



Wisconsin
Department of Health Services

DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Community Support Program 2013 Annual Program Survey

Report of 2013 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. Stats. § 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 2013, there were 74 DHS 63-certified CSPs across the state, 72 of which (97%) responded to the survey.

The number of reported consumers served in 2013 (5,577 consumers) was slightly lower than in 2012 (6%), yet still in line with the historical trends, and not unexpected given the slightly lower response rate from 2012 (99%). African-Americans remained over-represented in the CSP population (15% vs. 6.5% of Wisconsin's population), while Latinos and Hispanics were under-represented (3% vs. 6.2% of the general population). Most programs (69%) 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 2013 was 5.1 months; essentially the same as in 2012.

Approximately 13% of consumers were discharged during 2013, and the most common reason for discharge (42%) was that consumers had made strides to the point where CSP-level services were no longer needed. This was a significant increase over the previous year. In addition, compared with 2012, in 2013 discharged consumers were more likely to transfer to Comprehensive Community Services (CCS), which appears to be an appropriate level of care for many of those no longer needing CSPs.

While the 2012 survey indicated fairly high death rates (15% of those no longer in the program), in 2013 that number dropped to 12%. At the same time, unexpectedly low reported rates of various physical health ailments continue to reflect younger CSP consumers than the general population (with fewer health issues typically associated with aging). By contrast, rates of substance abuse remained higher than the general population, which was expected. However, tobacco rates did decline slightly from 2012 levels.

With regard to services offered, most CSPs (79%) follow at least one EBP. Surprisingly, only 58% of programs 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 than expected rates to male consumers and to African-American consumers, although the vast majority of those receiving EBPs were White. 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, 87% of programs 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 2013, there were 74 active CSPs, 72 of which (97%) 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

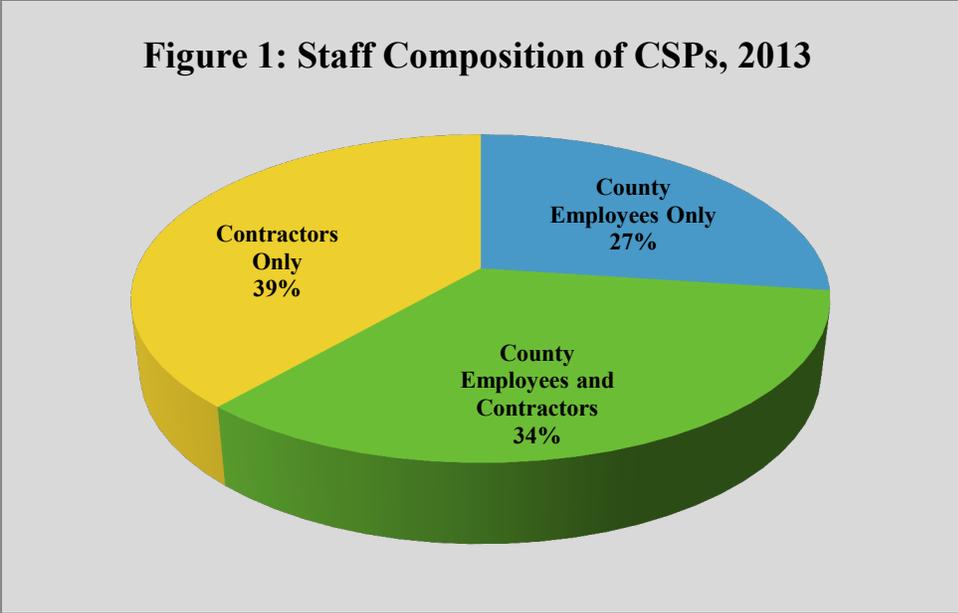
Taken together, these areas help paint a picture of how CSPs are functioning and who they are serving across the state. The survey captures some of the potential challenges that programs face (e.g., handling consumers' co-occurring physical health needs—see Appendix A for a list of Sources for Physical 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

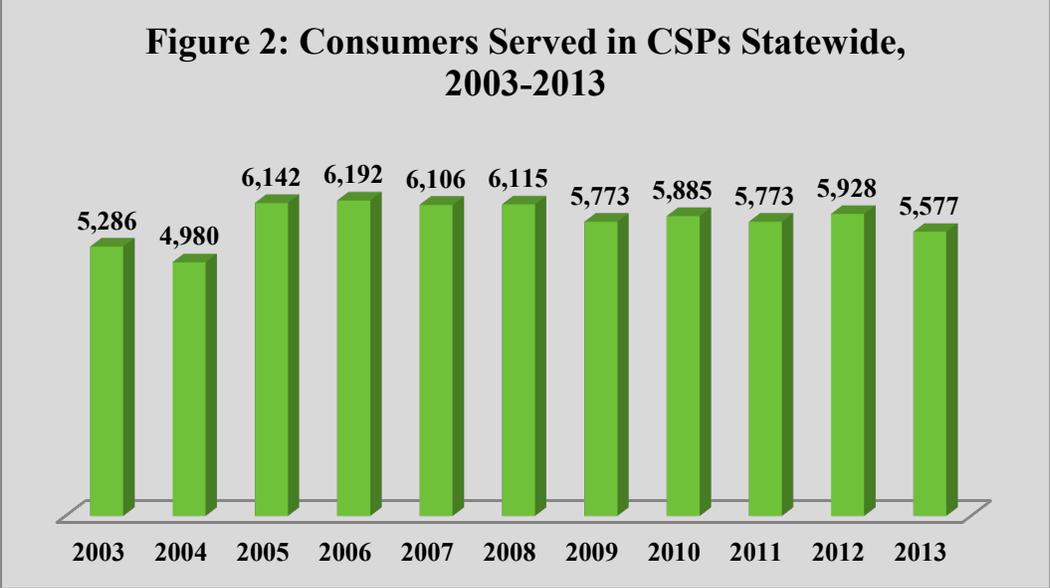
Figure 1 (below) shows that programs are fairly evenly divided between these three categories, with the most frequent configuration being contractors only (39%). This is consistent with the staffing patterns of the last few years.



CONSUMERS SERVED

Survey respondents reported a total of 5,577 consumers served in 2013. This is a 6% decrease from the previous year, and brings the total number of consumers served to the lowest level since 2004. However, some of this drop may be accounted for by the slightly lower response rate compared with 2012.

The survey asks how many CSP consumers are concurrently enrolled in Family Care. In 2013, 5.7% of consumers (n=316) were also enrolled in Family Care. Almost 29% of the consumers enrolled in Family Care (n=91) were discharged in 2013.



DISCHARGE REASONS AND DESTINATIONS

Consumers often spend long periods of time in CSPs, and discharges are relatively infrequent. In 2013, 728 consumers were discharged from CSPs; this constitutes approximately 13% of the total number of consumers served during the same time period, and is a slightly higher discharge rate than in 2012 (11%). In a reversal of the previous year's pattern, there were fewer new admissions than discharges in 2013. Approximately 9% of the consumers served in 2013 (n=519) were new to the program that year.

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 (42%). The second most common reason for discharge is that the consumer moved away from the service area (15%). A substantial percentage of consumers (12%) died during 2012; however, there was a slight decline in the percentage of consumers who died during the course of 2013. In general, a substantially higher percentage of consumers were discharged due to recovery in 2013 compared with 2012 (42% vs. 25%). This is largely accounted for by a decrease in both the relative number of consumers who moved out of a service area, and the number who experienced all types of adverse experiences, from lack of funding to incarceration and death. Thus, CSP consumers fared relatively well in 2013.

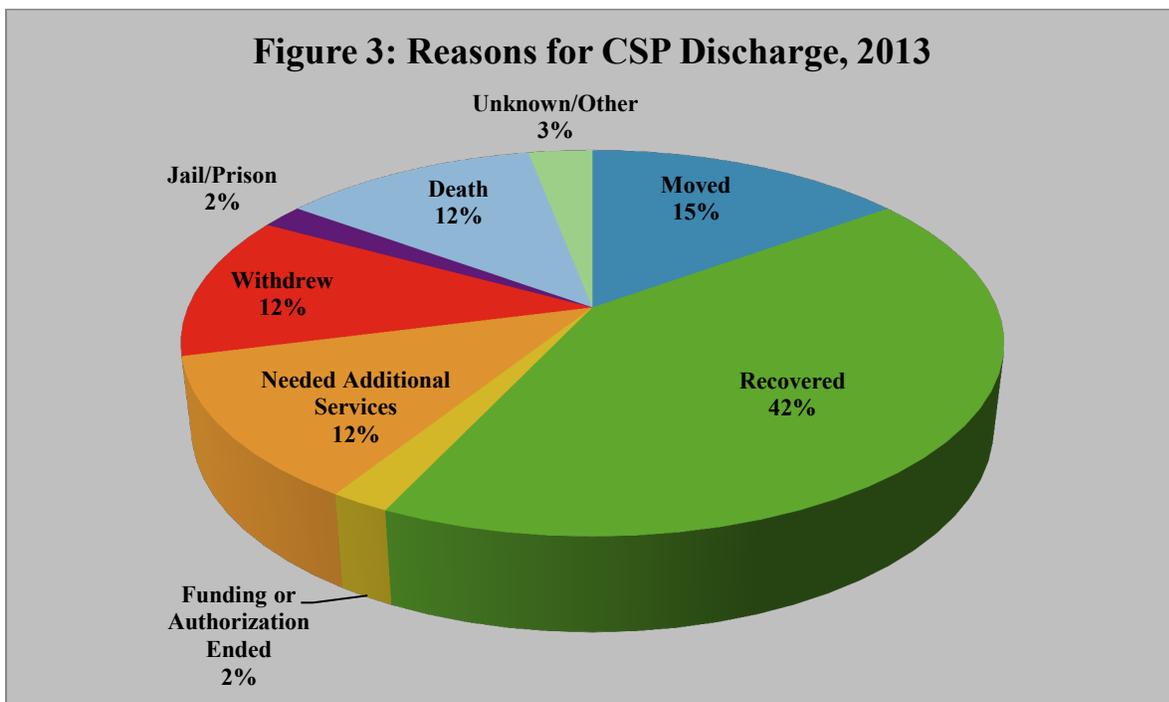


Table 1 (below) depicts the destinations of consumers who were discharged for various reasons. For instance, consumers who moved generally sought out individual types of services such as outpatient therapy (33%) or Targeted Case Management (TCM) (7%), or else enrolled in another CSP (23%). Unfortunately, 15% 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 (56%) moved to a Comprehensive Community Services (CCS) program. This is a reversal from 2012, when those who recovered were most likely to seek out outpatient therapy or TCM. Although those services are still very common for recovering consumers, the fact that more are stepping down to another comprehensive program (i.e., CCS) appears to be a positive shift.

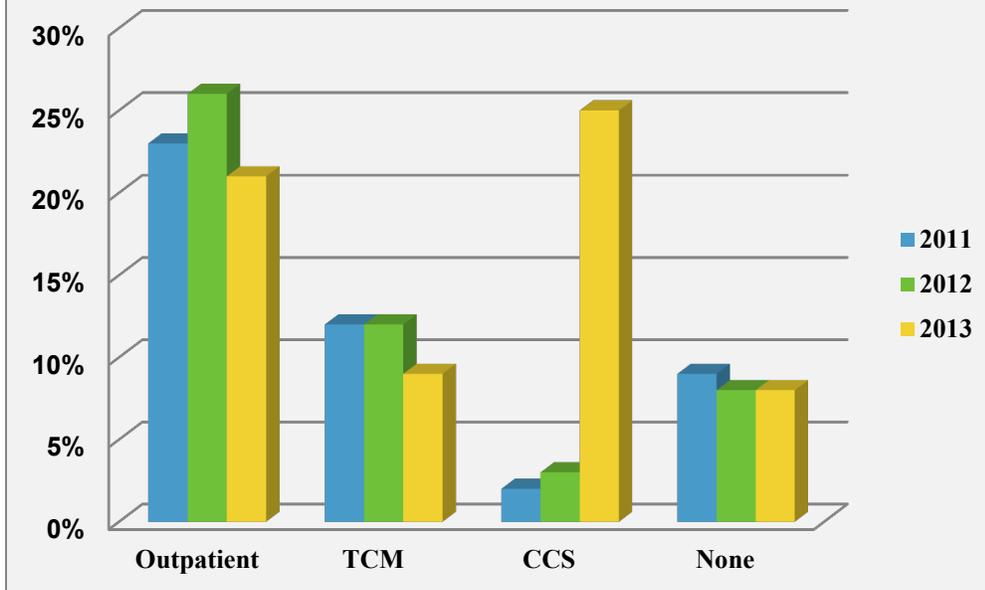
Very few consumers (n=7) were discharged due to a lack of funding or authorization. However, in those few cases, consumers generally did not receive other services (43%). Residential facilities were the primary destinations of those who needed additional services, along with inpatient stays. When consumers decided to withdraw from CSP, they either moved towards outpatient services (44%) or discontinued services altogether (37%). Whereas in 2012 most discharged consumers tended to gravitate towards outpatient services, in 2013 the discharge destinations were more diverse.

Table 1: Consumer Destinations by Reasons for Discharge, 2013

Reason for Discharge	Another CSP	Outpatient Therapy	TCM	CCS	Nursing Home	Group Home	Inpatient	No Other Services	Unknown	Other
Moved	23%	33%	7%	2%	4%	4%	1%	15%	5%	5%
Recovered	N/A	22%	16%	56%	N/A	1%	N/A	2%	0%	3%
Funding or Authorization Ended	N/A	0%	0%	0%	0%	29%	0%	43%	0%	29%
Needed Additional Services	N/A	N/A	N/A	N/A	31%	37%	9%	2%	0%	20%
Withdrew	3%	44%	5%	0%	1%	3%	0%	32%	9%	4%

Figure 4 (below) presents trend data for select treatment destinations over the past three years (2011-2013). While outpatient therapy and TCM services have been the most common destinations for discharged CSP consumers over the past few years, the percent of discharged consumers going to CCS jumped sharply in 2013 (to about 25%).

Figure 4: Percent of Discharged Consumers who Transitioned to Select Services, 2011-2013



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

As in previous years, the gender breakdown of participants was fairly evenly divided between men and women, with 49% of enrollees being male and 50% being female. The remaining consumers had no known gender (“unknown”).

Age

As can be seen in Table 2 (below), the majority of CSP consumers in 2013 (87%) were between the ages of 21 and 64. An additional 7% were between 65-74 years old. Less than one percent of consumers were children (ages 17 or under) and relatively few were youth (18-20 years) or elders (age 75 or over). This age distribution is comparable to that of previous years.¹

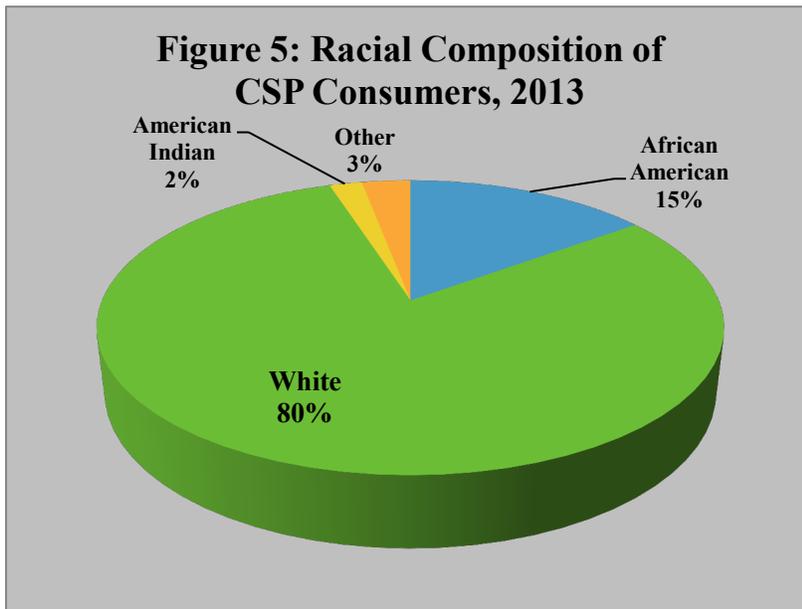
¹ To comply with federal Health Insurance Portability and Accountability Act (HIPAA) privacy provisions and minimize the risk of violating client confidentiality, age categories with small numbers of consumers (less than 25) are reported as percentages (reflected as “less than 1%”) rather than raw numbers.

Table 2: Age Distribution of CSP Consumers, 2013²

Age Range	Percent of Consumers
17 and under	< 1%
18-20	4%
21-64	88%
65-74	7%
75+	1%

Race

White consumers were under-represented based relative to the population at large, at 80% (vs. 88% of Wisconsin residents). In 2013, African American consumers remained over-represented in CSPs relative to their population (i.e., 15% of CSP consumers vs. 6.5% of Wisconsin residents),³ but their representation was also considerably lower than in the previous year (27%). All other racial groups (i.e., Asian American, Native American/American Indian, Hawaiian/Pacific Islander, and multi-racial individuals) continued to have minimal representation, on the order of 2%-3%.



² Percentages are based on the total number of consumers for whom an age range was recorded.

³ Based on figures from the U.S. Census Bureau: <http://quickfacts.census.gov/qfd/states/55000.html>.

Ethnicity

Survey respondents were asked to identify consumers' ethnicity as well as race. As in the previous year, approximately 3% of consumers were listed as Latino or Hispanic, which is roughly half the rate of Latino/Hispanic representation in Wisconsin.

Veteran Status

Although veterans make up approximately 7% of the population of Wisconsin,⁴ just under 4% of those served in CSPs were known veterans. This was identical to the response in the previous year. Whether veterans are under-served or merely under-reported remains a question.

HEALTH AND SUBSTANCE USE INFORMATION

CSPs were asked to report on the substance abuse patterns and various health issues for all consumers served in 2013. 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 slight majority of CSP consumers (52%) utilized tobacco in 2013, although this number was down from 2012 (57%). Tobacco cessation has been a priority in Wisconsin in recent years, so the decline in reported tobacco use is a hopeful sign. Approximately one-fifth of consumers also used other drugs (19%) and/or alcohol (21%).⁵ These rates were very similar to those reported in 2012 (see Figure 6, below). CSP substance use/abuse rates remain higher than for the general U.S. population⁶ and higher than rates reported by consumers in Wisconsin's CCS programs.⁷ 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.

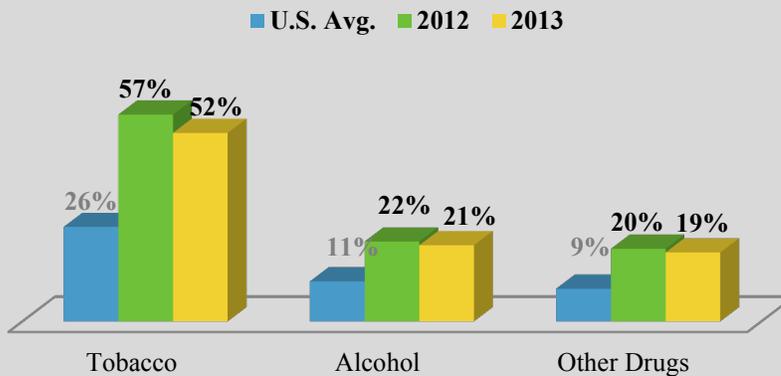
⁴ Statewide estimates of African Americans, Hispanics/Latinos and veterans are based on 2013 estimates from the U.S. Census Bureau, <http://quickfacts.census.gov/qfd/states/55000.html>.

⁵ One survey respondent noted that they reported only those consumers who were active users and not involved in any form of treatment or stage of recovery; therefore, some of these figures may be underreported.

⁶ 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

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

Figure 6: Comparison of Substance Use and Abuse Between CSP Consumers and the General Population, 2012-2013



Survey respondents were also asked to supply information on a wide array of physical health problems for their consumers. As in the previous year, CSP programs reported *lower* than expected prevalence rates for most of the 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 given the documented higher rates of these specific co-occurring physical health problems among individuals with mental health problems.⁸

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.⁹

⁸ 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.

⁹ One survey respondent noted that their consumers are likely to refuse to share medical information and/or see their health care providers.

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 KITS¹⁰ and are encouraged to incorporate such practices.

As seen in Figure 7, the vast majority of CSPs (79%) offer at least one EBP. Most programs (61%) offer between one and four EBPs, with the average number of EBPs per program being 2.5 (not shown here)—the same as in 2012. A few programs (18%) offered five or more EBPs, while 21% offered none at all.

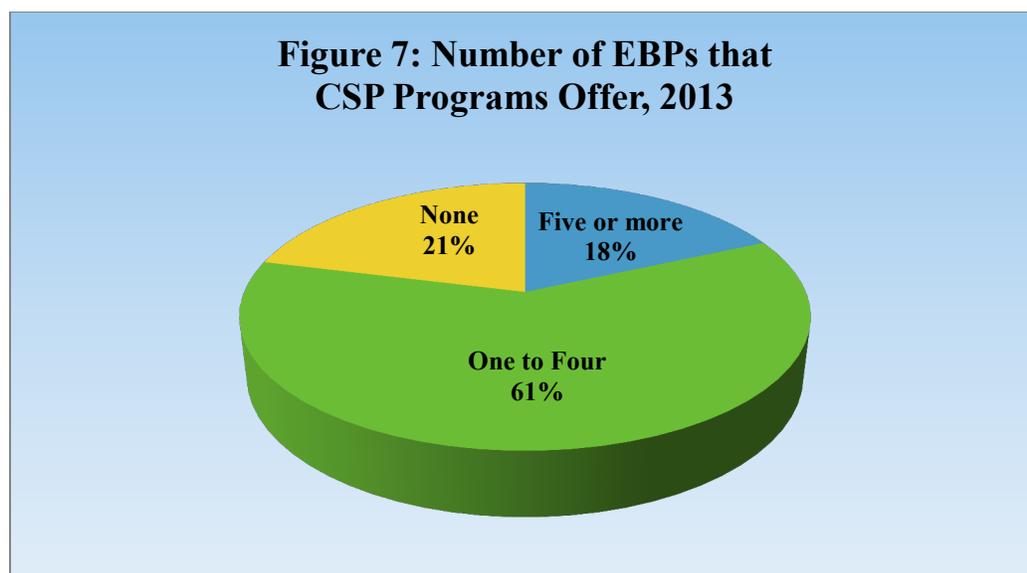
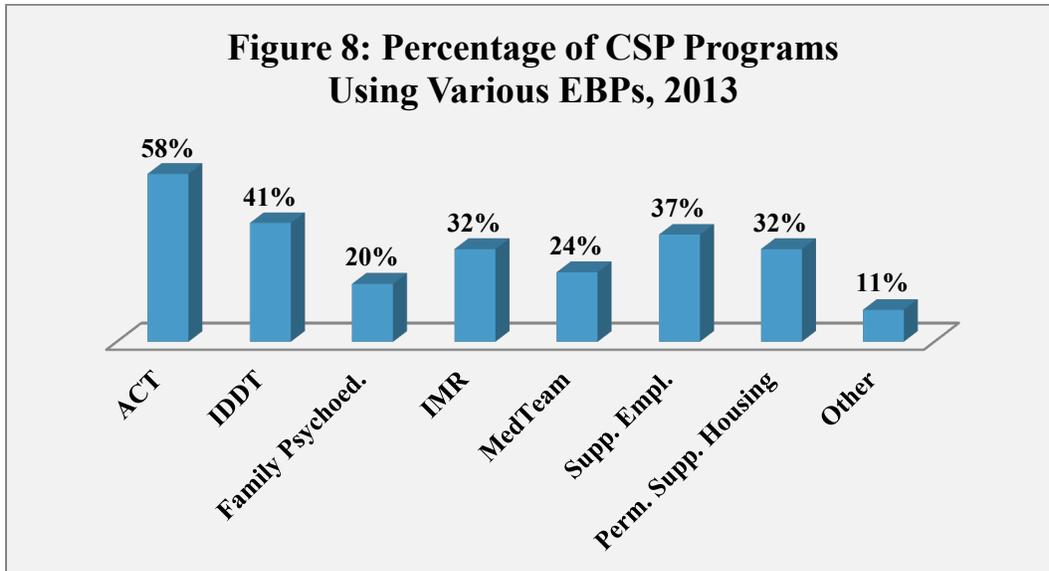


Figure 8 (below) displays the frequency with which programs used each EBP. Fifty-eight percent of all CSPs reported using ACT; a figure which is in line with the previous year (59%). Since the CSP model was originally based on a variation of ACT, it is not surprising that ACT would be the leading EBP for CSP programs. Ideally, all CSPs would report using a full-fidelity ACT model, which is much more

¹⁰ SAMHSA Evidence-Based Practices KITS:
<http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITS>

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.



As in the previous year, the second most common EBP offered was Integrated Treatment for Co-Occurring Disorders (IDDT) and the least common EBP specified in the survey was Family Psychoeducation. Given that CSP consumers do have reportedly high rates of substance abuse, IDDT seems to be an important and appropriate intervention. Several programs listed a variety of other EBPs or promising practices under the “Other” category (shown in Table 3).

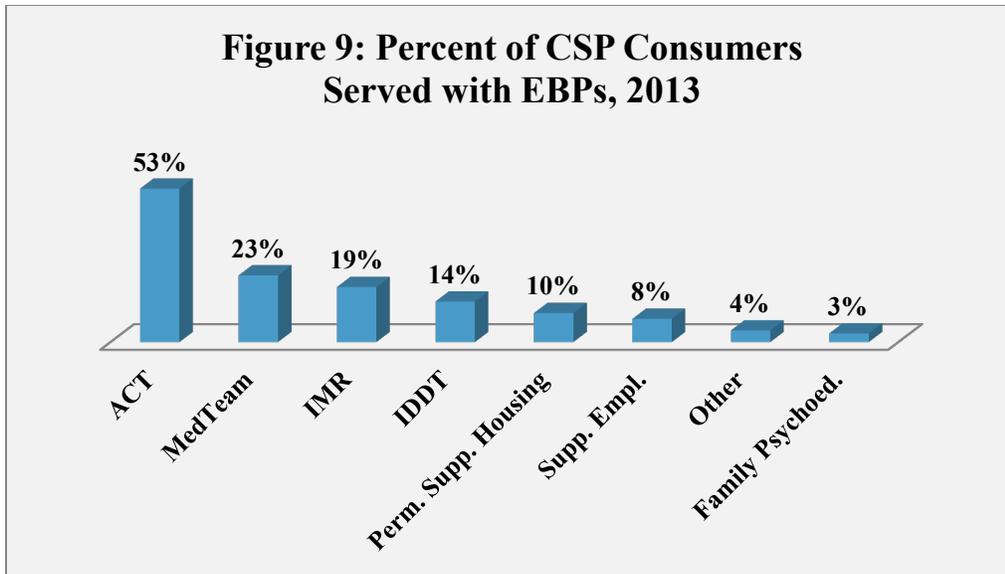
Table 3: Other Evidence-Based Practices Utilized by CSPs

Other EBPs/Practices	Number of Programs
Peer Specialists	3
Motivational Interviewing	3
Cognitive Behavioral Therapy ¹¹	3
Dialectical Behavioral Therapy	2
Incredible Years	1
Group Therapy/Social Skills	1

While most CSP programs offered at least one EBP, the percent of consumers served using those EBPs remains fairly low. ACT was the only model offered to more than half of all CSP consumers in 2013. All other models were offered to relatively few consumers (see Figure 9, below).

¹¹ This category includes two entries listed as CBT and one child/youth version, called “Coping CAT”.

Figure 9: Percent of CSP Consumers Served with EBPs, 2013



It should be noted that in responding to all the EBP questions, programs are asked to adhere to the strict definitions of 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. At least three programs noted that they are in the process of implementing new EBPs, but were not yet in the position to record them here. The main reason given for not meeting the strict definition of an EBP was inadequate staff to consumer ratios for practices such as ACT. A second reason was lack of information about what toolkits and technical assistance were available; many programs reported that they believed they incorporated many elements of EBPs, but did not use formal fidelity tools, toolkits, or monitors. 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. With the exception of Family Psychoeducation (which served almost exactly the same number of males and females), male consumers were more likely than female consumers to receive an EBP. In general, between 1.5 and two times more males were served with each EBP than females (not shown here)—despite the fact that in 2013 slightly more CSP consumers were females than males. 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.

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. The overwhelming majority of EBPs (92%) were offered to individuals between the ages of

21-64 (see Table 4), slightly higher than the representation of this age group within CSPs in general. Consumers aged 18-20 years old were much less likely to receive an EBP (only 1%) than their representation in CSPs general (4%) would suggest, and those aged 65-74 were somewhat less likely to be EBP recipients.¹²

Table 4: Age Distribution of All CSP Consumers vs. EBP Recipients

Age Group	Percent of All CSP Consumers	Percent of EBP Recipients
Age 17 and under	< 1%	< 1%
Age 18-20	4%	1%
Age 21-64	88%	92%
Age 65-74	7%	6%
Age 75+	1%	1%

The most common EBP across all age groups was ACT, including both adolescents age 17 and under (less than 1% of consumers receiving EBPs) and 38 senior consumers (aged 75 and older). The next highest EBPs offered to those in the less-represented age groups (including consumers age 75 and older) were IMR and MedTeam.

With regard to race, African Americans were slightly over-represented among EBP recipients, based on their representation in the CSP population in general (19% of EBP recipients vs. 14% of consumers). White consumers were slightly under-represented (77% of EBP recipients vs. 80% of enrollees). Other racial groups were provided EBPs relatively proportionate to their representation among consumers. The ethnic breakdown of those receiving EBPs exactly matched the ethnic breakdown of enrollees, with Hispanics/Latinos representing 3% of all CSP consumers and 3% of those receiving EBPs.

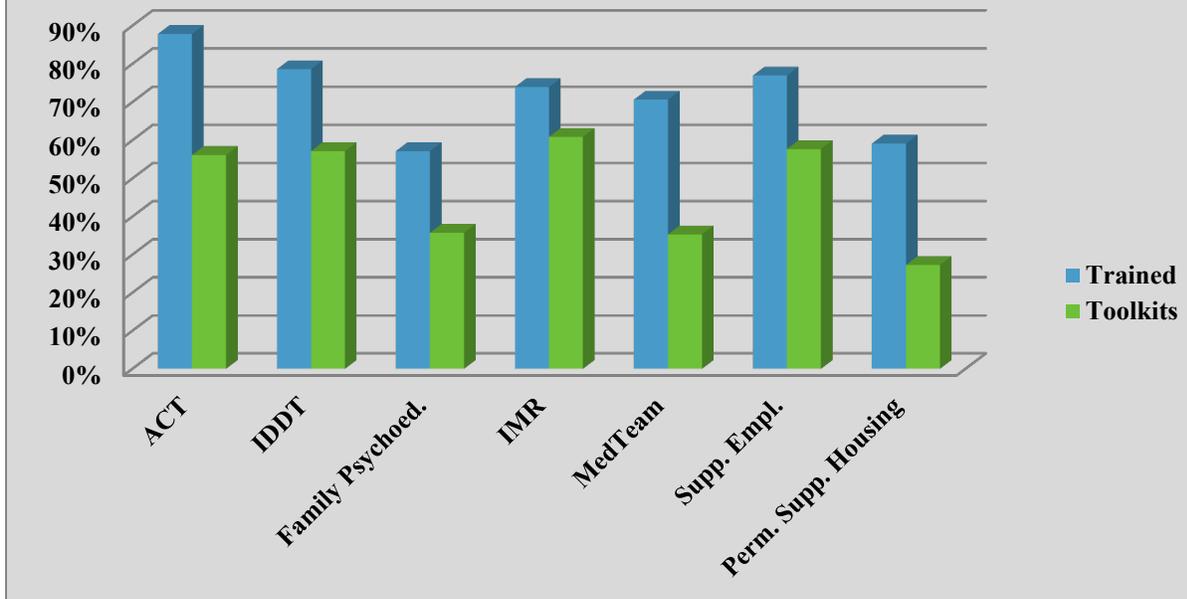
EBP Training and Monitoring

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

¹² 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 10: Percent of Programs Offering EBPs that Trained Staff or Used Toolkits



As can be seen in Figure 10, programs that offered EBPs were quite likely to have staff who were specifically trained in that EBP. Programs that utilized ACT were most likely to have staff trained to administer it (88%), whereas programs utilizing Family Psychoeducation (57%) and Permanent Supported Housing (59%) were the least likely to have staff trained in this area. Across all EBPs, fewer programs reported using toolkits to guide implementation (27%-61%). At least one long-standing program noted that it began implementing ACT prior to the release of specific toolkits, and so the question about use of toolkits at the implementation stage may not be relevant for the oldest programs, although they should still keep up with trainings.

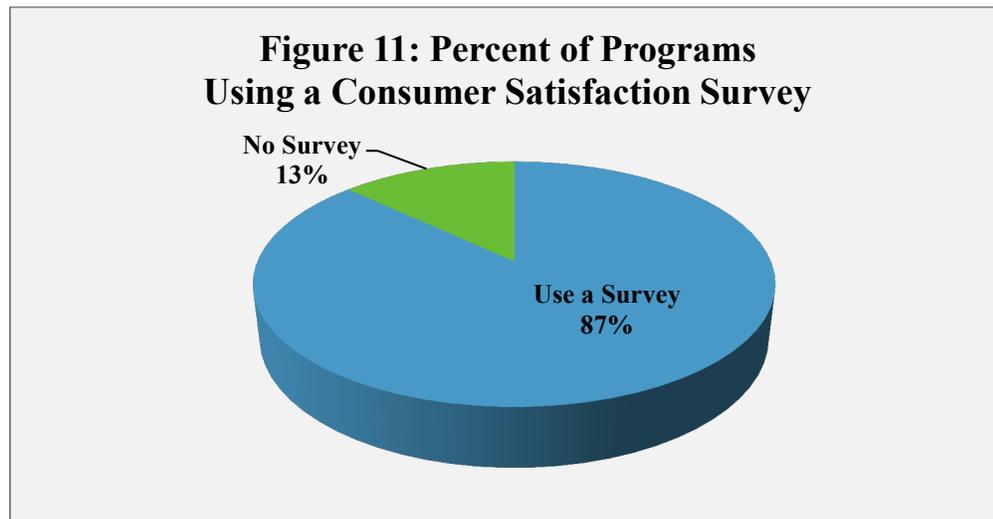
As can be seen in Table 5 (below), relatively few programs monitored fidelity of their EBPs (which is the only way to know if EBPs are actually being delivered). In a change from the previous year, in 2013 the most heavily monitored EBP was Supported Employment, at 58%. Supported Employment was also the EBP most likely to make use of an outside monitor. This is perhaps not surprising, given that the State’s Division of Mental Health and Substance Abuse Services has staff dedicated to training and monitoring supported employment—something that is not true of other EBPs listed here. Surprisingly, only 41% of programs that listed ACT as an EBP reported monitoring for fidelity, even though ACT is the model upon which the CSP program is based. ACT was also one of the EBPs least likely to deploy an outside monitor, with only 10% of participating programs doing so. The EBP least likely to be monitored for fidelity was Permanent Supported Housing.

Table 5: 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	41	41%	10%
IDDT	28	39%	21%
Family Psychoeducation	14	21%	14%
IMR	23	39%	13%
MedTeam	17	35%	18%
Supported Empl.	26	58%	38%
Perm. Supp. Housing	22	32%	9%

CONSUMER SATISFACTION SURVEYS

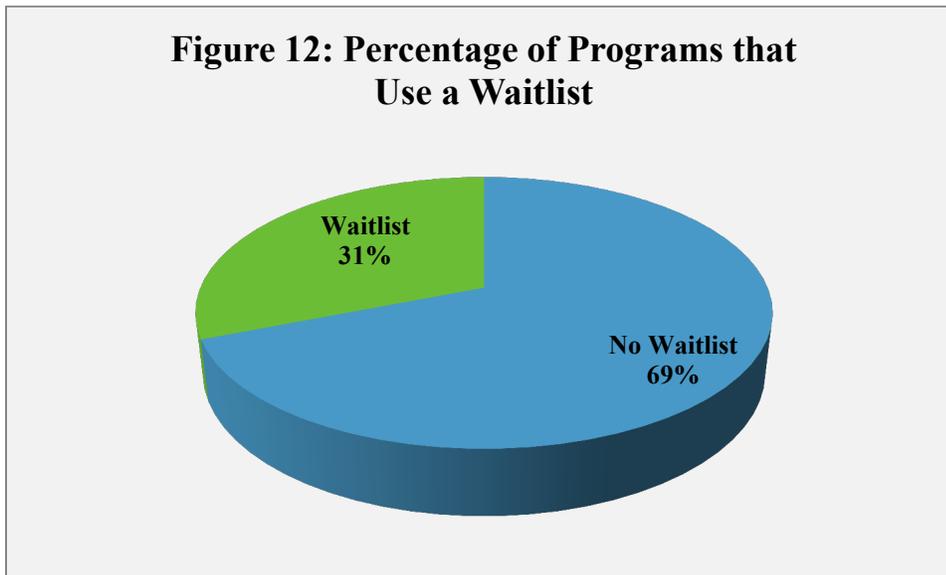
Measuring consumer satisfaction is an important part of quality assurance for any program. CSPs are not provided with any standard consumer satisfaction tool, but are encouraged to offer some form of satisfaction survey. Fully 87% of respondents replied that they did in fact use a consumer satisfaction survey or other tool in 2013, representing a 7% increase from the previous year.



Approximately thirty percent of respondents (21 programs) reported using the Recovery-Oriented Satisfaction Indicator Survey (ROSI) as their consumer satisfaction tool. Twelve programs (17%) reported using a tool that their agency had developed, two reported using the COMPASS EZ, one reported using the Client Experience Questionnaire, one reported using a modified version of the Client Satisfaction Questionnaire (CSQ-8), one reported using the Progress in Recovery Survey, one reported the Family Satisfaction Survey, and one listed an unnamed survey developed by University of Wisconsin-Madison PhD students.

WAITLISTS

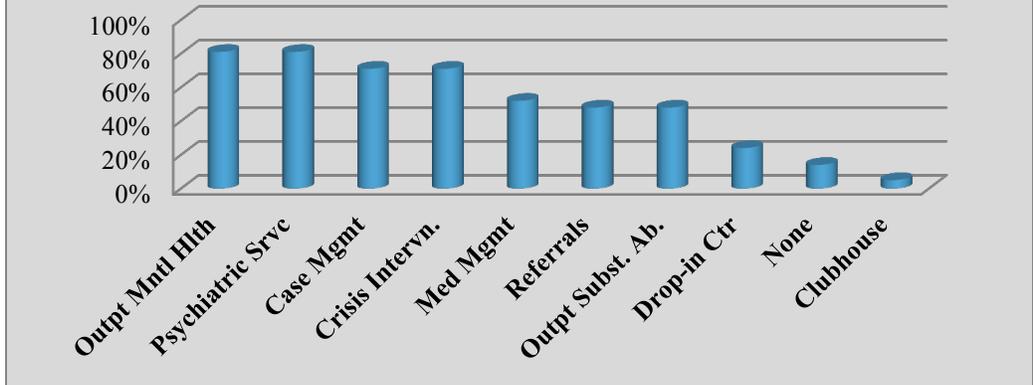
Programs were asked if they had to use a waitlist during the reporting period. Most programs (69%) did not report any need to utilize a waitlist. In the comments section, however, some respondents indicated that there was a local need for a waitlist, but that for specific, program-related reasons it was not being met.¹³ The number of people served on the waitlist and the wait times were very similar to 2012. Approximately 31% of programs did report the use of a waitlist, and they reported a total of 168 existing consumers and 242 new consumers had to wait for services in 2013. Of programs that used waitlists, the average number of consumers placed on the waitlist per program during 2013 was 11. The average wait was 5.1 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 (see Figure 13, below). The most common services were outpatient mental health services and Psychiatric Services (each of which were offered by 17 programs, or 81% of those with waitlists) and Crisis Intervention Services and Case Management (each of which were offered by 15 programs, or 71% of those with waitlists). Other services listed included referrals, medication management, outpatient substance abuse treatment, clubhouses, and drop-in centers. Only three programs (14%) reported that no services were offered to those on the waitlist.

¹³ For instance, Dane County has a CSP that specifically serves prisoners with charges pending. The respondent wrote that “a waiting list is not kept for [this program] since by the time the person might come to the top of our waiting list their charges may already be resolved. However, there remains a large unmet need for CSP services for people with serious and persistent mental illness who are incarcerated in the Dane County Jail.”

Figure 13: 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 2013 CSP survey. First, most CSPs appear to have embraced the concept of at least one EBP as part of their program, and programs claim when EBPs are not present, many of the principles of the practice are already in place. Compared with the previous year, in 2013 discharged CSP consumers were more likely to have positive reasons for discharge and placements. For instance, compared with the 2012 responses, in 2013 a higher percentage of consumers were discharged due to recovery and a lower percentage died or withdrew during the course of the year. Consumers who no longer needed such intensive services were more likely to step down to the less intensive CCS program, which—in the absence of specific, client-level information—would seem to be a positive and appropriate transition.

Looking forward, it will remain important for those programs that have not yet begun utilizing EBPs to move towards incorporating them into their programs and offering them to the majority of consumers. Likewise external monitoring and evaluation of evidence-based practices 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.

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: 2013 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.

Please complete the survey by March 28th. If you have any questions or difficulties with the survey, please contact Kate McCoy at 608-267-9391 or Katherine.McCoy@dhs.wisconsin.gov. Thank you.

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?*

- County employees only
 County employees and contractors
 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 12/31/2012?*

7. How many new admissions to your CSP did you have in 2013?*

8. *[Total number of clients served in 2013:
calculated automatically by the survey as the sum of #6 + #7]*

9. How many discharges from your CSP did you have in 2013?*

10. *[Number of active CSP consumers you had on 12/31/2013:
calculated automatically by the survey.]*

11. How many of the continuing 2012 enrollees plus the new 2013 enrollees served were concurrently enrolled in Family Care?*

12. How many of the total 2013 CSP discharges were in Family Care?*

Discharge Reasons

In this section, please provide information on the reasons why consumers were discharged in 2013, 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 2013 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** 2013 consumers were discharged because ...*
[The sum of the numbers entered for this question must equal the number of total 2013 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 2013 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 2013 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 2013. *[The totals for each of the questions in this section must equal the number of consumers you reported serving in 2013 (as calculated in #8).]*

26. Please enter the number of 2013 consumers of each gender.*

	# of Consumers
Female	
Male	
Unknown	

27. Please enter the number of 2013 consumers in each age group.*

	# of Consumers
17 and under	
18-20	
21-64	
65-74	
75+	
Unknown	

28. Please enter the number of 2013 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 2013 consumers with each ethnicity.*

	# of Consumers
Hispanic / Latino	
Not Hispanic / Latino	
Unknown	

30. Please enter the number of 2013 consumers who are veterans and non-veterans.*

	# of Consumers
Veterans	
Non-Veterans	
Unknown	

Medical Conditions & Substance Use

31. Please enter the number of 2013 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 2013 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 2013, instead of leaving it blank.]

33. Did you use the following Evidence-Based Practices (EBPs) in 2013? Please answer "Yes" or "No" for each EBP.*
["No" answers allow you to skip questions about an EBP you didn't use on the next pages of the online survey.]

	YES	NO
Assertive Community Treatment (ACT)	<input type="radio"/>	<input type="radio"/>
Integrated Treatment for Co-Occurring Disorders	<input type="radio"/>	<input type="radio"/>
Family Psychoeducation	<input type="radio"/>	<input type="radio"/>
Illness Management and Recovery (IMR)	<input type="radio"/>	<input type="radio"/>
MedTEAM	<input type="radio"/>	<input type="radio"/>
Supported Employment	<input type="radio"/>	<input type="radio"/>
Permanent Supportive Housing	<input type="radio"/>	<input type="radio"/>
Other EBP not listed (but is found on the SAMHSA website)	<input type="radio"/>	<input type="radio"/>

34. Please enter the number of 2013 consumers who received the following evidence-based practices. Please count a consumer multiple times if they received more than one evidence-based practice in 2013.*

	# 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 2013 of each gender. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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 2013 in each age group. Please count a consumer multiple times if they received more than one EBP in 2013. *

[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 2013 in each racial / ethnic group. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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 2013 with each ethnicity. Please count a consumer multiple times if they received more than one EBP in 2013.*

[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? _____

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?

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?

53. What EBPs not listed previously (but is found on the SAMHSA website) did you use in 2013?

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 2013?*

[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 2013 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 12/31/2012?*

58. How many additional consumers were placed on the CSP waiting list during 2013?*

59. How long was the average wait in months in 2013 before consumers on your waiting list received 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. Does your CSP have a specific policy or standard practice for assessing and managing suicide risk? Is the program using any particular tools? If so, please list them here.

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

63. Please record **your email address** below to ensure that we have received your survey. You will 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.*