



Wisconsin  
Department of Health Services

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

# Community Support Program 2012 Annual Program Survey

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Report of 2012 CSP Services and Practices

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## EXECUTIVE SUMMARY

The Division of Mental Health and Substance Abuse Services (DMHSAS) conducts an annual survey of all Community Support Programs (CSPs) across the state to support evaluation activities and meet both federal Community Mental Health Services Block Grant reporting requirements and state requirements, pursuant to Wis. Stat. § 51.03(3)(a)5. The survey asks about current program enrollment, consumer demographics, consumer medical conditions and substance use, use of Evidence-Based Practices (EBPs), use of waiting lists for CSP services, and use of consumer satisfaction measures for the participants served in a calendar year. In 2012, there were 74 DHS 63-certified CSPs across the state, 73 of which (99%) responded to the survey.

The number of reported consumers served in 2012 (5,928 consumers) was slightly higher than in recent years, yet still in line with the historical trends of CSPs serving approximately 6,000 consumers per year. African-Americans were over-represented in the CSP population (27% vs. 6.5% of Wisconsin's population), while Latinos and Hispanics were under-represented (3.5% vs. 6.2% of the general population). Most programs (71%) did not have to use a waitlist, and those that did generally reported that their system offered services to consumers during their waiting period. The average time a consumer had to wait for CSP services in 2012 was 5.5 months.

Eleven percent of consumers were discharged during 2012, and the most common reason for discharge (25%) was that consumers had made strides to the point where CSP-level services were no longer needed. Of those consumers who did step down their services, the vast majority went on to outpatient services or targeted case management, rather than other integrated programs such as Comprehensive Community Services (CCS).

The survey returned mixed results on consumers' health care needs. On the one hand, a sizeable proportion of consumers (100 individuals, or 15% of those listed as "discharged") died in 2012. While it is difficult to interpret this figure from the available data, this rate may indicate that more could be done to safeguard the health of this potentially fragile population. On the other hand, reported rates of various physical health ailments were lower than expected and generally below the prevalence in the U.S. population, perhaps because CSP consumers were younger than the general population (with fewer health issues typically associated with aging). By contrast, rates of substance abuse were higher than the general population, which was expected.

With regard to services offered, most CSPs (78%) follow at least one EBP. Surprisingly, only about two-thirds of the programs (63%) reported using Assertive Community Treatment (ACT)—the model upon which CSPs were originally developed. Respondents noted that the intensive staff-to-consumer ratios stipulated in ACT were a barrier given staffing shortages. EBPs were offered at slightly higher rates to male consumers, but no disparities were evident along racial lines. Most programs that used EBPs reported that their staff had been specifically trained in that practice, and many programs utilized standard toolkits to implement EBPs, although very few monitored for fidelity.

Lastly, four out of five programs (80%) reported that they used some form of consumer satisfaction survey. No standardized instrument is prescribed, and many programs use their own internal instrument to gauge a consumer's satisfaction with services. Data on consumers' reported satisfaction level was not included in this survey.

## **INTRODUCTION**

This report is based on the results of the annual Community Support Program (CSP) survey. Surveys are provided to all CSP programs at the beginning of a new calendar year. In 2012, there were 74 active CSP programs, 73 of which (99%) completed the survey.

The survey is intended to capture the following areas:

- Program utilization (i.e., number of consumers served, newly enrolled, and discharged)
- Consumer demographics and health status
- Discharge reasons and consumer destinations upon discharge
- Use of Evidence-Based Practices (EBPs)
- Waitlist information

Taken together, these areas help paint a picture of how CSPs are functioning and who they are serving across the state. The survey captures some of the potential challenges that programs face (e.g., handling consumers' co-occurring physical health needs—see Appendix A for a list of Sources for Physical Health Prevalence Rates—or substance abuse issues) as well as the ways that programs engage their consumers on the path to recovery (e.g., through the use of EBPs). While the survey is not exhaustive, it does help, through self-report, draw out some of the strengths and areas for improvement among CSPs at a given point in time. A copy of the survey instrument appears in Appendix B.

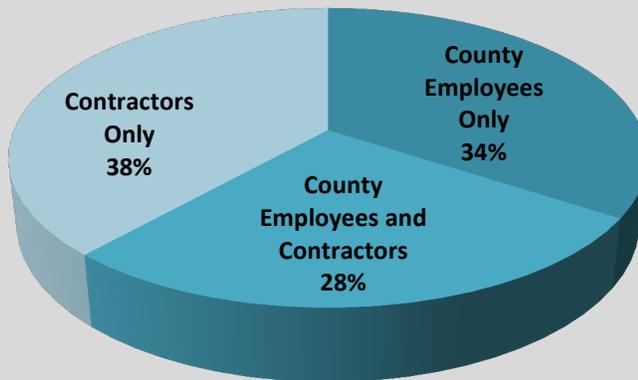
## **PROGRAM STAFFING**

CSP programs may differ in their staff composition. Programs can be staffed in one of three ways:

- Contractors only
- County employees only
- A mix of county employees and contractors

Figure 1 (below) shows that programs are fairly evenly divided between these three categories, with the most frequent configuration being contractors only (38%). This is actually a slight decline from 2011 responses (40% contractors only). Compared with 2011, in 2012 a larger percentage of programs reported that they were staffed by county employees only (19% in 2011 vs. 34% in 2012).

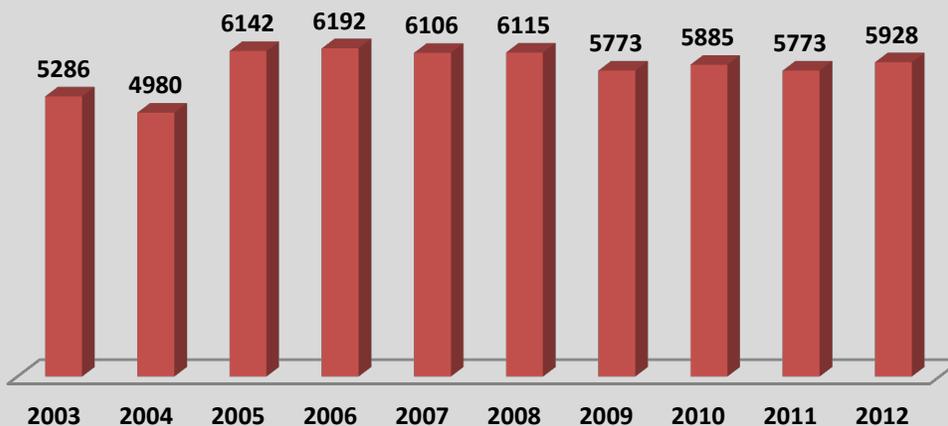
**Figure 1: Staff Composition of CSPs, 2012**



### CONSUMERS SERVED

Figure 2 shows the number of consumers served, based on those programs which responded to the survey. In 2012, 73 programs responded to the survey; up from 72 in 2011. The addition of one other respondent program in 2012 contributed somewhat to the increased numbers of consumers reportedly served, from 5,773 in 2011 to 5,928 in 2012. Both the number of programs and the number of consumers served has remained fairly static in recent years, with CSPs consistently reporting close to 6,000 consumers served.

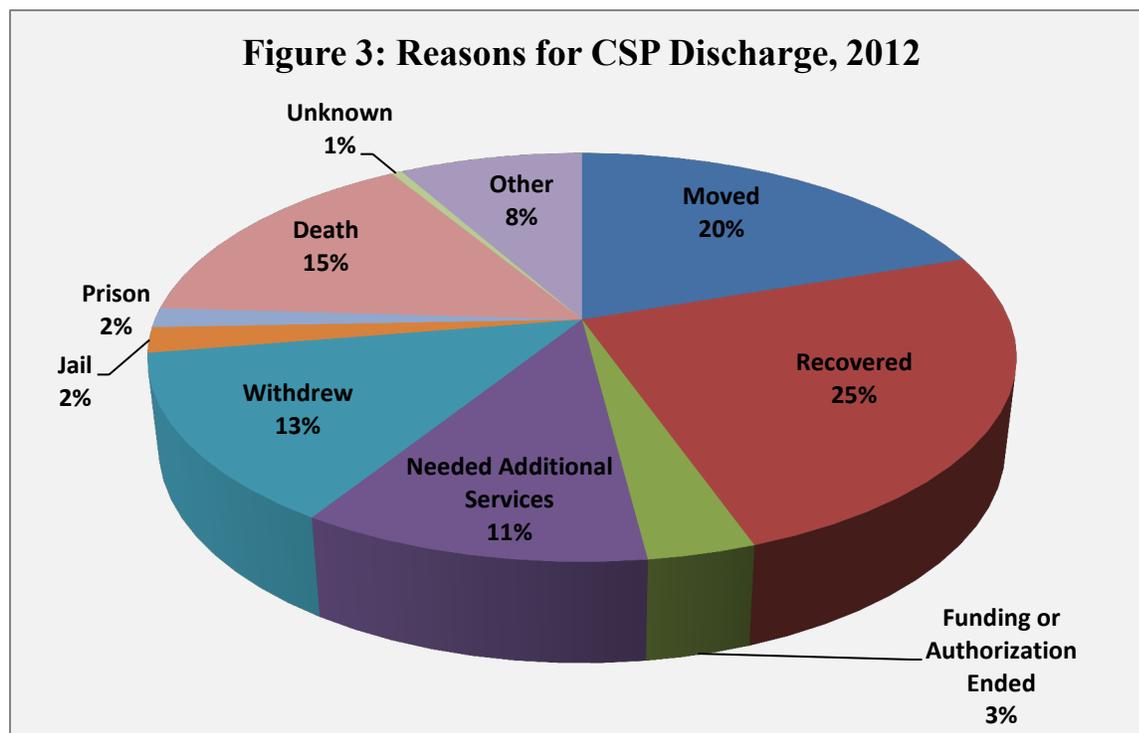
**Figure 2: Consumers Served in CSPs Statewide, 2003-2012**



## DISCHARGE REASONS AND DESTINATIONS

Consumers often spend long periods of time in CSPs, and discharges are relatively infrequent. In 2012, 648 consumers were discharged from CSPs; this constitutes nearly 11% of the total number of consumers served during the same time period. By contrast, a slightly higher number of consumers—697—were newly enrolled into a CSP program during 2012.

Despite the longitudinal infrastructure of CSPs, there are several reasons why a consumer might be discharged. The most common reason, as shown in Figure 3, is that the consumer has reportedly recovered to the extent that he or she no longer needs CSP-level services (25%). The second most common reason for discharge is that the consumer moved away from the service area. A substantial percentage of consumers (15% of discharges, or 100 individuals) died during 2012. This is notably higher than the death rate in the less-intensive but demographically similar Comprehensive Community Services (CCS) programs (1%) and is in line with the generally higher mortality rates for those with more severe and persistent mental health disorders;<sup>1</sup> it does not seem to be a function of having a higher percentage of elderly consumers (see section on Consumer Age, below). Somewhat surprising for a CSP, 11% of those who withdrew needed more intensive services than could be provided by the program. The insufficiency of CSP services for some clients is a matter of concern and warrants further understanding. For example, if a consumer's physical health needs necessitated placement in a nursing home, were accommodations made to support the consumers' mental health within the nursing home?



<sup>1</sup> Wisconsin Department of Health Services (DHS). "Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey." April 2009.

Table 1 and Figure 4 (below) depict the destinations of consumers who were discharged for various reasons. For instance, consumers who moved were most likely to re-enroll in another CSP (31%), but a substantial proportion also sought out individual types of services such as outpatient therapy or Targeted Case Management (TCM). Unfortunately, 11% of those who moved away from their CSP received no other services; an outcome which may be detrimental for those individuals.

Of those who recovered to the extent that CSP was deemed no longer appropriate or necessary, the majority (52%) moved to outpatient therapy. Although CCS might appear to be a logical placement for these consumers, a mere 8% reported moving in that direction. The percentage enrolling in CCS was even less than the percentage who did not enroll in any subsequent services (9%).

When funding or authorization for CSP enrollment ended, consumers generally either pursued other service options (TCM, outpatient) or moved to residential facilities (i.e., group home or nursing home). Residential facilities were also the primary destinations of those who needed additional services, along with inpatient stays. When consumers decided to withdraw from CSP, they either moved towards outpatient services (52%) or discontinued services altogether (27%). The overarching pattern across all types of discharge is that upon leaving a CSP, most consumers opt for other, less comprehensive types of services, such as TCM or outpatient therapy. They do not, by and large, enroll in CCS programs.

**Table 1: Consumer Destinations by Reasons for Discharge, 2012**

Reason for Discharge	Another CSP	Outpatient Therapy	TCM	CCS	Nursing Home	Group Home	Inpatient	No Other Services	Unknown	Other
Moved	31%	25%	14%	6%	1%	3%	1%	11%	7%	1%
Recovered	0%	52%	29%	8%	0%	1%	0%	9%	0%	1%
Funding or Authorization Ended	0%	19%	24%	0%	10%	24%	0%	5%	14%	5%
Needed Additional Services	0%	0%	0%	0%	17%	45%	20%	0%	3%	15%
Withdrew	1%	52%	3%	0%	0%	1%	0%	27%	10%	6%

Figure 4 (below) helps to display this point graphically. Overall, outpatient therapy tends to be the most common destination for those who are discharged, followed by TCM. Group homes are primary destinations for those who lost funding or needed additional services. The apparent fact that some program participants lose funding or authorization is concerning as well.

**Figure 4: Consumer Destinations by Reasons for Discharge, 2012**

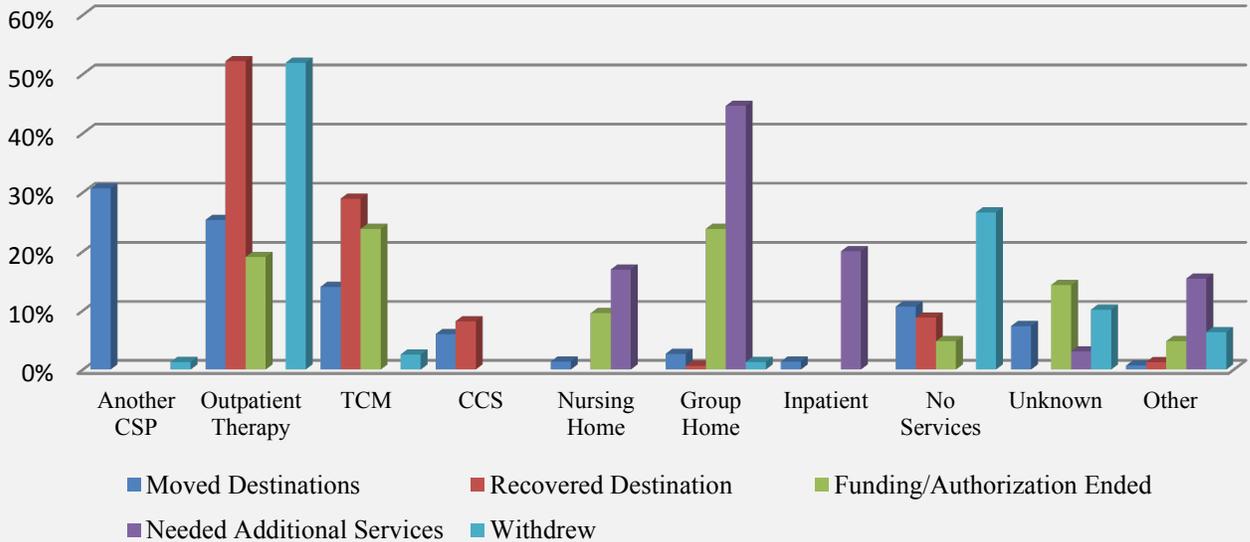
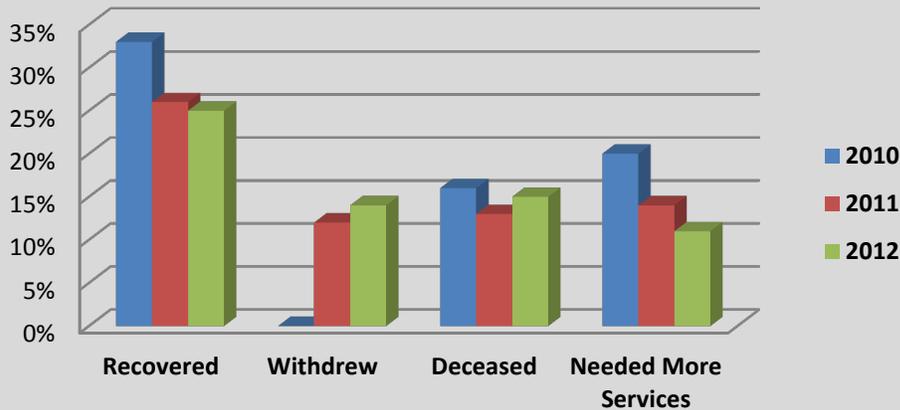


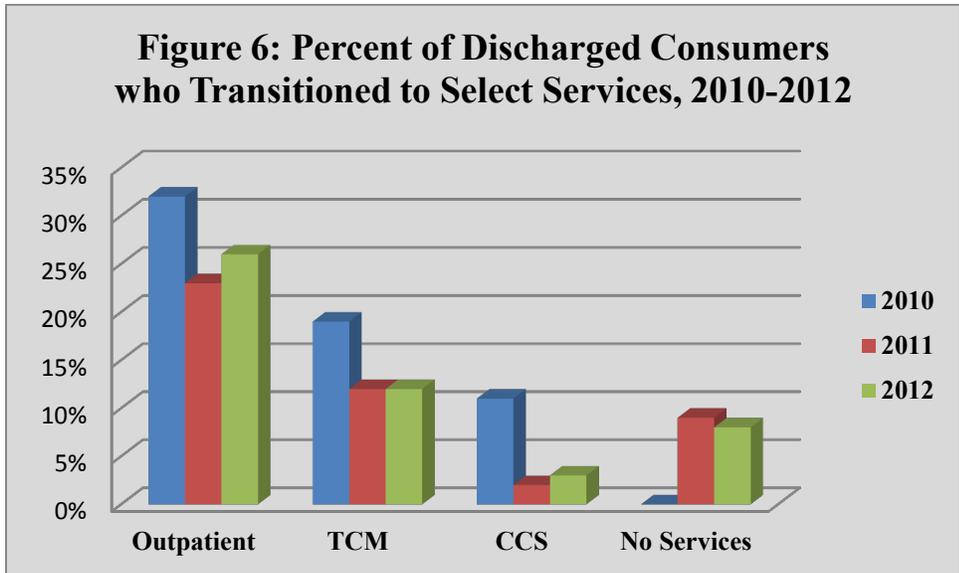
Figure 5 presents a comparison of some of the most pertinent reasons for discharge over the past three years (2010-2012). It shows decreases in the percent of consumers on both ends of the recovery spectrum: both those who withdrew due to improvements in recovery as well as those who needed more intensive services. The percent of consumers who died while in a CSP is down from 2010 levels, but higher than in 2011.<sup>2</sup> The percent of consumers who withdrew voluntarily is up from 2011.<sup>2</sup>

**Figure 5: Percent of Consumers Discharged for Select Reasons, 2010-2012**



<sup>2</sup> The 2010 survey did not ask about the number of consumers who withdrew, so there is no 2010 data for that category.

Figure 6 displays similar trend data for select treatment destinations. The data reveal that outpatient therapy and TCM have, in recent years, been leading destinations for discharged CSP consumers. The percent of discharged consumers going to CCS has been low in recent years and has declined since 2010. For both 2011 and 2012, consumers were more likely to receive no services than to move to CCS.<sup>3</sup>



## CONSUMER DEMOGRAPHICS

CSPs were asked to provide demographic information for all consumers served, including gender, age, race and ethnicity. Respondents were also asked to provide veteran status.

### *Gender*

The gender breakdown of participants was fairly evenly divided between men and women, with 51% of enrollees being male and 48% being female. An additional 1% had no known gender (“unknown”).

### *Age*

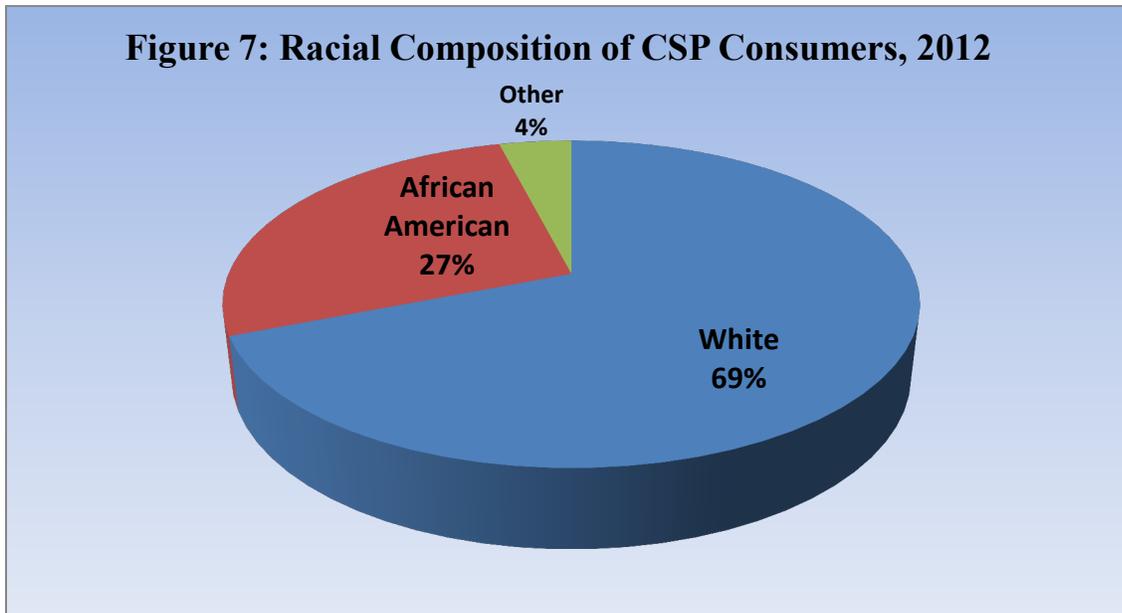
The overwhelming majority of consumers served by CSPs (91%) were between the ages of 21 and 64. Only 2% were under age 21 (including less than 1% ages “17 or under” and less than 2% ages “18-20”). Six percent of consumers were between the ages of 65-74, and 1% were age 75 or older.<sup>4</sup>

<sup>3</sup> The 2010 survey did not ask how many discharged consumers did not receive subsequent services.

<sup>4</sup> To comply with federal Health Insurance Portability and Accountability Act (HIPAA) privacy provisions and minimize the risk of violating client confidentiality, age categories with small numbers of consumers (less than 25) are reported as percentages (reflected as “less than 1%”) rather than raw numbers.

## Race

Programs were asked to provide information on consumers' race. Options for this question were American Indian/Alaskan Native, Asian, Black/African American, Hawaiian/Pacific Islander, White, More than One Race, and Unknown. Unsurprisingly, most of Wisconsin's CSP consumers are White. However, African Americans are approximately 6.5% of Wisconsin's population, but represent more than a quarter (27%) of those served by CSPs. All other racial groups combined make up 4% of CSP consumers.



## Ethnicity

While African Americans are over-represented among CSP consumers (see above), Hispanics and Latinos are slightly under-represented. That ethnic group constitutes approximately 6.2% of Wisconsin's population, but only 3.5% of CSP consumers. The remaining 96.5% are non-Hispanic/Latino.

## Veteran Status

Although veterans make up approximately 7% of the population of Wisconsin,<sup>5</sup> just under 4% of those served in CSPs were veterans. Ninety-five percent were non-veterans, and veteran status was unknown for the remaining 1%. Veterans are under-represented in Wisconsin's broader mental health data system (DHS's Program Participation System (PPS) Mental Health Module) of which CSP is a part. The discrepancy may be due to under-reporting by veterans, to under-use of mental health resources by veterans, or to veterans' use of alternate resources, such as VA hospitals.

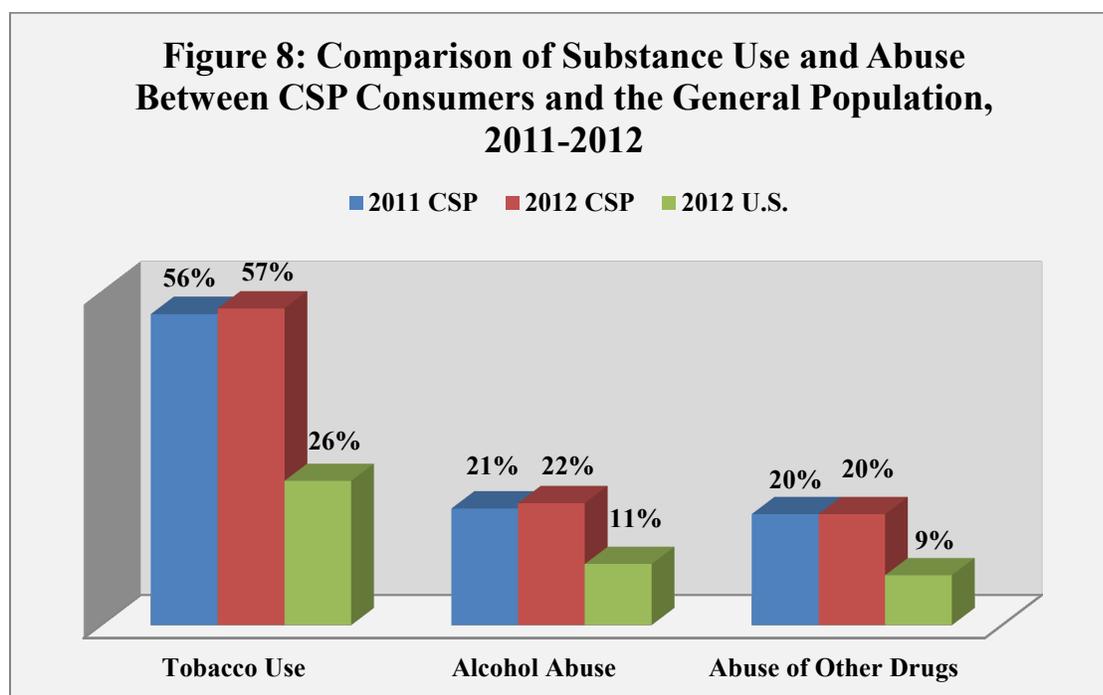
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<sup>5</sup> Statewide estimates of African Americans, Hispanics/Latinos and veterans are based on 2013 estimates from the U.S. Census Bureau, <http://quickfacts.census.gov/qfd/states/55000.html>.

## HEALTH AND SUBSTANCE USE INFORMATION

CSPs were asked to report on the substance abuse patterns and various health issues for all consumers served in 2012. Respondents were directed to mark all categories that applied for each individual, meaning that the same person could be counted across multiple categories of substance abuse or physical health concerns.

With regard to substance use, a majority of CSP consumers (57%) utilized tobacco in 2012. At least one-fifth of consumers also used other drugs (20%) and/or alcohol (22%). These rates were very similar to those reported in 2011 (see Figure 8), but are substantially higher than for the general U.S. population<sup>6</sup> and higher than rates reported by consumers in Wisconsin's CCS programs.<sup>7</sup> These higher substance abuse rates are, however, unsurprising given the presumed severity of mental health diagnoses among CSP consumers, which is known to have high rates of co-occurring substance abuse issues.



Survey respondents were also asked to supply information on a wide array of physical health problems for their consumers. In contrast to the substance abuse questions (above), the CSP programs reported *lower* than expected prevalence rates for most of the reported physical health issues. For instance, reported rates of obesity, high blood pressure, high cholesterol, metabolic syndrome and cardiovascular issues were significantly lower for CSP consumers than for the U.S. population at large. These results are puzzling

<sup>6</sup> SAMHSA, "Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings." [www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#ch4](http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#ch4)

<sup>7</sup> CCS rates in 2012 were as follows: tobacco use 26%; alcohol abuse 12%; abuse of other drugs 11%.

given the documented higher rates of these specific co-occurring physical health problems among individuals with mental health problems.<sup>8</sup>

One possible explanation for these unexpected results is that CSP consumers may actually be healthier (at least by these measures) than the average American. Another (more likely) explanation is that the CSP consumer population is younger (and therefore less likely to have experienced health issues typically associated with aging) than the average U.S. population. Also, CSP programs may not systematically ask consumers about their physical health needs (or in this much detail), so the rates reported for CSP consumers may underestimate their true health problems. If that is the case, the consumers who were reported from each of these health categories may be those with the most pronounced health needs, whose health status was therefore known to CSP staff even without directly asking. Given that CSP programs are tasked with helping consumers advance in all domains of recovery—including physical health—efforts will need to be made to request that programs more systematically record these diagnoses in the clinical record and collect these data more accurately in the future.

## **EVIDENCE-BASED PRACTICES**

A main goal of this survey was to determine the extent to which CSP programs incorporate the use of Evidence-Based Practices (EBPs). Specific practices included on the survey were:

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-Occurring Disorders, or Integrated Dual Disorder Treatment (IDDT)
- Family Psychoeducation
- Illness Management and Recovery (IMR)
- MedTeam
- Supported Employment
- Permanent Supportive Housing

Such practices provide a known and powerful way for CSP programs to enhance consumers' recovery process. However, CSPs are not required to use EBPs; rather, they are provided with information about the SAMHSA Evidence-Based Practices KITS<sup>9</sup> and are encouraged to incorporate such practices.

As can be seen in Figure 9 (below), the vast majority of CSPs (78%) offer at least one EBP. Most programs (61%) offered between one and four EBPs, with the average number of EBPs per program being 2.5 (not shown here). A few programs (17%) offered a wide variety of EBPs, while 22% offered none at all.

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<sup>8</sup> Ziege, Anne and Tim Connor. "Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey." Wisconsin Department of Health Services, Division of Public Health, Bureau of Health Information and Policy, 2009.

<sup>9</sup> SAMHSA Evidence-Based Practices KITS:  
<http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs>

**Figure 9: Number of EBPs that CSP Programs Offer, 2012**

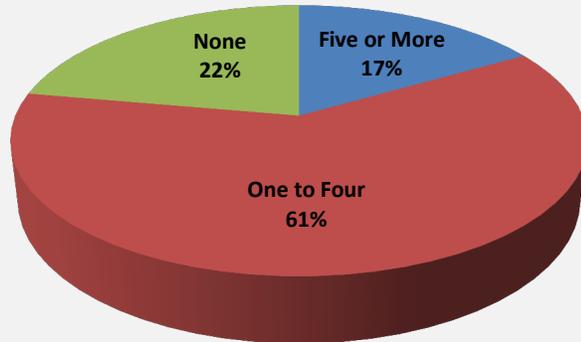
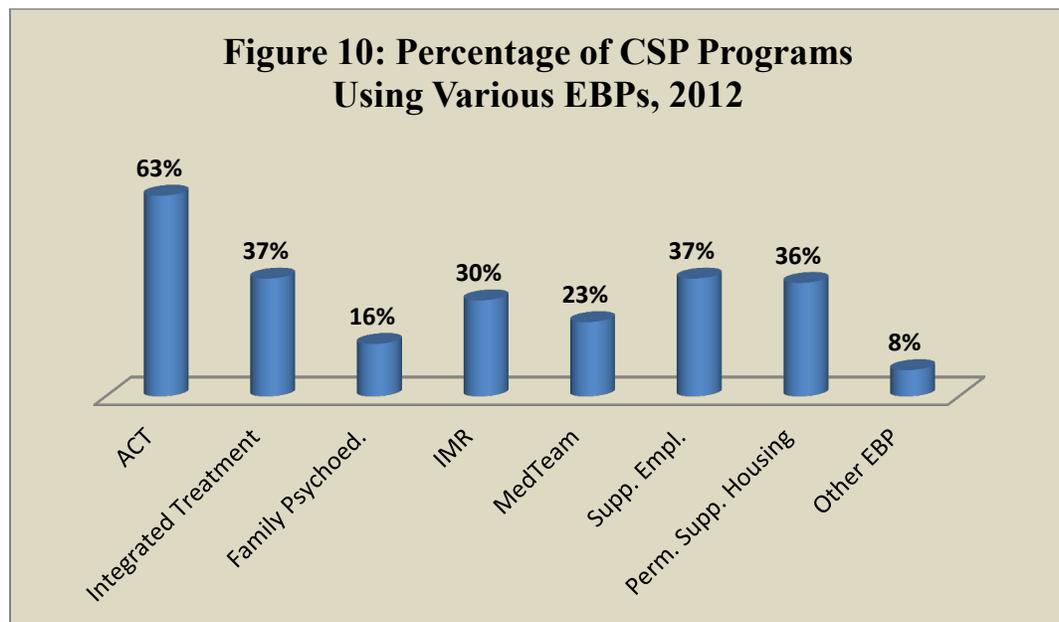


Figure 10 displays the frequency with which programs used each EBP. Two-thirds of all CSPs reported using ACT. Since the CSP model was originally based on a variation of ACT, it is not surprising that ACT would be the leading EBP for CSP programs. Ideally, all CSPs would report using a full-fidelity ACT model, which is much more rigorous than the DHS 63 CSP standards. In their written comments at the end of the survey, many programs noted that their main obstacle to faithfully applying the ACT model was meeting the maximum consumer-to-staff ratio (10:1) that ACT requires. Staffing shortages are thus a significant barrier to meeting this best practice.

**Figure 10: Percentage of CSP Programs Using Various EBPs, 2012**



Integrated Treatment for Co-Occurring Disorders (IDDT), Supported Employment, and Permanent Supported Housing were each offered by over a third of programs, followed by Illness Management and Recovery (IMR) at 30%.

Very few programs (8%) offered any EBPs beyond the list provided in the survey. However, several programs listed a variety of other EBPs (or promising practices) under the “Other” category, shown in Table 2 (below). Five programs provided Motivational Interviewing, four provided Dialectical Behavioral Therapy (DBT), three provided Cognitive Behavioral Therapy (CBT),<sup>10</sup> and one program each reported using Coping Cat for youth,<sup>11</sup> Peer Support, or Wellness Recovery Action Plan (WRAP)<sup>12</sup> planning.

**Table 2: Other Evidence-Based Practices Utilized by CSPs**

Other EBPs/Practices	Number of Programs
Motivational Interviewing	5
Dialectical Behavioral Therapy	4
Cognitive Behavioral Therapy	3
Peer Support	1
WRAP Planning	1
Coping Cat	1

While most CSP programs offered at least one EBP, the percent of consumers served using those EBPs remains fairly low (see Figure 11, below). ACT was the only model offered to more than half of all CSP consumers in 2012 (serving over 60% of all CSP consumers). Between a third and a quarter of CSP consumers received MedTeam and IMR services, but all other models were offered to relatively few consumers.

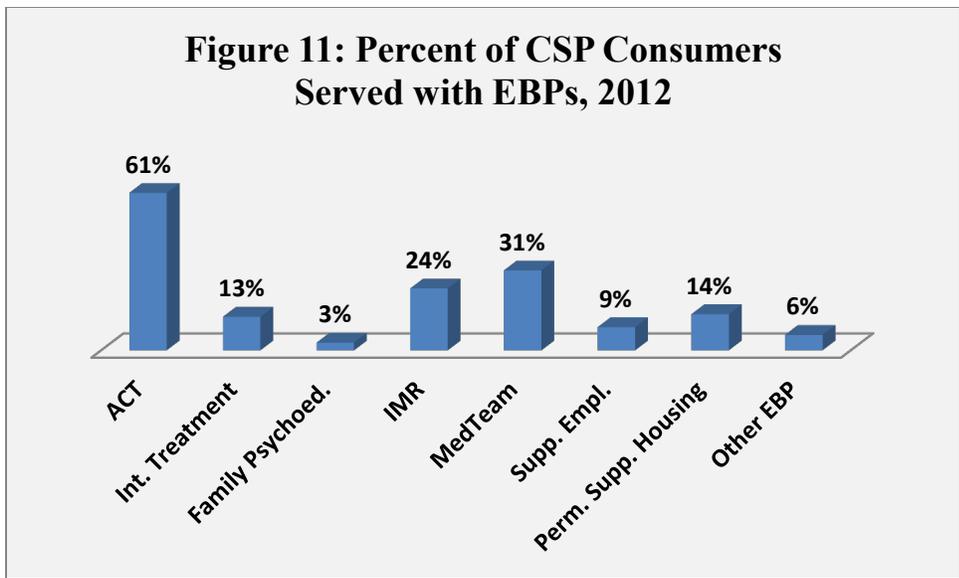
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<sup>10</sup> SAMHSA’s National Registry of Evidence-Based Programs and Practices: DBT.  
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36>

<sup>11</sup> SAMHSA’s National Registry of Evidence-Based Programs and Practices: Coping Cat.  
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=91>

<sup>12</sup> SAMHSA’s National Registry of Evidence-Based Programs and Practices: WRAP Planning.  
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=208>

**Figure 11: Percent of CSP Consumers Served with EBPs, 2012**

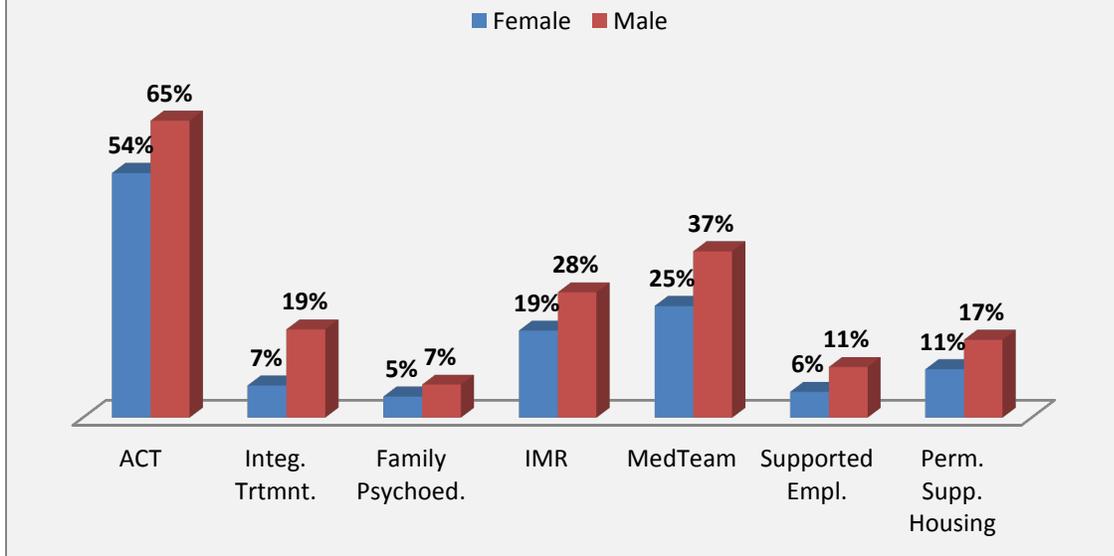


It should be noted that in responding to all of the EBP questions, programs are asked to adhere to the strict definitions of the EBP as laid out in a guiding document. Thus, many CSP programs noted in a final comments section of the survey that they follow many of the guiding principles or practices of a given EBP, but don't strictly qualify as providing that EBP. The main reason given for not meeting the strict definition of an EBP was inadequate staff to consumer ratios for practices such as ACT. For that reason, it can be assumed that more programs utilize some lower-fidelity variant of an EBP than is presented here.

#### *Demographics of Consumers Receiving EBPs*

Part of the survey asked about consumer demographics in relation to EBPs. Figure 12 (below) shows that, across all types of EBPs, male consumers were more likely than female consumers to receive an EBP. It is possible that there are underlying reasons for this disparity, such as greater diagnostic severity on average among males. However, given that all CSP consumers would presumably benefit from greater use of EBPs, it is worthwhile for programs to re-examine whether or not all consumers are being offered equal access to all available EBPs.

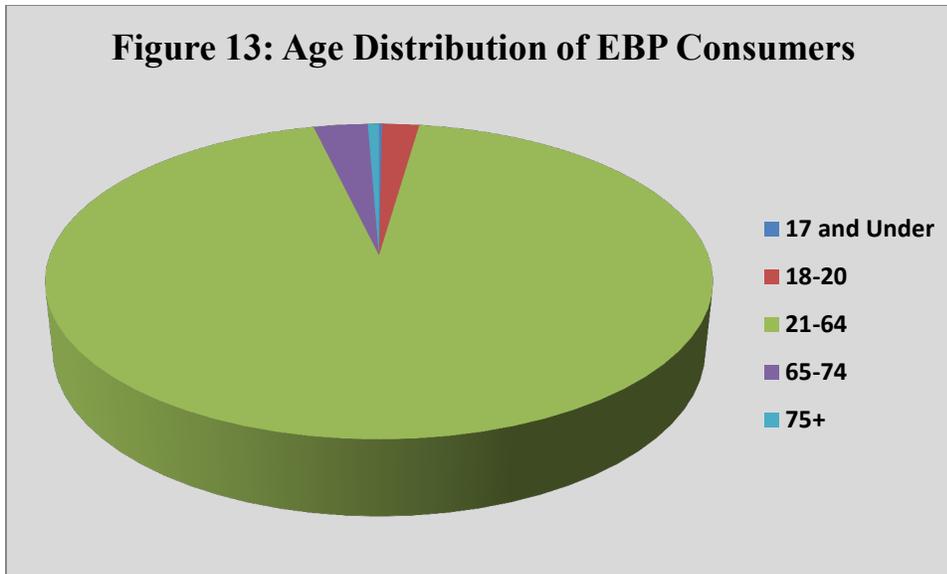
**Figure 12: Percent of Males vs. Females Who Received Each EBP**



Respondents were asked to report on the age category of consumers who received each type of EBP. Given that the same consumer may have received multiple EBPs, the same person might be counted more than once. Thus, Figure 13 (below) shows the breakdown of EBPs as the percentage of times an EBP was offered to a person within a given age category. The overwhelming majority of EBPs (94%) were offered to individuals between the ages of 21-64. This was slightly higher than the representation of this age group within CSPs in general (91%). The age group that was under-represented included individuals age 65-74, who made up 6% of all CSP consumers, but only 3% of those receiving EBPs. The other age groups received EBPs in proportion to their enrollment figures.<sup>13</sup>

<sup>13</sup> Fewer than 25 consumers age 17 and under received EBP services. Due to their small numbers, the percent served in this age category is reflected as “less than 1%” of all consumers.

**Figure 13: Age Distribution of EBP Consumers**



The most common EBP across all age groups was ACT, provided to adolescents age 17 and under (less than 1% of consumers receiving EBPs) as well as senior consumers aged 75 or older (28 consumers). The next highest EBP offered to those in less-represented age groups (including consumers age 75 or older) was Permanent Supportive Housing.

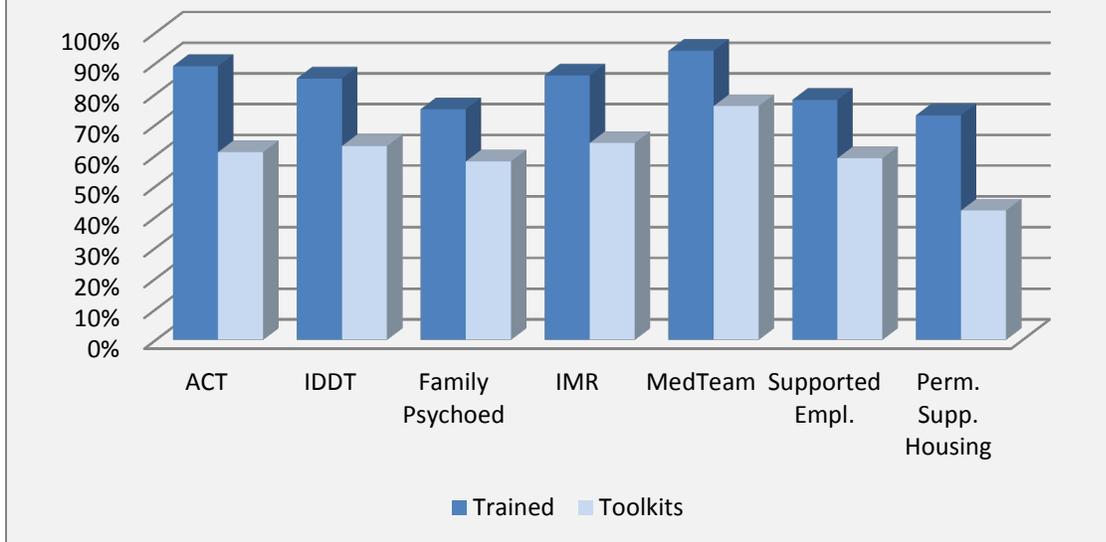
The racial composition of those receiving EBPs exactly matched the profile of the CSP consumer base, with 67% of those receiving EBPs being White, 27% being African American or Black, and 4% from any other racial category. The ethnic breakdown of those receiving EBPs also closely matched the ethnic breakdown of enrollees, with Hispanics/Latinos representing 3.5% of all CSP consumers and 4% of those receiving EBPs.

### *EBP Training and Monitoring*

The survey included a series of questions asking each program whether or not their staff were trained in particular EBPs, and whether or not the program utilized a toolkit to guide implementation. The questions asked whether:

- Staff had training in that EBP
- Programs used the EBP toolkits in implementation
- Programs monitored fidelity
- Assuming programs monitored fidelity, whether they used an outside monitor

**Figure 14: Percent of Programs Offering EBPs that Trained Staff or Used a Toolkit**



As can be seen in Figure 14, programs that offered EBPs were quite likely to have staff who were specifically trained in that EBP (73%-93%). Programs that utilized MedTeam were most likely to have staff trained to administer it, whereas programs utilizing Permanent Supportive Housing were the least likely to have staff trained in this area. Across all EBPs, fewer programs reported using toolkits to guide implementation (42%-76%).

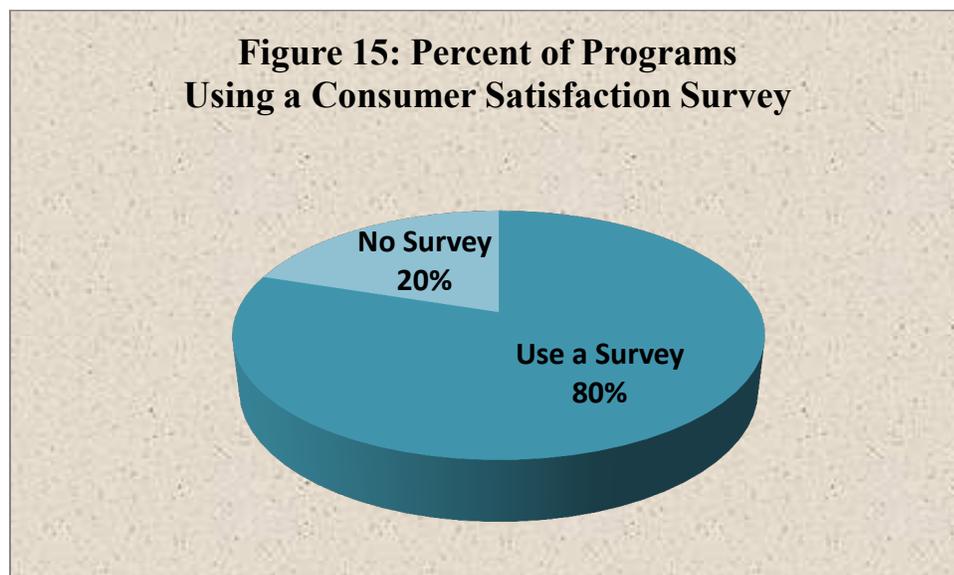
As can be seen in Table 3, relatively few programs monitored fidelity of their EBPs (which is the only way to know if EBPs are actually being delivered). The most heavily monitored EBP was Integrated Treatment for Co-Occurring Disorders (IDDT) at 44%. Similarly, no more than a quarter of programs utilizing EBPs turned to an outside monitor to help assess fidelity (7%-26%).

**Table 3: Fidelity Monitoring Practices among Programs Offering Each EBP**

EBP	Number of CSPs Offering This EBP	Percent of CSPs offering this EBP who Monitored Fidelity	Percent of CSPs offering this EBP who Used an Outside Monitor
ACT	46	43%	7%
IDDT	27	44%	22%
Family Psychoeducation	12	25%	8%
IMR	22	36%	9%
MedTeam	17	35%	18%
Supported Empl.	27	41%	26%
Perm. Supp. Housing	26	27%	8%

## CONSUMER SATISFACTION SURVEYS

Measuring consumer satisfaction is an important part of quality assurance for any program. CSPs are not provided with any standard consumer satisfaction tool, but are encouraged to offer some form of satisfaction survey. Four out of five CSPs report using some form of consumer satisfaction survey.



Thirty-four percent of programs that utilized a survey (20 programs in total) reported using the Recovery-Oriented Systems Inventory (ROSI). Only two programs reported using the instrument in their Evidence-Based Practice toolkit, while most of the programs reported using a survey developed by their own or another local agency or county. A few reported using other standard instruments, such as a National Alliance on Mental Illness (NAMI) survey or the national Mental Health Statistical Improvement Project (MHSIP) survey, as provided by Milwaukee's Vital Voices.<sup>14</sup>

## WAITLISTS

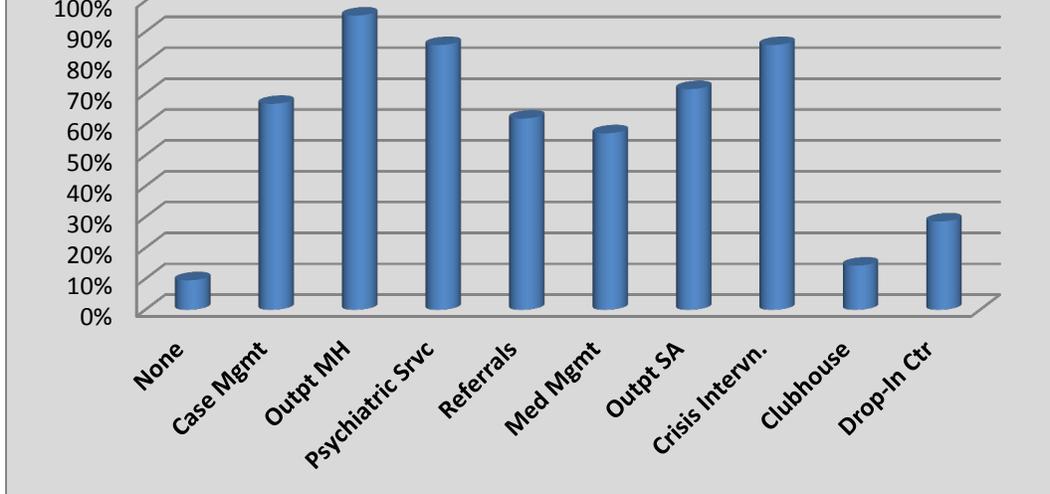
Programs were asked if they had to use a waitlist during the reporting period. Most programs did not report any need to utilize a waitlist. Approximately 29% of programs did report the use of a waitlist, and they reported a total of 196 existing consumers and 233 new consumers had to wait for services in 2012. Of programs that used waitlists, the average number of consumers placed on the waitlist per program during 2012 was 5. The average wait was 5.5 months, with wait times varying from one month in several places to 18 months in one county.

Of those programs that maintained waitlists (n=21), the vast majority offered services to consumers during their wait. The most common services were outpatient mental health services (20 programs, or 95% of relevant programs), Psychiatric Services (86%) and Crisis Intervention Services (86%). Other services listed included case management, referrals, medication management, outpatient substance abuse treatment, clubhouses, and drop-in centers. Only two programs reported that no services were offered to those on the waitlist.

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<sup>14</sup> <http://www.vital-voices.org/services/>.

**Figure 16: Services Offered To Consumers on the Waitlist (By % of Relevant Programs)**



## CONCLUSION

Although more information would be needed to perform a detailed evaluation of CSPs, several points emerge from the 2012 CSP survey. First, most CSPs appear to have embraced the concept of at least one EBP as part of their program, and programs claim that the majority of CSP consumers are receiving services according to EBPs. The fact that recovery is the primary reason for consumer discharge is encouraging, as is the fact that a high percentage of African Americans are receiving these services.

Looking forward, it will be important for those programs that have not yet begun utilizing EBPs to move towards incorporating them into their programs. Likewise external monitoring and evaluation of EBPs to assess fidelity to the practice will be critical. Moreover, given the apparently high death rates in CSPs—and the known high mortality rates of persons with serious and persistent mental illness—it is important for programs to conduct and record a comprehensive assessment of consumers’ physical health needs in order to assure proper medical treatment. Lastly, CSP programs may want to develop stronger linkages with their local CCS programs to help discharged consumers connect with that program, where appropriate. In addition, CSPs should more assertively assist consumers who move or withdraw to connect with other services before discharge.

## APPENDIX A: Sources for Physical Health Prevalence Rates

**Asthma:** Asthma and Allergy Foundation of America, “Asthma Facts and Figures”  
<http://www.aafa.org/display.cfm?id=9&sub=42>.

**Cardiovascular Problems:** Centers for Disease Control, “FastStats: Heart Disease”,  
<http://www.cdc.gov/nchs/fastats/heart.htm>.

**Chronic Obstructive Pulmonary Disease (COPD):** Centers for Disease Control, “CDC Features: 6.3% of Adults Report Having COPD”, <http://www.cdc.gov/Features/copdadults/index.html>.

**Diabetes, Type I:** National Diabetes Education Program. “The Facts About Diabetes: A Leading Cause of Death in the U.S.” <http://ndep.nih.gov/diabetes-facts/>. Note that the prevalence rate was calculated based on the fact that diabetes overall affects 8% of the adult population, and Type I makes up 5% of those cases.

**Diabetes, Type II:** Gardner, Amanda. “One in eight Americans diagnosed with Type II Diabetes: Poll.” *Health Day*, February 20, 2013. <http://health.usnews.com/health-news/news/articles/2013/02/20/1-in-8-americans-diagnosed-with-type-2-diabetes-poll>.

**High Blood Pressure:** Centers for Disease Control, “High Blood Pressure Facts”  
<http://www.cdc.gov/bloodpressure/facts.htm>

**High Cholesterol:** Centers for Disease Control, “Cholesterol” <http://www.cdc.gov/cholesterol/facts.htm>.

**Metabolic Syndrome:** Norton, Amy. “Metabolic Syndrome Continues to Climb in U.S.”, *Reuters*, October 15, 2010. <http://www.reuters.com/article/2010/10/15/us-metabolic-syndrome-idUSTRE69E5FL20101015>

**Obesity:** Centers for Disease Control, “Overweight and Obesity”:  
<http://www.cdc.gov/obesity/data/adult.html>

## APPENDIX B: 2012 CSP Program Survey Worksheet

This worksheet is provided to assist you in completing the annual survey. You can collect the information you need and record your answers on this worksheet first, then use it to enter your answers into the web survey. If you manage more than one CSP, please complete a separate survey for each program.

When you enter information into the web survey, do not leave the web survey screen idle for more than 15 minutes, or the survey will close and you may lose all of the information you've recorded. Questions with asterisks are required to complete the survey. Dashed lines indicate a page break in the online survey.

**Please do not submit copies of this worksheet with your responses. You will still need to complete the web survey.**

---

1. Please enter the names of each county contracting for or directly operating your CSP.\*

--

2. Please enter the formal name of the county agency or the contracted private agency that operates your CSP.\*

--

3. If your CSP is operated by your county governmental agency, does that CSP employ county employees only, or a mixture of county employees and contractors?\*

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | County employees only                             |
| <input type="checkbox"/> | County employees and contractors                  |
| <input type="checkbox"/> | My CSP is operated by a contracted private agency |

4. Please enter the DQA program certification number for the CSP.\*

--

5. Please enter the name of the person responsible for completing this survey.\*

--

6. How many active CSP consumers did you have on 12/31/2011?\*

7. How many new admissions to your CSP did you have in 2012?\*

8. *[Total number of clients served in 2012:  
calculated automatically by the survey as the sum of #6 + #7]*

9. How many discharges from your CSP did you have in 2012?\*

10. *[Number of active CSP consumers you had on 12/31/2012:  
calculated automatically by the survey.]*

11. How many of the continuing 2011 enrollees plus the new 2012 enrollees served were concurrently enrolled in Family Care?\*

12. How many of the total 2012 CSP discharges were in Family Care?\*

## Discharge Reasons

In this section, please provide information on the reasons why consumers were discharged in 2012, and where they went after discharge. When answering the following questions, if there was more than one reason for a consumer's discharge, please choose the most primary reason. In Question 14, please enter the number of consumers discharged for each reason. If you had zero consumers discharged for a particular reason, please enter 0 for your answer to that reason for discharge in Question 14. Your total number of discharges in Question 14 must match the total number of discharges reported in Question 9.

13. Were consumers discharged from your program in 2012 because ...\*  
*["No" answers allow you to skip further questions about a reason for discharge you didn't use on the next pages of the online survey.]*

	YES	NO
they moved from your geographic service area?	<input type="radio"/>	<input type="radio"/>
they recovered to the extent that CSP-level services were no longer needed?	<input type="radio"/>	<input type="radio"/>
funding or authorization ended for the consumer?	<input type="radio"/>	<input type="radio"/>
the consumer needed services beyond what CSP can offer (inpatient, etc.)?	<input type="radio"/>	<input type="radio"/>
the consumer decided to withdraw?	<input type="radio"/>	<input type="radio"/>
they were sent to jail?	<input type="radio"/>	<input type="radio"/>
they were sent to prison?	<input type="radio"/>	<input type="radio"/>
of death?	<input type="radio"/>	<input type="radio"/>
of unknown reasons?	<input type="radio"/>	<input type="radio"/>
of reasons not listed above (other)?	<input type="radio"/>	<input type="radio"/>

14. **How many** 2012 consumers were discharged because ...\*  
*[The sum of the numbers entered for this question must equal the number of total 2012 discharges reported in Question 9.]*

	# of Consumers
they moved from your geographic service area?	
they recovered to the extent that CSP-level services were no longer needed?	
funding or authorization ended for the consumer?	
the consumer needed services beyond what CSP can offer (inpatient, etc.)?	
the consumer decided to withdraw?	
they were sent to jail?	
they were sent to prison?	
of death?	
of unknown reasons?	
of reasons not listed above (other)?	

**Discharge Destinations**

For all consumers discharged for the reasons listed in this section, please list the number of consumers who transitioned to each of the following services. Please double check that your total for this question matches the number of consumers discharged for this reason you provided in Question 14.

*[The following questions on Discharge transition destinations will be on separate pages of the online survey. If you reported that no consumers were discharged for a particular reason in Question 13, you will not see further questions about that discharge reason.]*

15. For all 2012 consumers discharged because they moved from your geographic service area, how many went to each of the following:\*

*[The total number of consumers across each transition destination will automatically appear in the final row in the online survey. Please double-check that this number matches the total number of consumers reported as being discharged for this reason in Question 13.]*

	# of Consumers
Another CSP	
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Comprehensive Community Services (CCS)	
Nursing Home	
Group Home / CBRF	
Inpatient / IMD	
Consumer did not transfer to other services	
Unknown	
Other	

16. If answering "Other" in the question above about consumers who moved from your geographic service area, please describe where these consumers went.

---

17. How many of the consumers discharged because they recovered to the extent that CSP-level services were no longer needed went to each of the following:\*

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Comprehensive Community Services (CCS)	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

18. If answering "Other" in the question above about consumers who recovered to the extent that CSP-level services were no longer needed, please describe where these consumers went.

-----

19. How many of the consumers discharged because funding or authorization ended for the consumer went to each of the following:\*

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Comprehensive Community Services (CCS)	
Nursing Home	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

20. If answering "Other" in the question above about consumers for whom funding or authorization ended, please describe where these consumers went.

21. How many of the consumers discharged because the consumer needed services beyond what CSP can offer went to each of the following:\*

	# of Consumers
Nursing Home	
Group Home / CBRF	
Inpatient / IMD	
Consumer did not transfer to other services	
Unknown	
Other	

22. If answering "Other" in the question above about consumers who needed services beyond what CSP can offer, please describe where these consumers went.

-----

23. How many 2012 consumers were discharged because of consumer decision to withdraw went to each of the following:\*

	# of Consumers
Another CSP	
Outpatient therapy / psychiatry	
Targeted Case Management or other CM program	
Comprehensive Community Services (CCS)	
Nursing Home	
Group Home / CBRF	
Consumer did not transfer to other services	
Unknown	
Other	

24. If answering "Other" in the question above about consumers who were discharged because of consumer decision to withdraw, please describe where these consumers went.

25. For consumers who were reported as discharged for reasons not listed ("Other") in Question 13, please describe the reasons these consumers were discharged.

Other Reason 1:

---

Other Reason 2:

---

Other Reason 3:

---

**Demographic Information**

In this section, please provide information about the full group of CSP consumers you served in 2012. *[The totals for each of the questions in this section must equal the number of consumers you reported serving in 2012 (as calculated in #8).]*

26. Please enter the number of 2012 consumers of each gender.*	
	# of Consumers
Female	
Male	
Unknown	

27. Please enter the number of 2012 consumers in each age group.*	
	# of Consumers
17 and under	
18-20	
21-64	
65-74	
75+	
Unknown	

28. Please enter the number of 2012 consumers in each racial / ethnic group.*	
	# of Consumers
American Indian / Alaskan Native	
Asian	
Black / African American	
Hawaiian / Pacific Islander	
White	
More Than One Race	
Unknown	

29. Please enter the number of 2012 consumers with each ethnicity.*	
	# of Consumers
Hispanic / Latino	
Not Hispanic / Latino	
Unknown	

30. Please enter the number of 2012 consumers who are veterans and non-veterans.*	
	# of Consumers
Veterans	
Non-Veterans	
Unknown	

**Medical Conditions & Substance Use**

31. Please enter the number of 2012 consumers with the following substance use patterns. Please count a consumer multiple times if they qualify for more than one category on the list.\*

	# of Consumers
Use Tobacco	
Abuse Alcohol	
Abuse Other Drugs	

32. Please enter the number of 2012 consumers with the following medical conditions. Please count a consumer multiple times if they have more than one medical condition on the list.\*

	# of Consumers
Metabolic Syndrome (consumer has all of the following: high blood pressure / hypertension, high cholesterol, and obesity around the midsection)	
High blood pressure / Hypertension (exclude those with metabolic syndrome)	
High cholesterol (exclude those with metabolic syndrome)	
Obesity (exclude those with metabolic syndrome)	
Type I Diabetes	
Type II Diabetes	
Asthma	
COPD (Chronic Obstructive Pulmonary Disease)	
Cardiovascular problems (angina or coronary artery disease, heart attack, or stroke)	

**Evidence-Based Practices**

In this section, please report how many CSP consumers received any of the listed evidence-based practices (EBP). The EBP used must match the EBP definitions in the SAMHSA Resource Toolkits as described in the “EBP Definitions” document sent with the email invitation for this survey. Please review the “EBP Definitions” document before answering the questions in this section.

*["No" answers in Question 33 will allow you to skip additional questions about that EBP on the next pages. Please report a 0 for questions related to an EBP if you used that EBP with zero clients in 2012, instead of leaving it blank.]*

33. Did you use the following Evidence-Based Practices (EBPs) in 2012? Please answer "Yes" or "No" for each EBP.* <i>["No" answers allow you to skip questions about an EBP you didn't use on the next pages of the online survey.]</i>		
	YES	NO
Assertive Community Treatment (ACT)	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Integrated Treatment for Co-Occurring Disorders	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Family Psychoeducation	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Illness Management and Recovery (IMR)	<input checked="" type="radio"/>	<input checked="" type="radio"/>
MedTEAM	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Supported Employment	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Permanent Supportive Housing	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Other EBP not listed (but is found on the SAMHSA website)	<input checked="" type="radio"/>	<input checked="" type="radio"/>

34. Please enter the number of 2012 consumers who received the following evidence-based practices. Please count a consumer multiple times if they received more than one evidence-based practice in 2012.*	
	# of Consumers
Assertive Community Treatment (ACT)	
Integrated Treatment for Co-Occurring Disorders	
Family Psychoeducation	
Illness Management and Recovery (IMR)	
MedTEAM	
Supported Employment	
Permanent Supportive Housing	
Other EBP not listed (but is found on the SAMHSA website)	

35. Please enter the number of consumers who received an EBP in 2012 of each gender. Please count a consumer multiple times if they received more than one EBP in 2012.\*

*[On the online survey, the total number of consumers receiving each EBP across genders will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]*

	Female	Male	Unknown
Assertive Community Treatment (ACT)			
Integrated Treatment for Co-Occurring Disorders			
Family Psychoeducation			
Illness Management and Recovery (IMR)			
MedTEAM			
Supported Employment			
Permanent Supportive Housing			

36. Please enter the number of consumers who received an EBP in 2012 in each age group. Please count a consumer multiple times if they received more than one EBP in 2012. \*

*[On the online survey, the total number of consumers receiving each EBP across all age groups will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]*

	17 and under	18-20	21-64	65-74	75+	Un-known
Assertive Community Treatment (ACT)						
Integrated Treatment for Co-Occurring Disorders						
Family Psychoeducation						
Illness Management and Recovery (IMR)						
MedTEAM						
Supported Employment						
Permanent Supportive Housing						

37. Please enter the number of consumers who received an EBP in 2012 in each racial / ethnic group. Please count a consumer multiple times if they received more than one EBP in 2012.\*

*[On the online survey, the total number of consumers receiving each EBP across all racial / ethnic groups will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]*

	Amer. Indian/ Alaskan Native	Asian	Black/ African American	Hawaiian/ Pacific Islander	White	More than One Race	Un- known
Assertive Community Treatment (ACT)							
Integrated Treatment for Co-Occurring Disorders							
Family Psychoeducation							
Illness Management and Recovery (IMR)							
MedTEAM							
Supported Employment							
Permanent Supportive Housing							

38. Please enter the number of consumers who received an EBP in 2012 with each ethnicity. Please count a consumer multiple times if they received more than one EBP in 2012.\*

*[On the online survey, the total number of consumers receiving each EBP across ethnicities will automatically appear in the final column for each EBP listed. Please check that this number matches the total number of consumers reported as receiving that EBP in Question 34, not including those listed as "other EBP".]*

	Hispanic/ Latino	Not Hispanic/ Latino	Unknown
Assertive Community Treatment (ACT)			
Integrated Treatment for Co-Occurring Disorders			
Family Psychoeducation			
Illness Management and Recovery (IMR)			
MedTEAM			
Supported Employment			
Permanent Supportive Housing			

**Evidence-Based Practices, Continued**

In this section, please answer the following questions on your use of evidence-based practices (EBP). Please check that you have answered "Yes" or "No" for all questions. Refer to the “EBP Definitions” document to guide your answers to these questions.

*[The following questions on EBPs will be on separate pages of the online survey. If you reported that you did not use an EBP in Question 33, you will not see further questions about that EBP.]*

39. Assertive Community Treatment (ACT)*		
	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

40. If you monitored fidelity for Assertive Community Treatment (ACT), what fidelity measure did you use? \_\_\_\_\_

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41. Integrated Treatment for Co-Occurring Disorders*		
	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

42. If you monitored fidelity for Integrated Treatment for Co-Occurring Disorders, what fidelity measure did you use? \_\_\_\_\_

43. Family Psychoeducation\*

	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

44. If you monitored fidelity for Family Psychoeducation, what fidelity measure did you use?  
 \_\_\_\_\_

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45. Illness Management and Recovery (IMR)\*

	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

46. If you monitored fidelity for Illness Management and Recovery (IMR), what fidelity measure did you use?  
 \_\_\_\_\_

47. MedTEAM\*

	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

48. If you monitored fidelity for MedTEAM , what fidelity measure did you use?  
 \_\_\_\_\_  
 \_\_\_\_\_

-----

49. Supported Employment\*

	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

50. If you monitored fidelity for Supported Employment, what fidelity measure did you use?  
 \_\_\_\_\_  
 \_\_\_\_\_

51. Permanent Supportive Housing\*

	Yes	No
Have CSP staff been specifically trained to implement this evidence-based practice?		
Did you use the evidence-based practice toolkits defined in the “EBP Definition” document to guide your implementation?		
Did you monitor fidelity for this evidence-based practice?		
Did you use an outside monitor to review fidelity for this evidence-based practice?		

52. If you monitored fidelity for Permanent Supportive Housing, what fidelity measure did you use?  
 \_\_\_\_\_  
 \_\_\_\_\_

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53. What EBPs not listed previously (but is found on the SAMHSA website) did you use in 2012?

Other EBP 1: _____
Other EBP 2: _____
Other EBP 3: _____

**Consumer Satisfaction**

54. Did you use a survey or other tool to measure consumer satisfaction in 2012?\*

*[In the online survey, further questions about consumer satisfaction tools will not appear if you choose no.]*

\_\_\_ Yes \_\_\_ No

-----

55. Which survey or tool did you use to measure consumer satisfaction?\*

*(Please mark all that apply)*

The instrument in my Evidence-Based Practice toolkit

Recovery-Oriented Systems Inventory (ROSI)

Other tool *(please describe)*:

\_\_\_\_\_

**CSP Waiting List Information**

56. Were there times during 2012 when there was a waiting list for CSP services?\*

*[In the online survey, further questions about waiting lists will not appear if you choose no.]*

\_\_\_ Yes \_\_\_ No

57. How many consumers were on the CSP waiting list on 12/31/2011?\*

\_\_\_\_\_

58. How many additional consumers were placed on the CSP waiting list during 2012?\*

\_\_\_\_\_

59. How long is the average wait in months before consumers on your waiting list receive CSP services?\*

*(Please provide an average number of months, not a range of months)*

\_\_\_\_\_

60. Please report which of the following interim services consumers received while on your CSP waiting list.\* *(Please mark all that apply)*

None	
Case management services	
Outpatient mental health services	
Psychiatric services	
Assistance with locating community resources	
Medication management services	
Outpatient substance abuse services	
Crisis intervention services	
Clubhouse	
Drop-in center	
Other services <i>(please describe)</i> : _____	

61. Do you have any clarifications about your answers, additional comments, or suggestions about this survey?

62. Please record **your email address** below to ensure that we have received your survey, and to receive an email confirmation of your survey completion and a copy of your responses for your records. If you do not receive an email confirmation after you complete the survey, it means that we have not received your survey and you may need to submit it again. \*