appointments. **Fewer East County respondents reported that staff transport them**.
- Caregivers were more likely to report that a family/ caregiver drives consumers to appointments, while consumers were more likely to report that someone drives them for free, they walk, and take the shuttle or bus.
- **Adult clinic respondents were more likely to use the bus to get to their appointments**, while children's clinic respondents were more likely to have family/caregivers drive consumers to appointments.
- English survey respondents were more likely than Spanish survey respondents to report a staff member drives them, someone else drives them for free, they walk/bike, or use BART or bus to get to appointments. Spanish survey respondents were more likely to drive themselves to appointments.

Individuals use multiple modes of transportation to get to their appointments

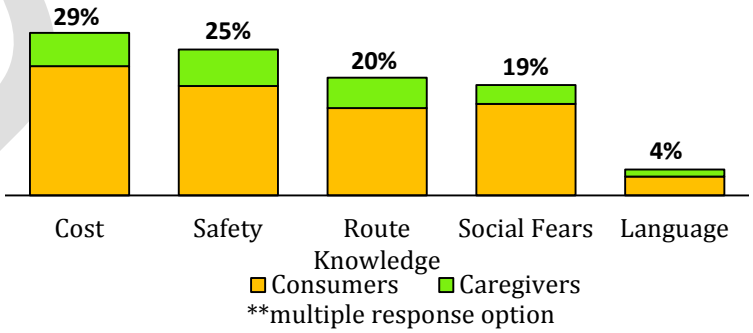


**multiple response option

Public Transportation Concerns (*n*=547)

In an effort to support greater transportation independence, the survey asked about concerns using public transportation. **Cost (29%), safety (25%), lack of knowledge on routes (20%), and social fears (19%) are each experienced by approximately one in five consumers.** A quarter each of respondents said they have no concerns or they do not use public transportation.

Individuals have several concerns about using public transportation



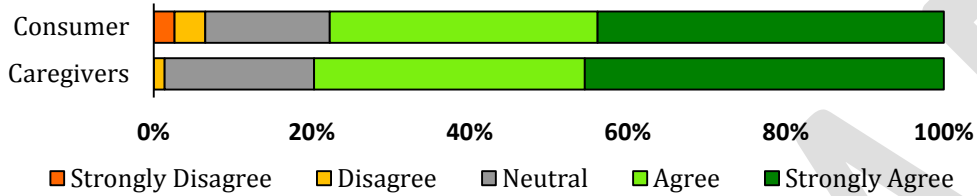
**multiple response option

Group differences in public transportation concerns:

- Consumers were more likely than caregivers to report social fears as a concern, while caregivers were more likely to report not using public transportation.
- **Adult clinic respondents were more likely than children's clinic respondents to report that cost is a concern** to using public transportation. Children's clinic respondents were more likely to report not using public transportation
- English survey respondents were more likely to report that cost, safety, and social fears are concerns than were Spanish survey respondents.

COMMUNICATION

Satisfaction with information and materials provided explaining the mental health systems and services was high



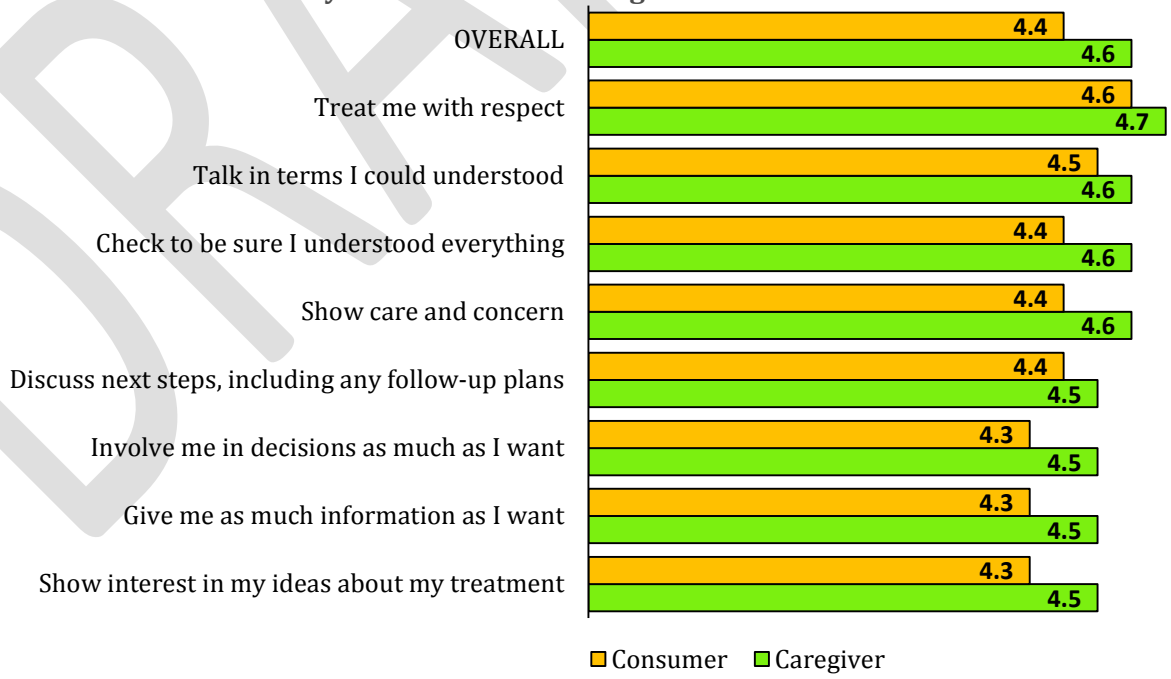
Satisfaction with Information and Materials (*n*=556)
When asked about satisfaction with information and materials provided, 78% of consumers and 80% of caregivers reported satisfaction.

Communication with Staff
On a 5-point scale from *1-Strongly Disagree* to *5-Strongly Agree*, individuals were asked to provide feedback on their communication with different staff roles. Overall, respondents were highly satisfied across staff roles.

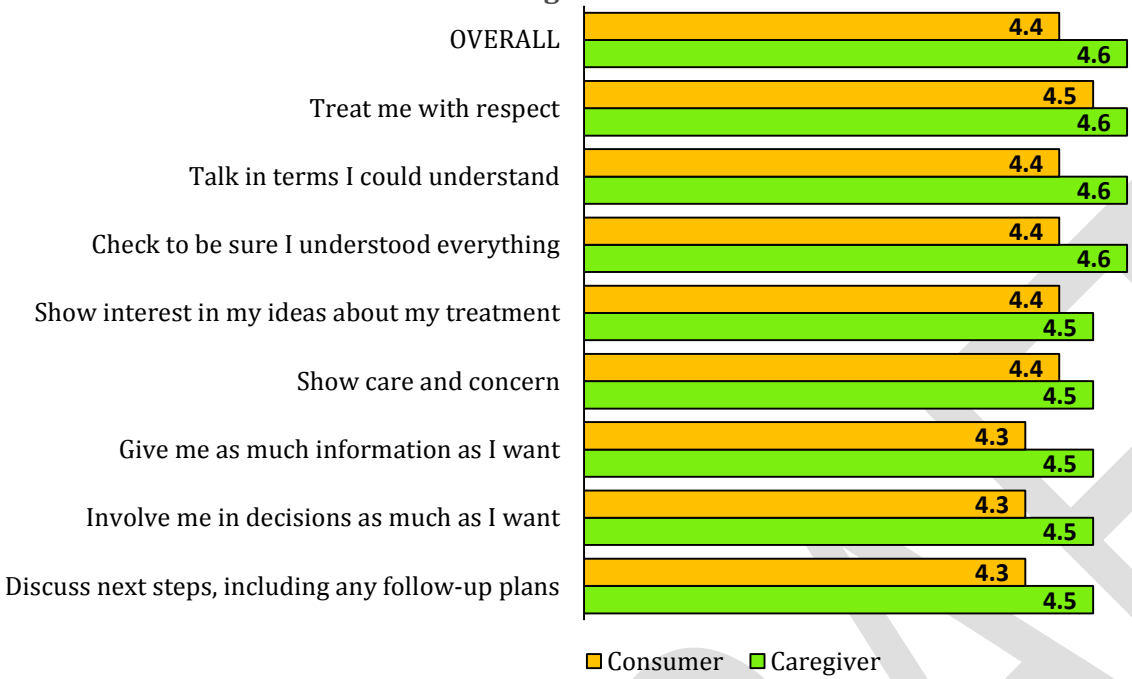
As for group differences:

- Compared to caregivers, **consumers were less satisfied with communication with psychiatrists and nurses.**
- Spanish survey respondents, overall, were more satisfied with communication than English survey respondents.

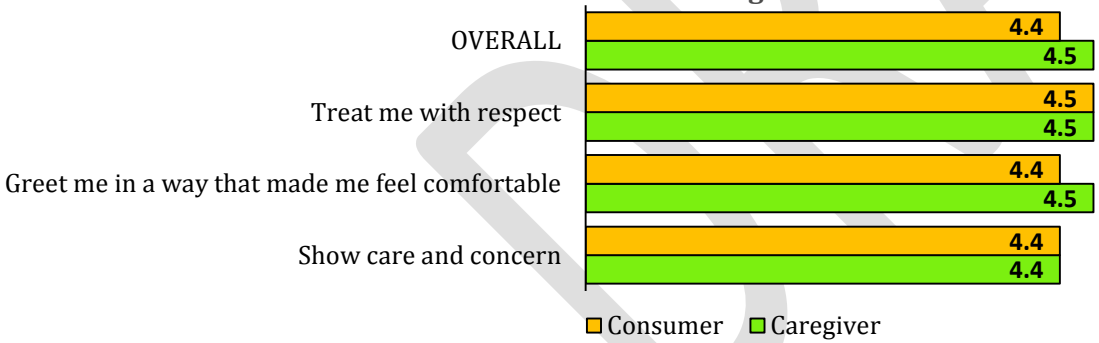
Communication with Psychiatrists: Mean ratings



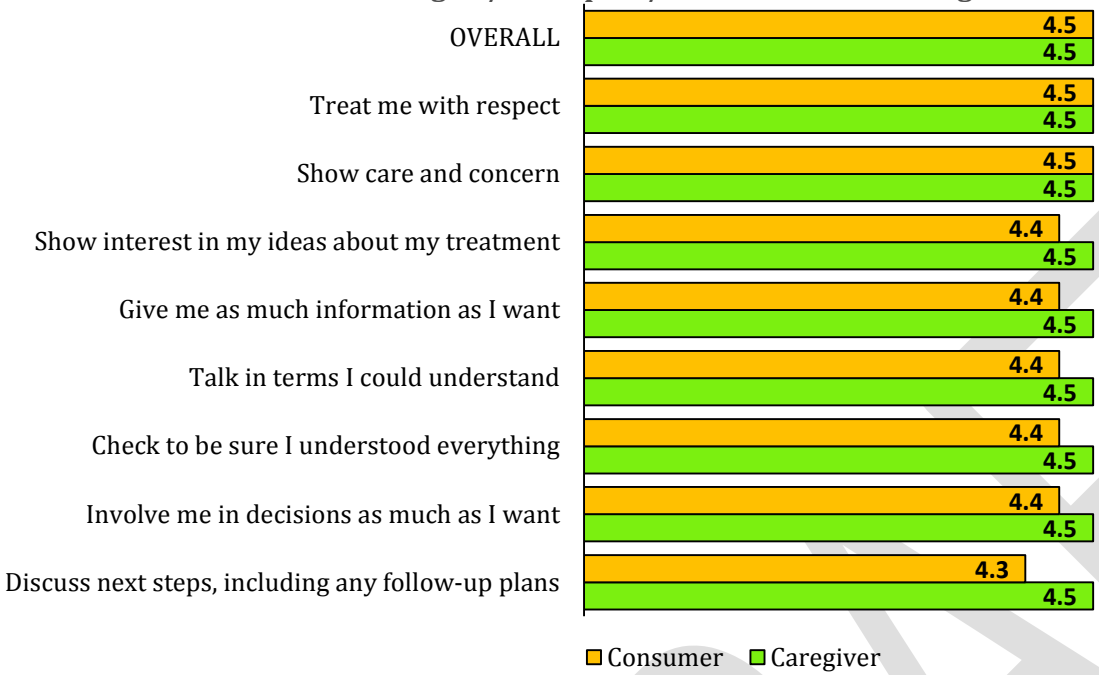
Communication with Nurses: Mean ratings



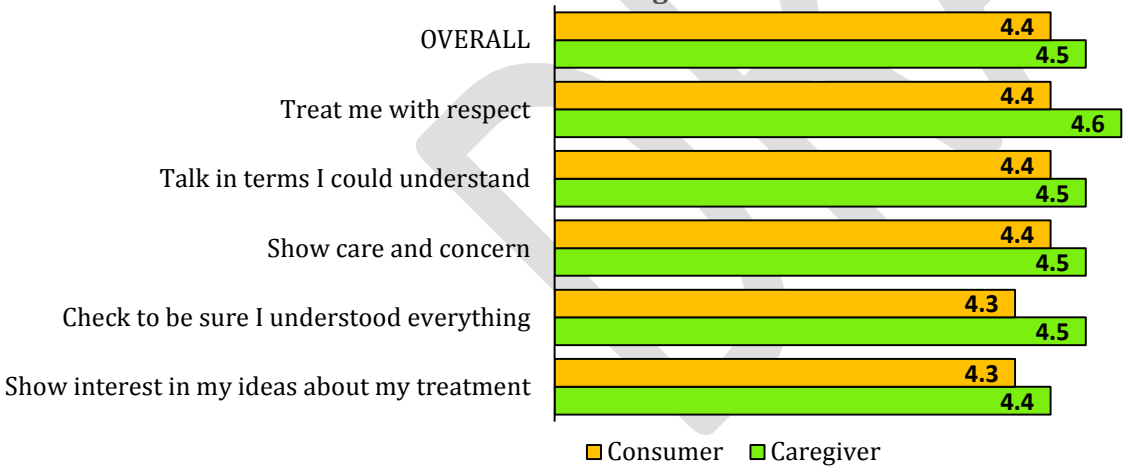
Communication with Clerks and Front Desk: Mean ratings



Communication with Case Managers/Therapists/Clinicians: Mean ratings



Communication with Peer Providers: Mean ratings

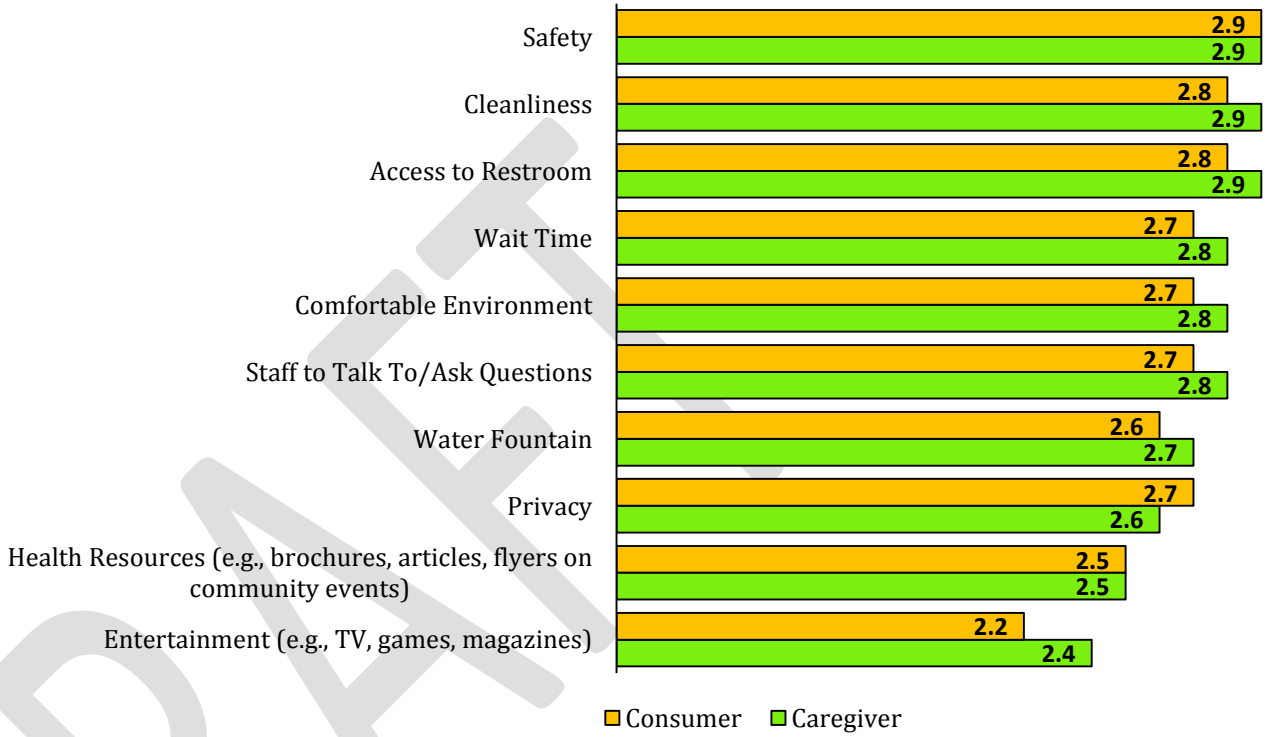


WAITING ROOM ENVIRONMENT

On a 3-point scale from *1-Not Important* to *3-Very Important*, individuals were asked how important different waiting room features were to them. Respondents valued most of the listed features, with safety being the most important.

Statistically significant differences included:

- Compared to other regions, respondents from **West County rated privacy higher and having entertainment available lower**. Those from **East County rated higher a comfortable waiting room and having staff available** to communicate with them.
- Compared to consumers, caregivers rated higher entertainment, staff available to communicate with, safety, and cleanliness.
- **Spanish survey respondents rated privacy and entertainment higher** than English survey respondents.



RECOMMENDATIONS[ii]

- **Appointment Adherence**: Ensure that we have the correct phone numbers of consumers so that appointment calls are useful; inquire if text or email reminders are feasible; follow up with individuals who chronically miss appointments to investigate support needed to attend appointments; and pilot a transportation education program.
- **Communication**: Survey consumers and their family on experiences with institutional stigma to follow up on separate focus group findings.
- **Waiting Room Environment**: Ensure they are well maintained through regular painting and carpet replacement; consider designating a peer provider to the waiting room to interact with individuals; ensure information resources are in the lobby and assign staff to monitor; and investigate how the television can be used to provide health education.

[i] The consumer survey was offered to consumers 13 years and older; the caregiver survey was offered to caregivers of youth and adult consumers. A greater number of caregiver surveys were submitted from Central County clinics and fewer Spanish language surveys were submitted from the West County clinics compared to other regions.

[ii] The survey ended with a space for other comments or suggestions. Most individuals left this blank or expressed thankfulness for services with some requesting specific resources such as housing or transportation support.

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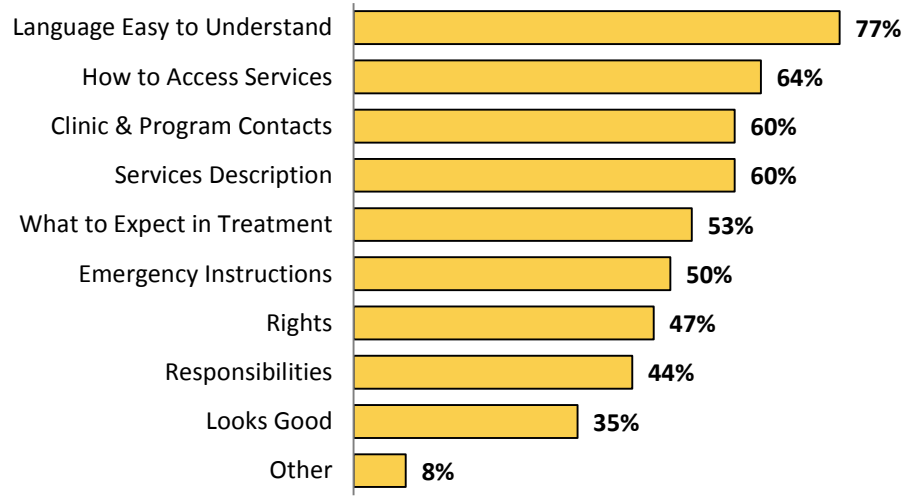
2017 Service Improvement Survey

Individuals receiving services at County-operated mental health clinics and programs and their caregivers had the opportunity to complete a Service Improvement Survey between May 15 and May 19, 2017. The purpose of the survey is to inform efforts to improve consumer experience through ensuring welcoming environments at the clinics. There were 290 (266 English, 24 Spanish) surveys submitted.

WELCOME HANDBOOK

Easy to Understand Language is Important in a Welcome Handbook



Contra Costa Behavioral Health Services is currently piloting a Welcome Handbook. Consumers were asked to identify what was important to them in a Welcome Handbook. The majority of respondents indicated they want easy to understand language, information on how to access services, contact information for clinics and programs, and a description of services. Half of consumers felt information on what to expect in treatment and instructions on what to do in an emergency was important to include.

18 respondents commented on additional things that would be helpful in a Welcome Handbook. Responses included information on: staff directory, collecting Social Security Disability, programs to prevent hospital visits, stigma reduction and peer run services, and procedures for filing complaints.

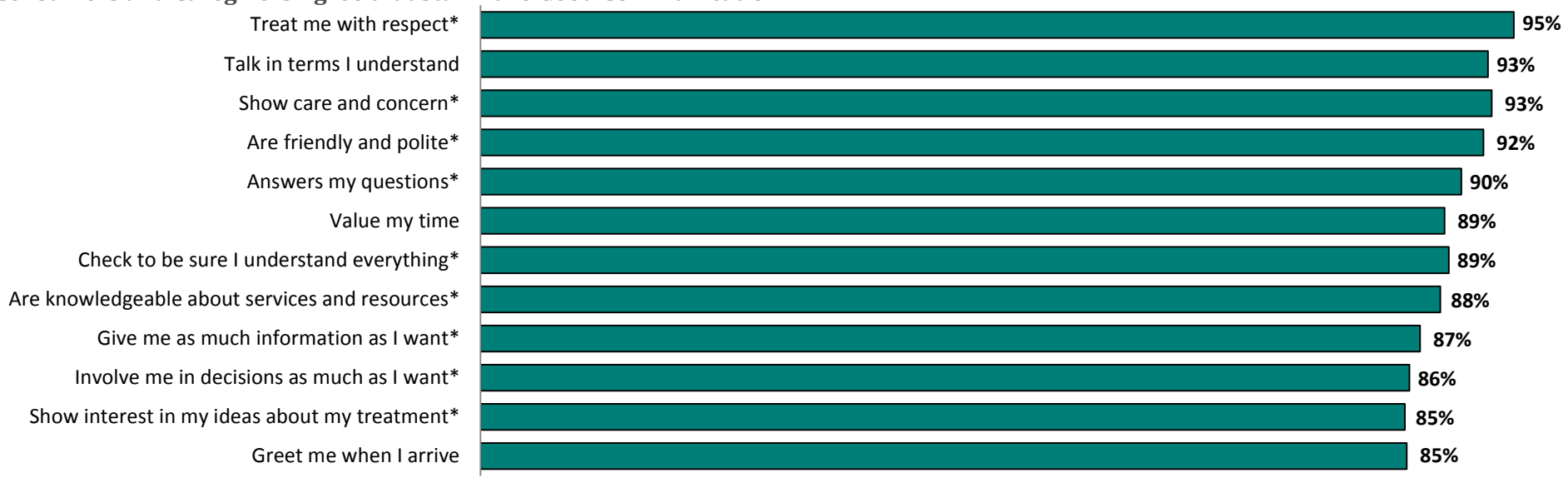
PERCEPTIONS OF STAFF

On a 5-point scale from *Strongly Disagree* to *Strongly Agree*, respondents were asked to rate their agreement with various statements about staff at their mental health clinic (see graph on following page). Overall, staff were rated highly, indicating consumer and caregiver satisfaction with communication**.** In particular, over 90% of consumers and caregivers agree that staff treat them with respect, talk in terms they understand, show care and concern, and are friendly and polite. On the other hand, consumers and caregivers had slightly lower agreement on items related to consumer-driven care.

Respondents who disagreed were asked for an explanation. Several respondents noted that they have never been greeted upon arrival, and staff sit "behind a glass window", are not at the desk, or are rude. Others talked about staff running late, rescheduling or cancelling appointments. A couple stated their providers do not respect their desires for treatment.

There were some statistically significant regional differences. Specifically, West and Central County staff, compared to East County staff, were rated higher on 9 of 12 items (see * items on graph).

Consumers and Caregivers Agree that Staff Have Good Communication



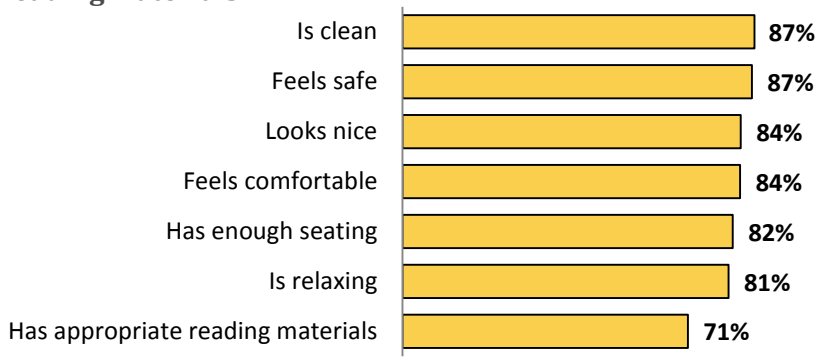
WAITING ROOM ENVIRONMENT

Consumers and caregivers were asked to rate the extent to which they agreed with various statements about their clinic's waiting room. The lowest rated item concerned reading material with 71% agreeing that their waiting room has appropriate reading materials. Waiting rooms were rated positively overall with 87% of consumers reporting that they feel safe in the waiting room and that the room is clean. Note that approximately 1 in 10 respondents do not feel safe and are not comfortable in the waiting room.

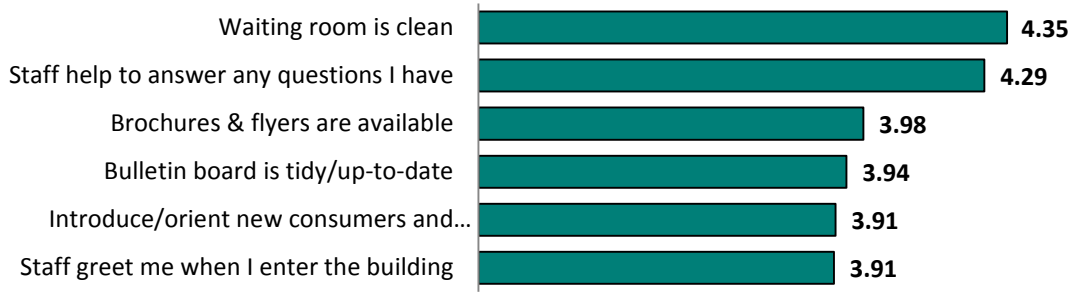
Statistically significant group differences included:

- Children's clinics were rated slightly higher in looking nice and having appropriate reading materials and enough seating than adult clinics.
- East and West County respondents were more likely to feel safe and relaxed in waiting rooms than Central County respondents.
- East County clinic waiting rooms were rated higher in looking nice compared to other regions.
- Central County clinic waiting rooms were least likely to be reported as having enough seating and appropriate reading materials.

Waiting Rooms Are Generally Clean and Safe But Could Improve on Reading Materials



Cleanliness and Staff Answering Questions are Essential to Have in Waiting Rooms



On a 5-point scale from *1=Not Important* to *5=Absolutely Essential*, individuals were asked how important different waiting room and clinic features were to them. Respondents valued most of the listed features, with cleanliness of the waiting room and having staff available to answer questions being the most important.

Statistically significant group differences included:

- Children's clinic respondents rated waiting room cleanliness as more important than those at the adult clinics.
- Central County clinic respondents were least likely to rate staff greeting them as an important feature.

The survey concluded by asking how else we could improve the waiting room experience. Responses discussed:

- More seating and space
- More comfortable seating
- Better lighting
- Happy decorations
- Tidiness
- Low volume music
- More reading materials such as magazines, guides on mental illness, health brochures, and information on community resources
- Snacks or beverages such as water
- Television or different television entertainment including G-rated movies, Recovery TV, and other shows besides cartoons
- Shorter wait times
- Better treatment from doctors and front desk staff

RECOMMENDATIONS

- **Welcome Handbook**: Pilot Welcome Handbook and during revision ensure Welcome Handbook has language that is accessible (e.g., at a 6th grade reading level) and provides sufficient information on services, how to access services, and current contact information for programs and clinics.
- **Staff**: Attend to clinic scheduling issues to better value consumers' time. Consider trainings to address how to involve consumers in decision-making and seek their feedback and ideas about treatment.
- **Waiting Room Environment**: Identify, develop, and stock appropriate reading materials (e.g., up to date flyers, health booklets, information on mental illness) in clinics and ensure there is sufficient seating and clean spaces (e.g., clean carpets). Have staff visible and accessible to answer questions and make sure waiting rooms are clean. Develop procedures on television use and appropriate content, such as identifying an menu of content and investigate the feasibility of using similar content used at the Regional Medical Center.

2016 Consumer and Family Member Focus Groups Summary

Background

Consumer and family member/caregiver satisfaction is an important factor when considering the quality of our mental health services. There are two main ways that Contra Costa Behavioral Health assesses satisfaction. Twice a year for a one week period, consumers and parents/caregivers of youth consumers receiving services at an outpatient mental health clinic are given the opportunity to complete a consumer perception survey of closed-ended and open-ended questions that collects demographic information, service history, and consumer satisfaction across several domains. Another means to gather satisfaction data is through focus groups. A focus group is a facilitated group discussion that allows for in-depth input on a select number of issues. In 2016, a focus group was held at each of 7 County-operated clinics. At our 4 Adult or Older Adult clinics, the focus groups were conducted with consumer participants. At our 3 Children's clinics, focus groups were held with parents and caregivers of consumers. Two focus groups were conducted in Spanish, one each at an Adult and Children's clinic. In addition, one of the Adult clinic focus groups was held specifically for transition aged youth (TAY) consumers ages 18-25.

Methodology

Facilitator Guide Development

To develop the Facilitator Guide, the Research and Evaluation Team began by reviewing the domain findings from recent consumer perception surveys and considered current quality improvement efforts. A list of potential questions was compiled and presented to the Quality Management Committee. The questions were narrowed down and reviewed by the Children's Chief and Adult and Children's Family Services Coordinators before being vetted again by the Quality Management Committee. The Guide is comprised of the following sections:

- Welcoming Participants
- Getting Consent
- Introductions
- Questions
- Closing and Distribution of Incentives

About the Participants

Adult consumer participants (n = 27) ranged in age from 20 to 76 years old (*mean* = 43 years old). The majority of adult participants was female (59%) and was White (52%) or Hispanic (37%). Youth (n = 24) of parent/caregiver participants (n = 21) ranged in age from 8 to 19 years old (*mean* = 13 years old). The majority of youth was male (58%) and was White (45%) or Hispanic (25%).

Themes

Question 1: What is Contra Costa Mental Health currently doing to help you [your family] achieve your goals and make progress?

Common Themes[1]

- In General Received Needed Services
- Individual Therapy / Counseling
- Peer Provider Support
- Quality Staff

Question 2: What else can Contra Costa Mental Health do to help you achieve your [their] goals and make progress?

Common Themes

- More Social Activities / Groups
- Provide Education on Medications
- Educate on How to Advocate
- Transportation Support
- Educate Other Agencies on Mental Health
- More Case Management / Therapy

Question 3: How can we better communicate services and programs offered by the mental health system?

Common Themes

Note that at all focus groups, participants shared information on resources with each other. It was also noted that participants tended to hear about services through word of mouth.

- Provide Written Materials on Services
- Staff Provide Information on Services

[1] Common Themes are themes that emerged in at least 4 or the 7 focus groups.

Question 4: What has the Contra Costa staff done to show you that they are aware and sensitive to you and your [child's] background? Are you included in decisions?

Common Theme

- See Them as a Person, Not Just a Case

Question 5: What have [has] you [your family] done to better connect to your [their] families or community?

Common Themes

- Family Is Supportive
- Need Family / Relationship Counseling

Recommendations

The focus groups are intended to lead to improvements in the services that individuals receive. Based on the results of the focus groups, it is recommended that the following areas be addressed.

- Welcoming Environments
  - Pilot Welcoming Packet materials
  - Ensure that informational materials like brochures on diagnoses are available in waiting rooms
- Overcoming Transportation Barriers
  - Compile transportation resources
  - Assess consumer readiness to use public transit and set up necessary supports for use
- Groups
  - Communicate groups to both staff and consumers (e.g., consider distributing monthly calendar)
  - Attain consumer and caregiver feedback on what group topics they are interested in
- Staff Training
  - Mandatory orientation for all staff emphasizing division structure and trauma-informed care
  - Consider trainings on active listening techniques, non-judgmental language, rapport building, and available resources for consumers
- County and Community Education
  - Coordinate with other agencies to educate non-behavioral health staff on mental health issues
  - Attend community events to distribute materials and convey services
  - Convene a Community Communication Workgroup to plan how to raise public awareness of behavioral health and increase community involvement
- Peer Expansion
  - Consider how peers can initiate new consumers to the mental health system
  - Pair consumers / families with peer(s) so they are a part of the treatment team from the start of treatment
- Family Connection
  - Consider modes to educate families on mental health issues such as producing written materials or hosting seminars similar to EES
  - Grow Family Support Workers positions

In closing, individuals are appreciative of services received but are looking for ways to better engage in treatment.

Quality of Care Mission Statement

- **To assist Contra Costa County mental health consumers, family members and the general public in advocating for the highest quality mental health services and supports delivered with dignity and respect.**

Quality of Care Committee 2016 Action Plan goals

I. Continue to advocate for the creation of crisis in-patient and residential facilities for children and adolescents

II. Continue to address gaps in medical, psychiatric, social and cultural services

- Explore and address concerns regarding time allotted for initial psychiatric exam
- Continue to monitor repairs at Crestwood to meet standard of care
- Advocate for a partial hospitalization program (PCP) for the severely mentally ill
- Respond on an ad hoc basis to acute issues brought to the Committee's attention

III. Continue to advocate for specialty mental health services for consumers who have chronic health difficulties, dual diagnosis of developmental disabilities & mental illness, and/or seniors with mental illness

IV. Continue to work with the Criminal Justice Committee to advocate for improvements in the care of inmates who are mentally ill

V. Investigate the deaths of the mentally ill consumers who are living in county homes and shelters

VI. Investigate drug and alcohol programs for mental health consumers, especially for youth (TAY population)

VII. Work with Behavior Health Services (BHS) and Contra Costa Regional Medical Centers (CCRMC) to define information needs and implement regular and adhoc reports that will answer questions regarding consumer usage and treatment, services, costs and other areas of concern and due diligence

Quality of Care Committee
Mental Health Commission
2017 Goals / Action Plan

I. Continue to address gaps in medical, psychiatric, social and cultural services

- Respond on an ad hoc basis to issues brought to the Committee's attention

II. Continue to advocate for the creation of crisis in-patient and residential facilities for children and adolescents

III. Continue to monitor quality of care issues at Psychiatric Emergency Services (PES)

IV. Research specialty mental health services for consumers who have chronic health difficulties and/or dual diagnosis of developmental disabilities and mental illness

V. Continue to work with the Criminal Justice Committee and full Commission to advocate for improvements in the care of inmates who are mentally ill

VI. Update the full Commission on key findings from the EQRO annual report and support quality of care-related challenges and opportunities for Behavioral Health Services as identified through the EQRO process

VII. Evaluate consumer rights and advocacy programs for gaps in the system