Community Support Programs
2021 Annual Report

P-00939 (04/2024)

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Introduction

Each year, the Division of Care and Treatment Services conducts a survey of all Community Support Programs (CSP) across the state. Pursuant to Wis. Stat. § 51.03(3)(a)5, the CSP Annual Survey supports evaluation activities and collects data to meet both state and federal Community Mental Health Services Block Grant reporting requirements.

This report is based on the results of the 2021 CSP Annual Survey provided to all CSP at the beginning of 2022. All 71 of the certified CSP responded to the survey. Not all questions had 71 responses. These occurrences are identified in the data sets and information.

The 2021 CSP Annual Survey intended to capture information in the following areas:

- Enrollment information
- Participant discharge status
- Participant discharge - transition to other services
- Participant demographic information
- Medical conditions and substance use
- Use of evidence-based practices
- Waiting list
- Suicide risk screening and assessment
- Staffing patterns and staffing designations
- COVID-19 and telehealth

Taken together, these areas help paint a picture of how CSP are operating and who they are serving. The survey captures potential challenges that programs and participants face. It also captures how programs assess and treat individuals on the path to recovery. While the survey is not exhaustive, it does help identify some of the strengths and areas for programmatic development among CSP in Wisconsin.

Program overview

CSP developed in Wisconsin because of the outcomes achieved from the Program for Assertive Community Treatment (PACT). PACT was developed on an inpatient research unit at Mendota State Hospital, now known as Mendota Mental Health Institute, in Madison in the late 1960s. The PACT model revolutionized the approach to services for people with severe and persistent mental illnesses. PACT, synonymous with Assertive Community Treatment (ACT), has gained worldwide popularity and received recognition as an evidence-based practice (EBP). The ACT model became one of Wisconsin's greatest contributions to the behavioral health field.

PACT evolved from the work of Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D. They found that gains made by people with mental health conditions in inpatient settings often faded after discharge; people treated in inpatient settings were frequently readmitted to the hospital. They believed that round-the-clock hospital support lessened symptoms but, to maintain that improvement, ongoing support following discharge was critical.

To test their assumptions, the researchers moved hospital unit staff into the community. In 1972, they rented a house in downtown Madison, a few miles from the hospital on Madison's north side. This house became known as the first PACT, and the first client was admitted October 9, 1972. The program maintained 24-hour staffing with professionals from multiple specialties to provide intensive care and treatment. Staff supported PACT participants in their homes, on the job, and in social settings.

As support for the ACT model began to grow statewide, as well as nationally, the Wisconsin Department of Health and Social Services, now known as the Department of Health Services, began to plan for program expansion in which counties could receive financial reimbursement through Medical Assistance for the services provided. In 1989, Wis. Admin. Code ch. DHS 63 was drafted which allowed counties to establish CSP with the hope that counties would use the PACT model as a basis for programming. The first Wisconsin county was certified to provide CSP services under Wis. Admin. Code ch. DHS 63 in 1991. There are now CSP in nearly every county in Wisconsin (see Figure 1).

Under Wis. Admin. Code ch. DHS 63, CSP provide community-based psychosocial rehabilitation to individuals with serious mental health conditions. These services include case management, psychiatry, nursing, medication management, supportive psychotherapy, individual and group therapy, support with daily living activities, socialization, crisis management, and vocational and educational rehabilitation. Using a team-based treatment model that stemmed from the PACT program, CSP offer high levels of care and services intended to help individuals avoid hospitalization and incarceration and achieve recovery in alignment with their goals and dreams.

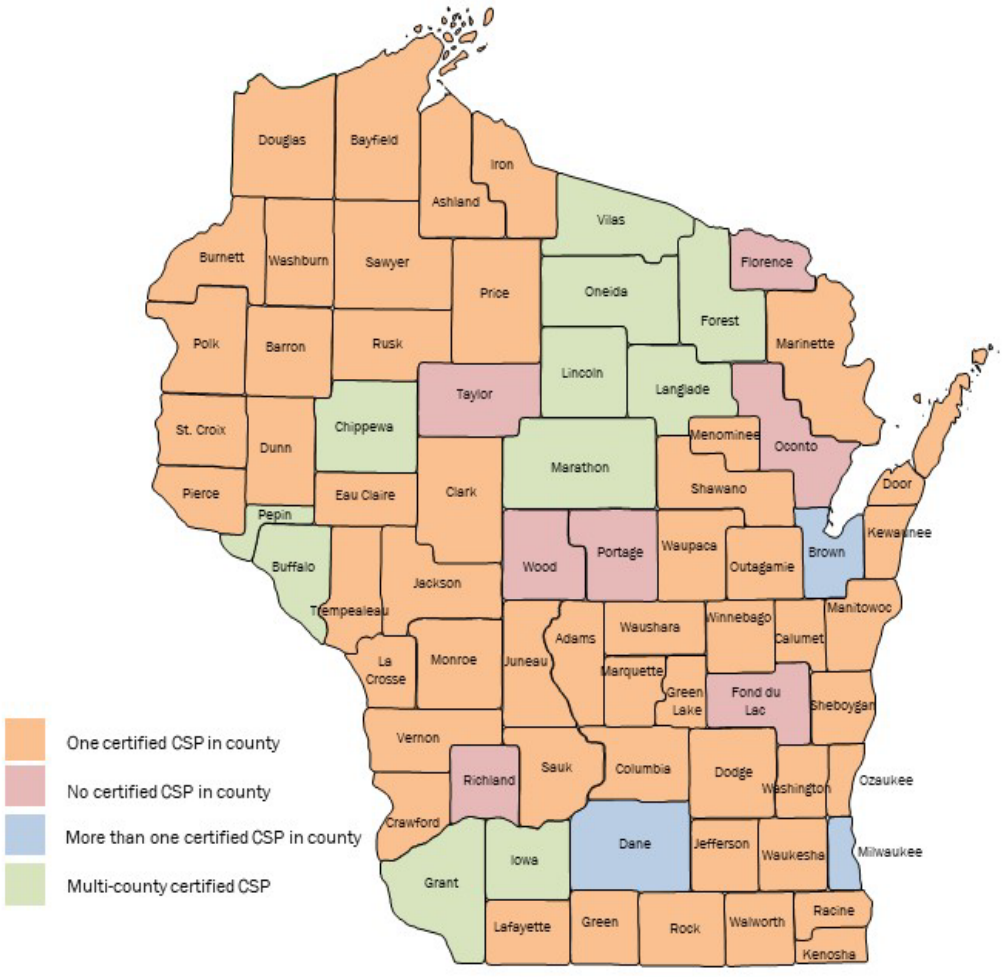
Certified programs in 2021

Figure 1: Community Support Programs (CSP) in Wisconsin, April 2021

There are 68 certified CSP in Wisconsin.

Seven out of 72 counties do not have certified CSP. Brown, Dane, and Milwaukee counties have more than one CSP. The following 11 counties have joint CSP:

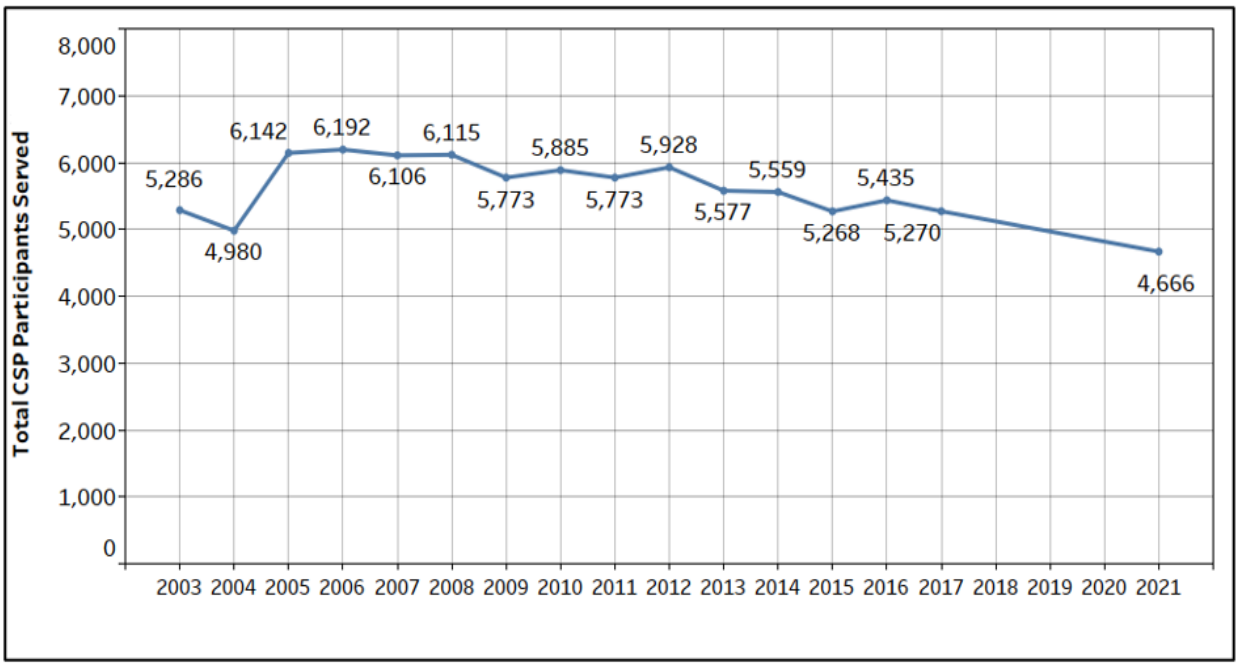
- Forest, Oneida, and Vilas counties
- Marathon, Lincoln, and Langlade counties
- Chippewa, Pepin, and Buffalo counties
- Grant and Iowa counties



Participants served

Figure 2 presents the number of CSP participants receiving services from 2003-2021. It should be noted that there was a gap in survey data collection between 2017-2021. This graph shows the total number of CSP participants served during the reporting year which includes the total number of participants at the end of the previous year plus the participants enrolled during the reporting year. Since 2006, there has been a gradual decline in the total number of CSP participants served statewide. From 2006 to 2021, this decrease was close to 25% of the total number served in 2006.

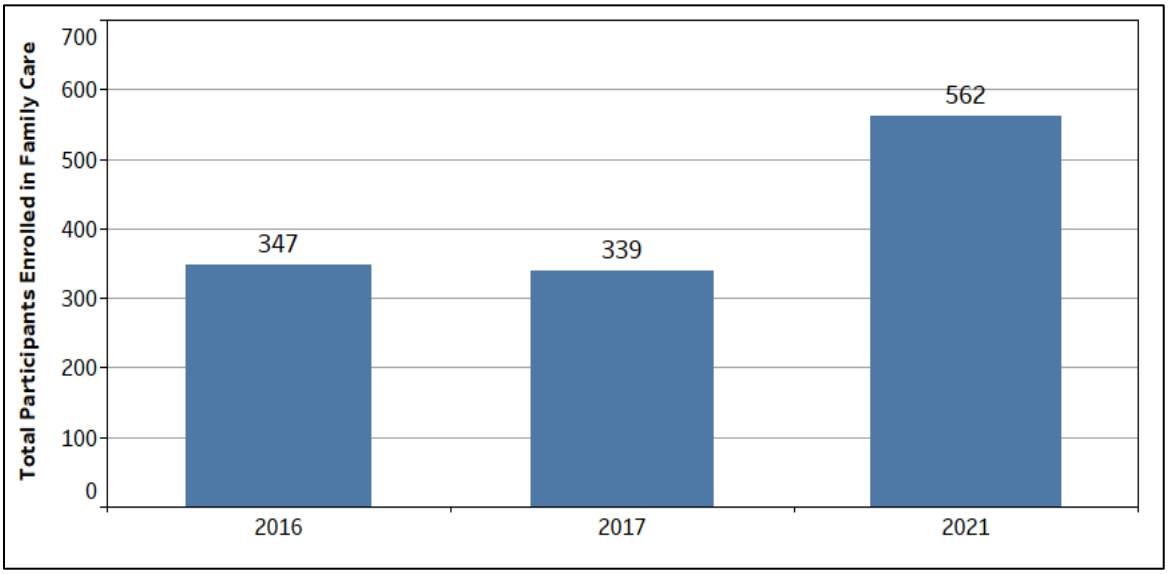
Figure 2: Total number of participants served, 2003-2021



The CSP Annual Survey asks agencies for the number of participants concurrently enrolled in CSP and Family Care. Family Care is a Medicaid long-term care program for older adults and adults with disabilities.

Figure 3 shows the number of CSP participants who were receiving both CSP and Family Care services from 2016-2021. Data for this program survey question was not gathered before 2016.

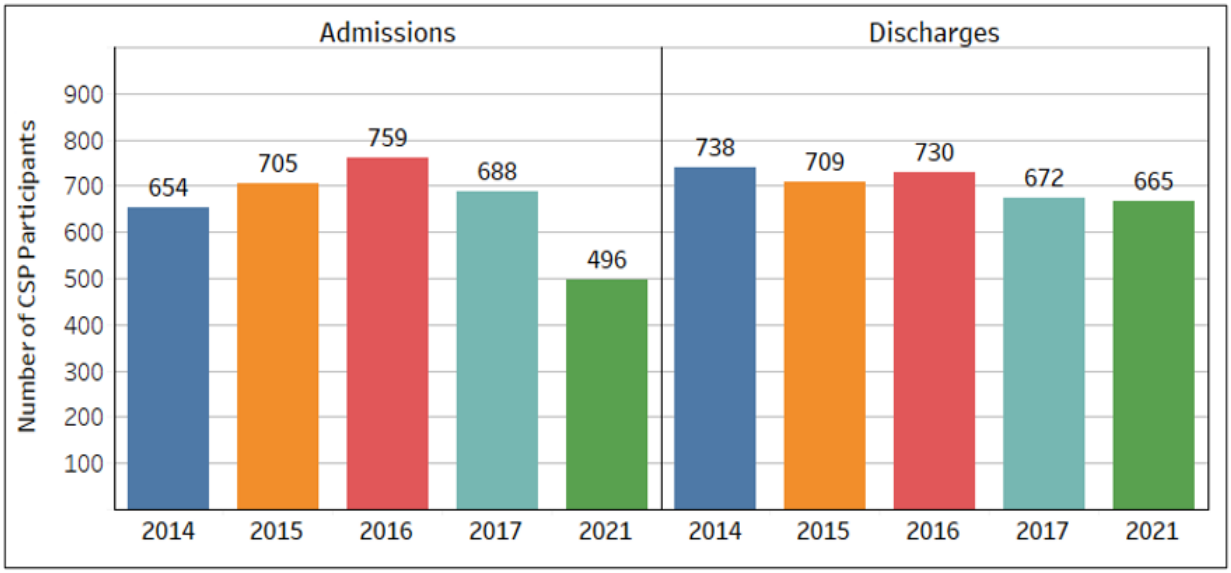
Figure 3: CSP participants concurrently enrolled in Family Care, 2016-2021



Participants admitted and discharged

During 2021, 496 people were admitted to CSP across Wisconsin (see Figure 4). This is a 28% decrease from 2017, in which 688 individuals were admitted. The number of discharges from the program have been relatively stable from 2014-2021. In 2021, 665 participants were discharged from CSP, approximately 14% of the total 4,666 participants served that year.

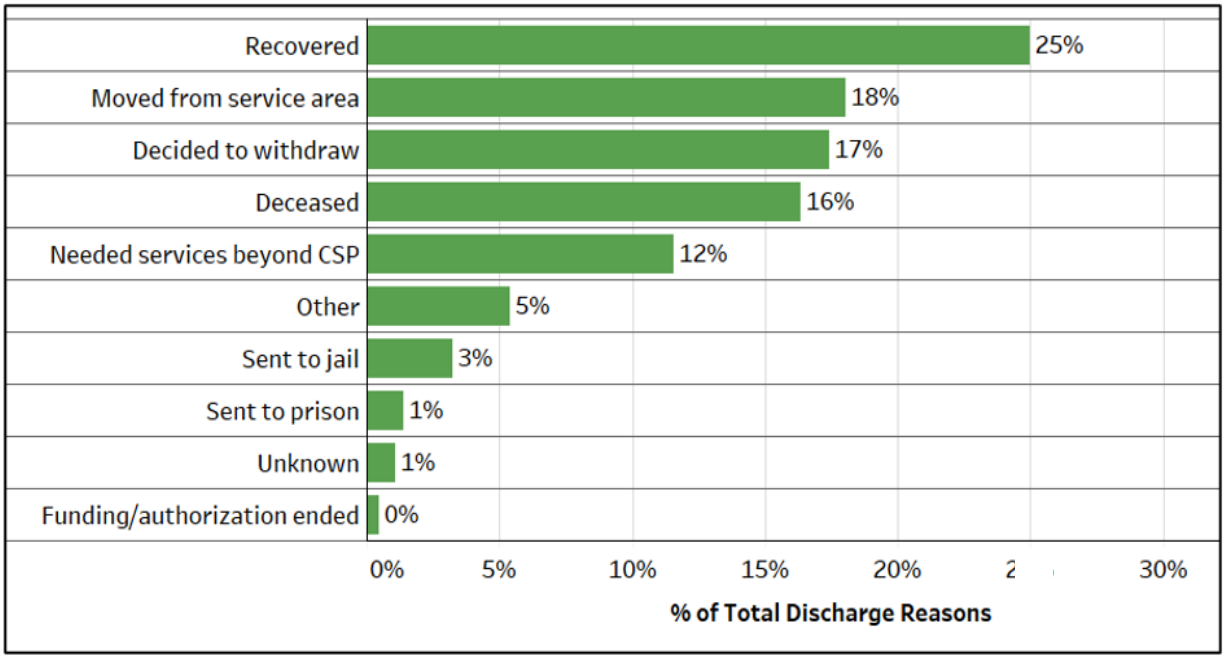
Figure 4: Admission and discharge trends, 2014-2021



Discharge reasons and destinations

Among the 665 individuals discharged from CSP during 2021, the majority (25%) recovered to the extent that they no longer needed CSP level services (shown in Figure 5). Other discharge reasons included: moved out of the geographic service area (18%), needed additional services beyond what CSP could offer (12%), decided to withdraw from the program (17%), sent to jail (3%), sent to prison (1%), lost their funding or authorization (1%), or passed away during the year (16%). A small number were discharged from CSP for some other or unknown reason (1%).

Figure 5: Participant discharge reasons, 2021



Information on the cause of death of CSP participants (see Figure 6) was collected for the first time in 2021. There were 120 CSP participant deaths in 2021. Of these, 71% were related to natural causes and health-related conditions. Of the 85 deaths related to natural causes and health-related conditions, 20% were from COVID-19.

Figure 6: Specific causes of death of participants, 2021

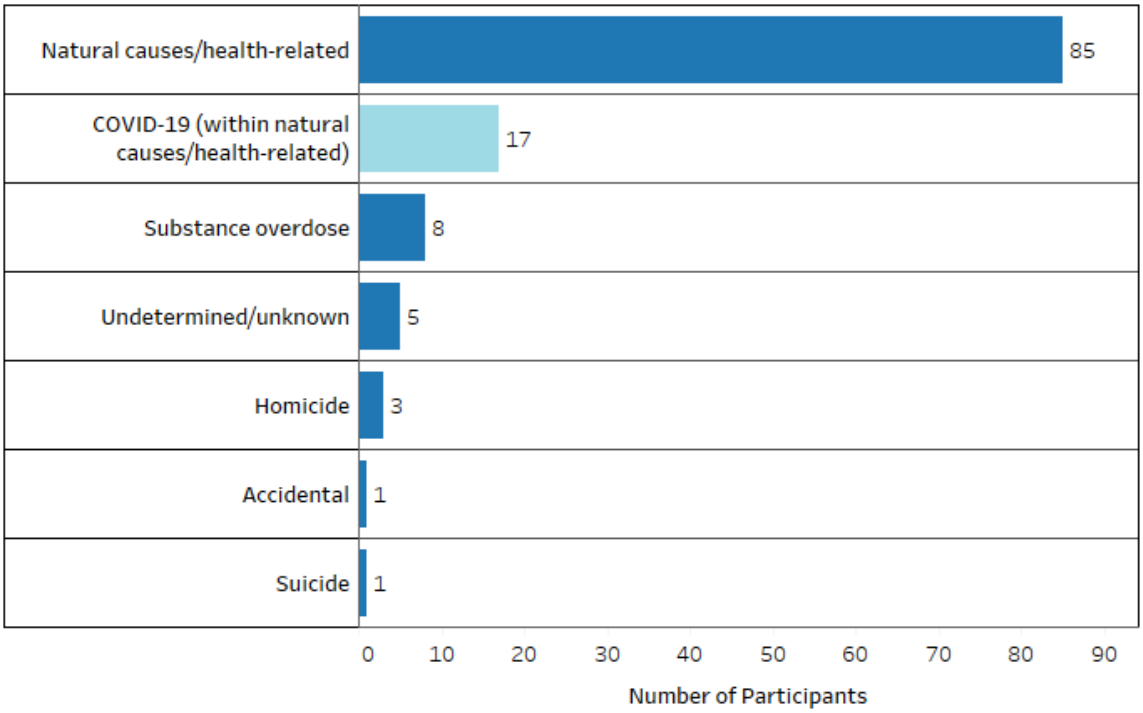
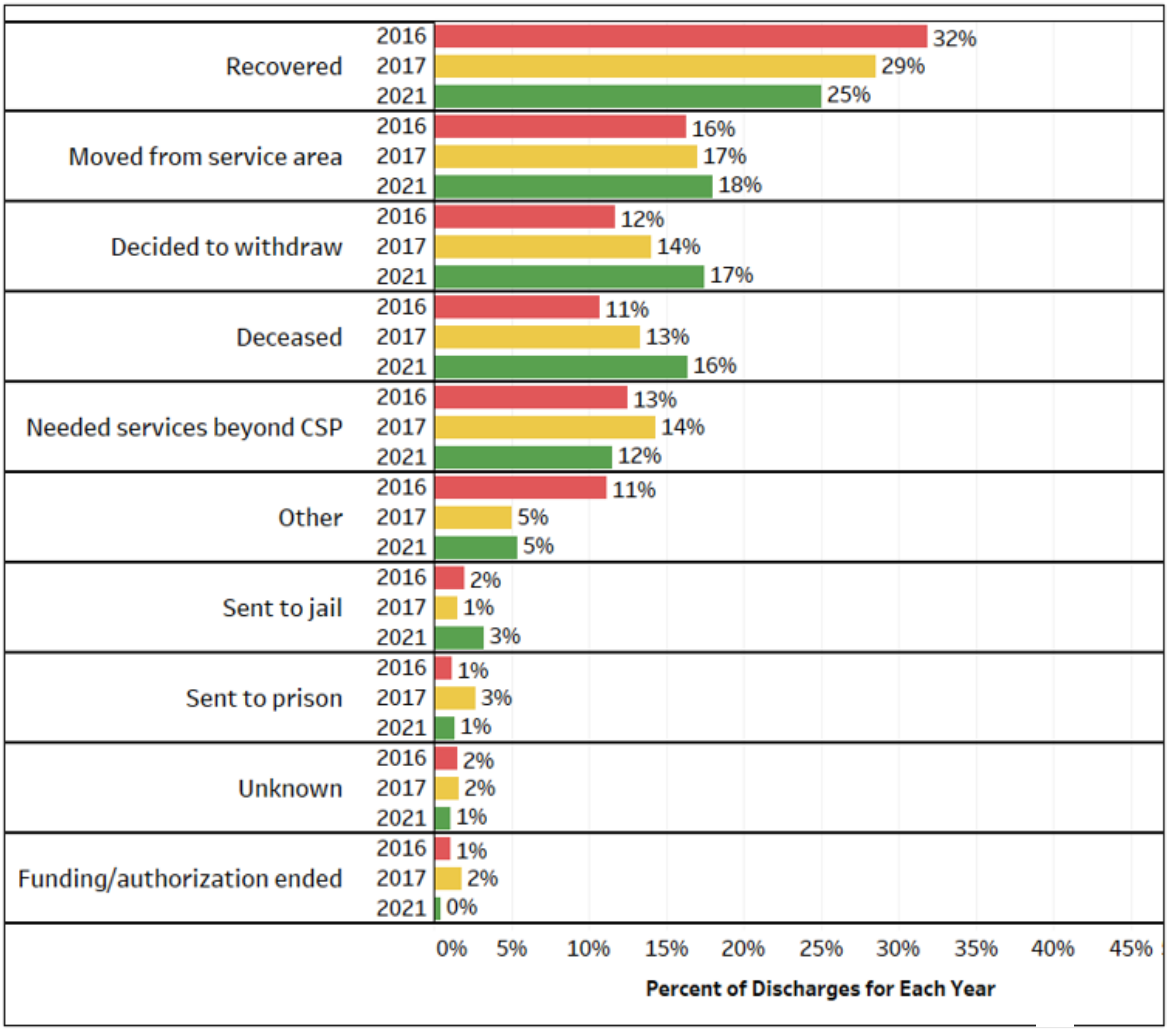


Figure 7 displays trends on discharge reasons from 2016-2021. Discharge reasons have remained stable over this period of time. There was a notable decrease in the percentage of participants discharged due to their recovering to the extent that they no longer needed the level of service a CSP provides. It should be noted these participants typically continue to need some level of support and will be transitioned to a less intensive program.

Figure 7: Participant discharge reasons, 2016-2021



When CSP participants discharge from the CSP, they typically continue to receive services in another mental health or residential program. Figure 8 provides data on the destinations of participants who were discharged for the various reasons given in Figure 7. Discharges to a lower level of care totaled 32% of the total discharge destinations. Those destinations included outpatient therapy (25%) and Comprehensive Community Services (7%). Other discharge destinations included: another CSP (10%), and case management (14%). Discharge destinations that provide a level of care higher than CSP include institutes for mental disease (IMD), nursing homes, and group home placements. Of the 22% of CSP participants who received no other service, 16% was due to participant death as reported in Figure 7. For the remaining 6% of CSP participants who did not transfer to other services, the reasons are unknown.

Figure 8: Participant destinations upon discharge, 2021

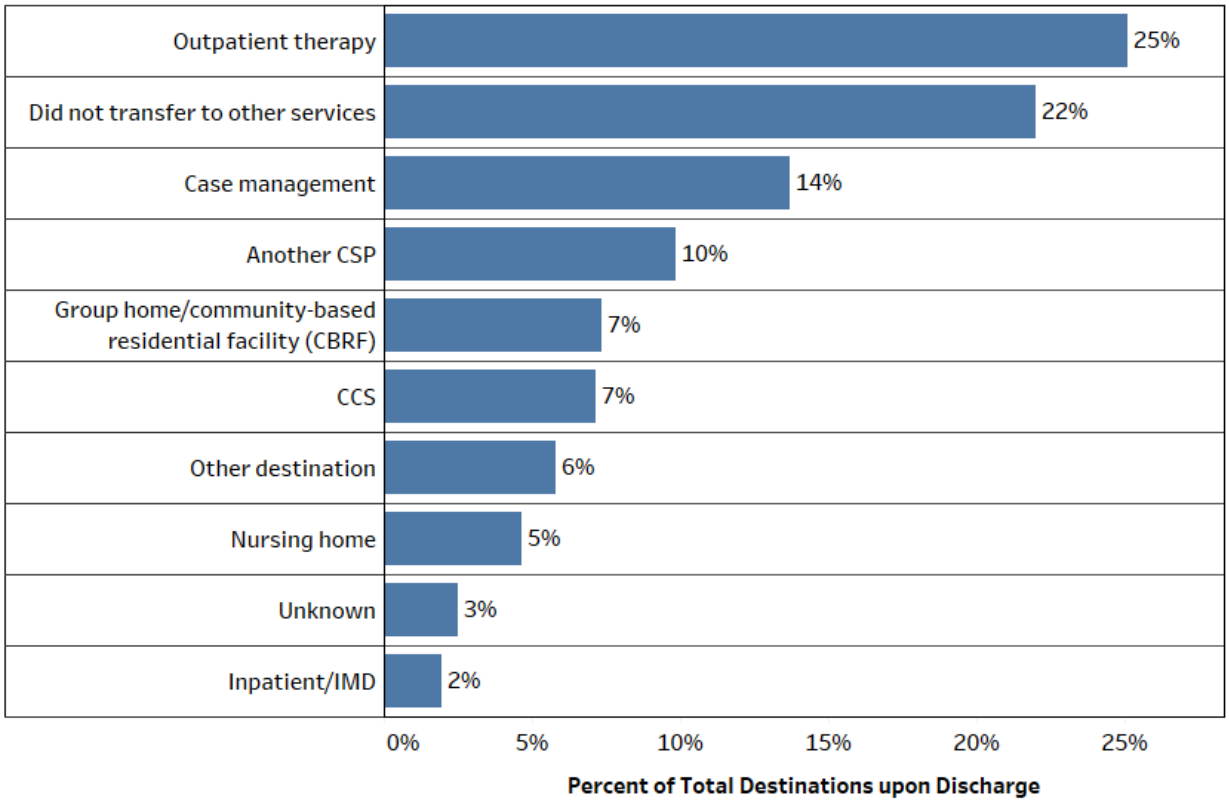
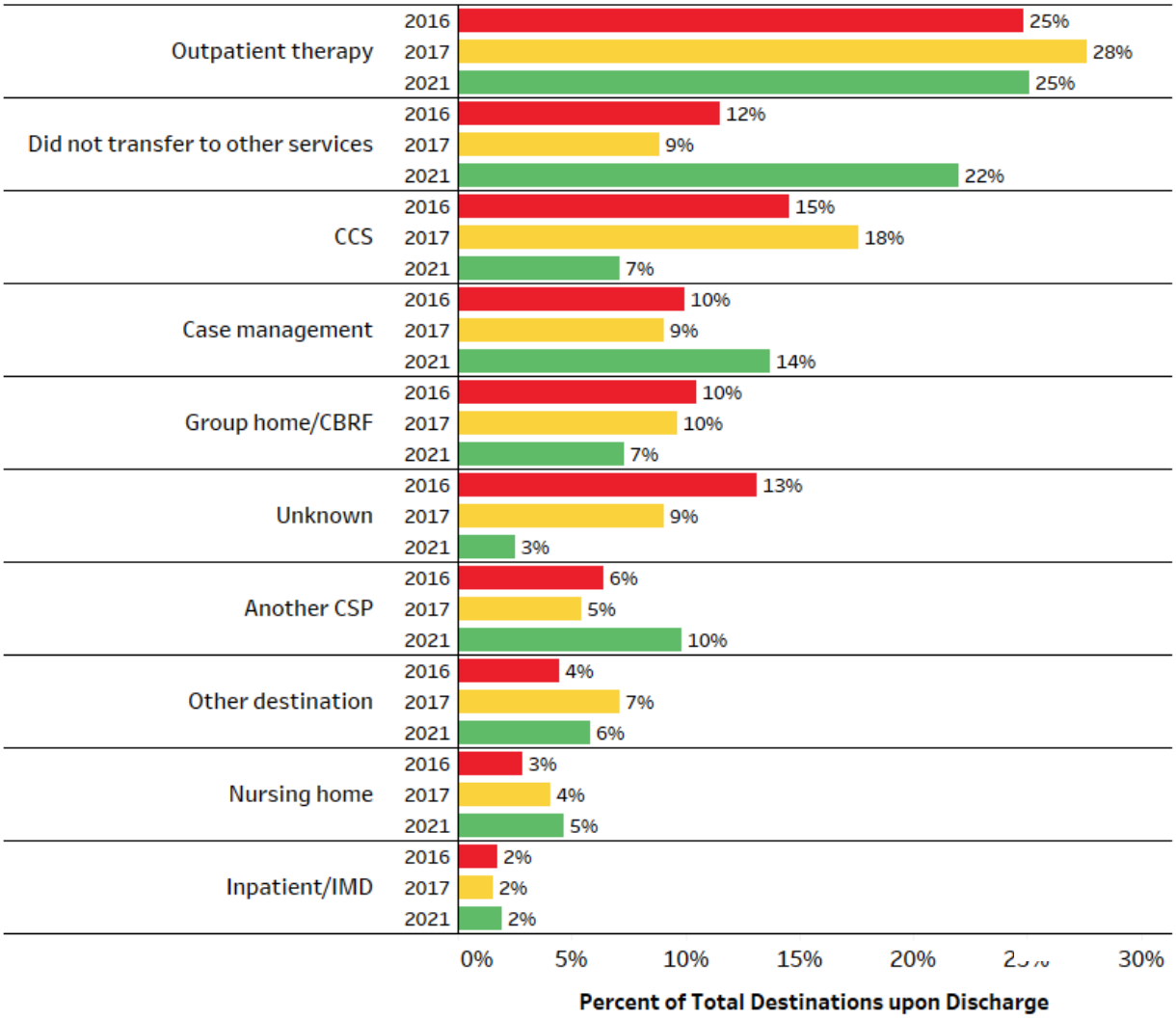


Figure 9 examines discharge destination trends from 2016-2021. Transition of participants to other CSP or case management both increased in 2021 compared to 2017 and 2016. The number of participant discharges due to unknown reasons also decreased in 2021 which may be attributed to better tracking statewide.

Figure 9: Participant destinations at discharge, 2016-2021



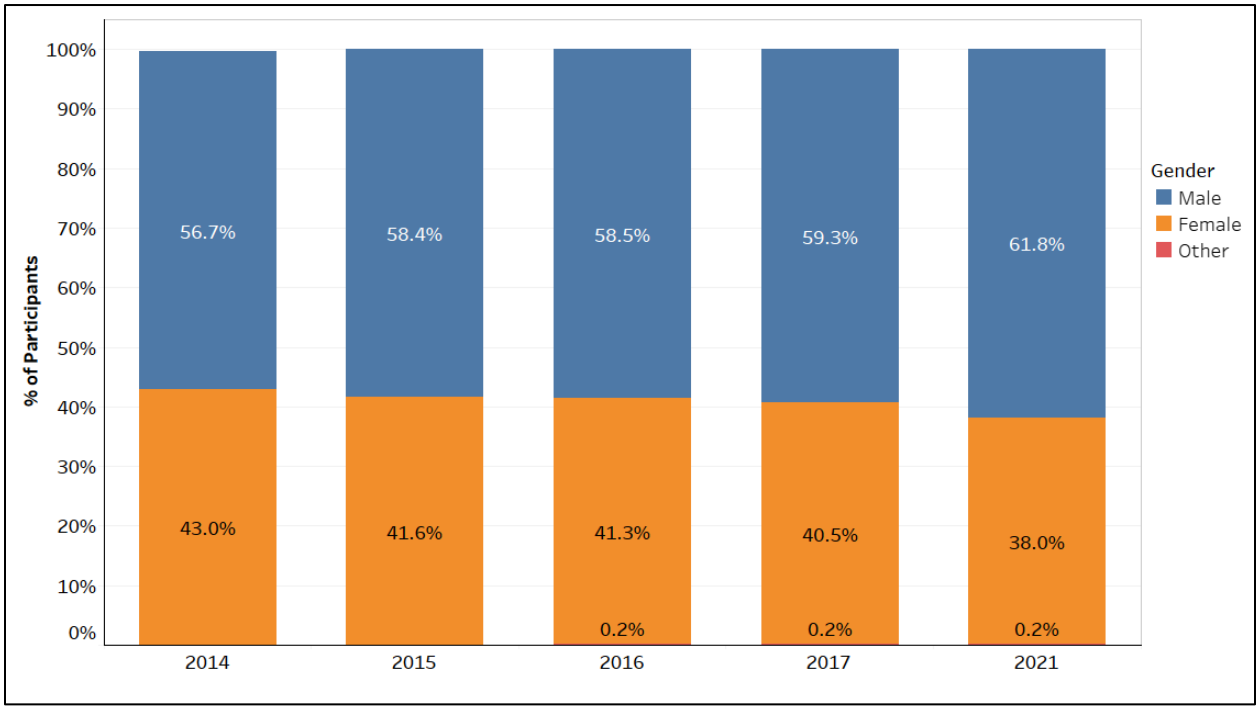
Participant demographics

CSP agencies are asked in the CSP Annual Survey to provide demographic information, including gender, age, race, ethnicity, and veteran status, for all participants served.

Gender

Figure 10 looks at the breakdown of the gender of CSP participants from 2014-2021. It is of interest that the percentage of male participants has gradually increased over the course of five years, while the percentage of female participants has gradually decreased. The designation of "Other" had no change from 2014-2021.

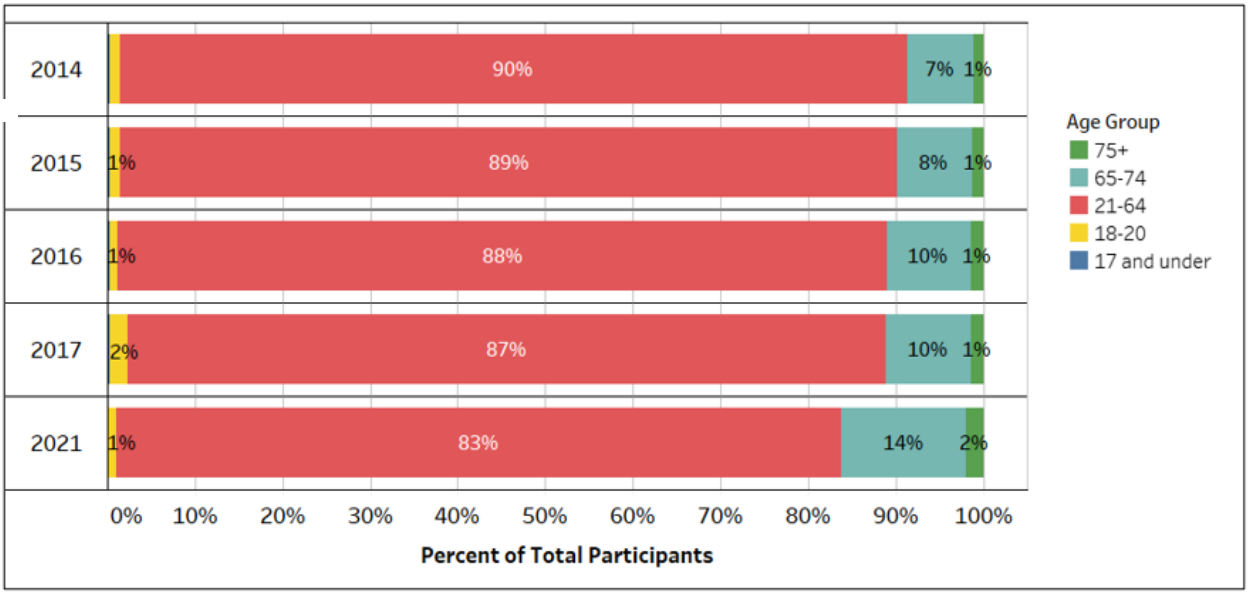
Figure 10: Participants by gender, 2014-2021



Age

As shown in Figure 11, the majority of CSP participants in 2021 were between the ages of 21-64 (83%) or working age adults. An additional 14% were between 65-74 years old and 2% were age 75 years or over. Trends indicate a CSP population that is gradually aging. Very few participants were children (ages 17 or under), although there were some young adults ages 18 to 20. It is noteworthy that Wis. Admin. Code ch. DHS 63 requires CSP to serve adults; however, minors can be admitted with a variance from the Division of Quality Assurance. The percentage of youth is very consistent with those from previous years.

Figure 11: Participants by age, 2014-2021



Race

Figure 12 shows trends in the race of CSP participants from 2014-2021. Figure 13 compares the percentages of each race in the Wisconsin CSP population to the percentages in the general population of Wisconsin according to the 2020 U.S. Census. There has been a gradual increase in participants that identified as black/African American served since 2014 and a small decline in participants that identified as white.

Figure 12: CSP participants by race, 2014-2021

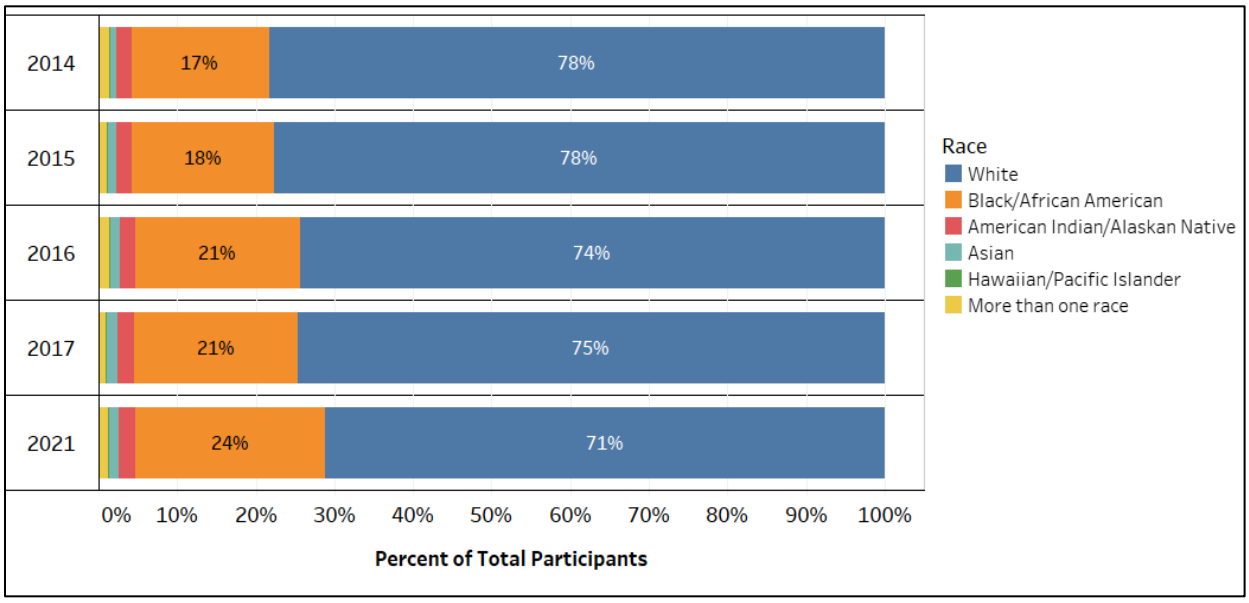
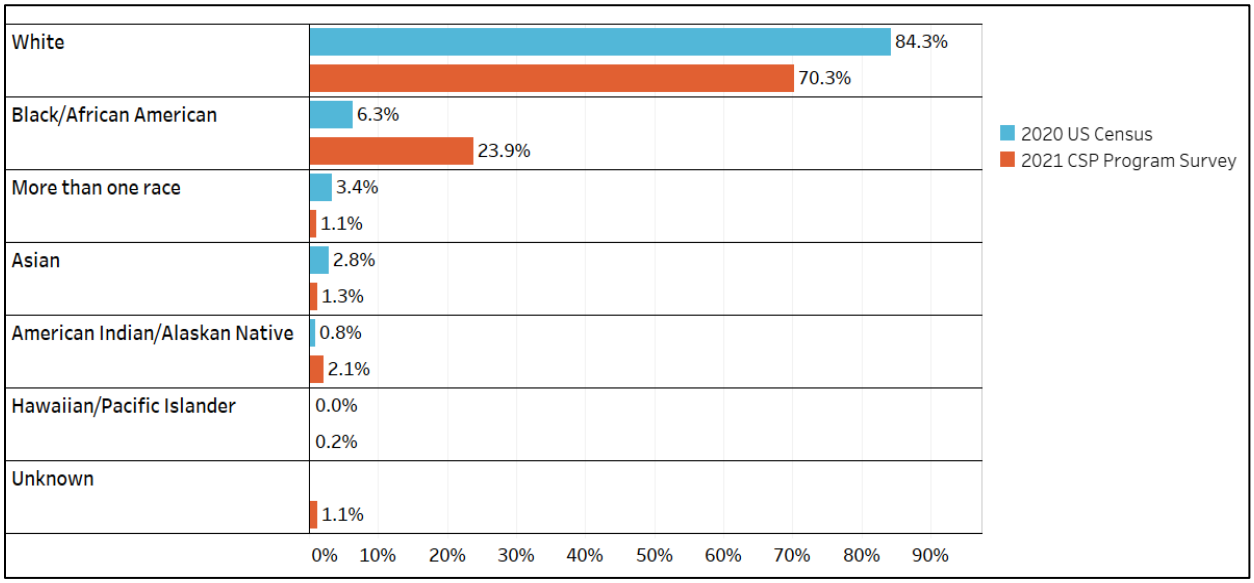


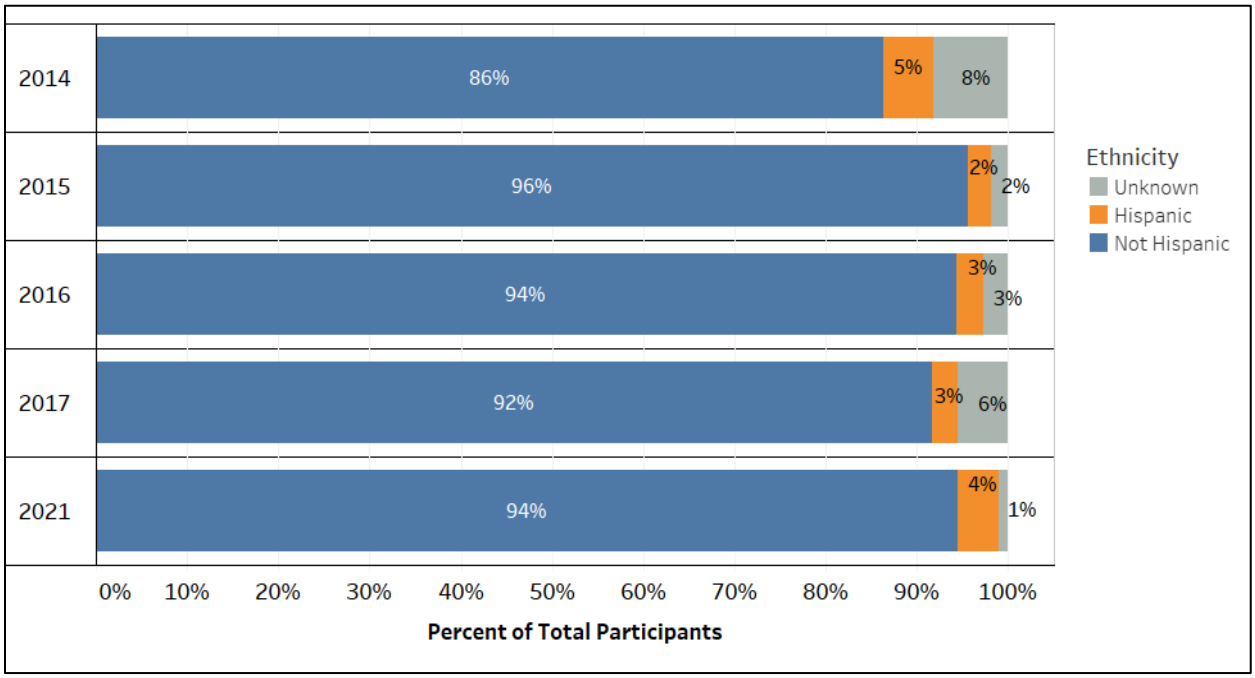
Figure 13: Race of CSP participants compared to Wisconsin general population, 2021



Ethnicity

Survey respondents were also asked to identify participants' ethnicity. Figure 14 illustrates trends in reported ethnicity from 2014-2021 for CSP participants.

Figure 14: Participants by *e*thnicity, 2014-2021

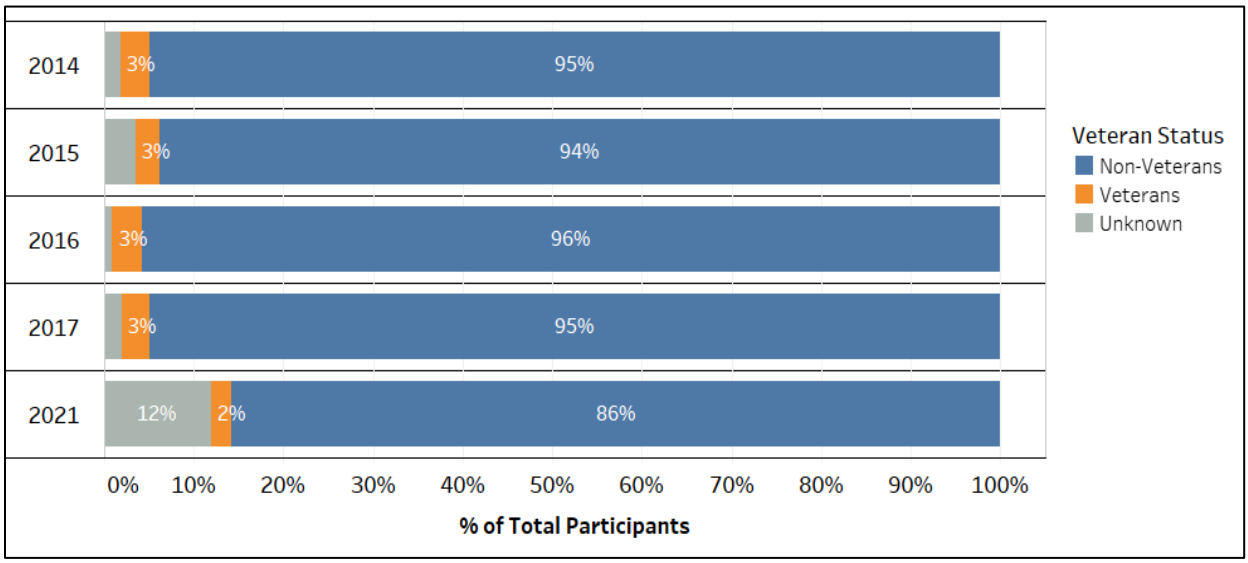


Veteran status

Veterans make up approximately 5% of the population of Wisconsin, but only 2% of those served by CSP in 2021 were known veterans. Statewide estimates are based on 2022 estimates from the U.S. Census Bureau, U.S. Census Bureau QuickFacts.

The number of unknown veteran participants has increased since 2014, but the reason for this trend is unclear.

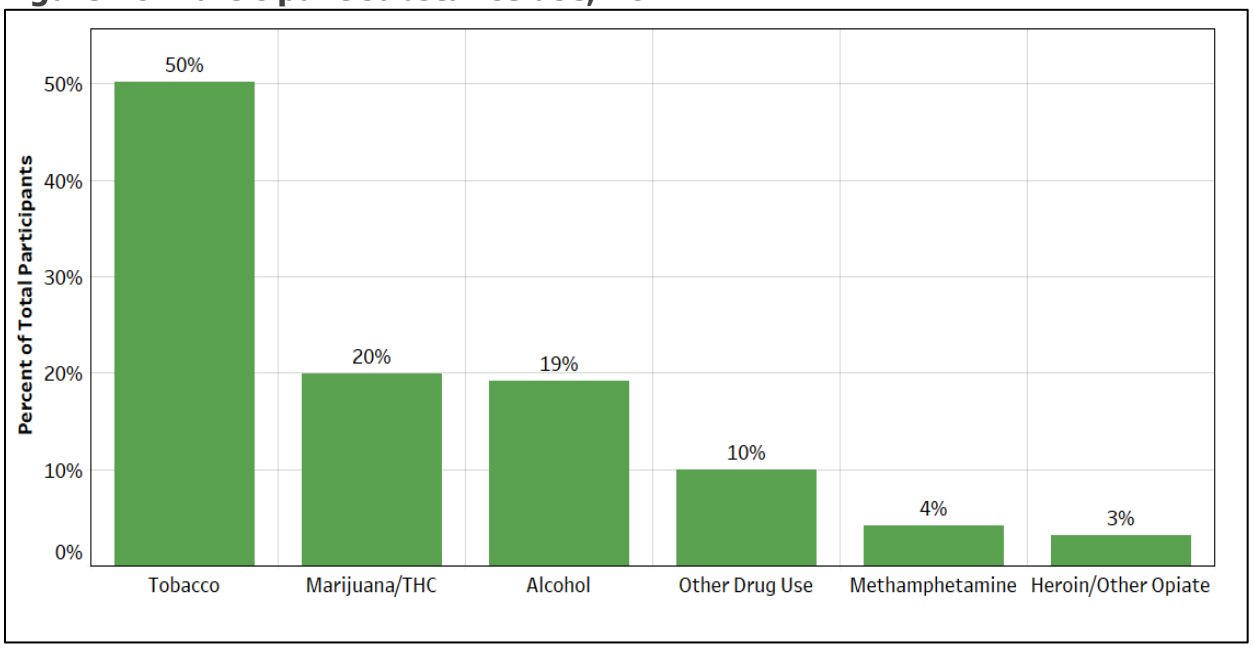
Figure 15: Participants by veteran status, 2014-2021



Substance use

CSP were asked to report on the substance use for all participants 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.

Figure 16: Participant substance use, 2021



Regarding substance use in 2021 (Figure 16), half of CSP participants (50%) were reported as using tobacco. Another 20% were reported as having a marijuana use problem, while 19% reported having an alcohol use problem. As seen in Figure 17, substance use rates among CSP participants are higher with tobacco and methamphetamine use when compared to the general U.S. population.

Figure 17: Participant substance use compared to national substance use, 2021

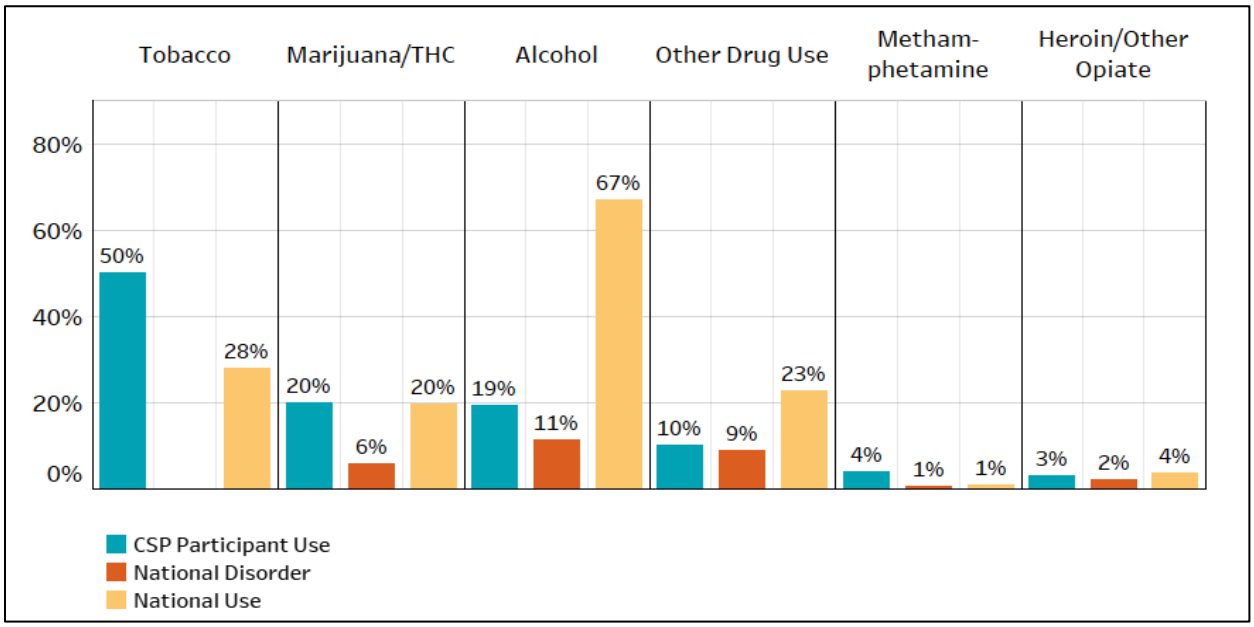
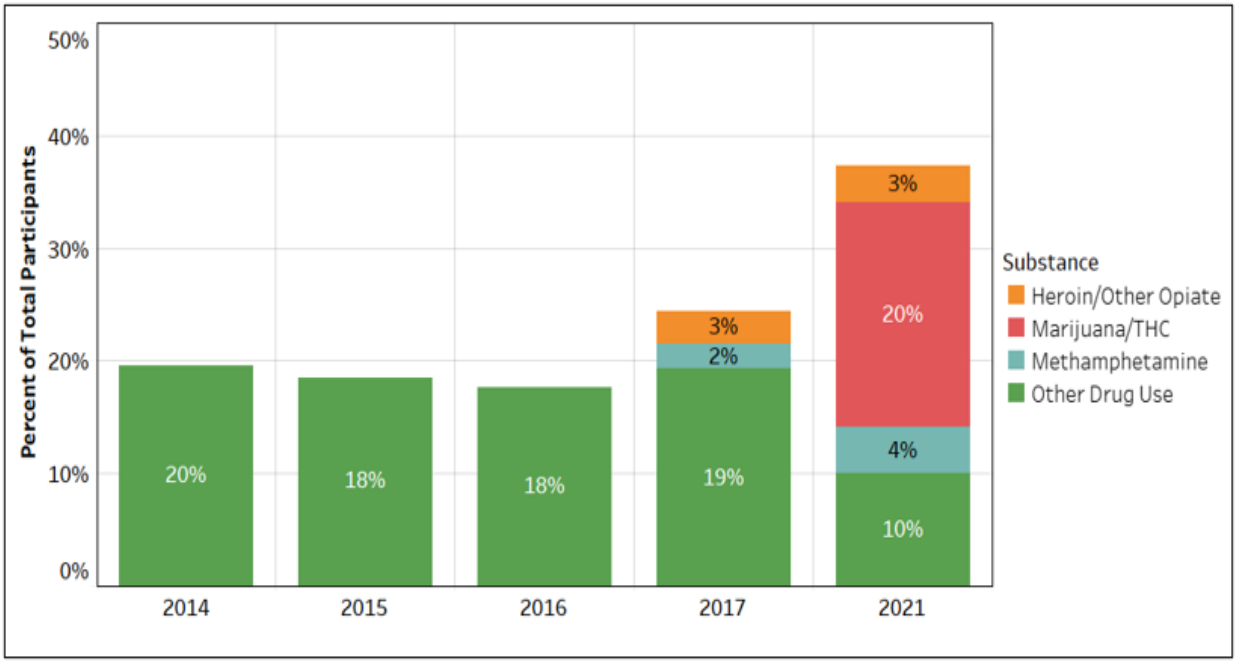


Figure 18 illustrates substance use trends from 2014-2021. More detailed questions about specific substance use were asked in the CSP survey starting in 2017. Prior to 2017, all substances were put in one category. The concerning marker on this graph is the increase in the use of substances from 2017 to 2021. However, since the categorization changed between program surveys, it is difficult to come to a definite conclusion about substance use trends. It will be beneficial to explore this further with CSP related to access to substance use resources and treatment.

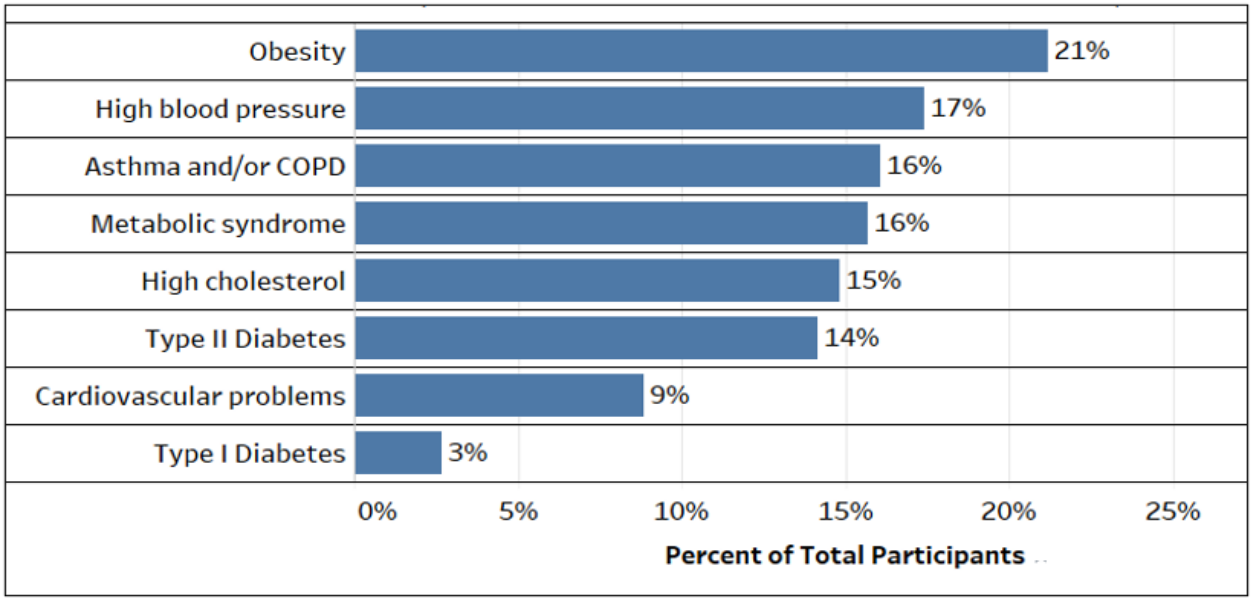
Figure 18: Participant substance use, 2014-2021



Physical health

For a variety of reasons, adequate physical health care and health care maintenance continues to be a barrier to longevity for those with serious mental health conditions. Research studies have shown that cardiometabolic disease is twice as high in adults with serious mental illness compared to the general population; these individuals also have an increased risk for chronic disease, diabetes, and cancer (National Alliance on Mental Illness, n.d.). CSP were asked to report on the number of individuals in their program who had the identified physical health diagnoses. The most often reported medical issue was obesity, occurring in 23.7% or 1,106 CSP participants statewide. This was followed by hypertension and asthma/chronic obstructive pulmonary disease (COPD). See additional information in Figure 19.

Figure 19: Participants with medical issues, 2021



Evidence-based practices

The CSP Annual Survey assesses the extent to which programs incorporate evidence-based practices (EBPs) into the services they provide. The survey asked about the following EBPs:

- **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.
- **Motivational interviewing (MI)** uses interviewing techniques and ongoing conversations to enhance one's internal motivation and commitment to make their own positive change.
- **Supported employment** focuses on the importance of work with relation to recovery and assists the participant in addressing symptoms that interfere with finding and securing employment.
- **MedTEAM**, also called medication management, uses best practices coupled with patient input to make medication management decisions.
- **Tobacco Cessation Bucket Approach** is an approach specifically to assist those with serious mental illness reduce or quit smoking.
- **Integrated Dual Disorder Treatment (IDDT)** is a team treatment approach to support individuals with co-occurring mental illness and substance use disorder.
- **Illness Management and Recovery (IMR)** focuses on education and skill development to help participants better understand their diagnosis, symptoms, and management of both in the journey of recovery.
- **Family psychoeducation** involves the development of a partnership among participants, families, practitioners, and supporters.
- **Permanent supportive housing** is a set of criteria to assist individuals with finding permanent, supportive, and long-lasting housing options.
- **Enhanced Illness Management and Recovery (E-IMR)** focuses on education and skill development to help participants better understand their mental health diagnosis, substance use disorder, symptoms, and management of these in the journey of recovery.

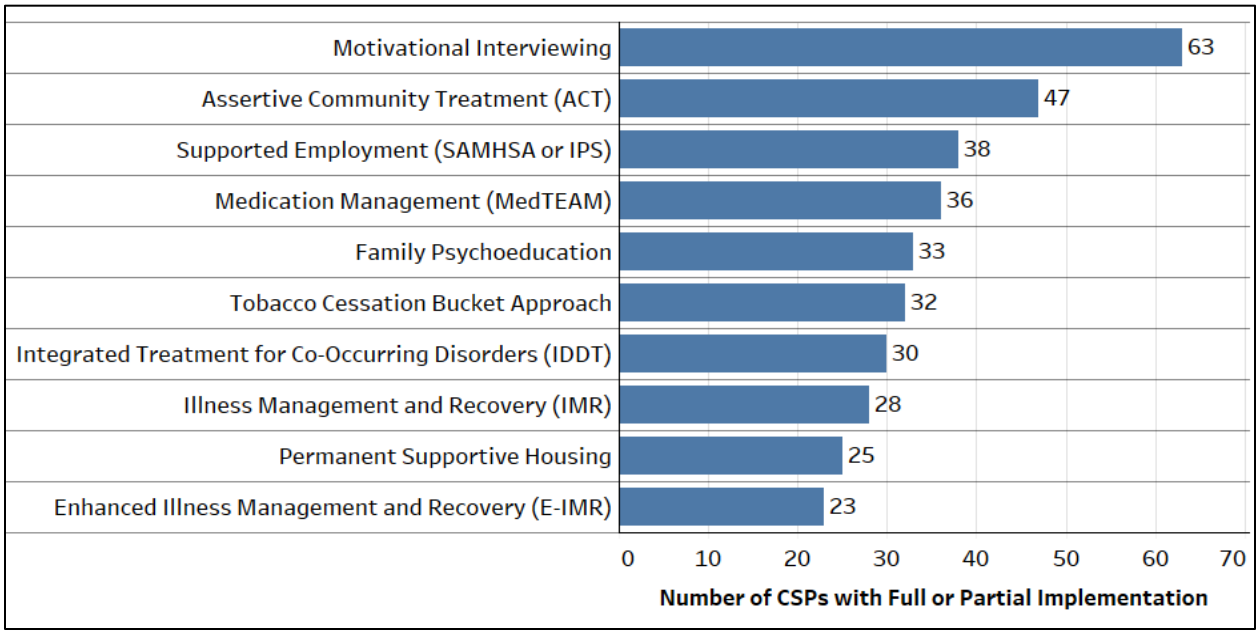
Each EBP provides an opportunity for CSP to enhance the recovery process for participants. CSP are not required to use EBPs; rather, they are provided with information about the Substance Abuse and Mental Health Services Administration Evidence-Based Practice toolkits and are encouraged to incorporate such practices. There are also many opportunities for CSP to seek EBP trainings through grants and statewide partnerships with universities and private organizations that specifically focus on training for behavioral health providers.

EBP offered

Figure 20 shows the implementation of EBPs within 70 CSP in Wisconsin. Program respondents could identify either full implementation, partial implementation, or no implementation for each identified evidence-based practice. For the ease of review, the fully

and partially implemented responses were combined. Motivational interviewing, ACT, and supported employment stand out as the most implemented in Wisconsin's CSP.

Figure 20: CSP implementation of EBPs, 2021



Tobacco Cessation Bucket Approach

More than one in three adults (36%) with serious mental health conditions smoke cigarettes compared to one in five (21%) adults with no mental health condition.

Individuals with mental health challenges are more likely to experience life stressors that impact their ability to easily quit. Cigarette smoking continues to be the leading preventable cause of disease, disability, and death in the U.S.

The Tobacco Cessation Bucket Approach was developed specifically as an evidence-based practice for those with serious mental health conditions. The approach was designed to be effective and easy for behavioral health providers to use and implement. The Division of Care and Treatment Services has continued to support providers statewide in becoming trained in this approach. For example, in 2021, providers could complete the training through the UW Center for Tobacco Research and Intervention at no cost.

In CSP across the state, 50% of the 4,666 individuals served were identified as using tobacco. In 2021, almost half (46%) of CSP in Wisconsin integrated tobacco cessation with participants into their practice.

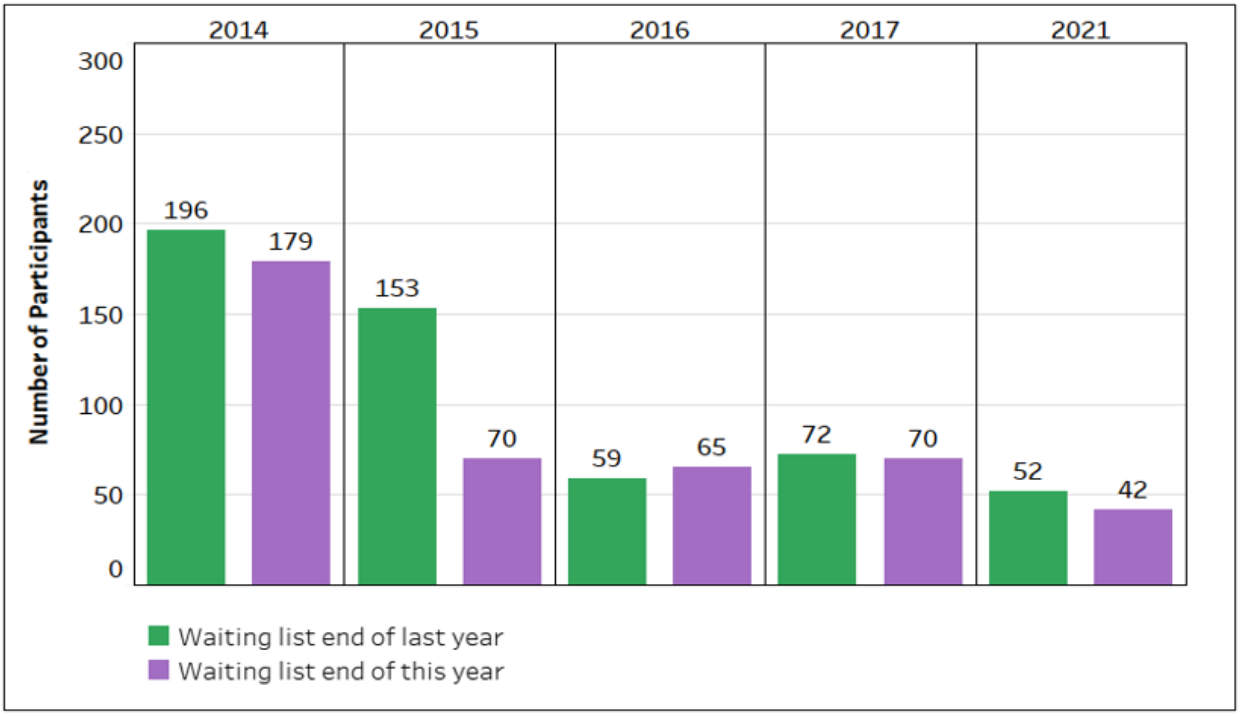
Waiting lists

Of the 70 CSP that responded to this question, 13 respondents (19%) used a waiting list in 2021 (refer to Figure 21). Fifty-two individuals were waiting for CSP services at the beginning of 2021, while 42 were waiting for services at the end of the year. A majority of CSP, or 81%, indicated they did not use a waiting list in 2021.

Figure 21: Waiting lists, 2021

	Count	% of Total
CSPs that had a waiting list during 2021	13	18.6%
Individuals on a waiting list at the beginning of 2021	52	1.2%
Individuals on a waiting list at the end of 2021	42	1.0%
Average wait time in months	3.5 months	

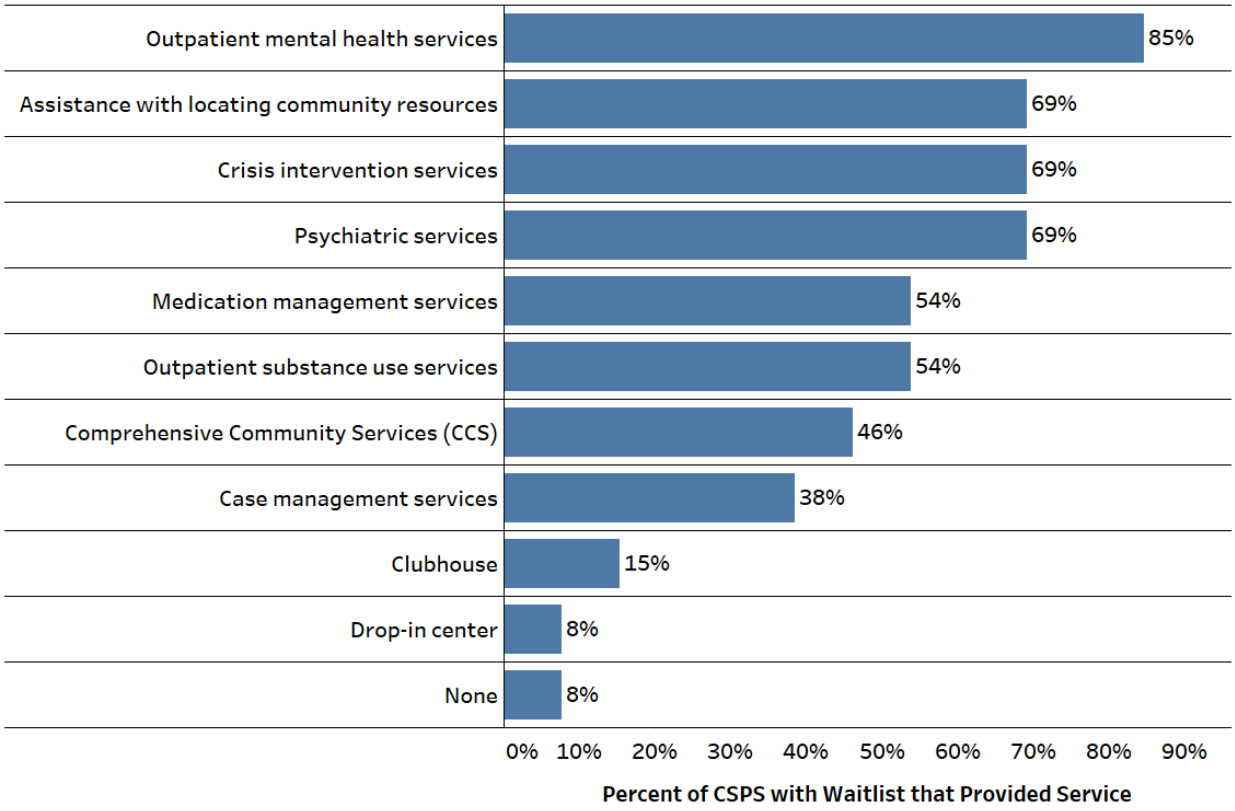
Figure 22: Participants on waiting lists, 2014-2021



The number of people identified as on a waiting list for CSP services has decreased dramatically since 2014. One proposed reason for this trend is the development and expansion of Comprehensive Community Services (CCS). The expansion of CCS in 2008 introduced another psychosocial rehabilitation program for people. CCS also filled a gap between outpatient level services and the intensity of CSP services.

Figure 23 shows which services individuals waiting for CSP most often use. Approximately 46% of CSP agencies who reported having a waitlist in 2021 were temporarily using CCS to serve individuals who had CSP levels of need.

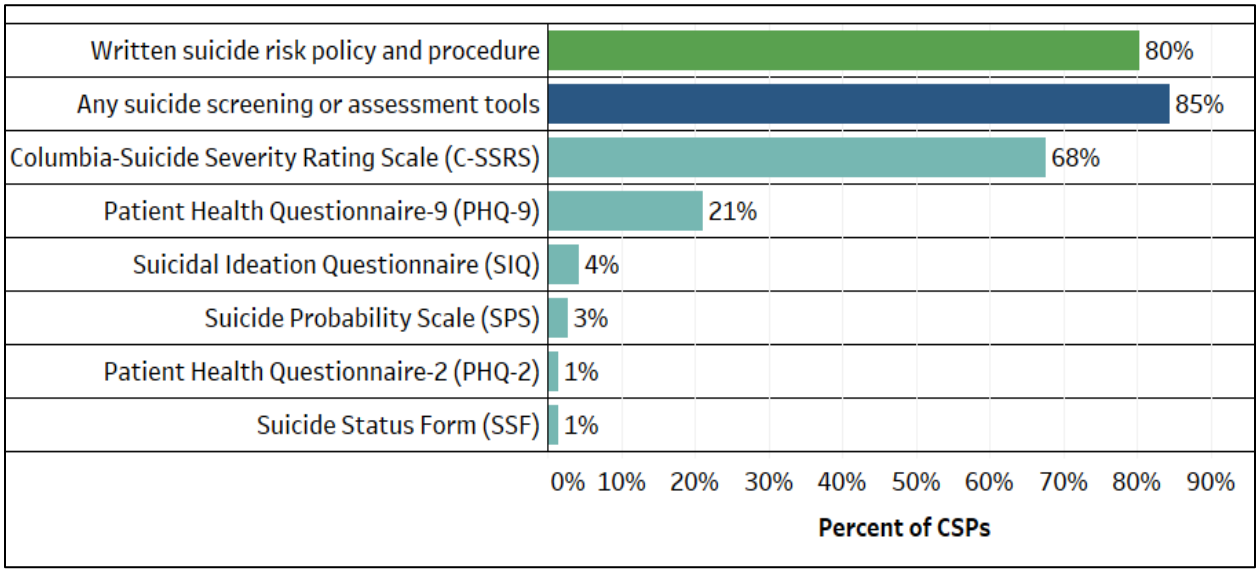
Figure 23: Services offered to participants on CSP waitlists, 2021



Suicide screening and assessment

CSP were asked to report whether they had written policies and procedures for assessing suicide risk among their participants. Of the 70 respondents to this question, 80% identified having written policies and procedures. When asked if they used a specific tool for screening and assessment of suicide, 85% reported they used any tool. The most used tool (68%) was the Columbia Suicide Severity Rating Scale (C-SSRS). Figure 24 identifies other suicide risk screening and assessment tools used by CSP.

Figure 24: Suicide screening and assessment, 2021

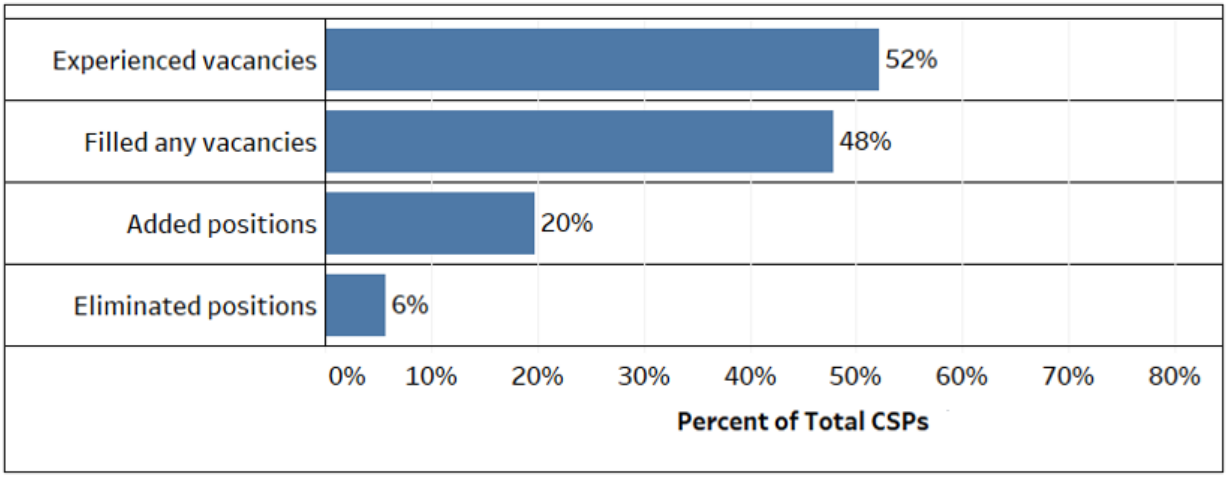


Staffing patterns and designations

Questions related to staffing within the CSP were introduced in the 2021 survey. There was an interest in gaining a better understanding of staffing needs in CSP due to the COVID-19 pandemic and statewide staffing shortages which began in 2020 and continued throughout the reporting period.

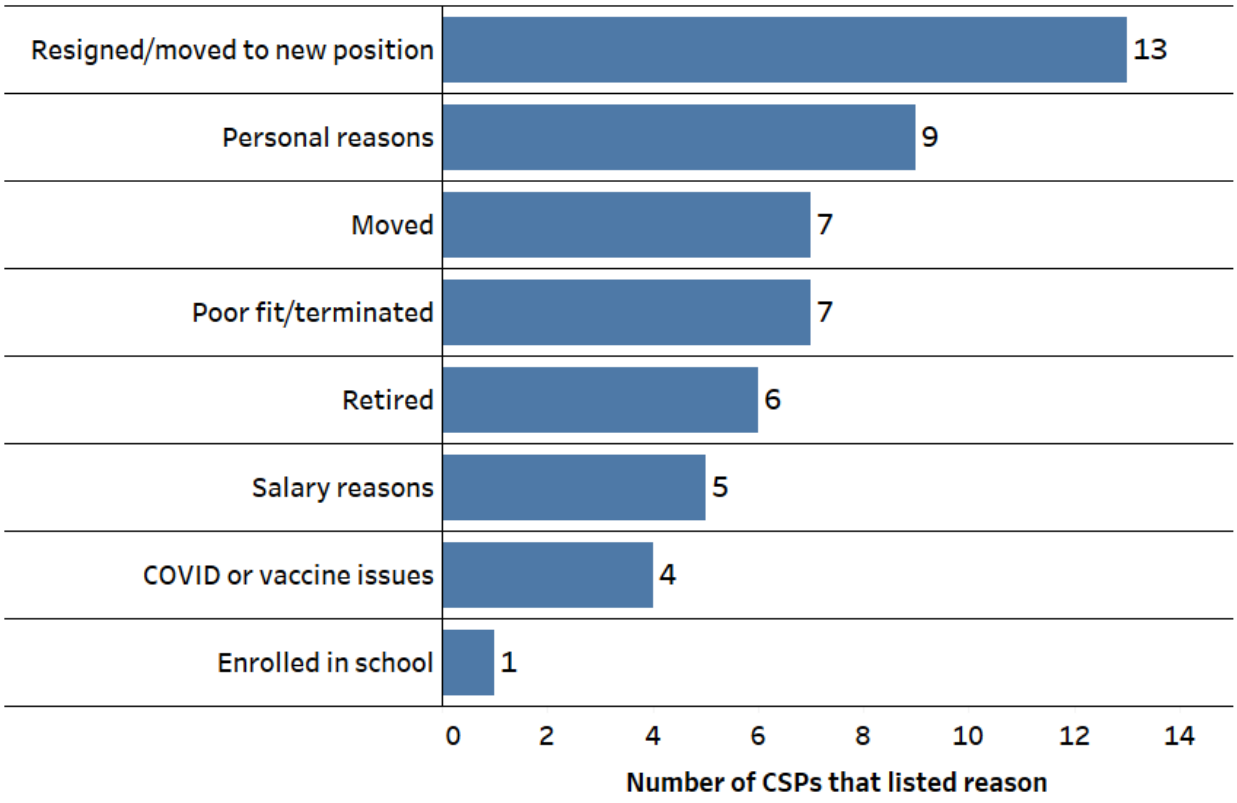
Of the 70 CSP that responded to staffing questions, 52% experienced vacancies in 2021, as identified in Figure 25. Of the CSP with vacancies, 48% were able to fill any vacant positions and experienced an average time of four months to fill an open position. This data indicates CSP experienced challenges with staffing turnover and hiring.

Figure 25: CSP staffing patterns, 2021



CSP were then asked to describe why staff left their positions. The most common reason was due to resignation or the staff member seeking employment elsewhere. Figure 26 identifies the frequency of other answers.

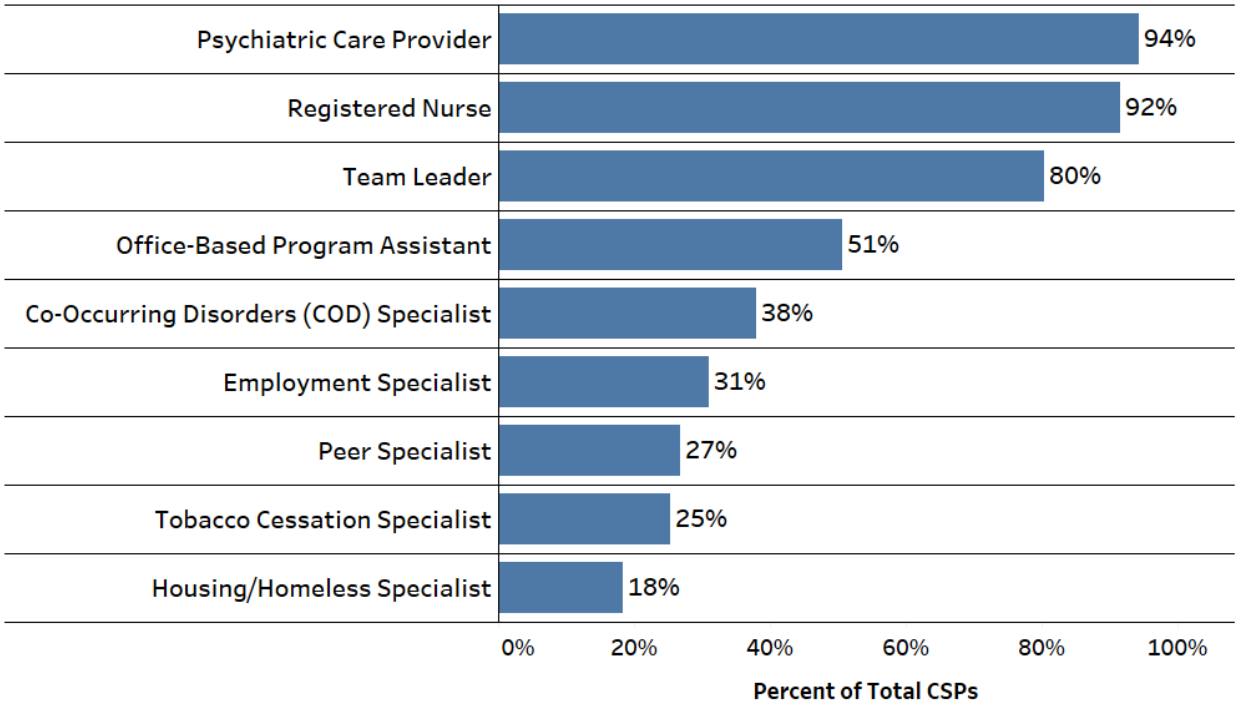
Figure 26: Reasons for vacancies, 2021



The ability for CSP to hire and maintain staff impacts programing and client care. As a program intended to provide assertive, comprehensive, and intensive mental health services to those in the community with the highest levels of mental health needs, lacking the staff necessary to provide these services can have serious population health and statewide financial impacts.

Having a fully staffed CSP team with designated roles on the team is a foundational component of CSP level care. CSP were asked to indicate whether their program had designated specialty roles.

Figure 27: Staff designations, 2021

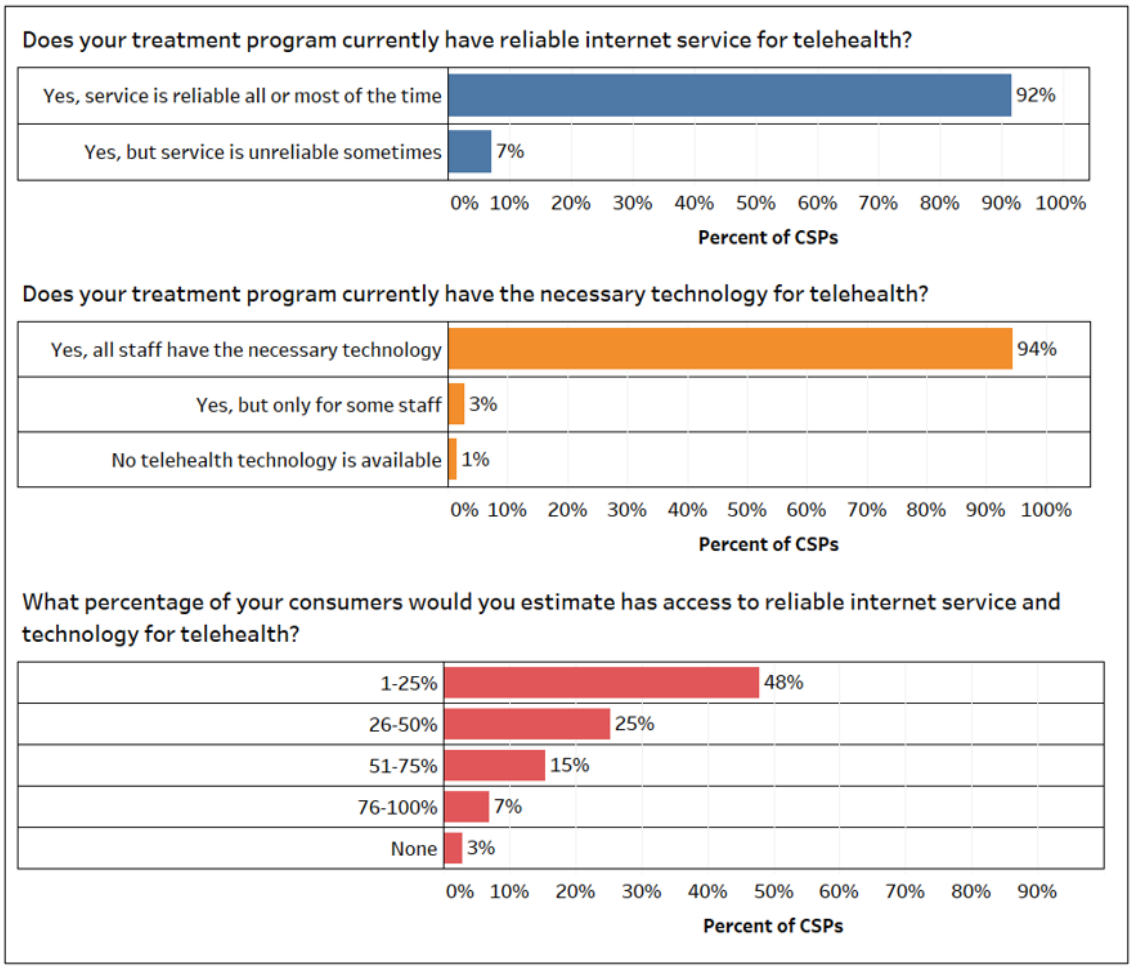


As displayed in Figure 27, 94% of CSP had a dedicated psychiatric care provider working as part of their team. The second most common role was registered nurse at 92%. The research on ACT has identified that the integrated roles of psychiatric provider, registered nurse, team leader, office-based assistant, co-occurring disorder specialist, employment specialist, and peer specialist are essential staff roles. Without these specific roles on the team, CSP fall short of providing the most effective elements of treatment.

Telehealth technology

Questions related to the use of telehealth and participant and CSP staff access to the internet and technology were also new to the 2021 survey. During the height of the COVID-19 pandemic (2020-2021), telehealth services became essential to continue to provide care while decreasing the potential to spread COVID-19, especially to those who were the most vulnerable. In 2021, 89% of the CSP surveyed reported to have used telehealth to provide services. Additional questions were asked about the reliability of the internet services and participant access (see Figure 28).

Figure 28: CSP and participant access to telehealth services, 2021



Of the CSP who responded, 92% reported agency internet services that were reliable all or most of the time to conduct telehealth appointments with participants.

When looking at whether CSP staff had access to the proper technology to perform telehealth services, 94% of CSP reported that their staff had the equipment to do so.

When CSP were asked to estimate the ability of their participants to access internet and technology, the responses were not as positive; the majority of CSP responded that few participants had easy access to these resources. Many factors may influence why participants appeared to have less access; these are important to continue to assess and mitigate as telehealth becomes a more standardized treatment approach for health care. While CSP services provide the most effective care through direct face-to-face contact and community-based interventions, assisting and teaching CSP participants how to access care through telehealth is still of value.

Conclusion

Several points emerge from this analysis of the 2021 CSP Annual Survey:

Declining enrollments

The total number of CSP participants statewide has decreased approximately 25% since 2006. This is consistent with a decline, since 2014, in the number of individuals on an annual waitlist for CSP services. The decrease of CSP participants may be corelated with the development and funding of CCS. CCS was developed in 2007 and became available for participant enrollment in 2008. CCS was implemented slowly statewide over the next several years. In 2013, full funding for CCS was approved; CSP were not included in this funding expansion and continue to require a county match for program operation.

Looking ahead

Given the declining number of admitted CSP participants since 2006, it is important to continue to monitor admissions for continuing declines and to examine the potential reasons for CSP population trends.

Serving a unique population

CSP use a team-based approach modeled after ACT. ACT, an evidence-based practice which originated in Wisconsin, was specifically designed to serve those with the highest levels of mental health needs to prevent hospitalizations and avoid institutional care. CSP serve primarily adults with serious and persistent mental health diagnoses while the CCS program provides services to individuals of all ages with a variety of diagnoses. The difference between CCS and CSP is that the CCS program uses contracted providers to meet the needs of its participants. CSP use a team-based approach where most services are provided by staff on the CSP treatment team. Having all staff on one team in one location makes consultation, coordination of participant care, and coverage for participant contacts easier. CSP teams meet frequently to strategize best treatment approaches, solve crisis situations, and support one another through team supervision. The differences in these approaches and the characteristics of the participants served by each program reinforce the continued need for CSP.

Looking ahead

Given the declining number of CSP participants statewide since 2006, it will be important to continue to assess whether those traditionally served by CSP due to their diagnosis, complexity of needs, and frequent hospitalizations are being treated successfully by alternative programs. Is the CSP funding structure impacting the ability to provide quality CSP services statewide including use of the ACT model and other evidence-based practices, and how does this impact those persons requiring the highest levels of mental health care.

Substance use

Between 2014-2021, the use of tobacco and other substances among CSP participants

appears to have increased. In comparing CSP participants to reported nationwide use, there are higher rates of tobacco and methamphetamine use among CSP participants. The percentage of CSP participants who use marijuana is comparable to that of the nationwide percentage (20%). In survey years, 2014, 2015, and 2016 all substance use was combined as one response; in 2017 and 2021, reports of substance use were made based off individual substances. Therefore, people who used more than one substance may have been counted under several substance selections. While this change provides more detailed information on the prevalence of specific substances used by CSP participants, it prevents a strong conclusion from being made about substance use trends over time.

Looking ahead

Although the trend appears to indicate increased substance use among CSP participants this trend cannot yet be confirmed. As the reporting of substance use becomes more consistent in the next few years, this will provide a better understanding for observed trends. Best practice continues to support the integration of mental health and substance use treatment. CSP should continue to use evidence-based practices such as ACT and IDDT that integrate co-occurring substance use treatment as part of the CSP treatment team. Only 38% of current CSP teams report a co-occurring substance use specialist as part of their team. Therapeutic approaches such as E-IMR and motivational interviewing should be considered for implementation as well.

Demographic changes

Between 2014-2021 there were two notable trends in participant demographics. One change was the decrease in female CSP participants and the increase in male participants. In 2014, female CSP participants accounted for 43% of those served while males were 57%. In 2021, female participants dropped to 38%, while male participants rose to 62%. A second notable change was with participants who identified as black/African American. In 2014 those identified were 17% of CSP participants which increased to 24% in 2021. Those who identify as black/African American make up approximately 6.3% of Wisconsin's residents however are represented as 23.9% of individuals served in CSP.

Looking ahead

Continuing to monitor demographic trends is important as outreach efforts and treatment approaches may need to be adjusted to improve disparities in mental health care. Further consideration and implementation of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care will be important to best engage and serve participants in ways that are culturally appropriate. It will also be important to look further into why those that identified as black/African American CSP participants are represented more often in CSP compared to their representation in the general population.

Aging population

The number of CSP participants enrolled in Family Care increased between 2016-2021 by approximately 38%. Family Care serves individuals with developmental disabilities, physical

health needs, and frail elders. Wisconsin demographics indicate a population statewide that is aging as the baby boomers, those born between 1946-1964 have moved into the range of those considered 60 and older. In congruence with the statewide trend, between 2014-2021, CSP participants aged 65 and older increased by 7.5%. It seems likely as there are larger numbers of CSP participants 65 and older that there might be increases in those who are becoming dually eligible for programs such as Family Care.

Looking ahead

As there are larger percentages of those 65 and older using CSP services, there is a need for CSP providers statewide to learn how to support those with serious mental health conditions in combination with age-related cognitive and physical health needs. Family Care agencies and CSP will need to work together to support the needs of those who are dually eligible and provide care that is coordinated and uses the resources and strengths from each program's array of services. Creativity may be needed to fill any gaps in the availability of community resources to meet those needs. A question will be added to the 2022 survey to assess whether dementia and other neurocognitive conditions are present amongst the CSP participants served.