GETTING STARTED WITH THE
Ontario Perception of Care Tool for Mental Health and Addictions

An implementation guide for service providers

6TH EDITION

Provincial System Support Program | December 2023

camh

For more information, please contact us at opoc.mha@camh.ca

http://improvingsystems.ca/projects/ontario-perception-of-care

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Finally, PSSP is grateful to the providers and staff who regularly share the successful strategies they use to support ongoing implementation of the OPOC-MHA, many of which are reflected in this guide.

Introduction

Ontario's mental health and addiction system recognizes the importance of quality care. Hospital and community providers work hard every day to improve their services. A critical foundation of quality improvement (QI) is the client experience of care. Understanding client experience enables health care organizations to improve service, such as by enhancing access, client-centeredness, and safety. The Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA) is an evidence-based tool that standardizes how substance use, mental health, and concurrent disorder services obtain client perception of care feedback.

If you are a health care provider, this implementation guide can help you implement the OPOC-MHA and use the client feedback you collect in both QI and performance monitoring work. Health system planners and program evaluators may also find value in the guide as they consider how to use client experience feedback to support decision-making.

This guide has five parts. If you're just getting started with the OPOC-MHA, you may not need or want to go through the whole guide right away. We suggest you review the table of contents to know that information is available to come back to as needed.

- Part 1 is a **Quick Start** section to learn about the essentials of the OPOC-MHA tool.
- Part 2 can assist you to **implement** the survey. For instance, it discusses implementation challenges with clients with complex needs.
- Part 3 clarifies how to **enter data and create reports** on the OPOC-MHA website.
- Part 4 discusses the **value of the OPOC-MHA** as a QI and evaluation tool and provides tips for qualitative and quantitative data analysis and reporting.
- Part 5 goes into more detail about the **different versions** of the OPOC-MHA.

You can also find sample scripts for introducing the OPOC-MHA to clients in Appendix 1.

A note about terminology

We'd like to clarify some terminology used in the guide:

- We use the words *tool*, *survey*, and *questionnaire* as synonyms for the OPOC-MHA to acknowledge the different terminology used in practice.

PART 1: QUICK START

What is the OPOC-MHA?

People commonly equate client experience with client satisfaction. However, measures of client satisfaction tend to be highly skewed and, therefore, cannot clearly inform QI efforts. As a result, there has been a move away from *client satisfaction* language. Instead, researchers have found that an effective way to evaluate client experiences is to measure clients' perceptions of care. Measures of perception of care ask more directly about clients' experiences in relation to standards of practice.

There is growing emphasis on client perception of care in health care. It is being included as a key indicator in QI plans. In addition, several provincial organizations have endorsed perception of care methods, including the Canadian Mental Health Association; Addictions and Mental Health Ontario[1]; and Ontario Health, Quality Unit (formerly Health Quality Ontario)[2].

The Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA) provides a comprehensive and validated method to gather perception of care information. As part of the Ontario Drug Treatment Funding Program, the Centre for Addiction and Mental Health (CAMH) developed the OPOC-MHA between 2011 and 2014. Accreditation Canada and the Canadian Centre for Accreditation have since endorsed the OPOC-MHA as a way to assess client experience of care. The tool focuses on measuring items that can influence how a provider delivers service. As a result, it is well suited to QI initiatives within a program, an organization, or across the broader system.

Ontario's addiction and mental health services are currently implementing the OPOC-MHA in programs funded by the Ontario Ministry of Health. CAMH's Provincial System Support Program (PSSP) is supporting this implementation.

For more about the development of the OPOC-MHA, including its validation process, refer to the additional resources links in Appendix 3 of this guide.

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[1] Excellence through Quality Improvement Project (E-QIP). (n.d.). Addictions and Mental Health Ontario. https://amho.ca/our-work/e-qip/

[2] Quality Improvement. (n.d.). Health Quality Ontario. https://www.hqontario.ca/quality-improvement

Brief description of the OPOC-MHA versions

There are a number of versions of the OPOC-MHA[3]:

1. OPOC-MHA for Registered Clients is for people **registered** in a program for treatment or support. This includes family members (or other supporters) who are registered to receive services, such as in a family support group.
2. OPOC-MHA for Non-Registered Clients is for people who are receiving service but **not registered** in a program (such as a drop-in peer support program). This includes family members or supporters who are receiving service but not registered.
3. OPOC-MHA for Caregivers is for people who (a) have a **family member or loved one** receiving service at your organization, but (b) are not receiving services themselves at your organization.
4. OPOC-MHA for Supportive Housing is for **residents or tenants** receiving services from organizations providing permanent supportive housing or long-term transitional housing.
5. OPOC-MHA for Crisis is for clients receiving **crisis** services or brief intervention from organizations.

All the versions are designed for people age 12 and older with a literacy level of grade six or higher. The Registered, Non-Registered, Caregiver and Supportive Housing versions are available in English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Punjabi, Vietnamese, Arabic, and Somali. The Crisis version is only available in English, French, Arabic, and Somali.

All OPOC-MHA versions include sociodemographic questions that ask respondents about their gender, age, language, ethno-cultural background, sexual orientation, and family income. These questions have been adapted from *Measuring Health Equity: Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres* and are aimed to develop an evidence-based approach for collecting sociodemographic information for individuals receiving health services in Ontario. These questions allow providers and funders to identify potential inequities in service or access. For more about the sociodemographic questions in the OPOC-MHA, see this section of the guide.

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[3] Follow the links in this list to be taken to more information about the specific OPOC-MHA versions later in this guide.

Which version should we use?

Figure 1 below is a decision tree to help you choose when to use each of the OPOC-MHA versions.

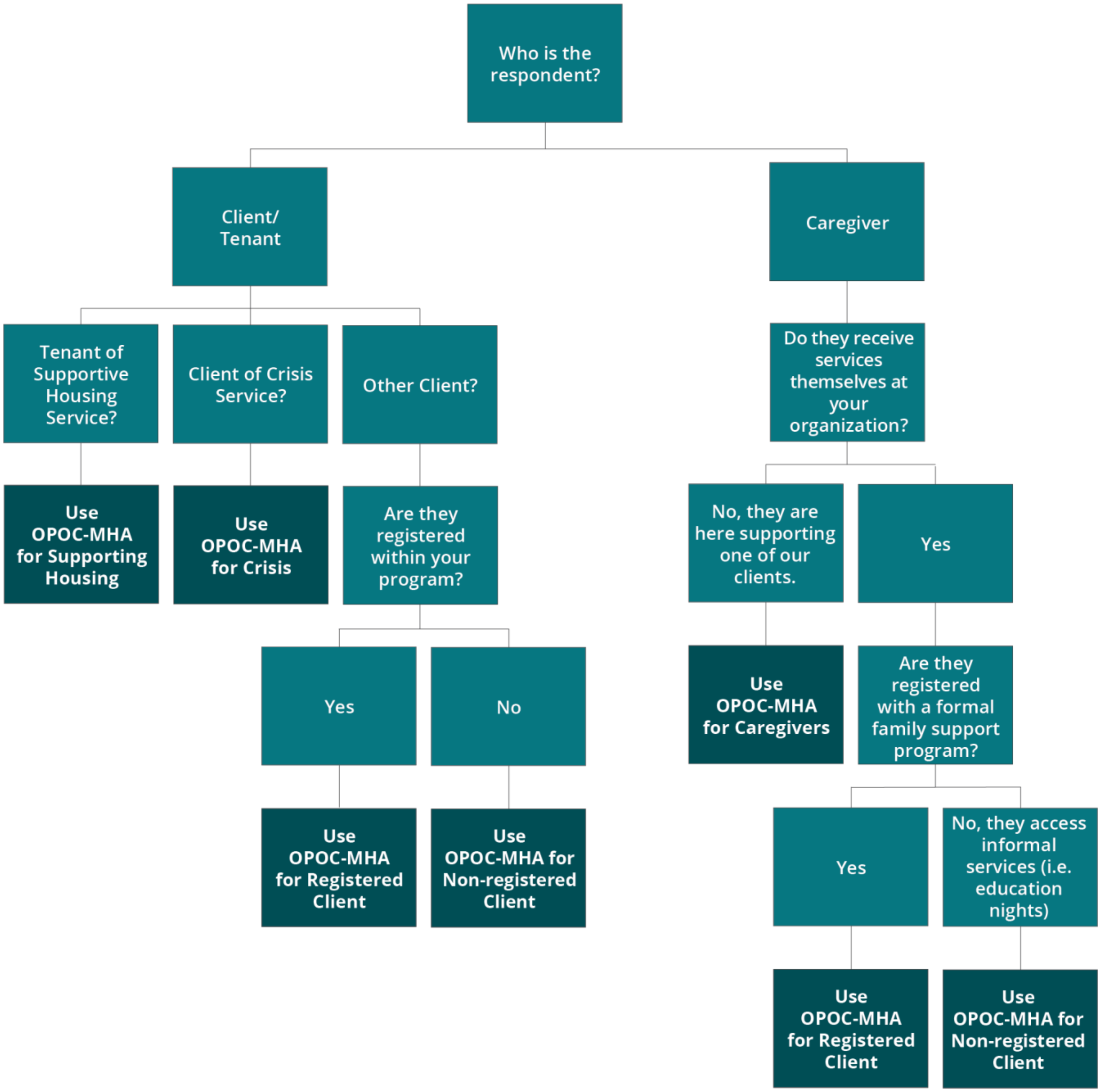

Figure 1

Administering the tool: The essentials

Provincial and local funders encourage the use of the OPOC-MHA to gather client feedback at mental health and addiction services funded by the Ontario Ministry of Health (MOH). Most of the planning to implement the tool occurs at the provider or program level. This ensures that the tool is responsive to the uniqueness of a program, appropriate for the individuals it serves, and in line with existing QI initiatives at the organization.

Even though there is no prescribed way to implement the OPOC-MHA, you need to follow **four requirements** when you administer the tool[4]:

1. Provide the entire questionnaire

You must provide the entire OPOC-MHA questionnaire to respondents. You cannot add to, change, reorder, or omit any of the questions. One of the benefits of the tool is that it allows for comparisons between programs and regions. Therefore, it is essential that all programs administer the same version of the tool.

Although the tool must be provided in full, you should also inform respondents that they can choose not to answer any or all of the questions. In other words, it is the respondent's choice to omit or refuse a question, not that of a staff, program, or agency.

A program may decide to ask additional questions. If you choose to add any, you should ask these additional questions **after** you administer the OPOC-MHA. This maximizes the benefits of the tool. Additional questions can be provided in a separate document to be given to the client in person or electronically.

2. Ensure anonymity

You must ensure a respondent's anonymity when you administer the OPOC-MHA. Identifying information, such as names, client numbers, or insurance numbers, should not be written anywhere on the tool. To help maintain anonymity, unique codes, or OPOC keys, are created to link each survey with your program and agency. When using the paper versions, you also need to provide a way for respondents to return the questionnaire anonymously, such as a secure drop box. In addition, do not link a respondent's results electronically to any identifying information.

3. Make completion voluntary

Let the respondent know that completing the OPOC-MHA is voluntary. Responses to questionnaires and surveys need to occur in the absence of any coercion, either direct or implied, to maintain the integrity of the results. This means that a respondent's decision on

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[4] These requirements are outlined in a provider's Memorandum of Understanding. If a provider is outside the scope of the Ontario Ministry of Health implementation, these requirements are stated in the end-user license agreement.

whether to complete the OPOC-MHA should have no consequence on any other aspect of their (or their family member's) service. It should not result in differential treatment by staff.

4. Provide help as needed

Provide respondents with the information and help they need to complete the OPOC-MHA. This includes explaining why and how to complete the survey. Some individuals may need support to complete the survey. If a staff member assists an individual to read the survey to them, they should take care to read the survey as written. If a survey respondent asks for clarity on a question, it is very important the facilitator not guide the respondent towards specific answers.

If you are administering the tool electronically, or sending out OPOC Keys or using OPOC Links, ask if the respondent needs help with the technology or other assistance based on ability (for example, because of learning disability, visual impairment, or literacy level). Ideally, a quiet space is available for individuals to complete the survey, both to accommodate those who experience sensory overload, and to ensure privacy. When possible, ask the respondent in what language they would be most comfortable completing the survey and provide translation services if available.

Providing facilitation improves completion rates by engaging respondents and helping resolve confusion about the questionnaire. A key aspect of facilitating the OPOC-MHA is how the survey is introduced. For example, individuals tend to be more motivated to complete the tool after they hear that the objective is to improve services and how the results will be shared. To help you with this, Appendix 1 provides a series of introductory scripts – one for each version of the tool. An introduction is a good opportunity to anticipate and address common questions that come up when people complete the tool. In addition, during an introduction, you can provide instructions to minimize errors that affect data quality.

More information on administering the tool can be found in the next section.

Where should we enter data and run reports?

When you administer the OPOC-MHA, all data from the questionnaires are stored in a secure, centralized database, which is accessed through www.opoc.ca. Once the data are entered, you can review and analyze them in many ways on the site. For more information, see the Entering data and running reports section.

PART 2: IMPLEMENTING THE TOOL

Surveying methods

The OPOC-MHA can be administered in a number of ways. Your preferred method will depend on the practices of your program and the unique characteristics of your client populations. The tool can be completed on paper, virtually, by phone, or electronically through www.opoc.ca. It can be administered in a group or individually, as well as, in person, by email, or through regular mail. Whatever your method, the goal is to maximize participation for all individuals served, including those who are most marginalized, so all voices can be represented. Consider the language preferences, location of service, cultural needs, comfort with method, and abilities of your client population in your administration plans.

Paper versus electronic administration

The following table describes common strengths and weaknesses of paper versus electronic survey administration.

	Paper survey	**Electronic survey**
Pros	• Most individuals are familiar with and comfortable completing paper surveys. • Some respondents feel paper administration is more personal. • Paper allows the survey to be offered to individuals who do not have access to computers or the internet.	• The survey is immediately entered into the OPOC-MHA database, eliminating the need for data entry by staff. • Service providers can email OPOC keys (as attachments or by using the OPOC Links feature) directly to potential respondents for online completion, provided a record of who receives which key is not maintained (to protect anonymity).

	- Providers can administer the survey to a group that is larger than their available computing resources.	- Because only a small number of questions are displayed at a time, the electronic version may feel less overwhelming than seeing the paper questionnaire in full.
Cons	- A respondent’s handwriting may be illegible or difficult to read. - It is more time consuming for staff to enter surveys manually into the database. - Providers need to track and secure completed surveys until they are entered into the database, - The OPOC key can become separated or detached from a completed questionnaire, making data entry difficult or impossible; therefore, it is recommended the OPOC key be recorded on each paper survey, which may take extra time. - Some respondents may feel the paper survey is overwhelming in length. - The paper tool allows respondents to mark the survey in un-prescribed ways (for example, selecting two numbers or half numbers). When using a paper survey, let service users know they must select one number for their response to be counted.	- Some respondents may find it difficult to use the website for completing the OPOC-MHA electronically. They may have concerns with internet strength and security. - If respondents are using a tablet to compete the survey, they can find it tedious to enter responses to open-ended questions because of the limited typing functionality on many of these devices. - Response buttons on the survey may appear tiny on some devices and this can lead to entry errors. - Group administration may be limited to the number of available computers. - Facilitation may be more difficult to provide if the agency sends out OPOC keys via email to prospective respondents

Regardless of the administration approach you choose, ideally the individual facilitating the survey is not directly involved in the respondent’s service provision. This helps minimize respondents’ concerns about the anonymity of their responses. In addition, response rates are typically higher if the survey is completed immediately when asked, regardless of whether it is on paper on electronic.

Survey timing

A provider or program team can also determine when they will distribute and collect the OPOC-MHA. It can be administered at any point in a person's treatment or support. For instance, you can provide the tool to each client at, or near, program completion, or schedule annual surveying for all clients. A question in the demographic section asks respondents at what point they are in their treatment or support (e.g., *just getting started, completed/almost completed*). This allows the data to be analyzed according to respondents' stage of treatment or support.

Flexibility in when you administer the tool enables you to achieve different evaluation objectives. For instance, you can use the OPOC-MHA at more than one point in time with a group of clients to examine how their perceptions of care change as they gain more experience in the program or are further along in their treatment. However, in keeping with the QI focus of the tool, providers should **not** just solicit feedback from people who have successfully completed treatment or support. If you do this, you will miss valuable information from those who do not reach this milestone.

The table below provides comments about periodic and ongoing administration:

Frequency	Comments
Periodic (a blitz)	• Administering **periodically** is popular because it allows service providers to plan and prepare the resources, such as personnel, that they need. • An **annual blitz** is the most common frequency. It can be timed to coincide with requirements for balanced scorecards, QI plans, or funder reporting. • **Semi-annual or quarterly** administration can also be timed to coincide with requirements for balanced scorecards, QI plans, or funder reporting. • **Periodic blitz** administration can also be timed for specific purposes such as program evaluation or accreditation. • **Note:** increased frequency with the same cohort of clients or caregivers is unlikely to produce a significant change in results.
Ongoing	• Ongoing administration occurs when service providers have respondents complete the OPOC-MHA at certain points in their treatment or support, such as after a set number of sessions (e.g., after 2-weeks or after 2-months) or at discharge. • Some organizations have set automatic pop-up reminders in their electronic medical records as a cue for survey completion. Otherwise, ongoing administration requires manual tracking of when potential respondents require the survey.

	- It also requires ongoing human resources to prepare surveys for administration.

Keep in mind that all items in the tool are phrased in the past tense. So, it may be helpful to explain to the respondent that they are answering based on their experience to date and that their perception may change at a later stage. In addition, if you administer the tool at discharge, it is ideal to do this after all core programming has taken place, including transition and discharge planning.

Administering the OPOC-MHA virtually

Although it is ideal to administer the OPOC-MHA in-person, it is not always practical. In this case, the tool can be administered virtually (e.g., by phone, e-mail, or videoconference). To help you administer the tool virtually, we have produced *Guidelines to Support Virtual OPOC-MHA Administration*. These guidelines are intended to complement, but not replace, your organization’s policies for communicating with service users virtually.

If you administer the survey virtually, you must still ensure the anonymity of respondents. No identifying information should link an individual with data entered in the provincial database. This includes the OPOC keys – they should never be linked to individual respondents.

Introducing the OPOC-MHA to survey respondents

Introducing the questionnaire to prospective respondents encourages participation and fosters completeness and accuracy. Let respondents know the OPOC-MHA is used for QI purposes and takes on average 10 – 20 minutes to complete. Also explain the structure of the questionnaire and, how the results will be shared.

Appendix 1 provides sample introductory scripts, which you can adapt for your purposes. These scripts include core components of a good introduction. If it is not feasible to introduce the tool in-person, ensure you provide the OPOC key to your survey respondents – as a hard copy or electronically – as this page contains important introductory details about the OPOC-MHA. OPOC keys can be sent via email as attachments or by way of the OPOC links feature to potential respondents.

Using the tool with clients with complex challenges

Service users with multiple challenges or complex clinical presentations may have some difficultly completing the OPOC-MHA. However, it is equally important to receive feedback from these individuals to inform your QI efforts. Below are implementation challenges shared with us by organizations using the tool, as well as suggestions to mitigate these challenges.

1. **A service user is interested in completing the survey, but finds the language confusing or the wording to be *over their head*.**

   You may find it helpful to adapt the way you administer the survey, such as by reading the questions, asking them in a slightly different way, supporting them to score their answers (as noted below), and staying nearby in case the individual becomes confused or distracted. You can try rephrasing the statements in the survey as questions (using the same wording) and then reading these questions to the respondent. For example, the statement "The wait time for services was reasonable for me" can be restated as, "Did you feel the wait time for services was reasonable?" If the individual responds yes, then their level of agreement (i.e., *strongly agree* versus *agree*) can be clarified in a follow-up question.

   You can also assist with basic clarification of words or phrases; however, you should avoid providing an in-depth interpretation of an item. A phrase you can use is, "whichever response you feel is most correct." If the individual still finds the survey overly challenging or confusing, you may decide they will not be able to complete the survey.

2. **A service user understands the questions but is struggling to answer them using the scaling system provided.**

   The abstract nature of the Likert scale used in the survey can be hard for some respondents to understand. If an individual understands the categorical responses (i.e., strongly agree, agree, etc.) but not the numerical responses used on the paper version of the survey (e.g., 1, 2, 3, 4), you can write the categorical responses on a separate sheet of paper for the person to reference, as indicated in **Figure 2**. Using this reference, you can help the individual circle the appropriate response on the survey.

Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable

Figure 2

   If a respondent is struggling to understand the scaling system in any format, it may be necessary to use a binary method, such as *thumbs up* or *thumbs down*. Depending on their response, you should code the person's answer consistently as *agree* or *disagree.*

3. **A service user looked at the paper survey and seemed overwhelmed. The website version was much more tolerable.**

   If an individual seems overwhelmed by the multiple-page paper survey, the online version may be a less stressful alternative: the sections appear on the screen one at a time, which can feel less overwhelming. However, keep in mind that some individuals have limited experience with tablets or personal computers and, for this reason, may find the online version intimidating. You can offer the respondent a choice between the paper and online versions so they can select the one they prefer.

Frequently asked questions about implementing the tool

1. What is an OPOC key?

An OPOC key is a unique code that allows an individual to enter the OPOC-MHA website – www.opoc.ca – to complete the survey, or enables staff to manually enter the data of a survey that has been completed on paper. The OPOC key has two purposes:

a. It links a survey in the provincial OPOC-MHA database to the agency and specific program(s) to which it relates.

b. It allows organizations to keep track of response rates.

OPOC keys should not be linked to any identifying or personal health information about the respondent. This is particularly important with virtual administration, for example, if you are sending OPOC keys as attachments to clients by email or using the new OPOC links feature.

You can generate an OPOC key by logging into www.opoc.ca and following these steps:

1. Go to the OPOC Survey Administration tab.
2. Click on *create key* to generate the number of keys you need.
3. Download the client information letter(s) associated with the key(s).
4. Make the key(s) *active* by clicking on the *distributed* button.

2. What is an OPOC Link?

The new feature OPOC Links allows you to create a URL for a specific program that you can send to multiple participants instead of sending individualized OPOC keys. As OPOC links are shareable, there is a potential for surveys to be completed multiple times or shared outside of intended recipients. We advise organizations to monitor data for unusual responses when using the OPOC links option.

You can generate and distribute an OPOC link by logging into www.opoc.ca and following these steps from the OPOC Links tab:

1. Click on *New OPOC Link*
2. Select *Site*
3. Select *Program*
4. Select *Survey type* – you can create multiple survey types for this program at the same time. Each survey type will have a unique OPOC link.
5. Select *Lifetime* – the default is for new OPOC links to expire in 6 months. You can change this to anywhere between 1 month and 12 months. The *Created Date* will be auto-filled, and the *Expiration Date* will be automatically calculated based on this value.

6. Select (this is optional): Add a *Campaign* name to group these surveys together in the OPOC Reports under the Campaign filter.
7. Click *Save Link* in order to create the new OPOC links.

More information on how to create OPOC keys and how to generate OPOC Links can be found in the OPOC-MHA Orientation Video and in the OPOC Website Navigation Guide.

3. What if a service user neither agrees nor disagrees with a survey item?

The OPOC-MHA intentionally does not include a *neutral* response. Respondents are encouraged to think about whether they agree or disagree with a given statement and answer accordingly. However, two sections of the *OPOC-MHA for Caregivers* include an *I Don't Know* option. In these two sections, the caregiver may not actually have the information to answer the questions. These *I Don't Know* responses could offer important feedback for agencies wishing to strengthen the involvement of caregivers in their loved one's care.

4. If an individual is receiving services in more than one program at an organization, which program should the person consider when answering the questionnaire?

In general, we recommend individuals fill out a separate questionnaire for each program. If they do this, you can run separate reports for each program. You can also combine the results from multiple programs into a single report. However, in certain situations, it is difficult for individuals to separate the services they have received according to a program, for instance, if the same staff members work with the person across multiple programs. Although it's not ideal, in this case, you can ask respondents to fill out the survey based on the services they have received across multiple programs.

Keep in mind, though, if you are taking this combined route, the service user should only complete the questionnaire once for all the programs they are considering together. In addition, a major limitation of this approach is that you can only run a report for the combined programs; you cannot later separate your results based on specific programs. This can hamper the QI benefits of the tool. Whichever route you take, communicate clearly with the person whether they are answering the survey in relation to a specific program or based on the overall services they have received across multiple programs at your organization.

5. What if a survey respondent needs help understanding a question?

There is a difficult but important balance in how much assistance you offer a respondent if they ask for help. You may assist with basic clarification of words or phrases. However, you should avoid providing an in-depth interpretation of an item. Additional suggestions on how you can support your respondents to complete the survey can be found in the section above.

6. Are there service users for whom the OPOC-MHA is not appropriate?

While the OPOC-MHA was designed to be used broadly, some programs may experience more challenges than others implementing the tool. Such may be the case for forensic mental health programs, in which individuals may be mandated to participate. With specific planning, including the approach taken to introduce the survey, the OPOC-MHA has been successfully administered in forensic programs and clients have provided valuable feedback to support service improvements.

Prior to administering the tool, develop clear inclusion and exclusion criteria so that staff are not arbitrarily deciding who is eligible to complete the survey. For example, it is reasonable to exclude individuals who are currently in crisis or who are formed under the Ontario *Mental Health Act's* Application by Physician for Psychiatric Assessment (i.e., Form 1). In addition, you should consider whether another version of the tool, such as the OPOC-MHA for Supportive Housing or the OPOC-MHA for Crisis, is more appropriate for service users in some programs.

7. Is it mandatory to implement the OPOC-MHA?

The OPOC-MHA is a recommended way to obtain and report service user satisfaction or perception of care, which is required in service agreements. At the time of publication of this new edition of the implementation guide, some Ontario Health Regions and provider associations have mandated the tool, but this varies by region. For example, one OH Region has stated in its Multi-Sector Accountability Agreements (MSAAs) that the OPOC-MHA is the **required** tool for collecting service user feedback data, while another has said it is an **appropriate** tool for assessing client experience indicators in its MSAAs. Overall, the OPOC-MHA is highly aligned to expectations in MSAAs to collect service user feedback data.

8. What if a respondent needs help with language interpretation?

If a service user indicates a preference to complete the OPOC-MHA in a language other than those available in written versions of the tool, or is unable to complete the survey on their own because of language, you are encouraged to provide a professional interpreter. Professional language interpreters are trained to convey information while avoiding altering the person's response. If a respondent completes the survey with the help of an interpreter, remind them to indicate in the appropriate question at the end of the survey that they received help from an interpreter.

All the versions are designed for people age 12 and older with a literacy level of grade six or higher. The Registered, Non-Registered, Caregiver and Supportive Housing versions are available in English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Vietnamese, Punjabi, Arabic, and Somali. The Crisis version is only available in English, French, Arabic, and Somali.

9. Is it appropriate to have volunteers assist in implementing the tool, or should this be limited to staff?

Some providers have successfully had volunteers help administer the tool. As with clinical staff, volunteers should be far enough removed from a respondent's care to:

- not influence the respondent's answers
- not create an impression that a respondent's participation was coerced
- not be able to identify who completed a particular survey.

If you use volunteers, you should provide them with the same training as staff. This training should include letting volunteers know not to arbitrarily select who receives the survey and not to interpret questions for respondents. If you would like more information about volunteer training, such as training materials, please contact us.

10. Should there be a different approach to administering the survey with family members and supporters than with clients?

Organizations have found that family members and supporters tend to be more willing to complete the OPOC-MHA when they are asked directly in a waiting room or at the start of a scheduled session, as compared to when they are asked by staff to complete the survey on a separate occasion. For example, response rates tend to be lower when family members are asked to complete the survey online at a later time. Therefore, you may find it helpful to create a different plan for administering the OPOC-MHA versions with family members and supporters.

11. Is the survey website, www.opoc.ca, compatible with tablets and cell phones, and are there plans to develop a mobile application?

Currently, the OPOC-MHA website works on cell phones and tablets running Apple and Android operating systems. Because of this, many service providers use tablets to administer the survey.

12. What should I do if a question in the survey is not applicable to the services my organization provides? Can I just skip it?

You should not ask respondents to skip a question on the survey. Instead, let service users know the OPOC-MHA is a standardized tool used across the province and some questions may not specifically apply to the services they have received from your organization. Invite them to select the not applicable (N/A) option as appropriate. The N/A response can help you interpret your results and provides useful information in the provincial aggregate reports. It may inform where there are gaps in services.

13. How often should I administer the OPOC-MHA at my organization?

The OPOC-MHA can be administered at any point during service, and each organization or program can determine when it will distribute and collect the tool. For example, a provider may choose to administer the OPOC-MHA on an ongoing basis to see how respondents’ perceptions of care change as their length of time in a program increases. Regardless, you can improve your ability to compare results if you administer the tool consistently. Common implementation time frames examples are an annual or semi-annual campaigns

PART 3: ENTERING DATA & RUNNING REPORTS

The data from OPOC-MHA questionnaires are consolidated into one online database, which is accessible through www.opoc.ca. Responses on the electronic version of the tool are automatically stored in this database. However, the paper surveys need to be manually entered into the database after respondents complete them. Once the data have been entered, they can be analyzed.

Steps for entering paper survey data

1. Log in to the OPOC-MHA website at www.opoc.ca.
2. Locate the OPOC key that is attached to the paper copy of the survey. This can be found on the second page of the client information letter.
3. Enter the OPOC key.

   Please note: If the key you are entering has not been *distributed* (i.e. it is not active), you will be sent to the OPOC home page when you try to enter the OPOC key. In this situation, you need to go to the Distribution List tab, find the relevant key, and click on *distribute*. If you need more information on this process, please refer to the [OPOC Website Navigation Guide](#).
4. Click on *Proceed to Survey*.

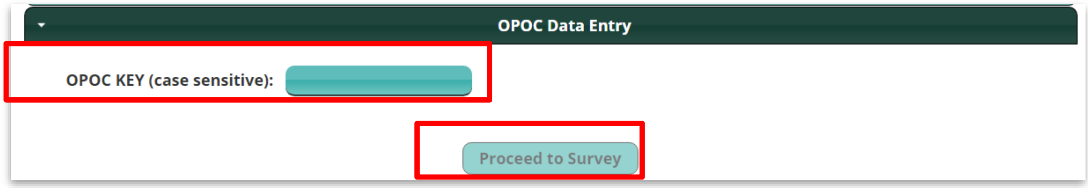


Figure 3

5. Enter the respondent's exact responses to all questions directly into the online version of the survey.
6. Click *Submit* after you have entered all the data on the paper survey.
   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.

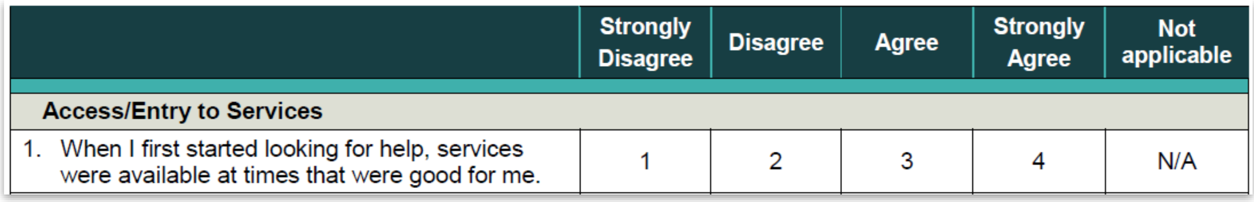
Again, please refer to the OPOC Website Navigation Guide for more details on this process.

Common problems when entering paper survey data

Completion errors on the paper survey can affect the quality of the data. Below are some common errors and strategies for dealing with them.

A missing response

If no option is circled or checked for an item, leave the corresponding entry in the web form blank, as illustrated in **Figure 4**.

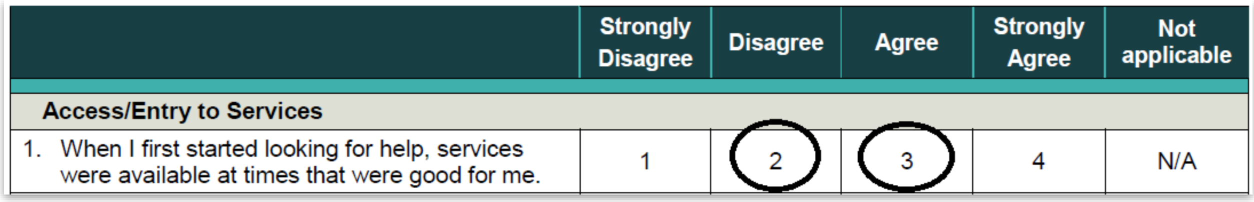


	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Access/Entry to Services					
1. When I first started looking for help, services were available at times that were good for me.	1	2	3	4	N/A

Figure 4

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 their response). This should be considered a missing response, with the corresponding entry left blank on the web form.

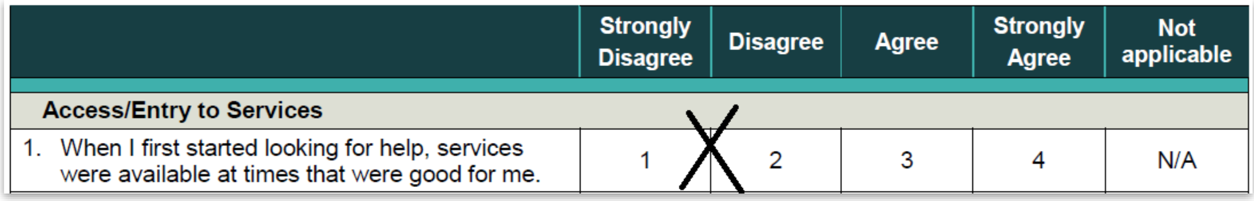


	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Access/Entry to Services					
1. When I first started looking for help, services were available at times that were good for me.	1	[✓ 2]	[✓ 3]	4	N/A

Figure 5

An unclear response

If a response 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, and the corresponding entry on the web form should be left blank.



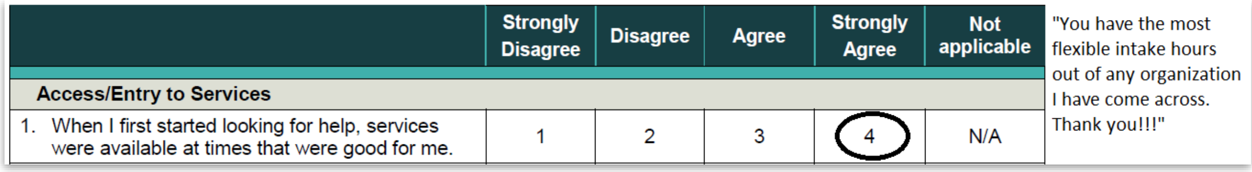
	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Access/Entry to Services					
1. When I first started looking for help, services were available at times that were good for me.	1	2	3	4	N/A

Figure 6

Notes next to a response

Occasionally, respondents will write additional comments next to a response category or question rather than in the space for open-ended responses. If these comments describe the individual's perception of care, the information should be entered into the corresponding open-ended comment field in the online survey.

The following figure illustrates this situation. The individual has written a strong endorsement of the organization in response to a question. This information should be entered as qualitative data in the online form, even though it was not written in the expected location on the survey.



	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable
Access/Entry to Services					
1. When I first started looking for help, services were available at times that were good for me.	1	2	3	[✓ 4]	N/A

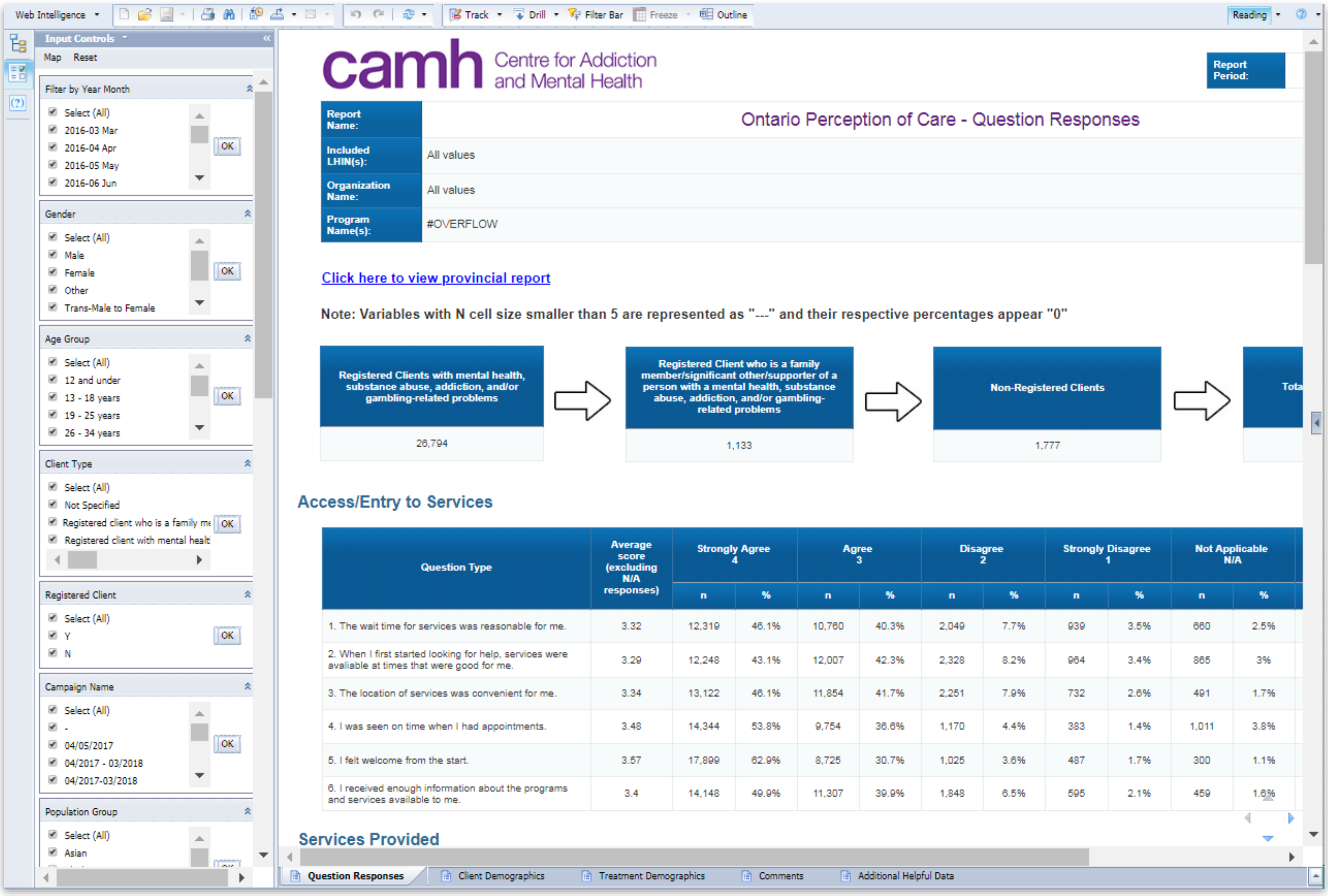
"You have the most flexible intake hours out of any organization I have come across. Thank you!!!"

Figure 7

Running reports

Service providers can extract raw data and generate customizable reports through a password-protected interface. Below are some images that illustrate this report generating platform. See the [Reporting Platform Navigation Guide]() to learn more about this platform.

The following screenshot (i.e., **Figure 8**) is of the primary OPOC reporting platform page. This page appears when you log in. Notice that there are filters on the left-hand side of the page. You can use these filters to look at your OPOC-MHA data and customize your reports in different ways. The screenshot also shows sample survey results for the Access/Entry to Services domain of the OPOC-MHA.



Filter by Year Month
- ☑ Select (All)
- ☑ 2016-03 Mar
- ☑ 2016-04 Apr
- ☑ 2016-05 May
- ☑ 2016-06 Jun

Gender
- ☑ Select (All)
- ☑ Male
- ☑ Female
- ☑ Other
- ☑ Trans-Male to Female

Age Group
- ☑ Select (All)
- ☑ 12 and under
- ☑ 13 - 18 years
- ☑ 19 - 25 years
- ☑ 26 - 34 years

Client Type
- ☑ Select (All)
- ☑ Not Specified
- ☑ Registered client who is a family me
- ☑ Registered client with mental healt

Registered Client
- ☑ Select (All)
- ☑ Y
- ☑ N

Campaign Name
- ☑ Select (All)
- ☑ -
- ☑ 04/05/2017
- ☑ 04/2017 - 03/2018
- ☑ 04/2017-03/2018

Population Group
- ☑ Select (All)
- ☑ Asian

Report Period:

Report Name:	Ontario Perception of Care - Question Responses
Included LHIN(s):	All values
Organization Name:	All values
Program Name(s):	#OVERFLOW

[Click here to view provincial report]()

Note: Variables with N cell size smaller than 5 are represented as "---" and their respective percentages appear "0"

Registered Clients with mental health, substance abuse, addiction, and/or gambling-related problems	Registered Client who is a family member/significant other/supporter of a person with a mental health, substance abuse, addiction, and/or gambling-related problems	Non-Registered Clients	Tota
26,794	1,133	1,777	

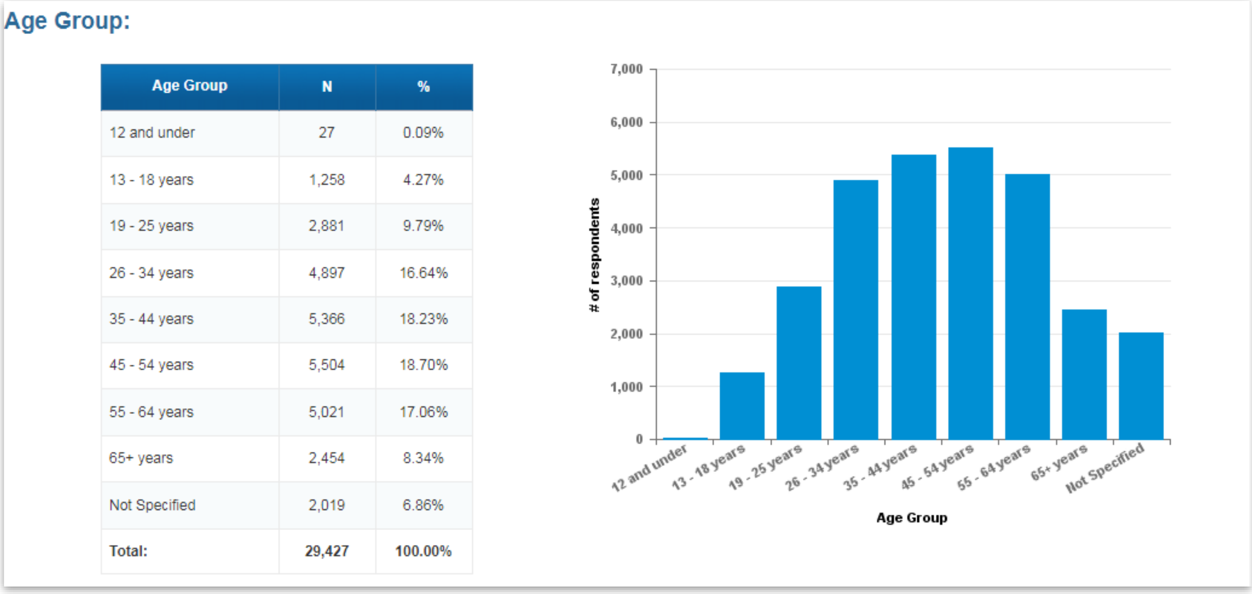
Access/Entry to Services

Question Type	Average score (excluding N/A responses)	Strongly Agree 4		Agree 3		Disagree 2		Strongly Disagree 1		Not Applicable N/A	
		n	%	n	%	n	%	n	%	n	%
1. The wait time for services was reasonable for me.	3.32	12,319	46.1%	10,760	40.3%	2,049	7.7%	939	3.5%	660	2.5%
2. When I first started looking for help, services were avaliable at times that were good for me.	3.29	12,248	43.1%	12,007	42.3%	2,328	8.2%	964	3.4%	865	3%
3. The location of services was convenient for me.	3.34	13,122	46.1%	11,854	41.7%	2,251	7.9%	732	2.6%	491	1.7%
4. I was seen on time when I had appointments.	3.48	14,344	53.8%	9,754	36.6%	1,170	4.4%	383	1.4%	1,011	3.8%
5. I felt welcome from the start.	3.57	17,899	62.9%	8,725	30.7%	1,025	3.6%	487	1.7%	300	1.1%
6. I received enough information about the programs and services available to me.	3.4	14,148	49.9%	11,307	39.9%	1,848	6.5%	595	2.1%	459	1.6%

Services Provided

Figure 8

The next screenshot is a demographic report. It is an example of an age breakdown of survey respondents. Both chart and bar graph formats are provided in the reporting platform.

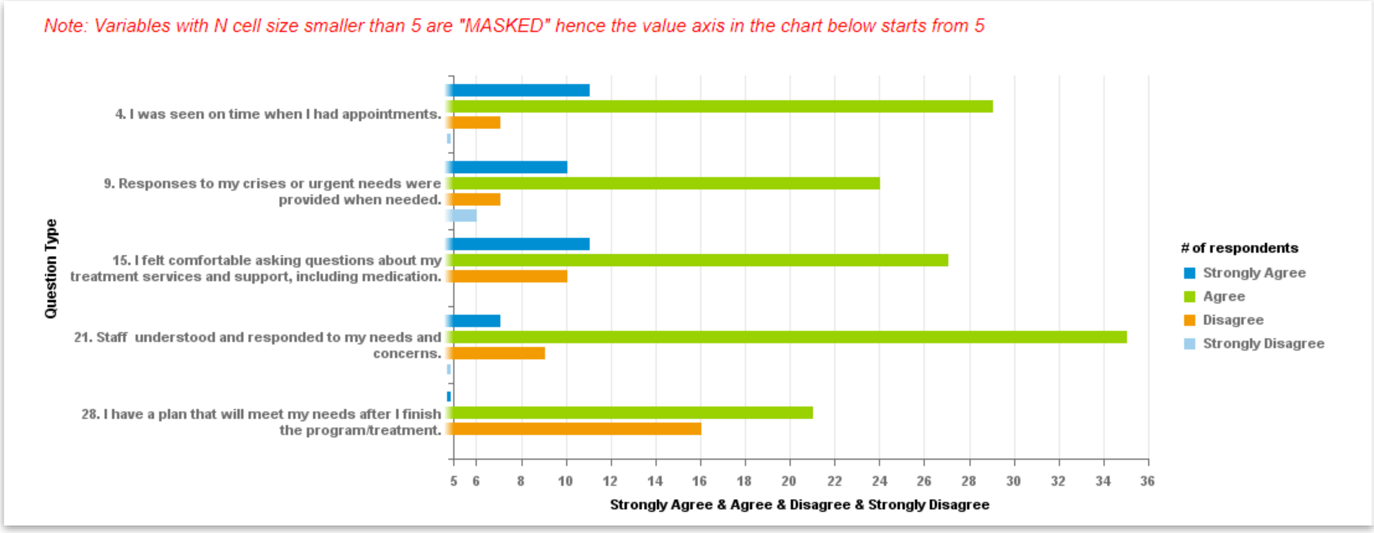


Age Group:

Age Group	N	%
12 and under	27	0.09%
13 - 18 years	1,258	4.27%
19 - 25 years	2,881	9.79%
26 - 34 years	4,897	16.64%
35 - 44 years	5,366	18.23%
45 - 54 years	5,504	18.70%
55 - 64 years	5,021	17.06%
65+ years	2,454	8.34%
Not Specified	2,019	6.86%
Total:	**29,427**	**100.00%**

Figure 9

The next image illustrates the top priorities report, which includes a bar graph. This report allows you to select up to five questions to examine. The results are then plotted on the bar graph.



Note: Variables with N cell size smaller than 5 are "MASKED" hence the value axis in the chart below starts from 5

Figure 10

PART 4: USING RESULTS FOR EVALUATION & QUALITY IMPROVEMENT

How can the OPOC-MHA support quality improvement?

Quality improvement (QI) is a systematic approach to making changes that aim to create better client outcomes, stronger system performance, and enhanced professional development.[5] Data from the OPOC-MHA can contribute significantly to QI in mental health and addiction services. The data from these questions can be used to evaluate the effectiveness of a service or to continuously monitor QI objectives. For instance, an organization can use results to look at specific characteristics of a service and then act on the results. In addition, many organizations use OPOC questions on their formal QI plans.

Furthermore, in Ontario, provincially-funded health service providers are required to have a Service Accountability Agreement with their Ontario Health (OH) region. These agreements outline required performance measures and QI indicators. Some Ontario Health regions have allowed providers to use OPOC-MHA items to meet reporting requirements for client satisfaction measures.

The OPOC-MHA can provide information on QI indicators of safety, accessibility, client-centredness, equity, integration, effectiveness, and the appropriate use of resources. The following table provides examples of how specific items on the OPOC-MHA for Registered Clients align with some of the common QI indicators:

Quality dimension	**OPOC-MHA for Registered Clients items**

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[5] Quality Improvement. (n.d.). Health Quality Ontario. https://www.hqontario.ca/quality-improvement

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*
Client-centred	Percentage of clients agreeing* with OPOC-MHA item #32 *If a friend were in need of similar help I would recommend this service*
	Percentage of clients agreeing* with OPOC-MHA item #16 *If I had a serious concern, I would know how to make a formal complaint to this organization*
	Percentage of clients agreeing* with OPOC-MHA item #19 *Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, race).*
Equitable	Percentage of clients agreeing* with OPOC-MHA item #22 *Overall, I found the facility welcoming, non-discriminating, and comfortable (e.g., entrance, waiting room, décor, posters, my room if applicable).*
	Percentage of clients agreeing* with OPOC-MHA item #26 *The program accommodated my needs related to mobility, hearing, vision, and learning, etc.*
Integrated	Percentage of clients agreeing* with OPOC-MHA item #11 *I was referred or had access to other services when needed, including alternative approaches (e.g., exercise, meditation, culturally appropriate approaches).*
Effective	Percentage of clients agreeing* with OPOC-MHA item #30 *The services I received helped me deal more effectively with my life’s challenges.*
	Percentage of clients agreeing* with OPOC-MHA item #31 *I think the services provided here are of high quality.*

---

[*] “Agreeing” includes clients who selected *agree* or *strongly agree* on a particular item.

[*] “Agreeing” includes clients who selected *agree* or *strongly agree* on a particular item.

In Appendix 2, we provide suggested mappings of OPOC-MHA questions onto the Institute of Medicine's six aims, or domains, of health care quality. These domains are: safety; effectiveness; patient-centeredness; timeliness; efficiency; and equity. Although system planners have not formally endorsed the mappings for reporting purposes, you may find them useful if you are measuring a specific quality domain.

Using specific questions for rapid improvement cycles

The OPOC-MHA is a comprehensive tool that assesses service user perception of care across a number of domains. You may also wish to use the OPOC-MHA to gather quick feedback from services users on a few specific areas of interest. *Guidelines for Using Select OPOC Questions* outline how you can administer specific questions as a complement to your regular OPOC-MHA administration. For example, you may choose to administer individual OPOC-MHA items more frequently as change indicators for specific QI initiatives. Keep in mind that administering individual items more frequently does not replace standard OPOC-MHA implementation. It is recommended you administer the full OPOC-MHA at least once annually.

We have also created a scoring template to use when administering individual questions, because data collected by this type of administration cannot be entered into the provincial database or included in your OPOC-MHA reports. This scoring template is available upon request from your OPOC implementation specialist.

Quantitative data analysis

Analyzing your OPOC-MHA data can provide important information for your organization's QI and program evaluation efforts. You can analyze data for individual questions and for groups of questions on the OPOC-MHA. For example, you can look at:

- the proportion of people who selected particular responses on individual items, such as *strongly agree* or *strongly disagree*;
- average scores on individual items; and/or,
- the comparison of scores from a number of items.

After you have completed more than one administration of the OPOC-MHA, you can compare your results over time. For example, reviewing average scores or the change in percentage of *strongly disagree* responses can help you determine if your QI efforts are successful. Note that OPOC-MHA results tend to be positively skewed, like client satisfaction data in general. Some organizations have found it easier to demonstrate change using the proportion of respondents who answer in a particular way rather than average scores. These issues are discussed further in the upcoming section in this guide, Integrating Quantitative and Qualitative Data for Quality Improvement.

We recommend that you analyze and report data for different user groups and programs separately, including:

- inpatient and outpatient services

- registered and non-registered service users
- family members and other clients
- crisis and supportive service users
- mental health, addiction, and concurrent disorder programs.

Respondents from these different population groups and programs tend to have differing experiences with service. You will find information below about analyzing and reporting data for different racial or ethnic groups.

A caution about small numbers

Although it is helpful to look at results by user group, it is sometimes difficult to collect enough data for a particular population group to draw conclusions. This is especially challenging in small programs. Regardless, you should avoid coming to conclusions based on small sample sizes. Results based on small numbers can fluctuate widely even though the variation may be the result of chance alone.

If you have small numbers of responses, you also need to be careful not to breach respondents' confidentiality. A breach can occur if you release results in a way that allows someone to be identified. For instance, reporting results based on gender identity may breach confidentiality if your program has a small number of clients who identify as transgender or gender non-conforming. Any time results are based on a small sample size, it may be possible to determine confidential information through a process of elimination. For this reason, data from groups with less than five respondents will not display in the standardized OPOC-MHA reports.

Health equity data reporting

Mental health and addiction service needs and outcomes have been found to vary according to social and demographic characteristics, such as gender, age, racialized status, and sexual orientation. As a result, it is important for service providers to monitor for inequities in service use and outcomes.

One of the benefits of the OPOC-MHA is that it can identify health equity issues. The survey captures extensive demographic information about service users, such as gender, age, and ethnic background. In addition, it includes many items that can be used to assess for potential inequities in access, quality, and satisfaction in relation to population groups. As a result, your analysis of your OPOC data can be critical in informing and addressing barriers faced by population groups, identifying QI interventions, and monitoring for improvements over time.

You can use the demographic data you obtain to create a general profile of your organization's service users to determine whether there is a need to adjust or create new programs to better serve specific groups. A way of examining whether your services are meeting the needs of diverse groups is to compare the characteristics of the individuals you serve with those of the broader population in the community in which you provide services. You can do this by comparing the demographic information of your organization's service users to census or population data for the area you serve. We also recommend you look at whether there are differences between the people who agree to complete the OPOC-MHA and the overall population of individuals you serve.

You may also use data from the tool to assess whether standards of equity are being met in the quality of services delivered. For example, you may be interested in seeing whether all groups of respondents perceive the environment as welcoming and inclusive. To do this, you can use the report filters to analyze the OPOC-MHA program environment indicators according to demographic groups. For instance, you can see whether respondents of different ethnic backgrounds find your facility equally welcoming, non-discriminating, and comfortable.

The OPOC-MHA can support your agency to action Ontario Health's Equity, Inclusion, Diversity and Anti-Racism Framework. The tool captures extensive demographic information and the reporting platform helps to establish a system for collecting, reporting, and using equity data to inform decisions and service improvements. Filtering the question responses through the sociodemographic filters can help your agency assess for potential disparities in service delivery in relation to population groups. In addition, the OPOC-MHA centers the client voice as a source of evidence, engaging key voices in service feedback and quality improvement initiatives. In addition to analysing the quantitative data in this way, you should look carefully at respondents' open-ended comments. These comments can provide details to help interpret the quantitative indicators.

Moving Knowledge to Action: the Ontario Perception of Care Tool Equity Improvement Modules

In 2021, we conducted a survey that showed many OPOC users feel uncertain about how to use the tool to help assess and address health equity issues in the delivery of service. We have heard your feedback and created a new OPOC equity improvement course to help build agency capacity to collect, understand, and use their client experience data for health equity-related service improvement.

Moving Knowledge to Action: the Ontario Perception of Care Tool Equity Improvement Modules are a set of five self-directed modules that will take you 3-4 hours to complete. The course will show you how to:

- ✓ Collect and analyze health equity data
- ✓ Take equity improvement action
- ✓ Share reporting results with stakeholders

This free module series is available to any organization implementing OPOC. Reach out to your OPOC implementation specialist for more information or follow this link to self-enroll today!

Sharing results with survey respondents

We strongly recommend that you share your OPOC-MHA survey results with service users. We base this recommendation on feedback we received from a panel of people with lived experience during the early implementation of the tool, as well as feedback from organizations that have been using the tool for several years. Letting your respondents know specifically how you will share the results and how they are being used for QI helps increase response rate and provides support for the OPOC-MHA in general. In addition, sharing results from your previous OPOC-MHA administration and what you have done to respond to this feedback, can help increase participation.

We've developed four poster templates that you can use to share findings with service users (see **Figure 11**). You can download these templates here.

ONTARIO PERCEPTION OF CARE TOOL
FOR MENTAL HEALTH AND ADDICTIONS

Thanks for giving us your feedback about the care you've received from us!

By filling out the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA), you're helping us to improve the services we provide.

WHAT YOU TOLD US

- You want to know how to make formal complaints.
- You want more activities you can do during your free time.
- You want a transition plan at the end of your program to help meet your needs.

WHAT WE LEARNED

Majority of our clients are satisfied with their access to services and overall experience. Some areas of improvement were also identified below.

YOUR VOICE IS IMPORTANT!

WHAT WE'RE DOING

- We added a complaints box to the waiting area and will check weekly.
- We created a planning committee that will include clients and family members to help develop more activities of interest. Stay tuned for more details!
- We formed a staff team who will look at ways to improve our transition planning process. Improvements will be made by August 2016 .

WHAT'S NEXT

Your feedback helped us identify what we need to do to improve your experience at our agency. We've already made some changes, while others will take longer.

To find out more, please ask your service provider.

We hope these changes will improve your client experience. Please give us your feedback in August 2016!

If you haven't had a chance to provide feedback about your experience, please ask your service provider about the OPOC-MHA.

Figure 11

Qualitative data analysis

Respondents can include comments after each section of the OPOC-MHA, as well as at the end of the tool. These free form text spaces allow people to highlight aspects of services that they found positive or concerning. Consistent with the privacy expectations regarding OPOC-MHA administration, it is important you not try to identify respondents based on their open-ended responses.

If the tool is administered orally by a surveyor, a respondent may make comments after being asked closed-ended items. The surveyor should add these comments to the qualitative comment space in the same section of the questionnaire. Even if the individual provides comments after closed-ended items, the surveyor should still ask the respondent the qualitative comment questions on the survey because the respondent may have additional feedback to provide.

The free-form responses from the OPOC-MHA do not appear on the standard reports. Instead, providers are responsible for downloading and analyzing this qualitative data separately. To retrieve these comments, you need to download the raw OPOC-MHA data in Microsoft Excel format. This raw data will include all the open-ended comments. You can then cut and paste these comments into another spreadsheet for analysis.

While qualitative data analysis can be complex, the primary goal is to uncover themes within the information. An analysis of the qualitative data can offer a deeper understanding of what was revealed by the quantitative responses on the questionnaire.

When you move the free-form responses to another spreadsheet for analysis, you should place each comment for a particular item on its own line. You can then review this qualitative data according to the procedure outlined in the following section.[6]

How to analyze qualitative data

1. Read through all the responses

First, read through all of the responses to get a preliminary sense of the content and emerging themes. Consider having another person review the responses independently. This will reduce the influence of your biases on the data, especially if you are closely connected with the program.

2. Develop categories

Come up with categories that reflect 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 be: *suggested changes to content, more group activities,* or *no changes needed.*

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[6] Larson, L., Malcolm, E., & Whelan Capell, J. (June, 2011). Analyzing outcomes data. Workshop at the 13th Annual Urban Initiatives Conference, Milwaukee, WI.

3. Assign each response to a category (or multiple categories)

Assign each comment to one or more categories. This is known as **coding**. There are many ways to perform the mechanics of coding, and Microsoft Excel can be helpful. For example, you can place all your responses in one column, and then use the adjacent column to enter the appropriate category label(s). Alternatively, you can create a column for each category and then cut and paste the comments under the appropriate column(s).

4. Check your categories

Check to see if your categories are correct – that they accurately reflect the themes in the comments. For instance, you might find that most of your responses fall into one category and that the category could actually be broken into more specific subcategories. Alternatively, you might find that you have some comments that fall into a new category altogether. Or, one of your categories might only have one or two comments and be better merged with another category.

5. Review for major themes

Look to see which categories have the most responses and, therefore, represent your major themes. Once you have done this, think about what the themes are really saying, and how they are applicable to your program. For example, a major theme might be that *most people want more group activities*; however, consider how you will explain this theme to others so that it can lead to program improvements.

6. Identify patterns and trends

Identify which categories are related, and look for potential linkages, patterns, and trends. Are the themes related in some way, or are they a series of unrelated ideas? We recommend keeping track of key demographic characteristics for the comments and look if patterns emerge. For example, are certain themes related to differences in gender, age, or cultural background?

7. Write-up your analysis

Summarize your analysis in a way that effectively communicates your findings to others, such as frontline staff, managers, clients, or family members. A summary normally includes a description with some comments that exemplify your major themes. You can use quotes to illustrate themes as long as they do not identify a particular individual. Your summary may complement or clarify what you learned from the quantitative data, and your write-up can tie it all together.

Integrating quantitative and qualitative data for quality improvement

After you have become familiar with the OPOC-MHA reports, we encourage you to examine your data in more detail to plan your QI efforts. Although there is no perfect way to look at data, we encourage you to start broad with a full report of all responses and then to use the filters to narrow the data that are displayed.

The real-time response of the reporting portal allows you to quickly and seamlessly generate reports with only the information you are interested in. Be guided by your curiosity and ask lots of questions. For instance, as mentioned in the Health Equity Data Reporting section of this guide, you can look at how different population groups are experiencing care at your organization. Or, you can examine if the results change based on what stage clients are in the program or whether they were mandated or pressured to attend. Use filters to answer these or other questions about your OPOC-MHA responses.

The following questions can guide you in using your results to inform your QI efforts:

1. What are your overall impressions of the data?

Take a first pass at the results, noting any general observations or initial reactions. You can perform subgroup analyses later; just observe your first impressions about what you are reading.

2. Do any of the results surprise you?

If your results are generally positive – as is often the case –a few may still catch your attention. What is it about these responses in particular that surprises you or makes them stand out?

3. Who answered the survey?

Knowing the groups that tended to complete the survey is critical to understanding whose perspective is represented in the data. Similarly, it provides important information about whose perspective is missing and the implications of that. Are the survey respondents reasonably similar to your organization’s service user population in terms of age, sexual orientation, ethnic background or other population groupings? 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 analyses can be especially useful. Using the filters to limit responses by different population groups, you can see whether particular groups answered the survey differently. If so, you might notice that results are better or worse for all questions or are isolated to certain questions. This can help you understand if and how care is experienced differently, where equity issues exist, and whether you should consider a QI initiative related to a particular group of service users.

5. How is my overall response to the OPOC survey?

In all initiatives that involve the administration of a survey to clients, customers, and service recipients, an important metric to consider is the overall response. It indicates how well your implementation approaches have worked and it offers clues as to whether you should collect more data or gather supplementary information before making significant changes. Here are some things to remember when considering the response to an OPOC administration:

- A true response rate --- that is the number of completed surveys divided by the number of surveys given out --- is very hard to calculate given the many administration methods now available for OPOC (e.g., paper, email, OPOC links, virtual, phone).

- When using some of these administration methods, there is no way to know exactly how many surveys were distributed (e.g., when using OPOC links, there is no way to know how many potential respondents might be given the opportunity to complete an OPOC survey).
- When administering OPOC surveys in person using paper or by emailing the OPOC keys as attachments to individual recipients, you must remember to delete all undistributed surveys to have an accurate count of the overall response.

We encourage agencies to focus less on the rate of return and more on the overall response to the OPOC during an administration. Focus on reaching as many clients and service users as possible. Focus on efforts to reach a representative sample of your client population (e.g., gender, age, sexual orientation, and ethnic background). You do not need a particular sample size. However, if the results suggest that substantial or detailed QI activities might be needed, consider if you have a representative sample of your client population to inform the decision. Remember to download a copy of our tip sheet, Looking at your OPOC-MHA data, to remind yourself of the key points in this section.

Contact your Implementation Specialist to discuss how to measure and maximize the overall response to you OPOC administrations.

Checking your (statistical) biases at the door

When interpreting surveys, it is important to be mindful of common biases and assumptions that can influence how data 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 about what it is asking, they may simply agree with it rather than seek clarification. To minimize this risk, it is important to provide facilitation and encourage respondents to seek assistance with survey items. While you need to avoid providing an in-depth interpretation of an item, you can offer basic clarification of words or phrases, as well as help with scoring. Additional suggestions on how you can support your respondents to complete the survey can be found in the section of this guide: Using the tool with clients with complex challenges.
2. **Social desirability response bias:** This bias refers to the possibility that respondents will answer questions in a way that they think will be viewed favorably by others, even if it is not an accurate reflection of their opinion. It 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 facilitating the survey should not be the individual's primary service provider. Even with the assurance of anonymity, respondents may answer in a manner that reflects what they think their service provider wants to hear *just in case* their provider finds out how they responded.
3. **Selection and volunteer response bias:** When respondents are selected purposefully, rather than randomly or based on some objective criteria, the results may be misleading because the group selected does not represent the actual population. This bias also occurs by restricting the survey to certain respondent groups, such as people who are being discharged. It is essential to be mindful of who was asked to complete the survey and who actually completed it. Otherwise, you could be making critical program decisions based on skewed information.
4. **Simpson's Paradox:** This refers to a phenomenon in statistics in which a trend appears in several different groups of data but disappears, or even reverses, when these groups are combined. In **Figure 12** below, a question related to discharge planning appears as one of the areas of improvement on an 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. 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 taken on a quality improvement exercise related to discharge planning that was not fully in line with the data. While the data do support some quality improvement, it may have been unnecessary in the inpatient program, where discharge planning 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.

Overall Group

Areas of Improvement

(this table is auto populated based on top 5 average score of disagree and & strongly disagree)

Question Type	Domain	Average Score (SD/D)	Disagree %	Strongly Disagree %
27. Staff helped me develop a plan for when I finish the program/treatment.	Discharge or Finishing the Program/Treatment	1.77	5.8%	1.7%

=

Outpatient Responses

Areas of Improvement

(this table is auto populated based on top 5 average score of disagree and & strongly disagree)

Question Type	Domain	Average Score (SD/D)	Disagree %	Strongly Disagree %
27. Staff helped me develop a plan for when I finish the program/treatment.	Discharge or Finishing the Program/Treatment	1.8	6.40%	1.60%

+

Inpatient Responses

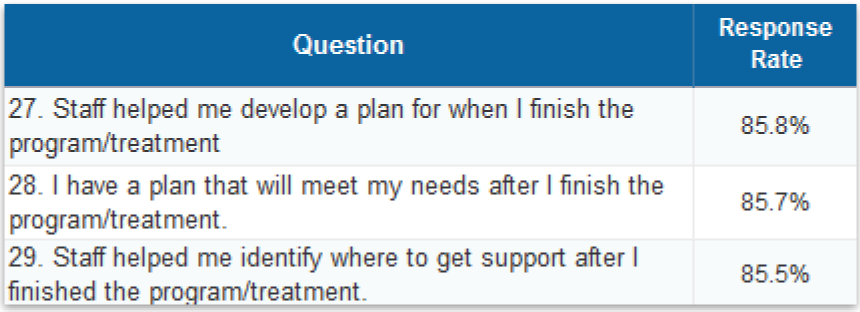
Areas of Excellence

(this table is auto populated based on top 5 average score of strongly agree and agree)

Question Type	Domain	Average Score (SD/D)	Disagree %	Strongly Disagree %
27. Staff helped me develop a plan for when I finish the program/treatment.	Discharge or Finishing the Program/Treatment	3.6	46.3%	24.4%

Figure 12

5. **Confirmation bias:** This refers to a cognitive bias in which people tend to overvalue information that supports their previously-held beliefs, assumptions, or opinions. This inclination is usually unintentional, but it is easy to fall victim to because the supporting evidence often *feels right.* When reviewing data, keep an open mind and don't limit findings to data that agree with your point of view. Ask a lot of questions, generate many reports, and seek additional information from survey respondents or agency staff when something is unclear.
6. **Confounding variables:** These variables are external, unexplored factors that influence the results or impact the apparent relationship between two concepts. If present, these variables can mean that a perceived relationship between two variables is actually partially or entirely false. Therefore, it's crucial to consider whether reasonable alternative explanations exist that explain your results better. For example, an organization was surprised to see that all three discharge items (i.e., questions 27-29) on the OPOC-MHA were areas for improvement because they had recently evaluated their discharge planning processes. Consequently, they wondered whether a confounding variable might be causing this result. After reflecting on the situation, they hypothesized that clients who had not yet begun discharge planning might be answering the discharge items negatively and, thus, *dragging down* the overall results. Based on how they were administering surveys, they estimated that one-third (33%) of respondents had not yet reached the discharge planning stage of their program. Looking at their report (see **Figure 13**), they noticed that the response rate for all three discharge items was close to 86%, meaning that an estimated 20% of clients answered this question when they had not yet reached the discharge planning stage of the program. Going forward, the agency ensured that all clients had a better understanding of the program's components and timelines.



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

Figure 13

Making the most out of the OPOC-MHA

As your organization continues to implement the OPOC-MHA, we recommend that you complete the OPOC Self-Assessment Tool for Organizations. This resource can help organizations assess areas of strength and areas for improvement. If you would like, you can review your results with your PSSP Implementation Specialist for additional support.

PART 5: MORE ABOUT THE OPOC-MHA VERSIONS

This part of the guide will describe the OPOC-MHA versions in more depth. It begins with similarities among all the versions and then looks at unique aspects of the different versions of the tool.

What is similar in some or all versions of the tool?

Sociodemographic questions

All OPOC-MHA versions ask respondents about their gender, age, language, ethno-cultural background, sexual orientation, and current housing status. These questions have been adapted from *Measuring Health Equity: Demographic Data Collection and Use in Toronto Central LHIN Hospitals and Community Health Centres* and are aimed to develop an evidence-based approach for collecting sociodemographic information for individuals receiving health services in Ontario.

Why ask sociodemographic questions?

These questions allow providers and funders to identify potential inequities in service or access. When data are combined across many survey respondents, perception of care can be summarized according to different sociodemographic groups. Though the questions may be difficult for some respondents to answer, the Ontario Human Rights Code encourages the collection of this type of data when the purpose is to monitor discrimination and promote equity. A respondent can choose not to respond to specific demographic questions if they do not feel comfortable answering.

In the demographic section, a question asks whether a client was required, mandated, or pressured to attend services. What does this question mean?

This question is asking about both formal mandates and informal pressures to attend service. *Required* or *mandated* applies to any formal requirement to obtain services 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.

Individuals can experience other forms of pressure to obtain services. For example, they may feel pressure from family to attend a program. In addition, a community treatment order is not a formal mandate to obtain services because the individual, or their substitute-decision maker, needs to provide informed consent for treatment. However, in most cases, a community treatment order is considered a form of pressure because the person is likely to face consequences for not complying with the community treatment plan.

Terminology

The OPOC-MHA is written in the past tense. Individuals completing the survey should respond to each item based on their most recent experience or *services to date*. This can include services they are still receiving.

What do the terms *services* and *treatment services* refer to in the OPOC-MHA?

Unless a question specifically says *treatment services*, the term *services* refers not only to treatment but also any other support services individuals receive from a single provider. For example, if an individual is placed on a waiting list for a treatment program after their initial assessment, but in the meantime is receiving other support services, then they should interpret the word *services* as both the treatment they are waiting for and the support services they are receiving at your organization. For the OPOC-MHA questions, services are just what is provided by your organization and do not include supports provided by any other provider.

In addition, some programs do not use the term *treatment services*. As a result, some respondents may be unfamiliar or uncomfortable with this terminology. If this is the case, you should clarify what treatment services refers to in your program. For instance, you can state, “When the survey asks about *treatment services*, it means _______ in our program.” This instruction can be written on the front of the OPOC-MHA or mentioned verbally at the outset.

The environment section of the OPOC-MHA refers to people receiving services in a *facility*. How should people respond if they do not actually receive services in our facilities?

Individuals who receive services in the community would respond based on their experiences with the settings where they regularly meet their primary worker(s). For instance, clients of an Assertive Community Treatment team would answer based on the settings where they regularly meet their provider, such as at a community health centre or in a public location. Individuals who receive services in their own home will likely select *not applicable* to several questions in this section.

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

Residential treatment involves living at a treatment facility while undergoing intensive services. The OPOC-MHA asks anyone participating in this type of program to respond to the six items in the residential/inpatient section.

OPOC-MHA for Registered Clients

Highlights about the version

Who is this version for?

This version is only for **registered** clients of a program. These clients include family members or supporters if the program has registered them to receive services, such as in a family support group.

What does it include?

OPOC-MHA for Registered Clients measures perceptions of care across the following seven domains:

Figure 14

The tool contains 38 items. The first 32 items measure perception of care for clients receiving services in either a community or a residential/inpatient setting. The remaining six items are *only* for clients receiving residential or inpatient services. The tool has space for clients to provide open-ended comments.

What languages are available?

This version is available in nine languages: English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Punjabi, Arabic, Somali, and Vietnamese.

If a respondent is a family member or supporter, when would we use the OPOC-MHA for Registered Clients?

The OPOC-MHA for Registered Clients should be used for family members or supporters who are registered to receive services in a program. It allows them to provide feedback about their own services at your organization. It should not be used by the family member or supporter to provide feedback on services that their loved one has received. We recommend that you clarify these instructions for these respondents.

OPOC-MHA for Non-Registered Clients

Highlights about the version

Who is it for?

This version is for two groups of respondents:

1. people with mental health and addiction problems who are receiving support from your organization but are **not registered** clients
2. family members or supporters who are receiving support from your organization but are **not registered** clients.

Examples of these support services could include a drop-in peer support program where clients are not rostered or a monthly educational session for family members and supporters.

What does it include?

The Non-Registered version of the tool contains 17 items across the following seven domains:

Figure 15

The tool also has space for clients to provide open-ended comments.

What languages are available?

This version is available in nine languages: English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Punjabi, Arabic, Somali, and Vietnamese.

If a respondent is a family member or supporter, when would we use the OPOC-MHA for Non-Registered Clients?

The OPOC-MHA for Non-Registered Clients should be used for family members or supporters who are receiving support from your organization but are not registered for services in a program. It allows them to provide feedback about their own services at your organization. It should not be used by the family member or supporter to provide feedback on services that their loved one has received at your organization. We recommend that you clarify these instructions for these respondents.

You can also use this version with family members or supporters whose loved one is not receiving service from your organization (or not receiving service at all), as long as they are supporting someone with an addiction or mental health concern.

OPOC-MHA for Caregivers

Highlights about the version

Who is it for?

This version of the tool is for family members and supporters that meet **both** of these conditions:

1. They have a loved one receiving services at your organization, and
2. They are not receiving their own services at your organization.

What does it include?

The Caregiver version allows family members and supporters to comment on the services received by their loved one and the potential benefits of these services for their loved ones and themselves.

It contains 39 items related to the following six domains:

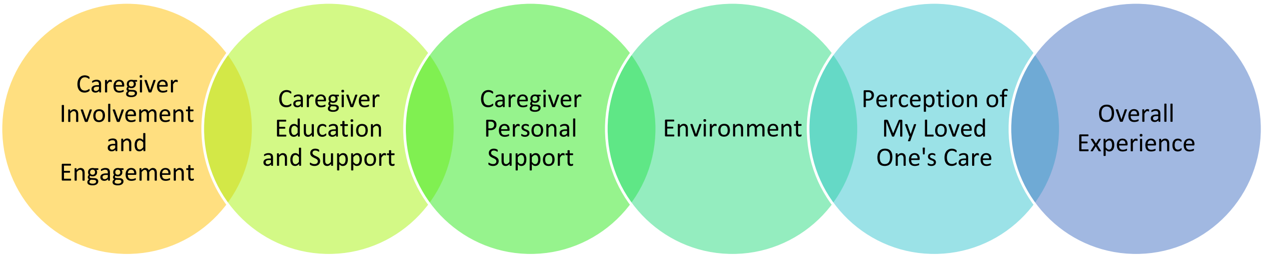


Figure 16

The first 33 items measure caregivers' perception of their loved one's care in either a community or a residential/inpatient setting. The remaining six items are only applicable for caregivers with loved ones in residential or inpatient services. The tool also has space for caregivers to provide open-ended comments.

What languages are available?

This version is available in nine languages: English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Punjabi, Arabic, Somali, and Vietnamese.

How is this version different?

The OPOC-MHA for Caregivers has some unique features. It includes a number of different domains, including: involvement and engagement; education and support; personal support; and perception of their loved one's care.

Two of the domains include an *I don't know* option. The respondent should select *I don't know* when they think the item applies to their loved one's care but they do not know about the item. However, they should select *not applicable* if they think the item does not apply to their loved one's care.

The Caregiver version also asks about both the caregiver's and their loved one's sociodemographic characteristics. As a result, respondents should be mindful about whether a question is asking for their own demographic information or that of their loved one.

When would we use the OPOC-MHA for Caregivers?

The OPOC-MHA for Caregivers allows family members and supporters to provide feedback about their loved one's care. However, it is **not** for family members or caregivers who are receiving their own service or support at your organization. This survey may be given both when the client has consented to the caregiver's involvement in their care and when they have not.

OPOC-MHA for Supportive Housing

Highlights about the version

Who is it for?

The supportive housing version is for residents or tenants of organizations providing permanent supportive housing or long-term transitional housing. It is primarily aimed at mental health and addiction permanent supportive housing organizations. However, it can also be used in rent supplement programs or transitional housing programs offering long stays.

What does it include?

This version contains 38 items across the following seven quality domains:

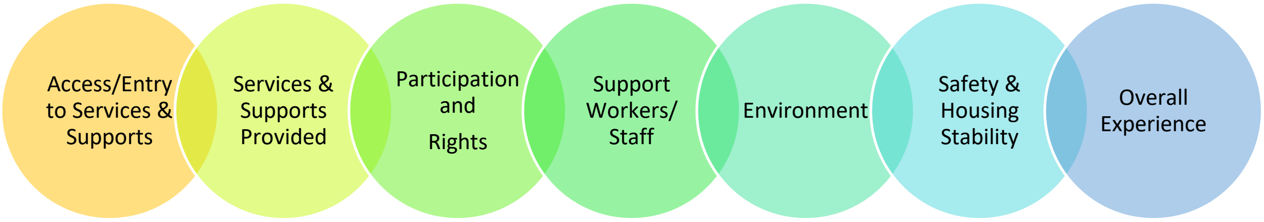


Figure 17

The tool also has space for clients to provide open-ended comments.

What languages are available?

This version is available in nine languages: English, French, Cambodian, Korean, Simplified Chinese, Traditional Chinese, Punjabi, Arabic, Somali, and Vietnamese.

How is this version different?

This version includes a *safety and housing stability* domain and, to align with supportive housing best practices, it does not include a discharge domain. Additional items ask about social support, pest control, building maintenance, and rent payments. The wording in the survey also reflects language used in supportive housing services.

There are minor changes to the sociodemographic items in this version of the OPOC-MHA. It includes items on income and income support and on the length of time respondents have been in their current housing situation.

FAQs about the OPOC-MHA for Supportive Housing

1. Tenants are receiving services from multiple programs at our agency. Which of the services should they consider when answering the questionnaire?

We recommend that whenever possible you ask your tenants to complete separate OPOC-MHA questionnaires for each program. If this is not feasible, you can combine programs on one survey. For instance, when the same staff members work with a tenant across multiple programs, it can be problematic for the tenant to try to separate these services on the OPOC-MHA. It is important to communicate to tenants the scope of services for which they are answering the questions on the OPOC-MHA for Supportive Housing.

2. Our respondents have third-party landlords. How do we handle this situation when implementing the questionnaire?

In this case, review the questionnaire first to determine which questions apply to your organization's services and which to services provided by the third-party landlord(s). In general, Items 10, 16, and 25 to 30 often apply to third-party landlords. However, your situation may be different. Although you may not have direct control over the landlord's services, the information you gather from these items can still inform your QI efforts.

Once you have determined which questions apply to the landlord and which to your organization, explain this clearly to your respondents.

3. Why is a question on transitional housing (i.e., item 11) included in the survey?

During the development of the survey, stakeholders recommended that an item should be included on transitional housing to capture the full range of housing supports available at some organizations.

4. What is meant by Item 7, *I am offered opportunities to become involved with others (e.g. join social groups or become involved in special projects)*?

This item measures the extent to which a respondent experiences social isolation or exclusion. It is included because many supportive housing providers are interested in reducing isolation or exclusion among tenants. This item can refer either to opportunities offered within your agency or, more generally, to opportunities provided in the broader community. If your organization does not offer this type of programming, you can ask respondents to consider only opportunities in the broader community when answering the item.

OPOC-MHA for Crisis

Highlights about the version

Who is this for?

The OPOC-MHA for Crisis is for clients of crisis services or single-session services. Although not specifically designed for the purpose, it can also be used in Rapid Access Addiction Medicine (RAAM) clinics or crisis bed programs.

What does it include?

This version contains 19 items related to the following six quality domains:

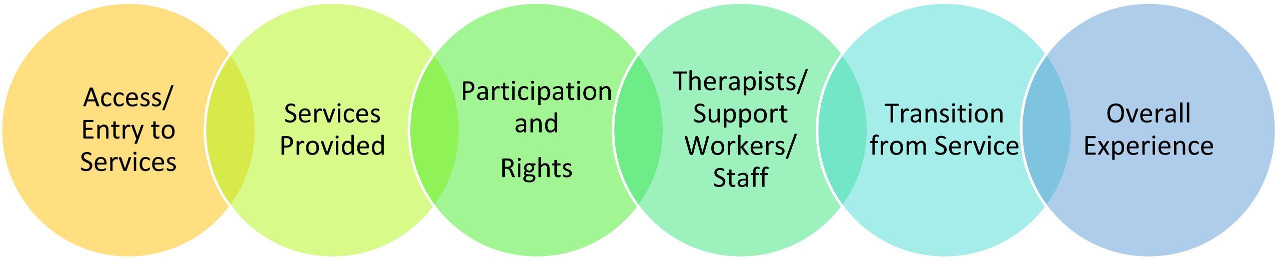


Figure 18

The tool also has space for clients to provide open-ended comments.

What languages are available?

This version is only available in English, French, Arabic, and Somali.

How is this version different?

The OPOC-MHA for Crisis is substantially shorter than the OPOC-MHA for Registered Clients. It does not include the environment and discharge domains but does have one additional domain – *Transition from Crisis Service*. The demographic section also asks about the type of crisis service the respondent accessed and how the service was delivered, such as online, by phone, or in person. This version takes only 5 – 10 minute to complete.

Are there differences in implementing this version?

Given the unique and sensitive nature of crisis services, we recommend that you reflect on and develop a separate plan for administering this version. Organizations administering this version have found that at times respondents become upset when thinking through some of the questions on the survey. This has been more common when the survey has been administered over the phone in response to phone-based crisis services. These reactions may occur because respondents may still be in a vulnerable state and because, when respondents think about the crisis services they received, they might be cued to other thoughts and emotions about their situation.

Some organizations have found that, when they increase the time between when a respondent completes service and when they receive the OPOC-MHA for Crisis, the respondent is less triggered by the questions. For instance, one organization administered the survey over the phone approximately one month after the respondent's interaction with their crisis service and, by doing so, they increased their response rate and reduced the chance that the respondent was still in a state of crisis. This approach also allowed individuals to have sufficient time to reflect on their experience with the service before completing the survey.

Regardless of when you administer the tool, it is important to put in place additional procedures to maintain the psychological safety of respondents and to have mental health resources available in the event a respondent needs them. We also recommend that you provide additional training to the people facilitating the survey on how to handle potential reactions of respondents.

FAQs about the OPOC-MHA for Crisis

1. A client is in a state of crisis. Should I administer the survey?

This version should not be administered while a respondent is in crisis. The respondent's safety is a higher priority. Instead, the survey can be offered later when your client is no longer in crisis and is more able to respond. Waiting to administer the survey also gives your client more time to reflect on their experience with your service. When you do administer the survey, we recommend that you have a survey facilitator available in case the client has questions or becomes upset.

2. Are there clients for whom this version is not appropriate?

As mentioned, the OPOC-MHA for Crisis should not be administered while a person is still in crisis. Although this version can be used in mobile crisis programs that have partnerships with the police, it may not be suitable or feasible to do so if a high proportion of these individuals are apprehended. It may also be difficult to implement in single-visit crisis drop-in programs or crisis programs with limited follow-up contact with clients: in this case, you may not have contact with clients when they are no longer in crisis. However, prior to administering the tool, you should develop clear inclusion and exclusion criteria so that staff are not arbitrarily deciding who is eligible to complete the survey.

3. How often should I administer the OPOC-MHA for Crisis at my organization?

The OPOC-MHA for Crisis can be administered at any point in an individual's treatment or support, as long as the respondent is no longer in crisis. Because a client's interaction with a crisis service is typically brief, organizations have found that they can improve response rates by administering the survey at the point when a client completes service or afterwards.

Providing the survey after a client has completed service has two primary benefits. First, the respondent is able to reflect on the full course of the crisis service they received, including the process of transitioning on from the service. As a result, you may receive less *not applicable* responses. Second, respondents are less likely to still be in crisis. One drawback is that, if you solicit feedback only when respondents successfully or purposefully complete your service, you omit information from clients who do not reach this stage.

Appendix 1: Introductory scripts

This appendix includes sample scripts for each version of the OPOC-MHA. The scripts can be used when you introduce the OPOC-MHA to individuals in-person or, with minor adjustments, for phone or video interviewing. If it is not feasible to introduce the tool verbally, ensure you provide the OPOC key to your survey respondents – as a hard copy or electronically – as this page contains important introductory details.

OPOC-MHA for Registered Clients

As part of your participation in (name of program) here at (name of provider), we 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. Please do not use any names or identifying information in the responses. Anything you would like to tell us will be used only for the purpose of making the quality of care better for our clients. We want to continue to improve our care here every day and your experience will help us do that.

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.

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

Do you need any assistance to complete the survey? 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. We let our clients know about the results of the survey and improvements being made by _______. I will provide you with an information sheet to read over, but do you have any questions before you begin?

*Please inform clients if the residential/inpatient section or other specific questions do not apply.

OPOC-MHA for Non-Registered Clients

As part of your participation in (name of program) here at (name of provider), we 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 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 17 questions related to the program, followed by 12 questions about you. It takes most people between 10 and 15 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.

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.

Do you need any assistance in completing the survey? 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. We let our clients know about the results of the survey and improvements being made by __________. I will provide you with an information sheet to read over, but do you have any questions before you begin?

OPOC-MHA for Caregivers

As a caregiver or family member of someone participating in (name of program) here at (name of provider), we 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 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.

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.

Do you need any assistance in completing the survey? 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. We let our clients know about the results of the survey and improvements being made by ____________. I will provide you with an information sheet to read over, but do you have any questions before you begin?

*Please inform clients if the residential/inpatient section or other specific questions do not apply.

OPOC-MHA for Supportive Housing

As part of your participation in (name of service) here at (name of provider), we value your opinion regarding 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 tenant records. Anything you would like to tell us will be used only for the purpose of making the quality of services better here for our residents. We want to continue to improve our services here every day and sharing your experience will help us do that. Please do not use any names or identifying information in the responses.

There are 38 questions related to your experience with our housing support services and about housing itself, 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.

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

Do you need any assistance in completing the survey? 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. We let our clients know about the results of the survey and improvements being made by ______________. I will provide you with an information sheet to read over, but do you have any questions before you begin?

OPOC-MHA for Crisis

As part of your participation in (name of program) here at (name of provider), we very much value your opinion. We would appreciate it if you would be willing to tell us about your experiences with us 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 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 service here every day and your experience will help us do that. To maintain your confidentiality, please do not use any names or identifying information in your responses.

There are 19 questions related to the service, followed by 7 questions about you. It takes most people between 5 and 10 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.

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.

Do you need any assistance in completing the survey? 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. We let our clients know about the results of the survey and improvements being made by ________. I will provide you with an information sheet to read over, but do you have any questions before you begin?

Appendix 2: Mapping of the OPOC-MHA onto quality improvement indicators

The tables in this appendix map questions from the different OPOC-MHA versions onto the Institute of Medicine's (IOM) six aims, or domains, of health care quality. These six domains are: safety; effectiveness; patient-centeredness; timeliness; efficiency; and equity.[7]

The mappings in the tables below are only examples, and other questions may apply. Additionally, some questions may overlap across multiple domains, which is why administering the full version of the tool still reflects the most comprehensive way of measuring client experience.

These mappings reflect PSSP's suggested alignment between these quality domains and specific items. They have not been formally endorsed by system planners for specific reporting purposes. However, they may be helpful if your organization, program, or QI project is interested in measuring a specific quality domain.

OPOC-MHA for Registered Clients

Quality of Care Domain	OPOC-MHA Registered Version Questions
Patient-centredness	12. I was involved as much as I wanted to be in decisions about my treatment services and supports. 18. I was treated with respect by program staff. 21. Staff understood and responded to my needs and concerns. 27. Staff helped me develop a plan for when I finish the program/ treatment.
Timeliness and Access to Care	1. The wait time for services was reasonable for me. 2. When I first started looking for help, services were available at times that were good for me. 3. The location of services was convenient for me. 4. I was seen on time when I had appointments.

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[7] Institute of Medicine. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press. https://doi.org/10.17226/10027.

Equity	19. Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, and race). 22. Overall, I found the facility welcoming, non-discriminating, and comfortable (e.g., entrance, waiting room, décor, posters, and my room if applicable). 26. The program accommodated my needs related to mobility, hearing, vision, and learning, etc. 38. My special dietary needs were met (e.g., diabetic, halal, vegetarian, kosher). We also recommend using the reporting portal filters, based on the sociodemographic questions embedded in the tool, to compare results for different population groups.
Efficiency	9. Responses to my crises or urgent needs were provided when needed. 11. I was referred or had access to other services when needed, including alternative approaches (e.g., exercise, meditation, culturally appropriate approaches). 21. Staff understood and responded to my needs and concerns. 29. Staff helped me identify where to get support after I finish the program/treatment.
Effectiveness	30. The services I have received have helped me deal more effectively with my life's challenges. 31. I think the services provided here are of high quality. 32. If a friend were in need of similar help I would recommend this service.
Safety	10. I received clear information about my medication (i.e., side effects, purpose, etc.) 16. If I had a serious concern, I would know how to make a formal complaint to this organization. 25. I felt safe in the facility at all times.

OPOC-MHA for Non-Registered Clients

Quality of Care Domain	OPOC-MHA Non-Registered Version Questions
Patient-centredness	9. I was treated with respect by program staff. 11. Staff understood and responded to my needs and concerns.
Timeliness and Access to Care	1. When I first started looking for help, services were available at times that were good for me. 2. The location of services was convenient for me.
Equity	10. Staff were sensitive to my cultural needs (e.g., religion, language, ethnic background, and race). 12. Overall, I found the facility welcoming, non-discriminating, and comfortable (e.g., entrance, waiting room, décor, posters). 16. The program accommodated my needs related to mobility, hearing, vision, and learning, etc. We also recommend using the reporting portal filters, based on the sociodemographic questions embedded in the tool, to compare results for different population groups.
Efficiency	5. Responses to my crises or urgent needs were provided when needed. 6. I was referred or had access to other services when needed, including alternative approaches (e.g., exercise, meditation, culturally appropriate approaches).
Effectiveness	17. I think the services provided here are of high quality.
Safety	7. If I had a serious concern, I would know how to make a formal complaint to this organization. 15. I felt safe in the facility at all times.

OPOC-MHA for Caregivers

Quality of Care Domain	OPOC-MHA Caregiver Version Questions
Patient-centredness	4. I was included in decisions made about my loved one's treatment. 7. Staff understood and responded to my needs and concerns. 9. My input was welcomed when staff made referrals for my loved one, including to alternative approaches (e.g., exercise, meditation, nutrition, culturally appropriate approaches). 25. Staff treated my loved one with respect.
Timeliness and Access to Care	14. Staff provided me with adequate information about what to do in case my loved one has a relapse or crisis. 21. The wait time for services was reasonable for my loved one.
Equity	27. Staff were sensitive to my loved one's cultural needs (e.g., religion, language, ethnic background, and race). 38. My loved one's special dietary needs were met (e.g., diabetic, halal, vegetarian, kosher). We also recommend using the reporting portal filters, based on the sociodemographic questions embedded in the tool, to compare results for different population groups.
Efficiency	6. Services were provided at a time that was convenient for me. 18. Responses to my crises or urgent needs were provided when needed.
Effectiveness	23. My loved one received adequate services to learn to cope with their mental illness and/or addiction. 30. The services and supports my loved one received helped them deal more effectively with the challenges in their life. 31. I think the services or supports provided here are of high quality. 32. If a friend were in need of similar services or supports, I would recommend this service.

	33. The services and supports I have received have helped me deal more effectively with the challenges experienced by my loved one.
Safety	8. If I had a serious concern, I would know how to make a formal complaint to the organization. 11. The discharge planning process took into account my safety. 20. I felt the facility was safe. 29. The discharge planning process took into account the safety of my loved one.

OPOC-MHA for Supportive Housing

Quality of Care Domain	OPOC-MHA Supportive Housing Version
Patient-centredness	12. Opportunities are provided to give input into my housing. 20. Staff support me in achieving my goals. 24. I am treated with respect by staff.
Timeliness and Access to Care	1. When I first needed help with housing, choices were available that were a good fit for me. 2. The wait time for accessing housing choices was reasonable to me.
Equity	22. Staff are sensitive to my cultural needs (e.g. language, ethnic background, and race). 27. My needs related to mobility, hearing, vision, learning, etc., are accommodated. We also recommend using the reporting portal filters, based on the sociodemographic questions embedded in the tool, to compare results for different population groups.
Efficiency	5. I receive enough information about the services and supports available to me through this housing provider. 9. Responses to crises or my urgent needs are provided when needed. 10. Issues related to my rent payments or lease are addressed quickly.

Effectiveness	34. The services and supports I receive help me deal more effectively with my life's challenges. 35. I think the services and supports provided here are of high quality. 36. If a friend were in need of similar help I would recommend this service. 38. My living situation is contributing to my overall well-being.
Safety	15. If I had a serious concern, I would know how to make a formal complaint or request. 31. Someone would notice if I was away an unusually long time (e.g. other tenants, staff, family, or landlord). 32. Staff are responsive to my concerns about safety. 33. Overall, I feel safe and comfortable in my home.

OPOC-MHA for Crisis

Quality of Care Domain	OPOC-MHA Crisis Version Questions
Patient-centredness	3. Staff and I agreed on my support plan. 13. I was treated with respect by program staff.
Timeliness and Access to Care	1. When I first started looking for help, I was able to access crisis services that were a good fit for me. 2. The method of accessing services was easy for me (e.g., text, phone, in person).
Equity	5. Overall, I found the service welcoming and non-discriminating. 8. My needs related to mobility, hearing, vision, and learning, etc. were accommodated. 14. Staff were sensitive to my culture and identity (e.g., religion, ethnic background, race, gender, sexual orientation). We also recommend using the reporting portal filters, based on the sociodemographic questions embedded in the tool, to compare results for different population groups.

Efficiency	4. Responses to my crises or urgent needs were provided when needed. 15. I received enough information about the programs and services available to me. 16. Staff helped me connect to ongoing supports and services.
Effectiveness	17. The services I have received have helped me deal more effectively with my current challenges. 18. I think the services provided here are of high quality. 19. I would come back to this service if in need of similar help.
Safety	7. I felt safe while receiving services that were being provided. 11. If I had a serious concern, I would know how to make a formal complaint or request.

Summary table of the mappings

The numbers in the cells below refer to the question number from the corresponding version of the OPOC survey.

Domain	Registered	Non-Registered	Caregiver	Supportive Housing	Crisis
Patient-centredness	12, 18, 21, 27	9, 11	4, 7, 9, 25	12, 20, 24	3, 13
Timeliness and Access to Care	1-4	1-2	14, 21	1-2	1-2
Equity	19, 22, 26, 38	10, 12, 16	27, 38	22, 27	5, 8, 14
	Subgroup analysis according to sociodemographic questions				
Efficiency	9, 11, 21, 29	5-6	6, 18	5, 9, 10	4, 15-16
Effectiveness	30-32	17	23, 30-33	34-36, 38	17-19
Safety	10, 16, 25	7, 15	8, 11, 20, 29	15, 31-33	7, 11

Appendix 3: Additional resources

For more information, please visit the following web sites:

- OPOC Project Home Page: http://improvingsystems.ca/projects/ontario-perception-of-care
- OPOC Orientation Video: https://vimeo.com/783724982
- About CAMH's Provincial System Support Program: http://improvingsystems.ca/about
- More on Quality Improvement: http://www.hqontario.ca/quality-improvement
- The Excellence through Quality Improvement Project: http://www.e-qip.ca