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The project team would also like to extend a sincere appreciation to Tracy Wrong and Jackie Desrochers at the Royal Ottawa Hospital, as well as Miriam McCann at the Centre for Addiction and Mental Health, who graciously shared their experiential learning with regards to implementing the OPOC-MHA with clients with complex challenges. The practical strategies they employed to facilitate survey administration with this population as well as their willingness to share this knowledge so openly were instrumental in developing this section of the guide.

For this Fourth Edition of the Implementation Guide, we acknowledge the many contributions by members of the Ontario Family Caregivers’ Advisory Network, whose work resulted in the Caregiver Version of the OPOC-MHA that we have included in this edition.
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Part 1: Introduction to the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA)

Evaluating service users’ perceptions of care is an important way to measure client experiences within the health care system, and can be used to bring about change in areas such as enhancing access, quality of care, client-centeredness, and safety. Ontario’s mental health and addiction system, which comprises both community providers and hospital-based services, recognizes the value of quality improvement (QI) initiatives as a vehicle to improve service delivery, and this approach has been endorsed in varying capacities by the Canadian Mental Health Association, Addictions and Mental Health Ontario,¹ and Health Quality Ontario.² There is a growing emphasis on client perception of care and its inclusion as a key indicator in QI plans, and the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA) provides a credible and comprehensive method to address this need.

Over the past few years, there has been a movement away from “client satisfaction” language, as measures of client satisfaction tend to be highly skewed and therefore may not always be able to inform QI plans in a clear way. Measures of perception of care, on the other hand, ask more directly about a client’s experience in relation to what is expected as standard practice among providers.

The OPOC-MHA was developed through the Centre for Addiction and Mental Health’s (CAMH) Client Satisfaction/Perception of Care Project as part of the Ontario Drug Treatment Funding Program (DTFP) between 2011 and 2014. Three versions of the tool are available.

¹ https://amho.ca/our-work/e-qip/
² http://www.hqontario.ca/quality-improvement
The tool’s focus on actionable items makes it ideal for promoting QI initiatives within a program, a provider, or across the broader system. Within Ontario, the OPOC-MHA is now being implemented within Ministry of Health and Long Term Care (MOHLTC) funded addiction and mental health services by CAMH’s Provincial System Support Program (PSSP) and with significant support from key stakeholders.

This implementation guide is intended for health service providers who are using the OPOC-MHA questionnaire as part of their QI and performance monitoring work; however, it also has value for health system planners and program evaluators. For more detailed information about the OPOC-MHA project, including its background and instrument development and validation processes, please refer to the “more information” links at the end of this guide.

This guide is divided into four sections:

- This first section, Part 1, introduces the OPOC-MHA project and tool and provides details about the different versions of the questionnaire.
- In Part 2, “Implementing the OPOC-MHA,” information that will assist with survey administration and implementation is provided. A discussion of implementation challenges with clients with complex needs, as well as Frequently Asked Questions, are also included.
- In Part 3, “Entering and Extracting Data,” information about entering data to the OPOC-MHA website and extracting data into reports are included.
- Lastly, in Part 4, “Using the Results for Evaluation and Quality Improvement,” the value of OPOC-MHA as a QI and evaluation tool is discussed, along with tips for data analysis and reporting.
About the OPOC-MHA

The OPOC-MHA is a validated and extensively tested questionnaire that was developed by CAMH to measure client perception of care in mental health and addiction services. It is endorsed by both Accreditation Canada and the Canadian Centre for Accreditation as an instrument approved for use for assessing client satisfaction/perception of care. There are three versions of the tool designed for use in mental health, addictions, and concurrent disorder programs with people with addiction and/or mental health challenges, as well as their family members/supporters. The tool is available in both English and French and is designed for people 12 years of age and older with a literacy level of grade-six or higher.

The tool evaluates perception of care across the following seven domains for the registered and non-registered client versions:

- Access/Entry to Services
- Services Provided
- Participation/Rights
- Therapists/Staff/Support Workers
- Environment
- Discharge/Program Completion/Treatment
- Overall Experience

Version 1: OPOC-MHA for Registered Clients and Family Members/Supporters

The first version of the tool is to be completed by registered clients of a program or service. This may include clients receiving services for their own treatment/support as well as clients who are family members/supporters who are receiving services in their own right, such as a family support group. The client version of the OPOC-MHA contains a total of 38 items. The first 32 items measure perception of care for clients receiving services in both community and residential/inpatient settings. The remaining six items are only applicable for clients receiving residential or inpatient services. The tool also provides respondents with the opportunity to provide written, open-ended comments related to each of the seven domains.
In addition, participants are asked to report their gender, age, language, ethno-cultural background, and sexual orientation. These questions are asked so that providers and funders are able to identify potential inequities in service or access. Other OPOC-MHA questions ask respondents whether participation in services is conditional (e.g., a condition of probation) and the types of conditions that apply, as well as the stage of treatment or support services the client is in at the point the tool is completed. When data are combined across many clients, this allows perception of care to be summarized based on different stages of treatment or support. While this is addressed further in Part 2 of this guide, it is important to note that all items in the OPOC-MHA must be administered in their entirety; however the client is free to elect not to respond to some questions.

**Version 2: OPOC-MHA for Non-Registered Clients/Family Members/Supporters**

The second, non-registered, version of the tool contains 17 items and is intended to be provided to 1) persons receiving support from an organization who are not registered clients, and 2) family members or supporters of persons with a mental health, substance use, or gambling-related problem who are receiving services from the provider for their own support. Examples would include a drop-in peer support program where clients are not rostered, a monthly educational session for family members/supporters, or telephone support services. Family members/supporters who are invited to complete the survey do not necessarily have a family member/loved one receiving service from the same provider, or receiving any service for that matter, as long as they are supporting someone with an addiction or mental health concern, or concurrent disorder.

It is important that members/supporters complete the OPOC-MHA as it relates to their own experience with the service. During the development process of the OPOC-MHA, the project team discussed two different approaches to obtaining perception of care feedback from family members. On one hand, they can reflect on the basis of the services they themselves receive or they can reflect on the services...
received by their family members and perhaps the indirect benefit to them. It is extremely challenging to structure one questionnaire to handle both perspectives. With support of the Advisory Committee the decision was made to develop the family members/supporters version of the OPOC-MHA in such a way to reflect the services they themselves receive. This approach formed the basis of validation work. As a result, the OPOC-MHA non-registered clients/family members/supporters version should not be used to have family members reflect on services their loved ones receive or to reflect on the potential benefit of those services for themselves or their family members. Providers must request that family members respond to the OPOC-MHA questions in this manner.

**Version 3: OPOC-MHA for Caregivers and Family Members**

The third version of the tool is intended to be completed by caregivers and family members that (1) have a loved one receiving services at the organization and (2) are not directly receiving services themselves at the organization. This version offers caregivers and family members an opportunity to comment on the care received by their loved one and reflect on the potential benefit of those services for themselves and their loved one. The caregiver version of the OPOC-MHA contains a total of 39 items. The first 33 items measure caregivers’ perception of their loved one’s care for clients receiving services in both community and residential/inpatient settings. The remaining six items are only applicable for caregivers with loved ones in residential or inpatient services. The tool also provides respondents with the opportunity to provide written, open-ended comments related to each of the seven domains.

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**The tool evaluates perception of care across the following six domains for the caregiver version:**

- Caregiver Involvement and Engagement
- Caregiver Education and Support
- Caregiver Personal Support
- Environment
- Perception of My Loved One’s Care
- Overall Experience
Similar to the client versions of the OPOC-MHA, participants are asked to report their demographic information so that providers and funders are able to identify potential inequities in service or access. These questions ask about the caregiver’s demographic information as well as their loved one’s involvement in service (e.g. whether participation in service is mandatory and stage of treatment). When data are combined across many caregivers, this allows perception of care to be summarized based on different stages of treatment or support.
Part 2: Implementing the OPOC-MHA

Administration Essentials

The OPOC-MHA was designed for widespread use and adoption across the entire MOHLTC funded mental health and addictions sector. Provincial and Local Health Integration Network discussions are supporting uptake across Ontario; however, most of the implementation planning occurs at the provider or program level. This ensures that the tool is responsive to the structure of the program, appropriate for its clientele, and congruent with existing QI initiatives in place at the organization, if applicable. While implementation can and will vary by service, there are four key requirements regarding administration that must be met in accordance with the Memorandum of Understanding for providers funded by the MOHLTC, or end-user license agreement for providers outside of the scope of supported implementation.

1. Provide the Entire Questionnaire
   The questionnaire must be provided to clients in its entirety. Providers are not permitted to add, change, reorder, or omit any of the existing questions. Clients and caregivers should be clearly informed that they can opt not to answer every question, but the tool itself must be provided in full. In other words, the choice to omit a question should be the respondent’s and not that of program staff or managers. Since one of the benefits of the tool is that it will allow for comparisons between programs and LHINs, all programs should administer identical versions of the tool to their respective clients. Providers or programs may provide a separate form or set of questions specific to their program should they choose to do so. It is important, however, to administer the OPOC-MHA before the other questions to ensure maximum benefit from the tool.

2. Ensure Anonymity
   The administration of the OPOC-MHA should ensure anonymity. Names or any other types of personal identifiers, such as client or insurance numbers, are not to be written anywhere on the tool. Having a location where clients can return the questionnaire, such as a drop box,
is one way of ensuring the tool remains anonymous. Furthermore, the results of tool administration should not be linked electronically to any other identifying client or personal health information.

3. **Ensure Completion is Voluntary**

It must be clearly communicated that completion of the OPOC-MHA is voluntary. To maintain integrity of the data, responses to questionnaires and surveys must be provided in the absence of any coercion, either direct or implied. In the case of the OPOC-MHA, this means that a client's or family member's decision to complete the questionnaire should not have any consequences towards any other aspect of their services, and should not result in differential treatment by staff.

4. **Provide Facilitation as Needed**

Pilot testing demonstrated the value of facilitation when administering the questionnaire. Facilitation was shown to be helpful in engaging clients in QI initiatives and in resolving any confusion over individual items in the questionnaire, thereby maximizing completion rates. Clients and caregivers were more motivated to complete the questionnaire after it was explained that the objective was to improve the services they were receiving. In addition, an introduction to the questionnaire is a great opportunity to address common questions that arise during administration such as items pertaining to residential/inpatient client groups, and the use of “not applicable” response category. Staff can also use this opportunity to provide instruction and guidance to minimize errors that impact data quality (see page 27 for more information). In addition to the facilitation provided with the questionnaire itself, staff should also anticipate some facilitation may be needed with the technology used for the electronic administration given varying levels of familiarity and comfort among clients. It is important to think of facilitation as the process of explaining the purpose and rationale of the survey rather than guiding specific responses, although some clients may require more intensive assistance than others depending on their needs.
**Survey Distribution and Timing**

There are a variety of ways the OPOC-MHA can be administered. There is no one prescribed way, as this depends on the practices of each provider or program and also unique aspects of the client population. The tool can be completed on paper or electronically through the www.opoc.ca website, which is described in Part 3 of this guide. Surveys can be distributed in a group setting or individually, and either in person, through email, or with regular mail. The following chart identifies common strengths and weaknesses of each administration method.

<table>
<thead>
<tr>
<th>Paper Survey</th>
<th>Electronic Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pros</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>• Most clients and caregivers are familiar with and comfortable completing paper surveys, forms, and assessments</td>
<td>• Handwriting may be illegible or difficult to read</td>
</tr>
<tr>
<td>• Some respondents feel that paper administration is more personal</td>
<td>• Time consuming to individually and manually enter surveys into database</td>
</tr>
<tr>
<td>• Allows survey to be offered to hard-to-reach clients and caregivers who may lack access to computing technology or the Internet</td>
<td>• Need to track completed surveys until they are entered into the database</td>
</tr>
<tr>
<td>• Group administration is possible with a group size that exceeds available computing resources</td>
<td>• OPOC keys could be misplaced, detached, or separated from the paper surveys themselves</td>
</tr>
<tr>
<td>• Immediate entry into database eliminates need for staff data entry</td>
<td>• Paper survey may appear overwhelming in length</td>
</tr>
<tr>
<td>• OPOC keys can be e-mailed to potential respondents, as long as service providers aren’t tracking which keys go to specific addressees (maintain privacy)</td>
<td>• Some individuals may find it difficult to use the web site</td>
</tr>
<tr>
<td>• Survey presented by section may appear less overwhelming compared to receiving entire paper document</td>
<td>• Entering responses to open-ended questions by tablet can be tedious due to limited typing functionality on most devices (i.e., virtual keyboard only)</td>
</tr>
<tr>
<td></td>
<td>• Radio buttons appear tiny in certain sections, which could lead to erroneous responses if not closely monitored</td>
</tr>
<tr>
<td></td>
<td>• Group administration is limited to the number of available computers as clients are unlikely to wait for an available machine to complete survey</td>
</tr>
</tbody>
</table>
Regardless of the administration method, the goal should be to maximize participation. In the case of the tool being distributed at the agency, it may be useful to have one staff member be the designated person to facilitate distribution, administration and collection of the tool. Ideally, the designated staff member should not be directly involved in clinical work with the clients and caregivers to minimize potential concerns clients may express regarding maintenance of their anonymity.

The OPOC-MHA has been specifically designed to be distributed at any point in the person’s treatment or support process. It is up to each provider or program to determine when they will distribute and collect the tool. Examples include providing the tool to each client at or near program completion, or scheduling a monthly or annual census of all clients. Comments about each administration type are included in the comparison chart below. One of the questions in the demographic section of the OPOC-MHA asks at what point in the treatment or support process a participant is currently engaged. For example, one person may check off “just getting started” while another participant can indicate “completed/almost completed”. This allows the data to be organized in the analysis according to respondents’ stage of the treatment or support process. A provider may choose to use the OPOC-MHA at different points in time for one group of clients to examine how perceptions of care may change as more experience is gained in the program. Flexibility in time of administration is intended to provide these options to providers or programs, including specific evaluation requirements; however, in keeping with the QI focus of the tool, providers are discouraged from soliciting feedback only after successful or planned program completion as valuable contributions from clients who do not reach this stage would not be captured.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly</td>
<td>• Can be timed to coincide with balanced scorecards, QI plans, or MSAA/LHIN/funder reporting requirements</td>
</tr>
<tr>
<td></td>
<td>• Quarterly administration with same cohort of clients or caregivers is unlikely to produce significant change in responses</td>
</tr>
<tr>
<td>Monthly, Bi-monthly, or Semi-Annually</td>
<td>• Less frequently employed administration approaches that could be used for specific purposes such as program evaluation</td>
</tr>
</tbody>
</table>
• More frequent administration with same cohort of clients or caregivers is unlikely to produce significant change in responses

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually</td>
<td>Most common administration frequency</td>
</tr>
<tr>
<td></td>
<td>Can be timed to coincide with balanced scorecards, QI plans, or MSAA/LHIN/funder reporting requirements</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Requires manual tracking of participating programs</td>
</tr>
<tr>
<td></td>
<td>Requires ongoing human resources to retrieve, collate, and process completed surveys</td>
</tr>
<tr>
<td>Occasionally (blitz)</td>
<td>Popular administration approach, often conducted annually</td>
</tr>
<tr>
<td></td>
<td>Allows service provider to plan and organize personnel required to support widespread implementation</td>
</tr>
</tbody>
</table>

One important point with respect to timing the person’s survey administration is that all items in the OPOC-MHA are phrased in the past tense. Pilot work identified some challenges with this, which may require some facilitation during data collection. It may be helpful to note for the client and caregiver that they are responding based on their experience to date, and their perception may change in a later stage of program involvement. When administering at discharge, it is ideal to do so after all core programming, including transition/discharge planning, has taken place.

**Introducing the OPOC-MHA to Survey Respondents**

Providing a general introduction about the questionnaire to prospective respondents both encourages participation and ensures completeness and accurate responses. When introducing the questionnaire, it is helpful to let respondents know that the OPOC-MHA is a tool used for QI purposes, and on average, takes about 10-20 minutes to complete. It is also recommended that the structure of the questionnaire be explained. A sample introductory script has been provided below, which can be used or adapted for providers’ purposes. Key components of a good introduction are included in this sample script. In the event that providing an in-person introduction is not feasible, providers should consider attaching a cover letter with the same information contained in the script. Please refer to the appendix for both letters of information (registered client and non-registered client/family member/supporter), one of which is to be included with each survey distribution depending on the version of the tool being administered.
Sample Introductory Script for Registered and Non-Registered Clients/Family Members/Supporters

As part of your participation in (name of program) here at (name of provider), we really value your opinion on your personal experiences with us. We would very much appreciate it if you would be willing to tell us about your experiences by completing this survey. This information is completely confidential and will not be connected in any way to you personally, to the services you receive here, or your client records. Anything you would like to tell us is very valuable to us, and will be used only for the purpose of making the quality of care better here for our clients. We want to continue to improve our care here every day and your experience will help us do that. Please do not use any names or identifying information in the responses.

There are (32 or 38)* questions related to the program, followed by 12 questions about you. It takes most people between 10 and 20 minutes to complete this survey, but there is no time limit, and you can take a break if needed. Not all items will apply to everyone, so if a question does not apply to you, please check the “Not applicable” box rather than leave the answer blank. (*Please inform clients if the residential/inpatient section or other specific questions do not apply.)

We understand that the last section contains questions about you which are personal. Please answer only the questions you feel comfortable answering. This information is important, however, as it helps us ensure that all clients, regardless of age, gender, ethnicity, or sexual orientation, are receiving help fairly.

Please read over the information sheet, and if you require any assistance completing the survey I will be nearby to help. You are making an important and valuable contribution to improving the quality of services here at (name of provider) and across Ontario by sharing your experience. I will provide you with an information sheet to read over, but do you have any questions before you begin?
Sample Introductory Script for Caregivers and Family Members

As a caregiver or family member of someone participating in (name of program) here at (name of provider), we really value your opinion on your personal experiences with us. We would very much appreciate it if you would be willing to tell us about your experiences by completing this survey. This information is completely confidential and will not be connected in any way to you or your loved one personally, to the services you or your loved one receive here, or your loved one’s client records. Anything you would like to tell us is very valuable to us, and will be used only for the purpose of making the quality of care better here for our clients. We want to continue to improve our care here every day and your experience will help us do that. Please do not use any names or identifying information in the responses.

There are (41)* questions related to the program, followed by 14 questions about you. It takes most people between 10 and 20 minutes to complete this survey, but there is no time limit, and you can take a break if needed. Not all items will apply to everyone, so if a question does not apply to you, please check the “Not applicable” box rather than leave the answer blank. (*Please inform clients if the residential/inpatient section or other specific questions do not apply.)

We understand that the last section contains questions about you which are personal. Please answer only the questions you feel comfortable answering. This information is important, however, as it helps us ensure that all clients and caregivers, regardless of age, gender, ethnicity, or sexual orientation, are receiving help fairly.

Please read over the information sheet, and if you require any assistance completing the survey I will be nearby to help. You are making an important and valuable contribution to improving the quality of services here at (name of provider) and across Ontario by sharing your experience. I will provide you with an information sheet to read over, but do you have any questions before you begin?
Administration with Clients with Complex Challenges

As a novel tool in the early stages of widespread implementation, there are client groups with whom the OPOC-MHA has not been extensively piloted. For example, the tool was not piloted extensively with clients with multiple challenges or complex clinical presentations, such as individuals with a serious and persistent mental illness, intellectual disability, severe cognitive impairment, or a learning disability. These clients may also have comorbid substance use, physical limitations such as tremors, or take psychotropic medications which can affect processing ability or function. In this section, some of the implementation challenges associated with these client groups are described, along with practical adaptations employed during survey administration.

Common Concerns

1. *My clients find the wording of some questions to be “over their heads.”*

   Generally, survey administrators or facilitators may need to provide basic interpretation of words or phrases, but they are discouraged from giving an in-depth interpretation of the item to a participant. With this client population, it may be necessary to explain the questions in greater detail than usual and stay nearby should the client become confused or distracted. It is especially important to be patient and calm when providing your explanation. It may also be helpful to rephrase the statements as questions (using the same wording) and ask the client directly in this format. For example, the statement “The wait time for services was reasonable for me” can be restated as “Did you feel that the wait time for services was reasonable?” If yes, the level of agreement (strongly agree versus agree) can be discerned through a follow-up question, or if the client is only able to provide yes/no responses, consistently coding one level of agreement is recommended.

2. *My client answered his entire survey in “code” and the results are unusable.*

   Generally speaking, clients who are impaired or distressed should not complete the questionnaire until they are in an appropriate condition to do so. It is okay for clients to stop and start again in the same day. If a client comes back a few days later, it is better for them to start over again. For example, a client diagnosed with schizophrenia who consistently
experiences disorganized speech or behaviour may not be appropriate for this survey. However, clients whose level of disorganization fluctuates may be able to provide meaningful survey results at a later point in time. In this case, it is recommended that facilitators attempt to administer the survey again.

3. **My client understands the questions but is struggling to answer them using the scaling system provided.**

The abstract nature of the Likert-type scale used in the survey can be challenging for some clients to understand. If clients understand the categorical responses (strongly agree, agree, etc.) but not the numerical responses used on the paper version of the survey (e.g., 1, 2, 3 4), facilitators can recreate the categorical responses on a separate sheet of paper for clients to reference. Then, using this as a reference, they can guide or circle the client’s appropriate response on the survey.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

If clients are struggling to understand the scaling system in any format, it may be necessary to resort to a binary, “thumbs up or thumbs down” system and then code the answer accordingly. Although not ideal, data should be consistently coded as agree or disagree so that one of the directional responses is not skewed by using a strongly agree or disagree category.

4. **My client looked at the paper survey and seemed overwhelmed. The website version was much more tolerable.**

If clients seem overwhelmed by the paper survey, the online version may be a suitable alternative since questions only appear one at a time. This allows the client to focus on each question as it is being asked, and is less daunting than a multipage paper document. At the same time, however, it is important to be considerate of the fact that some clients have limited experience with technology, including tablets or personal computers, and may find
this approach intimidating as well. Ideally, providers will offer both administration options so the one most suitable for each client’s preference is available.

5. **My client is very interested in completing the survey, but finds some of the language or terminology confusing.**

In the following two sections, several items and terms are further clarified for definitional purposes. If, even after clarifying survey items and providing alternative methods of administration, clients still find the process challenging or overly taxing, it is reasonable to assume they will not be able to complete the survey.

**Frequently Asked Questions about Administration**

This section provides responses to questions that were frequently encountered during pilot or early-adopter implementation.

1. **What is an OPOC key?**

An OPOC key is a unique code that allows a client or caregiver to enter the OPOC-MHA website to complete the survey, and/or allows for data entry of an OPOC-MHA completed on paper. OPOC keys have two purposes:

- They allow organizations to keep track of response rates; and,
- They allow participants to provide feedback about a particular program.

The OPOC keys are only used for these two purposes and are not saved once a survey is completed. In addition, OPOC keys are not linked to any identifying or personal health information about the client.

2. **What if a client or caregiver neither agrees nor disagrees with the statement described?**

For the client version of the OPOC-MHA, omitting a “neutral” response option in the OPOC-MHA was an intentional decision by the project team based on stakeholder input during the development and pilot testing stages. As a result, clients are encouraged to think about
whether they are more in agreement or disagreement with a given statement and answer accordingly. However, there is an “I Don’t Know” response option for two sections of the OPOC-MHA for Caregivers. The pilot testing of the OPOC-MHA for Caregivers highlighted a need for an “I Don’t Know” response option for the Perceptions of My Loved One’s Care domain and Inpatient/Residential section as it could be possible that a caregiver may not have access to that information. An “I Don’t Know” option for caregivers could also provide important quality improvement feedback for agencies wishing to strengthen caregiver involvement in their loved one’s care.

3. **If a client is receiving services from multiple programs by a single provider, on which program should the client reflect when answering the questionnaire?**

From time to time, clients will participate in more than one program by the same provider to meet their complex needs for treatment or support. Under this circumstance, it is important to communicate to clients the scope of services for which they are answering the questions in the OPOC-MHA, whether it is for a specific program or service, or for overall services received within a provider. For example, if a provider would like to collect program- or service-level data and decides to survey clients at the time of discharge, it is recommended that clients fill out the questionnaire with regard to the program or service they were being discharged from at the time of administration. There have been situations, however, where the same staff members work with the same clients through multiple programs, and it would be problematic to separate the programs for reporting purposes. It is encouraged that, wherever possible, clients answer surveys for separate programs, but if this isn’t feasible, programs can be combined. Please note, however, that when creating reports, multiple programs can be combined to produce single reports, but artificially-combined programs cannot be deciphered later on. This allows for the possibility that data can be reviewed separately for each of the two programs. To summarize, it is conceivable, but not ideal, that a provider could ask clients to complete the questionnaire for the overall services they receive. In this case, although questionnaires may be distributed through multiple programs, clients should complete the questionnaire only once. These options are
at the discretion of the provider, but it is important to recognize the limitations of this type of mass reporting with respect to QI initiatives.

4. **The OPOC-MHA is describing services received in the past. What if an item still applies to the client?**
   The questionnaire reads in the past tense and describes an experience as happening in the past. The client should evaluate each item based on their most recent experience, including those services in which they are still engaged, if applicable.

5. **What if a client or caregiver needs help understanding a question?**
   There is a difficult but important balance in how much assistance to offer someone if they ask for help. You may assist with some basic interpretation of words or phrases. However, it is very important to avoid giving an overall in depth interpretation of the item to a participant. One common phrase the staff used during the pilot project of the questionnaire when this circumstance arose was “whichever response you feel is most correct.”

6. **What if a respondent needs help with language interpretation?**
   If a client or caregiver speaks a language other than English, French, or a translated version and is not sufficiently proficient in any of these languages to complete the tool on their own, they may be able to access an interpreter through the provider. Interpreters are trained to convey information while avoiding significant interpretation of the participant’s response. Please also remind the client and caregiver, in this case, to indicate in question #14 and #56, respectively, that they received help completing the questionnaire by an interpreter. On a broader scale, the project team is exploring ways to make the OPOC-MHA accessible in other languages while still maintaining instrument validity and adhering to copyright restrictions.

7. **Are there clients for whom the OPOC-MHA is not appropriate?**
   As described in the previous section, while the OPOC-MHA was designed to have broad use across mental health and addiction programs, there may be some programs where there are
implementation challenges associated with using the tool. One population that is often referenced here includes clients in forensic mental health programs. While there may be additional challenges associated with mandated programs, it is noteworthy, however, that during CAMH implementation forensic programs were included and clients provided valuable feedback. Within specific programs, however, it is recommended that clear inclusion and exclusion criteria be developed ahead of time so that staff are not arbitrarily deciding who is eligible to complete the survey. It is reasonable, for example, to exclude clients in crisis or clients currently under an Application by Physician for Psychiatric Assessment (Form 1) under the Mental Health Act.

8. **Has the OPOC-MHA been adapted with a cultural lens for Indigenous people?**

During its development, the OPOC-MHA was presented for consultation at the Braiding Wisdoms forum in October 2013. This forum included approximately 30 leaders and staff representing a wide range of services for First Nations, Inuit and Métis peoples. Based on this consultation and feedback, some changes were made to the language contained in the tool while still preserving its validity and intended broad use. During the pilot testing of the OPOC-MHA, just over five percent of clients filling out the tool self-identified as First Nations, Inuit, or Métis.

9. **Is implementation of the OPOC-MHA mandatory?**

The OPOC-MHA is a recommended tool to fulfil service agreement requirements to obtain and report client satisfaction or perception of care data. At the time of publication, several Local Health Integration Networks (LHINs) and provider associations have shown an interest in mandating the tool but this varies extensively by region. One LHIN, for example, has named the OPOC-MHA specifically in its Multi-Sector/Multi-Sectoral Accountability Agreements (MSAAs) as the required tool to collect client feedback data, while another has deemed it an appropriate tool to assess the client experience indicators within its providers’ MSAAs. Overall, the OPOC-MHA is highly congruent with expectations outlined in MSAAs regarding collecting client feedback data.
10. Should there be a different approach to administering the survey for family members and supporters than for the clients themselves?

The answer to this question will significantly depend on the level of involvement and type of relationship between provider or program staff and the family members or supporters of people with mental health or addictions concerns that providers wish to survey. During the pilot and early implementation work, family members were more willing and likely to participate when the facilitator addressed them directly in a waiting room or at the start of a scheduled session compared to having patient relations or social work staff approach the matter with them. In addition, the response rate was lower when family members were asked to complete the survey online at a later time.

11. What is the difference between the OPOC-MHA for registered clients who are family members/supporters and the OPOC-MHA for Caregivers?

The OPOC-MHA for registered clients who are family members or supporters is intended to allow family members and supporters to provide feedback on the services that they themselves have received from mental health and addictions service providers while supporting their loved one. Conversely, the OPOC-MHA for Caregivers specifically allows family members and caregivers to provide feedback on their perception of their loved one’s care. The target audience for this version is family members and caregivers of clients who access your services and are not receiving services for their own care and support. This survey may be given both in situations where the client has consented to the caregivers’ involvement in their care, and in situations where consent has not been given.

12. Is it appropriate to have volunteers or peer supporters assist with implementation, or should this be limited to staff employed by a provider?

The use of volunteers to assist with implementation is a strategy that has been employed successfully in survey administration by some providers. Early implementation work demonstrated that volunteers can be used effectively as long as the volunteers are provided with the same instruction as staff about not arbitrarily selecting who receives the survey,
interpreting questions for clients, or becoming too involved in the participant’s response process. As with clinical staff, anyone who is involved in survey administration should be far enough removed from the client or caregiver completing the survey so as not to unduly influence their responses, create the illusion of coerced participation, or, in the case of paper surveys, be able to identify the respondents later on based on unique responses. At CAMH, this approach was used successfully and the project team would be pleased to share the training materials it used with volunteers upon request.

13. **We piloted the OPOC-MHA and have an established implementation plan for it. Can we continue to use the tool as we have been up to this point?**

As a result of pilot testing, minor changes were made to the tool; therefore, it is important that providers use the final version of the tool. As for existing implementation plans, providers are encouraged to connect with the DTFP Implementation Coach assigned to their area to ensure that programs continue to be organized appropriately for reporting purposes and that access to the central database has been arranged, as this was not available during the pilot implementation phase. The coaching role is provided by CAMH’s Provincial System Support Program (PSSP) as part of its overall approach to support OPOC-MHA implementation and ensure that providers’ experiential learning is shared province-wide.

14. **Is the survey website compatible with tablets and cell phones, and are there any plans to develop a mobile application?**

Early usability testing has demonstrated functionality with the OPOC-MHA website on cell phones and tablets running both Apple and Android operating systems. In fact, many service providers are using tablets exclusively to administer the survey. At this time, we are currently working on a tablet/mobile application. This will make administration on tablets and cellphones a lot easier.
15. **What should I do if a question in the survey isn’t applicable to the services my organization provides? Can I just skip it?**

It is best that you do not skip a question on the OPOC. Instead if this is the case, then please select the N/A option. This provides helpful information when looking at the provincial aggregated reports and can also help when looking at your own data. This also helps inform the system as a whole, where there may be gaps in services. So, please select the N/A option if something is not applicable to you.

**Frequently Requested Information about Specific Items or Terms**

This section provides information regarding several of the items and terms that required clarification during the pilot testing of OPOC-MHA.

1. **What does the term “services” mean in the OPOC-MHA?**

Unless the question clearly states “treatment services,” “services” described in the items of OPOC-MHA (e.g., questions #1, 2) refer not only to treatment, but also any other support services the clients or caregivers receive from a provider. For example, if a client is placed on a waiting list for the residential program after the initial assessment, but is receiving case management and other support services in the meantime, then he/she should be interpreting “services” as both treatment and support services from the provider when answering the OPOC-MHA. It is important to emphasize the scope of services described in the OPOC-MHA is restricted to those services provided by the provider only, and not to supports provided by external providers, such as pre-treatment or after-care services. Although important, this is beyond the scope of the questionnaire. In addition, some programs do not refer to the type of services and supports they offer to their clients as “treatment services” and clients may be unfamiliar and/or uncomfortable with this language. It may be helpful for providers to clearly articulate to clients at the outset of survey administration that “in our program, when a question asks about ‘treatment services’, it means ________”. This could be done in the form of a written glossary at the front of the OPOC-MHA, or through verbal instruction.
2. **In the demographic section: “What is your age?”**

This question provides choices of age groups as response categories. If a client or caregiver is having trouble choosing a category, he/she can either write down his/her date of birth or his/her age if completing a paper version of the survey. Staff who enter the data into the database can code it accordingly.

3. **In the demographic section: “What term do you prefer to use to describe your sexual orientation?”**

In pilot testing, there was concern asking people to voluntarily identify their sexual orientation given the highly sensitive nature of this question. Although the purpose for this question is to facilitate reviewing the results through an equity lens, some respondents may not feel comfortable answering this question or understand why it is included. Furthermore, agencies that work specifically with youth reported that this question would be difficult to assess as a young person’s response may fluctuate throughout their adolescence as well as during their time in treatment. The project team revised this item to make it more inclusive and also included definitions on the last page of the survey for respondents to reference. As the survey captures information at a particular point in time, it is okay if a respondent’s response changes over time. Lastly, as with all items, if a participant remains uncomfortable answering this question, he/she can be reminded that he/she can opt not to answer it.

4. **In the demographic section, question #8 of the client version: “If you identified yourself as being a family member/significant other/supporter of a person with mental health, substance use, addiction, and/or gambling-related problems, please note your relationship.”**

As mentioned in Part 1 of this guide there are three separate versions of the OPOC-MHA. One is completed by registered clients of the program and this may include clients receiving services for their own treatment/support as well as clients who are family members/supporters of people with mental health or addictions concerns who are receiving services for their own support. Respondents who fit this latter definition are asked to report
their relationship to their loved one(s) who have mental health, substance use, addiction, concurrent disorders, and/or gambling related problems.

5. **In the demographic section, question #9 of the client version: “Were you required, mandated, or pressured to attend treatment services and supports?” and #12 (caregiver version): “Were your loved one mandated or pressured to attend treatment services and supports?”**

   This question is intended to broadly capture both formal mandates as well as informal pressures. “Required” or “mandated” applies to any formal requirement to receive treatment or support services that is based on legal or quasi-legal conditions (e.g., a condition of parole, a medical certificate, a court order, a condition of employment, or a condition arising from a child custody dispute or protection issue). On the other hand, a community treatment order necessitates informed consent (from the client or substitute-decision maker) but is considered “pressure” in most circumstances, as there are consequences for not complying with the community treatment plan. Clients may also feel pressure from family to attend a program.

6. **For the environment section of the client version of the OPOC-MHA, what should clients refer to when answering the questions if they do not receive services in a “facility?”**

   Clients who receive services in the community, such as clients of Assertive Community Treatment teams, would answer this question in regards to their experience with the setting where they regularly meet their prime worker (e.g., ACT team office, community health centres, other public places). Clients who receive services in-home will likely select “not applicable” to several questions in this section.

7. **Who does the section about residential or inpatient programs apply to?**

   Residential treatment involves living at a treatment facility while undergoing intensive treatment during the day. Residential treatment normally lasts from 30-90 days, but can be
longer or shorter in some instances. Anyone participating in this type of program will be asked to respond to the six items in the residential/inpatient section.

**The OPOC Community of Practice**

If you still have questions or issues that you are encountering when implementing the OPOC-MHA, the OPOC community of practice is a great resource to check. The Community of Practice brings together people who share a common goal to collaborate, and to share and promote new knowledge to improve the understanding in a particular area. Providers can use the platform to share successes, challenges and creative strategies, while connecting with others who are also using and implementing the OPOC-MHA.

It is also a great resource for discussing quality improvement initiatives. The Community of Practice (CoP) brings together a wide range of service providers from across Ontario’s mental health and addictions system who recognize the value of quality improvement initiatives as a mechanism to not only enhance client outcomes and contribute to program evaluation, but also to strengthen and transform system-level performance. The CoP is hosted on EENetConnect at [https://www.eenetconnect.ca/g/provincial-opoc-cop](https://www.eenetconnect.ca/g/provincial-opoc-cop). If you are not sure how to join, please ask the Implementation Specialist supporting your LHIN area.
Part 3: Entering and Extracting Data

General Principles of Data Entry

Since surveys can be administered both electronically and on paper, consolidating all the collected data in one database is a necessary first step before commencing data analysis. Data collected electronically are automatically stored in a database accessible at [www.opoc.ca](http://www.opoc.ca), while data collected via paper surveys will need to be entered into this website by providers after completed surveys are returned by clients and caregivers. When entering paper survey data specifically, it is important to be aware of the following errors which can affect the quality of the data.

1. **Missing response:** If no option is circled or checked for an item, leave the corresponding entry in the web form blank.

<table>
<thead>
<tr>
<th>Access/Entry to Services</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I first started looking for help, services were available at times that were good for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

2. **Multiple responses:** Respondents may sometimes check off or circle more than one option for an item (e.g., circling both "agree" and "disagree" to indicate they are ambivalent about the question). This should be considered a missing response, with the corresponding entry left blank on the web form.

<table>
<thead>
<tr>
<th>Access/Entry to Services</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I first started looking for help, services were available at times that were good for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>N/A</td>
</tr>
</tbody>
</table>
3. **Unclear response**: If the client has made a response that does not clearly fall into one category (e.g., a check mark or circle that is drawn on the border between two options), this should also be treated as a missing response.

<table>
<thead>
<tr>
<th>Access/Entry to Services</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When I first started looking for help, services were available at times that were good for me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>N/A</td>
</tr>
</tbody>
</table>

4. **Notes next to response categories**: Occasionally respondents will make notes next to a response category or question, rather than in the designated space for open-ended responses, to provide additional comments. If the comments provide a detailed description of the client or caregiver’s perception of care relating to one or more items, this information should be analyzed together with data collected through the open-ended questions. In the following example, the client provided a strong endorsement for the organization in regards to this particular question. This information is valuable and should be recorded as qualitative data, even though it was not written in the expected location on the survey.

![Image](image.png)

**Entering Data in the Website from Paper Surveys**

1. Locate the OPOC key that is attached to the paper copy of the OPOC. This can be found on the second page of the client letter PDF.

2. Enter the OPOC key. **Please ensure that the key you are entering has been distributed and is no longer under the Distribution List tab.** If it has not been distributed yet, you will be sent to the OPOC home page upon entering the key and clicking on the Proceed to Survey button.

3. Click on “Proceed to Survey”.

4. Enter the respondent’s exact responses to all questions directly into the survey.
PLEASE NOTE: It is **VERY IMPORTANT** that you click the submit button at the end of the survey. If you do not, the data will not show up on your reports. Please ensure you complete that step once you are on the last page of the survey.

If you need more instructions on this process, please see the OPOC Website Navigation Guide.

**Extracting Data with Reports**

Health Service Providers will be able to extract raw data and generate customizable reports through a password-protected interface. Please see the Reporting Platform Navigation Guide to see what those reports look like and how to use the reporting platform.
Part 4: Using the Results for Evaluation and Quality Improvement

Quality Improvement is a systematic approach to making changes that are intended to lead to better client outcomes, stronger system performance, and enhanced professional development. The OPOC-MHA has significant potential to contribute to QI initiatives in mental health and addiction services because included items reflect actionable qualities or characteristics of the program or service. The OPOC-MHA may be used to evaluate the effectiveness of programs or services introduced by providers, as well as to continuously measure and monitor QI objectives.

In Ontario, provincially-funded health service providers are required to have a Service Accountability Agreement with their LHIN that outlines responsibilities with regards to performance measurement and QI. The OPOC-MHA is designed to capture information about many common QI indicators such as safety, accessibility, client-centredness, equity, integration, effectiveness, and appropriate use of resources. For example, the percentage of clients agreeing with specific items in the OPOC-MHA may be used to measure the following example quality dimensions:

<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>OPOC-MHA Measure</th>
</tr>
</thead>
</table>
| Accessibility     | Percentage of clients agreeing* with OPOC-MHA item #2  
                   | * When I first started looking for help, services were available at times that were good for me |
|                   | Percentage of clients agreeing* with OPOC-MHA item #3  
                   | * The location of services was convenient for me |


3 [http://www.hqontario.ca/quality-improvement](http://www.hqontario.ca/quality-improvement)

* Agreeing includes clients who selected “agree” or “strongly agree” on a particular item
<table>
<thead>
<tr>
<th>Quality Dimension</th>
<th>OPOC-MHA Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client-centred</td>
<td>Percentage of clients agreeing* with OPOC-MHA item #32 <em>If a friend were in need of similar help I would recommend this service</em></td>
</tr>
<tr>
<td></td>
<td>Percentage of clients agreeing* with OPOC-MHA item #16 <em>If I had a serious concern, I would know how to make a formal complaint to this organization</em></td>
</tr>
<tr>
<td></td>
<td>Percentage of clients agreeing* with OPOC-MHA item #19 <em>Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, race).</em></td>
</tr>
<tr>
<td>Integrated</td>
<td>Percentage of clients agreeing* with OPOC-MHA item #11 <em>I was referred or had access to other services when needed, including alternative approaches (e.g., exercise, meditation, culturally appropriate approaches).</em></td>
</tr>
<tr>
<td>Effective</td>
<td>Percentage of clients agreeing* with OPOC-MHA item #30 <em>The services I received helped me deal more effectively with my life’s challenges.</em></td>
</tr>
<tr>
<td></td>
<td>Percentage of clients agreeing* with OPOC-MHA item #31 <em>I think the services provided here are of high quality.</em></td>
</tr>
</tbody>
</table>

**Quantitative Data Analysis**

Analyzing OPOC-MHA data may involve individual or grouped items. Proportions of response categories and mean scores of individual items as well as aggregated data can all provide important information about QI indicators. Generally speaking, information about the number and percentage of clients and caregivers who answered strongly agree, agree, and so on for individual questions are easier to interpret and present to stakeholders. However, if the purpose of compiling the data is to make comparisons over time, considering average scores is also worthwhile. Having said that, early data analyses have shown that, like client satisfaction data in general, OPOC-MHA results may be positively skewed. Monitoring changes in the proportion of clients who answer in a particular way is one way to mitigate this limitation. This is further described in the section, “Integrating Quantitative and Qualitative Data for Quality Improvement.”
The implementation team recommends that provider-level data be analyzed and reported separately for different user groups, programs, and services. These include:

- Inpatient and outpatient services, as there are six additional items in the OPOC-MHA that are specific for inpatient/residential clients;
- Registered service users and non-registered service users, as they may have very different experiences with the provider in general;
- Supporters/family members and other clients; and,
- Mental health, addictions, and concurrent disorder program clients, as they can also report very different experiences with response items

**A Caution about Small Numbers**

Although it is advantageous to examine data by specific client groups, it is sometimes difficult to collect a sufficient amount of data from a particular client group to draw strong conclusions. This is especially challenging in smaller programs. It is important to avoid making decisions based on small sample sizes. For example, percentages based on small numbers may fluctuate dramatically from year to year even when differences are not meaningful because the variation could be attributed to chance. A related concern is the large fluctuation in a percentage if it is based on a small number of people in the denominator. Secondly, a breach of confidentiality may occur if providers release information in a way that allows an individual to be identified and reveals confidential information about that person. An example of this scenario would be reporting results of a group of transgendered clients within a provider since it is likely that a very low proportion of the client population identify themselves this way. In addition, when producing multiple statistical tables based on a small sample, it is important to be mindful that it is possible that users can derive confidential information through subtraction. For this reason, data from groups with less than five respondents will not display in the standardized reports.

**Data Reporting: Health Equity**

It is important to illustrate the value of OPOC-MHA data to examine issues related to health equity. It is widely acknowledged that there is variation in mental health and addiction service
needs and outcomes according to social and demographic indicators such as gender, age, racialized status, and sexual orientation. The OPOC-MHA includes many items that can be used to assess potential inequities in access, quality, and satisfaction of services received for different population groups. This information is critical to inform and address barriers specific to population groups, identify QI interventions and to monitor improvements over time. Also, as noted earlier, there should be some analysis undertaken to identify the difference between people who agreed to complete the OPOC-MHA and the total caseload. Comparing the characteristics of the client population with the population of the outside community is another potential way of examining whether the services are meeting the needs of diverse groups.

There is frequently a mismatch between the demographic profile of the population in a particular catchment area and people using various services. The OPOC-MHA is designed to capture extensive demographic characteristics about service users such as gender, age and ethnic background. This information can be used to make comparisons with census or population data to determine if there is an underrepresentation of certain groups. In addition to using the OPOC-MHA to identify and address possible barriers to accessing services, the data may be used to create a profile of service users, to determine whether there is a need for new services or programs to better serve specific groups of clients such as those who are mandated or reporting a specific sexual orientation.

Providers may be interested in determining whether standards of equity are being met in the quality of services delivered. For example, you may be interested in determining whether all clients perceive the environment as welcoming and socially inclusive. In this case, you may wish to examine program environment indicators for different client groups. Is there a difference in the proportion (or mean) of males versus females in their perception of the environment being safe? Is there a difference in the proportion (or mean) of clients of different ethnic backgrounds in finding the facility welcoming, non-discriminating and comfortable?

In addition to looking at the percentages, mean scores, and scale scores of the data, it is important for the QI team to carefully review the open-ended comments provided by
participants. These comments often provide additional details that help with interpretation of the quantitative indicators.

**Sharing Results with Survey Respondents**

Based on the contributions of the Persons with Lived Experience Panel at CAMH during early implementation, the project team strongly recommends that providers establish a protocol to share the survey results with service users. Establishing this practice upfront and informing clients that results will be returned in this way encourages an increased response rate and provides support for the OPOC-MHA in general. The following poster template was developed by PSSP and can be used to articulate key findings with a wider audience of service users.
Qualitative Data Analysis

The OPOC-MHA allows participants to write supplementary comments after each section as well as at the end of the tool. Comments allow participants to highlight particular aspects of their services they found positive or concerning. If the OPOC-MHA is administered by a surveyor, in addition to comments provided in the open-ended questions in the questionnaire, respondents may also make verbal or written comments to questions during administration to provide more detail of their perception of care. It is important that such data are captured and entered into the database where the rest of the data are stored. Comments can subsequently be entered in the relevant qualitative comment section of the questionnaire. Consistent with the privacy expectations regarding OPOC-MHA administration, providers are reminded not to try to identify clients and caregivers based on open-ended responses.

As responses to the open-ended comments will not appear on the generated reports, it is the responsibility of the provider to analyze these qualitative data. Providers will be able to extract raw data in Microsoft Excel format, which will contain the open-ended comments which can easily be reorganized for analysis with cutting and pasting. Qualitative data does not need to be entered or tracked separately. While qualitative data analysis can be complex, the general purpose is to discover themes or issues contained in the information from participants. Ideally, the qualitative data will provide depth and insight into what was obtained through the quantitative responses to the questionnaire. Using a spreadsheet program like Microsoft Excel, each comment should be arranged with one comment per line and then reviewed according to the following procedure.\(^5\)

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**How to Analyze Qualitative Data**

1. **Read through all the responses**
   
   Read through all of the responses to get an initial sense of the content and emerging themes. Having another person review the responses independently will help minimize the influence of your own biases on the data, especially if you are closely involved with the program.

2. **Develop categories**
   
   Develop categories that incorporate the topics that emerged in your initial review. For example, if the survey question asked people for suggestions on ways to improve a program, your categories might include things like “changes to content,” “more group activities,” or “no changes needed.”

3. **Assign each response to a category (or categories)**
   
   Assign each comment to one or several categories (this is known as “coding”). There are many ways to accomplish the mechanics of coding, and Microsoft Excel can often be helpful. For example, you can arrange all your responses in one column, and label each comment in the adjacent column with the appropriate category. Alternatively, you can arrange the comments under the category headings by cutting and pasting the cell contents into the appropriate columns.

4. **Check your categories**
   
   Check to see if your categories are actually appropriate. You might find that most of your responses fall into one category and that the category could actually be broken into more specific subcategories. You might also find that you have some comments that fall into a new category altogether or that one of your categories only has one or two comments and can be merged with another.
5. **Review for major themes**

   Review which of the categories have the most responses and, therefore, represent your major themes. Once you’ve done this, think about what the themes are really saying, and how they are applicable to your program. For example, it is one thing to say “most people wanted more group activities” but consider how you will explain this to others so that it will lead to program improvements.

6. **Identify patterns and trends**

   Identify which categories are related and where linkages, patterns and trends can be seen. Are the themes related in some way, or are there a series of unrelated points being mentioned? You may also want to keep track of key demographic characteristics in relation to the responses and patterns that emerge (e.g. gender, age, cultural background).

7. **Write-up your analysis**

   Summarize your analysis in such a way that it effectively communicates your findings to others, including frontline staff, managers, and clients or family members. This would normally be in the form of descriptive text incorporating some of the comments that exemplify your major themes. You can use key quotes that reflect the theme(s) you have identified, being sure that they cannot be attributed to a particular individual. Your summary of themes may complement or clarify what you obtained through quantitative data, and your write-up can tie it all together.

**Integrating Quantitative and Qualitative Data for Quality Improvement**

After familiarizing yourself with the OPOC-MHA reporting portal and the reports it can generate, you are encouraged to take a more detailed look at the data to plan your QI project. There is no “right” way to look at data, but we encourage starting broad with a full report of all responses and then using the filters to narrow the data that are displayed. The real-time interactivity of the portal allows you to quickly and seamlessly generate reports with only the information included that is of interest to you. Be guided by curiosity and ask lots of questions! For example, as
mentioned in the “Data Reporting: Health Equity” section, consider how different populations are experiencing care at your organization. Do the results change based on the clients’ stage in the program or whether they were mandated or pressured to attend? Use the filters to your advantage to answer any questions you may have.

The following guiding questions are also helpful when considering how your OPOC-MHA results can inform your quality improvement endeavors:

1. **What are your overall impressions of the data?**
   Begin by taking a first pass at the results, noting any general observations or reactions that you have. You can perform subgroup analysis later; just consider your first impressions to what you are reading.

2. **Do any of the results surprise you?**
   If your results are generally positive, as is often the case, there may be a few results that catch your attention. What is it about these results that surprise you or make them stand out from the rest?

3. **Who answered the survey?**
   Knowing who answered the survey is critical to understanding whose perspective is represented in the data. Similarly, it provides important information about whose perspective is missing, and what the implications are of that. Are the survey respondents reasonably similar to your client population in terms of age, sexual orientation, or population group? We aren’t looking for a statistically representative sample, but you can use census data, existing demographic profile data for your organization, or similar secondary data to compare the survey sample to the broader population.

4. **Who answered the survey differently?**
   This is where subgroup analysis can be particularly helpful. By using the reporting portal and limiting responses to those provided by different groups or health equity populations, you
can determine if particular groups of people answered your survey differently. You might find that results are better or worse and across the board or isolated to particular questions. By addressing this question, you’ll develop a better understanding of how care is experienced differently by program or according to the filters you apply, and whether a quality improvement activity for a particular group of clients should be considered.

5. **How is my overall response rate?**

Considering your survey response rate is important for a couple of reasons. First, it provides an indication of how well your particular implementation method worked. Second, it offers clues as to whether you should collect more surveys or supplementary information before making widespread changes at your organization. Consider how many surveys were completed in relation to how many clients you see in your program or organization. Again, you do not need a particular sample size, but if the results suggest that particularly widespread or detailed quality improvement activities might be needed, have enough clients provided input to inform that decision?

**Checking Your (Statistical) Biases at the Door**

When interpreting survey data in general, it is important to be mindful of common biases and assumptions that can influence how results are obtained and interpreted. Specifically, the following should be considered:

1. **Acquiescence Bias:** When survey respondents are ambivalent or neutral about a question, or unsure of what it is asking, there is a possibility that they will simply “agree” rather than seek clarification. To minimize this risk, it is important to provide facilitation and encourage clients to seek assistance with survey items.

2. **Social Desirability Response Bias:** Refers to the possibility that survey respondents will answer questions in a manner that will be viewed favorably by others, even if it is not an accurate reflection of their opinion. This may include over-reporting positive responses, under-reporting negative responses, or being selective with what information is included in
the open-ended comments. To minimize this risk, the person providing facilitation should not be the client’s primary service provider. In this case, even with the assurance of anonymity, people may answer in a manner that reflects what their service provider would want to hear, “just in case” they find out how the person answered.

3. **Selection and Volunteer Response Bias:** when respondents are selected purposefully rather than randomly or based on some objective criteria, the results might be misleading because the group selected does not represent the actual population. This bias can also occur by restricting the survey to certain client or respondent groups, such as only people who are being discharged. It is essential that we remain mindful of who was asked to complete the survey and who actually completed it in the first place, and not make critical decisions based on incomplete information.

4. **Simpson’s Paradox:** refers to a phenomenon in probability and statistics in which a trend appears in several different groups of data but disappears or even reverses when these groups are combined. In the following example (table on next page), we can see that question 27 appears as one of the areas of improvement on this organization’s report based on the responses of all clients. Similarly, it appears on the report when responses are limited to clients in outpatient programs. Interestingly, however, when the report is limited to responses provided only by clients in inpatient programs, this item appears as an area of excellence. Had this agency only generated the first report for the overall client population, they may have undertaken a quality improvement exercise related to discharge planning. While the data do support this, it may have been unnecessary in the inpatient program where this appears to be occurring quite well already. To minimize this risk, run as many subgroup analyses as possible before embarking on a widespread quality improvement project.
5. **Confirmation Bias**: refers to a cognitive bias in which people tend to overvalue information that supports their previously-held beliefs, assumptions, or opinions. This behaviour is often unintentional, but it is one of the cognitive biases that we can easily fall victim to because the supporting evidence or information often “feels right.” When reviewing data, keep an open mind and don’t limit findings to data that agrees with your point of view. Ask lots of questions, generate many reports, and seek additional information from survey respondents or agency staff when something is unclear.

6. **Confounding Variables**: refers to a third, unexplored factor that may be influencing the results or apparent relationship between two concepts. When alternative explanations are not appropriately considered, a perceived relationship between two variables may be
When you consider your results, it is important to think about whether alternative explanations could exist. For example, an organization was surprised to see that all three discharge items (questions 27-29) appeared on its areas of improvement report. Having previously evaluated their discharge planning process, they wondered if an alternative explanation existed that could be providing false data. They wondered if clients who had not yet begun discharge planning were answering the items negatively, thus “dragging down” the overall results. Based on how they were administering surveys, they estimated that one-third of clients had not yet reached the stage of their program where they would develop a discharge plan. Looking at their report, they noticed that the response rate for all three discharge items was almost 86%, meaning an estimated 20% of clients answered this question when they had not yet reached this stage of the program. Going forward, the agency ensured that clients had a better understanding of the program components and timeline.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Staff helped me develop a plan for when I finish the program/treatment</td>
<td>85.8%</td>
</tr>
<tr>
<td>28. I have a plan that will meet my needs after I finish the program/treatment</td>
<td>85.7%</td>
</tr>
<tr>
<td>29. Staff helped me identify where to get support after I finished the program/treatment</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

For more information, please visit the following websites:

- OPOC Community of Practice: [https://www.eenetconnect.ca/g/provincial-opoc-cop](https://www.eenetconnect.ca/g/provincial-opoc-cop)
- OPOC Orientation Webinar: [https://www.surveymonkey.com/r/TWXY5S8](https://www.surveymonkey.com/r/TWXY5S8)
- About CAMH’s Provincial System Support Program: [http://improvingsystems.ca/about](http://improvingsystems.ca/about)
- More on Quality Improvement: [http://www.hqontario.ca/quality-improvement](http://www.hqontario.ca/quality-improvement)
Appendix A: Information Letters
Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA)
Registered Client Information Letter

What is this about?
This questionnaire asks about your perceptions of the services or supports you have received from our agency/organization. This information is being collected to help us identify areas of strengths on which to build, and areas for improvement.

Why is this important?
Your feedback is very important and will help to enhance our programs, as well as mental health and addiction services across Ontario.

What will be involved?
As a client receiving our mental health and/or addiction services, we invite you to answer up to 38 core questions and some additional items (e.g. age, gender, language). It should take approximately 10-20 minutes to complete the questionnaire.

Is my participation voluntary?
Completing this questionnaire is completely voluntary. You do not need to complete this survey and all questions are optional. Choosing not to participate will not affect the treatment or support you receive in any way.

What are the risks and benefits?
There are no inherent risks or direct benefits to participating; however, the information you provide will help us understand how our services can be improved for others.

Is it confidential?
This questionnaire is anonymous and therefore all data collected will not be identified as your own responses. Your name or any personal identifiers (e.g. client number, insurance number) will not be included anywhere in the questionnaire. All responses will be securely stored on password protected computers and paper copies will be kept in a locked cabinet accessible only to the relevant staff. It is important to note that all staff are committed to maintaining your confidentiality and ensuring that the data collected in this questionnaire remain anonymous and no personal information or personal health information is inadvertently shared. Accordingly if you choose to include any comments in the questionnaire, please ensure that you do not include personal information (e.g. your name, your therapist/clinician’s name, or specific details about your personal situation) that may be identifiable.

How is the information I provide going to be used?
Your responses will be combined with responses from many other people in a province-wide database maintained by the Centre for Addiction and Mental Health (CAMH). The combined information will be shared with our agency/organization, the Local Health Integration Network (LHIN) in your area, and the Ministry of Health and Long-Term Care to provide important feedback about our services. The combined information will also be included in reports generated by CAMH which are designed to help enhance mental health and addiction services across Ontario. Again, your individual answers will not be identified.

Thank you for your participation!
Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA)
Non-Registered Client/Family Member/Supporter Information Letter

What is this about?
This questionnaire asks about your perceptions of the services or supports you have received from our agency/organization. This information is being collected to help us identify areas of strengths on which to build, and areas for improvement.

Why is this important?
Your feedback is very important and will help to enhance our programs, as well as mental health and addiction services across Ontario.

What will be involved?
As a family member/supporter of a client receiving mental health and/or addiction services, we invite you to answer up to 17 core questions and some additional items (e.g. age, gender, language). It should take approximately 5-10 minutes to complete the questionnaire.

Is my participation voluntary?
Completing this questionnaire is completely voluntary. You do not need to complete this survey and all questions are optional. Choosing not to participate will not affect the treatment or support you or your family member receives in any way.

What are the risks and benefits?
There are no inherent risks or direct benefits to participating; however, the information you provide will help us understand how our services can be improved for others.

Is it confidential?
This questionnaire is anonymous and therefore all data collected will not be identified as your own responses. Your name or any personal identifiers (e.g. client number, insurance number) will not be included anywhere in the questionnaire. All responses will be securely stored on password protected computers and paper copies will be kept in a locked cabinet accessible only to the relevant staff. It is important to note that all staff are committed to maintaining your confidentiality and ensuring that the data collected in this questionnaire remain anonymous and no personal information or personal health information is inadvertently shared. Accordingly if you choose to include any comments in the questionnaire, please ensure that you do not include personal information (e.g. your name, your family member’s name, or specific details about your personal situation) that may be identifiable.

How is the information I provide going to be used?
Your responses will be combined with responses from many other people in a province-wide database maintained by the Centre for Addiction and Mental Health (CAMH). The combined information will be shared with our agency/organization, the Local Health Integration Network (LHIN) in your area, and the Ministry of Health and Long-Term Care to provide important feedback about our services. The combined information will also be included in reports generated by CAMH which are designed to help enhance mental health and addiction services across Ontario. Again, your individual answers will not be identified.

Thank you for your participation!
What is this about?
This questionnaire asks about your perceptions of the services or supports you have received from our agency/organization. This information is being collected to help us identify areas of strengths on which to build, and areas for improvement.

Why is this important?
Your feedback is very important and will help to enhance our programs, as well as mental health and addiction services across Ontario.

What will be involved?
As a caregiver supporting someone receiving our mental health and/or addiction services, we invite you to answer up to 41 core questions and some additional items (e.g. age, gender, language). It should take approximately 10-20 minutes to complete the questionnaire.

Is my participation voluntary?
Completing this questionnaire is completely voluntary. You do not need to complete this survey and all questions are optional. Choosing not to participate will not affect the treatment or support you receive in any way.

What are the risks and benefits?
There are no inherent risks or direct benefits to participating; however, the information you provide will help us understand how our services can be improved for others.

Is it confidential?
This questionnaire is anonymous and therefore all data collected will not be identified on an individual basis. Your name or any personal identifiers (e.g. insurance number) or information regarding your loved one receiving treatment will not be included anywhere in the questionnaire or linked to your responses. All responses will be securely stored on password protected computers and paper copies will be kept in a locked cabinet accessible only to the authorized staff. It is important to note that all staff are committed to maintaining your confidentiality and ensuring that the data collected in this questionnaire remain anonymous and no personal information or personal health information is inadvertently shared. Accordingly if you choose to include any comments in the questionnaire, please ensure that you do not include personal information (e.g. your name, your therapist/clinician’s name, or specific details about your personal situation) that may be identifiable.

How is the information I provide going to be used?
Your responses will be combined with responses from many other people in a province-wide database maintained by the Centre for Addiction and Mental Health (CAMH). The combined aggregate information will be shared with our agency/organization, the Local Health Integration Network (LHIN) in your area, and the Ministry of Health and Long-Term Care to provide important feedback about our services. The combined information will also be included in reports generated by CAMH which are designed to help enhance mental health and addiction services across Ontario. Again, your individual answers will not be identified.

Thank you for your participation!
Appendix B: Which Version of the OPOC Should We Use?

Who is the respondent?

Client

Are they registered within your program?

Yes

- Use the "Registered Client OPOC"

No

- Use the "Non-registered Client OPOC"

Caregiver

Do they receive services themselves at your organization?

Yes

- Are they registered within a formalized family support program?
  - Yes
    - Use the "Registered Client OPOC"
  - No
    - Use the Caregiver OPOC

No, they are here supporting one of our clients

- No, they access informal services (i.e. education nights)
  - Yes
    - Use the "Registered Client OPOC"
  - No
    - Use the "Non-Registered Client OPOC"