



Wisconsin
Department of Health Services

DIVISION OF CARE AND TREATMENT SERVICES

Community Support Program 2014 Annual Program Survey

2014 Report of Services and Practices

EXECUTIVE SUMMARY

Each year, the Wisconsin Department of Health Services (DHS), Division of Care and Treatment Services (DCTS), conducts a program survey of all Community Support Programs (CSPs) across the state. Pursuant to Wis. Stat. § 51.03(3)(a)5, the CSP program surveys support evaluation activities and meets both state and federal Community Mental Health Services Block Grant reporting requirements.

The survey asks about program utilization and discharge during the previous calendar year; consumer demographics, medical conditions, and substance use; program use of evidence-based practices (EBPs), consumer satisfaction surveys, and waiting lists; and assessment of consumer suicide risk.

In 2014, there were 72 DHS 63-certified CSPs (per Wis. Admin. Code ch. DHS 63) across Wisconsin, 70 of which (97%) responded to this program survey. The number of consumers served in 2014 (5,559 consumers) was essentially unchanged from 2013, and roughly in line with the historical trends.

At the start of 2014, 4,905 consumers were still enrolled in CSPs from the previous year; during the year, 654 individuals were admitted (a 26% increase over 2013) and 738 consumers were discharged (most often because they had recovered to the extent they no longer needed CSP-level services or had moved out of their CSP service area).

More males than females were enrolled in CSPs during 2014. Blacks remained over-represented in CSPs relative to the state's population (17% versus 6.5%) while Hispanics were better represented than in past years (roughly 6% in both CSPs and Wisconsin). At the same time, unexpectedly low reported rates of various medical conditions suggested programs may need to improve efforts to collect data on consumers' physical health. By contrast, rates of reported substance use (tobacco, alcohol, and other drugs) among CSP consumers remained much higher than in the general population.

Seventy-five percent of CSPs offered at least one EBP. Surprisingly, only about half (54%) of CSPs reported using Assertive Community Treatment (ACT), the model upon which CSPs were originally developed; programs noted the intensive staff-to-consumer ratios stipulated in ACT were a barrier given staffing shortages. EBPs that were focused on treating co-occurring (mental health and substance use) disorders and providing Supported Employment services were received at higher rates among male consumers; Permanent Supportive Housing was a focus among the elderly; and blacks were especially likely to receive both Family Psychoeducation and MedTEAM services. Most programs that offered EBPs reported staff had been trained to implement the practice, although a smaller share utilized toolkits to implement those EBPs. As in past years, relatively few CSPs monitored for fidelity and, with the exception of Supported Employment, few, if any, used outside monitors to assess EBP implementation.

Seventy-five percent of CSPs reported using a survey to gauge consumer satisfaction in 2014 (down from 87% in 2013). No standardized instrument was prescribed. Many programs used an internal instrument to gauge satisfaction. Data on consumer satisfaction was not included in the program survey.

Lastly, most CSPs (69%) were able to provide services to all consumers in need of their services without using a waitlist. Those that did use a waitlist generally offered services (including crisis and outpatient mental health services) to consumers during their waiting period. The average time a consumer had to wait for CSP services was 3.8 months (down from 5.1 months in 2013 and 5.5 months in 2012).

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INTRODUCTION

This report is based on the results of the 2014 Community Support Program (CSP) Program Survey provided to all CSPs at the beginning of 2015. In 2014, there were 72 active CSPs, 70 of which (97%) completed the survey. (While La Crosse, Jackson, and Monroe counties were three separate certified CSPs, they returned only one combined program survey response for the Western Region Integrated Care (WRIC) CSP. Therefore, program data was provided by 70 CSPs in a total of 68 counties and regions.)

The CSP Program Survey is intended to capture information in the following areas:

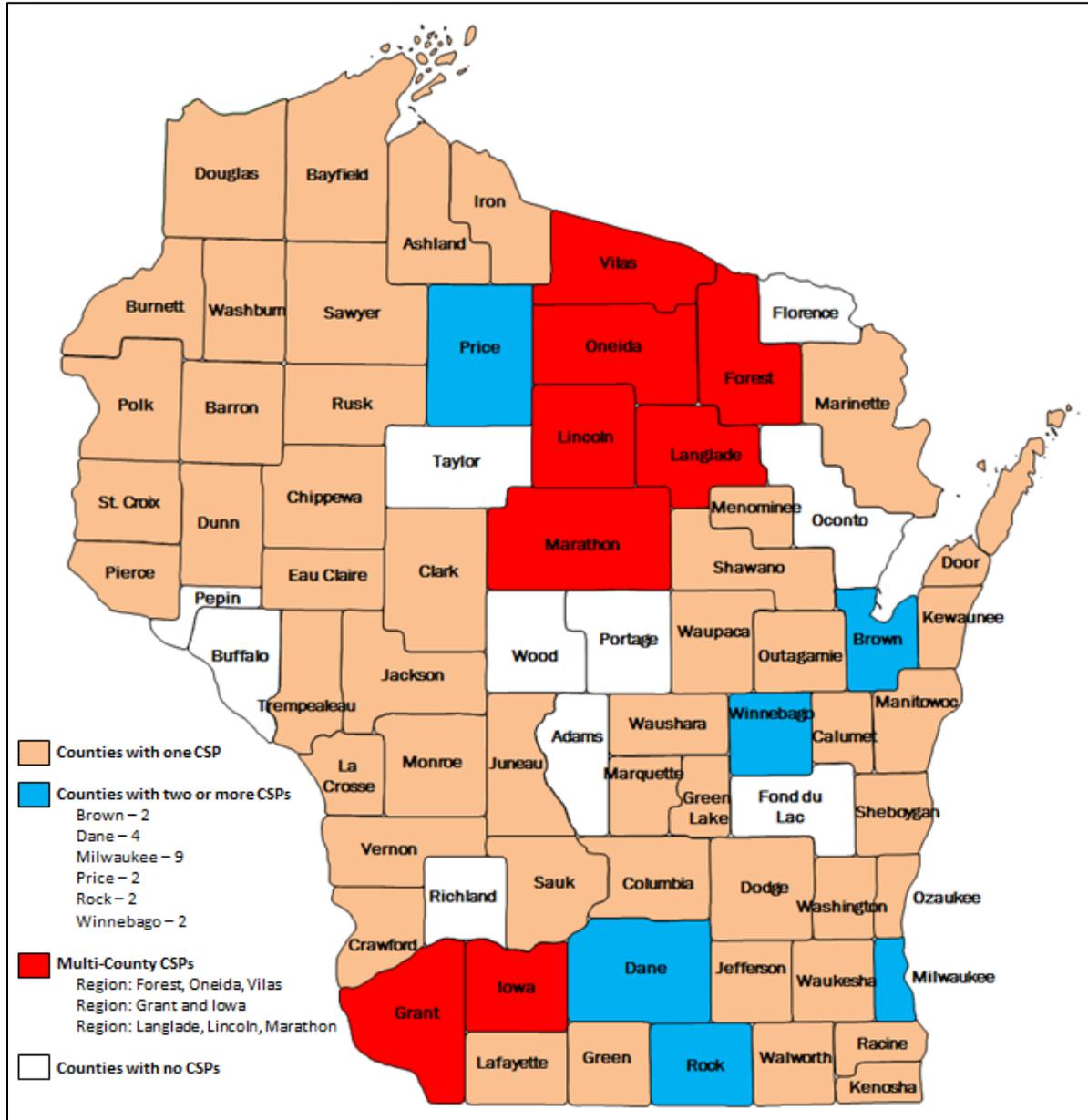
- Program utilization (numbers served, admitted, and discharged during the year);
- Discharge reasons and destinations for consumer who left CSPs;
- Consumer demographics, medical conditions, and substance use;
- Evidence-based practices (EBPs) offered and delivered by CSPs;
- Use of consumer satisfaction surveys;
- Waiting list information; and
- Suicide risk assessment.

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 substance use issues or physical health needs—see Appendix A for a list of Sources for Physical Health Prevalence Rates) 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, to draw out some of the strengths and areas for improvement among CSPs at a given point in time. A copy of the 2014 CSP Program Survey Worksheet appears in Appendix B.

CERTIFIED PROGRAMS 2014

Figure 1 is a map of the 72 certified CSPs in Wisconsin as of April 2014.

Figure 1: CSPs in Wisconsin, April 2014



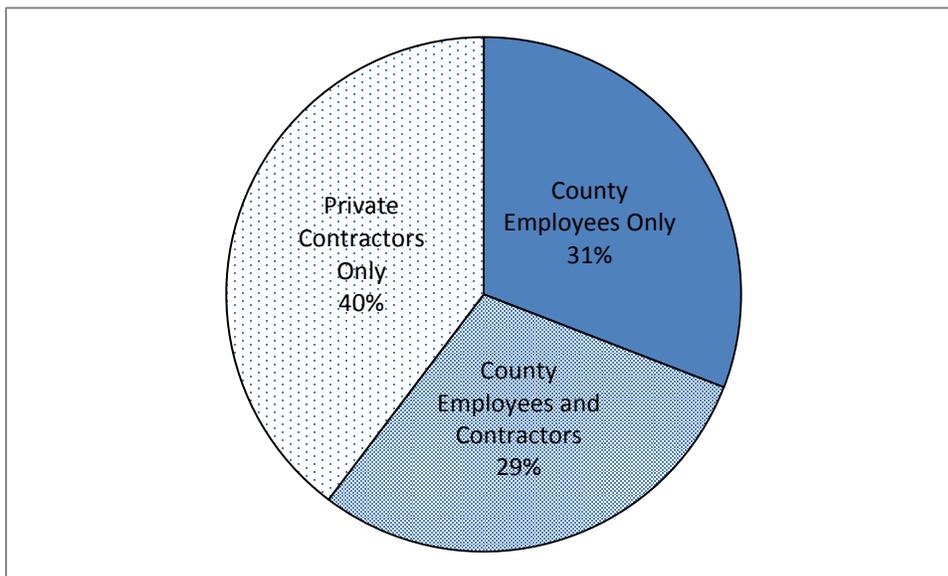
PROGRAM STAFFING

CSPs differ in their staff composition. Programs can be staffed in one of three ways:

- Private contractors only
- County employees only
- A mix of county employees and private contractors

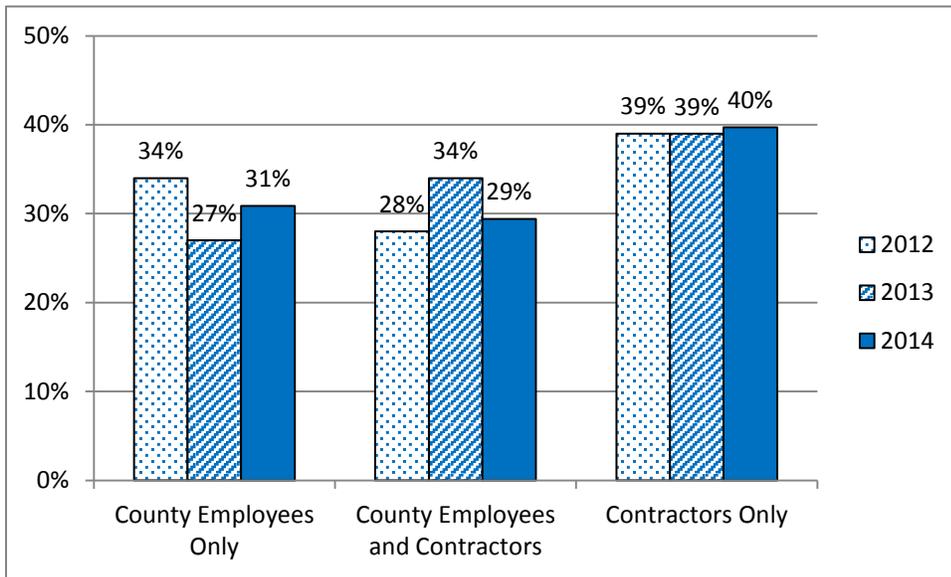
Figure 2 shows that CSP staffing in 2014 was fairly evenly divided between these three categories, but the most frequent staffing configuration was “private contractors only” (40%). Other counties were equally likely to have a staff composed of either “county employees only” (31%) or a combination of “county employees and private contractors” (29%). Over two-thirds of counties (69%) contracted out at least some program staffing to private contractors.

Figure 2: Staff Composition of CSPs, 2014



The pattern of CSP staff composition has not varied widely over the last few years (see Figure 3), especially the proportion of CSPs who were staffed just by private contractors. However, the proportion of CSPs staffed by either by just county employees or both county employees and private contractors fluctuated slightly over the past three years, returning in 2014 closer to the levels seen in 2012.

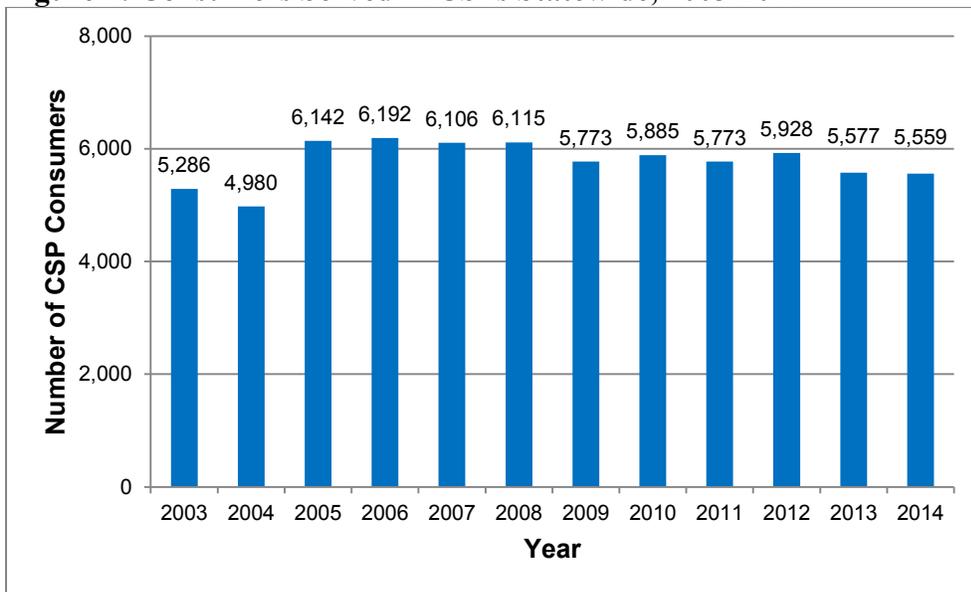
Figure 3: Staff Composition of CSPs, 2012-2014



CONSUMERS SERVED

The number of consumers served in CSPs each year is calculated by summing the number of consumers still enrolled from the previous year plus those consumers newly admitted during the current year. CSPs reported serving a total of 5,559 consumers statewide in 2014, including 4,905 consumers still enrolled from 2013 and 654 admitted in 2014. This number is less than a one percent (0.3%) decrease—essentially unchanged—from the 5,577 served during 2013 and slightly below the numbers served in the past several years (see Figure 4).

Figure 4: Consumers Served in CSPs Statewide, 2003-2014



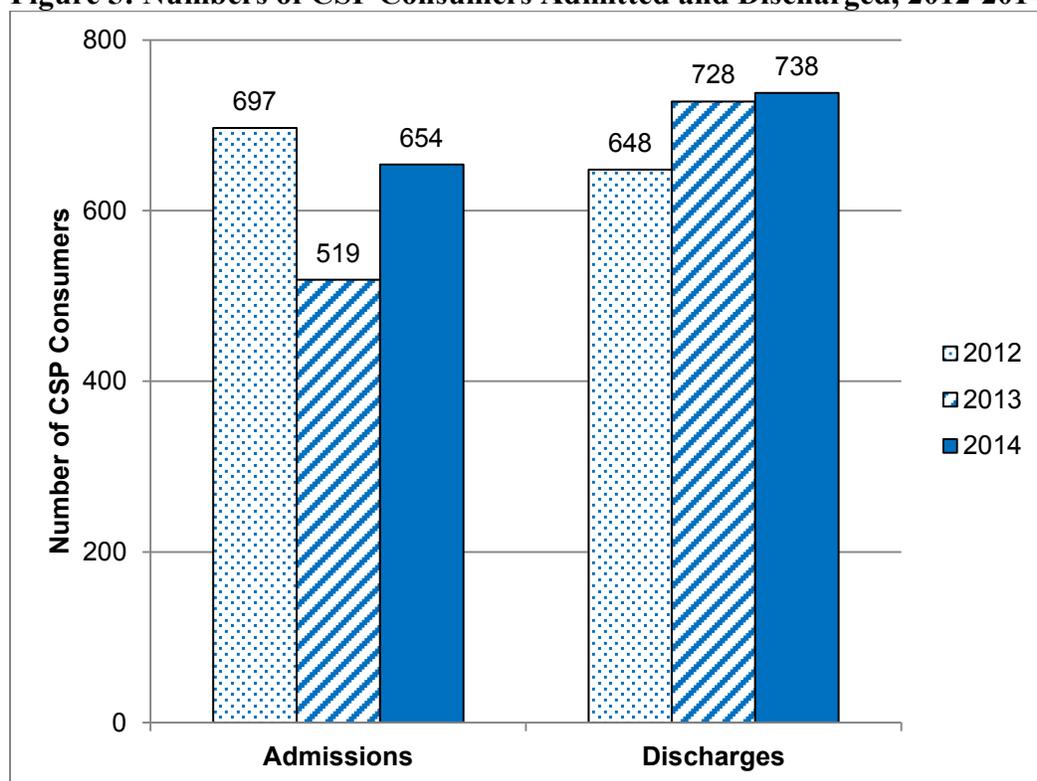
The survey also asked how many consumers were concurrently enrolled in both CSP and Family Care in 2014. Of the 5,559 CSP consumers served during the year, 287 (5%) were also enrolled in Family Care; 77 (27%) of these consumers enrolled in both CSP and Family Care were discharged during 2014.

CONSUMERS ADMITTED AND DISCHARGED

During 2014, 654 individuals were admitted to CSPs across Wisconsin (see Figure 5), a 26% increase over the number admitted in 2013 (and almost 12% of the 5,559 individuals served in 2014).

Consumers often spend long periods of time in CSPs, and discharges from the program are relatively infrequent. In 2014, 738 consumers were discharged from CSPs (approximately 13% of the total 5,559 consumers served during the year).

Figure 5: Numbers of CSP Consumers Admitted and Discharged, 2012-2014



DISCHARGE REASONS AND DESTINATIONS

Despite the longitudinal infrastructure of CSPs, there are several reasons why a consumer might be discharged from the program in any given year. Among the 726 individuals discharged from CSPs during 2014 for whom there was data on their discharge reason (see Figure 6), 36 percent reportedly recovered to the extent that he or she no longer needed CSP-level services while 19 percent moved out of the

geographic service area. A substantial percentage of consumers needed additional services beyond what CSPs could offer (12%) or decided to withdraw from the program (12%). Another 11 percent of consumers died during the year, 3 percent went to jail or prison, 1 percent lost their funding or authorization, and 5 percent were discharged from CSPs for some other or unknown reason.

Figure 6: Reasons for CSPs Discharge, 2014

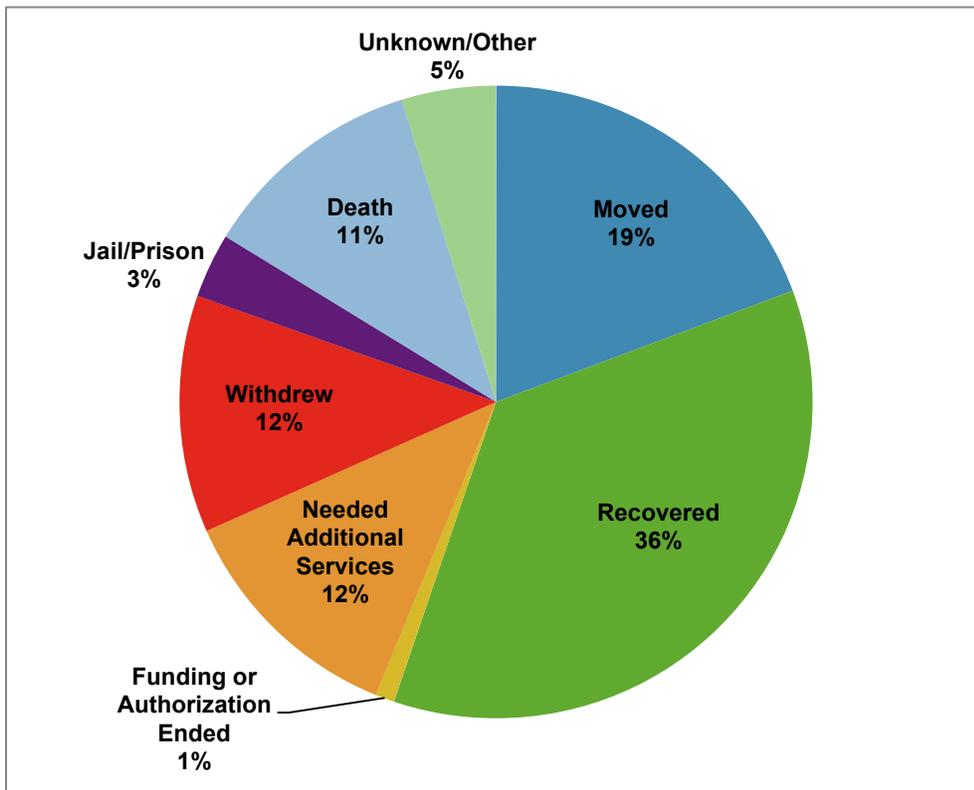


Table 1 provides data on the destination of consumers who were discharged for the various reasons given above. For instance, consumers who moved out of the geographic service area generally either sought services at another CSP (33%) or at a Comprehensive Community Services (CCS) Program (18%), or shifted to receiving individual services such as outpatient therapy (36%) or Targeted Case Management (TCM) (13%). Unfortunately, one in four (25%) of those who moved away from their CSP received no other services, an outcome which may be detrimental for those individuals.¹

As in 2012, the majority of consumers discharged from CSPs in 2014 because they had “recovered to the extent that CSP-level services were no longer needed” were most likely to seek either outpatient therapy (38%) or TCM (27%). This is a shift from 2013 when over half of discharged consumers who had recovered moved to a CCS program (more than twice the 25% in 2014). Still, all three of these destinations appear to provide ongoing support for consumers in recovery.

¹ Many programs checked multiple destinations for each discharge reason, so the total percent across destinations for each discharge reason may be greater than 100 percent.

When consumers were discharged from CSPs because they needed “additional services” beyond what CSPs could offer, most went on to receive residential services at a group home or community-based residential facility (CBRF) (30%), nursing home (22%), or inpatient services (22%).

Table 1: Consumer Destinations by Reasons for Discharge, 2014

Reason for Discharge	Another CSP	Outpatient Therapy	TCM	CCS	Nursing Home	Group Home	Inpatient	No Other Services	Unknown	Other
Moved (19%)	33%	36%	13%	18%	1%	6%	0%	25%	9%	9%
Recovered (36%)	N/A	38%	27%	25%	N/A	5%	N/A	6%	3%	3%
Needed Additional Services (12%)	N/A	N/A	N/A	N/A	22%	30%	22%	0%	3%	17%
Funding or Authorization Ended (1%)	N/A	14%	0%	0%	29%	29%	N/A	29%	0%	0%
Withdrew (12%)	15%	39%	11%	23%	0%	3%	N/A	64%	11%	7%

Very few consumers (n=7) were discharged in 2014 due to a lack of funding or authorization. However, in those few cases, residential facilities—nursing homes (29%) and group homes (29%)—along with outpatient therapy (14%) were the primary destinations of those who received additional services. At the same time, two of the seven consumers (29%) discharged due to a lack of funding or authorization received no other services after leaving CSPs suggesting there may be room to improve the follow-up with consumers who lost CSP support but who may be in need of continuing services.

When consumers decided to withdraw from CSPs, most (64%) discontinued services altogether. However, many others received outpatient therapy (39%) or CCS supports (23%) while still others went to another CSP (15%) or received TCM (11%); still other consumers had destinations that were unknown. As in past years, the destinations of consumers discharged from CSPs in 2014 were quite diverse.

CONSUMER DEMOGRAPHICS

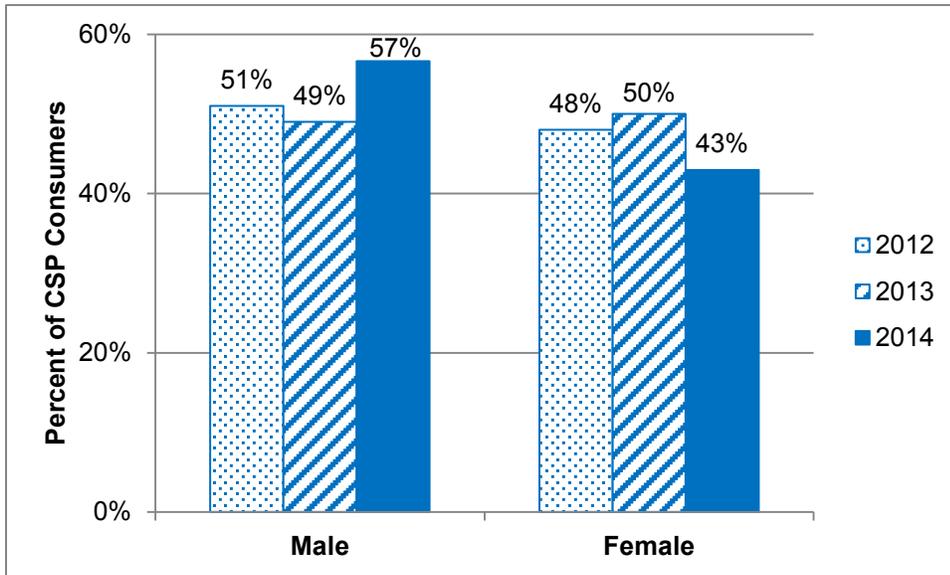
CSPs were asked in this survey to provide demographic information for all consumers served, including gender, age, race, ethnicity, and veteran status.

Gender

In previous years, the gender breakdown of CSP consumers (see Figure 7) was fairly evenly divided between men and women (with gender being “unknown” for the remaining 1% of participants). During

2014, however, CSPs had a much higher percentage of males (57%) than females (43%). The reason for this shift was not immediately clear.

Figure 7: Percent of CSP Consumers by Gender, 2012-2014



Age

As shown in Table 2, almost all of the CSP consumers in 2014 (89%) were between the ages of 21 and 64 (working age adults). An additional 7 percent were between 65 and 74 years old and 1 percent were age 75 years or over. Very few consumers were children (ages 17 or under),² although there were some youth (between 18-20 years old).³ This age distribution is very consistent with those from previous years.

² 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.

³ It is noteworthy that Wis. Admin. Code ch. DHS 63 requires CSPs to serve adults; however, minors can be admitted with a variance from the Wisconsin Department of Health Services, Division of Quality Assurance.

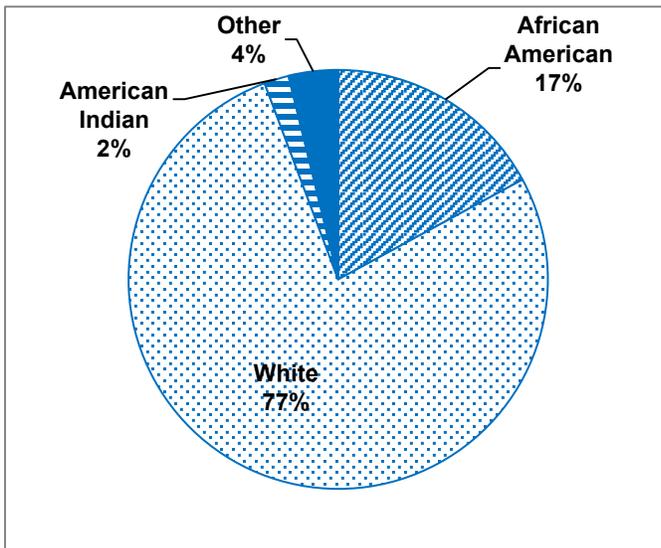
Table 2: Age Distribution of CSP Consumers, 2014⁴

Age Range	Number of Consumers	Percent of Consumers
17 and under	< 25	< 1%
18-20	67	1%
21-64	4,951	89%
65-74	413	7%
75 and over	64	1%

Race

Continuing with a trend seen in previous CSP program surveys, white consumers (see Figure 8) were underrepresented in CSPs (77% of all consumers served) relative to the Wisconsin population at large (where whites were 88% of total residents). At the same time, black consumers remained overrepresented in CSPs relative to their population (17% of CSP consumers but 6.5% of state residents).⁵ All other racial groups (i.e., Native American/American Indian, Asian, Hawaiian/Pacific Islander, and multi-racial individuals) continued to have minimal representation in CSPs (1% to 2%).

Figure 8: Racial Composition of CSP Consumers, 2014



⁴ Percentages are based on the total number of consumers for whom an age range was recorded.

⁵ 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. Six percent of CSP consumers (of those for whom ethnicity was reported—ethnicity was missing for 460 (8%) of the 5,559 consumers served during 2014) were listed as Hispanic or Latino. This rate is just slightly below the 6.5 percent Hispanic population among Wisconsin residents, and much higher than the 3 percent reported in previous CSP program surveys.

Veteran Status

Although veterans make up approximately 7 percent of the population of Wisconsin,⁶ only 3.3 percent of those served by CSPs in 2014 were known veterans, similar to the reported percent in previous years. It seems reasonable to expect that veterans would obtain services through the Veterans Administration (since the VA would be unlikely to authorize funding to serve veterans in CSPs, preferring to serve their own). Under the Veteran's Choice Program, individuals who must drive more than 40 miles to a VA medical facility may receive services through the program known as TRICARE Health Net Federal Services (phone: 866-606-8198). CSPs can contract with this organization in order to serve veterans.

SUBSTANCE USE AND PHYSICAL HEALTH

CSPs were asked to report on the substance use and various physical health issues for all consumers served during the year. 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 use or physical health concerns.

With regard to substance use, just over half of CSP consumers (54%) were reported as using tobacco in 2014 while about one in five abused alcohol (21%) or other drugs (20%).⁷ These rates were very similar to those reported by CSPs in previous years (see Figure 9). However, substance use rates among CSP consumers remain higher than for the general U.S. population⁸ and higher than rates reported by consumers in Wisconsin's CCS programs.⁹ These higher rates of substance abuse are not surprising given the presumed severity of mental health diagnoses among CSP consumers and the high rates of co-occurring mental health and substance use issues.

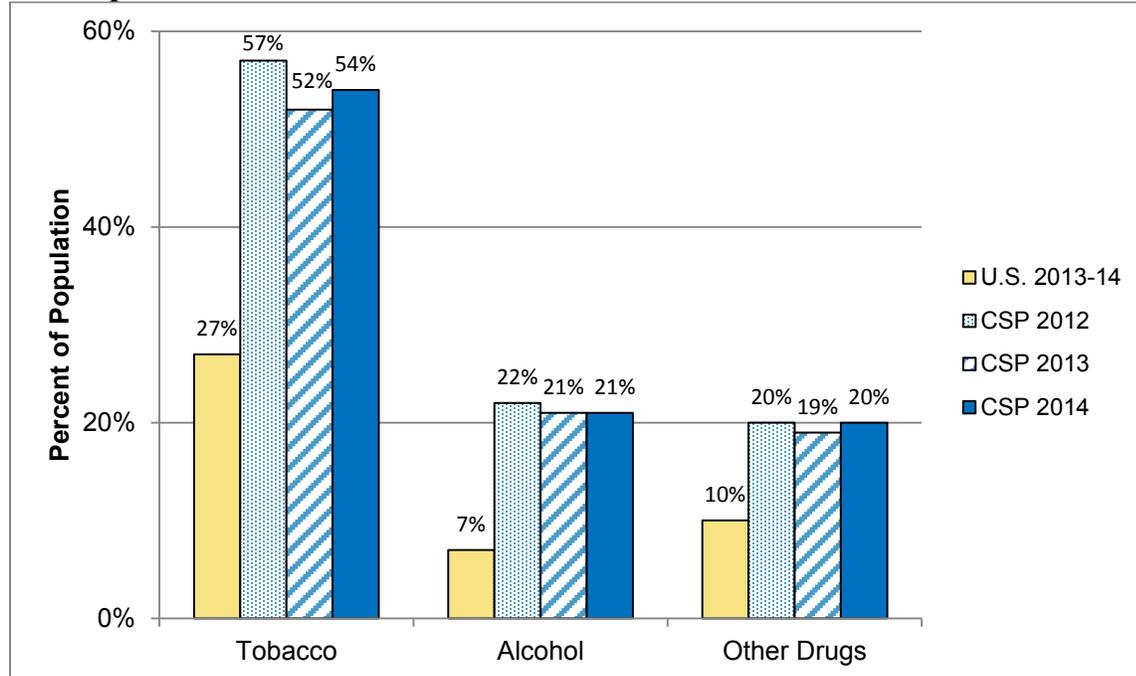
⁶ Statewide estimates are based on 2014 estimates from the U.S. Census Bureau, <http://quickfacts.census.gov/qfd/states/55000.html>.

⁷ One program commented that they only reported those consumers who were active substance users not involved in any form of treatment or recovery; since some consumers may be in the process of addressing their substance use, these figures may be underreported.

⁸ SAMHSA, "National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia)." <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeShortTermCHG2014/NSDUHsaeShortTermCHG2014.pdf>

⁹ CCS rates in 2014 were: tobacco use, 26 percent; alcohol abuse, 18 percent; abuse other drugs, 11 percent.

Figure 9: Comparison of Substance Use among CSP Consumers and the U.S. Population, 2012-2014



CSPs also were asked to supply information on an array of medical conditions among their consumers. As in previous years, respondents reported *lower* than expected prevalence rates for most of the physical health issues included in the survey. For instance, reported rates of obesity (21%), high blood pressure (19%), high cholesterol (16%), and Type II Diabetes (15%) among CSP consumers were all substantially lower than rates in the U.S. population at large.

At first, these results were puzzling given the higher rates of co-occurring physical health issues often found among individuals with mental health concerns.¹⁰ Feedback from service providers suggests several possible explanations for this discrepancy: CSPs may not systematically ask consumers for detailed information about their physical health; consumers may refuse to share medical information or see their health care providers; and mental health record systems do not always provide the ability to document physical health data. As a result, the rates of medical conditions reported for CSP consumers may underestimate the true prevalence of physical health problems in this population.

Given CSPs are tasked with helping consumers advance in all domains of recovery—including physical health—additional efforts could be made to more systematically collect and record these data in the future.

¹⁰ 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.

EVIDENCE-BASED PRACTICES (EBPs)

A main goal of the annual CSP Program Survey is to assess the extent to which programs incorporate evidence-based practices (EBPs) into the services they provide. EBPs asked about on the survey were:

- Assertive Community Treatment (ACT)—uses a multi-disciplinary team-based approach to the provision of treatment, rehabilitation, and support services for clients with severe and persistent mental illness.
- Integrated Dual Disorder Treatment (IDDT) or Integrated Treatment for Co-Occurring Disorders—supports individuals with co-occurring mental illness and substance use disorder.
- Family Psychoeducation—involves the development of a partnership among consumers, families, practitioners, and supporters.
- Illness Management and Recovery (IMR)—focuses on education of the consumer regarding illness, symptoms and management of both in the journey of recovery.
- MedTEAM—also called Medication Management, uses best practices coupled with patient input to make medication management decisions.
- Supported Employment—focuses on the importance of work with relation to recovery and assists the consumer in addressing symptoms that interfere with finding and securing employment.
- Permanent Supportive Housing (PSH)—helps individuals secure and maintain safe housing.

Such practices provide a known and powerful way for CSPs to enhance their consumers' recovery process. However, CSPs are not required to use EBPs; rather, they are provided with information about the SAMHSA Evidence-Based Practices KITS¹¹ and are simply encouraged to incorporate such practices.

EBP Services Offered and Received

Figure 10 shows that, while one in five programs (17 out of 68 programs, or 25%) offered no EBPs at all, the majority of CSPs offer at least one EBP. Most programs (41 of 68, or 60%) offered between one and four EBPs and 10 programs (15%) offered five or more. The average CSP offered 2.3 EBPs, a little below the average of 2.5 in both 2012 and 2013.

¹¹ SAMHSA Evidence-Based Practices KITS:
<http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITS>

Figure 10: Number of EBPs that CSP Programs Offer, 2014

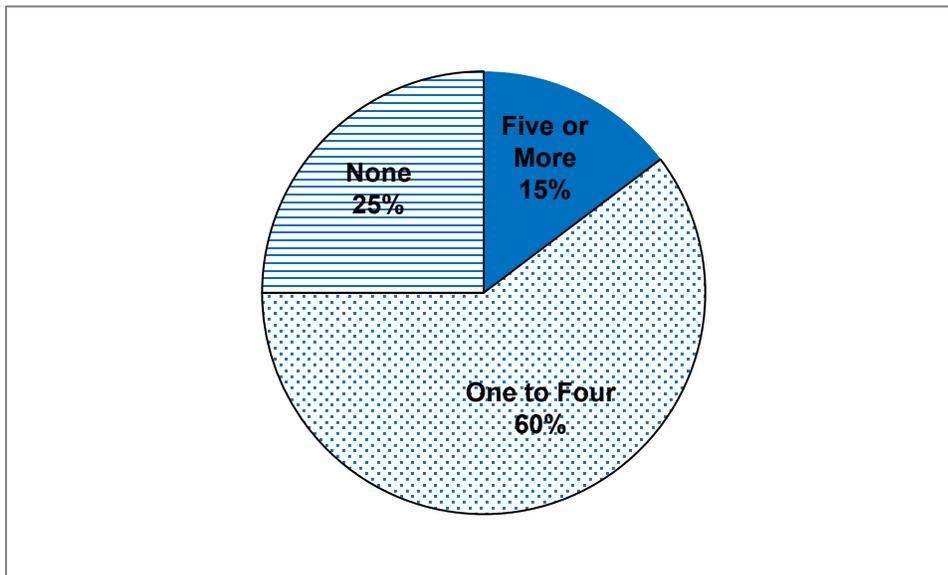


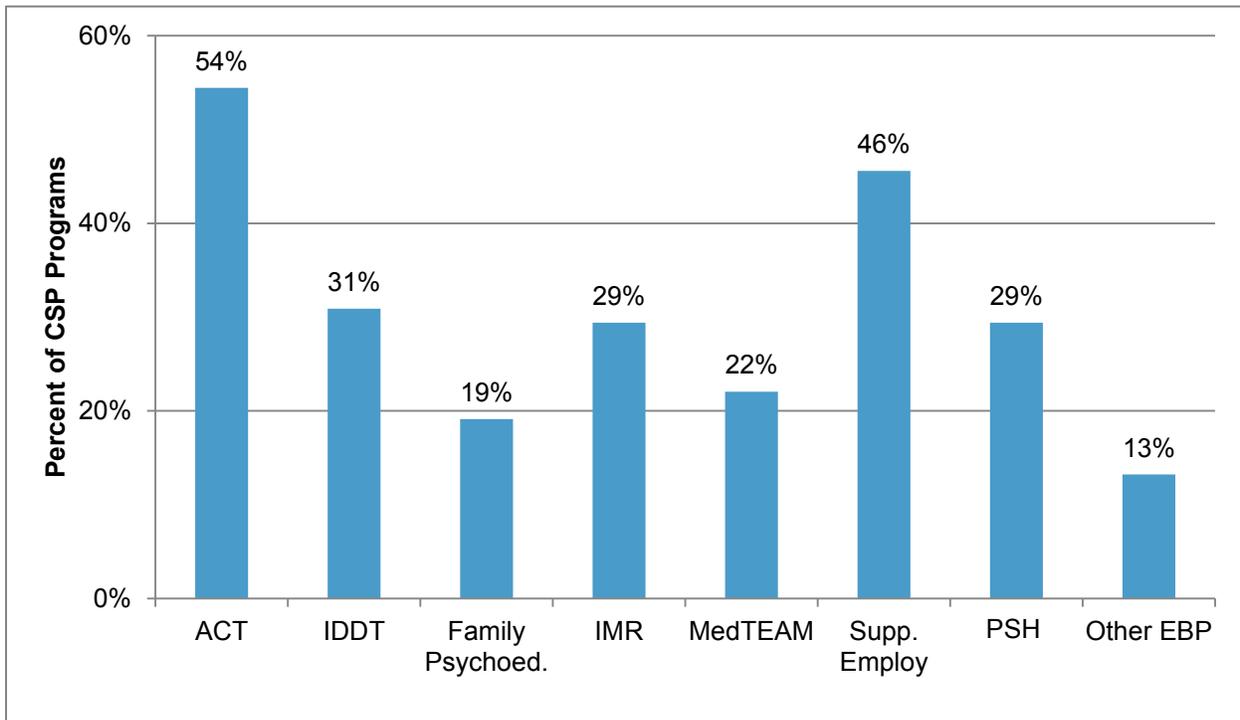
Figure 11 displays the percent of CSPs that offered various EBPs in 2014. Fifty-four percent of all programs (37 of 68 CSPs) reported offering ACT; a slightly smaller share than the previous two years (58% in 2013 and 63% in 2012). Since the CSP model was originally based on a variation of ACT, it is not a surprise that ACT would be the leading EBP offered by CSPs, but perhaps surprising that more CSPs did not offer the service. In 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. Ideally, all CSPs would report using a full-fidelity ACT model, which is much more rigorous than the Wis. Admin. Code ch. DHS 63 CSP standards.

The second most common EBP offered by CSPs in 2014 was Supported Employment with almost half (46%) of CSPs providing the service.¹² Other common EBPs, each offered by about one third of the programs, were IDDT (31%), IMR (29%), and PSH (29%).¹³ Given that CSP consumers have reportedly high rates of substance use, IDDT seems to be an important and appropriate intervention. MedTEAM and Family Psychoeducation were the least commonly offered EBPs.

¹² Results might be skewed because of our directive to CSPs about reporting Supported Employment: “NOTE: If an employment specialist is part of an ACT team, this should be reported only under ACT and not separately as supported employment.”

¹³ These results may be fuzzy with respect to PSH since ACT closely approximates the PSH model, but by definition PSH is not considered a component of ACT. Thus it is incumbent on the ACT Program to report PSH as a separate EBP from ACT.

Figure 11: Percent of CSPs Offering Various EBPs, 2014



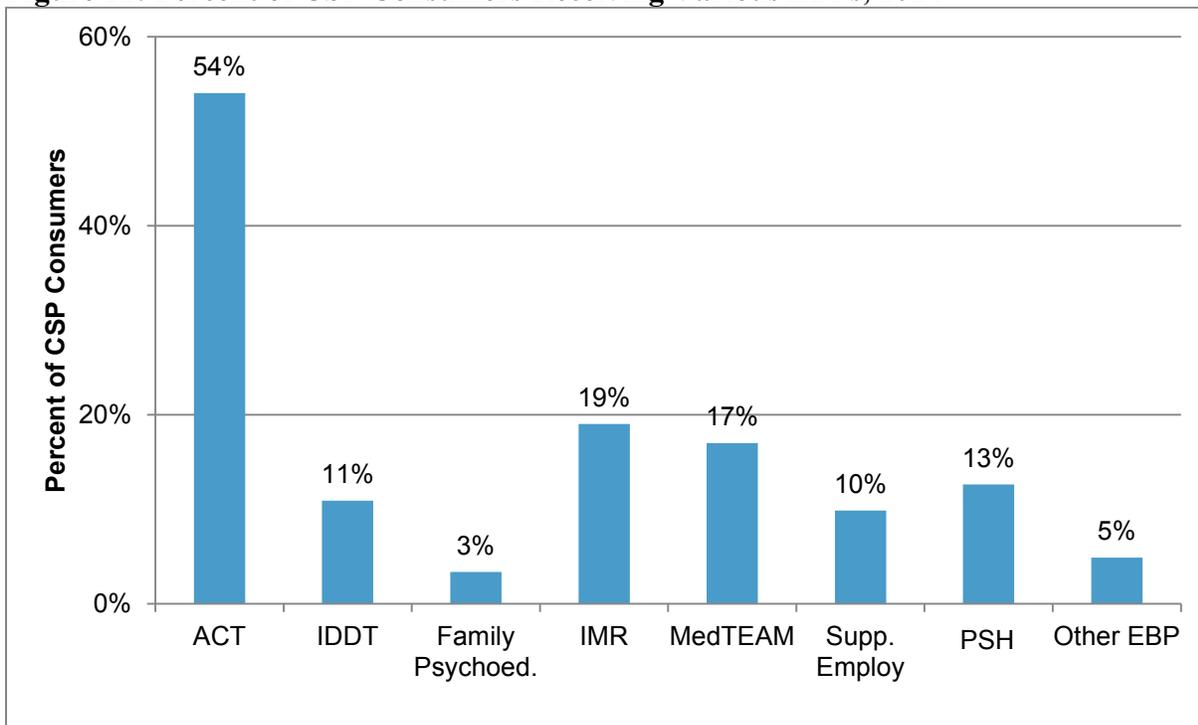
Several programs listed additional EBPs under the “Other” category (shown in Table 3).

Table 3: Other Evidence-Based Practices (EBPs) Offered by CSPs, 2014

Other EBPs/Practices	Number of Programs	Percent of Programs
Motivational Interviewing (MI)	6	9%
Dialectical Behavioral Therapy (DBT)	4	6%
Cognitive Behavioral Therapy (CBT)	2	3%
Peer Recovery Support Specialists	2	3%
Incredible Years	1	1%
Group Therapy/Social Skills	1	1%
Seeking Safety	1	1%

While most CSP programs offered at least one EBP, relatively few CSP consumers actually received those services in 2014. ACT was the only EBP offered to more than half of all CSP consumers during the year; all other EBPs were delivered to less than 20% of CSP consumers (see Figure 12).

Figure 12: Percent of CSP Consumers Receiving Various EBPs, 2014



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 SAMHSA’s guiding documents. Thus, many CSPs 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 fully providing that EBP because they do not meet all the minimum requirements of the practice as described in the EBP Definition Sheet (see Appendix C) that programs are asked to consult when completing the survey. For that reason, it might be assumed that more programs offer and deliver some lower-fidelity variants of these EBPs than these results suggest.

Demographics of Consumers Receiving EBPs

Part of the survey asked programs to describe the demographics of consumers who received each EBP. The tables in this section (Tables 4-7) report the percent distribution of these characteristics (gender, age, race, and ethnicity) both among all CSP consumers as well as among consumers who received each type of EBP service. Given all CSP consumers would presumably benefit from greater use of available EBPs, it is worth examining whether consumers are being offered equal access to these important services.

Table 4 shows that the gender distribution among consumers who received IMR and MedTEAM services (44% female and 56% male) was about the same as the gender distribution of all CSP consumers (43% female, 57% male). On the other hand, males were more likely than females to receive several EBPs—ACT (60%) and PSH (61%)—and much more likely to receive IDDT (73%) and Supported Employment (69%) while females were more likely than males (relative to CSP consumers as a whole) to receive Family Psychoeducation services (50%).

Table 4: Gender Distribution of All CSP Consumers vs. Recipients of each EBP, 2014

Gender	All CSP	ACT	IDDT	Fam Psych	IMR	Med TEAM	Supp Emp	PSH
Female	43%	40%	27%	50%	44%	44%	31%	39%
Male	57%	60%	73%	50%	56%	56%	69%	61%
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Total Count	5,536	2,939	602	161	1,099	944	545	689

Relative to the share of working age adults among all CSP consumers (90%, the largest age group among consumers overall), a much higher percentage of consumers who received IDDT (96%) were ages 21-64 years. On the other hand, consumers in this age group were much less likely to receive PSH services (only 77%) while the youngest consumers (ages 17 and under) and older consumers (aged 65-74 years) were both more likely to get PSH (4% and 15%, respectively) relative to their share of all CSP consumers. Understandably, consumers aged 65 and over received Supported Employment services less frequently (only 4%, compared with 8% among all CSP consumers) while the youngest consumers were more likely to receive IMR and MedTEAM (each 3%, compared with less than 1% among all CSP consumers).

Table 5: Age Distribution of All CSP Consumers vs. Recipients of each EBP, 2014

Age	All CSP	ACT	IDDT	Fam Psych	IMR	Med TEAM	SE	PSH
<=Age 17	0%	*	*	*	3%	3%	*	4%
Age 18-20	1%	1%	*	*	*	*	*	*
Age 21-64	90%	89%	96%	91%	88%	87%	93%	77%
Age 65-74	8%	8%	*	*	7%	7%	4%	15%
Age 75+	1%	1%	*	*	*	*	*	*
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Total Count	5,510	2,737	605	161	1,069	976	644	720

Note: To preserve consumer confidentiality, when fewer than 25 consumers in any one demographic category received a particular EBP service, the percent served is reflected as an asterisk (*).

With regard to race, blacks were especially likely to receive both Family Psychoeducation and MedTEAM services (29% and 25% of EBP recipients respectively, compared with 17% among all CSP consumers). At the same time, white consumers were somewhat underrepresented within these services (71% of EBP recipients vs. 78% of consumers). Other racial groups were provided EBPs proportionate to their representation among consumers (although their numbers in CSPs are so small as to make valid comparisons difficult).

Table 6: Race Distribution of All CSP Consumers vs. Recipients of each EBP, 2014

Race	All CSP	ACT	IDDT	Fam Psych	IMR	Med TEAM	SE	PSH
AIAN	2%	2%	*	*	*	*	*	*
Asian	1%	1%	*	*	*	*	*	*
Black	17%	19%	22%	29%	21%	25%	16%	23%
Haw/PI	0%	2%	*	*	*	*	*	*
White	78%	75%	75%	71%	76%	71%	78%	74%
2+Races	1%	1%	*	*	*	*	*	*
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Total Count	5,475	2,862	680	123	998	903	486	673

Note: To preserve consumer confidentiality, when fewer than 25 consumers in any one demographic category received a particular EBP service, the percent served is reflected as an asterisk (*).

With the exception of IMR and MedTEAM, Hispanic consumers were less likely (and non-Hispanic consumers were more likely to receive) to receive most EBPs, including Family Psychoeducation, IDDT, Supportive Employment and ACT.

Table 7: Ethnicity Distribution of All CSP Consumers vs. Recipients of each EBP, 2014

Ethnicity	All CSP	ACT	IDDT	Fam Psych	IMR	Med TEAM	SE	PSH
Hispanic	6%	3%	*	*	5%	6%	*	*
Non-Hispanic	94%	97%	98%	99%	95%	94%	98%	96%
Total Percent	100%	100%	100%	100%	100%	100%	100%	100%
Total Count	5,099	2555	615	277	1037	917	501	624

Note: To preserve consumer confidentiality, when fewer than 25 consumers in any one demographic category received a particular EBP service, the percent served is reflected as an asterisk (*).

EBP Training and Monitoring

The survey also included a series of questions asking whether:

- Staff had been specifically trained to implement each EBP.
- Programs used toolkits defined in the EBP Definition Sheet to guide implementation.
- Programs monitored fidelity of each EBP.
- Programs used an outside monitor to review fidelity for each EBP.

As can be seen in Figure 13, programs were quite likely to have trained staff to implement many EBPs. In particular, programs that used IMR were most likely to have trained staff to administer that service (85%), followed closely by ACT (81% of programs) and IDDT (81%). Staff also were likely to have been trained to deliver Supported Employment (71%) and PSH (65%), but less likely to have received training on MedTEAM (60%) and Family Psychoeducation (54%).

Overall, programs did not always use toolkits to guide implementation of these EBPs. Programs used toolkits more often to guide implementation of ACT (68%), IMR (65%), Supported Employment (58%), and IDDT (57%), but less often with PSH, MedTEAM, and Family Psychoeducation (used by 45%, 40% and 31% of CSPs, respectively).

Figure 13: Percent of CSPs that Used EBP Training and Toolkits, 2014

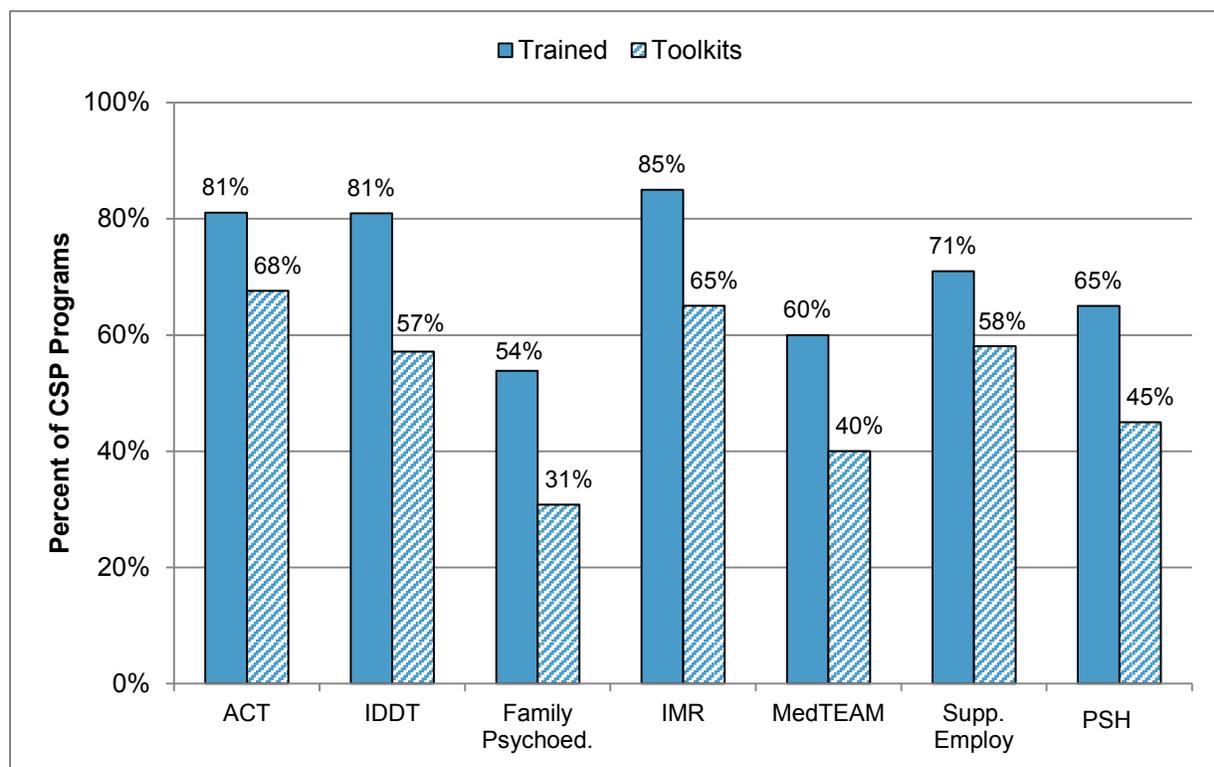


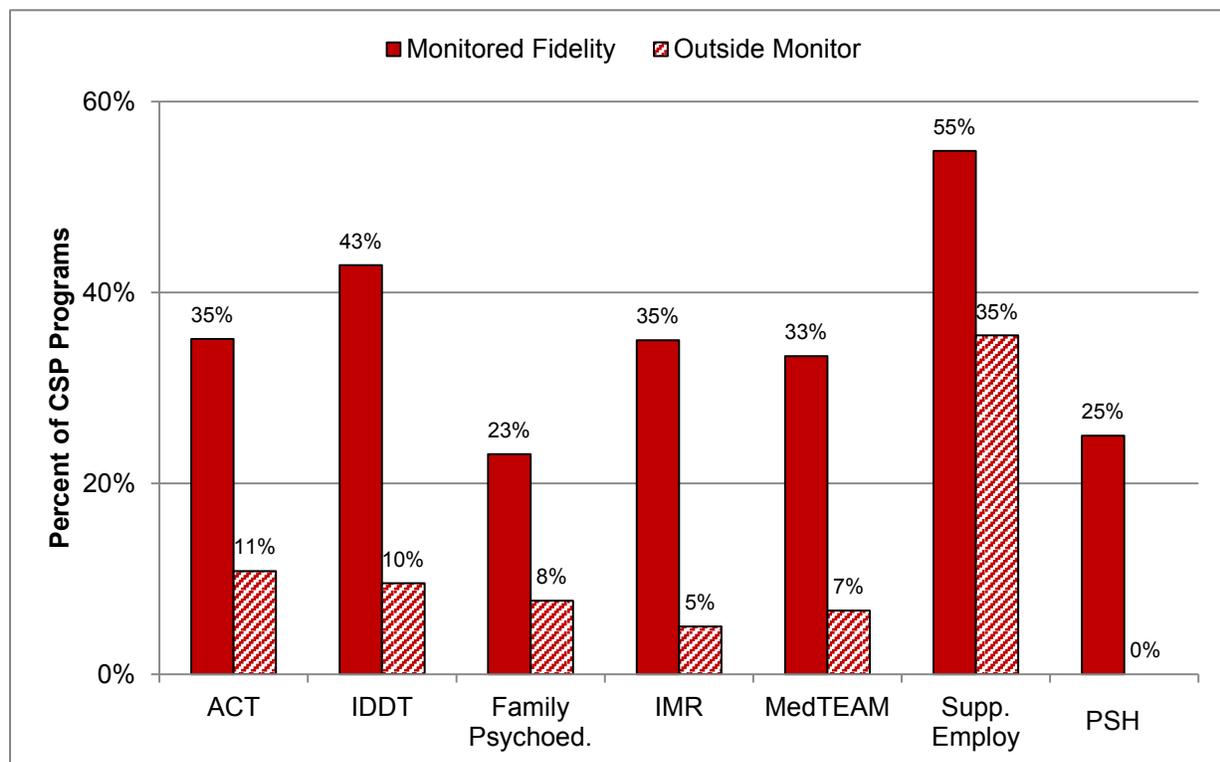
Figure 14 illustrates that relatively few programs monitored fidelity of their EBPs (to know if the EBPs are actually being delivered as intended). As in 2013, Supported Employment was the most frequently monitored EBP in 2014 (at 55%) as well as the EBP most likely to make use of an outside monitor (35%). This is perhaps not surprising, given that DCTS has staff dedicated to training and monitoring Supported Employment—something that is not true of other EBPs listed in the survey.

Surprisingly, only about one third (35%) of CSPs that listed ACT as an EBP they offered reported monitoring for fidelity, even though ACT is the model upon which CSPs are based. CSPs also were unlikely to deploy an outside monitor to assess ACT services, with only 11% of participating programs doing so. Less than half of programs monitored the fidelity of other EBPs they offered and, with the

exception of Supported Employment, few if any CSPs used outside monitors to assess implementation of other EBPs.

Fidelity tools used to monitor ACT services included tools provided by SAMHSA's EBP KITS; Dartmouth Assertive Community Treatment Scale (DACTS), Program of Assertive Community Treatment (PACT)¹⁴ Fidelity Tool, and National ACT Standards. Tools used to monitor other EBPs included the Integrated Dual Disorder Treatment (IDDT) Fidelity Scale, the Center for Evidence-Based Practices at Case Western Reserve University, Individual Placement and Support (IPS) Fidelity Assurance Specialist, PACT Integrated Vocational Model, IPS Fidelity Standards (from the Dartmouth Psychiatric Research Center), and tools provided by external agencies (e.g., Chrysalis).

Figure 14: Percent of CSPs that Monitored EBP Fidelity and Used Outside Monitors, 2014



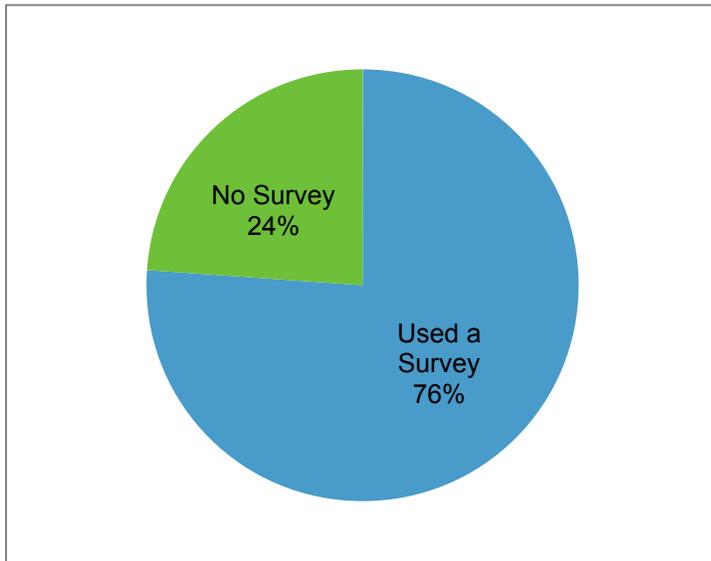
¹⁴ The Program of Assertive Community Treatment (PACT), an outpatient, clinical research unit of the Mendota Mental Health Institute, aims to develop, provide, and investigate innovative mental health treatments for persons who have not had optimal treatment responses to existing forms of treatment.

CONSUMER SATISFACTION SURVEYS

Measuring consumer satisfaction is an important part of quality assurance for any program. While CSPs are not provided with any standard consumer satisfaction tool, they are encouraged to assess their consumers' program satisfaction on an annual basis using some form of questionnaire.

As shown in Figure 15, 76 percent of the 68 CSPs that responded to the program survey said they used a survey or other tool to gauge consumer satisfaction in 2014. While these results are promising, they actually represent a decline from 2012 and 2013 when 80 percent and 87 percent of programs, respectively, collected consumer satisfaction data.

Figure 15: Percent of CSPs Using a Consumer Satisfaction Survey, 2014

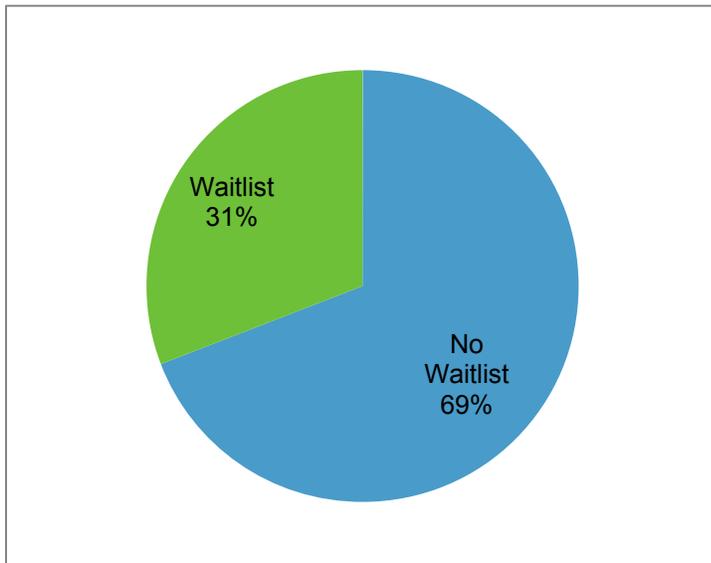


Almost two of every five CSPs (19 of 51 respondents, 37%) reported using the Recovery-Oriented System Indicator (ROSI) survey, a consumer self-report survey and administrative profile designed to assess the recovery orientation of community mental health systems for adults with serious and prolonged psychiatric disorders. Four programs said they used the Mental Health Statistics Improvement Program (MHSIP) survey and two reported using the survey instrument provided in their EBP toolkit, but about one-third (16 programs, 31%) reported using a tool that their own county or agency had developed.

WAITING LISTS

Programs were asked if they used a waiting list, a list of individuals waiting for needed CSP services. While the majority of programs (69%) reported not needing to utilize a waitlist (see Figure 16), 31 percent maintained such a list of individuals (about the same proportions as reported in the two previous years).

Figure 16: Percent of CSPs Using a Waitlist, 2014

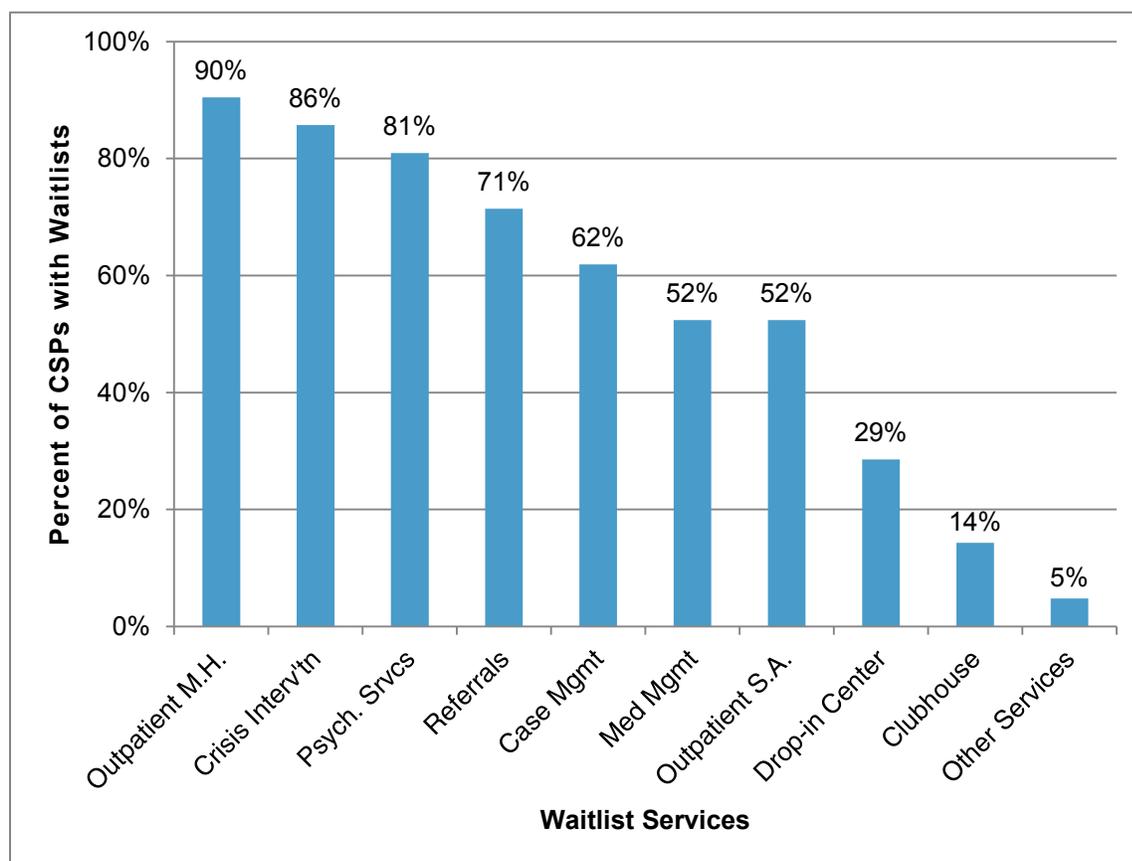


The number of people served on waitlists in 2014 was a bit higher than in 2013. The 21 CSPs with a waitlist in 2014 had 193 existing consumers in need of services at the beginning of 2014 (up from 168 at the start of 2013, but about the same number as the 196 individuals waiting in 2012) and added 241 new individuals to their waitlist during the year (about the same as was added in both 2013 and 2012). Across all programs with waitlists, 176 individuals were waiting for CSP services on December 31, 2014.

The average length of time before individuals received CSP services during 2014 was 3.8 months (down from 5.1 months in 2013 and 5.5 months in 2012). The most common wait time was three months (reported by 44% of programs) while wait times varied between one and 12 months (less than the 18-month maximum in 2013).

Of those CSPs that maintained waitlists, the vast majority offered services to consumers during their wait (see Figure 17). The most common services offered were outpatient mental health services (offered by 19 of the 21 programs with waitlists, 90%), crisis intervention services (86%), and psychiatric services (81%). CSPs also offered referrals (assistance locating community resources), case management, medication management, or outpatient substance abuse services to over half (between 52% and 71%) of the individuals on their waitlists. Less common, but still offered, were drop-in center, clubhouse, and other services (including Family Care and Comprehensive Community Services).

Figure 17: Services Offered to Consumers on CSP Waitlists, 2014



SUICIDE RISK ASSESSMENT

Finally, CSPs were asked to report whether or not they had a policy or standard practice for assessing and managing suicide risk among their consumers and, if so, what tools they used. Sixty-one of the 68 programs (90%) said they did have a policy to assess their consumers for suicide risk.

Many of the CSPs did not have a particular tool to assess suicide risk among their consumers. However, these programs generally indicated they evaluated suicide risk during daily and weekly interactions with clients, at home visits or as part of a crisis plan (e.g., the Wellness Recovery Action Plan™ (WRAP) based crisis plan) for every individual enrolled in the program, using their clinical judgment as part of their regular practice.

Other CSPs worked with a Wis. Admin. Code ch. DHS 34 crisis team or mobile crisis team to evaluate and manage suicide risks. Still other programs referenced the SAMHSA's SAFE-T 5-Step resource, the Question, Persuade and Refer (QPR) training tool, or reported staff had gone through ASIST training.

Among those CSPs that said they did use a particular tool, the Columbia Suicide Severity Rating Scale (C-SSRS) was the most frequently mentioned suicide assessment tool. Many other programs used the Suicide Assessment Checklist or a locally developed tool to assess suicide risk among their consumers,

including an assessment tool created by North West Connections, the Beck Depression Module, the Crisis Triage Rating Scale, the Suicide Probability Scale, and the Bell Therapy Suicide Assessment.

CONCLUSION

Several points emerged from this analysis of the 2014 CSP Program Survey:

- The number of consumers served in 2014 remained essentially unchanged from 2013 and in line with historical trends. Also, many of the consumers discharged during the year left because they had recovered to the extent they no longer needed CSP-level services. More males than females received CSP services during 2014 and blacks continued to be overrepresented among CSP consumers (relative to the Wisconsin population).
- Substance use among CSP consumers remained higher than for the U.S. population in general, but prevalence of medical conditions among consumers continued to be lower than expected (given the higher rates of co-occurring physical health issues often found among individuals with mental health concerns).
- In terms of services provided, most CSPs offer at least some evidence-based practices (EBPs) as part of their program, although only about half reported using Assertive Community Treatment (ACT), the model upon which CSPs were originally developed. As in previous years, relatively few CSPs reported monitoring for fidelity and few, if any used outside monitors to assess EBP implementation.

Looking forward:

- Given the known physical health issues common among individuals with serious and persistent mental illness, it is important for programs to conduct and record comprehensive assessments of consumers' medical conditions.
- It will remain important for programs that have not yet begun offering, or do not fully implement, EBP services to better incorporate them into their programs and offer them equitably to all their consumers. Likewise, external monitoring of EBPs is critical to providing services with fidelity to the standard practice.

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-disease.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: 2014 CSP PROGRAM SURVEY WORKSHEET

This worksheet is provided to assist you in completing the 2014 CSP Program Survey. You can collect the information you need and record your answers on this worksheet, then use it to enter your responses into the online survey. Please do not submit copies of this worksheet with your responses. **For us to receive your program data, you will need to complete the online survey.**

If you manage more than one CSP, please complete a separate survey for each program.

Questions with asterisks (*) are required to complete the survey. Dashed lines on this worksheet indicate a page break in the online survey.

Please complete the survey by March 27. If you have questions or difficulties with the survey, please contact Laura Blakeslee at Laura.Blakeslee@wisconsin.gov. Thank you!

Administrative Information

1. Please enter the name of the county contracting for or directly operating your CSP.*

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

3. Does your CSP employ county employees only, a mixture of county employees and private contractors, or private contractors only? *

- _____ County employees only
_____ County employees and contractors
_____ Private contractors only

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

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

Program Information

6. How many active CSP consumers did you have on 12/31/2013? *

--

7. How many new admissions to your CSP did you have in 2014? *

--

page 2

8. Total number of consumers served by your CSP in 2014:
[This number is calculated automatically by the online survey = #6 + #7]

--

9. How many discharges from your CSP did you have in 2014? *

--

page 3

10. Number of active CSP consumers you had on 12/31/2014:
[This number is calculated automatically by the online survey = #8 - #9]

--

11. How many of the continuing 2013 enrollees plus new 2014 enrollees served were concurrently enrolled in Family Care? *

--

12. How many of the total 2014 CSP consumers discharged in 2014 were in Family Care? *

--

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Discharge Reasons

In this section, please provide information on reasons why consumers were discharged in 2014 and where they went after discharge. In Question 13, please indicate whether or not consumers were discharged from your CSP in 2014 for each reason listed. In Question 14, please enter the number of consumers discharged for each reason: if zero consumers were discharged for a particular reason, enter “0” for your answer to that reason; if there was more than one reason for a consumer’s discharge, please choose the primary reason. Your total number of discharges in Question 14 must match the number of discharges during 2014 (reported in Question 9).

13. Were consumers discharged from your program in 2014 because ...*
[If you answer "No" to any of these reasons for discharge, the online survey will automatically skip further questions about that particular reason.]

	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 other reasons not listed above?	<input type="radio"/>	<input type="radio"/>

14. How many 2014 consumers were discharged because ...*
[The sum of the numbers entered for this question must equal the total number of 2014 discharges (reported in Question 9). Please enter “0” if no consumers were discharged for a particular reason.]

	# 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 other reasons not listed above?	

Discharge Destinations

For all CSP consumers, who were discharged in 2014 for each the reason listed in this section, please provide the number of consumers who transitioned to each of the following destinations.

[The total number of consumers discharged for each reason (across all transition destinations) will automatically appear in the final row for each question in the online survey. Please double-check that these totals match the number of consumers who were discharged for each reason (that you reported in Question 14).]

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

15. For all 2014 consumers discharged because they moved from your geographic service area, how many went to each of the following destinations? *

	# of Consumers
Another CSP	
Outpatient therapy / psychiatry	
Targeted Case Management (TCM) 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. For all 2014 consumers discharged because they recovered to the extent that CSP-level services were no longer needed, how many went to each of the following destinations? *

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management (TCM) 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 CCS-level services were no longer needed), please describe where these consumers went.

page 7

19. For all 2014 consumers discharged because funding or authorization ended for the consumer, how many went to each of the following destinations? *

	# 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.

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21. For all 2014 consumers discharged because the consumer needed services beyond what CSP can offer, how many went to each of the following destinations? *

	# 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.

page 9

23. For all 2014 consumers discharged because the consumer decided to withdraw, how many went to each of the following destinations? *

	# of Consumers
Another CSP	
Outpatient therapy / psychiatry	
Targeted Case Management (TCM) 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 discharged because the consumer decided to withdraw), please describe where these consumers went.

page 10

25. For consumers who were reported as discharged for other reasons not listed in Question 14, please describe the reasons these consumers were discharged.

Other Reason 1:

Other Reason 2:

Other Reason 3:

page 11

Demographic Information

Please provide information about the full group of CSP consumers you served in 2014.

[The total for each question in this section must equal the total number of consumers you reported serving in 2014 (as calculated in #8).]

26. Please enter the number of 2014 consumers of each gender.*

	# of Consumers
Female	
Male	
Unknown	

27. Please enter the number of 2014 consumers in each age group.*

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

28. Please enter the number of 2014 consumers of each race.*

	# 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 2014 consumers of each ethnicity.*

	# of Consumers
Hispanic / Latino	
Not Hispanic / Latino	
Unknown	

30. Please enter the number of 2014 consumers who are veterans and non-veterans.*

	# of Consumers
Veterans	
Non-Veterans	
Unknown	

Medical Conditions & Substance Use

31. Please enter the number of 2014 consumers with the following substance use patterns. *
[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 2014 consumers with the following medical conditions. *
[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 / coronary artery disease, heart attack, or stroke)	

Evidence-Based Practices (EBPs)

This section asks you to report on evidence-based practices (EBPs) received by your consumers. 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.

[If you answer "No" to any of the EBPs in Question 33 (to indicate you did not use that EBP with any clients in 2014), the online survey will automatically skip other questions about that EBP on the following pages. If you did not use an EBP with any clients in 2014, please report a "0" for that EBP in Question 34, instead of leaving it blank.]

33. Did you use the following Evidence-Based Practices (EBPs) in 2014? *
[Please answer "Yes" or "No" for each EBP.]

	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 found on the SAMHSA website)	<input type="radio"/>	<input type="radio"/>

34. How many consumers received each of the following EBPs in 2014? *
[Please count a consumer multiple times if they received more than one EBP during 2014.]

	# 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 found on the SAMHA website)	

35. How many consumers of each gender received each of the following EBPs in 2014? *
Please count a consumer multiple times if they received more than one EBP during the year.

[On the online survey, the total number of consumers receiving each EBP across gender 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.]

EBPs	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. How many consumers in each age group received each of the following EBPs in 2014? *
Please count a consumer multiple times if they received more than one EBP during the year.

[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.]

EBPs	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						

page 14, cont.

37. How many consumers of each race received each of the following EBPs in 2014? *
 Please count a consumer multiple times if they received more than one EBP during the year.

[On the online survey, the total number of consumers receiving each EBP across all races 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.]

EBPs	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							

page 14, cont.

38. How many consumers of each ethnicity received each of the following EBPs in 2014? *
 Please count a consumer multiple times if they received more than one EBP during the year.

[On the online survey, the total number of consumers receiving each EBP across ethnicity 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.]

EBPs	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			

page 14, cont.

Evidence-Based Practices (EBPs), Continued

Please answer the following set of questions on your use of each specific 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.

[If you answered "No" to any of the EBPs in Question 33 (to indicate you did not use that EBP with any clients in 2014), the online survey will automatically skip questions about that EBP on the following pages.]

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

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

page 15

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

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

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43. Family Psychoeducation *

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

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

page 17

45. Illness Management and Recovery (IMR) *

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

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

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47. MedTEAM *

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

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

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49. Supported Employment *

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

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

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51. Permanent Supportive Housing *

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

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

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53. What other EBPs (not listed previously, but found on the SAMHSA website) did you use in 2014?

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

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Consumer Satisfaction

54. Did your CSP use a survey or other tool to measure consumer satisfaction in 2014? *

[If you answer "No" to this question, the online survey will automatically skip other questions about consumer satisfaction.]

___ Yes ___ No

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55. Which surveys or tools did you use to measure consumer satisfaction? *

[Please check all that apply.]

The instrument in my Evidence-Based Practice (EBP) toolkit	
Recovery-Oriented Systems Inventory (ROSI) survey	
Mental Health Statistical Improvement Project (MHSIP) survey	
Other tool <i>(please describe)</i> :	

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CSP Waiting List Information

56. Were there times during 2014 when there was a waiting list for CSP services? *

[If you answer "No" to this question, the online survey will automatically skip further questions about waiting lists.]

___ Yes ___ No

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57. How many individuals were on the CSP waiting list on 12/31/2013? *

58. How many *additional* individuals were placed on the CSP waiting list during 2014? *

59. How many individuals were on the CSP waiting list on 12/31/2014? *

60. How long was the average wait (in months) during 2014 before individuals on your waiting list received CSP services? *

[Please provide an average number of months, not a range of months.] _____

61. Which of the following interim services did individuals receive while they were on your CSP waiting list? * *[Please check 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> :	

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Suicide Risk Assessment

62. Does your CSP have a policy or standard practice for assessing and managing suicide risk? Is your program using any particular tools? If so, please list them here.

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Final Comments

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

64. Please record your email address below so that we may send you an email confirmation of your survey completion and a copy of your survey 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.]

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Thank you for completing this survey!

APPENDIX C: EBP DEFINITION SHEET

DEFINITION OF EVIDENCE-BASED PRACTICES for the 2014 CSP and 2014 CCS SURVEYS

DEFINITION OF EVIDENCE-BASED PRACTICES (EBPs) FOR THE 2014 CSP and 2014 CCS PROGRAM SURVEYS

INSTRUCTIONS: You are asked to report how many consumers received evidence-based practices (EBPs) on the Program Survey. This document provides a one-page description of each EBP to help you determine whether you provided the EBP and should report consumers who received it on the survey.

- Any EBP that you report should match the description on the following pages as well as the description in the formal EBP toolkits found through the web links on each page.
- Any EBP that you report should meet the *minimum requirements* specified on the following pages. Complete details about implementing an EBP can be found at the web links listed for each EBP within this document. To report the use of an EBP for the CSP Program Survey, you may use the summary of the EBP *minimum requirements* specified on the following pages.
- Some survey questions ask whether your program monitors the fidelity of each EBP you've implemented. To determine if you formally monitor fidelity, refer to the description of fidelity tools and methods through the web links on each page.

ASSERTIVE COMMUNITY TREATMENT

I. DEFINITION

This is a team-based approach to the provision of treatment, rehabilitation, and support services. ACT/PACT models of treatment are built around a self-contained, multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

III. MINIMUM REQUIREMENTS FOR REPORTING ACT

- **Small caseload:** Client/ provider ratio of 10:1 or fewer is the ideal.
- **Multidisciplinary team approach:** This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTEs on the team
- **Includes clinical component:** In addition to case management, the program directly provides services such as: psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- **Services provided in community settings:** Program works to monitor status and develop community living skills in the community rather than the office.
- **Responsibility for crisis services:** Program has 24-hour responsibility for covering psychiatric crises.

IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER (MENTAL HEALTH & SUBSTANCE ABUSE)

I. DEFINITION

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>

III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT

- **Multidisciplinary team:** A team of clinicians, working in one setting to provide MH and SA interventions in a coordinated fashion.
- **Stagewise interventions:** That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)

IV. INTEGRATED TREATMENT IS NOT:

Coordination of clinical services across provider agencies

FAMILY PSYCHOEDUCATION

I. DEFINITION

Family Psychoeducation is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family Psychoeducation programs may be either multi-family or single-family focused. Core characteristics of family Psychoeducation programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Please include NAMI's Family-to-Family program in your reporting for Family Psychoeducation.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423>

III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHOEDUCATION

- A structured curriculum is used.
- Family Psychoeducation is a part of clinical treatment.

IV. FAMILY PSYCHOEDUCATION IS NOT:

Several mechanisms for Family Psychoeducation exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For DHS reporting, do not include Family Psychoeducation models that lack a clinician as part of clinical treatment.

ILLNESS MANAGEMENT AND RECOVERY (IMR)

I. DEFINITION

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are: psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463>

III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT AND RECOVERY

Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum be used for these components to be counted for reporting.

IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:

Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

MedTEAM

I. DEFINITION

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcomes are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549>

III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:

Medication prescription administration that occurs without the minimum requirements specified above.

SUPPORTED EMPLOYMENT

I. DEFINITION

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365>

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT

- **Competitive employment:** Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.
- **Integration with treatment:** Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.
- **Rapid job search:** The search for competitive jobs occurs rapidly after program entry.
- **Eligibility based on consumer choice (not client characteristics):** No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, intellectual functioning, and symptom management.
- **Follow-along support:** Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

IV. SUPPORTED EMPLOYMENT IS NOT:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [NOTE: If an employment specialist is part of an ACT team, this should be reported only under ACT and not separately as supported employment.]

PERMANENT SUPPORTIVE HOUSING

I. DEFINITION

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

II. TOOLKIT AND FIDELITY MEASURE

<http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>

III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING

- **Target population:** Targeted to persons who would not have a viable housing arrangement without this service.
- **Staff assigned:** Specific staff are assigned to provide supported housing services.
- **Housing is integrated:** That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- **Consumer has the right to tenure:** The ownership or lease documents are in the name of the consumer.
- **Affordability:** Supported housing assures that housing is affordable (consumers pay no more than 30-40 percent on rent and utilities) through adequate rent subsidies, etc.

IV. SUPPORTED HOUSING IS NOT:

- Residential treatment services.
- A component of case management or ACT.

Other EBPs that Your Program May Use:

Please refer to these toolkits if deciding whether or not to list the following interventions in your survey responses.

- Treatment of Depression in Older Adults:
<http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD>
- Interventions for Disruptive Behavior Disorders:
<http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMA11-4634CD-DVD>
- Consumer Operated Services:
<http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD>