

THE DELAWARE DSAMH CONSUMER/CLIENT SATISFACTION SURVEY

FY 2001-2002



DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE
AND
MENTAL HEALTH

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EXECUTIVE SUMMARY

This report summarizes the findings from a statewide satisfaction survey of 1,286 consumers and clients of the Delaware Division of Substance Abuse and Mental Health (DSAMH) which was conducted between July, 2001 and March, 2002.

Overall, consumers are highly satisfied with services they receive through treatment programs funded by DSAMH as measured by the four MHSIP indicators of consumer perception of treatment quality:

- Nearly three-quarters of consumers are satisfied with the timeliness and convenience of access to services (73.1%) and the quality and appropriateness of services (74.4%) ;
- However, only two-thirds (67.1%) of consumers are satisfied that as a result of the services they receive they have had a positive change in their life and even fewer (58.3%) are satisfied with their ability to participate in their treatment planning.

In general, consumers of both mental health and substance abuse services are less satisfied than mental health only or substance abuse only consumers along all four MSHIP indicators of consumer satisfaction. DSAMH may wish to explore why these consumers are not as satisfied and how to improve services for this population. In addition, DSAMH may wish to explore how to improve consumer participation in developing treatment plans and how to have a greater impact on treatment outcomes.

This report also examined the process of collecting data for this study and suggests the following recommendations in order to facilitate the more timely collection of data in future surveys:

- Streamline the interviewer hiring process as much as possible and hire and train more interviewers;
- Conduct extensive outreach to providers before the survey is fielded and provide a written list of clear expectations to them;
- Consider using different survey instruments for substance abuse clients and mental health consumers, shortening the length of both surveys, and using simpler, clearer language in problematic questions; and
- Conduct a marketing campaign aimed at consumers to explain the survey to them and provide small incentives for completing the survey, such as refreshments.

INTRODUCTION

This report summarizes the findings from a statewide satisfaction survey of 1,286 consumers and clients of the Delaware Division of Substance Abuse and Mental Health (DSAMH) which was conducted between July, 2001 and March, 2002. The survey was administered by the Philadelphia Health Management Corporation. The purpose of the survey was to collect information on consumer/client satisfaction with treatment in order to assure that these programs provided high quality services to Delaware consumers and clients.

DELAWARE'S CURRENT BEHAVIORAL HEALTH CARE SERVICE SYSTEM¹

Responsibility for Delaware's public behavioral health treatment and prevention services is decentralized and divided between two cabinet level agencies. Delaware Health and Social Services/Division of Substance Abuse and Mental Health (DHSS/DSAMH) is the single state agency for mental health and substance abuse prevention and treatment services for adults aged 18 years and older. DSAMH is responsible for meeting the treatment, rehabilitation and support needs of consumers and clients. The Department of Services for Children, Youth and Their Families/Division of Child Mental Health Services serves children and youth under the age of 18. DSAMH's mission is:

to improve the quality of life for adults with mental illness, alcoholism, drug addiction or gambling addiction by promoting their health and well-being, fostering their self-sufficiency, and protecting those who are at-risk.

In keeping with its mission, DSAMH maintains the following goals:

- integrate and maintain a coordinated and comprehensive statewide public and private, inpatient, residential and community-based behavioral health service system;
- promote inter-agency and intra-agency collaboration and cooperation to ensure accessibility, responsiveness and continuity of services;
- develop and maintain a statewide management system to ensure quality, appropriateness and efficient utilization of services;
- ensure consumer and family involvement in the development and operation of the mental health and substance abuse service system;
- develop and maintain programs that are culturally competent; and

¹ Source: Program Description of the Managed Long Term Care System. S. Pfeifer, 2001.
Edited 05/14/02 by E. Dubravcic
Further Edited 05/24/02 by M. Tippet (added section on Service Statistics)

- develop and maintain a culturally diverse and culturally competent workforce.

SERVICE STATISTICS

In State Fiscal Year 2001 DSAMH served 11,872 unique clients, based on numbers unduplicated within general service categories. This represents 2.0% of the Delaware adult population. DSAMH provided 15,703 episodes of care during the year. Of these episodes of care, 7.4% were in Delaware Psychiatric Center, 29.9% were in the Community Mental Health system, and 62.7% were in the Substance Abuse treatment system. At any given time DSAMH has approximately 6,000 active episodes of treatment.

CURRENT ADMINISTRATIVE STRUCTURE AND SERVICE SYSTEM

Administration of statewide behavioral health treatment and prevention services for adults is a function of the Division's *Central Office*. The Central Office has the following responsibilities: implement DHSS policy; establish the mission, values and policy within the Division; plan, develop and evaluate services; allocate resources; manage State and Federal inter-governmental relations; provide staff training; and manage the mental health and substance abuse delivery systems. The Central Office staff is divided into the following sections: Administrative Services; Management Information Systems; Planning, Program Development and Evaluation; and Training. The Alcohol and Drug Services Director and the Consumer Relations Director are situated in the Central Office.

The Delaware Psychiatric Center (DPC) is the single State psychiatric hospital for adults. DPC operates three discrete programs: a 230-bed acute and long-term psychiatric hospital; a 42-bed forensic program; and an 83-bed psychiatric nursing facility.

The primary functions of the *Community Mental Health System* include: operating statewide 24-hour mobile crisis intervention services; approving consumers for intensive community-based mental health services; helping to manage consumer utilization of Delaware Psychiatric Center services; operating clinic-based community support services; coordinating and managing community support service contracts in each county; and working with agencies of local government, other state human service systems and private sector organizations in the management of the mental health service system.

Over the last ten years, DSAMH focused on developing a statewide system of community support programs (CSPs) dedicated to meeting the multiple needs of adults with severe and persistent mental illness. All programs are designed to serve approximately 100 consumers. In many cases, one agency operates more than one community support program. However, each community support program operates with a high degree of resource control and clinical autonomy. Services are delivered via a team approach referred to as *Continuous Treatment Teams (CTT)*. The CTTs are based on the Program of Assertive Community Treatment model. As of January 1, 2000,

there were 13 CTT programs operating in the State.

Four *Community Mental Health Clinics*, two serving consumers residing in New Castle County and two serving consumers residing in Kent and Sussex Counties, provide mental health treatment services throughout the state. Services include: short-term counseling; psychiatric and supportive counseling; crisis intervention; limited case management; and medication administration and monitoring.

There are three *day programs* operating in Delaware. One program, serving consumers in New Castle County and two programs serving consumers in Kent and Sussex Counties, provide facility-based rehabilitative services in a group format.

Twenty-four hour supervised residences are either linked as program components to CTTs, or are organized as self-contained programs. There are ten 24-hour supervised group residences (eight in New Castle County, one in Kent County and one in Sussex County), each ranging in capacity from seven to ten residents. Four of the group homes, referred to as the Meadows program, are located in buildings on a DHSS campus in southern New Castle County. The Meadows program is specifically designed to serve consumers, 55 years of age and older. Two residences in Kent and Sussex Counties are operated by contractors that also operate CTTs. While self-contained for those consumers in residence, consumers transition from the residences to the CTTs when they become able to live in supported independent living arrangements.

The primary functions of the *Substance Abuse Treatment and Prevention Service System* include: assessment and evaluation; coordinating and managing community-based programs throughout the state; overseeing the administration, planning, design and evaluation of a comprehensive substance abuse treatment service network ; and working with agencies of local government, other state human service systems and private sector organizations in the management of the substance abuse treatment and prevention service system.

Currently, the continuum of substance abuse services is made available via contractual arrangements with substance abuse treatment and prevention providers throughout the state. Services include: prevention services; residential and ambulatory detoxification services; variable length of stay and long term residential treatment; halfway house; methadone maintenance; and outpatient treatment, including counseling, CTTs, case management and intensive outpatient treatment. In addition, specialized treatment services are available for homeless persons, persons with co-occurring disorders of severe and persistent mental illness and substance dependence, pregnant women and women with children, and injecting drug users.

DSAMH directly operates the *Kent/Sussex Detoxification Center*, a 17-bed residential detoxification program located in Sussex County. The program provides supervised detoxification services, counseling, group lectures, evaluation and referral for substance abuse treatment.

Corinthian House is a State-operated half-way house for men recovering from substance abuse. The program has a 9-bed capacity and provides transitional care and counseling.

In July 1995, through the Budget Act, DSAMH received administrative responsibility and oversight for the *Treatment Access Center (TASC)*. TASC provides case management for adult offenders who have been referred for substance abuse services through the Superior Court and the Court of Common Pleas Drug Courts.

DIAMOND STATE HEALTH PLAN (DSHP)

In July 1994, Delaware submitted a Section 1115 waiver application to Health Care Financing Administration (HCFA) to shift the majority of its Medicaid population into a mandatory managed care program. The program, referred to as the Diamond State Health Plan (DSHP), was implemented in January 1996. The DSHP is a fully capitated managed care plan providing a comprehensive benefit package of acute and primary health services through contracts with Managed Care Organizations.

Under the provisions of the Section 1115 waiver, the DSHP expanded Medicaid coverage to a previously uninsured population of adults whose income falls between the Temporary Assistance for Needy Families (TANF) cash assistance level and 100% of the federal poverty level. Persons who are exempt from participation in the DSHP include: (1) all persons who are dually eligible for Medicaid and Medicare; and (2) all persons who are receiving Medicaid-financed long term care services either under Medicaid Home and Community-Based Waiver Programs, or in Medicaid-certified nursing homes.

Behavioral health services are included in the DSHP. Medicaid-eligible adults with behavioral health treatment needs, who are not in need of intensive community-based support services, receive behavioral health treatment services under the basic benefit. The basic benefit includes twenty outpatient units and thirty days of inpatient hospitalization per year, with substitution of outpatient and residential service permitted for inpatient care.

For Medicaid-eligible adults who are in need of intensive community-based behavioral health treatment and support services, these services are carved out of the DSHP and are provided by DSAMH. Such individuals are those who have a severe and persistent mental illness and/or substance dependence disorder, as determined by *diagnosis, duration of treatment and illness and level of disability*.

The next section, Methodology, describes how the survey was conducted, followed by the survey findings. The last section of the report contains conclusions and recommendations for reviewing DSAMH's treatment programs and for conducting future consumer/client surveys.

METHODOLOGY

SAMPLING PLAN

The findings in this report are based on a written survey administered to a sample of 1,286 Delaware mental health and substance abuse services consumers and clients. The sample was based on the 13,016 unduplicated mental health consumers and substance abuse clients treated in Delaware-funded programs from April 30, 2000 through March 31, 2001.² As shown in Table 1 (Appendix A) the sample was stratified according to the type of treatment program and the number of persons seen annually. Programs were sampled at a 10% rate except for Continuous Treatment Team programs which were over sampled at a rate of 30% and programs with less than 50 clients annually which were assigned a sample of 10 clients per site to include sufficient cases for analysis. This plan resulted in a sample of 1,757 cases. Of these, 1,286 (73%) interviews were completed. It is important to note that, due to low turnover rates in some programs and time limits for fielding the survey, it was not possible to complete interviews for 100% of the sample at some programs. The use of the stratified sample drawn from an annual census also resulted in a greater number of surveys from Delaware's two short-term detoxification sites, which have a much higher rate of turnover than any of the programs at mental health treatment sites.

SURVEY INSTRUMENT

The 32-item survey instrument was based on a 28-item satisfaction survey developed by the U.S. Substance Abuse and Mental Health Services Administration, Office of Mental Health Services, Mental Health Statistics Improvement Program (MHSIP). The MHSIP consumer survey was developed and proposed as one of several instruments to measure the domains, concerns and indicators of the MHSIP Consumer-Oriented Report Card, which was developed by a task force of consumers, family members, researchers, and federal, state, and local mental health agency representatives in April, 1996. The consumer survey was specifically designed to measure concerns that were important to consumers in the areas of Access, Quality/Appropriateness, Outcomes, and Participation in Treatment Planning. Pilot tests of the consumer survey were conducted in several states. Some states have successfully used the survey with adults with episodic mental illness and with adults with a history of substance abuse.³

The Delaware survey employs a five-point scale to measure agreement with 32 statements regarding the consumer's perception of the treatment program the consumer or client is currently attending (See Appendix B for a copy of the Delaware survey). The 32 statements include the 28-item MHSIP survey and 4 additional questions measuring

² The Delaware Psychiatric Center conducts a separate consumer satisfaction survey and therefore was not included in the sample.

³ Ganju, V. The MHSIP Consumer Survey: History, Development, Revisions, Applications, Commonly-asked Questions. Texas Department of Mental Health/Mental Retardation, May 13, 1999.

the ease a case manager can be contacted in time of crisis, how staff treat people of different races and gay and lesbian clients/consumers, and whether consumers were helped with job skills.

Included in the survey are the questions used to construct the four scales contained in the MHSIP survey. The statements concern four important aspects of consumer perceptions of treatment which have been identified by MHSIP as being correlated with positive treatment outcomes: access to care, quality and appropriateness of services, outcomes, and consumer participation in treatment planning. Positive consumer perceptions in these four areas were measured by calculating the percentage of consumers agreeing with the following statements:⁴

Access:

Location of the services was convenient.

Staff were willing to see me as often as I felt was necessary.

Staff returned my calls within 24 hours.

Services were available at times that were good for me.

Quality and Appropriateness of Services:

Staff believed I could grow, change and recover.

I felt free to complain.

Staff told me what side effects to watch for.

Staff respected my wishes about who is and is not to be given information about my treatment.

Staff were sensitive about my cultural/ethnic background.

Staff helped me obtain the information I needed so I could take charge of managing my illness.

Outcomes:

I am dealing 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.

⁴ Missing values and "not applicable" answers were excluded.

I do better in social situations.

I do better in school and/or work.

My symptoms are not bothering me as much.

Consumer Participation in Treatment Planning:

I, not staff, decided my treatment goals.

I felt comfortable asking questions about my treatment and medication.

SURVEY ADMINISTRATION

The MHSIP survey has been administered with varying response rates in at least 10 other states, using a variety of methods, including mail and telephone surveys, face to face consumer interviews, and self-administration with drop off boxes.⁵ In Delaware, the 40-item survey was originally administered in a pilot project conducted in 1997-1998. The pilot project compared three different methods of survey administration: mail survey with telephone follow-up, in person one-to-one administration by consumer interviewers, and group administration by consumer interviewers. The pilot project found that face to face administration to individuals or groups of consumers was more efficient and produced more reliable results than the mail/telephone survey method. Therefore, this follow-up survey of a sample of consumers from all DSAMH treatment programs except the Delaware Psychiatric Center was administered by trained consumer interviewers who distributed the surveys to a convenience sample of consumers at each treatment site and assisted them with their responses as necessary (See Appendix C for a copy of the interviewer training manual). The questionnaire was available in both English and Spanish. Written, informed consent to participate was obtained from each consumer and survey responses were anonymous and confidential.

Obtaining interviews from approximately three-quarters of the sample took nine months, a longer period than was originally anticipated. Some factors which delayed the completion of the interviews included:

- Delays in hiring the interviewers, which caused the data collection to begin later than was originally intended and led to some interviewers being unavailable due to other commitments, such as school, work, or moving to another state;
- Unanticipated turnover in interviewers, which caused delays in data collection while more interviewers were hired and trained;

⁵ AZ, CO, DC, NY, OK, RI, SC, TX, VA, and VT.

- Difficulties scheduling with some providers the most productive times to interview consumers due to provider resistance to the survey, use of a coordinator from outside DSAMH who was previously unknown to the providers, and lack of understanding of the survey process on the part of the provider;
- Reluctance to completing the survey on the part of some consumers due to confidentiality concerns;
- Discomfort with answering survey questions on the part of some substance abuse clients, who felt the survey was too focused on mental health issues;
- Consumer difficulties with the length of the survey and in the wording of some of the questions;
- Seasonal variations in the number of consumers served by certain programs, such as detoxification;
- Problems contacting consumers who did not travel to the program site frequently.

These issues are further addressed in the Conclusion and Recommendations section of this report.

CHARACTERISTICS OF SURVEY RESPONDENTS

Of the total of 1,286 consumers who participated in the survey, 668 (52.9%) attended programs providing substance abuse treatment, 486 (38.5%) attended programs providing mental health treatment, and 108 (8.6%) attended programs that serve both mental health and substance abuse clients (Figure 1).⁶⁷ This reflects the composition of the Delaware DSAMH mental health and substance abuse consumer population, excluding individuals treated at the Delaware Psychiatric Center. Substance abuse consumers received treatment at Continuous Treatment Team programs (n=44), Case Management (21), Outpatient (275), Detoxification (276), Long-term residential (32) and variable-length residential programs (20) (Table 2). Treatment programs among mental health consumers included Continuous Treatment Team programs (211), Group Homes (43), and Outpatient programs (232). All of the consumers receiving treatment at sites serving both mental health and substance abuse clients service participated in Continuous Treatment Team programs (108).

A comparison of the demographic characteristics of survey respondents and all substance abuse and mental health consumers receiving services in Delaware during Fiscal Year 2001 (n=11,862) shows that the racial, ethnic, and gender

⁶ The treatment focus (i.e., substance abuse, mental health, or both SA & MH) and type of treatment (e.g., group home, detoxification) was unknown for 24 respondents.

⁷ The following sites serve both SA & MH clients: Connections Cornerstone CTT, PSI CTT (Dover), and FHS Sussex East CTT.

characteristics of the survey sample were similar to those of the entire DSAMH consumer population. However, survey respondents are slightly older than the overall consumer population. For example, more than one half (55.4%) of the survey respondents were 35-54 years of age and 15.4% were aged 55 years and older. Among the DSAMH consumer population, 44.3% were between 35 and 54 years of age and only 7.9% were 55 years or older (Tables 3 and 4). Therefore some selection bias may have resulted.

As described in the section about the sampling plan and survey administration, this study involved a stratified sample of treatment sites and convenience sample of consumers. The study oversampled CTT sites and programs with fewer than 50 clients to ensure a sufficient number of cases for analysis. Caution should be used when interpreting results from case management and variable-length residential treatments because less than 30 interviews were completed at these type of treatments.

The findings from this study are somewhat limited in their ability to generalize to the entire population of mental health consumers and substance abuse clients treated in Delaware-funded programs because consumers were not randomly selected for participation in the survey. A convenience sample was chosen as the best possible method to preserve confidentiality and encourage consumer participation.

FINDINGS

DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS

The demographic characteristics of consumers who responded to the survey are shown in Table 4. The majority of the respondents are aged 35-54 (55.4%), white (63.9%), and male (62.5%). However, nearly one-third (31.7%) of survey respondents are African American and 3.2% are of Latino origin. While African Americans are overrepresented among survey respondents in comparison to their representation in the statewide population (31.7% versus 19.2%), Latinos are slightly underrepresented (3.2% versus 4.8%).⁸ Most Latino respondents are Puerto Rican (68.3%), followed by Cuban (24.4%), and Mexican (7.3%). More than one-third of respondents are female (37.5%).

The demographic characteristics of respondents from substance abuse sites, mental health sites, or sites providing both mental health and substance abuse services differ, as shown in Table 5. For example, respondents from substance abuse treatment sites tend to be younger than those receiving treatment at mental health or sites providing both mental health and substance abuse services. One out of five (19.9%) substance abuse clients are aged 18-24 compared to 7.6% of mental health clients and only 4.2% of survey respondents receiving services at programs serving both mental health and substance abuse clients. Substance abuse clients are also more likely to be male (71.7%) than mental health clients (51.2%) or clients of sites providing both mental

⁸ U.S. Census of Population and Housing, 2000.

health and substance abuse services (61.9%) (Figure 2). However, the racial characteristics of respondents are similar across different types of treatment programs. For example, one-third (33.7%) of substance abuse clients are African American, compared to 29.0% of survey respondents receiving mental health services and 32.6% of respondents at sites providing both mental health and substance abuse (Figure 3). Survey respondents receiving substance abuse treatment are more likely to be Latino (4.0%) than are respondents receiving mental health services (2.3%) or respondents from sites providing both mental health and substance abuse services (2.8%).

SURVEY RESULTS

The 32-item DSAMH Consumer/Client Survey measured consumer satisfaction in four broad areas which are critical to program success: 1) overall satisfaction; 2) access to services; 3) quality and appropriateness of treatment by staff, including staff sensitivity, respect for confidentiality, and ability to empower consumers; and 4) treatment outcomes.

OVERALL SATISFACTION

Overall satisfaction among respondents is high, as shown on Table 6. More than three-quarters of respondents (77.9%) would recommend their agency to a friend or family, and three-quarters (75.0%) like the services they receive. A slightly lower percentage, 70.9%, would still get services from their agency if they had other choices. However, satisfaction among respondents receiving different types of treatment varied somewhat, with less than two-thirds of respondents from programs providing both mental health and substance abuse services feeling that they would recommend their agency to a friend or family (65.1%), liking the services they receive (64.5%), or that they would still get services from their agency if they had other choices (64.5%). In comparison to respondents from programs providing both mental health and substance abuse services, substance abuse clients are slightly more satisfied with these three measures of overall satisfaction (78.7%, 72.4%, and 67.4%, respectively). Mental health services respondents are the most satisfied among the three different treatment groups, with more than three-quarters reporting that they would recommend their agency to a friend or family (79.7%), that they like the services (80.7%), and that they would still get services from their agency if they had other choices (77.0%). This pattern is found for the three treatment programs for the three other areas of respondent satisfaction measured by the survey. These findings are discussed below.

ACCESS TO SERVICES

Consumer satisfaction is also relatively high as measured by the seven items of the survey pertaining access to services. As shown in Table 6, more than three-quarters of respondents are satisfied with the willingness of staff to see them as often as necessary (79.3%), staff availability at convenient times (78.3%), and the location of services (75.0%). Respondents are least satisfied with their ability to see a psychiatrist when they want (61.9%), and the ease of contacting their case manager or counselor in times of crisis (71.8%). It is important to note, however, that these results may overreport the number of respondents who are dissatisfied with these aspects of access to care due to the fact that certain programs (i.e. detoxification) do not provide this type of service and

respondents may have failed to answer "Not applicable" to these questions. As with the results for overall satisfaction with services, respondents from programs providing both mental health and substance abuse services tend to be least satisfied with their access to care, followed by substance abuse clients. Mental health services respondents show the highest levels of satisfaction with access to care. However, respondents in all three types of treatment report that they are least satisfied with their ability to see a psychiatrist when they want to (55.9%, 52.5%, and 72.6%, respectively).

QUALITY AND APPROPRIATENESS OF SERVICES

In general, survey respondents are satisfied with the quality of staff and the clinical treatment they receive. For example, eighty percent or more of respondents agree or strongly agree with the following statements (Table 6):

- Staff believe I can grow, change and recover (85.6%)
- Staff encourage me to take responsibility for how I live my life (83.9%)
- I felt comfortable asking questions about my medications (81.7%)
- Staff respected my wishes about who is not to be given information about my treatment (81.7%)
- Staff treat people of my race with dignity (81.2%).

Survey respondents are least satisfied with their ability to participate in deciding treatment goals (55.9%), the treatment of respondents who might be gay or lesbian (67.0%), and the information they receive from staff about potential side effects from medication (69.9%).

This pattern is generally repeated across the three different types of treatment, with respondents receiving treatment at sites providing both mental health and substance abuse services being least satisfied, and mental health respondents being most satisfied. All three groups are least satisfied with their ability to participate in treatment planning, with only 39.2% of dually diagnosed respondents reporting satisfaction in this area, followed by 57.4% of mental health respondents and 57.6% of substance abuse clients.

OUTCOMES

Survey respondents in all three types of treatment are generally less satisfied with treatment outcomes than with access to services and quality of treatment. For example, less than two-thirds of respondents are satisfied with treatment outcomes related to housing (58.3%), securing employment (60.9%), school or work (64.1%), and social situations (64.9%). However, 72.3% of respondents are satisfied with their ability to deal more effectively with daily problems.

All three groups of respondents are most likely to be satisfied with their ability to control their lives: 79.4% of mental health respondents, 71.1% of substance abuse clients, and 67.0% of respondents from sites providing both mental health and substance abuse services were satisfied with this treatment outcome. Respondents from programs providing both mental health and substance abuse services tend to be less satisfied with outcomes than mental health services respondents or substance

abuse clients. For respondents from sites providing both treatment focuses and mental health services respondents, the ability to get and keep a job (51.5% and 55.4%, respectively) is the area of least satisfaction, while for substance abuse clients, improvement in housing (55.6%) is the least satisfying. However, it is important to note that many substance abuse programs do not address housing issues, and some substance abuse clients who responded to the survey may have failed to correctly answer this question as "not applicable."

SURVEY RESPONDENT COMMENTS

Survey respondents had the opportunity to write-in additional comments on the survey regarding their experiences in mental health and/or substance abuse treatment. A total of 361 respondents choose to give additional comments regarding services. Respondents wrote about a variety of topics, and responses ranged from very broad statements of satisfaction to very specific suggestions or complaints. The majority of responses (42.7%) were negative comments with suggestions for improvement or specific references to problems encountered in treatment. However, a number of respondents (32.7%) also wrote-in regarding positive experiences with counseling services or staff, and concerning their success in the program (Table 7).

Most of the positive comments by respondents across all treatment types were general statements of satisfaction with treatment and with their own personal success in the program. A number of respondents commented specifically that they had had good experiences with the staff, that they felt the program had allowed them to live differently and cope with mental illness or addiction, and that their counselors and case managers had had a positive impact on their treatment (Table 8).

Negative comments tended to be very specific; however a number of clients did make comments and suggestions regarding staff's attitude towards clients; problems with understaffing and a high turnover rate for counselors and caseworkers; a lack of personal choice in day-to-day living activities; problems obtaining or with the administration of medications; and a lack of choice in creating a treatment plan (Table 8).

MHSIP SATISFACTION INDICATORS

As noted previously, four indicators developed by MHSIP that measure respondent satisfaction with treatment were examined: access, quality and appropriateness of services, outcomes, and participation in treatment planning. Nearly three-quarters of respondents are satisfied with the timeliness and convenience of services (73.1%) (Figure 4). In addition, a similar percentage of respondents, nearly three-quarters, are satisfied with the quality and appropriateness of services (74.4%). Fewer respondents, slightly more than two-thirds (67.1%), are satisfied with the extent of positive change in their lives and even fewer (58.3%) are satisfied with their ability to participate in their treatment planning. These four indicators are discussed in more detail below.

ACCESS TO TREATMENT

“I am very pleased with the services I have received here. All staff are supportive, friendly and helpful.”

“If there was a crisis on the weekend there is no one to talk to. I feel I’m on a staircase and not going anywhere...”

Satisfaction with access to treatment includes convenient locations and office hours and staff who are willing to see respondents as often as they feel was necessary and staff who return calls within 24 hours.

As noted above, most respondents are satisfied with their access to services. However, younger respondents are less likely to be satisfied with access to services than older respondents. For example, 71.0% of respondents aged 18-24 are satisfied with access to services (Table 9). Older respondents are more likely to be satisfied with access to services: 82.0% of adults 45-54 years of age, 84.5% of 55-64 year old respondents, and 87.2% of respondents 65 years of age and older are satisfied with access to services. On the other hand, access to services is perceived as being equally convenient by both male and female respondents (74.8% and 74.3%, respectively) (Table 10) and by African American (74.4%) and white (74.2%) respondents (Table 11). The majority of the Latino respondents (82.1%) are satisfied with access to services.

Generally, satisfaction with treatment access is highest among mental health services respondents and lowest among respondents from programs providing both mental health and substance abuse services. Four out of five respondents of mental health services (80.2%) are satisfied with access to services compared to only 69.3% of substance abuse clients and 64.2% of respondents from sites providing both mental health and substance abuse (Table 12, Figure 5). Satisfaction with access to services was also examined by the different type of treatment programs used by substance abuse clients and mental health respondents⁹. Among substance abuse clients, 80.0% of those in variable-length residential programs and more than 78.0% of substance abuse clients in detoxification programs are satisfied with the timeliness and convenience of services (Table 13). Among mental health respondents, 82.5% of Continuous Treatment Team (CTT) clients are satisfied with access to treatment (Table 14).

⁹ All the consumers from programs providing both mental health and substance abuse are in CTT programs, thus for this group it is not possible to look at differences between types of treatment.

QUALITY AND APPROPRIATENESS OF SERVICES

“I like the quality of services I get here. More staff is needed because their case load is too full. I like the respect and confidentiality I get. I think my doctor is very understanding and is knowledgeable about my medical conditions.”

The quality and appropriateness of services is measured by consumer satisfaction with the following items: staff belief in consumer ability to change and recover; consumer freedom to complain about staff; staff respect for consumers' confidentiality and cultural/ethnic background; the amount of information provided by staff on potential side effects of medication; and staff's ability to provide consumers with sufficient information to allow them to take charge of managing their own illness.

Young adults, those between 18 and 24 years, are most likely to be satisfied with the quality and appropriateness of services (81.9%) (Table 9). Adults between 55 and 64 years of age are slightly less likely than adults aged 18 to 24 to be satisfied with the quality and appropriateness of services (80%). Among the other age groups, less than 80% are satisfied with the quality and appropriateness of services. Females (77%) are slightly more likely than males (74.6%) to be satisfied with the quality and appropriateness of services (Table 10). African American respondents (73.2%) are slightly less likely to be satisfied with quality and appropriateness than white respondents (76.5%) (Table 11). Almost nine out of ten Latino respondents (89.7%) are satisfied with the quality and appropriateness of services.

The majority of substance abuse clients (76.5%) and mental health (77.1%) respondents are also satisfied with the quality and appropriateness of services. In contrast to substance abuse clients and mental health respondents, only one-half (51.4%) of respondents from programs providing both types of treatment are satisfied (Figure 6, Table 12). Among substance abuse clients, those in long-term residential services (81.3%) and those receiving case management (71.4%) are most and least likely to be satisfied, respectively (Table 13). Among mental health respondents, those in outpatient treatment (81.1%) and those in group homes (58.5%) are most and least likely to be satisfied, respectively.

OUTCOMES

“I really believe that this program is essential to my life and my recovery. I have learned to manage my problems and issues more effectively than before I came here. My counselor is very caring and has helped me in my journey to recovery.”

***“I think that the clinic’s staff has helped me to take back my life.
And has helped me with my self-esteem.”***

Satisfaction with treatment outcomes was measured by satisfaction with consumers' ability to: deal more effectively with daily problems, control their lives, deal with crisis, get along better with family, do better in social situations and school and/or work, and to be bothered less by symptoms. Satisfaction levels varied among different demographic subgroups of respondents. For example, younger adults between 25 and 34 years of age are least likely to be satisfied with treatment outcomes (61%) while adults 65 years of age and older are most satisfied (87.2%) (Table 9). Female respondents (70.7%) are slightly more likely than males (65.7%) to be satisfied with treatment outcomes (Table 10) and African American respondents (74.1%) are more likely than white respondents (63.2%) to be satisfied with their treatment outcomes (Table 11). Most Latino respondents (81.1%) are satisfied with treatment outcomes.

Satisfaction with outcomes also differed across the type of treatment received. The majority of substance abuse clients (67.1%) and mental health respondents (70.2%) are satisfied with the outcome of the services they received. However, only 55.9% of dually diagnosed respondents are satisfied with treatment results (Figure 7, Table 12). Among substance abuse clients, those in variable-length and long-term residential programs (90% and 87.5%, respectively) are most likely to be satisfied with treatment outcomes. Detoxification program clients are least likely to be satisfied with outcomes (56.0%) (Table 13). Among mental health respondents, 75.0% of group home residents are satisfied with treatment outcomes, compared to 73% of respondents in CTTs, and only 66.2% of respondents receiving outpatient services (Table 14).

PARTICIPATION IN TREATMENT PLANNING

“I feel that the nurse’s have too much power in terms of my treatment, and that we need a very strong advocate group to help us deal with [the site’s] staff. We need more client’s participation in [the treatment site’s] overall treatment plans.”

“In a non-disrespectful way, I strongly disagree with other people planning my treatment goals...”

Survey respondent satisfaction with participation in treatment planning was measured by respondent's ability to decide their treatment goals and the extent to which they felt comfortable asking questions about treatment and medication. Respondents generally gave this area the lowest satisfaction scores. Only 58.3% of respondents overall are satisfied with their ability to participate in treatment planning. Contrary to the pattern for satisfaction with treatment outcomes, young adults between 18 and 24 years of age (64.1%) and older adults 65 years of age and older (47.5%) are most and least likely, respectively, to be satisfied with their ability to participate in treatment planning (Table 9). Satisfaction with the ability to participate in treatment planning is similar among males (57.9%) and females (59.7%) (Table 10) as it is among African American (56.3%) and white (58.0%) respondents (Table 11). However, most Latino respondents (82.1%) are satisfied with their participation in treatment planning.

Among substance abuse clients and mental health respondents, more than one-half (59.9% and 59.6% respectively) are satisfied with their level of involvement in treatment planning. Only 40.2% of respondents from sites treating both mental health and substance abuse clients are satisfied (Figure 8). Among substance abuse clients those in detoxification programs (67.5%) and long-term residential programs (62.5%) are most likely to be satisfied with their ability to participate in treatment planning, compared to only 37.5% of those in variable-length residential programs (Table 13). Among the mental health respondents, three-quarters (74.3%) of those in outpatient programs are satisfied with their ability to participate in treatment planning, while less than one-half of those in a group home (47.6%) or a CTT program (46%) are satisfied.

CONCLUSION AND RECOMMENDATIONS

Overall, respondents are highly satisfied with services they receive through treatment programs funded by the Division of Substance Abuse and Mental Health (DSAMH), Delaware Health and Social Services. The majority of respondents are satisfied with the timeliness and convenience of services and with the quality and appropriateness of services. Fewer respondents are satisfied with the extent of positive change in their life and even fewer respondents are satisfied with their level of participation in developing their treatment plan. DSAMH may wish to explore how to improve respondent participation in developing treatment plans and how to have a greater impact on the outcomes of services.

In general, respondents receiving treatment at sites serving both mental health and substance abuse clients are less pleased than respondents from sites serving only mental health clients or respondents from sites serving only substance abuse clients along all four MHSIP indicators of consumer satisfaction. It is possible that clients from sites providing both mental health and substance abuse treatment, many of whom have dual diagnoses, have more complex issues to address in treatment that inhibit their satisfaction with treatment; however, DSAMH may wish to explore why these respondents are not very satisfied and how to improve services for this population.

In addition to focusing on involvement with treatment planning, outcomes of services, and sites providing both mental health and substance abuse services, DSAMH may wish to further explore the services of other populations reporting low satisfaction with

services:

- Access to services among substance abuse consumers in case management and outpatient services,
- Quality and appropriateness of services among mental health consumers in group homes,
- Outcomes among substance abuse consumers in detoxification and mental health consumers in outpatient treatment, and
- Treatment planning for substance abuse consumers in variable length residential programs and mental health consumers in group homes and CTT.

This report also explored how Delaware mental health consumers perceive services compared to mental health consumers in other states. Delaware mental health survey respondents on average are more pleased with outcomes than are consumers in other states. In addition, Delaware mental health survey respondents are slightly less satisfied with access to timely and convenient treatment and the quality and appropriateness of services than consumers in other states. Delaware mental health survey respondents are much less likely to be satisfied with involvement in treatment planning. Again this finding suggests that DSAMH explore how to improve consumer involvement in treatment planning.

As part of this study, we also examined the process of collecting data and the findings support the following recommendations in order to facilitate the more timely collection of data in future surveys:

- Streamline the hiring process as much as possible (or begin the process much earlier), hire and train more interviewers than seem necessary in order to account for higher attrition rates of consumer interviewers, and hire interviewers who do not have other commitments during the survey fielding period;
- Conduct extensive outreach to providers before the survey is fielded to introduce the interviewers and survey coordinators to providers, explain the purpose and content of the survey, and develop a relationship with the contact person chosen by the provider;
- Provide a written list of clear expectations and survey procedures for the providers, DSAMH, and the consumer interviewers to all providers;
- Include as much information on the different types of treatment programs and consumers, treatment program locations and contacts, and best times for interviews in the interviewer training;
- Provide the interviewers with training and written instructions on adapting survey questions for consumers with different levels of understanding;
- Consider using different survey instruments for substance abuse clients and mental health consumers, shortening the length of both surveys, and using

simpler, clearer language in problematic questions; and

- Conduct a marketing campaign aimed at consumers to explain the survey to them and provide small incentives for completing the survey, such as refreshments.

APPENDIX A.

TABLES

Table 1. Sampling Plan for Consumer/Client Satisfaction Survey					
Treatment Unit	TXUNITID	Census on 3/31/01	Consumers in Treatment 4/30/00-3/31/01	# of Consumers to be Surveyed	# Consumers Actually Surveyed
ANKH Tau House Halfway House	100170-01	5	34	10	1
BCI IV Drug Abuse CTT - Methadone	100139-12	75	178	53	26
BCI Lancaster Outpatient Clinic	100139-01	9	26	10	3
BCI NSAFE - Methadone	100139-15	41	48	10	0
BCI Outpatient - Methadone	100139-10	287	787	79	69
BCI Outpatient VIP Newark	100139-26	3	3	10	0
BCI Perinatal Clinic	100139-05	5	21	10	0
BCI Perinatal Clinic - Methadone	100139-13	23	41	10	11
BCI Revial\Trexan - Lancaster Ave.	100139-17	13	164	10	1
BCI Riverfront NSAFE Outpatient Clinic	100139-07	136	344	34	16
BCI TASC Court of Common Pleas	100139-18	209	651	65	76
BCI TASC Drug Free - Superior, Diversion	100139-08	22	69	7	7
BCI The Bridge - Drug Free	100139-19	14	46	10	0
BCI The Bridge - Methadone	100139-20	13	23	10	10
Brandywine Hills Group Home	108013-01	8	8	10	5
Connections Cornerstone CTT	100015-04	95	110	33	43
Connections Crosslinks CTT (Meadows I)	100015-02	113	131	39	44
Connections CTT	100015-03	116	121	36	22
Connections Meadows Residential GH1	100015-01	9	12	10	2
Connections Meadows Residential GH2	100015-07	10	10	10	4
Connections Meadows Residential GH3	100015-08	10	13	10	3
Connections Meadows Residential GH4	100015-09	10	14	10	4
DADAMH Corinthian Halfway House	900538-01	5	30	10	7
Delaware Elwyn CTT	109010-01	91	93	28	24
Ellendale Detox Center	750024-01	10	965	97	87
FHR Georgetown GH	106101-02	7	8	10	7
FHR Seaford CTT	106101-01	95	107	32	25
FHR Sussex East CTT	106101-04	106	113	34	19
Horizon House Adult Group Home	100010-02	8	8	10	7
Horizon House CTT	100010-03	74	90	27	27
Horizon House Young Adult Group Home	100010-01	7	14	10	4
Independent Living (Carelinks) CTT	108004-01	87	102	31	15
Kent Co Counseling TASC Diver & Misc.	100055-08	49	96	10	10
Kent Co Counseling TASC Superior Diversi	100055-05	34	64	10	7
Kent County Alcohol/Drug Counseling Cen	100055-01	61	288	29	27

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Treatment Unit	TXUNITID	Census on 3/31/01	Consumers in Treatment 4/30/00-3/31/01	# of Consumers to be Surveyed	# Consumers Actually Surveyed
Kent County Counseling Methadone Clinic	100055-04	61	97	10	10
KS CMHC Crossroads CTT/Psychosocial	100020-06	83	89	27	15
KS CMHC Kent MHC (Dover)	100020-04	494	854	85	36
KS CMHC Sussex MHC (Georgetown)	100020-01	383	753	75	61
Limen Halfway House for Women	900587-01	10	26	10	8
NCC CMHC 809 Washington St.	100050-05	669	990	99	105
NCC CMHC Canby Park CTT	100050-09	94	108	32	28
NCC CMHC Newark	100050-06	254	431	43	15
NCC CMHC Proact CTT	100050-08	91	104	31	26
NET Alternatives (long term care)	100600-01	18	47	10	8
NET New Castle County Kirkwood Detox	100022-01	20	2448	245	189
NET RCD VLS Residential	900553-01	60	721	72	10
NET Reflection House	100725-01	8	43	10	5
NET TASC Residential	900553-07	3	65	10	10
Open Door Inc.	100337-01	112	147	15	7
Open Door TASC Outpatient	100337-04	10	13	10	6
PSI (PCSA) A&D Georgetown CTT	100576-02	47	63	19	9
PSI A&D Wilmington CTT	100576-01	91	137	41	9
PSI CTT (MH/AD - Dover)	100125-00	134	157	47	46
PSI Felton Group Home	100125-01	8	12	10	7
Serenity Place Halfway House	100634-01	6	30	10	3
SODAT TASC Diversion Superior Court	100105-03	220	321	32	13
Sussex County Counseling Service	100055-06	143	341	34	15
Thresholds TASC	100204-01	87	187	19	8
Unknown Treatment Unit					24
			13,016	1,757	1,286

Table 2. Distribution of Survey Respondents by Type of Treatment Program						
Program Focus						
	Substance Abuse		Mental Health		Both Substance Abuse and Mental Health	
Treatment Modality	Number	Percentage	Number	Percentage	Number	Percentage
Continuous Treatment Team	44	6.6	211	43.4	108	100
Case Management	21	3.1				
Group Home			43	8.8		
Outpatient	275	41.2	232	47.7		
Detoxification	276	41.3				
Long-term residential	32	4.8				
Variable Length residential	20	3.0				
Total	668	100.0	486	100	108	100

Source: 2001-2001 Delaware Consumer/Client Satisfaction Survey (n=1,262)
 Prepared by PHMC.

Table 3. Demographic Characteristics of Consumers/Clients of Delaware Health and Social Services Division of Substance Abuse and Mental Health, FY 01		
	Number¹	Percentage
Characteristic		
Age		
18-24	2490	21.1%
25-34	3174	26.8%
35-44	3510	29.7%
45-54	1725	14.6%
55-64	574	4.9%
65 +	354	3.0%
Race		
African American/Black	3809	33.5%
White	7451	65.5%
American Indian/Alaskan Native	50	0.4%
Asian/Other	64	0.6%
Ethnicity		
Latino	601	5.1%
Non-Latino	11261	94.9%
Latino Origin		
Puerto Rican	334	55.6%
Mexican	46	7.7%
Cuban	14	2.3%
Other	207	34.4%
Gender		
Male	7628	64.3%
Female	4227	35.7%
Source: Delaware Health and Social Services, Division of Substance Abuse and Mental Health		
¹ Totals for categories do not add to 1,286 due to missing data.		

Table 4. Demographic Characteristics of Survey Respondents

	Number	Percentage
Characteristic		
Age		
18-24	98	13.0%
25-34	125	16.6%
35-44	238	31.7%
45-54	178	23.7%
55-64	71	9.5%
65 +	41	5.5%
Race		
African American/Black	350	31.7%
White	705	63.9%
American Indian/Alaskan Native	23	2.1%
Asian/Other	25	2.3%
Ethnicity		
Latino	41	3.2%
Non-Latino	1,245	96.8%
Latino Origin		
Puerto Rican	28	68.3%
Mexican	3	7.3%
Cuban	10	24.4%
Gender		
Male	736	62.5%
Female	441	37.5%
Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=1,286). Totals do not add to 1,286 due to missing responses.		
Prepared by PHMC.		

**Table 5. Demographic Characteristics of Survey Respondents
by Type of Treatment Program**

Characteristic	Substance Abuse		Mental Health		Mental Health & Substance Abuse	
	Number	Percentage	Number	Percentage	Number	Percentage
Age						
18-24	68	19.9	24	7.6	3	4.2
25-34	70	20.5	45	14.2	5	6.9
35-44	116	34.0	90	28.5	21	29.2
45-54	68	19.9	81	25.6	26	36.1
55-64	17	5.0	43	13.6	11	15.3
65 +	2	0.6	33	10.4	6	8.3
Race						
African American/Black	187	33.7	126	29	30	32.6
White	348	62.7	290	66.7	55	59.8
American Indian/Alaskan Native	11	2.0	8	1.8	4	4.3
Asian/Other	9	1.6	11	2.5	3	3.3
Ethnicity						
Latino	27	4.0	11	2.3	3	2.8
Non-Latino	641	95.9	475	97.7	105	97.2
Latino Origin						
Puerto Rican	20	74.1	8	72.7	0	0
Mexican	2	7.4	1	9.1	0	0
Cuban	5	18.5	2	18.2	3	100
Gender						
Male	425	71.7	237	51.2	60	61.9
Female	168	28.3	226	48.8	37	38.1

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=1,262). Totals may not add up to 1,262 due to missing information.

Prepared by PHMC.

Table 6. Percentage of Consumer/Clients Who Agree or Strongly Agree								
with Survey Statements by Type of Treatment Program								
	Substance Abuse		Mental Health		Mental Health & Substance Abuse		Total	
	(n=1,262)						(n=1,286)	
	Number and Percentage Agreeing with Statement							
Statement	#	%	#	%	#	%	#	%
Like the services received	475	72.4	390	80.7	69	64.5	934	75
If had other choices, would still get services from this agency	438	67.4	368	77	69	65.1	875	70.9
Would recommend this agency to friend or family	513	78.7	380	79.7	69	65.1	962	77.9
Location of services was convenient	459	70.5	374	80.3	80	80	913	75
Staff willing to see me as often as necessary	505	79.5	393	82.6	68	63.6	966	79.3
Staff returned my call in 24 hours	347	69.4	332	78.5	64	63.4	743	72.6
In time of crisis, case manager/counselor can be easily contacted	408	70.7	335	75.5	66	62.9	809	71.8
Services were available at times that were good for me	480	74.4	408	84.8	77	72.6	965	78.3
Able to get all services I thought I needed	434	68.8	374	79.1	67	63.2	875	72.3
Able to see a psychiatrist when I wanted	239	52.5	334	72.6	57	55.9	630	61.9
Staff believe that I can grow, change, and recover	567	87.9	370	84.9	74	74	1011	85.6
Felt comfortable asking questions about my treatment and medication	525	82.8	403	84	70	65.4	998	81.7
Felt free to complain	444	70.8	326	74.4	61	62.2	831	71.5
Was given information about my rights	518	79.8	348	74.4	69	67.6	935	76.7
Staff encouraged me to take responsibility for how I live my life	556	86.9	386	83.4	71	68.3	1013	83.9
Staff told me what side effects to watch out for	440	72.1	331	70.6	57	54.3	828	69.9
Staff respected my wishes about who is not to be given information about my treatment	520	81.8	379	81.9	80	80	979	81.7
I, not staff, decided my treatment goals	356	57.6	260	57.4	40	39.2	656	55.9
Staff sensitive to my cultural background	436	74.1	383	83.8	65	66.3	884	77.3
Staff treat people of my race with dignity	491	80.2	386	85.4	68	68	945	81.2
Staff treat people who may be gay or lesbian with dignity	324	69.8	176	65.7	39	54.2	539	67
Staff helped me obtain the information I needed so that I could take charge of managing my illness	485	78.7	352	75.7	55	53.4	892	75.3
Encouraged to use consumer-run programs	440	73.3	326	73.1	67	69.1	833	72.9
As a direct result of services I received I:								
Deal more effectively with daily problems	431	70.1	362	77.5	62	61.4	855	72.3
Better able to control my life	438	71.1	370	79.4	67	67	875	74
Better able to deal with crisis	424	68.8	336	73	62	62	822	69.9
Get along better with my family	387	64.7	297	67.3	57	57	741	65.1
Do better in social situations	401	66.1	299	64.9	57	58.2	757	64.9
Do better in school/work	347	66.1	191	63	37	53.6	575	64.1
Better able to get and keep a job	346	65.2	169	55.4	34	51.5	549	60.9
Housing situation has improved	310	55.6	263	61.6	58	59.2	631	58.3
Symptoms are not bothering me as much	397	65.7	330	70.5	58	58.6	785	67

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey
Prepared by PHMC.

Table 7. Distribution of Survey Respondent's Comments

Tone	Number	Percentage
Positive	118	32.7%
Negative	154	42.7%
Mixed	27	7.5%
Unrelated	62	17.2%
Total	361	100.0%

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=361). Prepared by PHMC.

Table 8. Comments of Survey Respondents

Comment Category	Number	Percent
Staff is great.	26	8.3%
I like the program.	56	17.9%
Taught client to live differently, cope with addiction.	16	5.1%
Program has changed client's life for the better.	24	7.7%
Counselors/casemanagers had a positive impact.	41	13.1%
Need for better quality counseling/support groups.	18	5.8%
Need increased/more convenient hours for appts./support groups.	13	4.2%
Problems with high turnover rate for caseworkers/counselors.	7	2.2%
Problems with understaffing.	11	3.5%
Lack of confidentiality among counselors/caseworkers/staff.	6	1.9%
Staff has a bad attitude towards clients.	22	7.1%
Problems with transitional housing for residents.	9	2.9%
Problems with homelessness.	5	1.6%
Lack of personal choice in day-to-day living.	14	4.5%
Lack of financial freedom while in treatment.	5	1.6%
Problems obtaining/with administration of medications.	12	3.8%
Problems with food quality.	8	2.6%
Problems with quality of residential housing.	10	3.2%
Problems paying for services/problems with insurance.	5	1.6%
Lack of choice in treatment plan.	4	1.3%
Total	312	100%
<p>*Comment categories included 'other,' however due to the high total percentage of comments coded as 'other' (31.0%), including all comments not relating to the assessment of services, it is not included in this table. Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=361) Prepared by PHMC.</p>		

Table 9. Consumers Satisfied with Selected Aspects of Treatment by Age													
Satisfaction with Treatment	Age												
	18-24		25-34		35-44		45-54		55-64		65+		
	#	%	#	%	#	%	#	%	#	%	#	%	
Access	66	71.0%	88	71.5%	173	73.0%	146	82.0%	60	84.5%	34	87.2%	
Quality and Appropriateness	77	81.9%	86	71.1%	170	72.6%	138	78.0%	56	80.0%	30	76.9%	
Outcomes	62	66.0%	72	61.0%	155	67.7%	130	74.7%	48	68.6%	34	87.2%	
Consumer Participation in Treatment Planning	59	64.1%	74	60.7%	135	57.0%	106	59.6%	43	60.6%	19	47.5%	

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=751)
Prepared by PHMC.

Table 10. Number and Percentage of Consumers Satisfied with Selected Aspects of Treatment by Gender				
Satisfaction with Treatment	Male		Female	
	#	%	#	%
Access	542	74.8%	327	74.3%
Quality and Appropriateness	538	74.6%	335	77.0%
Outcomes	458	65.7%	307	70.7%
Consumer Participation in Treatment Planning	420	57.9%	261	59.7%

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=1,177)
Prepared by PHMC.

Table 11. Consumer Satisfaction with Selected Aspects of Treatment by Race				
Race				
	African American		White	
Satisfaction with Treatment	#	%	#	%
Access	258	74.4%	521	74.2%
Quality and Appropriateness	251	73.2%	532	76.5%
Outcomes	249	74.1%	430	63.2%
Consumer Participation in Treatment Planning	196	56.3%	404	58.0%

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=1,055)
 Prepared by PHMC.

Table 12. Consumer Satisfaction with Selected Aspects of Treatment by Type of Treatment Program						
	Type of Treatment Program					
	Substance Abuse		Mental Health		Mental Health and Substance Abuse	
Satisfaction with Treatment	#	%	#	%	#	%
Access	456	69.3%	388	80.2%	68	64.2%
Quality and Appropriateness	499	76.5%	368	77.1%	54	51.4%
Outcomes	420	67.1%	330	70.2%	57	55.9%
Consumer Participation in Treatment Planning	393	59.9%	288	59.6%	43	40.2%
Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=1,262)						
Prepared by PHMC.						

Table 13. Substance Abuse Treatment Clients' Satisfaction with Selected Aspects of Treatment by Program Modality								
	Aspect of Treatment							
	Access		Quality and Appropriateness		Outcomes		Client Participation in Treatment Planning	
Program Modality	#	%	#	%	#	%	#	%
Continuous Treatment Team	32	72.7%	33	75.0%	34	77.3%	22	50.0%
Case Management	12	57.1%	15	71.4%	17	81.0%	11	52.4%
Outpatient	158	59.4%	200	75.8%	184	70.5%	141	53.6%
Detoxification	216	78.5%	210	77.5%	139	56.0%	186	67.4%
Long Term Residential	22	68.8%	26	81.3%	28	87.5%	20	62.5%
Varying Length Residential	16	80.0%	15	75.0%	18	90.0%	12	37.5%

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=668)
Prepared by PHMC.

Table 14. Mental Health Treatment Consumers' Satisfaction with Selected Aspects of Treatment by Program Modality								
Program Modality	Aspect of Treatment							
	Access		Quality and Appropriateness		Outcomes		Consumer Participation in Treatment Planning	
	#	%	#	%	#	%	#	%
Continuous Treatment Team	174	82.5%	159	76.4%	153	73.6%	97	46.0%
Group Home	30	73.2%	24	58.5%	30	75.0%	20	47.6%
Outpatient	184	79.3%	185	81.1%	147	66.2%	171	74.3%

Source: 2001-2002 Delaware Consumer/Client Satisfaction Survey (n=486)
 Prepared by PHMC.

APPENDIX B.
SURVEY INSTRUMENT



Delaware Health and Social Services

Division of Alcoholism, Drug Abuse and Mental Health

DADAMH Consumer Survey (Version 2.2, May 2001)

Treatment Unit ID: - **Date:** / /

In order to provide the best possible behavioral health services, we need to know what you think about the services you received **at this agency** during the **last year**, the people who provided it, and the results. There is space at the end of the survey to comment on any of your answers.

Please indicate your agreement/ disagreement with each of the following statements by circling the number that best represents your opinion. If the question is about something you have not experienced, circle the number 9, to indicate that this item is "not applicable" to you.

	<u>Strongly Disagree</u>	<u>Disagree</u>	<u>I am Neutral</u>	<u>Agree</u>	<u>Strongly Agree</u>	<u>Not Applicable</u>
1. I like the services that I received here.	1	2	3	4	5	9
2. If I had other choices, I would still get services from this agency.	1	2	3	4	5	9
3. I would recommend this agency to a friend or family member.	1	2	3	4	5	9
4. The location of services was convenient (parking, public transportation, distance, etc.).	1	2	3	4	5	9
5. Staff were willing to see me as often as I felt it was necessary.	1	2	3	4	5	9
6. Staff returned my call in 24 hours.	1	2	3	4	5	9
7. In a time of crisis my case manager or counselor can be easily contacted.	1	2	3	4	5	9
8. Services were available at times that were good for me.	1	2	3	4	5	9
9. I was able to get all the services I thought I needed.	1	2	3	4	5	9
10. I was able to see a psychiatrist when I wanted to.	1	2	3	4	5	9
11. Staff here believe that I can grow, change and recover.	1	2	3	4	5	9
12. I felt comfortable asking questions about my treatment and medication.	1	2	3	4	5	9
13. I felt free to complain	1	2	3	4	5	9
14. I was given information about my rights.	1	2	3	4	5	9
15. Staff encouraged me to take responsibility for how I live my life.	1	2	3	4	5	9
16. Staff told me what side effects to watch out for.	1	2	3	4	5	9



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	<u>Strongly Disagree</u>	<u>Disagree</u>	<u>I am Neutral</u>	<u>Agree</u>	<u>Strongly Agree</u>	<u>Not Applicable</u>
17. Staff respected my wishes about who is and who is not to be given information about my treatment.	1	2	3	4	5	9
18. I, not staff, decided my treatment goals.	1	2	3	4	5	9
19. Staff were sensitive to my cultural background (race, religion, language, etc.)	1	2	3	4	5	9
20. The Staff treat people of my race with dignity.	1	2	3	4	5	9
21. The Staff treat people who may be gay or lesbian with dignity.	1	2	3	4	5	9
22. Staff helped me obtain the information I needed so that I could take charge of my managing my illness.	1	2	3	4	5	9
23. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	1	2	3	4	5	9
As a Direct Result of Services I Received:						
24. I deal more effectively with daily problems.	1	2	3	4	5	9
25. I am better able to control my life.	1	2	3	4	5	9
26. I am better able to deal with crisis.	1	2	3	4	5	9
27. I am getting along better with my family.	1	2	3	4	5	9
28. I do better in social situations.	1	2	3	4	5	9
29. I do better in school and/or work.	1	2	3	4	5	9
30. I am better able to get and keep a job.	1	2	3	4	5	9
31. My housing situation has improved.	1	2	3	4	5	9
32. My symptoms are not bothering me as much.	1	2	3	4	5	9



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Please feel free to use this space to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please write them here. Thank you for your time and cooperation in completing this questionnaire.

The following section is optional and will only be used for statistical compilation purposes.

Year of Birth: _____

Gender: (check one)

Male _____, Female _____

Race: (check one)

- African-American,
- African-American plus other races,
- American Indian/Alaskan Native,
- American Indian/Alaskan Native plus other races,
- Asian,
- Asian plus other races,
- Caucasian,
- Caucasian plus other races,
- Native Hawaiian/Other Pacific Islander,
- Native Hawaiian/Other Pacific Islander plus other races,
- Multi-Racial

Ethnicity: (check one)

None, _____ Cuban, _____ Mexican, _____ Puerto Rican, _____ Other

APPENDIX C.

FIGURES

Figure 1. Type of Treatment Evaluated by Survey Respondents

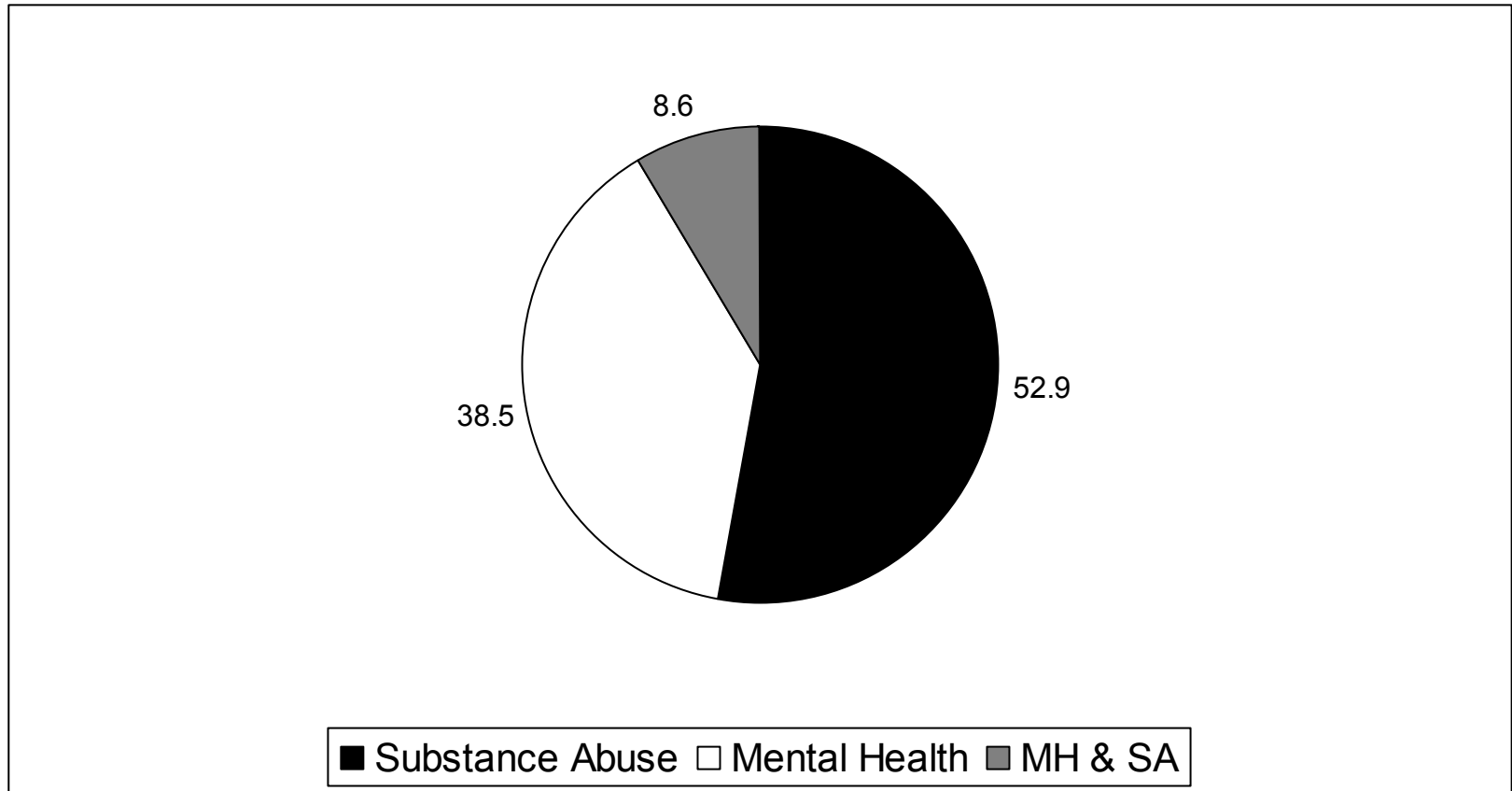


Figure 2. Gender of Survey Respondents by Type of Treatment

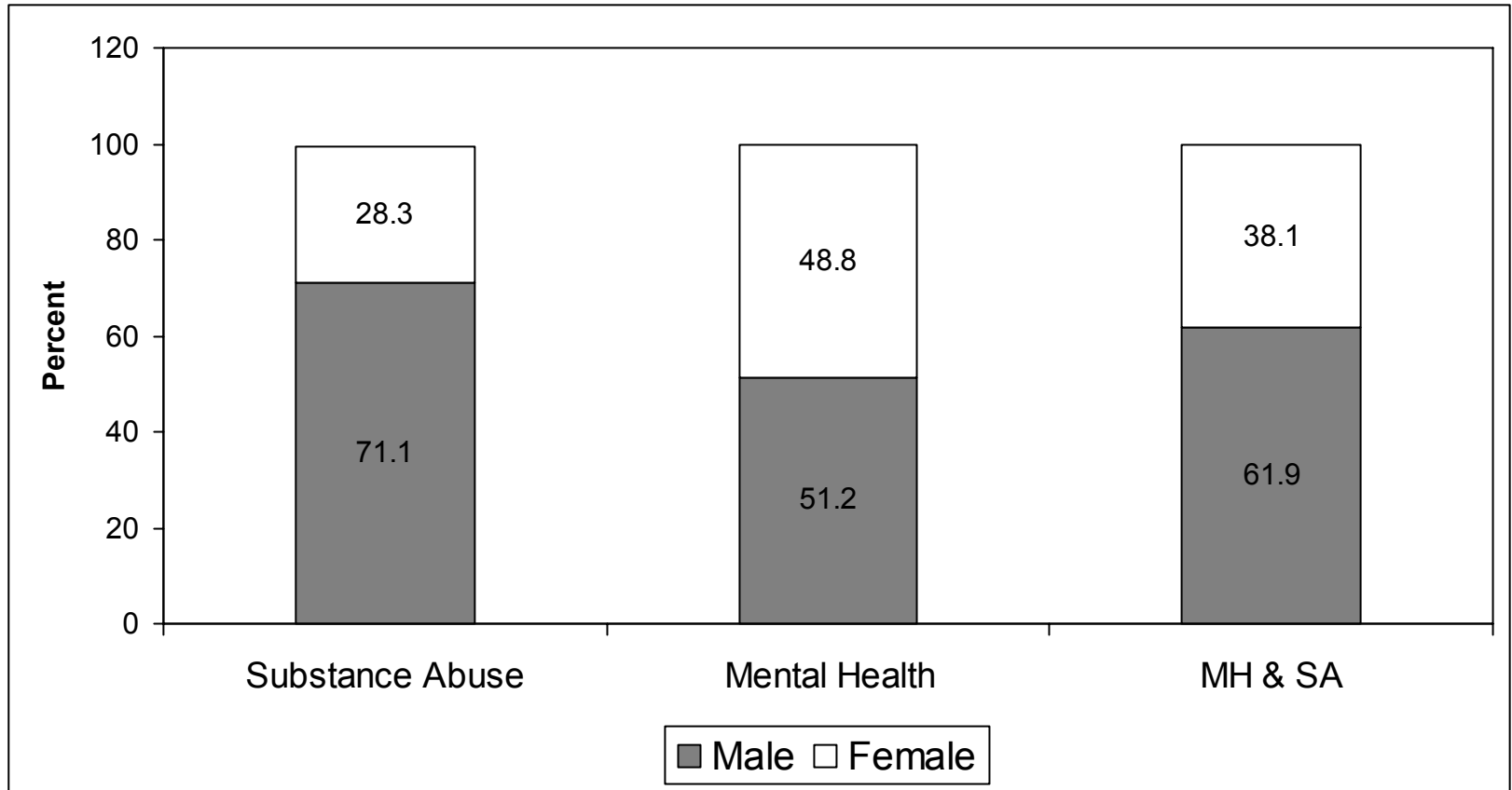


Figure 3. Race of Survey Respondents by Type of Treatment

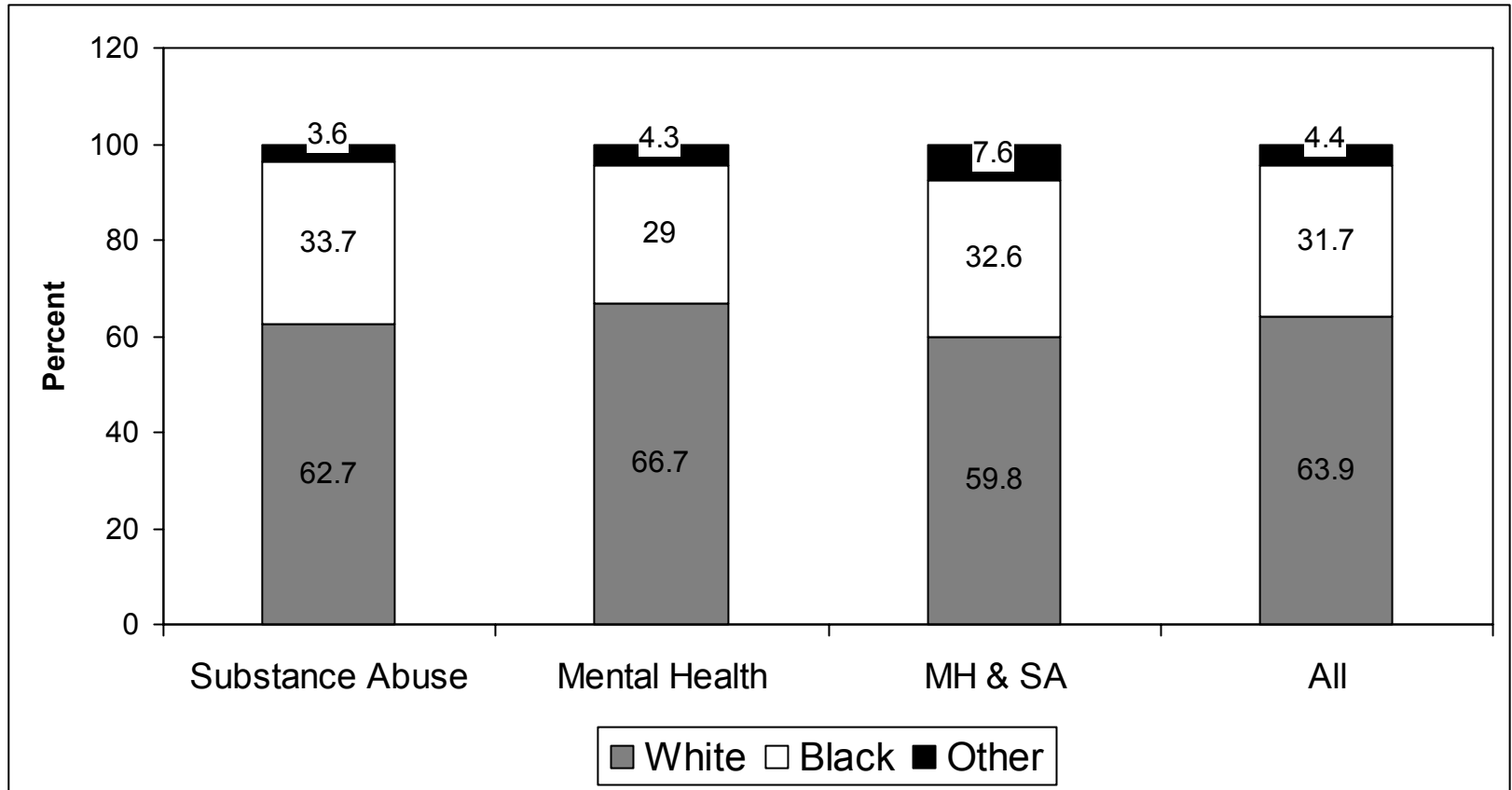


Figure 4. Consumer Satisfaction with Selected Aspects of Treatment

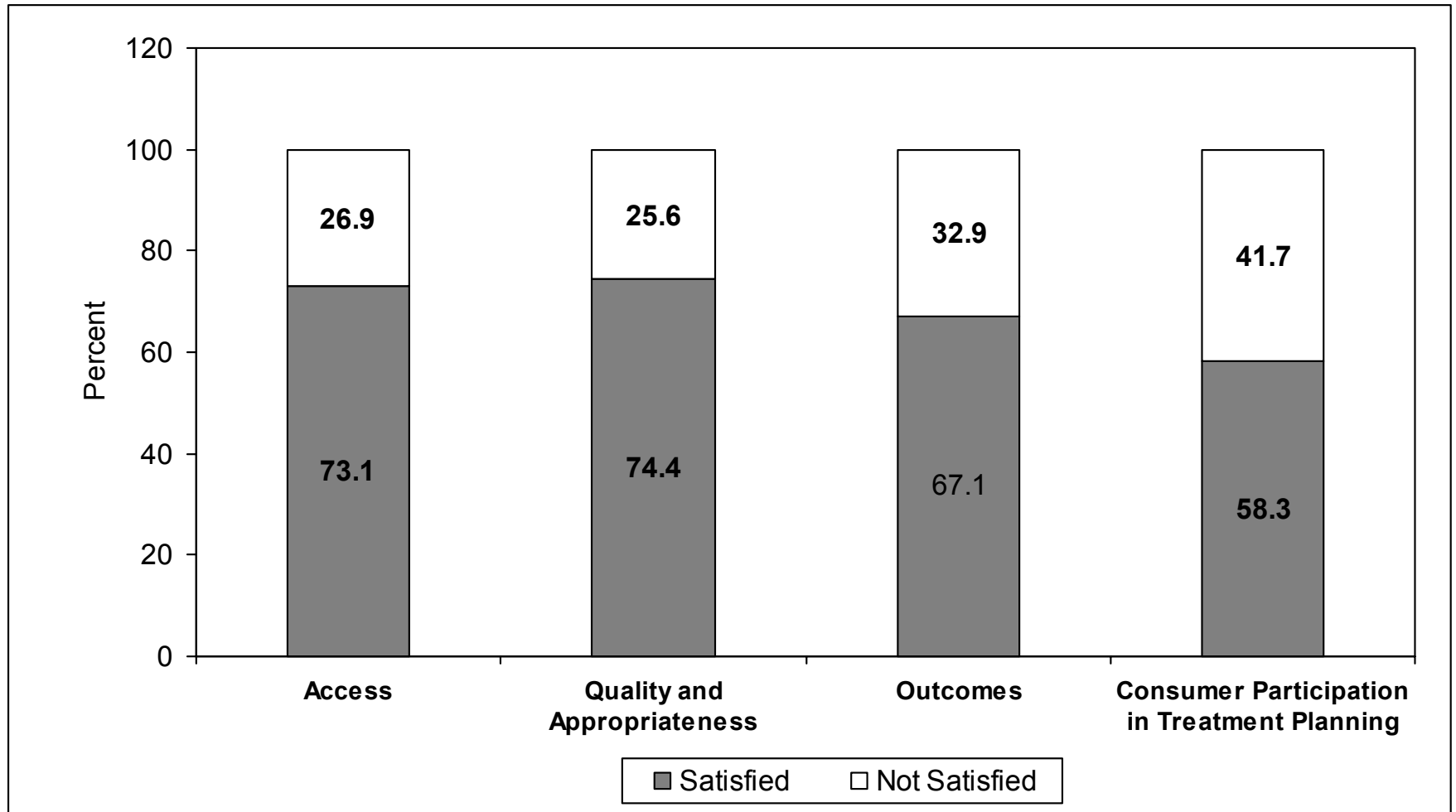


Figure 5. Consumer Satisfaction with Access to Treatment by Type of Treatment

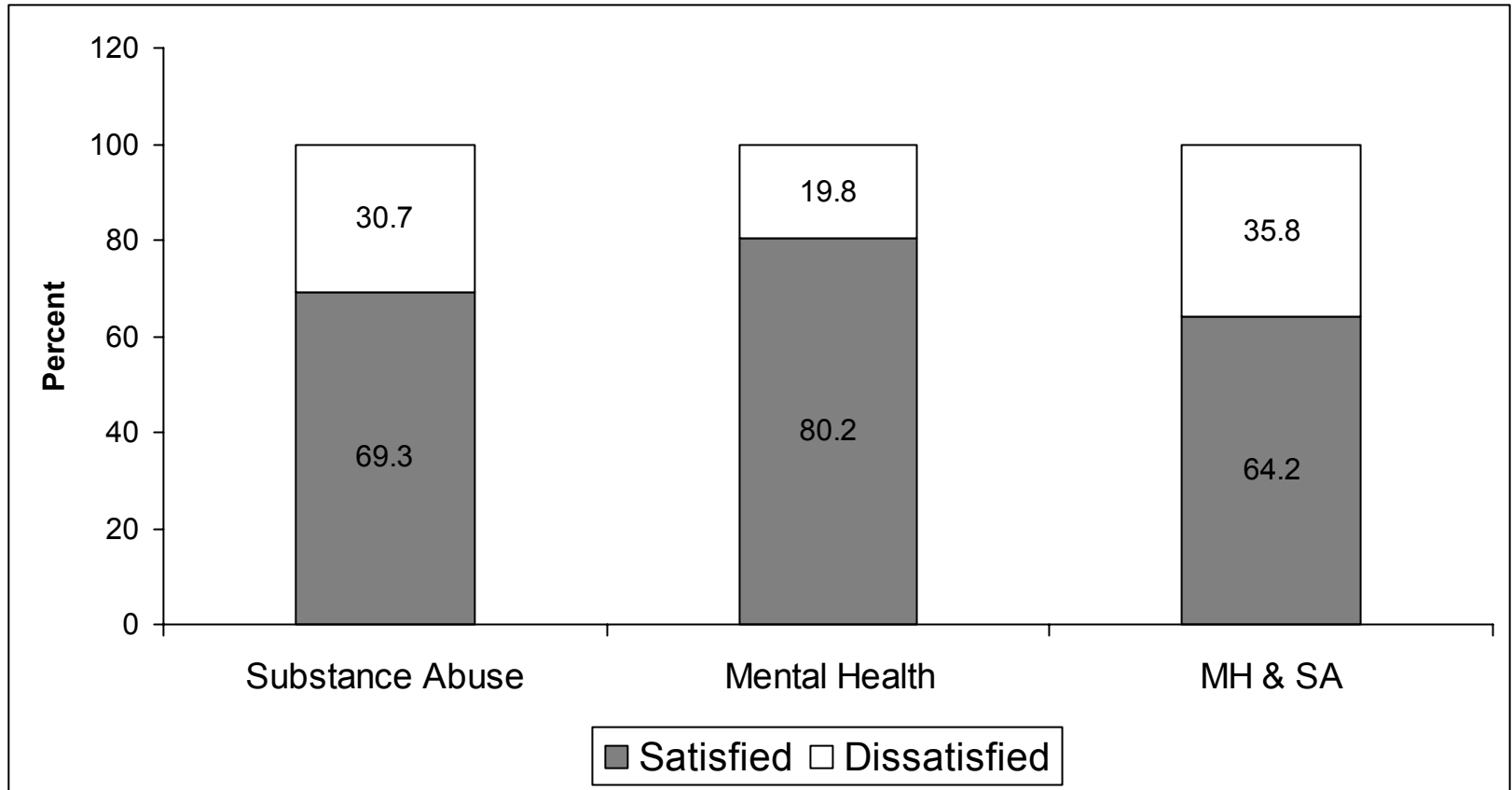


Figure 6. Consumer Satisfaction with Quality of Services by Type of Treatment

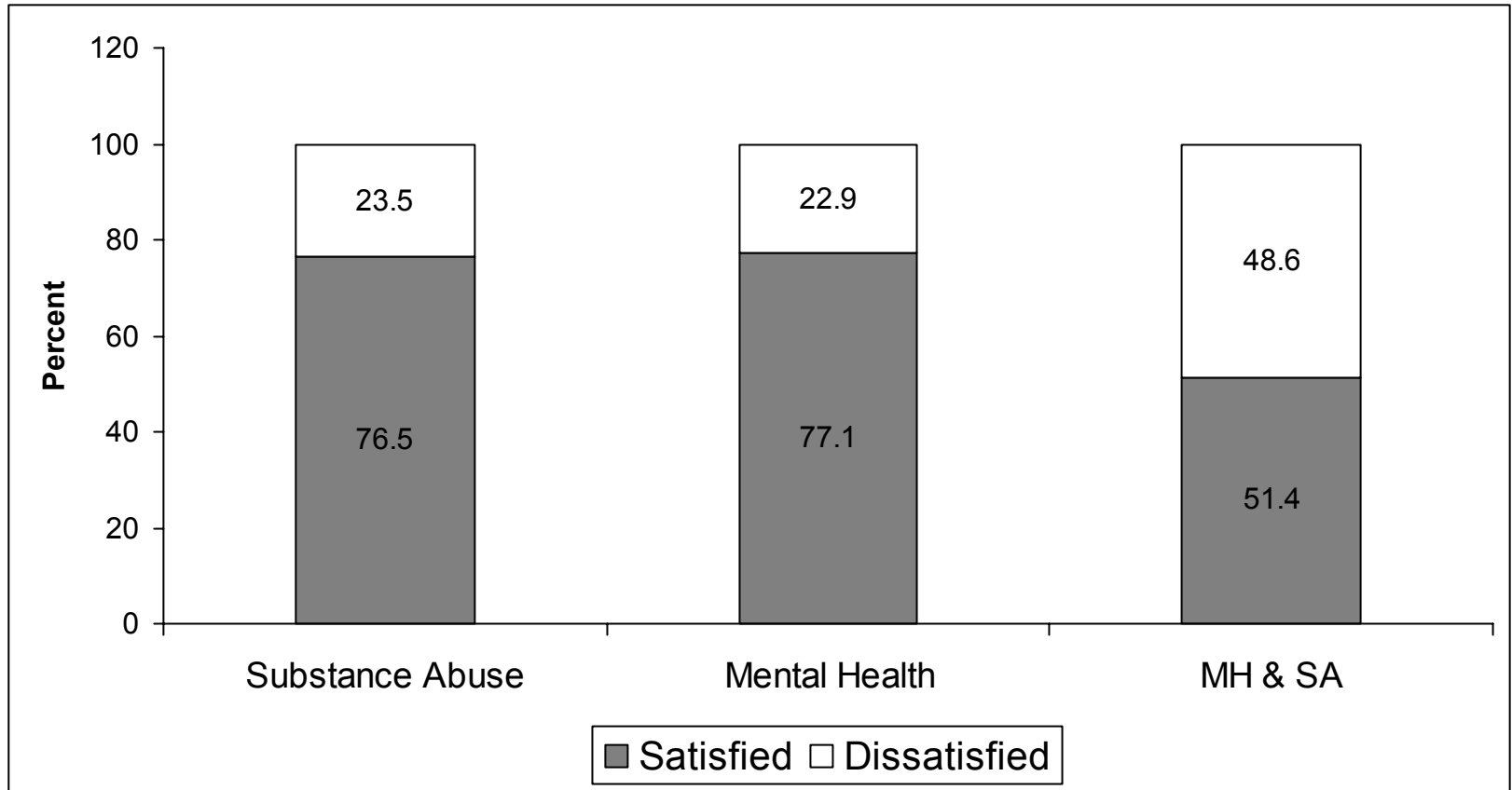


Figure 7. Consumer Satisfaction with Treatment Outcomes by Type of Treatment

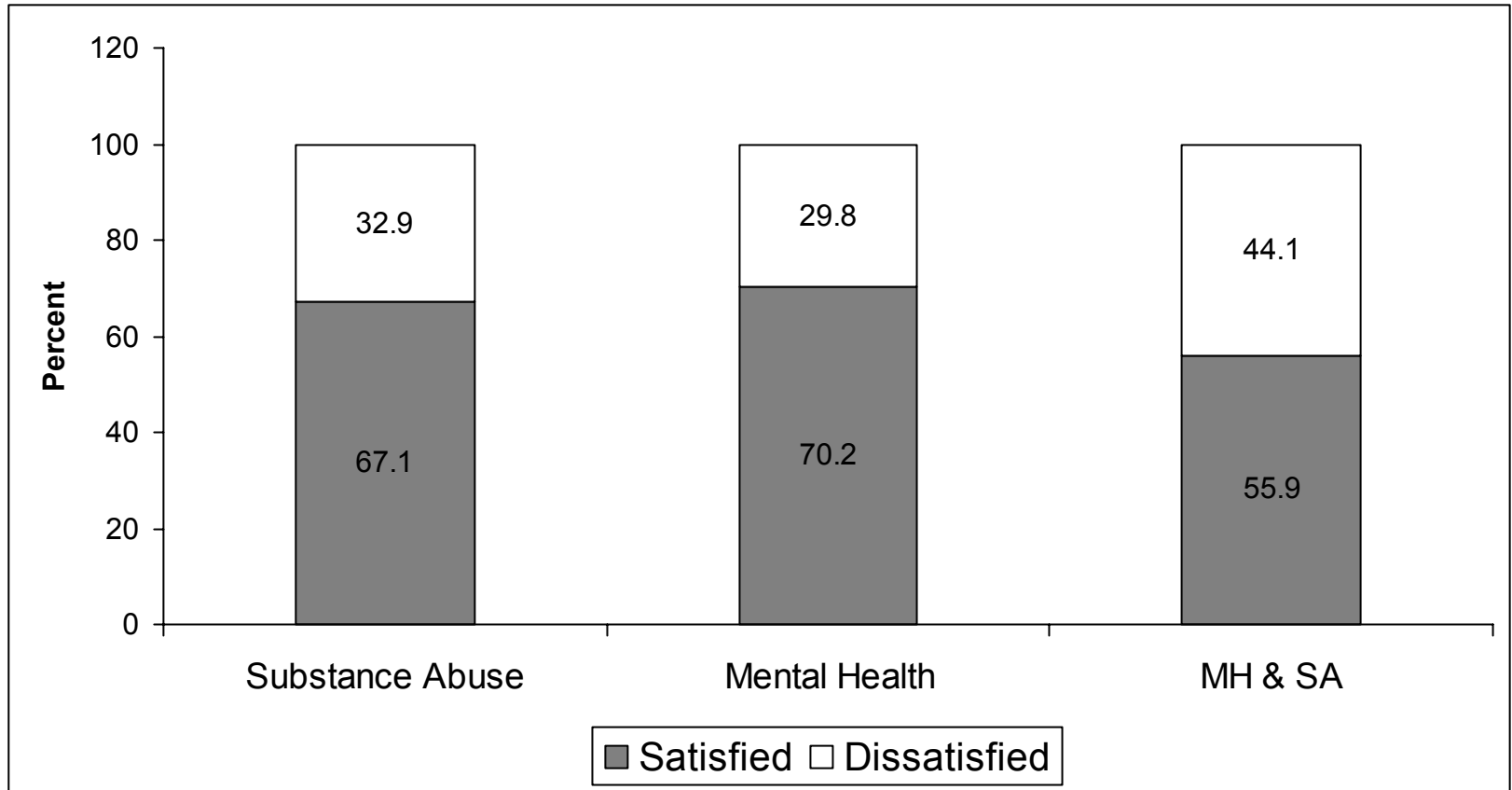


Figure 8. Consumer Satisfaction with Participation in Treatment Planning by Type of Treatment

