

2016 Oregon Youth Services Survey for Families and Youth Services Survey Report

Oregon Health Authority
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EXECUTIVE SUMMARY

In 2016, the Oregon Health Authority (OHA) Health Services Division (HSD) surveyed family members/caregivers¹ of children and youth enrolled in the Oregon Health Plan (OHP) about their perceptions of the mental health services delivered to their children and youth between May 1 and December 31, 2015. OHA HSD also surveyed young people ages 14 to 17 years about their perceptions of services they received during the same period.

The Youth Services Survey for Families (YSS-F) instrument asked questions about caregivers' perception of services delivered in seven performance domains:

- **Access to Services:** service location, frequency and availability of appointments, and responsiveness of staff
- **Appropriateness of Services:** general satisfaction, someone for child or young person to talk to, family had providers that stuck with them, received the right services, and received the right quantity of services
- **Cultural Sensitivity:** staff respect of client, family, cultural/ethnic background, and religious/spiritual beliefs
- **Daily Functioning:** ability to take care of needs, reduction in symptoms, and participation in meaningful activities
- **Family Participation in Treatment:** family's participation in determining treatment goals and comfort asking questions
- **Social Connectedness:** friendships, belonging, and social supports
- **Treatment Outcomes:** client's ability to deal with problems and crisis, control life, relationships with family, functioning in social situations and school or work, housing, and reduction in symptoms

The 2016 YSS-F replicated previous surveys by asking caregivers to report their perceptions of the coordination of services among different mental health care providers, between mental and physical health care providers, and between

¹ The survey was mailed to parents and guardians, as well as to residential treatment centers. This report refers to survey respondents as "family members" or "caregivers" throughout.

mental health care providers and state government agencies that provide other services for children and youth. These services include child welfare, the Oregon Youth Authority, local juvenile justice, education, developmental disabilities services, and substance abuse treatment providers. The survey also included questions about children’s school attendance, arrest history, alcohol and drug abuse, primary health care providers, psychotropic medications, and history of trauma.

The Youth Services Survey (YSS), like the YSS-F, included a cluster of questions designed to assess young people’s perceptions of their experiences with mental health services, including access, appropriateness, cultural sensitivity, participation, and treatment outcomes. The YSS also asked young people about where they had lived in the past six months, school absences, utilization of health care services, medication for emotional/behavioral problems, and arrest history.

Oregon’s 16 coordinated care organizations (CCOs) manage physical, behavioral, and dental health services for their assigned OHP enrollees. Per Oregon’s Medicaid demonstration waiver, Oregon must conduct statewide standardized surveys of consumers’ experience of care (satisfaction) and allow for plan-to-plan comparisons.

OHA-HSD will use the survey findings to help guide its ongoing efforts to improve the quality of state-funded mental health services and supports for children and their families. CCOs should use information from all satisfaction surveys (YSS-F, YSS, CAHPS, etc.) when assessing the quality and appropriateness of care provided, and incorporate this information into their ongoing care integration efforts.

Survey Results

The YSS-F had 3,212 responses from caregivers of 13,794 children and youth for an overall response rate of 23%. This is an increase from the 2015 survey, but similar to other recent years. The YSS had 1,025 responses from 5,714 young people who received a survey for an overall response rate of 22%, also an increase from the 2015 survey and similar to other recent years.

Survey respondents had the option of filling out a paper questionnaire or completing an online survey form. Incentives in the form of a \$10 gift card were

offered for completing the survey online. Seventy-two percent of YSS-F respondents completed the survey online, an increase from 55% in 2015. Seventy-five percent (75%) of YSS respondents completed the survey online, an increase from 60% in from 2015.

Highlights of Survey Results

Youth Services Survey for Families (YSS-F)

Overall domain satisfaction

- Satisfaction in all domains increased slightly in 2016, while satisfaction in the cultural sensitivity, outcomes, and social connectedness domains have trended significantly upward since 2012.

Satisfaction by treatment setting

- Satisfaction with residential and day treatment access was significantly lower in 2016 than satisfaction with outpatient access, although satisfaction with treatment outcomes and daily functioning has trended significantly higher in the last five years.
- Satisfaction with access and social connectedness has increased significantly among caregivers of children and youth in day treatment settings in the last five years.
- Satisfaction with social connectedness has significantly increased among caregivers of children and youth in outpatient treatment in the last five years.

Fee-for-service (FFS)

- Significantly fewer FFS respondents were satisfied with access when compared to all other CCOs.

Satisfaction by rural vs. urban residence

- Satisfaction among rural respondents has not trended upward or downward in the last five years. Among caregivers in urban areas, however, satisfaction has increased in three domains.

Satisfaction by race and ethnicity

- Satisfaction among American Indian or Alaskan Native respondents has decreased in two domains; satisfaction among White respondents has increased in four domains; and satisfaction among Black or African American respondents has increased in two domains.
- Satisfaction among Hispanic respondents has decreased in four domains over the last five years, while satisfaction among non-Hispanic respondents has increased in six domains over the last five years.

System of Care/Wraparound program

- Participation in the wraparound program did not increase satisfaction with service coordination. Dissatisfied respondents often identified the mental health provider's lack of communication or unwillingness to reach out to others as a key factor.

Treatment expectations vs. results

- Expectations and results of treatment are often similar (e.g., become happier), but sometimes there are discrepancies. The largest discrepancies between expectations and results were in
 - stopping or reducing the use of drugs or alcohol (7% had that expectation, while 48% reported that result)
 - starting or continuing a program of recovery (11% expectation; 50% result)
 - stopping hurting himself or herself (23% expectation; 54% result)
 - stopping hurting others (17% expectation; 36% result)

Health status

- Health status decreases among children and youth without a primary care health provider: 95% of children and youth with excellent or very good health status had a primary health care provider; this dropped to 92% of children and youth with good health; 86% of those with fair health status, and 81% of those with poor health status.

Medication

- Psychotropic medication prescribing has trended significantly downward over the last five years from 38% in 2012 to 31% in 2016.

School attendance

- School attendance appeared to improve with mental health services:
 - 23.9% reported an increase in number of days in school
 - 40.0% of respondents indicated that the number of days their child had been in school was about the same
 - 6.6% reported a decrease in school attendance

Mental health crisis

- The percentage of youth experiencing a mental health crisis has shown a statistically significant downward trend from 26% to 25%, while the percentage of caregivers who were satisfied with the mental health provider's response has also shown a significant downward trend from 68% to 65%.

Police encounters

- Of respondents whose child had ever encountered the police, 65% reported a decrease in encounters, while 21% reported that encounters had stayed the same and 14% reported an increase in encounters.

Alcohol and drug treatment

- There is still a need for increased access to alcohol and drug treatment: 23% of caregivers of youth ages 13–17 believed that their child either has used or now uses alcohol or drugs. Of these, fewer than half (44%) reported the youth had received treatment or other help, and of those who did receive help, 61% thought the treatment or other help provided what the youth needed.

Trauma-informed care

- Trauma-informed care is not provided consistently: 58% of respondents said their child was asked if they had a history of trauma. If the child or young person had experienced serious trauma, 53% of respondents felt the

problems related to this trauma were adequately addressed during treatment.

Youth Services Survey (YSS)

Overall domain satisfaction

- Over the last five years, the percentage of respondents that were satisfied with their treatment outcomes has shown a significant downward trend.

Satisfaction by language

- Spanish-speaking respondents were significantly more satisfied than all other language speakers in three domains, while English-speaking respondents have shown a significant decreasing trend in satisfaction with treatment outcomes.

Satisfaction by gender

- Girls have shown a significant downward trend in satisfaction with treatment outcomes over time, and were less satisfied with treatment outcomes than boys in 2016 as in previous years.

Satisfaction by rural vs. urban residence

- Rural respondents have shown a significantly decreasing trend in satisfaction with treatment outcomes over time, while urban respondents' satisfaction has remained consistent.

Living situation

- The percentage of respondents who lived with one or both parents or another family member has increased in the last five years, while the percentage who lived in a foster home decreased.

Court appearances

- Court appearances have trended significantly downward while the percentage of youth that were arrested by the police has remained stable.

Primary care provider visits

- Most (77%) respondents saw a doctor in the last year. These visits are a good opportunity to provide well-care services; however, CCO incentive

measure reporting showed that only 32% of Medicaid enrollees ages 12–21 received a well-care visit.

- **Among the paired adolescent/caregiver respondents, the proportion of youth who only saw a provider in a hospital emergency room doubled from 5% to 10% between those with and without a primary care provider, and the proportion who saw a provider in a clinic or office dropped from 76% to 45% if they had a primary care provider.**

Medication

- Psychotropic medication use has not changed in the last 5 years: 43% of respondents are currently taking medication for their emotional/behavioral problems, and 91% were told about possible side effects.
 - **Among the paired adolescent/caregiver respondents, more adolescents reported taking a medication for their emotional/behavioral problems than their caregivers, suggesting that caregivers were not always aware of the medications their child was taking. More caregivers were told what side effects to watch out for than their adolescent children.**

INTRODUCTION

The Mental Health Statistics Improvement Program (MHSIP) designed and validated the YSS-F to measure caregivers' perceptions of their child's experiences with mental health services.² The survey has been used annually since 2002 to measure caregivers' satisfaction with their child's experience with mental health services in seven domains:

- Access to services
- Appropriateness of services
- Cultural sensitivity
- Daily functioning
- Family participation in treatment
- Social connectedness
- Treatment outcomes

Over the years, the state has widened the scope of the YSS-F by 1) including in the survey population the families of children and youth who received services in psychiatric residential and psychiatric day treatment facilities, 2) adding questions about the coordination of services for children and youth, both within the mental health system and between mental health care providers and other state-funded agencies, and 3) adding questions about children's and youth's school attendance, arrest history, and use of alcohol or drugs.

The YSS is a MHSIP tool designed for adolescents ages 14–17 who receive mental health services. Acumentra Health, now HealthInsight Oregon, has conducted the YSS since 2011. The state has not widened the scope of the YSS, and continues to use the original validated version published by the MHSIP. The YSS includes the same domains as the YSS-F, excluding the daily functioning and social connectedness domains.

This year, as in previous years, the survey sample was determined by HSD, and included a representative sample by CCO and an oversample of racial minorities.

² The YSS-F is endorsed by the National Association of State Mental Health Program Directors.

METHODOLOGY

The YSS-F is designed to assess responses from caregivers of children and youth who received state-funded mental health services from May 1, 2015, through December 31, 2015, as identified by claims and encounter data from OHA's Medicaid Management Information System (MMIS) operated by HSD. The YSS is intended to collect responses directly from adolescent service recipients identified in the same manner.

The YSS-F instrument presents questions designed to measure respondent perception of the performance and services of mental health service providers in the domains of access to services, family participation in treatment, cultural sensitivity, appropriateness of services, social connectedness, treatment outcomes, and daily functioning. The YSS presents similar questions in the above domains, excluding social connectedness and daily functioning. Both surveys use a 5-point Likert scale, with responses ranging from "Strongly Agree" (5) to "Strongly Disagree" (1). There are no reverse scored items.

The 2016 YSS-F and YSS questionnaires were fielded in English and Spanish, according to the member's primary language identified in Oregon's MMIS.

Survey Methods

The 2016 survey population included a random sample of 16,200 children and youth ages 1–17 who received mental health services between May and December 2015. Within this sample, 5,714 young people ages 14–17 who received services during that period were identified to receive the YSS. OHA pulled the sample, ensuring at least 244 survey recipients in each CCO and over-sampling minority race and ethnic populations. Greater Oregon Behavioral Health Incorporated (GOBHI), is the mental health organization for individuals whose mental health services are not covered under a CCO. GOBHI was not specifically sampled for this population.

HSD classified the children and youth by the setting in which they received mental health services. If a child or young person received services at more than one level of care, they were identified in the highest level of care.

- The **Psychiatric Residential Treatment** group consisted of children and youth who received at least one day of psychiatric residential treatment services. This group comprised 2.1% of the surveys distributed.
- The **Psychiatric Day Treatment** group consisted of children and youth who received at least one day of psychiatric day treatment services, but who did not receive psychiatric treatment in residential settings. This group comprised 2.8% of the surveys distributed.
- The **Outpatient Treatment** group consisted of children and youth who received only outpatient mental health services. This group comprised 95.1% of the surveys distributed.

HealthInsight Oregon mailed letters to eligible caregivers and young people in May 2016 informing them about survey objectives. The letters instructed recipients how to access the online survey using a unique password, and informed recipients that if they did not complete the online survey within three weeks, they would receive a paper questionnaire by mail. Letters sent to caregivers and young people offered them a \$10 gift card as an incentive for completing the online survey.

The letters, like the surveys themselves, were available in both English and Spanish, depending on the family’s language preference identified in the state enrollment data.

In June 2016, the first follow-up letter and survey was mailed to caregivers and young people. After filtering out incorrect addresses and respondents who had already returned the survey, HealthInsight Oregon mailed a second survey form to non-responding caregivers in July and to young people in August. Each time recipients were offered the incentive for completing the survey online.

Please refer to Appendix A for survey data security and quality assurance procedures.

Domain Scoring Analysis

HealthInsight Oregon calculated scores of the respondents’ perception of the services provided for each performance domain, with higher Likert scores representing higher levels of positive perception (e.g., 4 = “Agree” and 5 =

“Strongly Agree”). Data from surveys lacking responses for more than one-third of the items for a domain were excluded from the analysis of that domain.

Domain scores were calculated for a particular respondent by averaging the scores on all answered items for a domain (as long as at least two thirds of the items were answered). An average score greater than 3.5 represented positive perception of mental health services provided for the child in that domain. For example, the treatment participation domain contains three items:

- “I helped to choose my child’s services.”
- “I helped to choose my child’s treatment goals.”
- “I participated in my child’s treatment.”

A respondent’s score for this domain was calculated if the respondent reported a score for at least two of the three items in the domain. If a respondent answered all three and reported the scores 3, 4, and 5, respectively, the average of those scores would be $(3+4+5)/3 = 4$. Since 4 is greater than 3.5, this respondent would be considered satisfied within the participation domain.³ **Throughout this report, we reference the percentage of respondents satisfied in various domains. This refers to the percentage of respondents whose domain score was >3.5.**

³ The number of responses reported in each data table may be lower than the total number of survey respondents, as some respondents may not have answered all items needed to calculate a particular domain score.

2016 YSS-F RESULTS

This section presents results of the YSS-F, including responses about satisfaction with coordination of various services and about expectations for treatment and results of treatment. The Additional Analyses section, beginning on page 42, contains responses to questions about young people’s alcohol or drug use and treatment, as well as questions about young people’s school attendance and arrest history before and after receiving services.

Details of the YSS results begin on page 62.

Survey Response

From the 13,794 YSS-F surveys mailed to valid addresses, 3,212 respondents returned a survey form or completed the survey online by the completion deadline for an overall response rate of 23%. Individuals who refused to complete the survey by calling or writing were excluded from the denominator for the response rate calculation. More respondents filled out the survey online than by mail this year.

HealthInsight Oregon’s survey analysis excluded data from surveys received after the deadline of September 15, 2016.

OHA contracted with 16 CCOs and one mental health organization (MHO) to manage OHP mental health services during the survey period. HealthInsight Oregon analyzed some of the results by CCO.

Table 1 displays the YSS-F responses from caregivers whose children received outpatient, psychiatric residential, and psychiatric day treatment services from each CCO. Response rates varied according to CCO. The number of surveys sent excludes surveys that were sent to bad addresses and recipients who opted out of the survey.

Table 1. YSS-F Response Rate by CCO.

CCO	Number of responses	Number of surveys sent	Response rate (%)
AllCare	120	510	24
Cascade Health Alliance (CHA)	72	288	25
Columbia Pacific CCO (CPCCO)	66	293	23
Eastern Oregon CCO (EOCCO)	104	511	20
FamilyCare Health	458	1,660	28
Health Share of Oregon	687	3,113	22
InterCommunity Health Network (IHN)	208	822	25
Jackson Care Connect (JCC)	64	318	20
PacificSource Community Solutions–Central Oregon (PCS-CO)	137	640	21
PacificSource Community Solutions–Columbia Gorge (PCS-CG)	52	212	25
Primary Health of Josephine County (PHJC)	38	211	18
Trillium Community Health Plan (TCHP)	375	1,607	23
Umpqua Health Alliance (UHA)	47	196	24
Western Oregon Advanced Health (WOAH)	56	257	22
Willamette Valley Community Health (WVCH)	377	1,679	22
Yamhill Community Care Organization (YCCO)	76	350	22
Greater Oregon Behavioral Health Inc. (GOBHI) MHO*	16	40	40
Fee-for-service (FFS)	259	1,087	24
Total	3,212	13,794	23

*GOBHI is not a CCO, but a Medicaid managed mental health care organization. GOBHI members were not explicitly sampled, so the number of responses was too small to perform any MHO-specific analyses.

Note: Surveys sent exclude opt-outs and bad addresses.

Table 2 presents the YSS-F survey response rate by the type of facility in which the respondent's child or young person received treatment.

Table 2. YSS-F Response Rate by Treatment Setting.

Setting	Number of responses	Number surveys sent	Response rate (%)
Outpatient	3,081	13,113	23
Psychiatric Day	70	291	24
Psychiatric Residential	61	390	16
Total	3,212	13,794	23

Note: Surveys sent exclude opt-outs and bad addresses. All surveys were sent to the most current address on file for the child or youth, so the caregiver/respondent could have been the foster parent, residential facility administrator, caseworker, or other adults currently living with the child.

Table 3 shows response rates by member demographics as they are noted in Medicaid enrollment data. Response rates were similar between the gender, age groups, and race categories (around 23% or 24%). Recipients of the English language survey had a higher response rate than recipients of the Spanish language survey (23% vs. 16%). Recipients of the English language survey whose primary language was not English returned a survey had the highest response rate at 25%.

Table 3. YSS-F Response Rate by Demographic Characteristics.

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	1,573	6,544	24
	Male	1,639	7,250	23
Age group	0–5	322	1,302	25
	6–12	1,547	6,594	23
	13–17	1,343	5,898	23

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Race	Non-white	508	2,114	24
	White (Caucasian)	2,096	8,715	24
	Race unknown	608	2,965	21
Location of residence	Rural	1,168	5,137	23
	Urban	2,016	8,492	24
	Unknown	28	165	17
Language	English	1,982	8,525	23
	Spanish	175	1,126	16
	Other	1,055	4,143	25

Note: Surveys sent exclude opt-outs and bad addresses.

All demographic information comes from state Medicaid enrollment data.

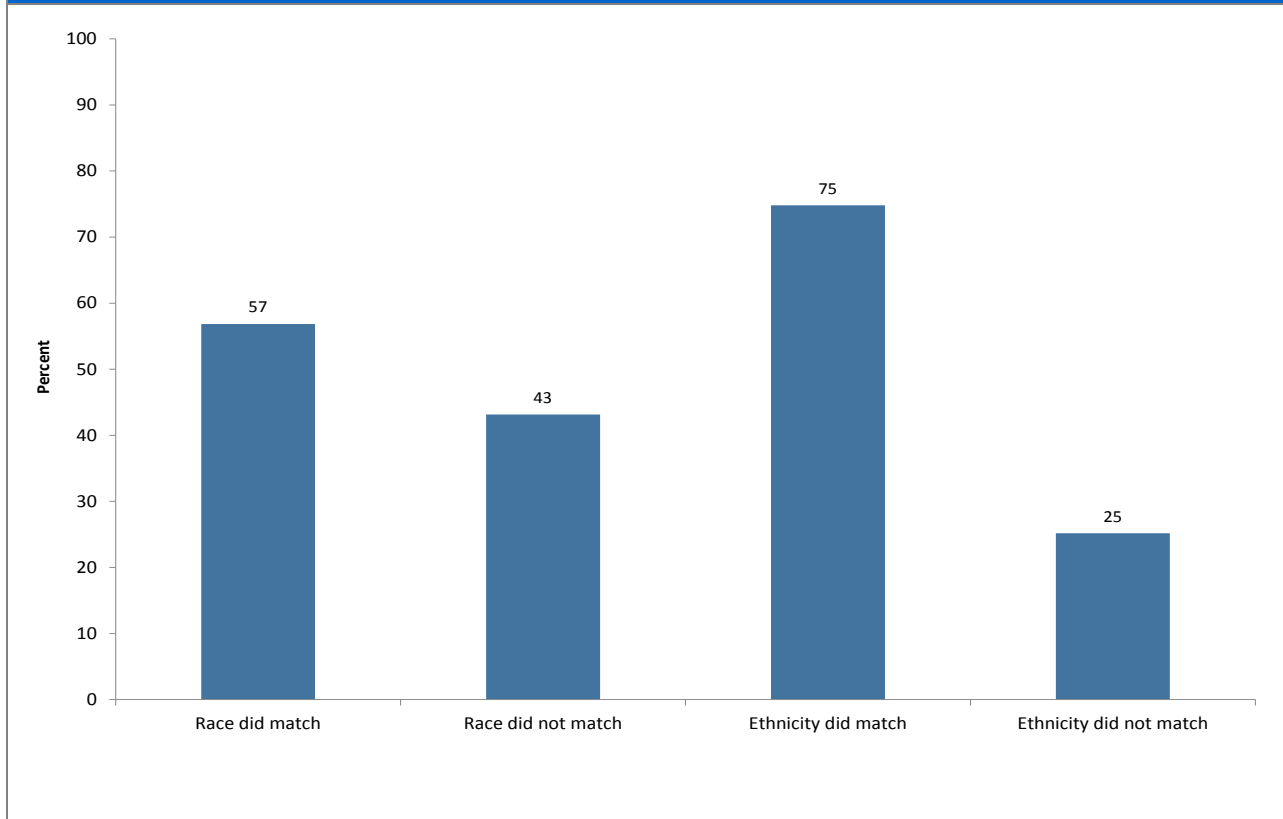
Respondent Race and Ethnicity

Neither race nor ethnicity are required fields in Medicaid enrollment forms, and as a result this information is missing for many Medicaid enrollees in the state’s dataset. Obtaining accurate information about enrollee’s race and ethnicity is an important tool in addressing health equity. The survey asked respondents to self-identify their race and ethnicity, enabling comparison between state data and self-reported data. Figure 1 shows these results.

Among YSS-F respondents, ethnicity was consistent between state data and self-reported data for 75% of respondents (25% did not match). Overall, state ethnicity data overestimates the number of non-Hispanic enrollees.

Race categories on the Medicaid enrollment form do not match race categories on the survey. To facilitate the best comparison, responses from the survey question allowing multiple race selections was used, and respondents who selected multiple races were rolled into a “multiracial” category. Race was consistent between state data and self-reported data for 57% of respondents, and did not match for 43%. Overall, state race data overestimates the number of white enrollees.

Figure 1. Comparison of State-Recorded and Self-Reported Race and Ethnicity Data, by Respondent.

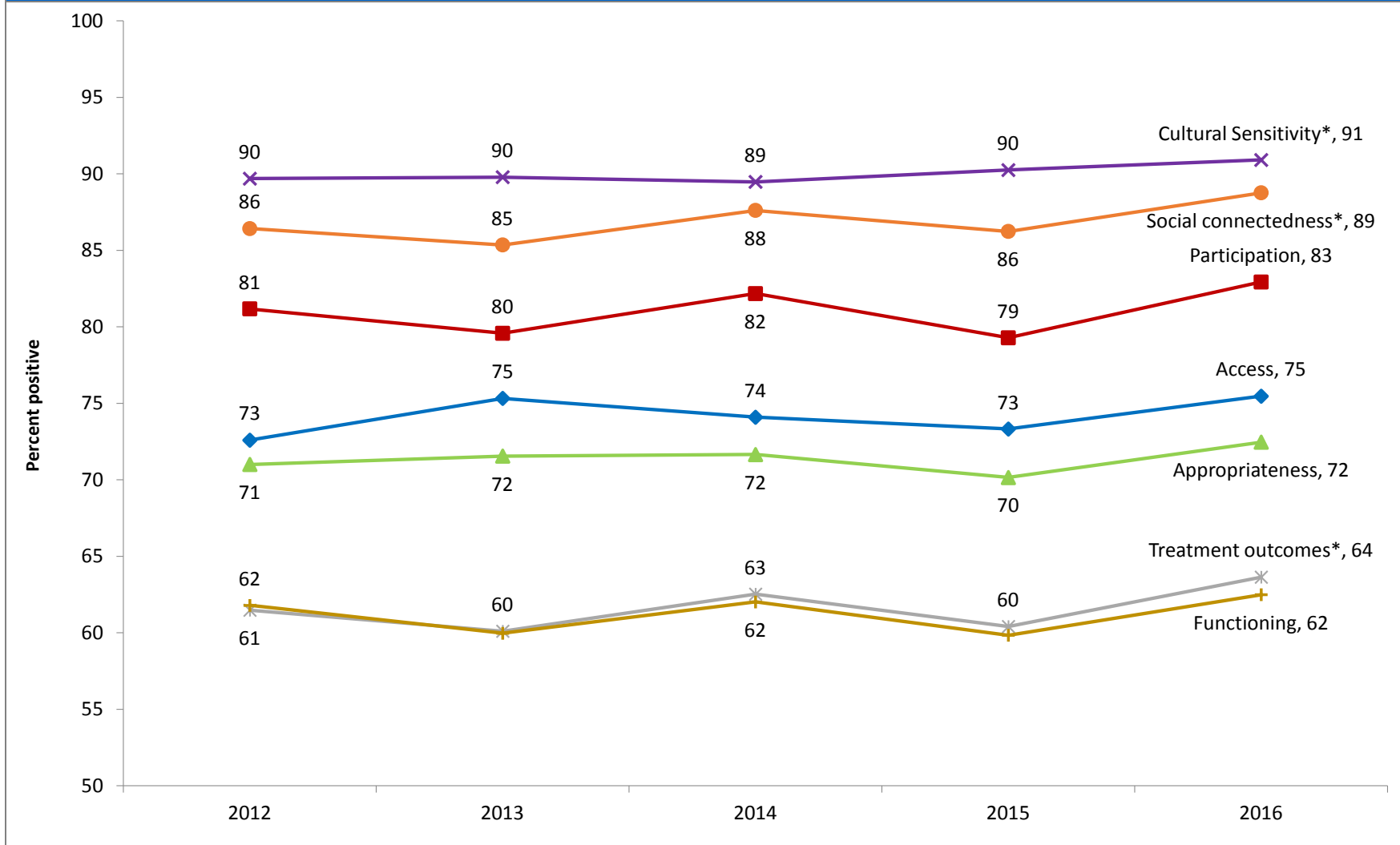


Domain Satisfaction

The satisfaction according to domain represents the percentage of respondents who were satisfied in that domain (see Methodology, page 9, for further explanation).

Figure 2 shows that overall, the percentages of respondents satisfied in each domain have remained relatively stable over the past five years. Satisfaction in all domains increased slightly in 2016, while the percentages of respondents satisfied in the cultural sensitivity, social connectedness and treatment outcomes domains have trended significantly upwards since 2012.

Figure 2. 2012–2016 Comparison of YSS-F Domain Satisfaction.



*Indicates statistically significant upward or downward trend ($p < .05$) over time for that domain.

Domain satisfaction according to treatment setting

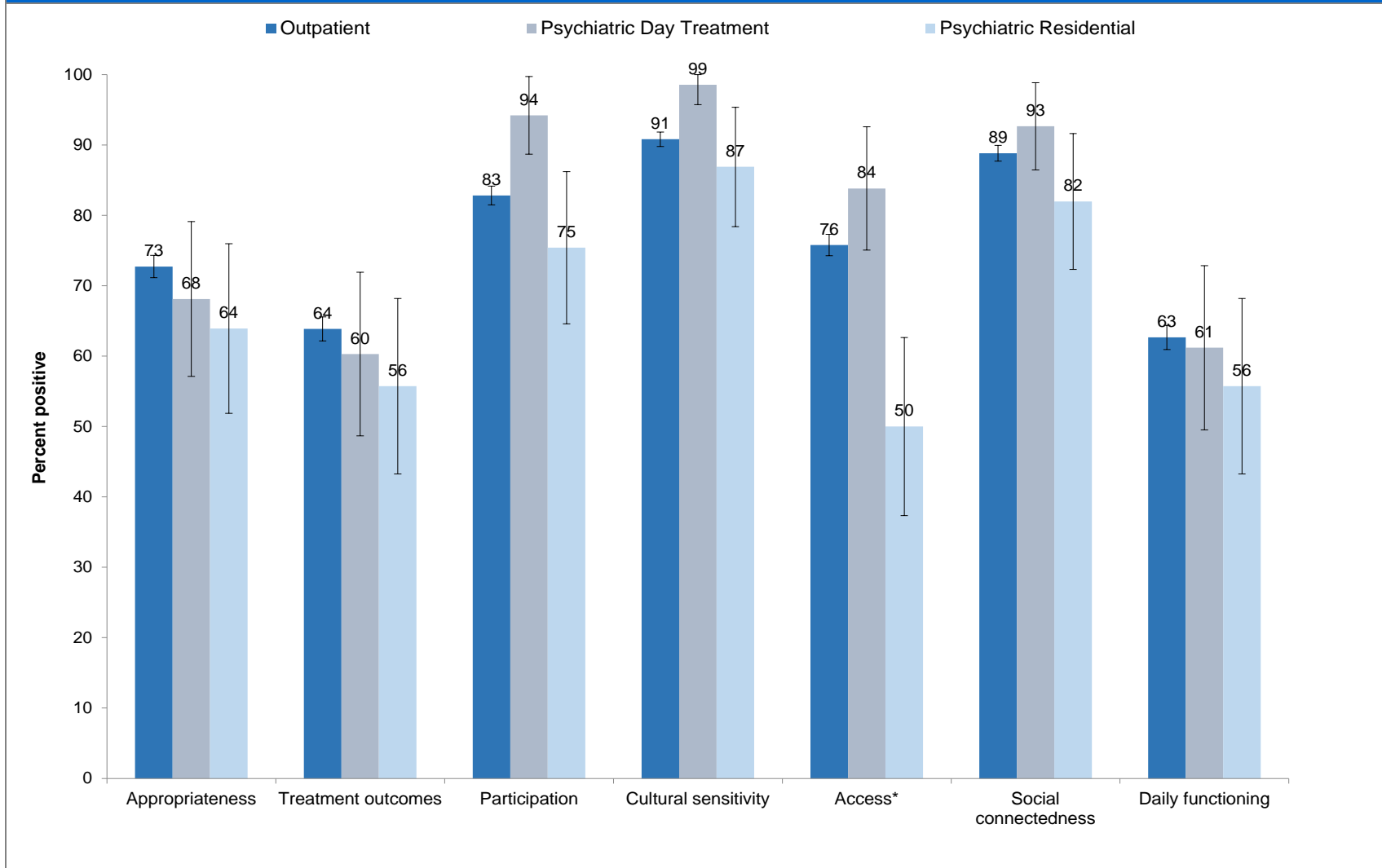
Figure 3 shows the 2016 satisfaction by domain, with 95% confidence intervals (CIs), by treatment setting. The CI indicates the upper and lower limits within which the score would be expected to fall 95 times if 100 identical surveys were conducted.

The percentage of caregivers satisfied decreased as level of care increased in the appropriateness, treatment outcomes, and daily functioning domains, while a greater percentage of caregivers of children and youth in psychiatric day treatment reported satisfaction in the participation, cultural sensitivity, and social connectedness domains. To test for statistical significance, the psychiatric residential and psychiatric day treatment groups were combined and compared against the outpatient group. A significantly smaller percentage of caregivers of children and youth in psychiatric residential treatment were satisfied with access.

The following notable trends were observed over the past five years:

- **Outpatient treatment settings:** The percentage of caregivers that were satisfied in the social connectedness domain has significantly increased in the last five years. Satisfaction in all other domains has remained stable.
- **Psychiatric day treatment settings:** The percentage of caregivers that were satisfied in the access and social connectedness domains has significantly increased in the last five years. Satisfaction in all other domains has varied over the years, without a significant upward or downward trend.
- **Psychiatric residential treatment settings:** The percentage of caregivers that were satisfied in the treatment outcomes and daily functioning domains has significantly increased in the last five years. Satisfaction in all other domains has varied over the years without a significant upward or downward trend.

Figure 3. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals.



*Indicates a statistically significant difference ($p < .05$) between treatment settings.

Domain satisfaction according to CCO

Table 4 shows the 2016 percentage of respondents satisfied in each domain, with the 95% confidence interval displayed, according to CCO. Note that the survey questions asked respondents to rate their satisfaction with services delivered by contracted service providers, not satisfaction with the CCO itself.

Because GOBHI MHO was not sampled, not enough responses were received to present the mental health organization's results (n=16).

The percentage of satisfied respondents in each CCO was compared against all other CCOs combined. Some notable findings include:

- CPCCO had significantly fewer satisfied respondents in the appropriateness, cultural sensitivity, and daily functioning domains than all other CCOs.
- PHJC had significantly fewer satisfied respondents in the appropriateness domain than all other CCOs, although satisfaction was lower in CPCCO.
- FamilyCare had significantly more satisfied respondents in the appropriateness and participation domains.
- EOCCO had significantly fewer satisfied respondents in the participation domain than all other CCOs combined.
- Significantly fewer FFS respondents were satisfied with access when compared to all other CCOs, while IHN had significantly more satisfied respondents in the access domain than all other CCOs combined.
- CHA and UHA had significantly fewer satisfied respondents in the social connectedness domain.

Table 4. Domain Satisfaction by CCO, with 95% CI, 2016.

CCO	Appropriateness (CI)	Treatment Outcomes (CI)	Participation (CI)	Cultural Sensitivity (CI)	Access (CI)	Social Connectedness (CI)	Daily Functioning (CI)
AllCare	76 (69-84)	65 (56-73)	86 (79-92)	87 (81-93)	81 (74-88)	88 (82-94)	65 (56-73)
CHA	64 (53-76)	63 (52-75)	77 (67-87)	89 (81-96)	84 (75-93)	80 (71-90)*	61 (50-73)
CPCCO	54 (42-66)*	52 (40-64)	68 (56-79)*	80 (70-90)*	74 (63-85)	83 (74-92)	49 (37-61)*
EOCCO	70 (61-79)	60 (51-70)	75 (66-83)*	87 (81-94)	83 (75-90)	87 (80-93)	60 (51-70)
FamilyCare	79 (75-82)*	67 (62-71)	88 (85-91)*	93 (90-95)	76 (72-80)	91 (88-94)	64 (60-69)
Health Share	71 (68-75)	63 (59-66)	85 (82-87)	93 (91-95)	76 (72-79)	89 (86-91)	63 (59-66)
IHN	78 (73-84)*	67 (60-73)	84 (79-89)	95 (92-98)	82 (76-87)*	91 (87-95)	65 (58-71)
JCC	72 (61-83)	64 (52-76)	75 (64-86)	95 (90-100)	79 (69-89)	88 (79-96)	61 (49-73)
PCS-CO	74 (66-81)	64 (56-72)	80 (73-87)	95 (91-99)	78 (71-85)	92 (87-96)	63 (55-71)
PCS-CG	79 (68-90)	69 (57-82)	88 (79-97)	94 (88-100)	67 (55-80)	84 (74-94)	71 (59-83)
PHJC	58 (42-74)*	59 (44-75)	74 (60-88)	95 (87-100)	81 (68-93)	87 (76-98)	59 (44-75)
TCHP	71 (66-75)	66 (61-71)	82 (78-86)	89 (86-93)	72 (67-76)	90 (87-93)	66 (61-71)
UHA	70 (57-83)	51 (37-65)	79 (67-90)	89 (81-98)	85 (75-95)	79 (67-90)*	49 (35-63)
WOAH	75 (64-86)	59 (46-72)	79 (68-89)	87 (78-96)	73 (61-85)	94 (88-100)	63 (50-75)
WVCH	74 (70-79)	65 (60-70)	84 (80-87)	90 (87-93)	72 (67-76)	88 (85-91)	62 (57-67)
YCCO	64 (53-75)	59 (48-70)	84 (76-92)	87 (79-94)	76 (66-86)	85 (77-93)	59 (48-70)
FFS	69 (63-75)	59 (53-65)	82 (77-86)	88 (84-92)	69 (63-74)*	89 (85-93)	59 (53-65)

*Indicates statistically significant difference ($p < .05$) between CCO and other CCOs grouped together.

Demographic Comparisons

Domain satisfaction by child's or young person's age

Caregivers' satisfaction scores were clustered into groups based on the current age of the child or young person who had received services: 0–5, 6–12, and 13–17. Key findings are listed below:

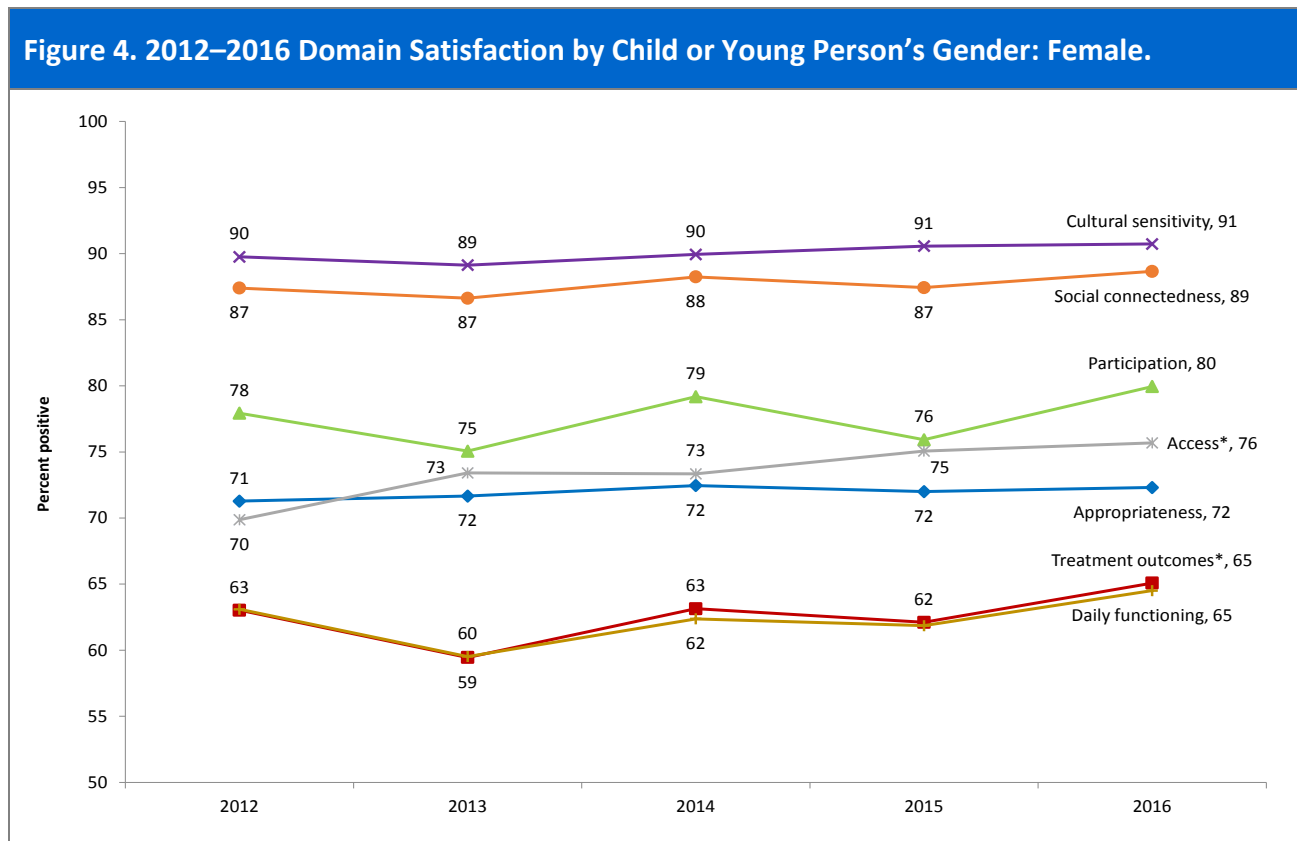
- **Ages 0–5:** Significant increase in the last five years in the percentage of respondents satisfied in the cultural sensitivity and participation domains. All other domains remained consistent.
- **Ages 6–12:** Significant increase in the last five years in the percentage of respondents satisfied in the social connectedness domain. All other domains remained consistent.
- **Ages 13–17:** Significant increase in the last five years in the percentage of respondents satisfied in the treatment outcomes domain. All other domains remained consistent.

Consistent with previous years, caregivers of youth ages 13–17 were the least satisfied in all domains.

Domain satisfaction by child’s or young person’s gender

Domain satisfaction according to gender was similar between boys and girls. Over the last five years, a significantly increasing percentage of caregivers of girls reported satisfaction in the treatment outcomes and access domains, while a significantly increasing percentage of caregivers of boys reported satisfaction in the social connectedness domain (see Figures 4 and 5).

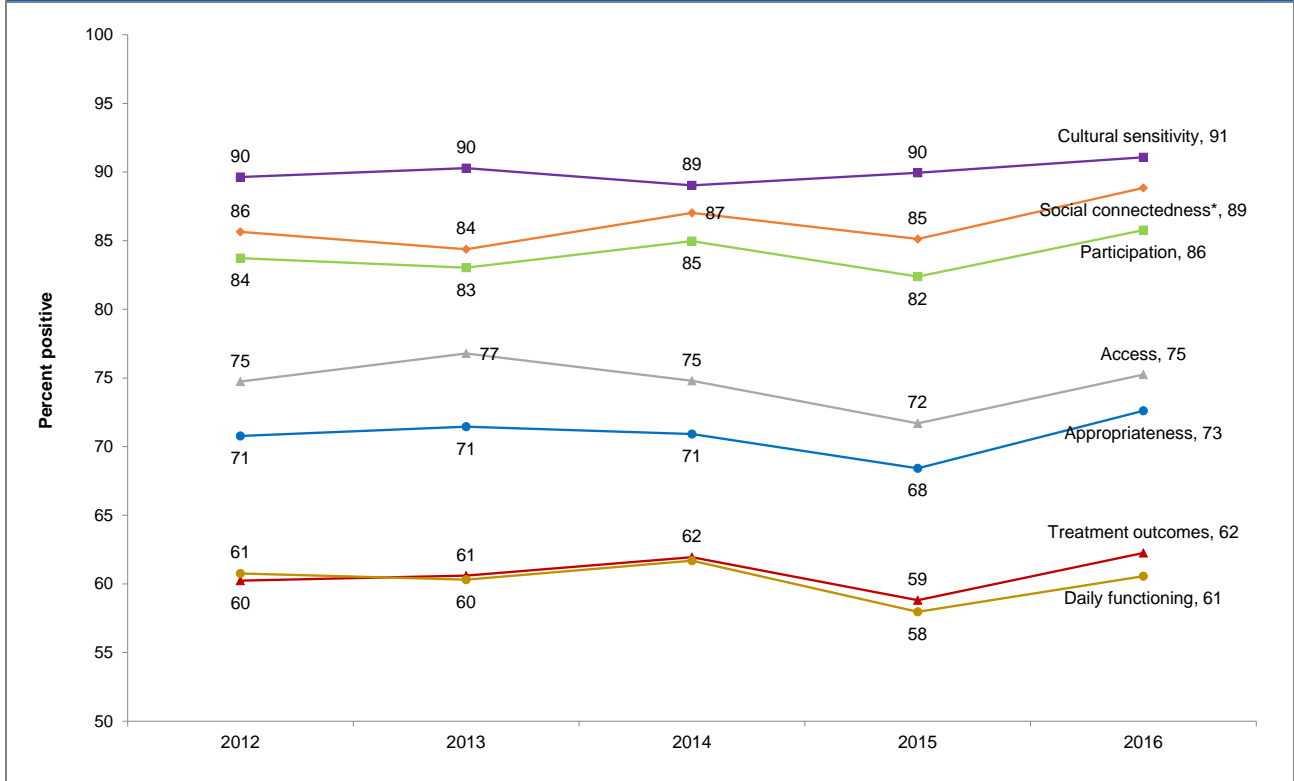
From 2012 to 2016, a significantly increasing percentage of caregivers of girls was satisfied with treatment outcomes and access. Other domains varied slightly year to year, with most increasing in 2016, though not significantly.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that domain.

From 2012 to 2016, a significantly increasing percentage of caregivers of male children was satisfied with social connectedness. Satisfaction in most other domains also increased, though these changes were not statistically significant.

Figure 5. 2012–2016 Domain Satisfaction by Child’s or Young Person’s Gender: Male.

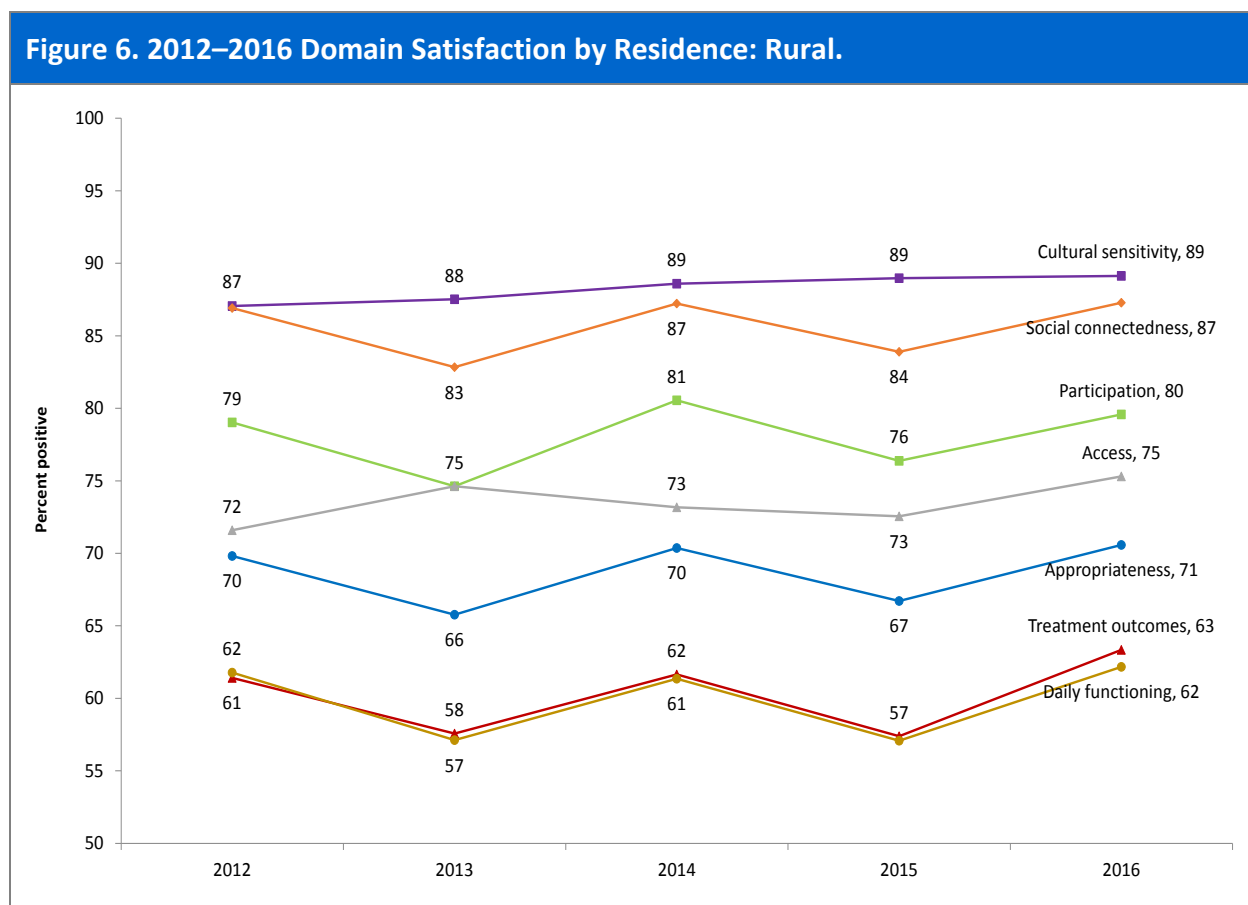


*Indicates a statistically significant upward or downward trend ($p < .05$) for that domain.

Domain satisfaction by rural/urban residence

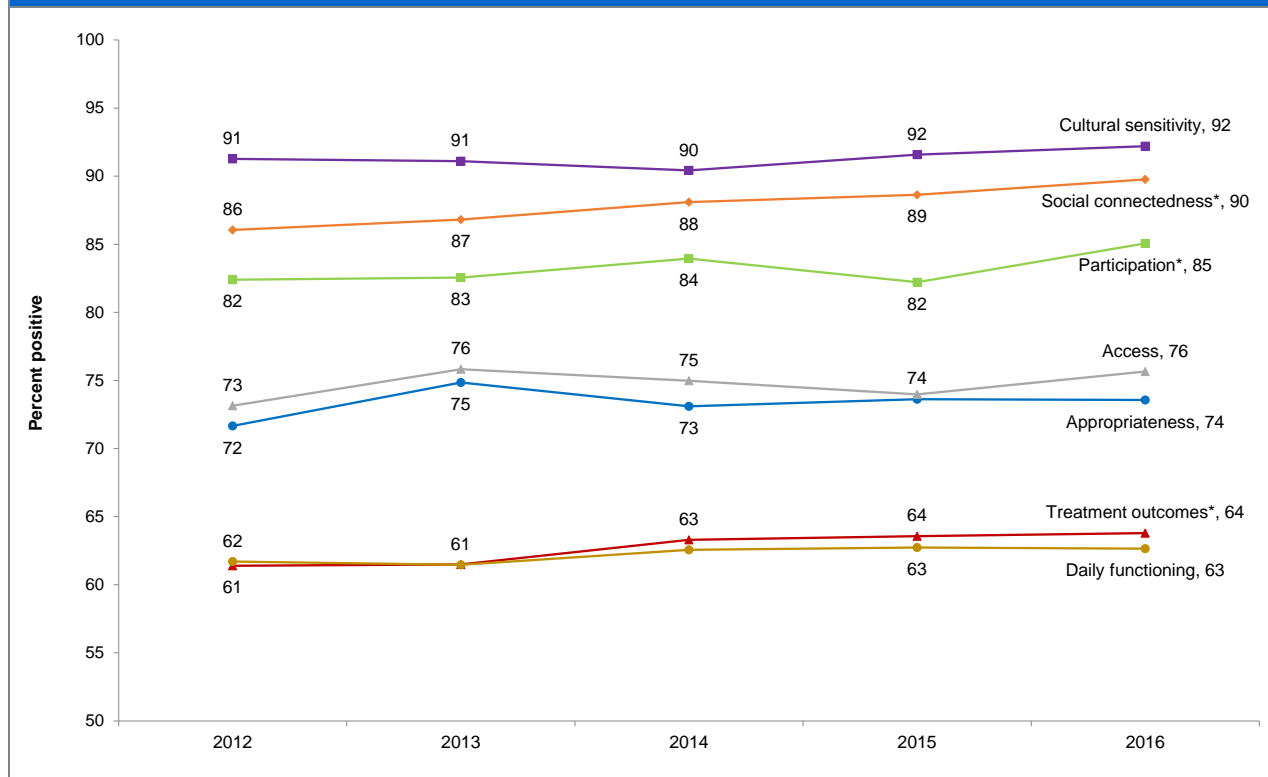
Caregivers were classified as rural or urban based on the ZIP code of their current residence, even though their children may have received mental health services in another ZIP code. Classifications came from the Oregon Office of Rural Health.

Figures 6 and 7 display the 2012–2016 results of respondent satisfaction by place of residence. As in previous years, more caregivers in urban areas were satisfied in every domain than caregivers in rural areas. There have not been any significant changes in satisfaction in the last five years among caregivers in rural areas. Among caregivers in urban areas, however, the percentage of satisfied respondents has significantly increased in the treatment outcomes, participation, and social connectedness domains.



There were no statistically significant trends.

Figure 7. 2012–2016 Domain Satisfaction by Residence: Urban.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that domain.

Domain satisfaction by child's or young person's race

Even though race information was self-reported this year, the results presented below are based on the state's MMIS data to allow comparison with the previous four years (self-reported race data were used for the first time in the 2015 survey analysis). Using race information provided on children's and youth's Medicaid enrollment form, we examined domain satisfaction according to identified race in 2016. There were no significant differences in the percentage of respondents indicating satisfaction between race groups on any domain.

We also examined changes over the last five years in reported satisfaction by race. There were fewer than 30 respondents indicating Asian, Native Hawaiian or Other Pacific Islander, or Unknown race in at least one year; therefore, those groups have been excluded from the figures below (Figures 8–14).

Key findings include:

- **American Indian or Alaskan Native:** Significantly fewer respondents have been satisfied in the Treatment Outcomes and Daily Functioning domains over the last five years.
- **White:** Significantly more respondents have reported satisfaction in the Treatment Outcomes, Participation, Social Connectedness, and Daily Functioning domains over the last five years.
- **Black or African American:** Significantly more respondents have reported satisfaction in the Social Connectedness and Access domains over the last five years.

In 2016, respondents were asked to identify their racial and ethnic identity in three separate questions: the first to identify ethnicity, the second to identify as many race categories as apply, and the third to identify a single race category. The second question, which provided the option to select more than one race category, is especially illuminating because respondents with more than one race identity have the lived experience of each race, and identifying respondents accurately is a critical component of improving the equity of services. As we gather additional years of survey data with self-reported race information we will use this self-report to examine results over time.

Figure 8. 2012–2016 Domain Satisfaction by Race: Appropriateness.

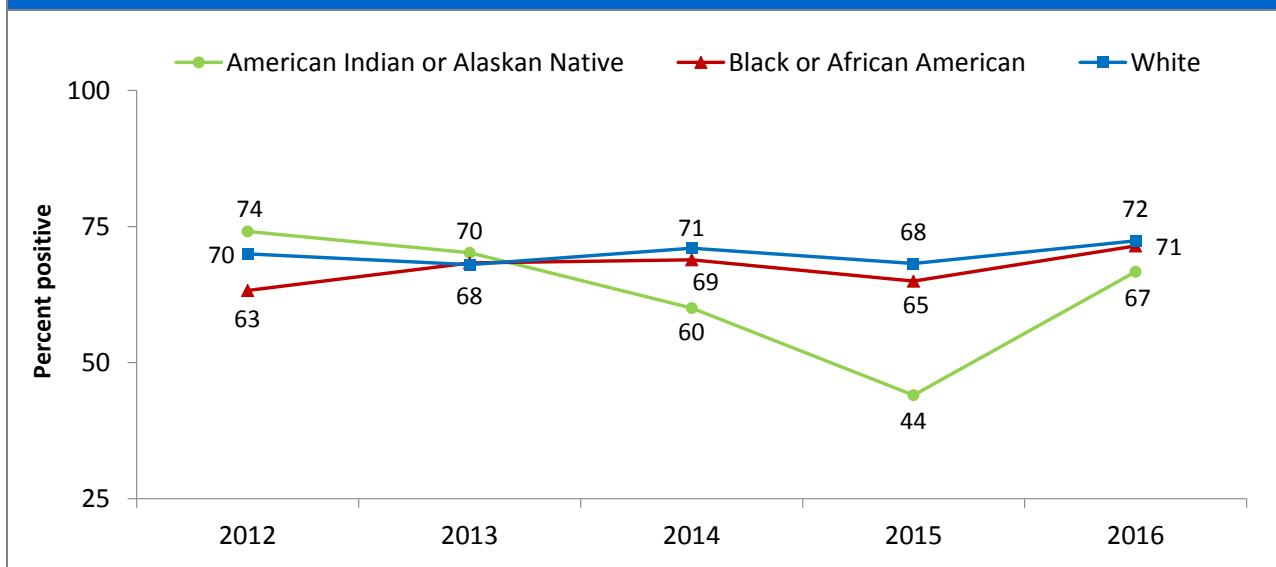
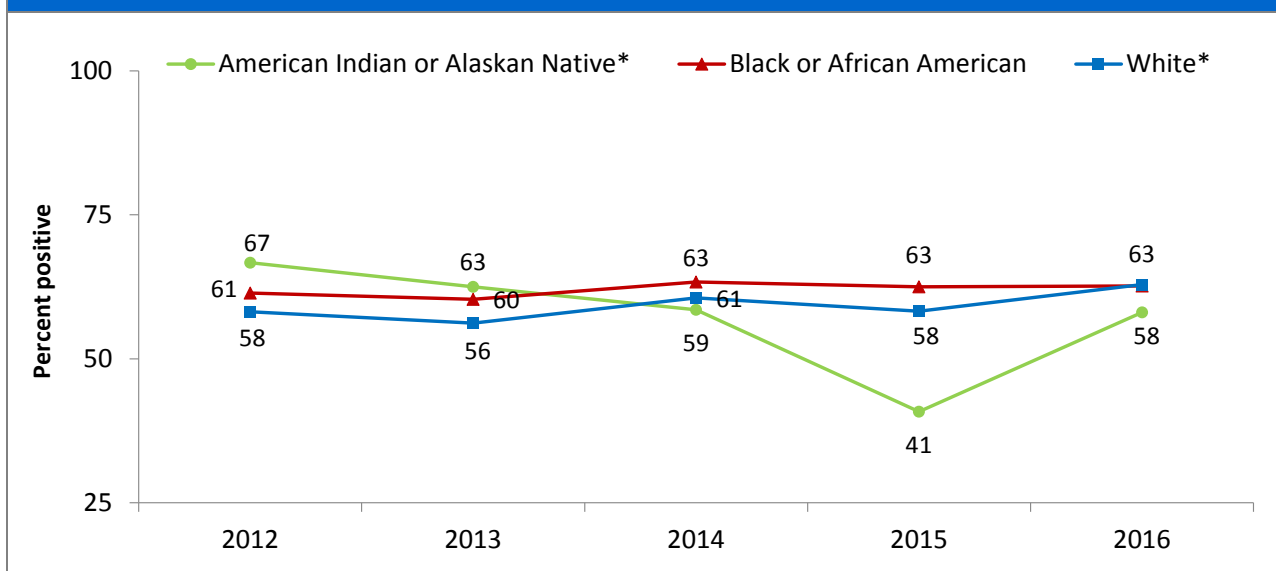
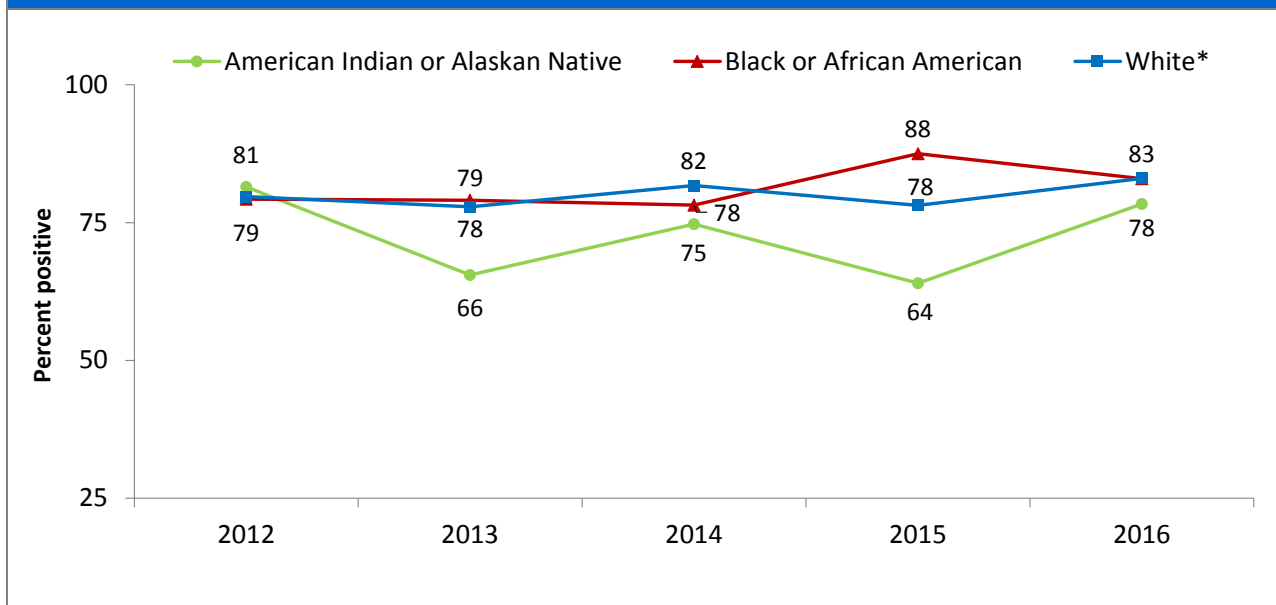


Figure 9. 2012–2016 Domain Satisfaction by Race: Treatment Outcomes.



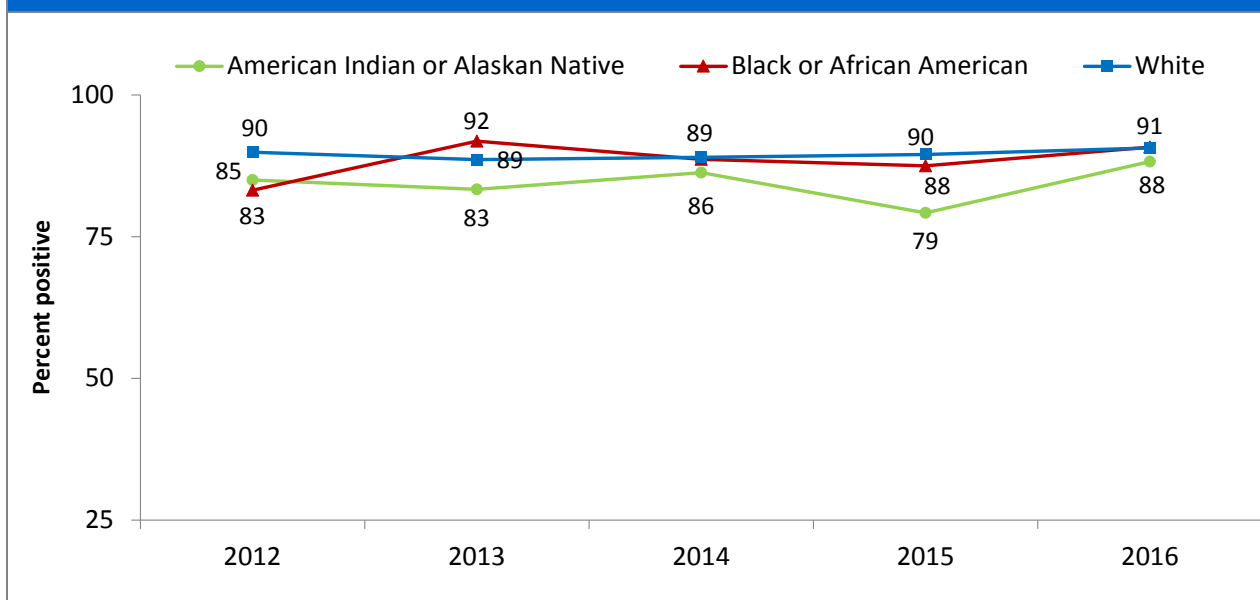
*Indicates a statistically significant upward or downward trend ($p < .05$) for that race group.

Figure 10. 2012–2016 Domain Satisfaction by Race: Participation.



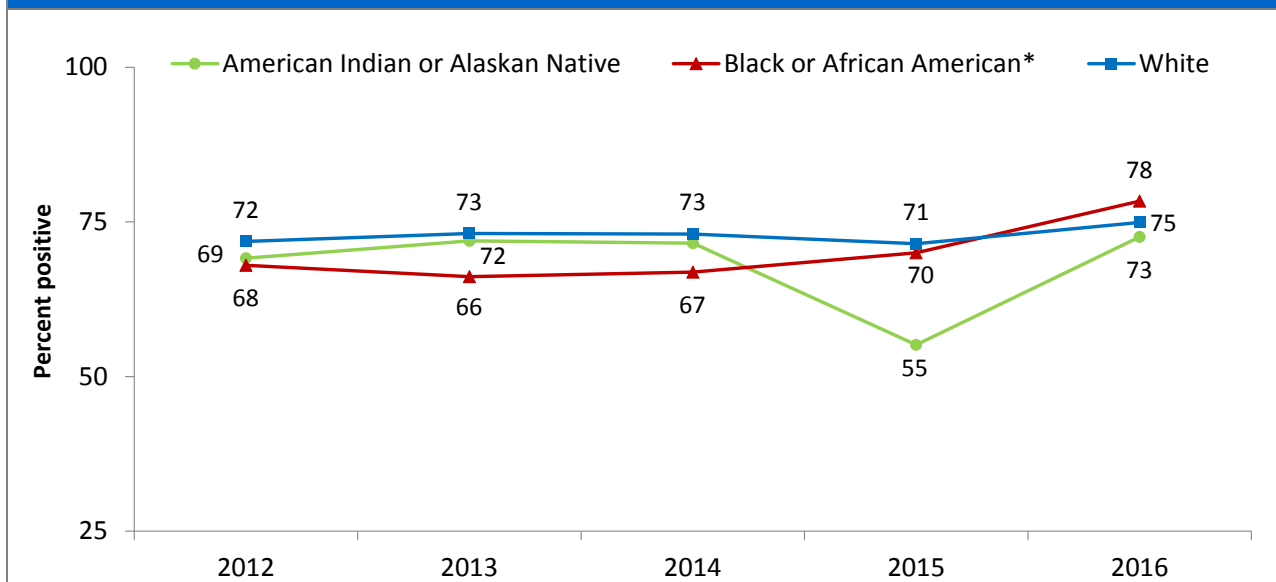
*Indicates a statistically significant upward or downward trend ($p < .05$) for that race group.

Figure 11. 2012–2016 Domain Satisfaction by Race: Cultural Sensitivity.



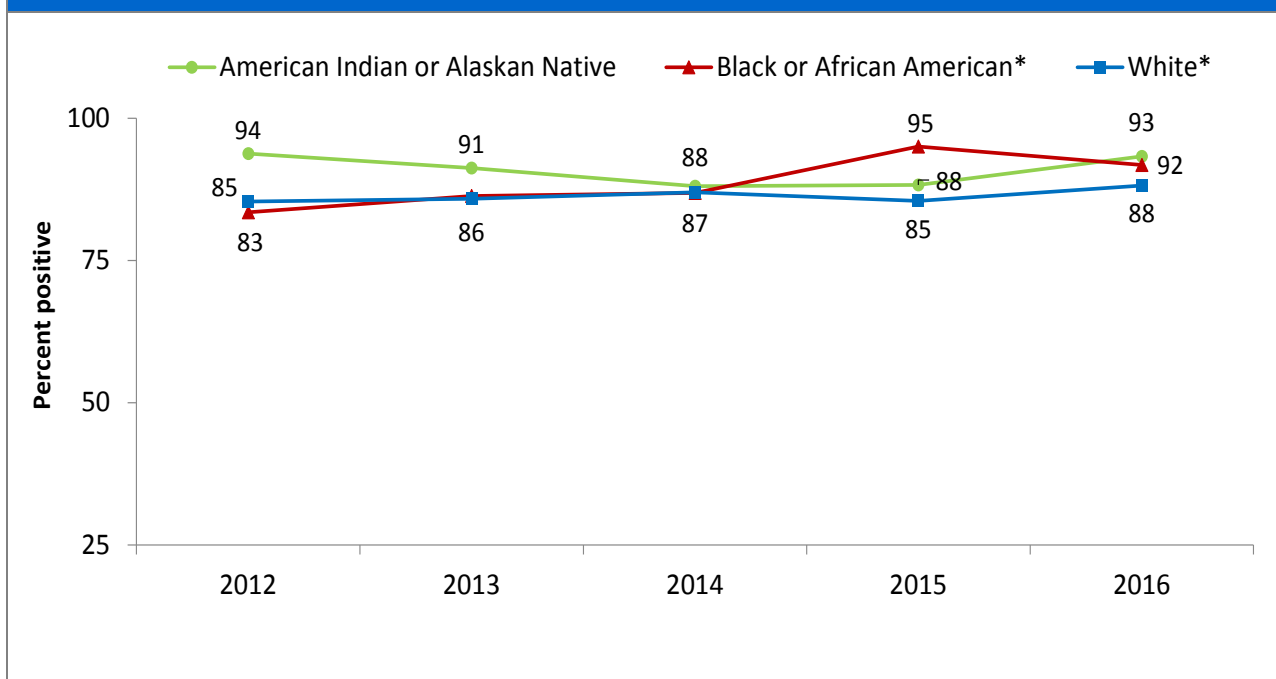
There were no statistically significant trends.

Figure 12. 2012–2016 Domain Satisfaction by Race: Access.



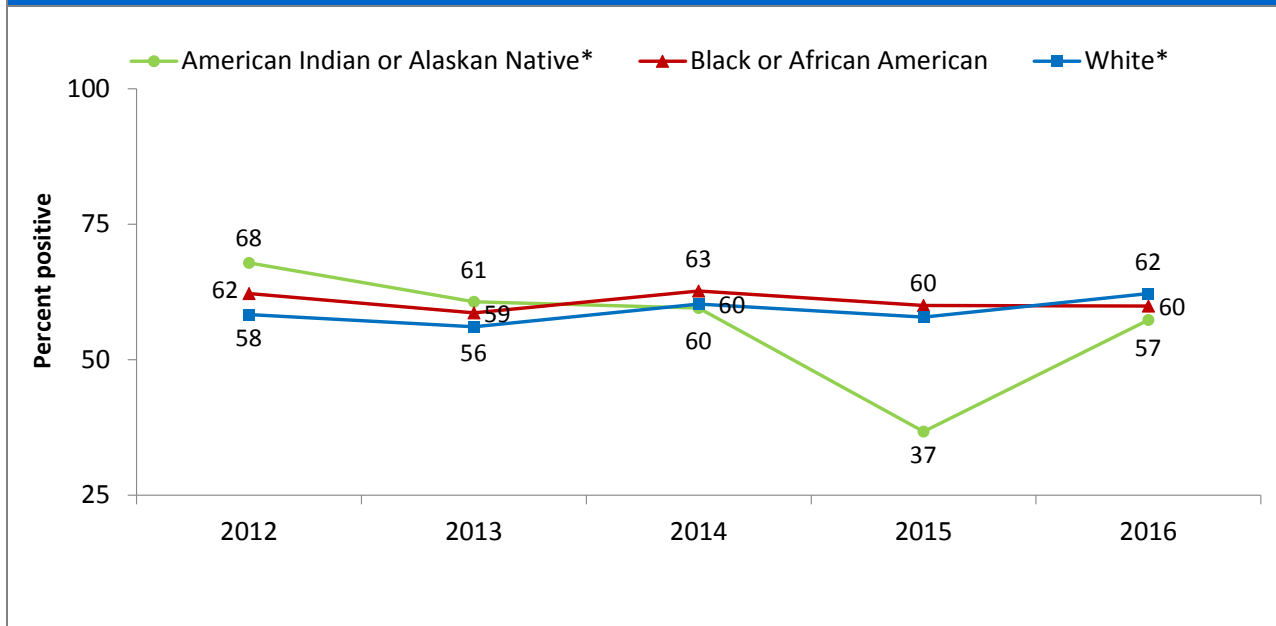
*Indicates a statistically significant upward or downward trend ($p < .05$) for that race group.

Figure 13. 2012–2016 Domain Satisfaction by Race: Social Connectedness.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that race group.

Figure 14. 2012–2016 Domain Satisfaction by Race: Daily Functioning.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that race group.

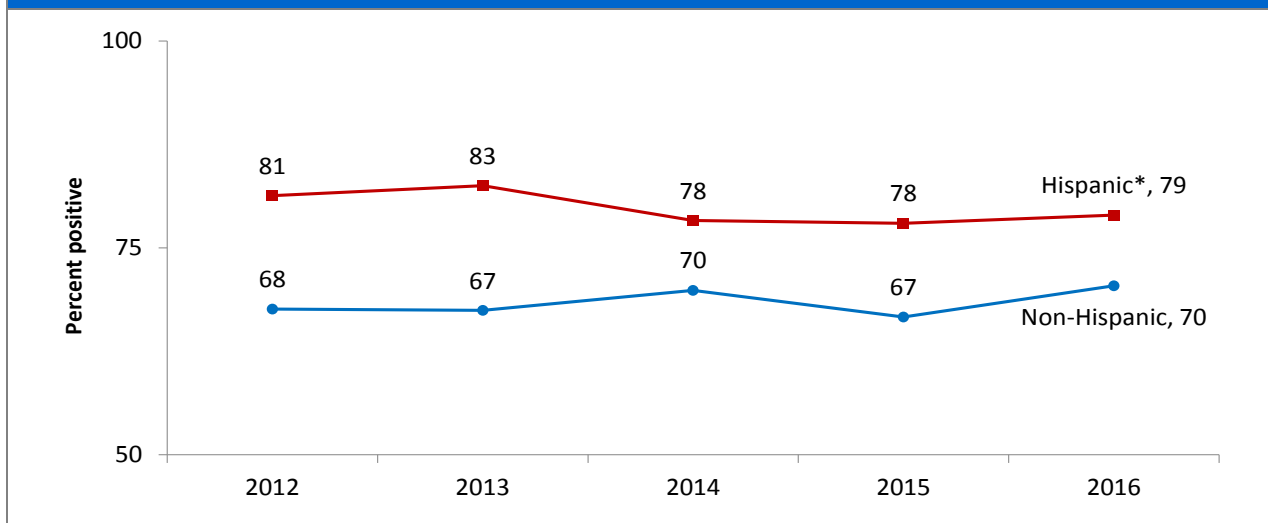
Domain satisfaction by ethnicity

Even though ethnicity information was self-reported this year, the results presented below are based on the state's MMIS data to allow comparison with the previous four years (self-reported race data were used for the first time in the 2015 survey analysis). Figures 15–21 display the percentage caregivers of Hispanic children and youth and caregivers of non-Hispanic children and youth who were satisfied in that domain for 2012 to 2016. Also included are those who did not select ethnicity or indicated their ethnicity as unknown.

Key findings include:

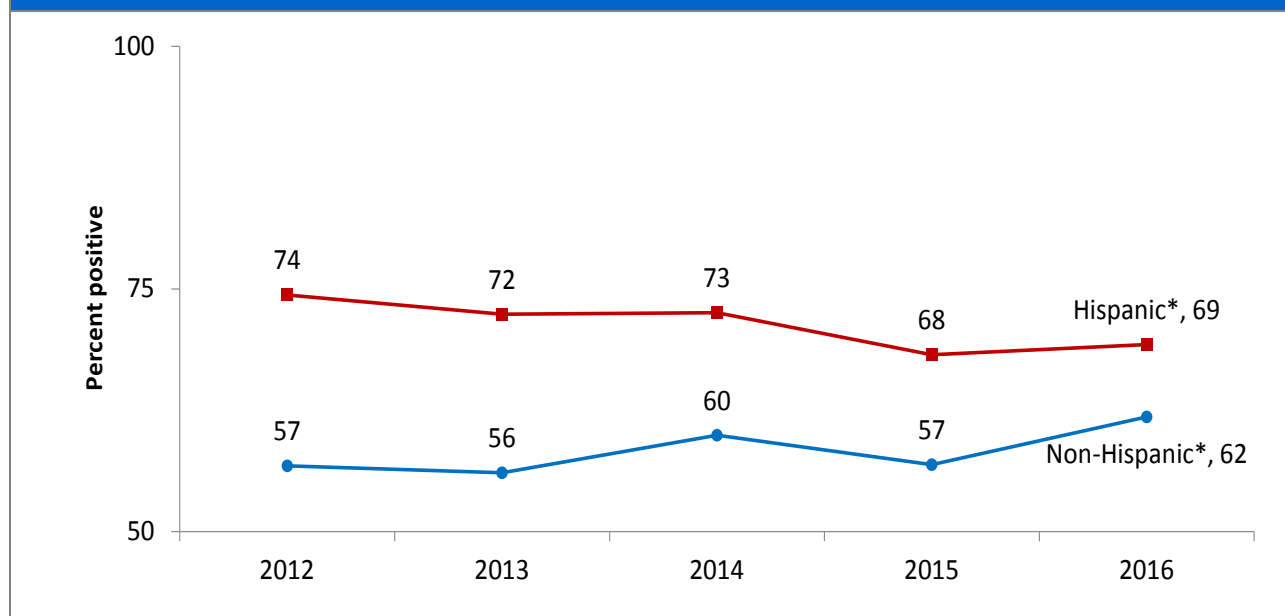
- Caregivers of Hispanic or Latino(a) children and youth were slightly more satisfied in most domains in 2016.
- Satisfaction among Hispanic respondents has decreased in several domains. Significantly fewer respondents with Hispanic or Latino(a) children and youth have been satisfied with appropriateness, treatment outcomes, access, and daily functioning over the last five years.
- Satisfaction among non-Hispanic respondents has increased in many domains. Significantly more respondents with non-Hispanic children and youth have been satisfied with treatment outcomes, participation, cultural sensitivity, access, social connectedness, and daily functioning over the last five years.

Figure 15. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness.



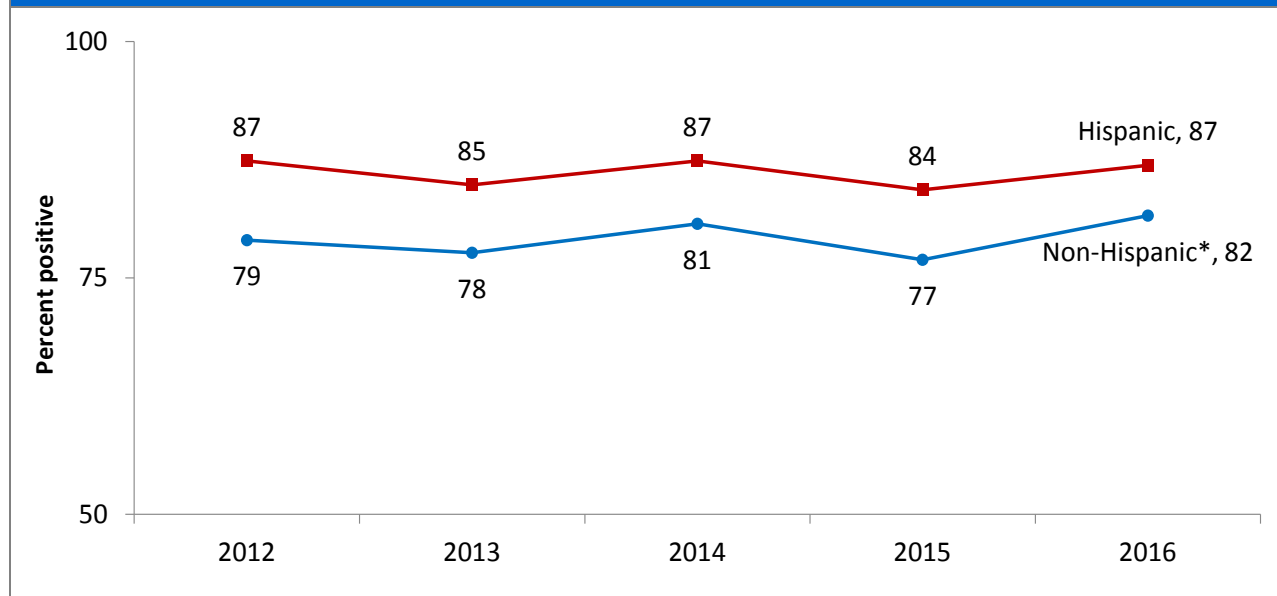
*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 16. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes.



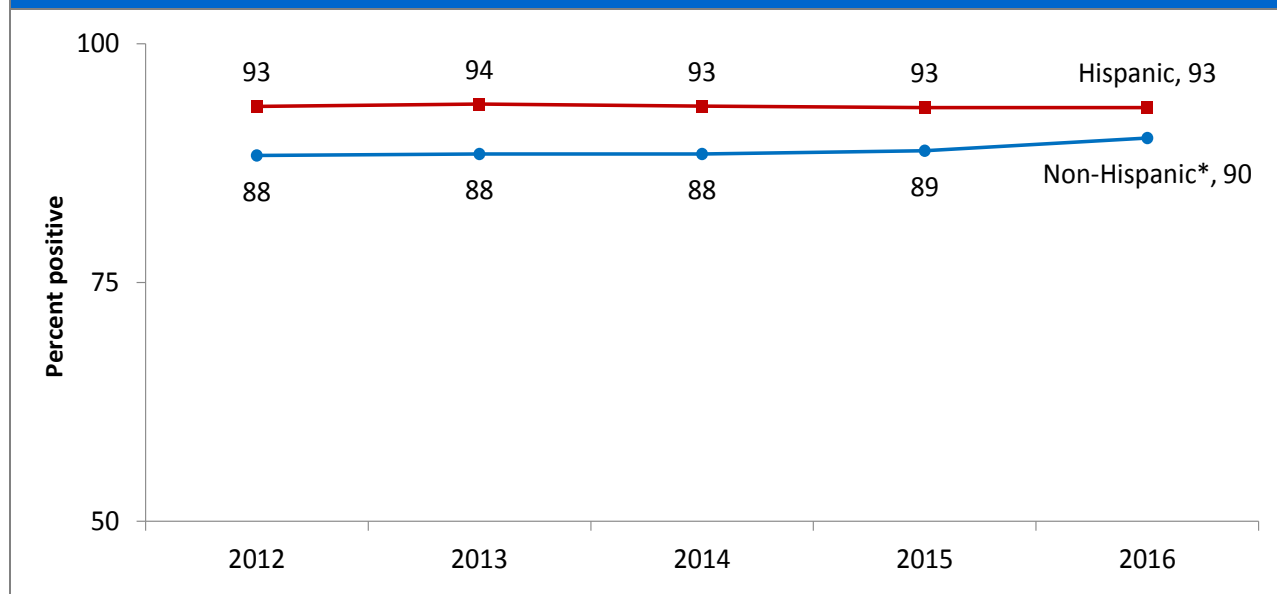
*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 17. 2012–2016 Domain Satisfaction by Ethnicity: Participation.



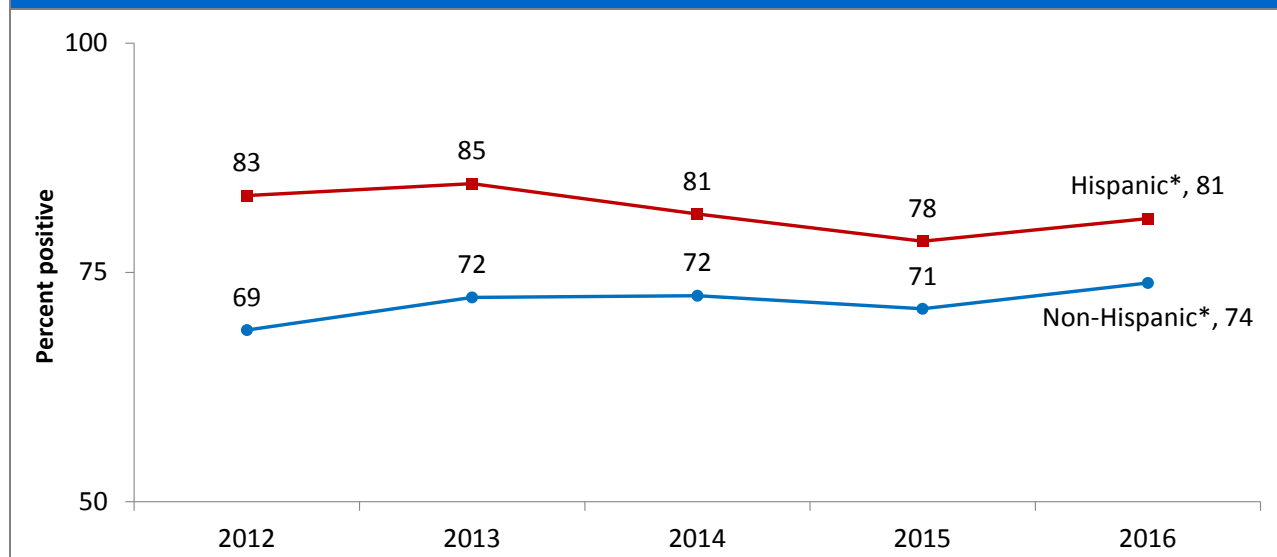
*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 18. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity.



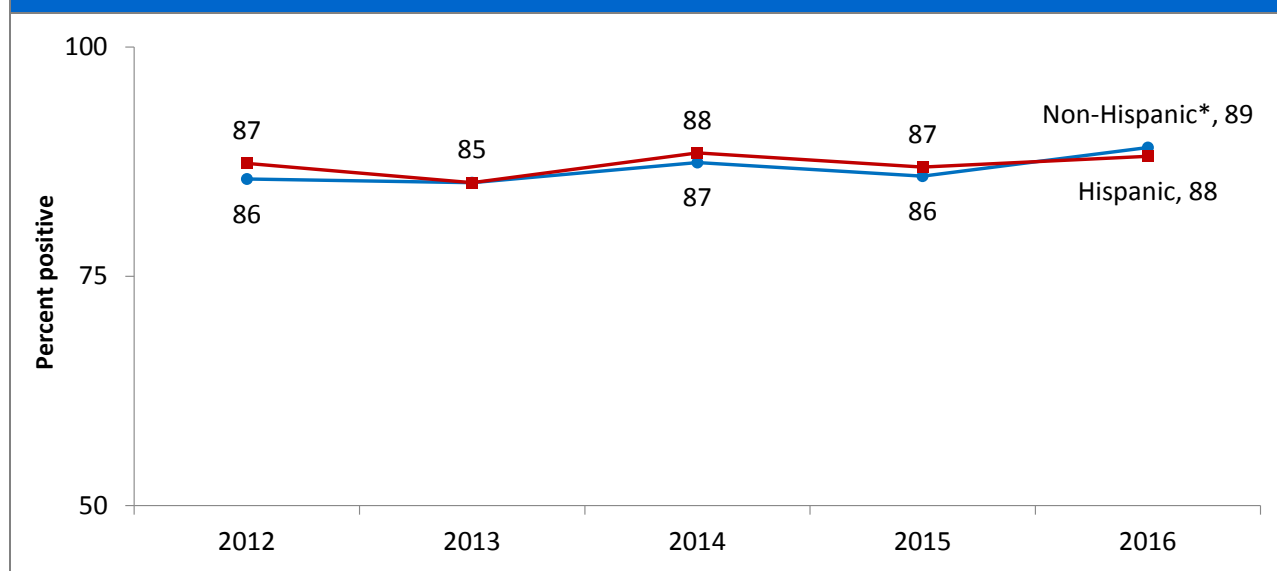
*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 19. 2012–2016 Domain Satisfaction by Ethnicity: Access.



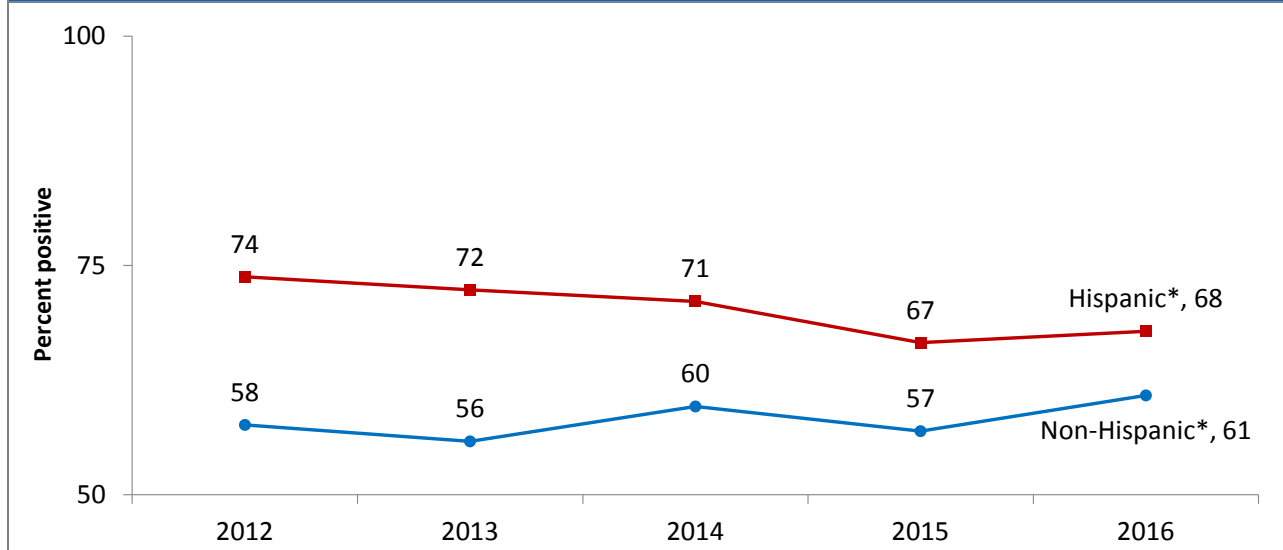
*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 20. 2012–2016 Domain Satisfaction by Ethnicity: Social Connectedness.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 21. 2012–2016 Domain Satisfaction by Ethnicity: Daily Functioning.

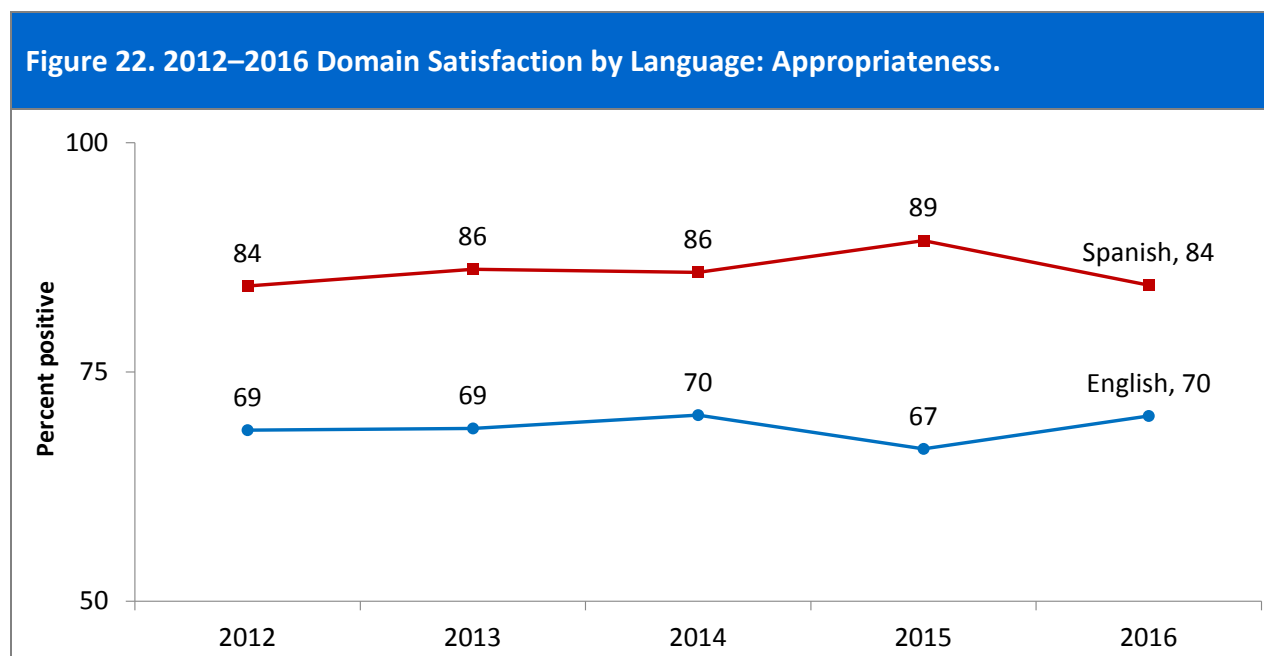


*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Domain satisfaction by survey language

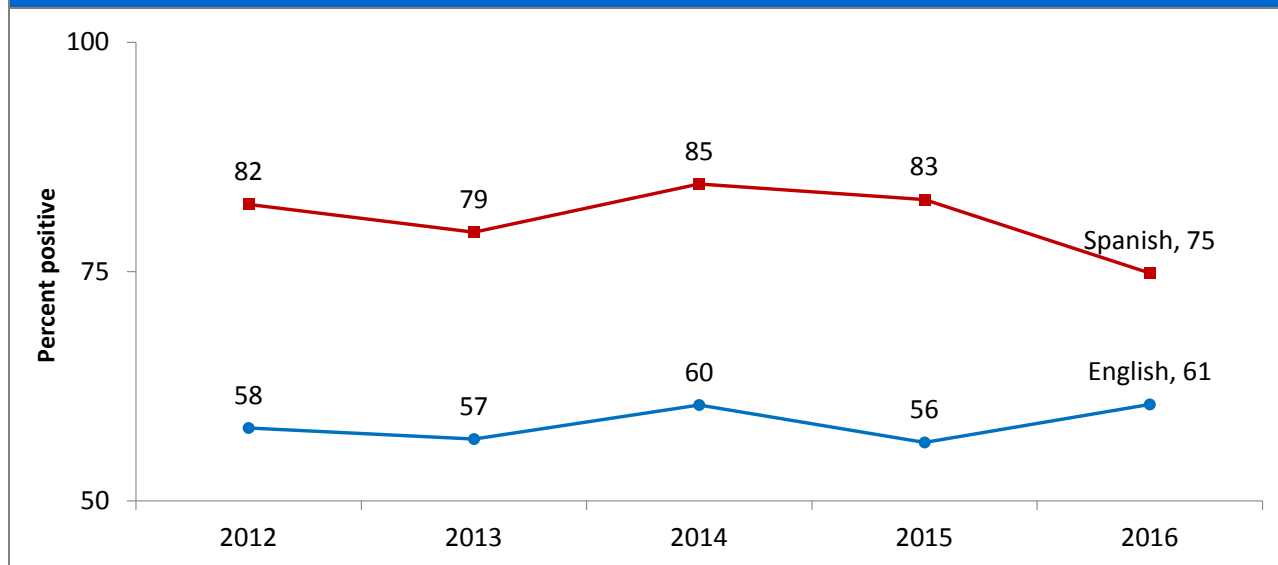
Spanish-speaking mental health recipients received a survey in Spanish. All others received a survey in English. (The English and Spanish versions of the survey are presented in Appendix B.) As shown in Figures 22–28, a larger percentage of Spanish-speaking respondents reported satisfaction in all domains except social connectedness in 2016, which is consistent with previous years.

- Satisfaction among **English-speaking respondents** has increased significantly in the participation, access, and social connectedness domains over the last five years.
- Satisfaction with cultural sensitivity increased significantly among **Spanish-speaking respondents**, and declined significantly in the daily functioning domain over the last five years.



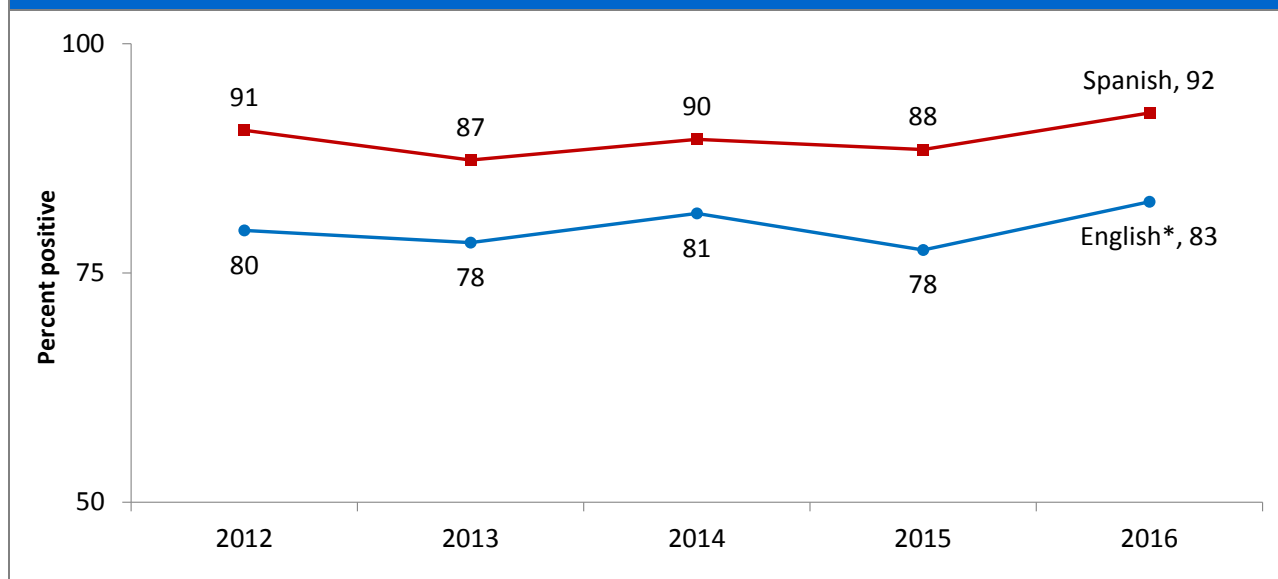
There were no statistically significant trends.

Figure 23. 2012–2016 Domain Satisfaction by Language: Treatment Outcomes.



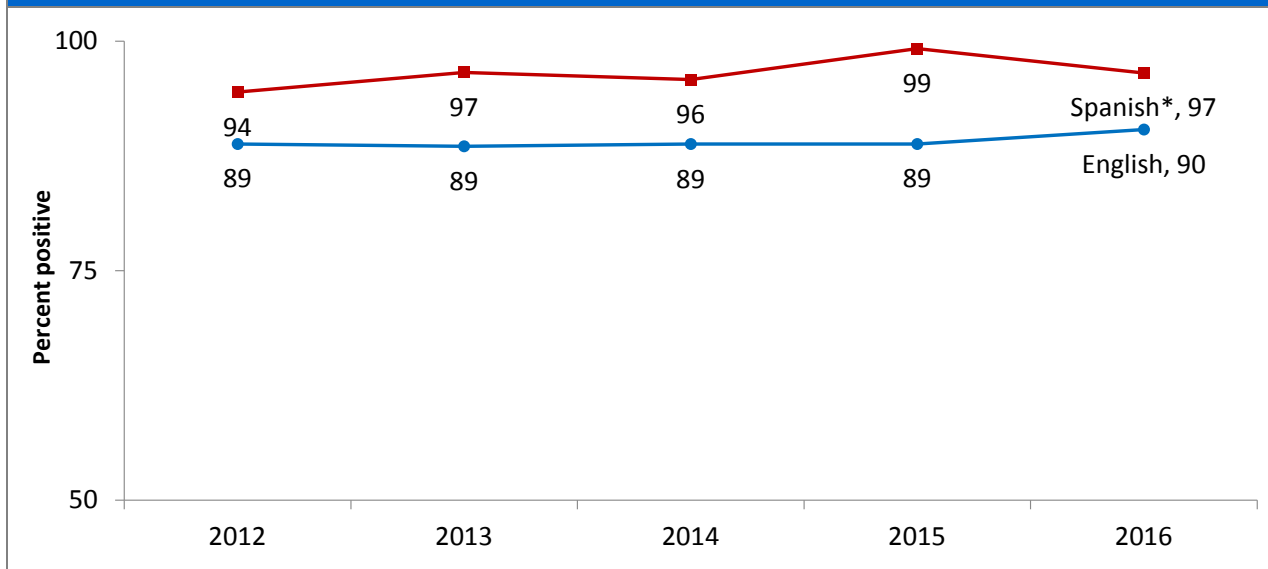
There were no statistically significant trends.

Figure 24. 2012–2016 Domain Satisfaction by Language: Participation.



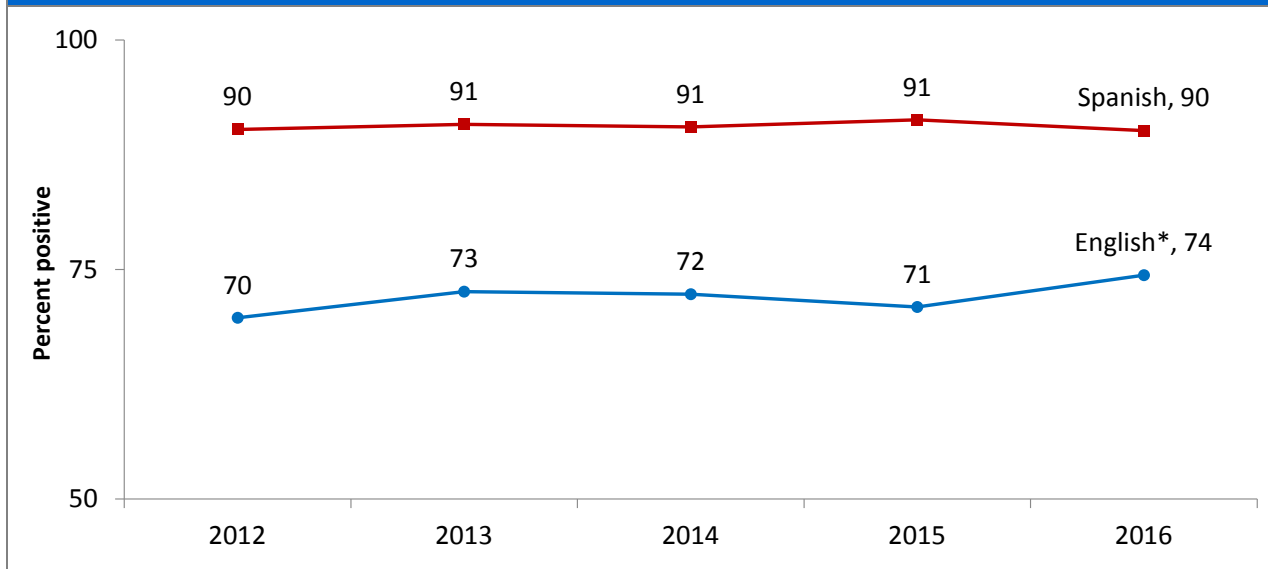
*Indicates a statistically significant upward or downward trend ($p < .05$) for that language group.

Figure 25. 2012–2016 Domain Satisfaction by Language: Cultural Sensitivity.



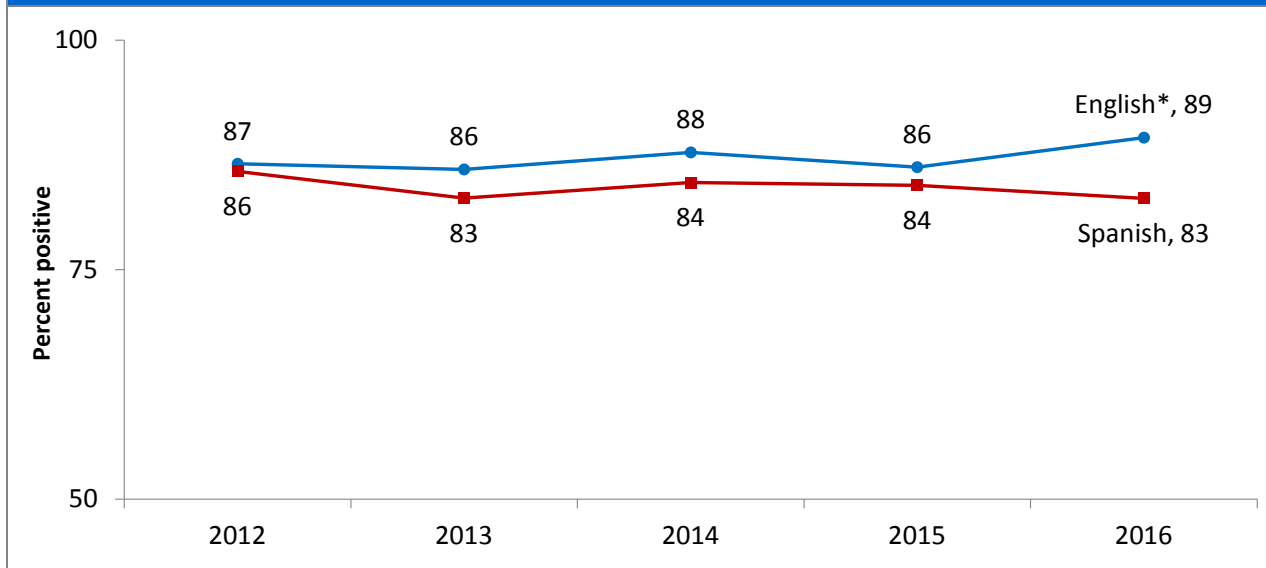
*Indicates a statistically significant upward or downward trend ($p < .05$) for that language group.

Figure 26. 2012–2016 Domain Satisfaction by Language: Access.



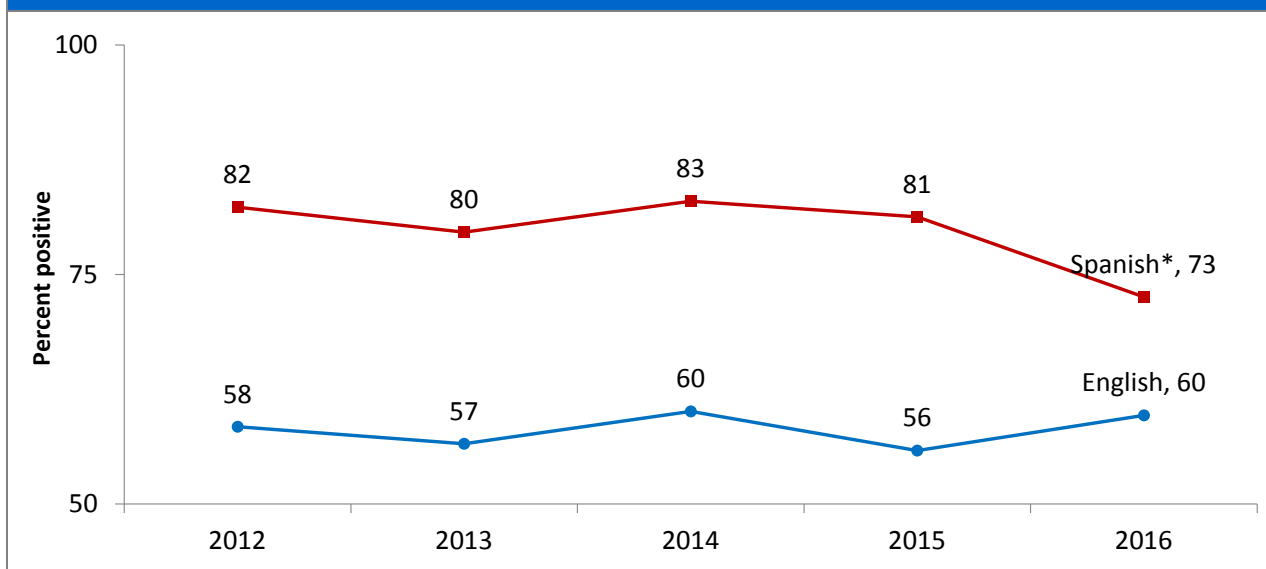
*Indicates a statistically significant upward or downward trend ($p < .05$) for that language group.

Figure 27. 2012–2016 Domain Satisfaction by Language: Social Connectedness.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that language group.

Figure 28. 2012–2016 Domain Satisfaction by Language: Daily Functioning.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that language group.

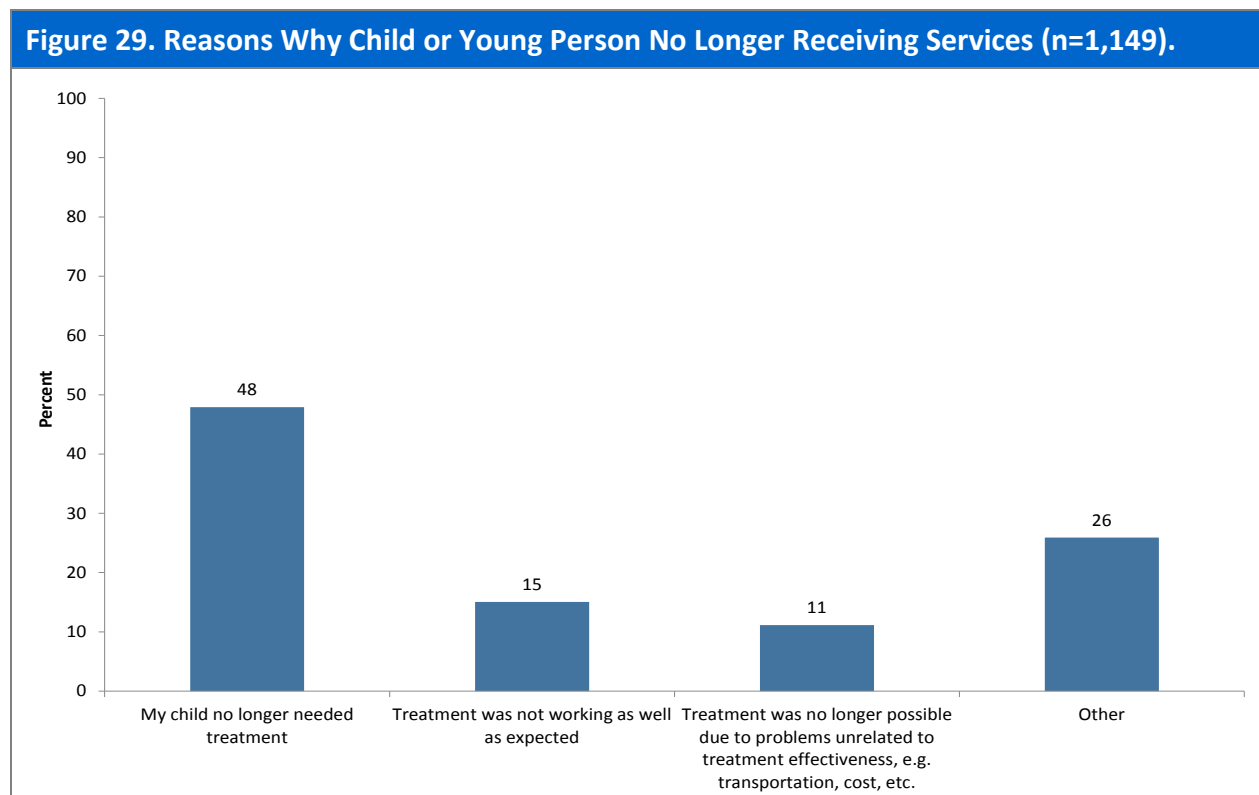
Analyses of State-Added Questions

In addition to analyzing the data on YSS-F performance domains, HealthInsight Oregon analyzed responses to the survey questions related to service coordination, school attendance, arrest history, use of alcohol or drugs, service plans (treatment plans), primary health care providers and health status, psychotropic medication use, and history of trauma. The following tables and charts summarize these results.

Receiving services

At the time of survey completion, 1,857 (60%) of respondents indicated that their child was still receiving mental health services; 1,149 (37%) were not receiving mental health services; and 98 (3%) did not know.

Respondents whose child was no longer receiving mental health services were asked to indicate why they were not receiving services. Figure 29 presents these results.



Respondents who selected “Other” were given open space to elaborate. A qualitative analysis indicated that access issues, having time to attend sessions and scheduling issues, and the child’s or young person’s refusal to attend were the most common reasons that service was discontinued. Payment issues, resolution of issues, summer break, insurance changes, and age were also cited as reasons for no longer receiving services.

Coordination of services

Many children and youth receiving mental health services and supports also receive services and supports from other agencies and providers including child welfare, the Oregon Youth Authority, juvenile justice, special education, services to persons with developmental disabilities, substance abuse treatment, and physical health care providers. In 2016, 1,816 (57%) respondents indicated that their child had received services and supports from other agencies. Of those, 881 (49%) received services from one additional agency; 549 (30%) received services from two additional agencies; and 386 (21%) received services from three or more additional agencies.

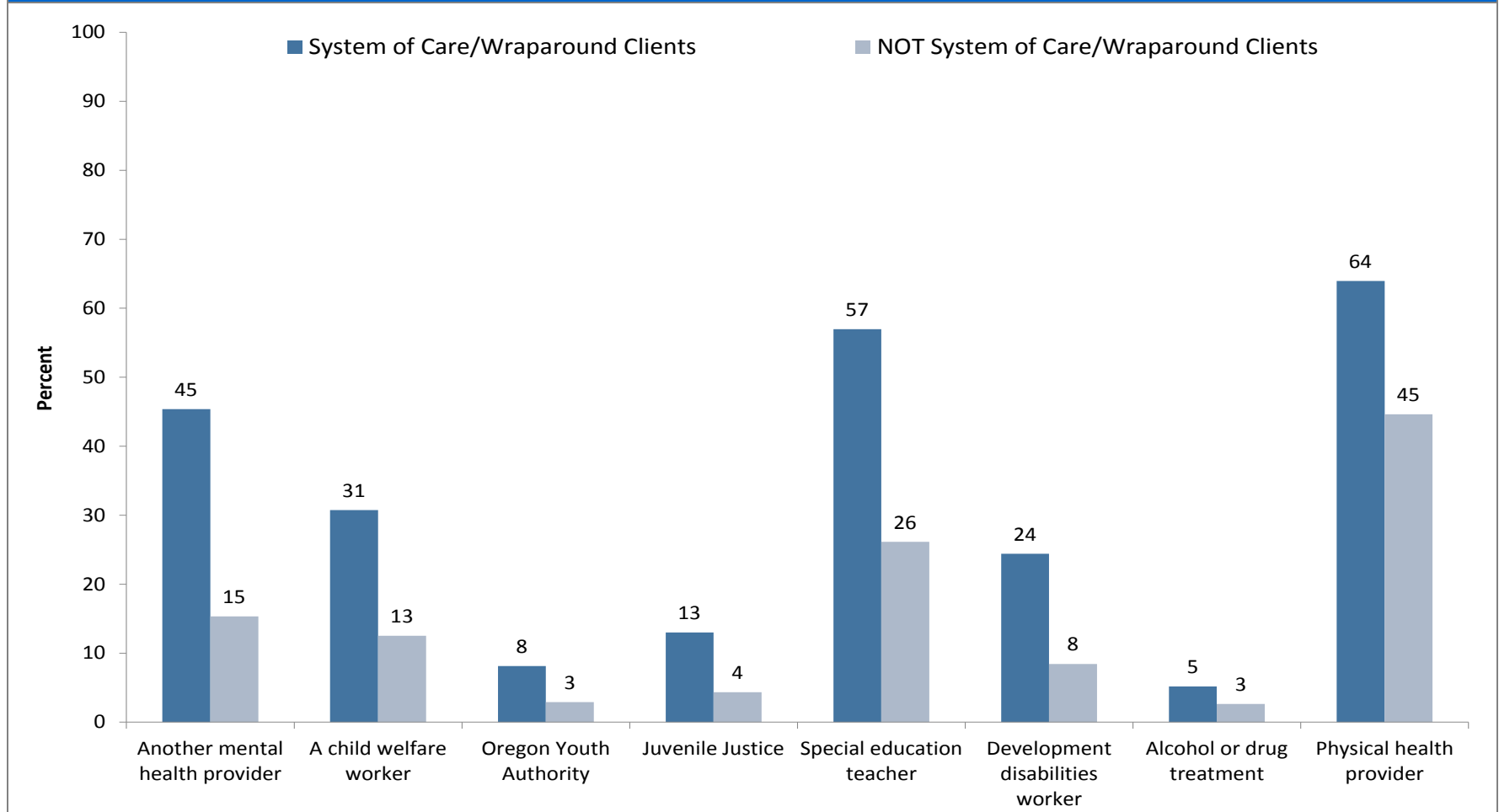
OHA’s System of Care Wraparound Initiative uses coordinated, community-based services to provide individualized care for youth with complex behavioral health needs who are involved in multiple systems.⁴ Of 3,060 respondents, 356 (12%) reported that their child was served under the system of care/wraparound process; 871 (29%) reported that their child was not served; and 1,833 (60%) did not know if their child was served. Figure 30 displays the percentages of caregivers who identified their children as receiving one or more of these services in 2016, according to whether that child or young person was served under the system of care/wraparound process.

As expected, caregivers of children and youth who were served under the system of care/wraparound process reported more involvement with multiple state agencies than caregivers whose children were not served under the wraparound process. Notably, more children and youth served under the system

⁴ Oregon Health Authority. System of Care Wraparound Initiative, Oregon Health Plan. February 2016. Available at: <https://www.oregon.gov/oha/amh/ChildMHPProviderSWCIDocs/SOCWI%20-%20Guidance%20Document.pdf>.

of care/wraparound process saw more than one mental health provider (45% vs. 15%), a child welfare worker (31% vs. 13%), a special education teacher (57% vs. 26%), a developmental disabilities worker (24% vs. 8%), and a physical health provider (64% vs. 45%).

Figure 30. Percentage of Caregivers whose Children Received Services from Specific State-Funded, Non-Mental Health Agencies/Systems, According to whether that Child Was Served by Wraparound, 2016.

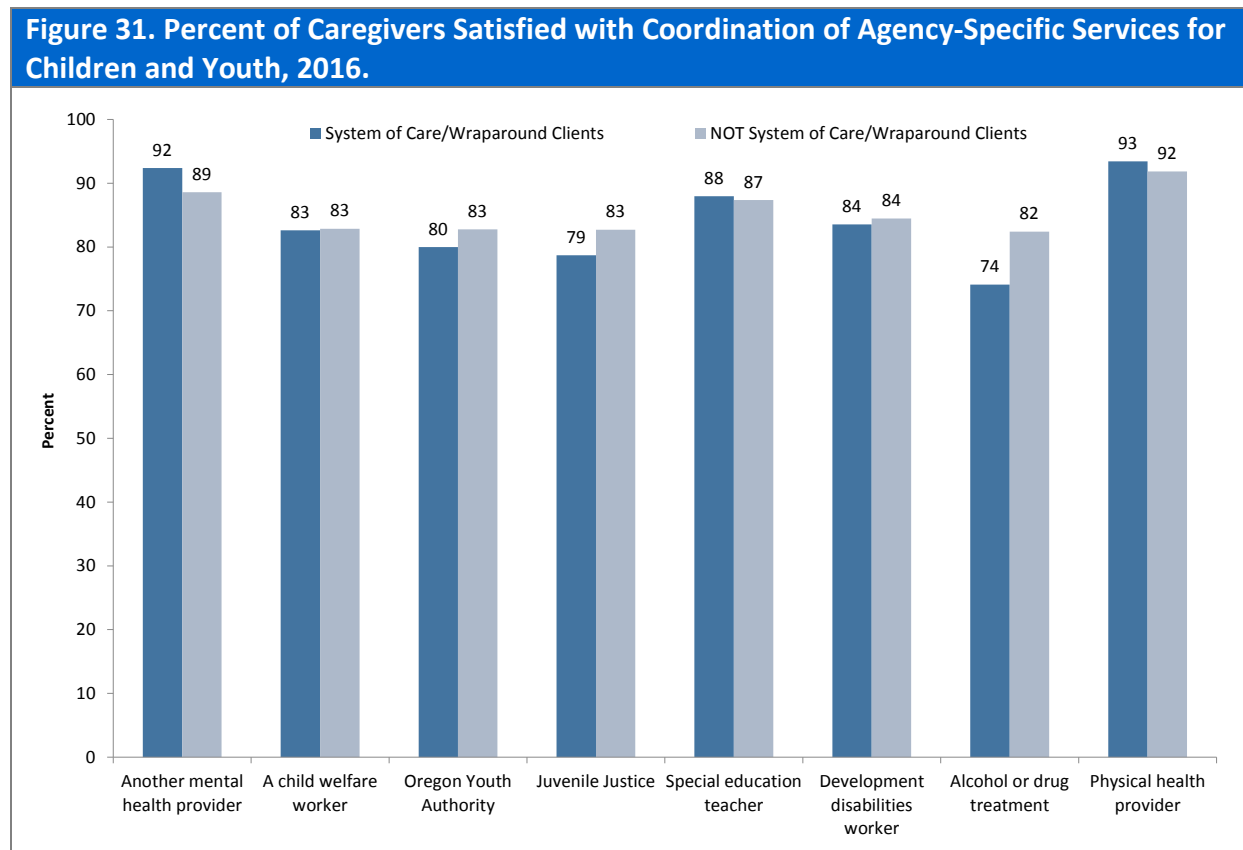


Relatively few respondents reported that the child or young person needed but did not receive services from specific service agencies, ranging from 0.41% (n=12) for a development disabilities worker to 1.61% (n=47) for juvenile justice.

Satisfaction with coordination between systems

The survey asked caregivers to indicate their satisfaction with the way their child’s most recent mental health provider and other providers worked together to help their child.

Figure 31 shows the percentages of caregivers in 2016 who were either “strongly satisfied,” “satisfied,” or “somewhat satisfied” with the way their child’s mental health services provider and other providers worked together. Caregivers of children and youth served and not served by wraparound were similarly satisfied with coordination of services in most areas.



A follow-up question asked dissatisfied respondents to elaborate on why they were dissatisfied with the willingness of the mental health provider and other providers to work together. A qualitative analysis indicated that lack of communication and unwillingness to reach out to others were common. In some cases, when the child or young person was receiving services from multiple providers, the caregiver was frustrated that the multiple providers didn't talk or share chart notes, resulting in inconsistency. Other times the caregiver was frustrated that the mental health provider didn't initiate contact with other service providers to help get the child or young person set up with services. Responses often tied in to dissatisfaction with the mental health provider.

Table 5 presents the percentage of respondents who were satisfied with the way the child's or young person's mental health services provider and other providers worked together according to CCO in 2016. (Note: The number of respondents by CCO is the maximum that responded to any one question; the actual number of responses varies according to service type. The survey did not ask respondents about satisfaction with the CCO, only service providers.)

Table 5. Percent (n) of Responders Satisfied with Coordination of Agency-Specific Services by CCO, 2016.

CCO**	Another mental health provider*	A child welfare worker*	Oregon Youth Authority*	Juvenile Justice*	Special education teacher	Development disabilities worker*	Alcohol or drug treatment*	Physical health provider
AllCare (n=71)	92	84	81	79	86	90	71	92
CHA (n=31)	79	78	73	75	93	86	79	90
CPCCO (n=43)	84	77	65	76	83	68	70	91
EOCCO (n=61)	85	67	69	69	74	65	68	84
FamilyCare (n=254)	94	92	91	91	92	94	93	95
Health Share (n=392)	88	83	82	81	89	85	78	91
IHN (n=121)	96	86	87	89	85	89	91	97
JCC (n=36)	67	77	76	75	73	60	76	84
PCS-CO (n=65)	98	80	83	86	85	89	82	95
PCS-CG (n=32)	97	100	89	89	93	88	100	100
TCHP (n=196)	89	83	88	88	86	81	86	91
WOAH (n=34)	94	92	91	90	93	86	89	94
WVCH (n=198)	88	79	81	79	89	85	79	91
YCCO (n=41)	84	71	80	75	81	78	76	93
FFS (n=149)	90	78	74	74	84	80	72	89

*Indicates statistically significant difference ($p < .05$) between CCOs.

**PHJC and UHA are not included in order to protect respondents' privacy because their sample size was less than 30.

Also, GOBHI is not included because GOBHI members were not explicitly sampled; therefore, the number of responses was too small to perform any MHO-specific analyses.

Caregivers' expectations about the results of children's and youth's mental health treatment

The 2016 survey asked family members about the expectations and hopes they held when their children began mental health treatment, and whether the treatment results met those expectations. As Figure 32 shows, the most frequent expectations were that the child or young person would:

- Feel better about himself/herself (74%)
- Become happier (71%)
- Become less anxious or fearful (70%)

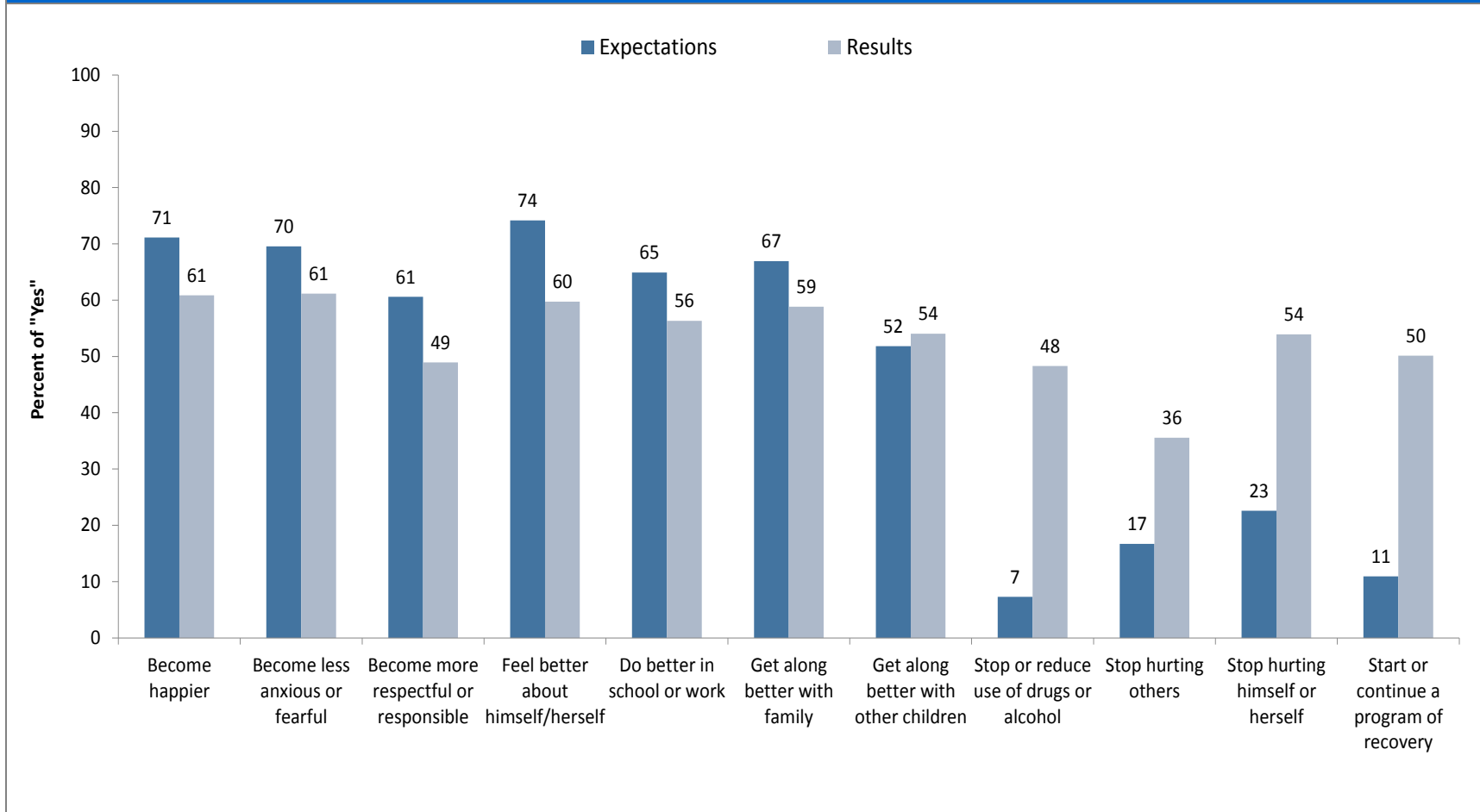
Among respondents with each expectation, we tabulated how many got the result they were expecting. The most frequently met expectations were that the child or young person:

- Became less anxious or fearful (61%)
- Became happier (61%)
- Felt better about himself/herself (60%)

The largest discrepancies between expectations and results were in the self-harm and substance use areas.

- Stop or reduce use of drugs or alcohol (7% expectation, 48% result)
- Start or continue a program of recovery (11% expectation, 50% result)
- Stop hurting himself or herself (23% expectation, 54% result)
- Stop hurting others (17% expectation, 36% result)

Figure 32. Expectations for the Child’s or Young Person’s Mental Health Treatment (N=3,212), and Results of Mental Health Services. “I expected my child would...”



Respondents could select all answer options that applied; therefore, all are included in the denominator.

Child’s or young person’s service plan

Service plans are individualized treatment plans completed before services begin that include the level of care to be provided, projected treatment timelines, personnel involved and treatment objectives. Plans should be created with participation from youth and their families and include “services and supports that will be used to meet the treatment objectives.” (See Oregon Administrative Rule [OAR] 309-022-0140 for all required elements.)⁵

The survey asked whether the child’s or young person’s service plan supported the child’s and caregiver’s culture and language. A majority that responded to the question agreed or strongly agreed that the plans did (Table 6). Results were consistent with 2015 findings.

Table 6. Child's or Young Person’s Individual Services and Supports Plan Supports the Following:

	Strongly Agree/ Agree	Strongly Agree/ Agree	Undecided	Undecided	Strongly Disagree/ Disagree	Strongly Disagree/ Disagree
Options	2015	2016	2015	2016	2015	2016
Considered and included my cultural values in my child's care	77	82	20	16	3	2
Communicated effectively in my primary language	93	95	5	4	2	2
Communicated effectively in my child's primary language	93	96	5	4	1	1
Made me feel welcome and comfortable when I spoke to them	89	91	7	6	4	3

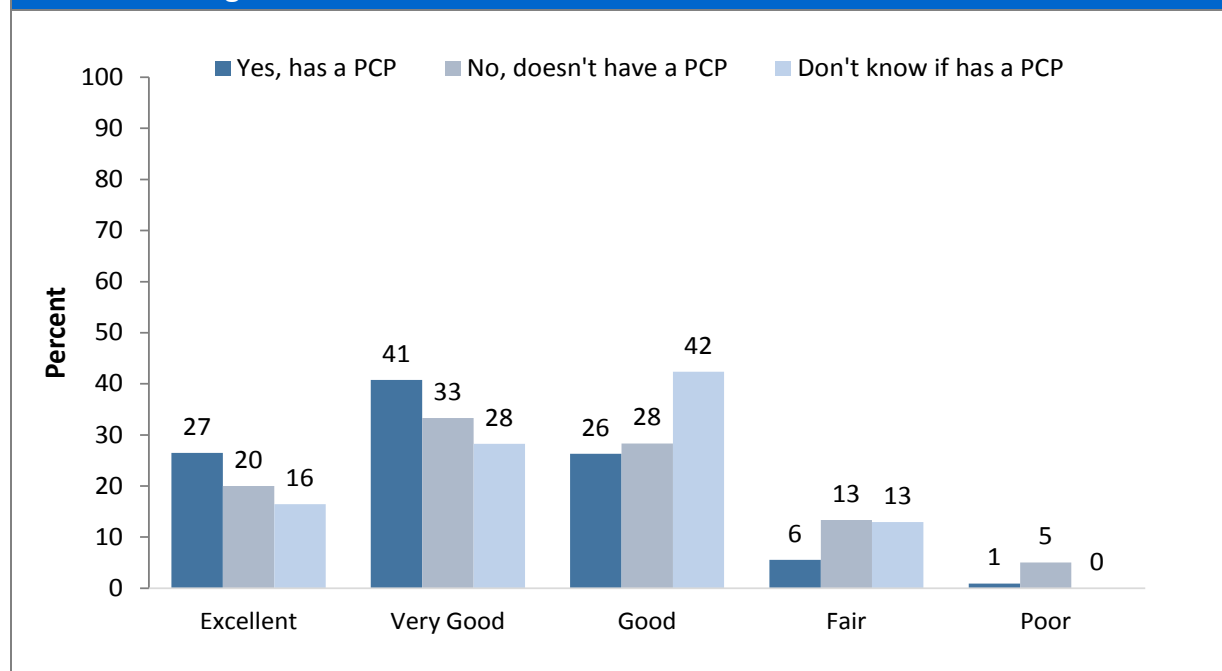
⁵ Oregon Administrative Rules: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Health status

Health status in childhood and adolescence is a major determinant of adult health status. The state has incentivized CCOs to provide annual wellness visits for adolescents and ensure all children and youth are up to date on vaccinations, among other childhood health initiatives.

Figure 33 shows that children and youth with excellent and very good health status are more likely to have a primary care health provider or other practitioner who provides check-ups, routine medical care and advice (PCP). Overall, 66% of caregivers reported that their child had excellent or very good health status; of these, 95% reported that their child had a primary health care provider. Among children and youth with good health status, 92% had a primary health care provider; as did 86% of those with fair health status, and 81% of those with poor health status.

Figure 33. Presence of a Primary Health Care Provider or Other Practitioner, According to Child's or Young Person's Health Status.



Psychotropic medications

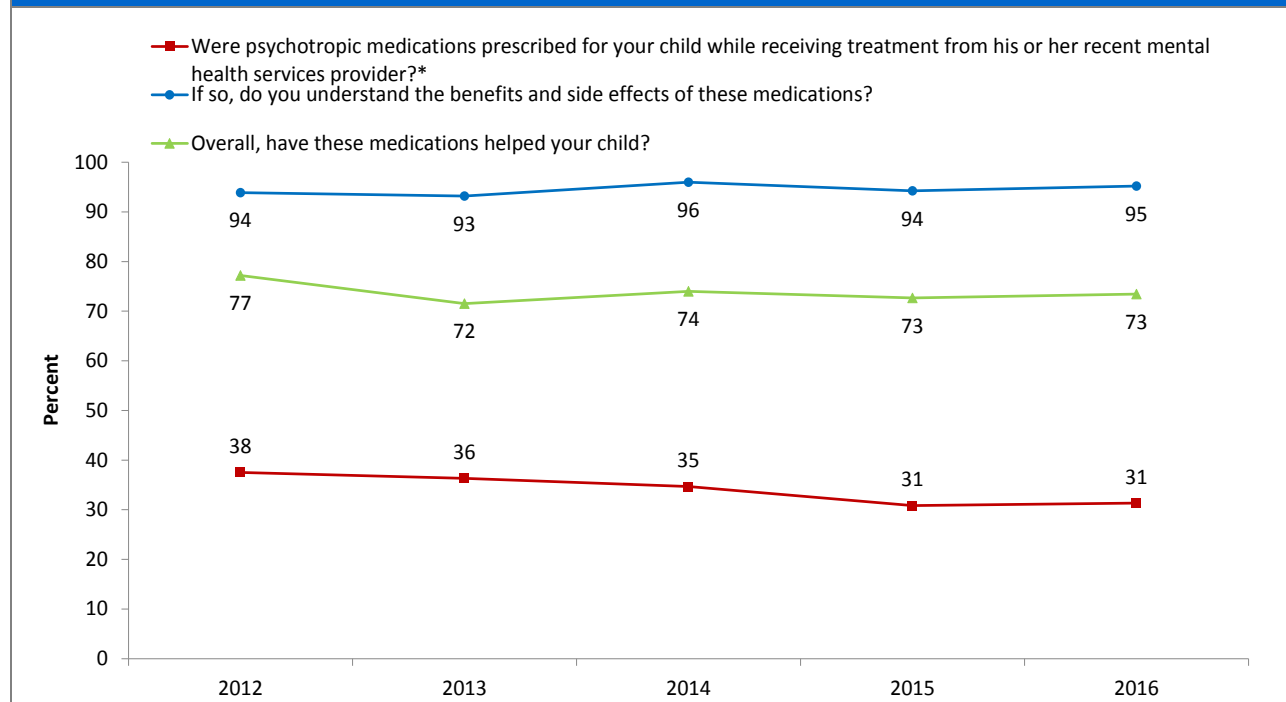
Oregon has taken a number of steps to address the use of psychotropic medications in children. For example, in 2012 OHA was awarded a technical assistance grant from the Center for Health Care Strategies which aimed to reduce the use of antipsychotic medications for unapproved indications and minimize polypharmacy use for children in foster care. Another initiative, the Oregon Psychiatric Access Line about Kids, provides free child psychiatric phone consultations to primary care providers in Oregon.^{6,7}

Caregivers were asked three questions about psychotropic medications that were prescribed for their children or youth while they were receiving treatment from their current (or most recent) mental health services provider. As Figure 34 shows, the percentage of caregivers who reported that psychotropic medications were prescribed for the child or young person trended significantly downward over the last five years from 38% in 2012 to 31% in 2016. Of those whose child received psychotropic medications, the percentage who understood the benefits and side effects remained fairly consistent (94% to 95%), as has the percentage who thought the medications helped their child (77% to 73%).

⁶ Presentation: Improving the Use of Psychotropic Medications in Children and Youth in Foster Care. December 2015 Update. Available at: <http://www.oregon.gov/oha/pharmacy/CCOPharmacyDirectors/Presentation%20Improving%20prescribing%20practices%20122015.pdf>.

⁷ OHSU School of Medicine, Department of Psychiatry. Oregon Psychiatric Access Line about Kids (OPAL-K). <http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/index.cfm>.

Figure 34. Psychotropic Medications Prescriptions, 2012–2016.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that question.

School attendance

A common goal of mental health treatment is to improve functioning of the child or young person in order to improve school attendance and thereby school success. The YSS-F survey asked caregivers several questions about school attendance, suspensions, and expulsions.

There were 446 (15%) respondents who reported that their child did not attend a public or private school during the time they were served by their most recent mental health services provider and were excluded from these analyses.

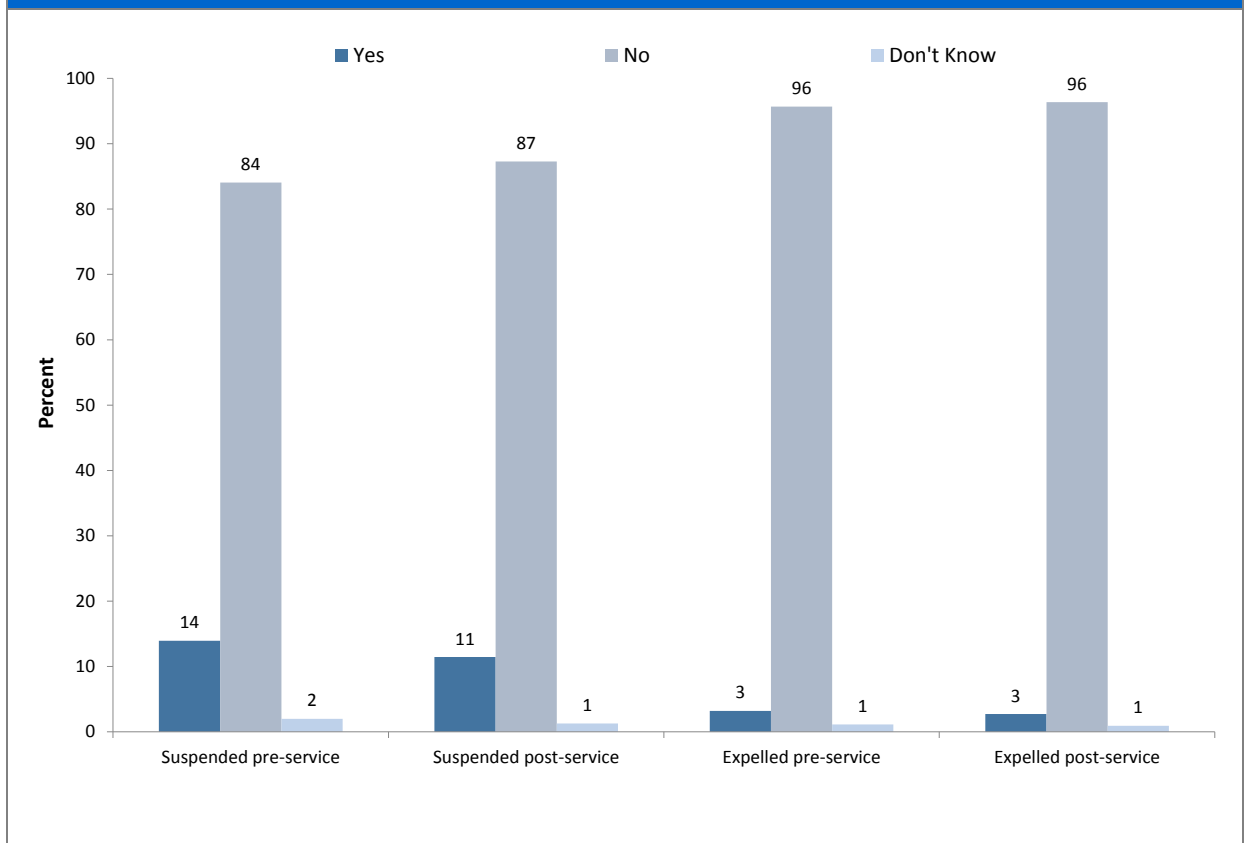
In the time since the child or young person started to receive mental health services, 40% of respondents indicated that the number of days their child had been in school was about the same; 24% reported an increase in school days; and 7% reported a decrease in school days. The remaining 30% of respondents said the question did not apply for the following reasons:

- Child had no problem with attendance before starting school (86%)

- Other (8%)
- Child is too young to be in school (0.7%)
- Child is home schooled (3%)
- Child dropped out of school (2%)
- Child was expelled from school (0.4%)

As Figure 35 shows, the percentage of respondents who indicated that their child was suspended before or after receiving mental health services declined from 14% to 11%. The percentage of respondents who indicated that the child or young person was expelled before or after receiving mental health services remained stable at 3%.

Figure 35. School Suspensions or Expulsions Pre- and Post-Service Initiation.



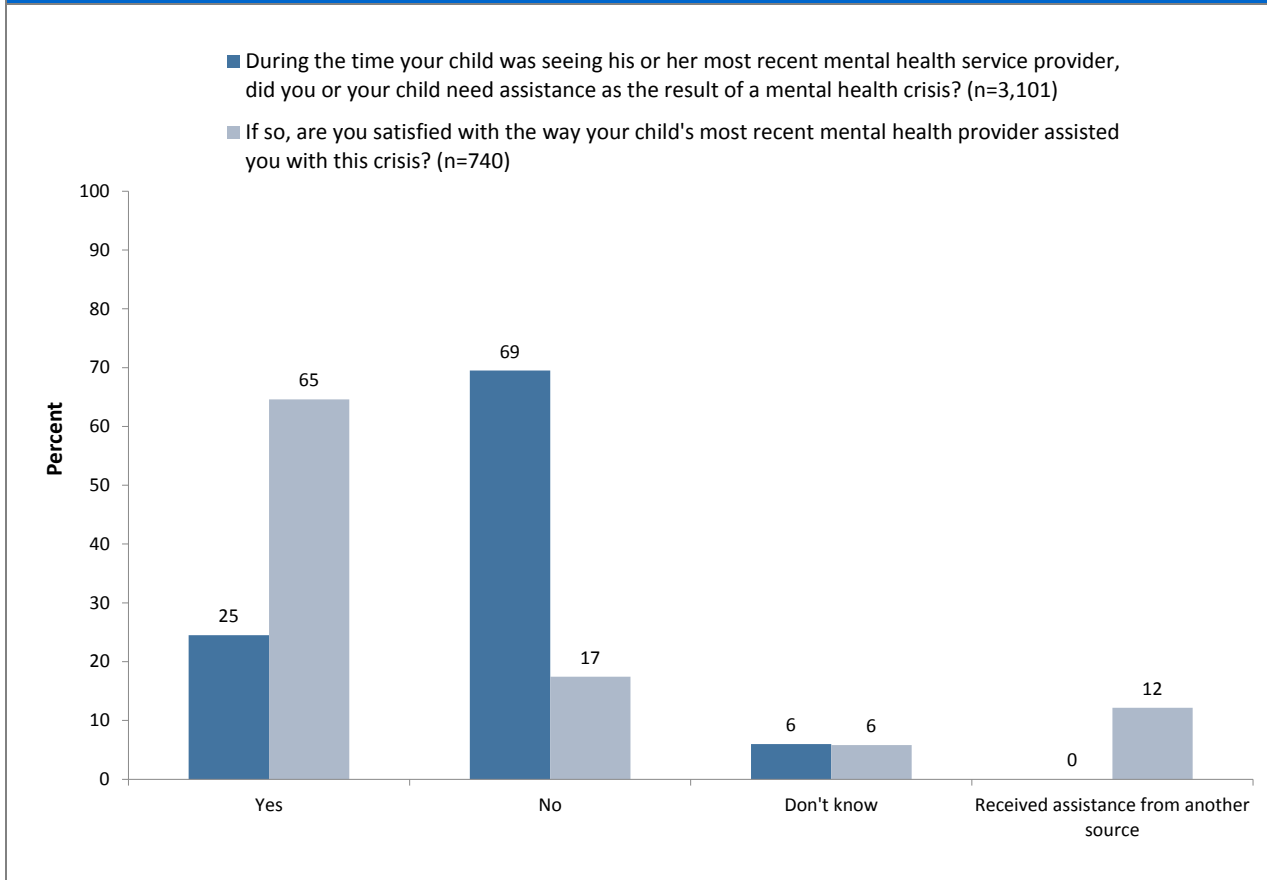
Mental health crisis

A mental health crisis is an unfortunate, but not uncommon experience of children and youth with a mental health diagnosis. State law dictates that service plans, required for each member, must include “proactive safety and crisis planning.”⁸

Figure 36 shows that during the time the child or young person was seeing his or her most recent mental health services provider, 25% needed assistance as the result of a mental health crisis. Of these, 65% of caregivers were satisfied with the way the mental health provider assisted them. Over the last four years, the percent of caregivers reporting that their child had a mental health crisis has shown a significant downward trend from 26% to 25%, while the percent of caregivers who were satisfied with the mental health provider’s response has also shown a significant downward trend from 68% to 65%.

⁸ OAR 309-022-0140(3)(e), Service Planning and Coordination. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Figure 36. Mental Health Crisis and Provider Assistance.



Youth's arrest history

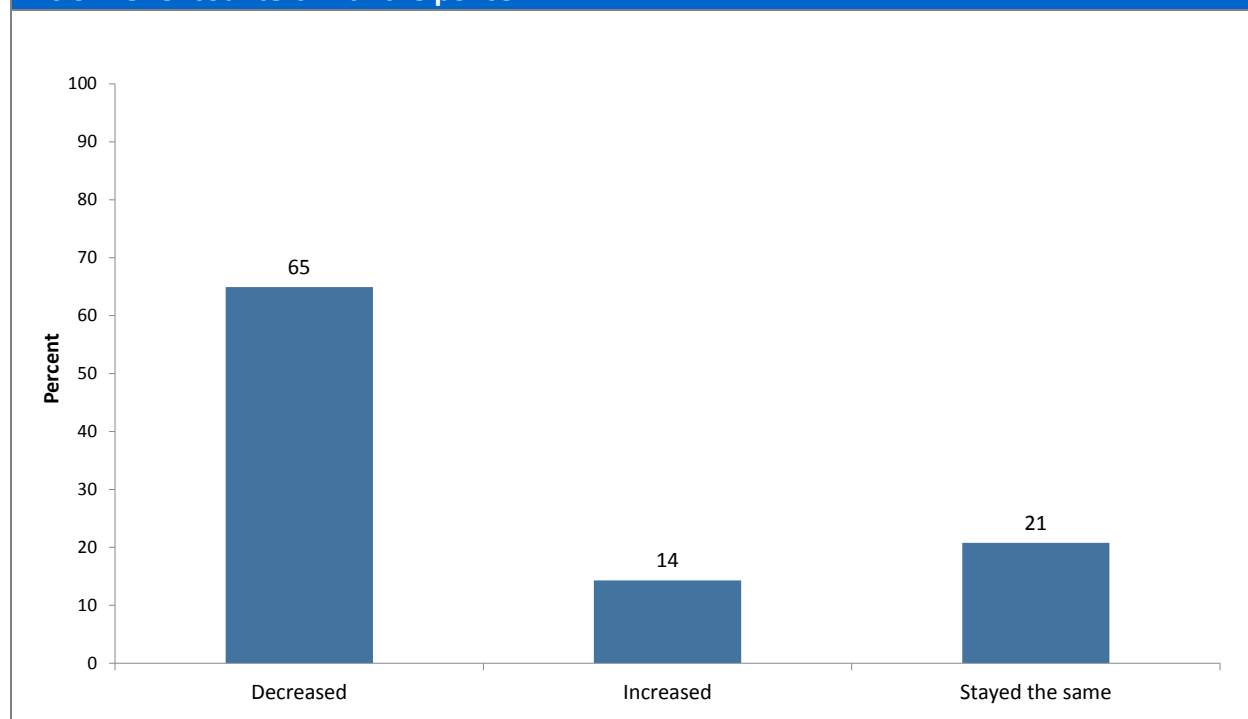
Improved management of a young person's behavioral health symptoms should lead to a reduction in arrests and other encounters with police.

- 13% of respondents indicated that their child has ever had an encounter with the police, including being arrested, hassled by police, or taken by the police to a shelter or crisis program
- 2% were uncertain
- 85% reported that their child had never had an encounter with police

Of respondents whose children or youth had ever encountered the police, 21% reported that encounters with the police had stayed the same after their child began receiving mental health services; 65% reported a decrease in encounters; and 14% reported an increase in encounters (Figure 37).

Among respondents whose child had ever encountered the police, 27% reported that their child was arrested before starting treatment and 15% reported an arrest after starting treatment.

Figure 37. Youth's Encounters with Police since Receiving Mental Health Treatment, Ages 14–18. "Since your child began to receive mental health services from this provider, have his or her encounters with the police..."

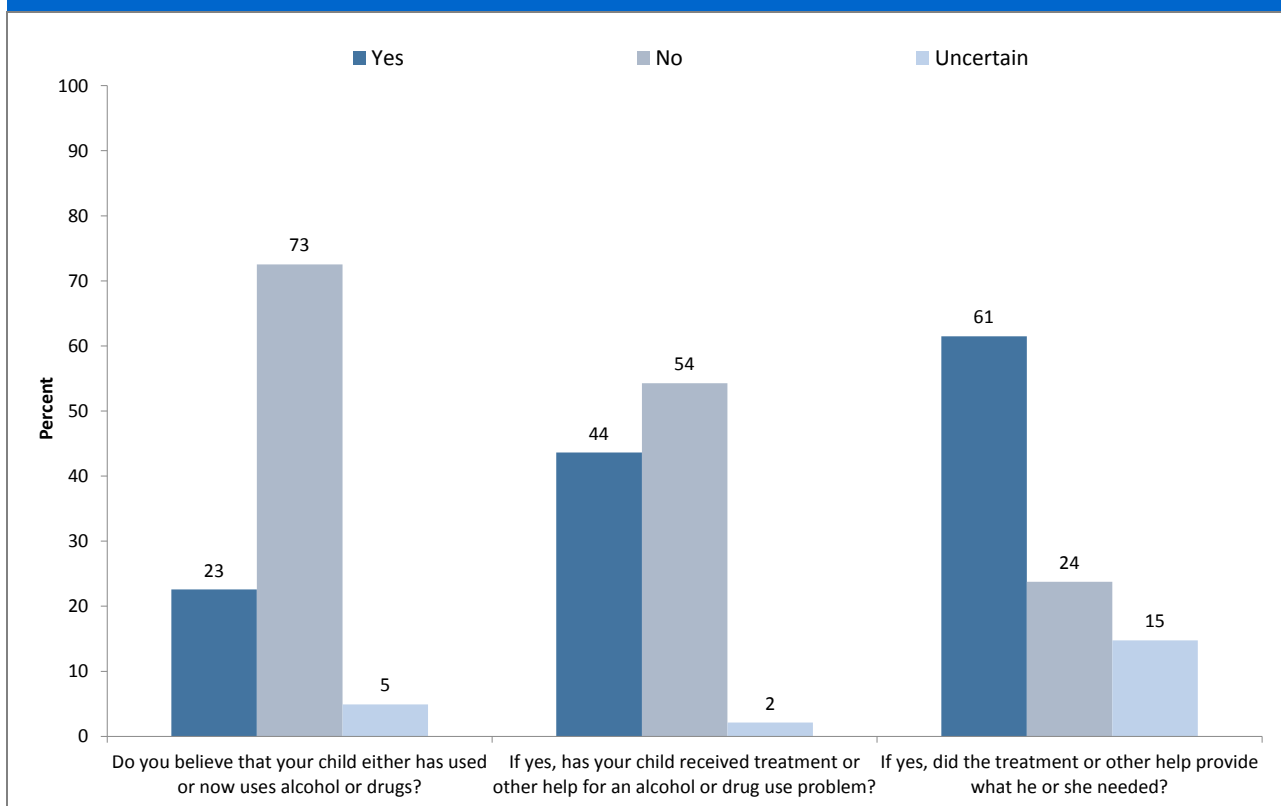


Alcohol and drug use

For some youth, mental illness and substance use disorder occur simultaneously. These co-morbidities can be complex to address, but must be addressed together to increase the odds of improvement for the young person and their family.

As shown in Figure 38 below, 23% of caregivers of youth ages 13–17 believed that their child either has used or now uses alcohol or drugs. While similar to 2015, this is an increase from 19% in 2014 when this question was modified to its current form. Of these, fewer than half (44%) reported that their child had received treatment or other help, and of those who did receive help, 61% thought the treatment or other help provided what the young person needed. The survey did not allow respondents to elaborate on what other help youth may have received.

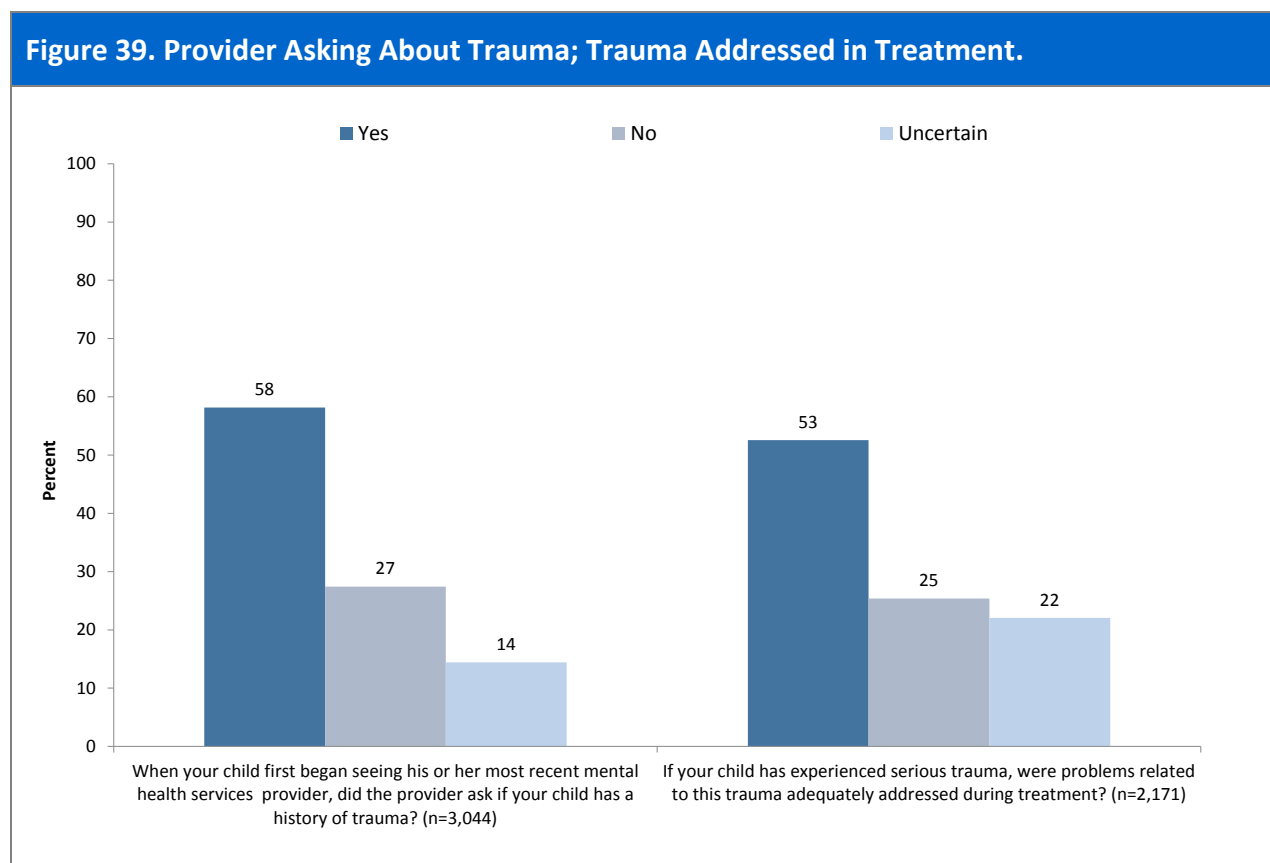
Figure 38. Status Substance Abuse Treatment for Youth Ages 13–17.



History of trauma

For many children and youth, a history of trauma is interwoven with their mental illness. The YSS-F survey defined trauma as: “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”

Providers must screen for trauma and include trauma-informed services in behavior support plans.⁹ As Figure 39 shows, 58% of respondents said their child was asked if they had a history of trauma. If the child or young person had experienced serious trauma, 53% of respondents felt the problems related to this trauma were adequately addressed during treatment.



⁹ OARs 309-022-0135 and 309-022-0165. Available at: http://arcweb.sos.state.or.us/pages/rules/oars_300/oar_309/309_022.html.

Housing stability

Housing instability, especially for children and youth, can cause stress and, therefore, an aggravation of mental health symptoms. Caregivers were asked how many times in the last three years their child had changed residence (for example, moved from one house to another house, or moved from home to residential treatment). More than half (58.8%) reported at least one move in the last 3 years. The average number of moves was 2.3 (standard deviation 1.6), with a maximum of 16 moves.

2016 YOUTH SERVICES SURVEY RESULTS

The YSS measures young people’s perceptions of the mental health services they receive in five performance domains:

- **Access to Services:** service location, frequency and availability of appointments, and responsiveness of staff
- **Appropriateness of Services:** general satisfaction, someone for child to talk to, had providers that stuck with them, received the right services, and received the right quantity of services
- **Cultural Sensitivity:** staff respect of client, family, cultural/ethnic background, and religious/spiritual beliefs
- **Participation in Treatment:** client’s participation in determining treatment goals and comfort asking questions
- **Treatment Outcomes:** client’s ability to deal with problems and crisis, control life, relationships with family, functioning in social situations and school or work, housing, and reduction in symptoms

Like the YSS-F, the YSS includes a cluster of questions designed to assess young people’s perceptions of different aspects of access, appropriateness, cultural sensitivity, participation, and outcomes. For example, responses to two statements measure the perception of access to services:

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

These questions are similar to those used in the YSS-F to evaluate access.

Each question uses a 5-point Likert scale, with responses ranging from “Strongly Agree” (5) to “Strongly Disagree” (1). Domain scores are calculated with the same methodology as used for the YSS-F. The comparable approach of the two surveys makes it possible to compare the responses of young respondents with those of their caregivers, both for individual questions and for overall domain scores.

In order to gain more insight into the population’s satisfaction with mental health services, HSD added survey items. The YSS includes additional questions about:

- current and past living arrangements
- utilization of physical health care services

- school absenteeism
- what has been helpful about the services the young person responding has received and what would improve services

As designed by the MHSIP, the YSS instrument contains 38 questions. Oregon's HSD modified the YSS instrument slightly, removing questions about the respondent's Medicaid status (not necessary because the survey was sent only to Medicaid enrollees) and adding a "Not applicable" option for the first 21 questions.

According to the MHSIP, the YSS is appropriate for young people ages 13 to 18. Using the sample provided for the YSS-F, HSD identified young people who were at least 14 years of age during the period they were in treatment, and assigned these respondents to the same categories (outpatient, psychiatric residential, and psychiatric day treatment) as used in the YSS-F. No sample size criteria were applied for the YSS; rather the YSS sample is pulled directly from the YSS-F sample. YSS results by CCO are not presented in this report because more than half of the CCOs had fewer than 30 respondents, the threshold below which results are suppressed to maintain the respondents' confidentiality.

The YSS questionnaire was fielded in English and Spanish, according to the young person's primary language on file in MMIS. Both survey versions are presented in Appendix A.

Survey Response

HealthInsight Oregon mailed an introductory letter to 5,714 young people in May 2016. Three quarters (75%) of the YSS surveys were completed online in 2016, an increase in online submissions over previous years. Respondents were incentivized with a \$10 gift card for completing the survey online. As of September 15, the day when data entry ended, 1,025 surveys had been received from among 4,672 sent to valid addresses, for an overall response rate of 22%. Mental health recipients who refused or opted out of the survey were excluded from the denominator for response rate calculations.

Table 7 shows the response rate by treatment setting. The outpatient group had the highest response rate at 23% while the psychiatric residential and psychiatric day groups were notably lower at 13%. Due to low population numbers in the

psychiatric day treatment and psychiatric residential groups, domain scores are not broken down by treatment setting except where noted.

Table 7. YSS Response Rate by Treatment Setting.

Setting	Number of responses	Number of surveys sent	Response rate (%)
Outpatient	980	4,317	23
Psychiatric Day	8	61	13
Psychiatric Residential	37	294	13
Total	1,025	4,672	22

Note: surveys sent exclude opt-outs and bad addresses.

As shown in Table 8, response rates were notably higher for female than for male respondents and for white vs. non-white respondents.

Table 8. YSS Response Rate by Demographic Characteristics.

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
Gender	Female	661	2,712	24
	Male	364	1,960	19
Age group	13–15	541	2,320	23
	16–18	484	2,352	21
Race	Non-white	151	731	21
	White (Caucasian)	654	2,914	22
	Race unknown	220	1,027	21
Location of residence	Rural	380	1,756	22
	Urban	633	2,870	22
	Unknown	12	46	26
Language	English	579	2,791	21

Categories	Characteristics	Number of responses	Number of surveys sent	Response rate (%)
	Spanish	68	384	18
	Other	378	1,497	25

Note: surveys sent exclude opt-outs and bad addresses. All demographic information presented above comes from the state's Medicaid enrollment data.

Table 9 shows the response rate by the young person's CCO. EOCCO had the highest response rate at 26%, followed by FamilyCare, JCC and PSCS-CO (25% each). Several other CCOs following closely with response rates of 20% to 23%.

Table 9. YSS Response Rate by CCO.

CCO	Number of responses	Number of surveys sent	Response rate (%)
AllCare	36	162	22
CHA	16	89	18
CPCCO	18	91	20
EOCCO	42	161	26
FamilyCare	131	522	25
Health Share	222	1,090	20
IHN	50	256	20
JCC	28	110	25
PSCS-CO	60	239	25
PSCS-CG	9	70	13
PHJC	13	71	18
TCHP	120	507	24
UHA	15	72	21
WOAH	12	76	16
WVCH	139	591	24
YCCO	21	116	18
GOBHI MHO*	2	9	22
FFS	91	440	21

CCO	Number of responses	Number of surveys sent	Response rate (%)
Total	1,025	4,672	22

*GOBHI was not sampled as a CCO.

Surveys sent exclude opt-outs and bad addresses.

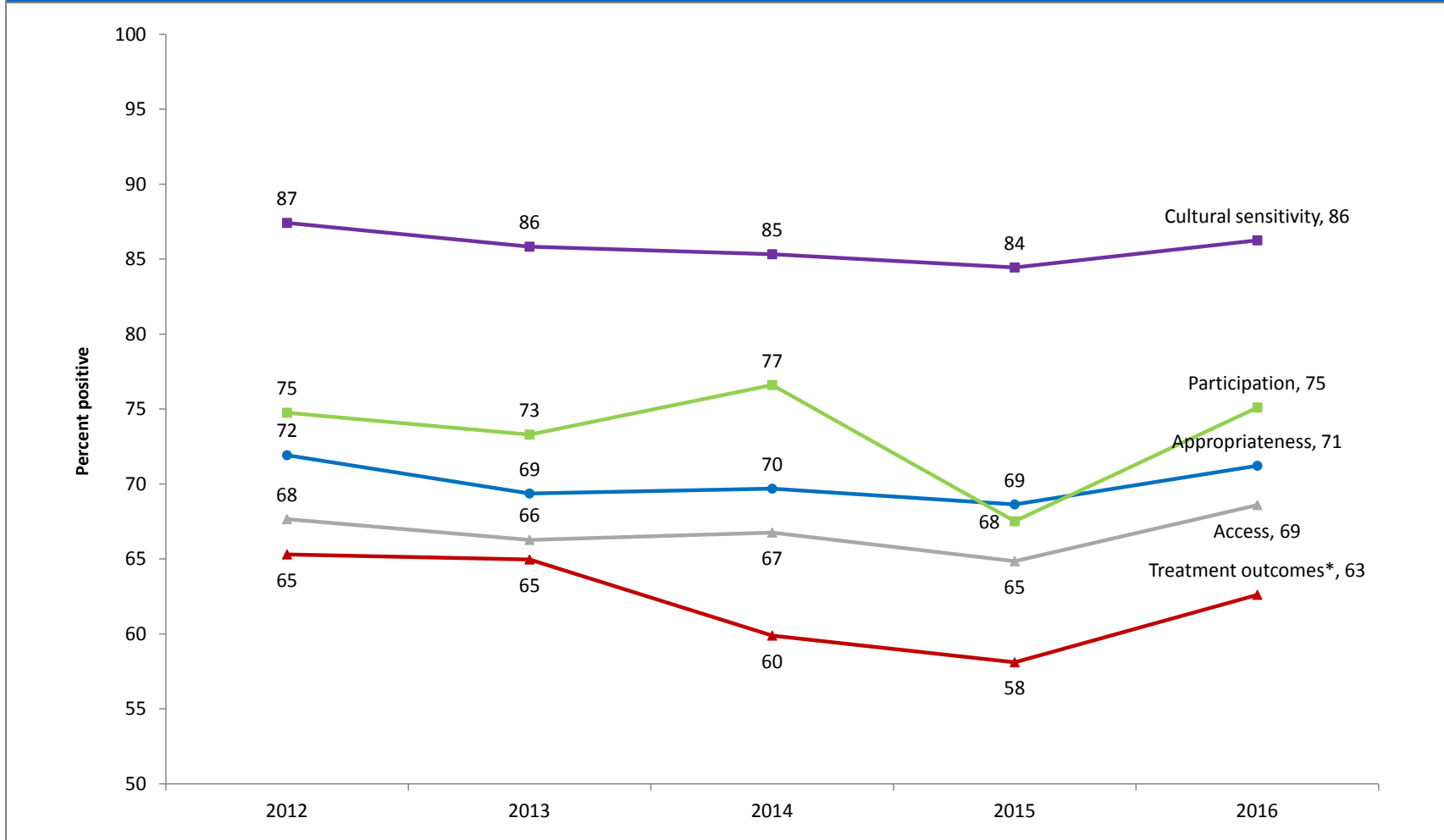
Domain Satisfaction

Figure 40 shows the percentage of respondents that were satisfied in each domain. Over the last five years, the percentage of respondents who were satisfied with their treatment outcomes has trended significantly downward. While satisfaction in other domains has varied year to year, none showed a significant upward or downward trend.

Domain satisfaction according to CCO assignment is not presented in this report due to the low number of respondents (< 30) in 9 of the CCOs. OHA is considering methods to increase the sample and response rate among youth.

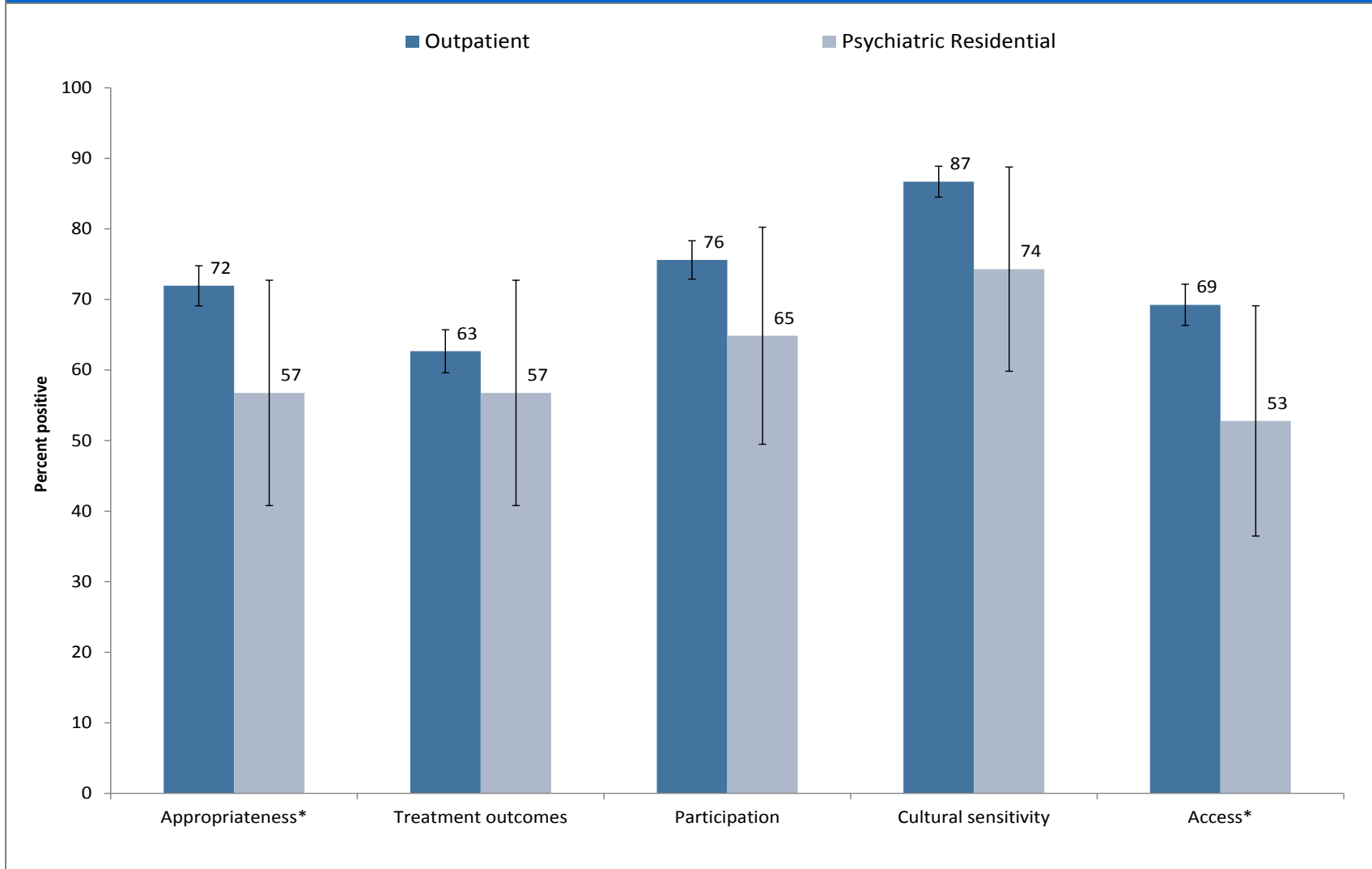
Figure 41 shows domain satisfaction by treatment setting. The outpatient group was more satisfied than the psychiatric residential group in all domains, and significantly more so in the access and appropriateness domains.

Figure 40. 2012–2016 Comparison of YSS Domain Satisfaction.



*Indicates statistically significant upward or downward trend ($p < .05$) over time for that domain.

Figure 41. Domain Satisfaction by Treatment Setting with 95% Confidence Intervals.



*Indicates a statistically significant difference ($p < .05$) between the two groups.

Table 10 shows 2016 YSS domain scores by demographic characteristics. Spanish speakers were significantly more satisfied than all other language speakers in the appropriateness, treatment and access domains. Domain satisfaction was similar between all other demographic groups.

Domain satisfaction according to the young person's specific race is rolled up to non-white, white, and unknown due to the small number of respondents in all race groups except white and unknown.

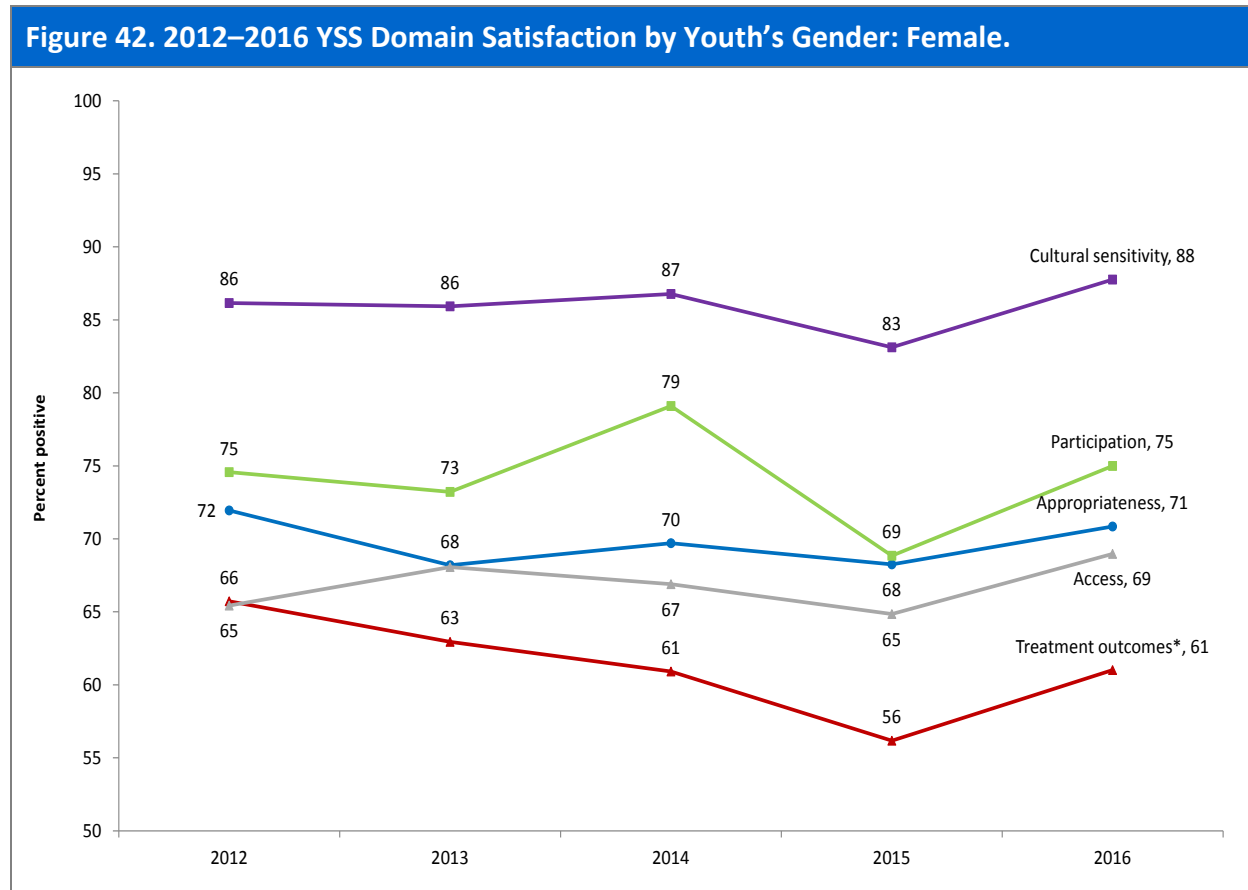
Table 10. YSS Domain Scores by Demographic Characteristics.

Categories	Characteristics	Appropriateness	Treatment outcomes	Participation	Cultural Sensitivity	Access
Gender	Female	71	61	75	88	69
	Male	72	66	75	83	68
Age Group	13–15	71	63	74	85	66
	16–17	72	62	76	88	71
Race	Non-white	68	56	73	85	64
	White (Caucasian)	71	63	76	86	70
	Race unknown	73	66	75	87	68
Location of Residence	Rural	70	62	76	84	70
	Urban	72	63	75	87	67
Survey Language	English	73*	61*	75	85	67*
	Spanish	82*	82*	82	94	82*
	Other	67*	62*	74	87	68*

*Indicates a statistically significant difference ($p < .05$) between group domain scores.

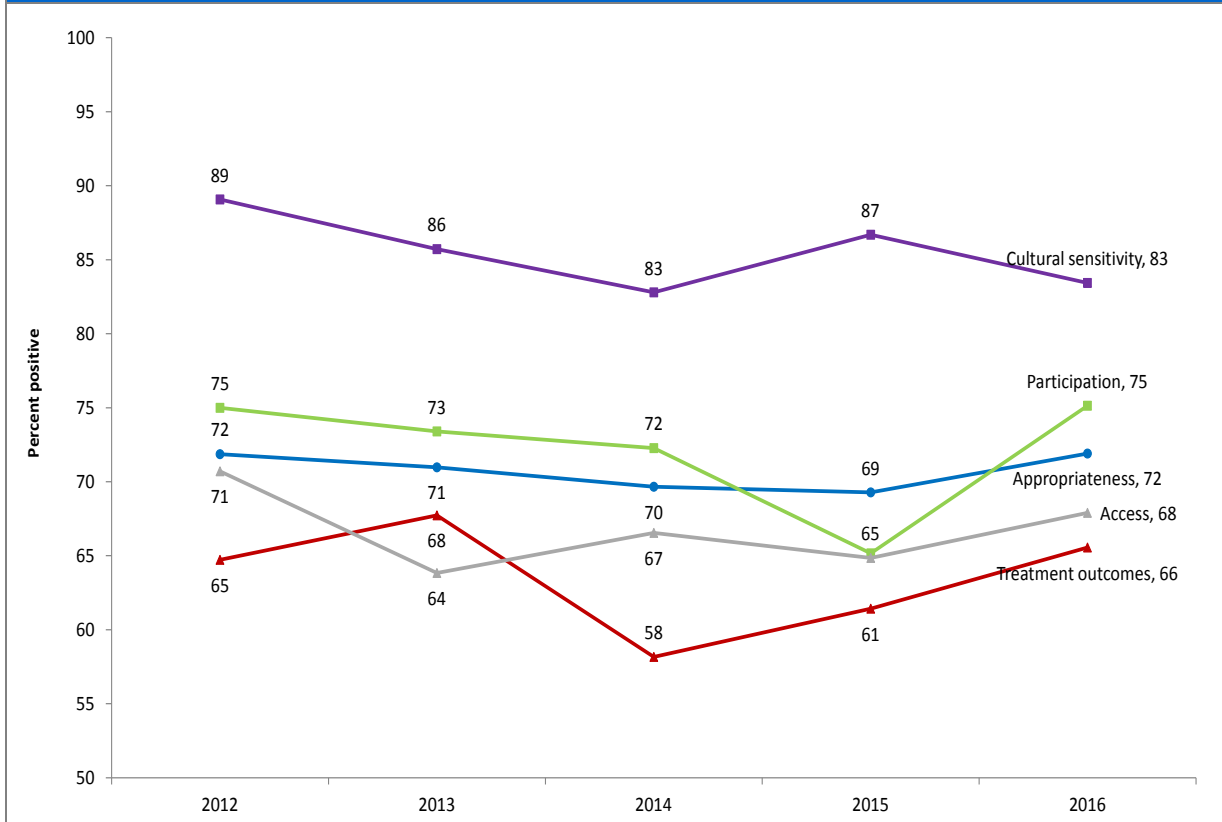
Domain Satisfaction by Gender

Figures 42 and 43 show satisfaction in each domain by gender for the past five years. Girls have shown a significant downward trend in satisfaction with treatment outcomes over time, and are generally less satisfied with treatment outcomes than boys.



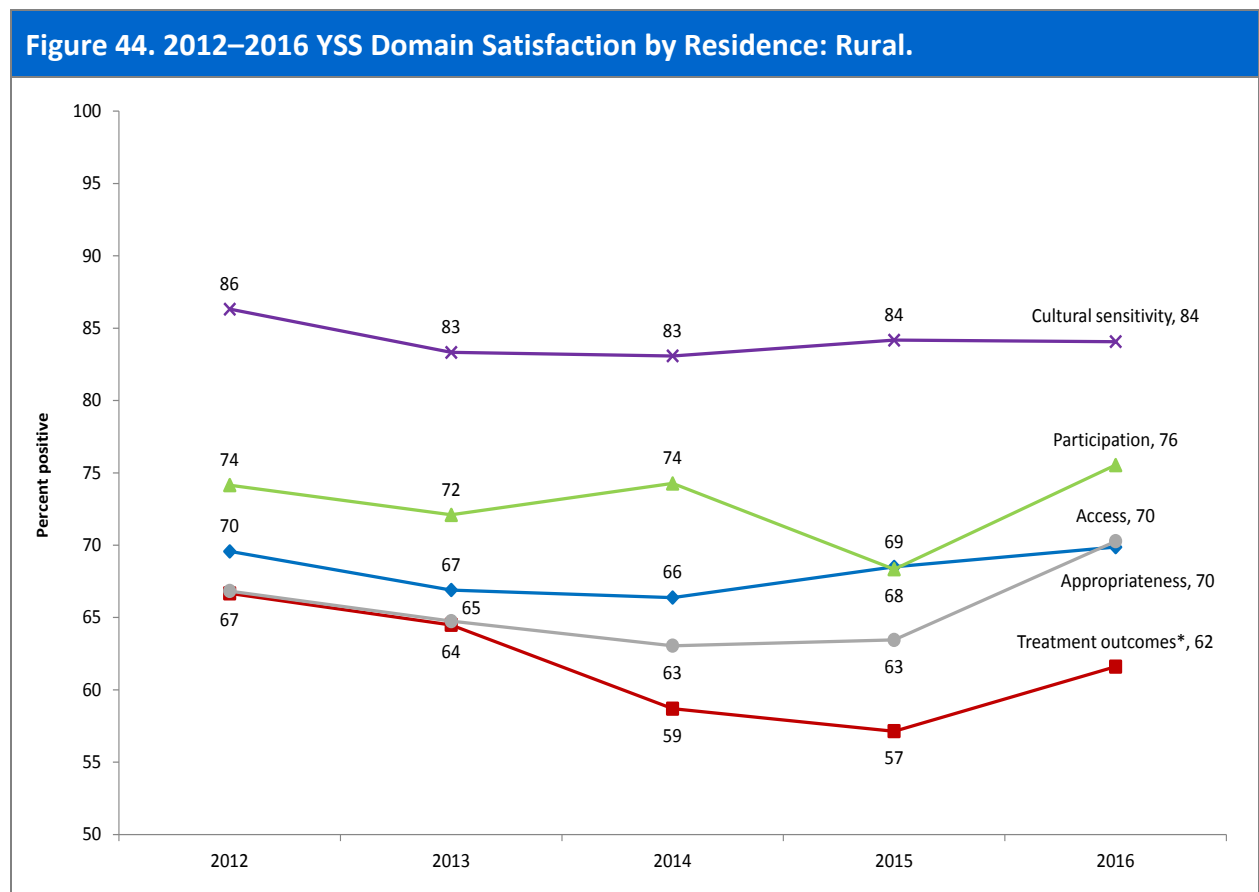
*Indicates a statistically significant upward or downward trend ($p < .05$) for that domain.

Figure 43. 2012–2016 YSS Domain Satisfaction by Youth’s Gender: Male.



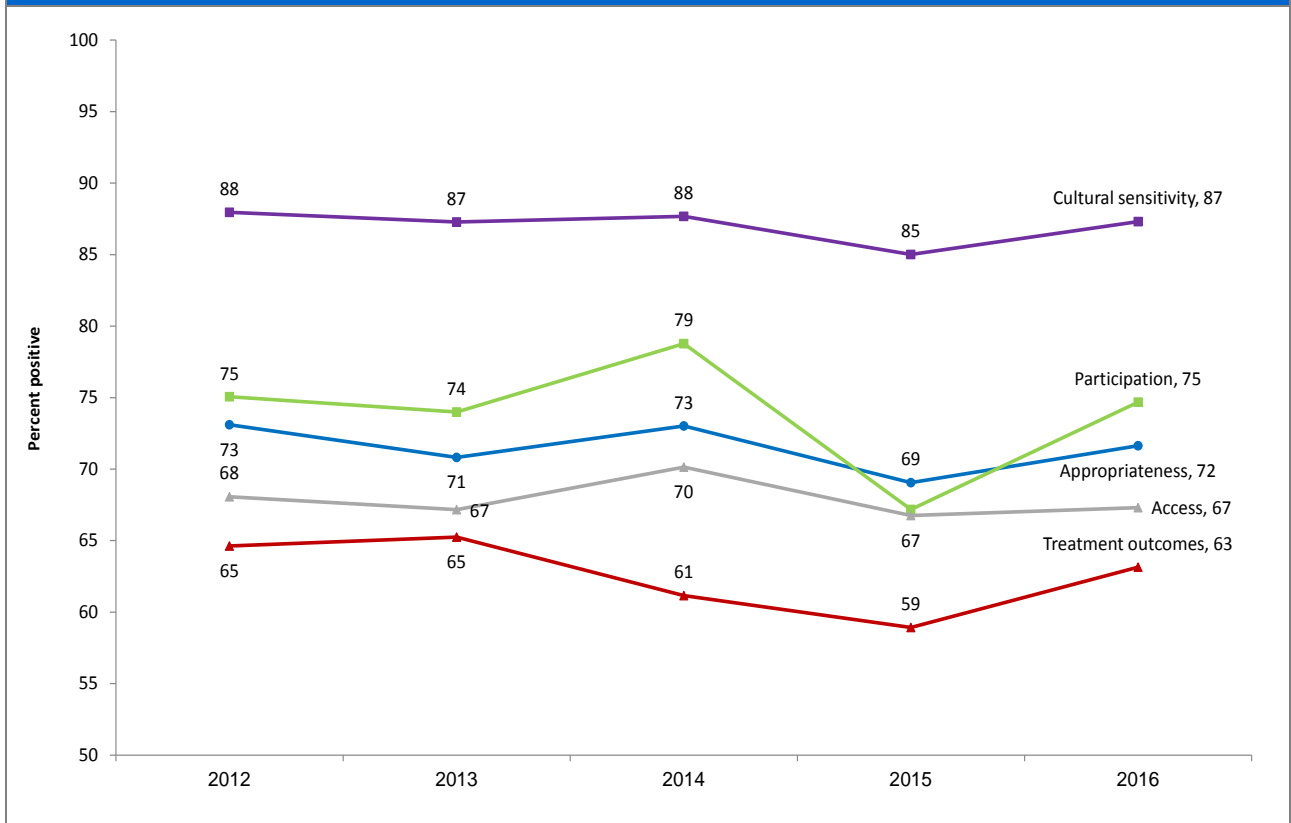
Domain Satisfaction by Residence

Figure 44 and 45 shows rural and urban respondents’ satisfaction in each domain for the past five years. Rural respondents have shown a significantly decreasing trend in satisfaction with treatment outcomes over time, while urban respondents’ satisfaction has remained consistent or varied up and down without a notable trend.



*Indicates statistically significant upward or downward trend over time for that domain.

Figure 45. 2012–2016 YSS Domain Satisfaction by Residence: Urban.



Domain Satisfaction by Ethnicity

Figures 46–50 show satisfaction in each domain by ethnicity for the past five years. Hispanic or non-Hispanic identification comes from Medicaid enrollment data. Consistently, more Hispanic respondents reported satisfaction in all domains over time. Non-Hispanic respondents have shown a significant downward trend in satisfaction with treatment outcomes.

A similar result appeared when comparing English and Spanish language speakers' domain satisfaction over time. More Spanish-speaking youth were satisfied in all domains consistently over time. Satisfaction with treatment outcomes among English-speaking respondents has trended downward significantly.

Figure 46. 2012–2016 Domain Satisfaction by Ethnicity: Appropriateness.

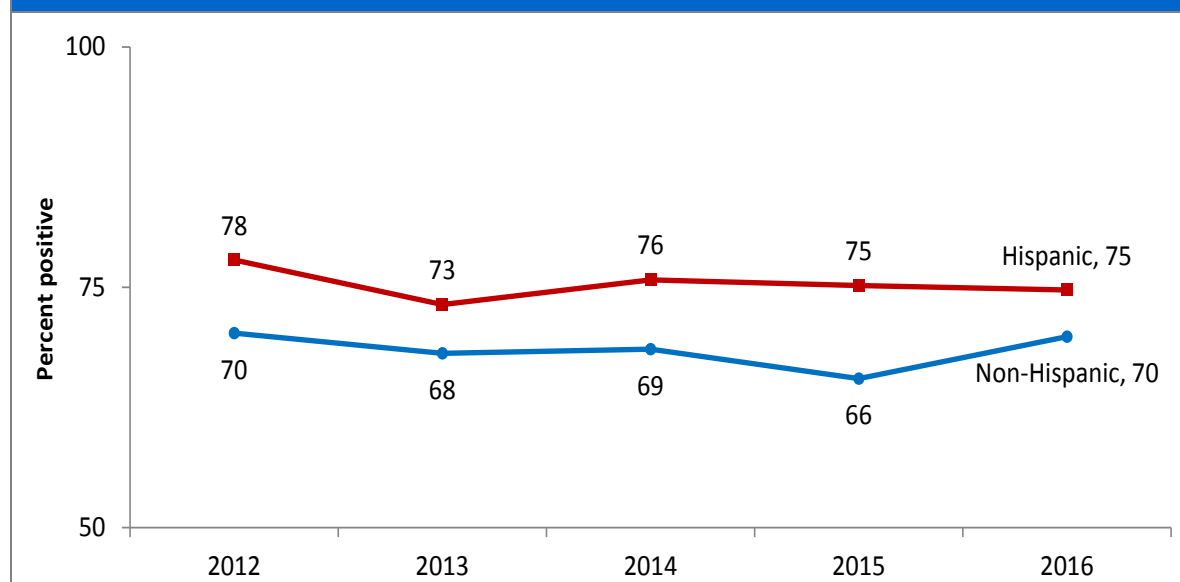
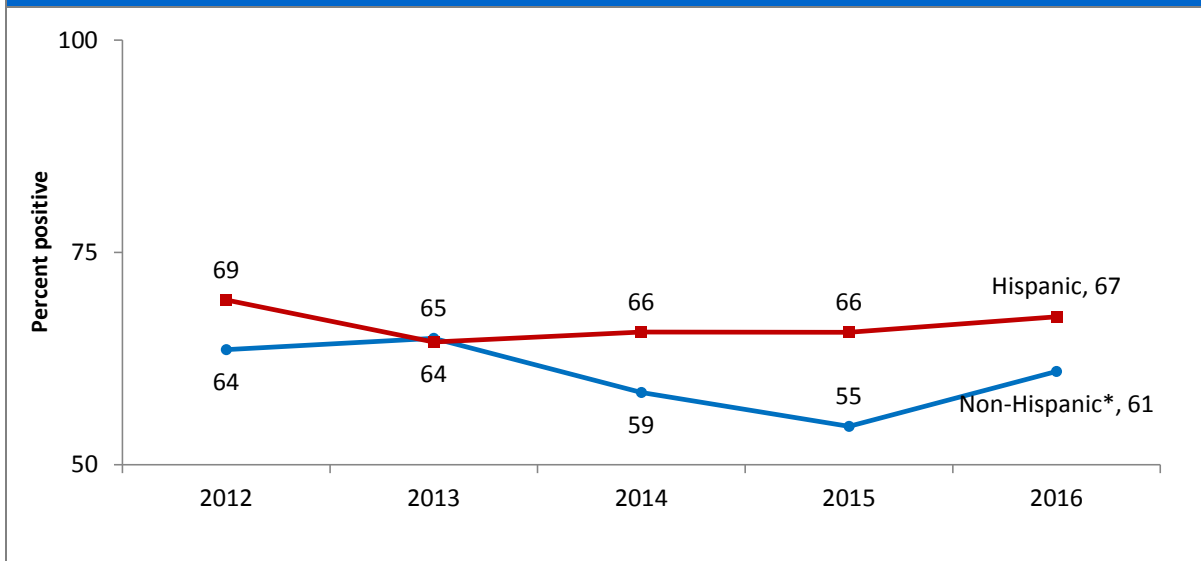


Figure 47. 2012–2016 Domain Satisfaction by Ethnicity: Treatment Outcomes.



*Indicates a statistically significant upward or downward trend ($p < .05$) for that ethnic group.

Figure 48. 2012–2016 Domain Satisfaction by Ethnicity: Participation.

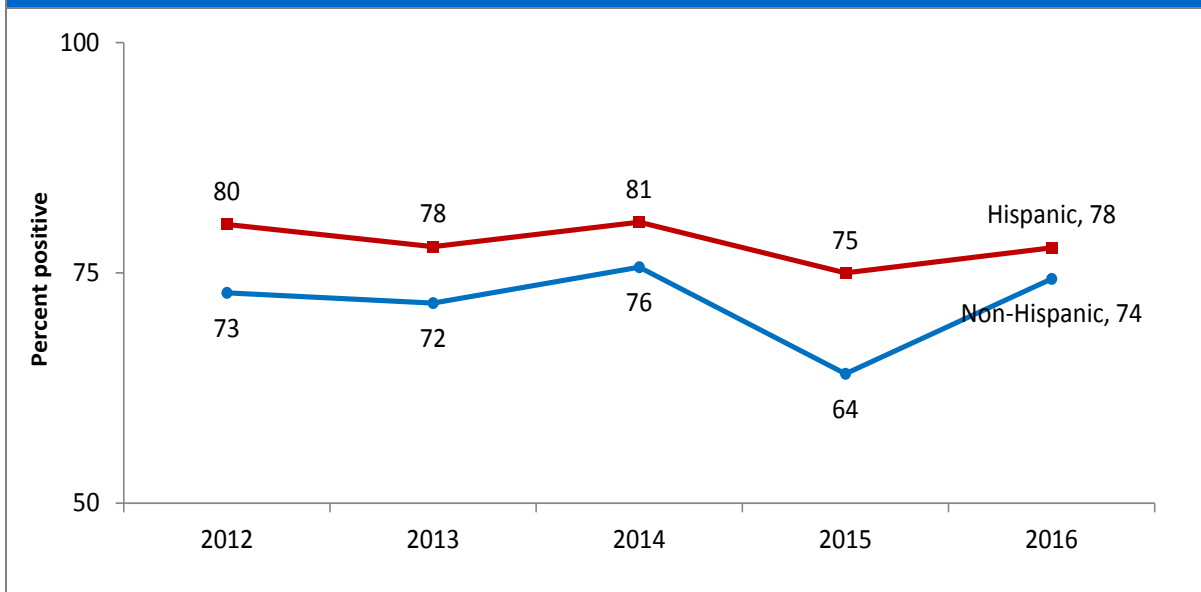


Figure 49. 2012–2016 Domain Satisfaction by Ethnicity: Cultural Sensitivity

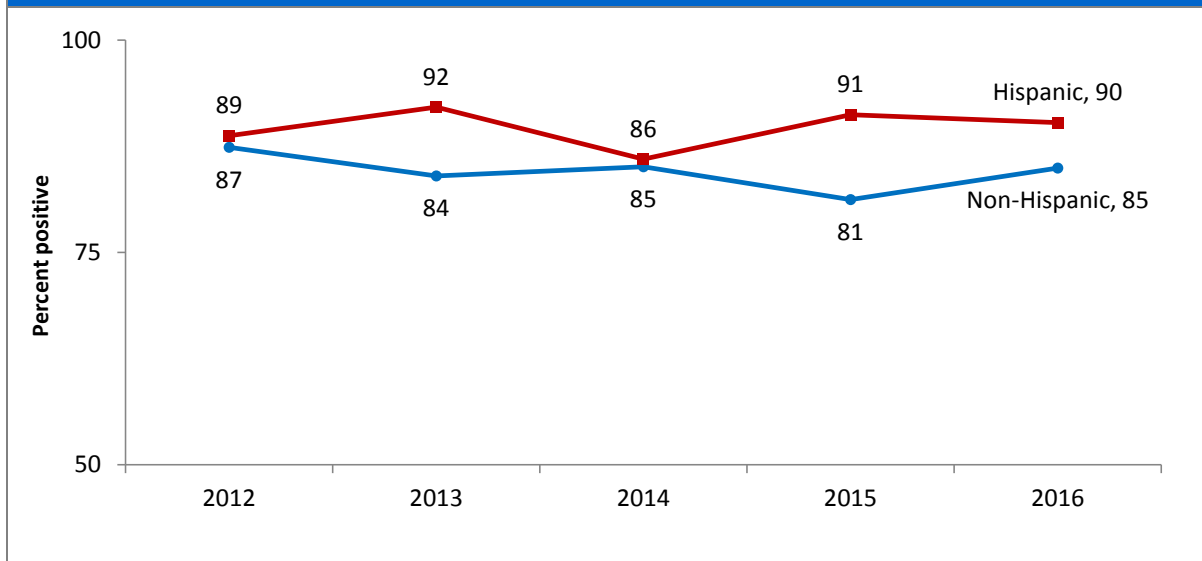
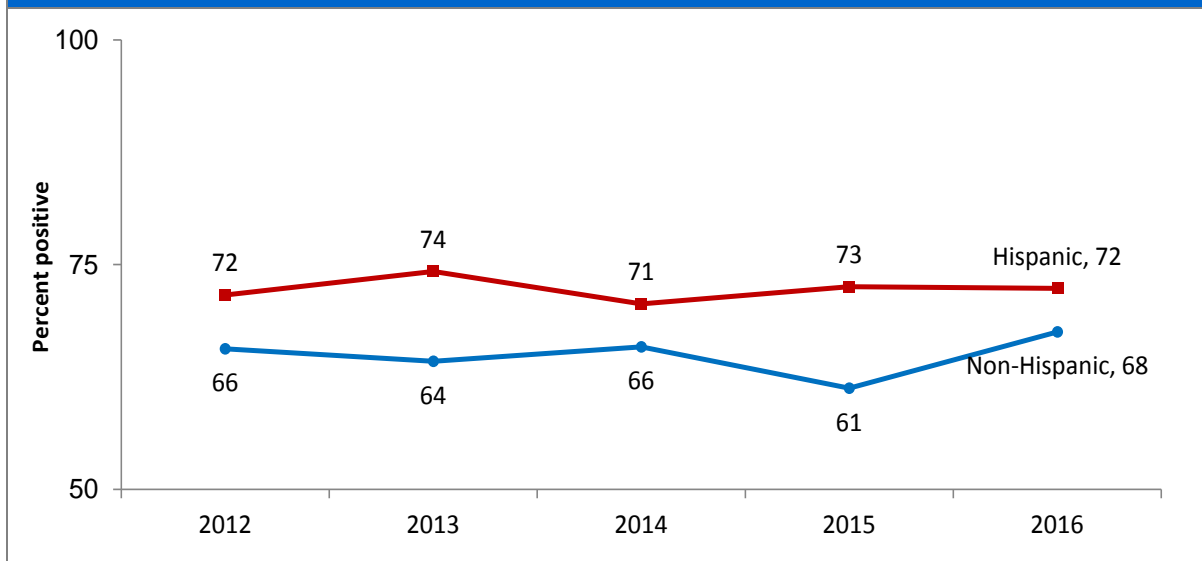


Figure 50. 2012–2016 Domain Satisfaction by Ethnicity: Access.



Analyses of Additional Questions

For youth receiving mental health services, many factors compound to influence satisfaction and improvement including living situation, school absences, utilization of health care services, medication for emotional/behavioral problems, and arrest history. The YSS survey asks about these areas.

Open-ended questions

Two open-ended questions asked youth to describe the most helpful thing about the services they received over the last six months, and what would improve services. Handling issues better, having someone to listen and share their feelings with, and feeling supported were most commonly cited as the most helpful things about services. Others mentioned getting help, being respected, and having a good therapist as the most helpful things. More services and better schedules or therapist availability were most commonly cited as things that would improve services. More caring or understanding therapists, more therapist variety, increased punctuality by therapists, and general comfort (e.g., comfortable chairs, having things to fidget with) were also mentioned as things that would improve services.

Living situation during past six months

Stable and safe housing is instrumental in helping youth address their mental health symptoms. Currently 82% of respondents lived with one or both parents. Another question asked about different places the young respondent might have lived in the previous six months (the respondent could choose more than one place). Table 11 shows that the percentage of respondents who lived with one or both parents or another family member has increased in the last 5 years, while the percentage who lived in a foster home decreased. The percentage of youth encountering all other living situations has remained relatively stable.

OHA's System of Care Wraparound Initiative emphasizes family involvement in youth mental health treatment decisions. Key outcome measures include reducing the number of youth in substitute care and increasing the percentage of youth served in their home community.¹⁰

¹⁰ Oregon Health Authority. System of Care Wraparound Initiative, Oregon Health Plan. February 2016. Available at: <https://www.oregon.gov/oha/amh/ChildMHPProviderSWCIDocs/SOCWI%20-%20Guidance%20Document.pdf>.

Table 11. Living Arrangements in the Previous Six Months, Five-Year Comparison.

Living situation	2012	2013	2014	2015	2016
With one or both parents	70	74	74	80	81
With another family member	13	20	17	17	17
Foster home	13	12	11	7	7
Therapeutic foster home	3	3	2	1	1
Crisis shelter	1	1	1	<1	1
Homeless shelter	1	1	1	1	2
Group home	2	3	2	2	3
Residential treatment center	5	7	5	4	5
Hospital	2	3	3	2	3
Local jail or detention facility	3	3	3	1	2
State correctional facility	<1	0	0	<1	1
Runaway/homeless/on the streets	4	3	2	3	3
Other	6	5	5	4	5

*Percentages may not add to 100 because respondents could choose more than one living arrangement.

Utilization of physical health care services

The American Academy of Pediatrics (AAP) recommends an annual well-visit for all children from birth through age 21.¹¹ The AAP identifies the following priority topics for adolescent well care visits:

- Physical growth and development
- Social and academic competence
- Emotional well-being
- Risk reduction (tobacco, alcohol and other drugs, pregnancy, sexually transmitted infections)
- Violence and injury prevention

¹¹ Bright Futures/American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. January 2016. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

Scheduling these visits, especially for adolescents, can be challenging but is critical for their health and well-being. Some youth will visit a medical doctor for an illness or injury. Any encounter with a medical doctor, regardless of the reason for the visit, could be a good time to address the priority areas identified by the AAP.

In 2014, data collected by the CCOs for incentive measure reporting requirements showed that 32% of Medicaid enrollees ages 12–21 received a well-care visit.¹² But as shown in Table 12, 78% of adolescent respondents—all of whom received this survey because they received mental health services paid for by Medicaid in Oregon—reported visiting a doctor for any reason in the last year. If both of these metrics are representative of the adolescent Medicaid population, there may be an opportunity for an additional 46% of adolescent Medicaid members to receive well-care services when they visit the doctor for an illness or injury.

Table 12. Utilization of Physical Healthcare Services in the Past Year. “In the last year, did you see a medical doctor (or nurse) for a health checkup or because you were sick?”

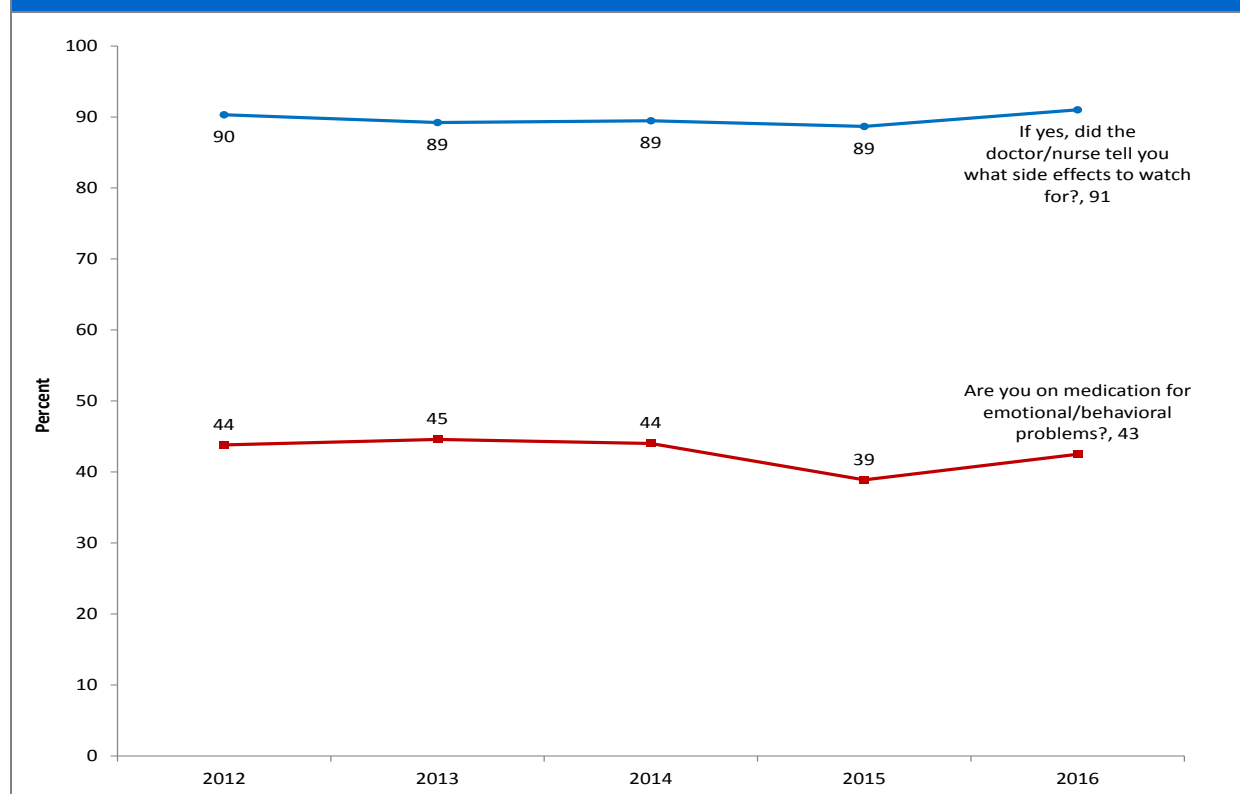
Responses	2015		2016	
	Number (n=796)	% of respondents	Number (n=1,012)	% of respondents
Yes, in a clinic or office	568	71	724	72
Yes, but only in a hospital emergency room	47	6	57	6
No	125	16	146	14
Do not remember	56	7	85	8

¹² Oregon Health Authority. Adolescent Well Care Visits Guidance Document. November 2015. Available at: <http://www.oregon.gov/oha/analytics/CCOData/Adolescent%20Well%20Care%20Visits%20Guidance%20Document%20-%20Nov%202015.pdf>.

Medication

While medication for emotional and behavioral health issues can be very effective, it is not always the solution (see page 52). Figure 51 shows that 43% of respondents are currently taking medication for their emotional/behavioral problems, and 91% were told about possible side effects. These percentages have not shown any significant upward or downward trends over the last five years.

Figure 51. Current Use of Medications for Emotional/Behavioral Problems, 2012–2016 Comparison.

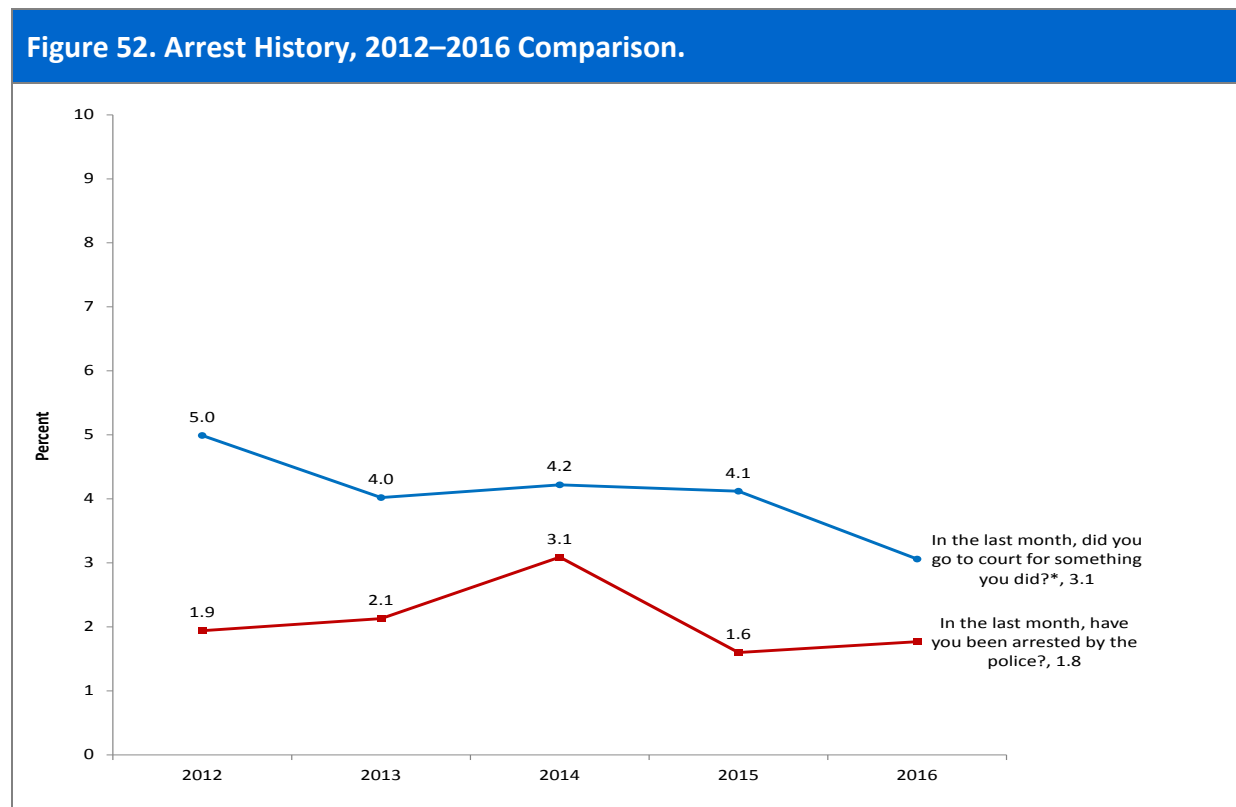


Arrest history

Youth involved in the criminal justice system have poor outcomes related to reintegration into society and recidivism. According to a 2016 report by the Oregon State Court Juvenile Justice Mental Health Task Force, “it is estimated that 70 percent of youth in the juvenile justice system meet the criteria for at least

one mental health disorder.”¹³ The report recommends screening and diverting youth with mental health conditions into “more appropriate evidence based trauma interventions.” One initiative related to this recommendation, the Criminal Justice Feeder System Project, attempts to identify high risk youth and provide opportunities to intervene before they become involved in the criminal justice system.

Figure 52 shows that in the last five years, a significantly decreasing percentage of youth respondents went to court for something they did while the percentage of youth that were arrested by the police has remained stable with a notable increase in 2014.



*Indicates statistically significant upward or downward trend over time for that question.

¹³ State of Oregon Judicial Department. Oregon State Court Juvenile Justice Mental Health Task Force, Report and Recommendations. January 2016. Available at: <http://www.oregonyouthdevelopmentcouncil.org/wp-content/uploads/2016/06/Oregon-Chief-Justice-Task-Force-on-Juvenile-Justice-and-Mental-Health-Report-2016.pdf>.

School absences

School attendance is often negatively affected by a young person's mental illness. The survey asked, "How often were you absent from school during the last month?" Respondents could select all answers that applied; therefore, all were included in the denominator. Fifty-eight percent of respondents said they were absent from school for two or more days, with 12.6% of respondents reporting more than 10 days of absences in the last month.

This question does not control for summer break, and with survey administration occurring between April and September, it is likely that many of the respondents reporting a high number of absences were out of school for the summer.

COMPARISON OF YOUTH AND CAREGIVER RESPONSES

Because the YSS sample is pulled directly from the YSS-F sample, both the caregiver and young person could respond to their respective surveys, providing two perspectives on the same episode of care. In 2016, there were 486 pairs of respondents who answered at least one question.

Table 13 shows the result of this analysis. Significantly more caregivers were satisfied than their adolescent children on the following questions:

- Services were available at the times that were convenient for me (81% vs. 72%).
- I helped to choose my services (77% vs. 65%).
- Staff spoke with me in a way that I understood (92% vs. 86%).
- I felt I had someone to talk to when I was troubled (83% vs. 76%).

Significantly more adolescents were satisfied than their adult caregivers on the following question:

- I helped to choose my treatment goals (79% vs. 70%).

Table 13. Youth and Caregiver Perceptions of Treatment Services (Percent who Strongly Agree/Agree with each Statement), 2016 (n=486).

Domain	Question	YSS	YSS-F
<i>Access to services</i>			
8	The location of the services was convenient.	76	80
9	Services were available at times that were convenient for me.*	72	81
<i>Treatment Outcomes</i>			
16	I am better at handling daily life.	74	70
17	I get along better with family members.	67	67
18	I get along better with friends and other people.	72	70
19	I am doing better in school and/or work.	64	64
20	I am better able to cope when things go wrong.	65	67
21	I am satisfied with my family life right now.	65	69

Domain	Question	YSS	YSS-F
<i>Participation in treatment</i>			
2	I helped to choose my services.*	65	77
3	I helped to choose my treatment goals.*	79	70
6	I participated in my own treatment.	85	83
<i>Cultural sensitivity</i>			
12	Staff treated me with respect.	89	91
13	Staff respected my family's religious/spiritual beliefs.	87	87
14	Staff spoke with me in a way that I understood.*	86	92
15	Staff was sensitive to my cultural/ethnic background.	85	86
<i>Appropriateness of services</i>			
1	I am satisfied with the services I received.	82	80
4	The people helping me stuck with me no matter what.	78	78
5	I felt I had someone to talk to when I was troubled.*	76	83
7	I received services that were right for me.	74	76
10	I got the help I wanted.	70	73
11	I got as much help as I needed.	65	67

*Indicates a statistically significant difference ($p < .05$) between YSS and YSS-F scores.

Youth and their caregivers also reported differences of opinion in domain scores. Table 14 shows that caregivers were significantly more satisfied than their adolescent children with access, participation and cultural sensitivity in 2016. Domain scores for youth and their caregivers increased in all domains between 2015 and 2016.

Table 14. YSS-F and YSS Domain Scores, 2012–2016.

Domain	YSS-F						YSS					
	2012	2013	2014	2015	2016	Change	2012	2013	2014	2015	2016	Change
Access*	73	75	74	73	75	+2	68	66	67	65	69	+4
Participation*	81	80	82	79	83	+4	75	73	77	68	75	+7
Appropriateness	71	72	72	70	72	+2	72	69	70	69	71	+2
Cultural sensitivity*	90	90	89	90	91	+1	87	86	85	84	86	+2
Treatment outcomes	61	60	63	60	64	+4	65	65	60	58	63	+5

*Indicates a statistically significant difference ($p < .05$) between YSS and YSS-F domain score in 2016.

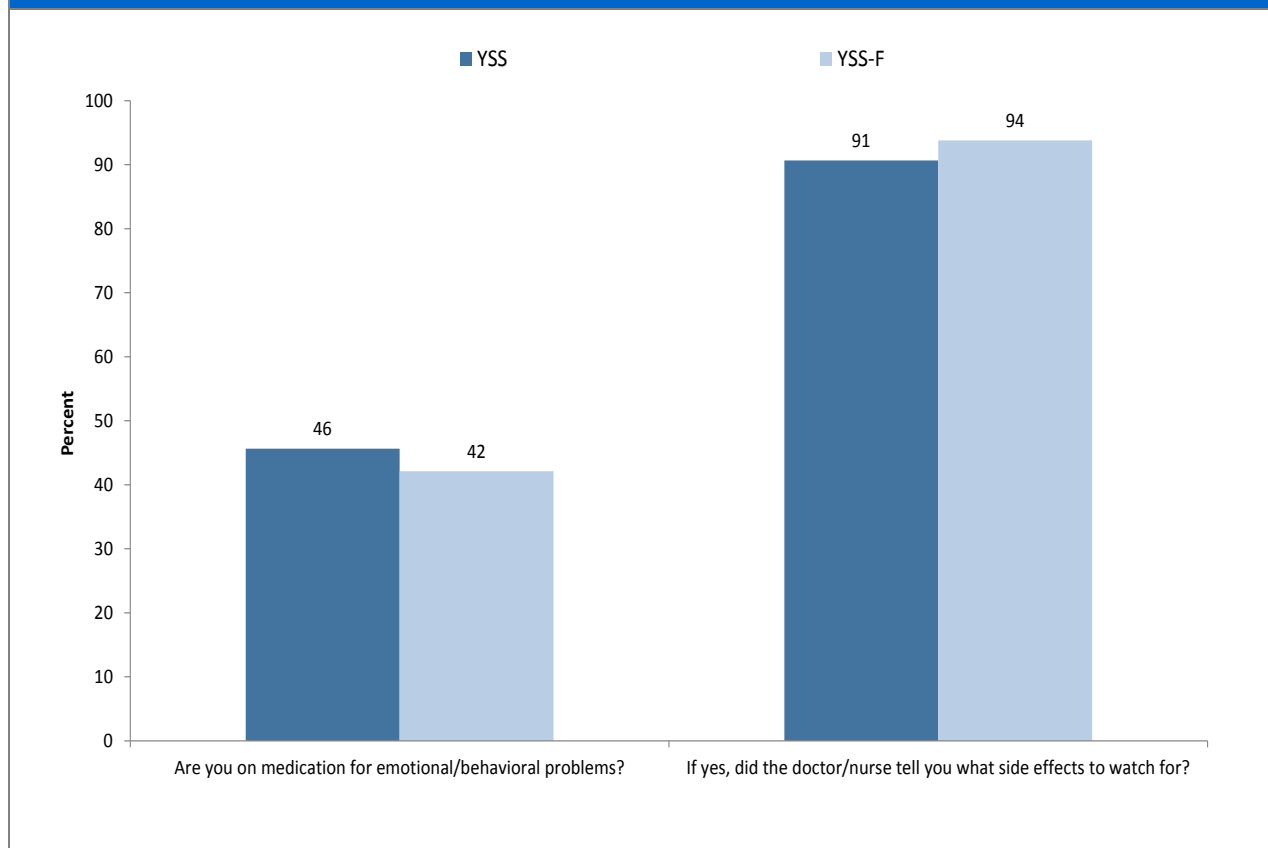
Note: The social connectedness and daily functioning domains are not included in this table since it only applies to the YSS-F survey.

Medication

As shown in Figure 53, among the paired adolescent/caregiver respondents, more adolescents reported taking a medication for their emotional/behavioral problems than their caregivers, suggesting that caregivers were not always aware of the medications their child was taking.

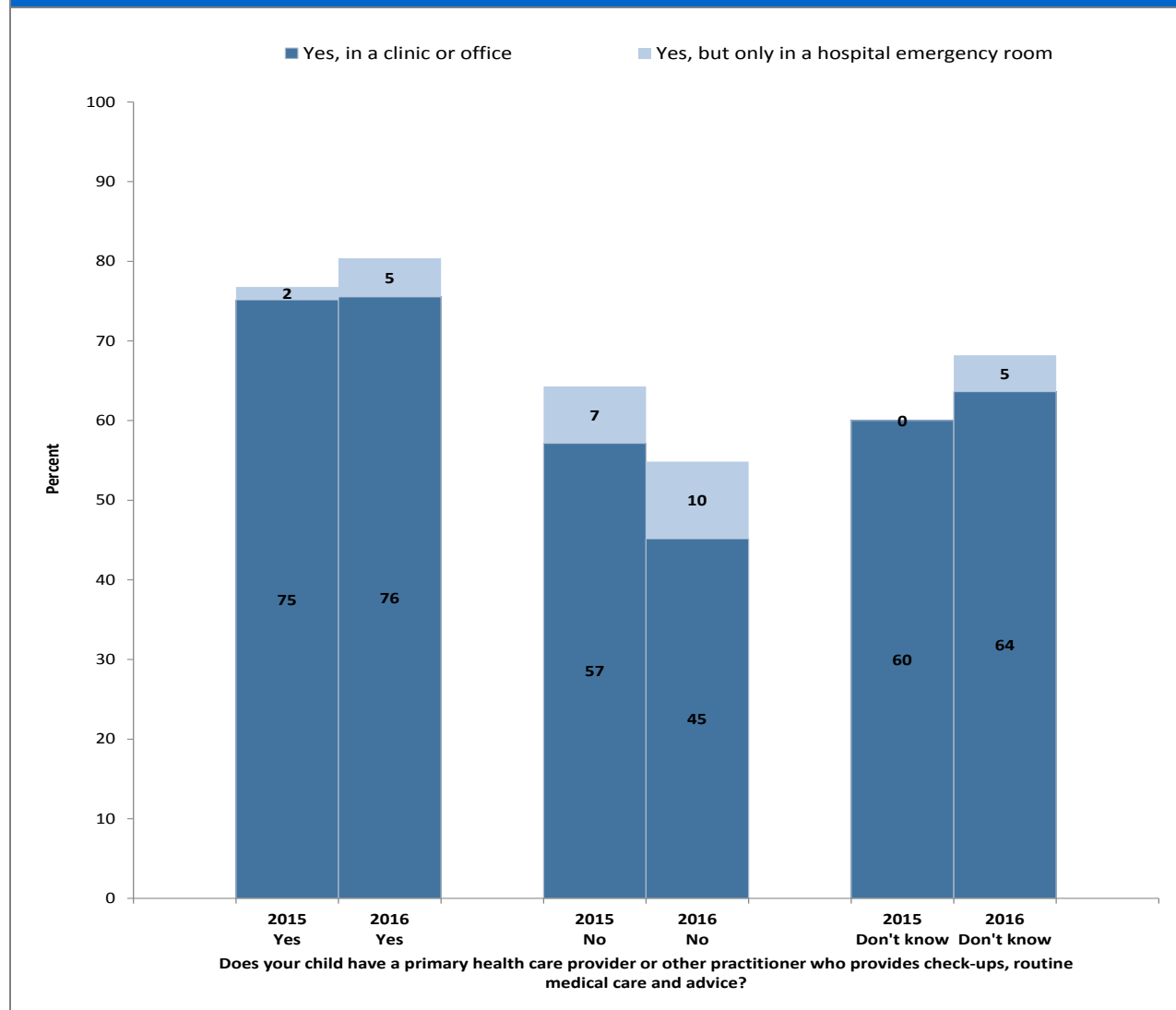
More caregivers were told what side effects to watch out for than their adolescent children. The questions in the two surveys were slightly different: “Were psychotropic medications prescribed for your child while receiving treatment from his or her recent mental health services provider?” (YSS-F) and, “Are you on medication for emotional/behavioral problems?” (YSS). The past-tense inclusion in the YSS-F question with the present-tense in the YSS question may have the effect of under-estimating the difference between the two.

Figure 53. Medication Use as Reported by Youth and Caregivers.



Among respondent pairs, if the caregiver indicated that the young person had a primary care provider (a question only asked of caregivers), the young person was more likely to have seen a provider in a clinic or office (a question only asked of adolescents) than youth whose caregivers indicated that they did not have a primary care provider (Figure 54). The proportion of youth who only saw a provider in a hospital emergency room was higher for those without a primary care provider (10%) than those with a primary care provider (5%).

Figure 54. In the last year, did you see a medical doctor (or nurse) for a health check-up or because you were sick? (YSS-F and YSS respondent pairs): 2015 and 2016 comparison.



DISCUSSION AND RECOMMENDATIONS

Overall Survey Results

In 2016, 3,212 responses from caregivers of 13,794 children and youth for an overall response rate of 23%. For the first time this year, more respondents filled out the survey online than by mail.

A total of 1,025 young people submitted surveys in 2016, for an overall response rate of 22%. Most of these surveys (75%) were completed online.

In the YSS-F, satisfaction has remained relatively stable across domains for the past five years, with a slight increase in satisfaction in all domains in 2016. Over the past five years, satisfaction among YSS respondents has varied in domains year to year, with a significant downward trend in treatment outcomes.

As in previous years, young people were less satisfied in all domains when compared to their caregivers, with significant differences in the access, participation, and cultural sensitivity domains.

Survey Limitations

While a client survey has many benefits (e.g., ease of administration, first-hand experience reports, and client involvement), there are limitations as well. As in any survey, social desirability may bias some results. This is especially true in questions on sensitive topics such as alcohol and drug use. These surveys also rely on a respondent's memory of events that occurred sometime in the past year.

While the MHSIP domain portions of the survey have remained untouched, additional questions are added and/or removed each year by HSD. Some of these questions have not been validated, and it is unknown what effect, if any, they have on the validity of the preceding MHSIP items.

The length of the survey may deter some potential respondents. Totalling seven printed pages with 53 questions and many sub-questions, the YSS-F may take significant time to complete. Caregivers may have different perceptions of their child's treatment than the child has for a number of reasons. If the caregiver has different treatment expectations, different opinions on presenting issues, or limited information (e.g., caregivers may not know about the young person's

school attendance or alcohol or substance use), their report about the child's or young person's treatment may not reflect the episode of care the way the therapist or young person would report. The YSS is only three pages with 37 questions, but could still be daunting. Mental or cognitive challenges may have impacted the respondents' ability to understand and respond accurately to some questions. Youth may view services through a different lens than adults, but this is a benefit rather than a detriment to the survey. It is important to hear and consider the young person's voice.

Finally, the survey results combine data from surveys completed on paper and returned by mail, and surveys completed online. There are potential differences in the way respondents answer the same questions in the two modes. Also, there may be differences in age, disability, treatment setting, or living situation between online and paper respondents that would affect the way they answered the questions. Web respondents may feel more anonymous, and therefore likely to answer more honestly than paper survey respondents. These differences were not the focus of this survey or analysis, but may be interesting to study in the future.

Highlights and Recommendations

Responses by race and ethnicity

Race and ethnicity data are missing for many Medicaid enrollees in the state's dataset because neither of these fields are required in MMIS. The surveys asked respondents to self-identify their race and ethnicity, which enabled comparisons between the state dataset and the self-reported data. This analysis found that the state ethnicity data overestimates the number of non-Hispanic enrollees and the number of white enrollees.

Obtaining accurate race and ethnicity data is a key component of addressing health equity in Oregon, and the state should continue efforts to do so.

- **HealthInsight Oregon encourages OHA-HSD to work with the CCOs to gather and update these data at points of contact to obtain the most accurate race and ethnicity data. OHA-HSD could provide policy direction and technical assistance to CCOs to follow best practices in gathering these data to improve quality of care and reduce disparities.**

Urban vs. rural respondents

As in previous years, more urban YSS-F respondents were satisfied than rural respondents in most domains. Over the past five years, the percentage of satisfied respondents in urban areas has significantly increased in treatment outcomes, participation, and social connectedness, while there has been no significant changes among rural respondents.

Satisfaction with treatment outcomes among rural YSS respondents has trended significantly downward over the past five years. Satisfaction among urban YSS respondents in all domains has remained consistent over time or varied up and down without significant trends.

- **OHA-HSD, CCOs, and providers should continue to explore opportunities for the use of technology (e.g., telehealth) for screening, assessment, treatment, and care coordination in rural areas.**

Health status

Children and youth with excellent and very good health were more likely to have a primary care provider or other practitioner who provides regular care (check-ups, routine medical care and advice).

- **OHA-HSD should work with CCOs to continue to focus on initiatives to ensure adolescents receive well visits.**

Substance abuse treatment (youth 13–18)

Of caregivers who reported that their adolescent child had or currently uses alcohol or drugs, fewer than half reported the young person had received treatment or other help. Of those who did receive help, 61% thought the treatment or other help provided what the young person needed.

- **OHA-HSD should work with CCOs to increase treatment for alcohol and drug use. CCOs should ensure that appropriate referrals, care coordination and follow-up occur after substance abuse screening.**

Trauma screening

Only 58% of caregivers indicated that their child was asked if they had a history of trauma. Of caregivers with children or youth who had experienced serious trauma, 53% felt it had been adequately addressed during treatment.

- **OHA-HSD should work with CCOs and continue efforts to increase trauma screening and provision of trauma-informed care for Oregon’s youth.**

Mental health crisis

While the percentage of youth experiencing mental health crisis has trended significantly downward over the past five years, so has the caregivers’ satisfaction with the mental health provider’s response.

- **OHA-HSD should work with CCOs on improving services provided to children and youth in mental health crises.**

Lower satisfaction with treatment outcomes in YSS

Satisfaction with treatment outcomes has trended significantly downward over the past five years. This was especially true for female respondents compared to male respondents.

- **OHA-HSD should work with CCOs to further investigate adolescents’ lower satisfaction, particularly girls, and determine steps to increase satisfaction.**

Provider visits

Most (77%) YSS respondents saw a doctor in the last year. These visits are a good opportunity to provide well-care services; however, CCO incentive measure reporting showed that only 32% of Medicaid enrollees ages 12–21 received a well-care visit. Having a primary care provider also appears to prevent emergency department visits, as the proportion of youth who only saw a provider in a hospital emergency room doubled from 5% to 10% between those with and without a primary care provider.

- **OHA-HSD should continue working with the CCOs to increase regular adolescent wellness visits.**

Service convenience, choices, and communication

Youth were not as satisfied as their caregivers regarding the convenience of services, being able to choose services, having someone to talk to, and being spoken to by staff in a way they understood.

- **OHA-HSD should encourage CCOs to ensure they have an adequate number of providers in their panels who have expertise in treating adolescents.**

Medication

Over the past five years, the percentage of caregivers reporting that their child was prescribed psychotropic medications has trended significantly downward.

Among the paired adolescent/caregiver respondents, more youth reported taking medication than their caregivers, suggesting that caregivers were not always aware of what medications their child was taking. (Note: the questions were worded differently between the surveys, which may have contributed to the differences.)

Also, more caregivers reported being informed about medication side effects than the adolescents.

- **OHA-HSD should continue to work with CCOs in focusing on communicating with youth about medication side effects.**
- **Providers should be sure that adolescents are informed about and understand the side effects of their medications because the caregivers may or may not be part of that conversation/oversight.**

APPENDIX A: SURVEY DATA SECURITY AND QUALITY ASSURANCE PROCEDURES

HealthInsight Oregon stored the electronic data for this survey in REDCap software on a secure server. Only essential team members had access to the raw data to perform data entry. Exported data files were also saved on the secure server, where access was limited. HealthInsight Oregon kept the original paper copies of the surveys in a secure location.

Data entry staff members were trained on entering the survey data, and other authorized staff checked every tenth survey to ensure consistent and correct data entry. HealthInsight Oregon maintained data quality on two tiers. First, built-in data checks in the REDCap software ensured that only valid field values could be entered, and enforced the use of custom codes to note missing or out-of-range data. For example, the application checked to make sure that the field corresponding to Question 1 was coded with 1–5 (Strongly Disagree to Strongly Agree), or 9 for NA, or 0 for missing or invalid response on the paper copy.

Second, SAS recheck programs written by the data analyst scanned each field of each survey response and checked for missing and out-of-range data or logic check problems.

HealthInsight Oregon used tabulations and univariate analysis to examine demographic variables and other frequencies; cross-tabulations to examine the relationship between and among different categorical variables; chi-square analyses to identify statistically significant differences between groups; and Cochran-Armitage tests of trend to identify changes over time.

APPENDIX B: SURVEY FORMS IN ENGLISH AND SPANISH