

Comprehensive Community Services 2014 Monitoring Report



Wisconsin
Department of Health Services

Division of Mental Health and Substance Abuse Services

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EXECUTIVE SUMMARY

In Wisconsin, state, county, and tribal governments work cooperatively to meet the needs of individuals living with mental health and substance use concerns. Comprehensive Community Services (CCS) is one of the supportive programs for this population. CCS is a key part of Wisconsin's efforts to improve community-based mental health and substance use disorder services and reduce inpatient hospitalizations.

Available to Wisconsin counties and tribes since 2005, CCS is for individuals who need ongoing services beyond occasional outpatient care, but less than the intensive care provided in a hospital setting. CCS is unique in that services are available to people of all ages across their lifespan for either a mental illness, substance use disorder, or a dual diagnosis.

CCS is built around proven treatment and support methods. The services offered through CCS are designed to promote and support long-term recovery by stabilizing and addressing an individual's critical needs, including an individual's ability to self-manage their physical and social health; and an individual's ability to meet their basic needs, including housing, education, and employment skills.

In the 2013-2015 Biennial Budget, Governor Walker invested nearly \$30 million in mental health and substance use disorder services, including an expansion of CCS. The implementation date of the expansion of CCS was July 2014.

The *Comprehensive Community Services Monitoring Report* is published annually. This performance report covers calendar year 2014 and includes enrollment data, outcome data, and other program measures, including the first five months of the expansion effort.

State investment fuels expansion, six new programs certified in 2014

In 2014, six new CCS programs across the state were certified by the Wisconsin Department of Health Services (DHS), Division of Quality Assurance (DQA) to provide services, driven largely by the state budget initiative to provide funding to counties that offered CCS in a regional model. Additionally, in 2014, many counties started the process to become DQA-certified, a process which can take several months.

CCS utilization continues to grow

CCS program surveys showed a 25 percent increase over 2014 in the number of consumers enrolled in the program (from 1,544 in December 2013 to 1,937 in December 2014). There were 894 individuals newly admitted to CCS programs during the year (a 36 percent increase in the number of new consumers over the previous year) with a total of 2,438 consumers being served by CCS at some point during 2014.

CCS serves more consumers with substance use concerns

The most significant change in the characteristics of CCS consumers from 2013 is the increase in reported substance use, especially alcohol abuse. This may be attributed to efforts to enroll more people with substance use issues. Other characteristics, including gender, age, race/ethnicity, and veteran status, have remained fairly steady, while medical conditions among this segment of the population continue to appear under-reported.

Most consumers benefit from CCS participation

The reported incidence of various risk factors among adult consumers (e.g., psychiatric inpatient hospitalizations, emergency detentions) declined markedly after being enrolled in CCS. The reported incidence of substance use with negative consequences also fell. While the percent in need of health management assistance increased, the living situation of many adults appeared to improve with many moving into their own home or apartment.

Among child consumers, most continued to need mental health services, but the percentage of children exhibiting various high-risk behaviors (destruction of property, self-injury, violence, and stealing) declined

between initial and update assessments. Youth employment often increased, but there was little change in academic status or living arrangements.

About one in five CCS consumers were discharged in 2014

In 2014, among the 493 consumers for whom a discharge reason was reported, 38 percent left because they had recovered to the extent CCS services were no longer needed, 20 percent withdrew from CCS, 20 percent moved, and 11 percent needed additional services beyond what CCS could offer.

CCS works for adults, but improvement is needed for youth and families

Satisfaction surveys showed most adult, youth, and families were satisfied with CCS services. The majority of adults reported their experiences with CCS were person-centered and empowering. Youth and families felt strongly that services were culturally sensitive, but were less satisfied with the impact that CCS services had made on their lives.

CCS data

The Wisconsin Department of Health Services posts CCS enrollment data on the CCS Program website (<https://www.dhs.wisconsin.gov/ccs/index.htm>) on a quarterly basis. Outcome data and other program performance measures are only documented in this report.

INTRODUCTION

Comprehensive Community Services (CCS) is a recovery-focused, integrated behavioral health program that provides a flexible array of individualized, person-centered yet coordinated, community-based rehabilitation services for adults with severe mental illness and children with severe emotional disorder, as well as for adults and transition-age youth with substance use disorders. CCS provides a wide range of recovery, treatment, and psychosocial services using consumer- and family-directed service plans that assist individuals in utilizing professional, community, and natural supports to address the consumer's needs and achieve their recovery goals. The intent of CCS is to provide the maximum reduction of the effects of an individual's mental health and substance use disorders, and restoration of the consumer to their highest possible level of functioning. The majority of CCS services are provided in the consumer's home and local community by a team of professionals, peer specialists, and natural supports, all coordinated by a CCS service facilitator.

CCS programs are certified and services are governed per the requirements of Wis. Admin. Code ch. DHS 36. CCS services are eligible for Medicaid reimbursement for those individuals that qualify for Medicaid and whose services fall within the federal definition of "rehabilitative services" under 42 CFS § 440.130(d). Both Wisconsin Administrative Code and Medicaid allow for CCS services to be consumer directed, flexible, and individualized.

Eligibility for CCS is based on an individual's level of need determined by a Department of Health Services (DHS) approved Mental Health and Alcohol and Other Drug Abuse Functional Eligibility Screen. Under Wis. Admin. Code § DHS 36.15, certified programs are authorized to provide mental health and/or substance abuse services to consumers across the lifespan who require more than outpatient counseling but less than an intensive wraparound psychosocial rehabilitation program. In addition to mental and substance use disorders, consumers must have an impairment that limits one or more major life activities, which results in the need for services.

CCS services must be individualized to each person's needs and recovery goals as identified through a comprehensive assessment. Services that must be available for consumers are: assessment, recovery and service planning, service facilitation, and individually authorized psychosocial rehabilitation services.

CCS programs are designed to be community-based, enhance consumer's recovery and satisfaction, and continually build on quality improvement. First, CCS service arrays are developed to interface and enhance available behavioral health services and crisis services. Second, CCS programs focus on quality improvement through consumer satisfaction and progress toward consumer outcomes. Third, CCS programs appoint a coordination committee comprised of various stakeholders and develop and implement a quality improvement plan to evaluate the effectiveness of CCS and incorporate the feedback of consumers and the committee.

This CCS 2014 Monitoring Report will describe:

- The recent expansion of CCS services across Wisconsin, facilitated by the DHS Division of Mental Health and Substance Abuse Services (DMHSAS).
- DQA-certified programs, as well as DMHSAS-approved and DQA-certified regions providing CCS services.
- Numbers and characteristics of consumers enrolled in and served by CCS.
- CCS Medicaid recipients and expenditures.
- Services offered through CCS, including evidence-based practices (EBPs).
- Discharge reasons and outcomes for CCS consumers.
- Satisfaction with CCS services among adult, youth, and family consumers.

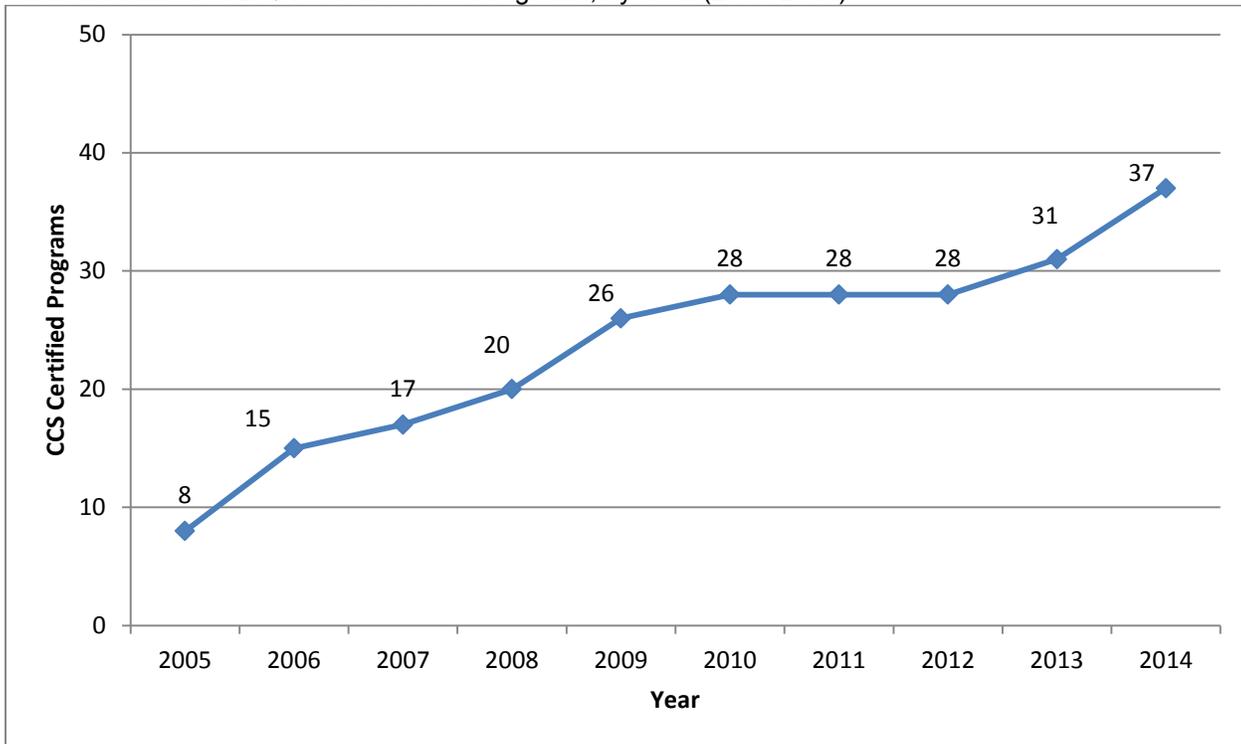
CCS EXPANSION IN WISCONSIN

In July 2014, Wisconsin expanded CCS by making state funds available for existing and new programs (counties and tribes) to become certified and provide CCS in a regional model. The ultimate goal of this initiative was to expand CCS statewide so programs could offer services to more children and adults who experience mental health and/or substance use disorders. This significant expansion of CCS warrants monitoring the effectiveness of the program by ensuring children and adults are provided high-quality care.

CCS Programs

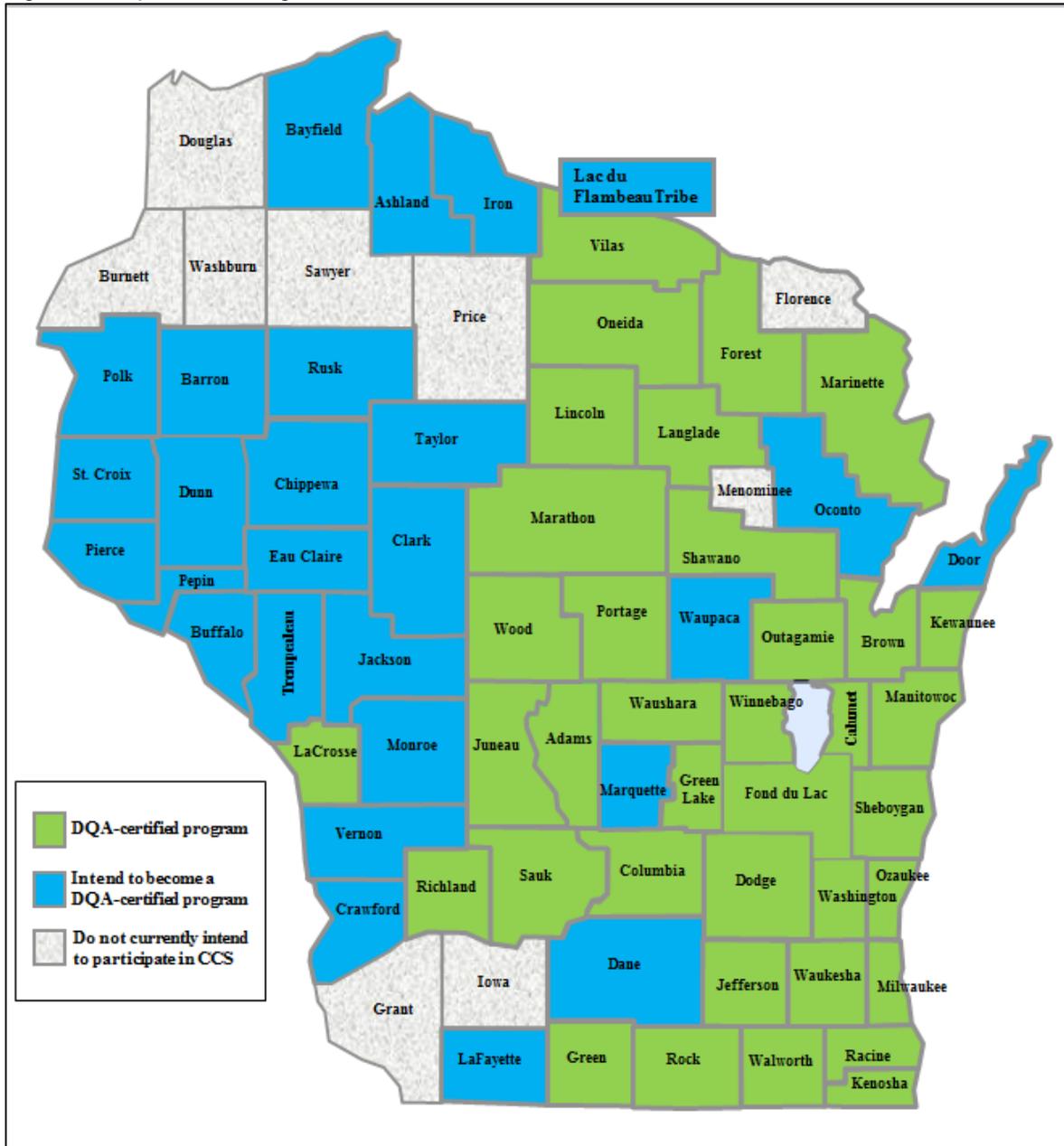
From the inception of CCS in 2005, the number of programs certified by the Wisconsin Department of Health Services Division of Quality Assurance (DQA) to deliver the CCS benefit grew over four-fold (from eight counties the first year to 37 counties in 2014) including six new CCS programs in 2014. The increased number of CCS programs over time is tracked in Chart 1. In addition, many more counties declared their intention in 2014 to become DQA-certified CCS programs, driven largely by the state’s commitment to use state funds for the non-federal share of Medicaid expenses, if programs provide CCS within a regional model.

Chart 1: Number of DQA-Certified CCS Programs, by Year (2005-2014)



CCS programs across the state can also be tracked geographically on the following map.

Figure 1: Map of CCS Programs, as of December 31, 2014



CCS Regions

By the end of 2014, 10 regions across Wisconsin had been approved by DMHSAS and certified by DQA to provide CCS. CCS counties are organized into one of four region models: population-based, shared services, multi-county, and 51.42.

Population-Based Model

Individual counties with a population over 350,000 or sovereign tribal nations can be certified to provide CCS as a population-based region. These counties and tribes are not required to collaborate with other counties or tribes, but are required to maintain DQA and Medicaid certifications for CCS. These counties and tribes are considered a regional service-delivery system eligible for state CCS expansion funding.

In 2014, the two population-based regions were Milwaukee County and Waukesha County.

Shared Services Model

Counties in this model agree to share some significant resources, expenses, and components of CCS programming (such as providers, supervision, training, and administrative operations) while being responsible for maintaining individual county CCS certifications for DQA and Medicaid billing. Counties with existing or new CCS certifications are allowed to share services and/or expenses to create efficiencies. These counties are considered a regional service delivery system eligible for the state CCS expansion funding

In 2014, the five shared services regions were:

- Central Wisconsin Health Partnership (CWHP): Adams, Green Lake, Juneau and Waushara counties. (Marquette and Waupaca counties also plan to join this region, but were not DQA-certified programs in 2014.)
- JRW Tri-County Region: Jefferson, Rock and Walworth counties.
- Northeast Wisconsin Behavioral Health Consortium: Brown, Calumet, Manitowoc, Outagamie, and Winnebago counties.
- Portage-Wood Partnership: Portage and Wood counties.
- Wisconsin River CCS Collaboration: Columbia, Richland, and Sauk counties.

Multi-County Model

In this model, two or more counties partner under a single CCS program certification. A multi-county region is certified as a program, with one county identified as the lead administrative agency with responsibility to maintain CCS certification. Counties collaborate to create a single CCS service area, encouraging the expansion of CCS programming to larger geographic areas. Each region is considered a distinct service delivery system eligible for the state CCS expansion funding.

In 2014, there was one multi-county region, Western Region Integrated Care (WRIC): La Crosse (lead), Monroe, and Jackson counties.

51.42 Model

In this model, two or more counties join as a legal entity to provide a number of human service programs, one of which is CCS. The region is required to have DQA and Medicaid CCS certification. These regions are statutorily based and currently exist in Wisconsin. These entities serve an area to provide regional programming, including CCS services. The region is considered a regional service-delivery system eligible for state CCS expansion funding.

In 2014, there were two 51.42 regions:

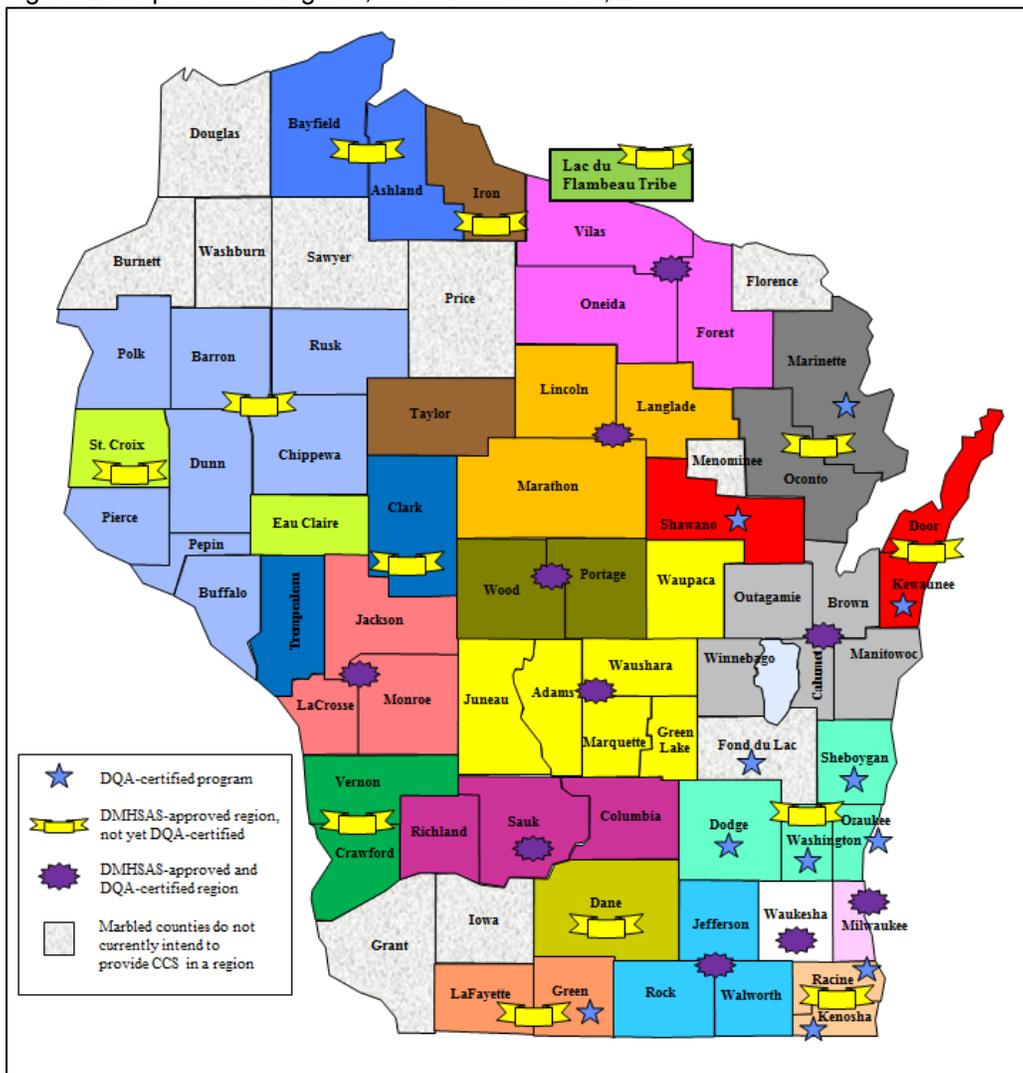
- The Human Service Center (HSC): Forest, Oneida, and Vilas counties.
- North Central Health Care (NCHC): Langlade, Lincoln, and Marathon counties.

Figure 2 illustrates the regions across Wisconsin that were DMHSAS-approved and DQA-certified (medallion) to provide CCS services by the end of 2014. DMHSAS-approved regions that were not also certified by DQA to provide services through a regional model are indicated by a banner. Several DQA-certified programs that were not currently operating in a region are shown with a star.

At the end of 2014, counties and regions were in various stages of becoming certified to provide CCS services. For example, Marinette County was already a DQA-certified county and had become a DMHSAS-approved region with Oconto County, but because Oconto County had not yet become a DQA-certified county, the region was still working to become DQA-certified. Both Racine and Kenosha counties were DQA-certified and the

Kenosha-Racine region had been DMHSAS-approved, but the region had not yet been DQA-certified. Fond du Lac County was DQA-certified but, at the time, did not intend to provide CCS services in a regional model.

Figure 2: Map of CCS Regions, as of December 31, 2014



CCS Utilization

Consumers Enrolled

Starting in December 2013, CCS programs and regions were asked to report quarterly on the number of consumers enrolled in their DQA-certified county or tribe (and DMHSAS-approved and DQA-certified region, if applicable). The following table presents the number of consumers enrolled in each program and region at the end of 2013 and 2014, respectively.

Between December 2013 and December 2014, CCS saw a 28 percent increase (from 1,519 to 1,947) in the number of consumers enrolled across the state, coinciding with a 19 percent rise in the number of certified programs (from 31 to 37 programs by the end of 2014).

Table 1: Consumers Enrolled in CCS Programs and Regions (December 2013 and December 2014)

DMHSAS Regions (and DQA-Certified Programs)	December 2013	December 2014
Central Wisconsin Health Partnership (CWHP)	53	68
Adams County	<25	27
Green Lake County	<25	<25
Juneau County	-	<25
Waushara County	<25	<25
Human Service Center (HSC)	<25	30
Forest County	NA	NA
Oneida County	NA	NA
Vilas County	NA	NA
JRW Tri-County Region CCS	74	98
Jefferson County	52	67
Rock County	-	<25
Walworth County	<25	<25
Milwaukee County	-	69
North Central Health Care (NCHC)	355	401
Langlade County	30	NA
Lincoln County	35	NA
Marathon County	290	NA
Northeast Wisconsin Behavioral Health Consortium	271	316
Brown County	70	97
Calumet County	<25	<25
Manitowoc County	<25	27
Outagamie County	112	120
Winnebago County	51	52
Portage-Wood Partnership	93	113
Portage County	45	41
Wood County	48	72
Waukesha County	104	100
Western Region Integrated Care (WRIC)	143	198
La Crosse County	143	181
Jackson County	-	<25
Monroe County	-	<25
Wisconsin River CCS Collaboration	112	147
Columbia County	<25	26
Richland County	48	44
Sauk County	49	77
DQA-Certified Programs Not in Regions		
Dodge County	<25	34
Fond du Lac County	<25	<25
Green County	36	34
Kenosha County	75	98
Kewaunee County	<25	27
Marinette County	58	56
Shawano County	-	<25
Sheboygan County	40	84
Washington County	48	53
Total Number of Consumers (Across All CCS's)	1,519	1,947

Source: Enrollment numbers provided directly by CCS programs and compiled by DMHSAS.

NA = Not Available (For example, data were available only for a region, not individual counties.)

Note: This table lists all programs and regions that were DQA-certified or DMHSAS-approved by December 2014.

Note: Counts less than 25 are shown in the table as "<25" to protect client confidentiality and comply with federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

Note: A dash (-) indicates the program/region was not certified/approved during a previous period. (For example, the CCS program in Juneau County was not DQA-certified until 2014, but the Central Wisconsin Health Partnership region was DMHSAS-approved in 2013.)

Consumers Admitted, Served, and Discharged

Based on data collected using an annual survey completed by each CCS program, the number of consumers enrolled in CCS increased 25 percent from 1,544 at the end of 2013 to 1,937 by the end of 2014. During the 2014 calendar year, 894 individuals were newly admitted to CCS, a 36 percent increase over the 656 consumers admitted in 2013 (as shown in Chart 2).

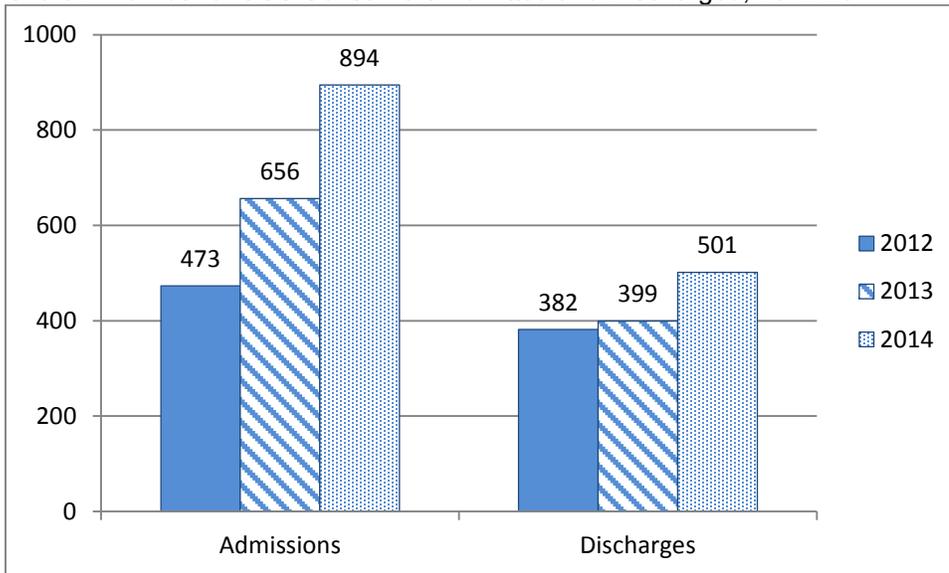
A total of 2,438 consumers were served in their CCS at some point during 2014 (either having already been enrolled at the end of 2013 or being admitted during 2014). This was a 25 percent increase over the 1,947 consumers served during 2013 and mirrors the higher reported consumer enrollment (discussed above).

The chart also shows that the number of CCS consumers discharged during 2014 (501) was higher than the number discharged in 2013 (399), but this 26 percent increase was not as large as the recent rise in admissions (a 36% increase) from 656 admitted in 2013 to 894 admitted in 2014.

While the majority of consumers stayed in CCS at the end of 2014, the 501 individuals discharged by the end of the year was approximately one-fifth (21%) of the 2,438 consumers served during the year, leaving 1,937 active CCS consumers still enrolled. **Note:** this number is slightly lower than the 1,947 consumers reported in the Program Participation System (PPS) database as enrolled in the CCS program at the end of 2014 (in Table 1 in the previous section on “Enrollment”). The difference may simply be due to variations in the number of consumers enrolled in CCS at any given time.

Eighty-one CCS consumers were concurrently enrolled in Family Care, and 34 of the consumers discharged during 2014 were in Family Care.

Chart 2: Number of CCS Consumers Admitted and Discharged, 2012-2014



Source: 2012-2014 Comprehensive Community Services (CCS) Program Surveys.

About one-fifth of the consumers served in CCS (those enrolled at the end of the previous year, plus those admitted during the following year) were discharged in each of the past three years (see Table 2).

Table 2: Number and Percent of CCS Consumer Discharged, 2012-2014

Year	Number of Consumers Discharged	Number of Consumers Served	Percent of Consumers Discharged (among those Served)
2012	382	1,698	22.5%
2013	399	1,947	20.5%
2014	501	2,438	20.5%

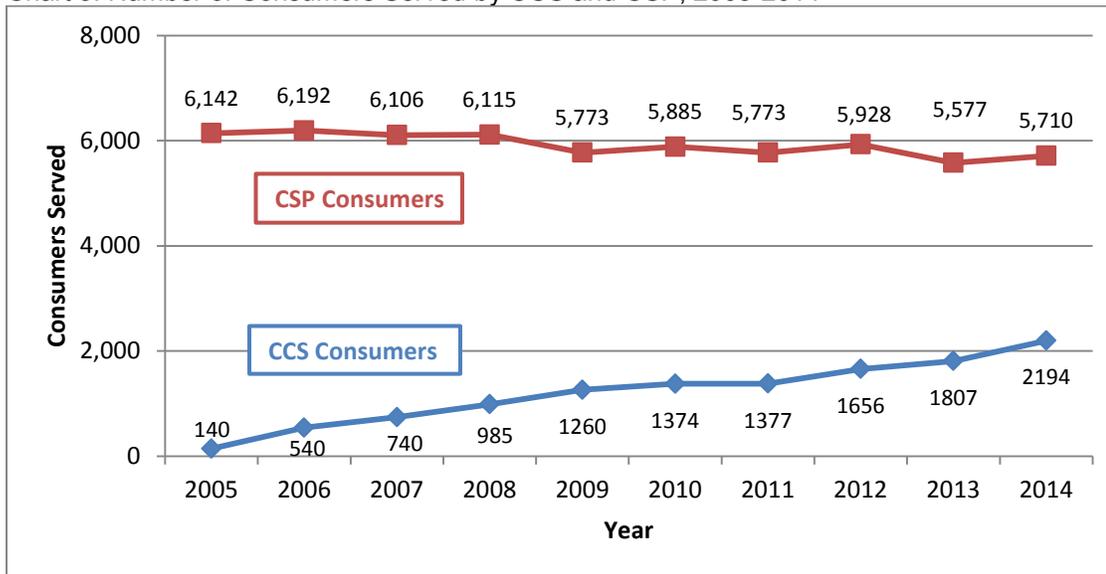
Source: 2012-2014 Comprehensive Community Services (CCS) Program Surveys.

Consumers Served by CCS and CSP

The number of consumers served by CCS has increased steadily between 2005 (when only 140 consumers were served) and 2014 (when nearly 2,200 consumers received CCS services) as more counties and tribes became DQA-certified. Chart 3 indicates the number of CCS consumers rose from 2005 to 2010, leveled off slightly in 2011, and increased again starting in 2012, with a visible rise in the numbers served in the past year.

Note: This section evaluates the number of consumers served by CCS based on service data entered into the Human Services Resource System (HSRS) and PPS systems (which may parallel but be inconsistent with enrollment and survey data collected from programs directly and presented in the previous “Consumers Enrolled” section).

Chart 3: Number of Consumers Served by CCS and CSP, 2005-2014



Source: Human Services Reporting System (HSRS) and Program Participation System (PPS) Mental Health Modules, and 2005-2014 Community Support Program (CSP) Program Surveys.

Community Support Programs (CSP) is another psychosocial rehabilitation Medicaid benefit in Wisconsin that has been available since 1990. CSPs overall are designed to serve consumers with more serious needs than CCS programs. While the 2013-2015 state budget initiative provides state general purpose revenue funding for the Medicaid non-federal share CCS funding, the CSP Medicaid matching funds must come from county revenue sources. To monitor potential changes in enrollment related to the two different funding arrangements, the number of consumers served by CSP is also evaluated in the annual CCS monitoring report.

Based on data collected using CSP Program Surveys between 2005 and 2014, there appears to have been a small drop in recent years in the number of consumers served through CSPs (starting in 2009, with fewer than 6,000 consumers receiving CSP services for the first time in several years). There was another decline in the number of CSP consumers in 2013 (down about 350 consumers from 2012), with a slight increase in 2014 (with 5,710 consumers being served). Over time, the number of CCS consumers has grown substantially but it is too early to tell what the impact of this increase has on the number of individuals served by CSPs.

Medicaid Recipients and Expenditures

CCS programs provide and arrange for the provision of psychosocial rehabilitation, including services and supportive activities that assist members with mental health and/or substance abuse conditions to achieve their highest possible level of independent functioning, stability, and independence, and to facilitate recovery. All services must be non-institutional and fall within the definition of rehabilitative services as defined in federal code 42 CFR 440.130(d). Members across the lifespan (minors, adults, and elders) can receive CCS services.

One does not need to be Medicaid eligible to receive CCS services. However, county and tribal agencies have funding constraints that prohibit or severely limit their ability to offer CCS services apart from Medicaid. Some counties serve a small number of persons in CCS that are not on Medicaid or are awaiting Medicaid eligibility. In order for Medicaid to reimburse for CCS services, the CCS member must be Medicaid eligible.

Members enrolled in the Medicaid or BadgerCare Plus programs who are determined to need CCS services are eligible for CCS enrollment. All services provided under the CCS benefit are reimbursed fee-for-service regardless of whether the member is enrolled in a BadgerCare Plus Health Maintenance Organization (HMO), a Medicaid Supplemental Security Income (SSI) HMO, or a special managed care program (such as Family Care and the Family Care Partnership Program). Health care providers may refer potential members to their county or tribal human services department. Each county or tribe determines its access point for CCS and has policies and procedures on referral and screening for the program. Once members are evaluated through a screening and eligibility process, the members are informed of the services for which they are eligible and referred to those services in the manner the county or tribe has established.

It is important to note that the CCS program is not currently available to members who receive services under the Medicaid Managed Care Benefit for either Wraparound Milwaukee or Dane County Children Come First. These two other programs include case management as a covered service and, as a result, additional care coordination may not be billed separately at the same time through Medicaid.

Prior to July 2014, counties were responsible for paying the non-federal share of Medicaid expenses incurred by providing CCS services. However, the 2013-2015 state budget authorized DHS to increase funding for CCS programs. As a result, effective for dates of service on and after July 1, 2014, Wisconsin's Medicaid program (state funds) will pay the non-federal share of Medicaid and BadgerCare Plus allowable program costs to counties and tribes that operate in regional (not individual county) CCS programs. Regionalization is expected not only to create administrative efficiencies but also to increase access to CCS services.

In addition to potential changes in the number of consumers served through CCS, the availability of state funds for the non-federal Medicaid share of CCS may also change the state's Medicaid program expenditures for CCS across the state. Medicaid expenditures for CCS are tracked by county to determine the impact of the new funds on local services and expenditures. Since counties paid the non-federal share of CCS costs prior to July 2014, the expenditure totals (in Table 3) represent only the federal share paid through the state's Medicaid program through June 2014. Expenditures beginning July 2014 include both the federal and non-federal share of Medicaid CCS costs (although Medicaid-paid claims are typically not all finalized until one year after the claim date, so the 2014 data presented here should be considered preliminary). Both persons and costs were expected to increase in 2014 with the new regional initiative.

Medicaid Recipients and Expenditures, by County

Table 3 presents the total count of Medicaid CCS recipients (number of persons served) and claims expenditures (amount paid by Medicaid to each county) by county in 2011-2014 for CCS services provided under the standard Medicaid fee-for-service system. The number of CCS Medicaid recipients increased from 1,849 in 2013 to 2,328 in 2014. Likewise, claims expenditures for CCS services provided increased from \$10.6 million in 2013 to \$14.9 million in 2014.

The new state funds used to pay for CCS services are expected to drive the expansion of the use of the CCS benefit. However, the CCS capacity-building efforts and certification process takes more than six months for many county agencies. Thus, as illustrated in Chart 1, only six counties gained certification in 2014, indicating that the majority of the impact of the CCS expansion will occur in 2015 and be described in the next CCS Monitoring Report.

Table 3: CCS Medicaid Count of Recipients and Expenditures Paid to Counties, 2011-2014

County	2011		2012		2013		2014	
	Count	Paid	Count	Paid	Count	Paid	Count	Paid
Adams	33	\$154,349	31	\$173,488	33	\$128,853	38	\$142,453
Brown	96	\$710,367	130	\$863,237	86	\$862,583	118	\$939,886
Calumet	40	\$169,242	44	\$128,954	33	\$94,692	38	\$94,070
Columbia	<25	\$74,177	<25	\$79,835	<25	\$147,040	38	\$160,525
Dodge	26	\$63,200	34	\$72,975	31	\$67,324	41	\$63,211
Fond du Lac	<25	\$94,765	<25	\$81,647	<25	\$102,778	<25	\$204,445
Green	30	\$84,258	37	\$100,496	41	\$112,884	42	\$145,448
Green Lake	<25	\$34,889	<25	\$18,934	<25	\$38,968	<25	\$23,547
HSC	29	\$133,452	25	\$166,491	<25	\$72,350	37	\$208,115
Jefferson	67	\$315,182	81	\$395,363	79	\$356,871	79	\$356,353
Juneau	NA	NA	NA	NA	NA	NA	<25	\$61,941
Kenosha	69	\$114,735	73	\$177,991	87	\$249,979	115	\$487,598
Kewaunee	<25	\$7,645	<25	\$36,898	<25	\$85,204	30	\$113,479
La Crosse	131	\$1,177,821	140	\$1,007,000	160	\$1,242,971	244	\$2,440,924
Manitowoc	25	\$155,114	<25	\$156,894	<25	\$89,389	<25	\$71,493
Marinette	NA	NA	<25	\$47,509	70	\$370,203	76	\$475,280
NCHC	214	\$861,364	224	\$970,185	364	\$1,124,809	435	\$2,471,059
Outagamie	143	\$1,155,622	138	\$1,188,500	134	\$1,016,604	140	\$1,319,980
Portage	36	\$125,224	44	\$217,691	38	\$154,580	53	\$288,395
Richland	74	\$359,091	74	\$351,481	70	\$276,281	66	\$392,995
Rock	NA	NA	NA	NA	NA	NA	<25	\$43,704
Sauk	46	\$404,415	59	\$521,111	70	\$761,406	94	\$1,248,686
Shawano	NA	NA	NA	NA	NA	NA	<25	\$34,542
Sheboygan	31	\$108,208	31	\$129,187	58	\$213,345	110	\$353,216
Walworth	27	\$317,282	32	\$296,495	32	\$205,972	29	\$271,930
Washington	53	\$339,902	54	\$424,570	55	\$455,161	68	\$452,726
Waukesha	100	\$1,005,789	103	\$1,141,232	108	\$1,113,528	105	\$571,058
Waushara	36	\$165,258	34	\$209,130	29	\$207,798	36	\$210,924
Winnebago	87	\$454,615	96	\$452,013	97	\$716,308	115	\$666,761
Wood	71	\$453,488	69	\$401,364	69	\$338,495	90	\$559,730
Total	1,509	\$9,039,454	1,649	\$9,810,669	1,849	\$10,606,377	2,328	\$14,874,473

Source: DMHSAS extract from InterChange, the online Medicaid fee-for-service claims analysis universe. Individuals served in a CCS program who are members of a Medicaid HMO plan are covered under a fee-for-service arrangement.

HSC = Health Services Center (includes Forest, Oneida, and Vilas counties)

NCHC = North Central Health Care (includes Langlade, Lincoln, and Marathon counties)

Note: Counts less than 25 are shown in the table as "<25" to protect client confidentiality and comply with federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

Note: A dash (-) indicates the program was not DQA-certified during the specified period. For example, the CCS program in Juneau County was not certified until 2014.

Note: These claims expenditure figures do not include county cost settlement amounts which, if included, would slightly increase or decrease overall expenditures to individual counties.

CONSUMER CHARACTERISTICS

In the spring of 2015, the Division of Mental Health and Substance Abuse Services (DMHSAS) administered the fourth annual Comprehensive Community Services (CCS) Program Survey for 2014. Each year, all certified CCS programs are provided with and asked to complete this survey, reporting on program characteristics, services provided to their consumers, and characteristics of consumers served during the previous year. The CCS Program Survey mirrors the survey that has long been administered to Community Support Programs (CSPs). A copy of the 2014 CCS Program Survey appears in Appendix II.

With regard to consumer characteristics, the 2014 CCS Program Survey asks programs to report on the demographics (gender, age, race/ethnicity, and veteran status), substance use, and medical conditions of individuals they served in 2014. Together, these data illustrate who CCS is serving across Wisconsin.

Gender

Based on 2014 CCS Program Survey data, the gender composition of CCS consumers during the year was fairly evenly divided between males and females, with slightly more consumers being male (51.5%, 1,246 males of 2,420 total consumers) than female (48.5%, 1,174 females of 2,420 total consumers). This is a reversal from 2013 (when 51% of consumers were female) and more like 2012 (when 47% were female). While the proportions change slightly each year, there has been a relatively equitable gender breakdown over time among CCS consumers.

Age

County agencies approved under Wis. Admin. Code ch. DHS 36 to provide CCS services are required to offer the CCS benefit to eligible consumers of all ages, including children (ages 17 years and under) and elderly adults (ages 65-74 years, and 75 years and over), in addition to adults ages 18-64 years. CCS services are to be tailored to the individual needs of consumers of varying ages and thus can afford access to mental health services for everyone within a county.

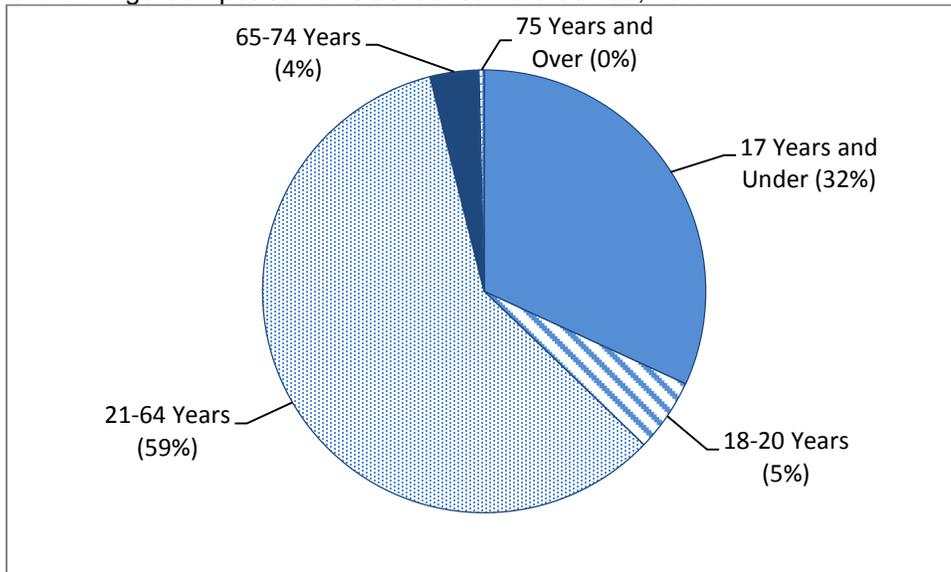
Program Survey Data

The age distribution of CCS consumers in 2014 (Chart 4) remains essentially unchanged from 2013, with slightly more children (ages 17 and under) and slightly fewer consumers aged 75 years and over being served. Thirty-two percent of consumers are minors (under age 18), while a total of 4 percent are ages 65 or over. The majority of consumers (59%) are working-age adults, ages 21-64.

These findings indicate more youth were served by CCS than might be expected given the composition of Wisconsin's population in 2014 when only 23 percent were under 18 years of age. At the same time, 15 percent of the state's population was 65 years or older, suggesting more elderly may be in need of CCS than are currently being served.¹

¹ Wisconsin age statistics were taken from the United States Census Bureau QuickFacts website. (Accessed on February 12, 2016.) Available at: <http://www.census.gov/quickfacts/table/PST045214/00,55>.

Chart 4: Age Composition of CCS Consumers Served, 2014



Source: 2014 Comprehensive Community Services (CCS) Program Surveys.

Medicaid Data

The result of recent efforts to serve consumers across the age spectrum is described in Table 4. Both the count and percent of Medicaid consumers served, distinguished by these three age groups, are shown for each county and region certified to provide CCS services during 2014. While most programs focused on providing services to adults, children represented more than half of the CCS consumers served in 12 (40%) of the 30 certified counties and regions, including: Calumet, Columbia, Fond du Lac, Human Service Center (Forest, Oneida, and Vilas counties), Jefferson, Manitowoc, Marinette, Portage, Sauk, Shawano, Walworth, and Waushara counties. Another 12 counties and regions reported serving at least some older adults (ages 65 years or older).

Table 4: CCS Consumers Served by Age, by County, 2014

Billing Provider County Name	Children Age 17 and Under		Adults Age 18 - 64		Older Adults Age 65 and Over		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Adams	<25	x	<25	x	<25	x	39	100%
Brown	<25	x	97	85.1%	<25	x	114	100%
Calumet	<25	x	<25	x	<25	x	38	100%
Columbia	26	68.4%	<25	x	<25	x	38	100%
Dodge	<25	x	<25	x	<25	x	40	100%
Fond du Lac	<25	x	<25	x	<25	x	<25	100%
Green	<25	x	40	95.2%	<25	x	42	100%
Green Lake	<25	x	<25	x	<25	x	<25	100%
HSC	<25	x	<25	x	<25	x	37	100%
Jefferson	43	54.4%	35	44.3%	<25	x	79	100%
Juneau	<25	x	<25	x	<25	x	<25	100%
Kenosha	28	24.3%	77	67.0%	<25	x	115	100%
Kewaunee	<25	x	<25	x	<25	x	30	100%
La Crosse	93	38.1%	147	60.2%	<25	x	244	100%
Manitowoc	<25	x	<25	x	<25	x	<25	100%
Marinette	48	63.2%	28	36.8%	<25	x	76	100%
NCHC	127	29.5%	278	64.7%	25	5.8%	430	100%
Outagamie	31	22.6%	103	75.2%	<25	x	137	100%
Portage	34	63.0%	<25	x	<25	x	54	100%
Richland	<25	x	43	65.2%	<25	x	66	100%
Rock	<25	x	<25	x	<25	x	<25	100%
Sauk	60	63.8%	34	36.2%	<25	x	94	100%
Shawano	<25	x	<25	x	<25	x	<25	100%
Sheboygan	<25	x	82	80.4%	<25	x	102	100%
Walworth	<25	x	<25	x	<25	x	29	100%
Washington	<25	x	49	73.1%	<25	x	67	100%
Waukesha	<25	x	105	100.0%	<25	x	105	100%
Waushara	<25	x	<25	x	<25	x	36	100%
Winnebago	52	45.2%	61	53.0%	<25	x	115	100%
Wood	32	35.6%	58	64.4%	<25	x	90	100%
Total	808	35.0%	1,431	62.0%	69	3.0%	2,308	100%

Source: InterChange, DHS Medicaid fee-for-service claims analysis universe. Individuals served in a CCS program who are members of a Medicaid HMO plan are covered under a fee-for-service arrangement.

HSC = Health Services Center (includes Forest, Oneida, and Vilas counties)

NCHC = North Central Health Care (includes Lincoln, Langlade, and Marathon counties)

Note: Counties have up to one year to submit claims to Medicaid, so 2014 Medicaid data may be incomplete.

Note: Counts less than 25 are shown as “<25” (and percents are shown as “x”) to protect client confidentiality and comply with federal Health Insurance Portability and Accountability Act (HIPAA) requirements.

Race and Ethnicity

The racial and ethnic composition of CCS consumers remained essentially unchanged from previous years. The great majority of consumers (90%) whose race was recorded were White. Among other racial groups represented, 5 percent were Black/African American, 2 percent were American Indian/Alaskan Native, 1 percent were either Asian or Hawaiian/Pacific Islander, and 3 percent were reported to have more than one race.

Racial minority groups were under-represented relative to their representation in Wisconsin as a whole. For instance, African Americans made up 6.6 percent of Wisconsin residents in 2014 (among persons reporting only one race),² but only 5 percent of CCS consumers.

The ethnic composition of CCS consumers in 2014 was also consistent with previous years. The percentage of known Hispanic/Latino consumers remained stable (at 2%). As noted in previous years, this is approximately one-third the rate of representation of Hispanics or Latinos in Wisconsin as a whole (6.5%).³

It should be noted that the CCS service area in 2014 did not include all Wisconsin counties. In particular, Milwaukee County (a county whose population has a much higher percentage of racial and ethnic minorities than Wisconsin as a whole) was not certified to provide CCS services until September 2014. The lower rate of racial and ethnic minorities among CCS consumers is likely at least partially explained by the fact that CCS services were not available in Milwaukee for two-thirds of the year.

Veteran Status

Only 2 percent of those served in CCS in 2014 were recorded as veterans. This percent is quite low, given that veterans represent approximately 7 percent of Wisconsin's total population.⁴ However, identified veterans also are under-represented in the county mental health system as a whole, with only 568 total consumers recorded as being veterans in the PPS database between 2008 and 2014. Whether veterans are truly under-represented among CCS consumers (or merely not identified as such) is unknown at this time.

Substance Use

CCS programs were asked to report on their knowledge of CCS consumers' current tobacco use, alcohol abuse, and use of illicit drugs. Programs were asked to count consumers in each category that applied, so categories likely include overlap between consumers. (For example, a consumer who smokes and abuses alcohol will appear in both categories in Chart 5).

Substance use within the Wisconsin population is presented as a gauge for comparison with CCS consumers. State data on tobacco use reflect the percent of individuals aged 18 or older who reported being current smokers in 2012.⁵ Alcohol abuse includes individuals aged 12 or older who were "dependent on or abused alcohol" (based on the DSM-IV criteria) in the year prior to being surveyed in 2011-2012. Illicit drug use includes the percentage of individuals who used "marijuana/hashish, cocaine/crack, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics...non-medically" during the past month in 2011-2012.⁶

National research indicates that mental health consumers are more likely than other adults to have a variety of co-occurring substance use ailments⁷ and, indeed, results from the 2014 CCS program survey showed a comparable or higher incidence of substance use than the Wisconsin population in general. According to the survey results, CCS consumers' tobacco use was somewhat higher than the state population; they were also

² Wisconsin race statistics were taken from the United States Census Bureau QuickFacts website. (Accessed on September 16, 2015.) Available at: <http://www.census.gov/quickfacts/table/PST045214/00,55>.

³ Wisconsin ethnicity statistics were taken from the United States Census Bureau QuickFacts website. (Accessed on September 16, 2015.) Available at: <http://www.census.gov/quickfacts/table/PST045214/00,55>.

⁴ Wisconsin veteran statistics were taken from the United States Census Bureau QuickFacts website. (Accessed on September 16, 2015.) Available at: <http://www.census.gov/quickfacts/table/PST045214/00,55>.

⁵ Tobacco use data taken from the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health, BRFSS Prevalence & Trends Data. 2015. (Accessed on October 23, 2015.) Available at: <http://www.cdc.gov/brfss/brfssprevalence/>.

⁶ Alcohol abuse and illicit drug use data taken from the SAMHSA, Center for Behavioral Health Statistics and Quality (CBHSQ), National Survey on Drug Use and Health (NSDUH), 2009 to 2013. (Accessed on September 16, 2015.) Available at: http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-WI.pdf

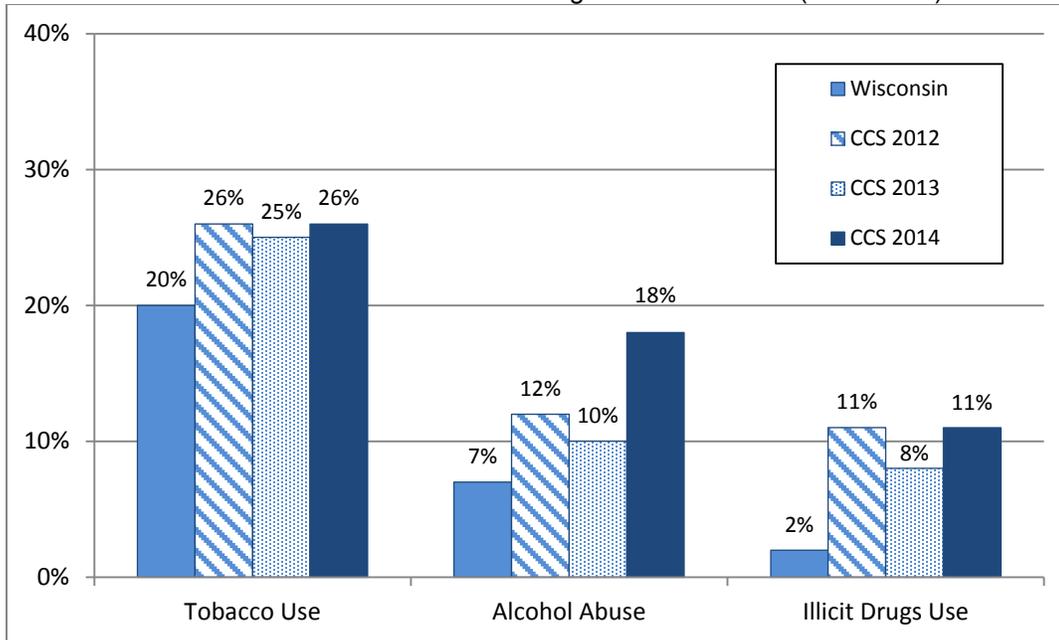
⁷ Regier DA, Farmer ME, Rae DS, et al. (1990). "Co-morbidity of mental disorders with alcohol and other drug abuse: results from an epidemiological catchment area (ECA) study." *JAMA*, 264: 2511-2518.

more likely to be dependent on or abuse alcohol, and much more likely to use illicit drugs than other individuals in Wisconsin.

Comparing CCS consumers over time, all reported rates of substance use were lower in 2013 than 2012, but 2014 rates were equal to or higher than 2013: tobacco use has remained fairly steady from one year to the next (at 26% in 2014); use of other drugs returned to 2012 levels (11%); and rates of alcohol abuse rose sharply (to 18%).

Given the focus CCS programs have on providing psychosocial and substance abuse services, the differences in levels of substance use between CCS consumers and the general state population were not unexpected.

Chart 5: Substance Use in Wisconsin and among CCS Consumers (2012-2014)



Sources: 2012-2014 Comprehensive Community Services (CCS) Program Surveys; Tobacco Use: CDC, Behavioral Risk Factor Surveillance System (WI 2012, age 18+ years); Alcohol Abuse: SAMHSA, National Survey on Drug Use and Health (WI 2011-2012, ages 12+ years); Illicit Drug Use: SAMHSA, National Survey on Drug Use and Health (WI 2011-2012, ages 12+ years).

Medical Conditions

Another set of questions asked CCS programs to report the rates of a variety of health issues among their consumers. The question is based on research showing that individuals with mental health and substance use disorders are generally more likely to have a variety of physical health issues, putting consumers at risk for health complications and early death.^{8,9}

However, while previous research indicates mental health consumers often have a higher incidence of physical health ailments than the general population, results from the CCS Program Survey (over the past several years) show a lower incidence of a variety of physical ailments among CCS consumers than the population as a whole.¹⁰

⁸ Ziege, Anne and Tim Connor. (2009). "Linking Mental and Physical Health: Results from the Wisconsin Behavioral Risk Factor Survey." Wisconsin DHS, Division of Public Health, Bureau of Health Information and Policy.

⁹ Schulte, MT and Y-I Hser. (2014). "Substance use and associated health conditions throughout the lifespan." *Public Health Reviews*, 35(2): epub: www.publichealthreviews.eu.

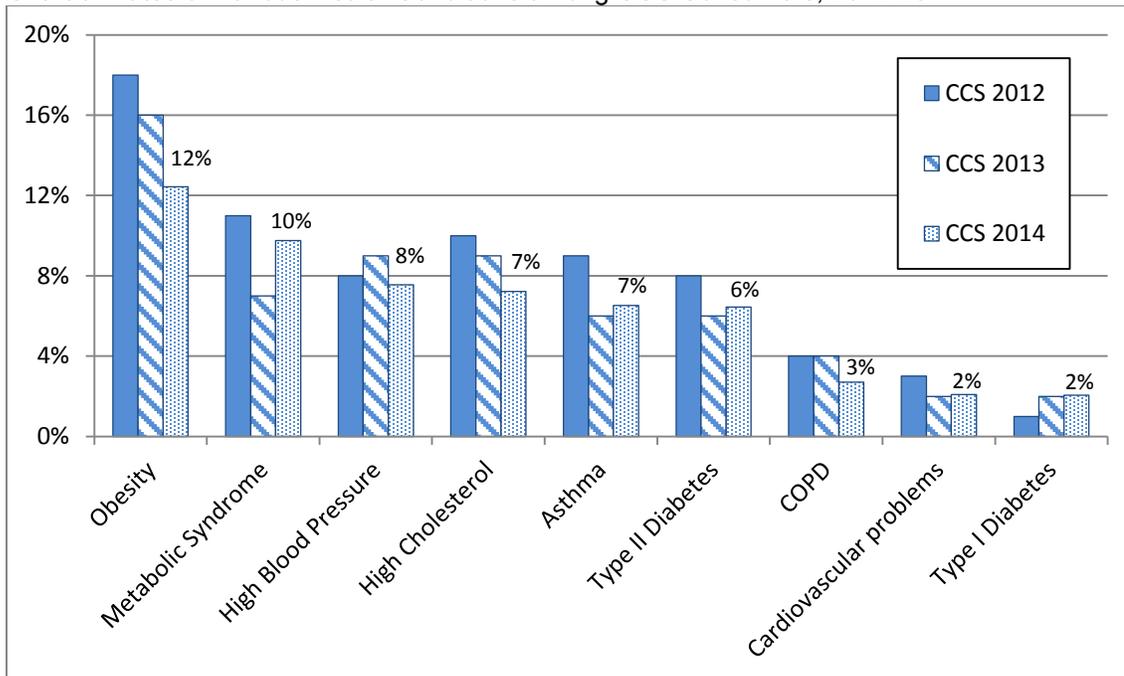
¹⁰ National health estimates were drawn from a variety of sources. See Appendix I.

Two possible reasons for this unexpected result include:

- Incomplete collection of data on consumers' physical health needs. Most CCS programs do not systematically ask consumers for detailed information about their physical health, so the rates of these ailments for CCS consumers are likely under-reported.
- CCS consumers include both more youth (ages 17 and younger) and fewer elderly (age 65 and older) than typical research study populations (which focus mostly on older adult populations with more health issues) so CCS consumers may appear healthier than the population as a whole simply because of their smaller share of older adults.

Unfortunately, the CCS Program Survey collects aggregate data (not individual consumer records), so it is not possible to make a direct comparison between CCS and U.S. rates (by controlling for age to adjust for the different age distributions of these two groups).

Chart 6: Rates of Various Health Conditions among CCS Consumers, 2012-2014



Source: 2012-2014 Comprehensive Community Services (CCS) Program Surveys.

PROGRAM CHARACTERISTICS

With regard to program characteristics and services provided, the Program Survey asks programs to report on program staffing, program utilization (numbers of consumers served during the year, the number of newly enrolled and discharged consumers), consumer discharge status (reasons consumers left CCS and their destinations), as well as the availability and use of evidence-based practices (EBPs). Taken together, these data help paint a picture of how CCS programs function and what services they provide. Through self-report, programs demonstrate the ways that they engage their consumers on the path to recovery as well as potential challenges they may face. A copy of the 2014 CCS Program Survey appears in Appendix II.

In 2014, there were 36 active CCS programs, all of whom completed and returned the survey.

Program Staffing

CCS programs may differ in their staff composition. Programs can be staffed either entirely by county employees or by a mix of county employees and contractors. In 2014, three-quarters of the programs (27 out of 36, 75%) fall into the latter category, being staffed by a mix of county workers and contractors.

Evidence-Based Practices

A main goal of the CCS Program Survey is to determine the extent to which CCS programs incorporate the use of EBPs into the services they provide. Using EBPs is a way for CCS programs to enhance consumers' recovery process. However, CCS programs are not required to use EBPs. Rather, programs are provided with the information and encouraged to incorporate EBPs to the best of their ability.

Much of the CCS Program Survey is devoted to questions around the use of EBPs. Programs are asked not only which EBPs they offered and which EBPs their consumers received (to track trends and identify potential disparities in EBP usage), but also a series of questions around EBP training and monitoring EBP fidelity. In responding to all of the EBP questions, programs are asked to adhere to the strict definitions of the EBP as laid out in a guiding document. Thus, many CCS programs report that they follow many of the guiding principles or practices of a given EBP, but don't strictly qualify as providing that EBP. For that reason, it can be assumed that more programs utilize some variation of an EBP other than what is presented here.

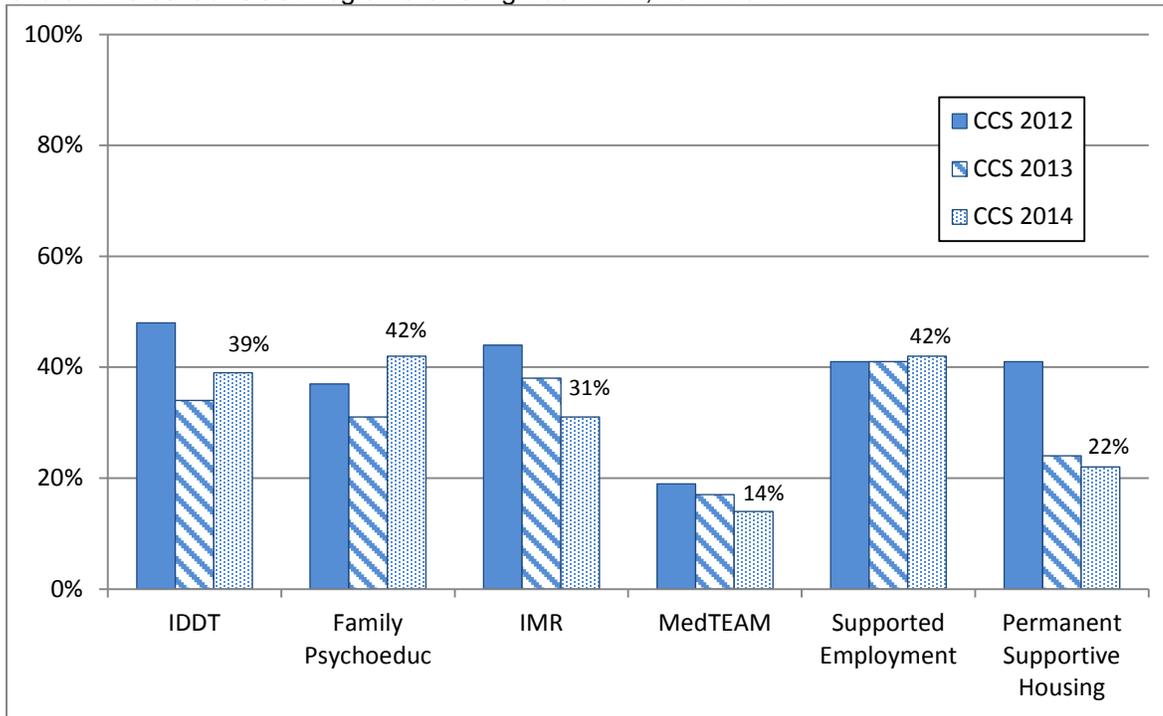
The specific EBPs asked about on the survey include the following:

- Integrated Dual Disorder Treatment (IDDT) or Integrated Treatment for Co-Occurring Disorders.
- Family Psychoeducation.
- Illness Management and Recovery (IMR).
- MedTEAM.
- Supported Employment.
- Permanent Supportive Housing.

EBPs Offered

Fewer than half of all CCS programs reported offering any particular EBP. Of the six EBPs listed on the survey, Family Psychoeducation, Supported Employment, and Integrated Dual Disorder Treatment (IDDT) were the most commonly offered EBPs: Fifteen of the 36 programs (42%) said they offered Family Psychoeducation (an EBP that involves the development of a partnership among consumers, families, practitioners, and supporters); another 42 percent offered Supported Employment, which focuses on the importance of work with relation to recovery and assists the consumer in addressing symptoms that interfere with finding and securing employment; and 14 programs (39%) offered IDDT, which supports individuals with co-occurring mental illness and substance use disorder.

Chart 7: Percent of CCS Programs Offering Each EBP, 2012-2014



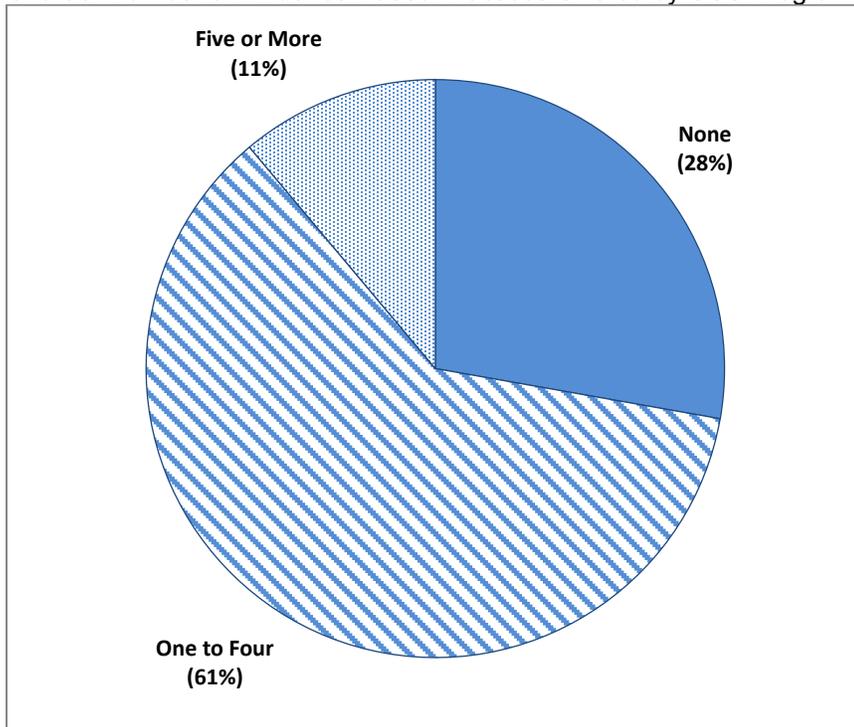
Source: 2012-2014 Comprehensive Community Services (CCS) Program Surveys.

Less than one third of CCSs (11 programs, 31%) offered IMR, which focuses on education of the consumer regarding the illness and symptoms and management of both in the journey of recovery. Even fewer programs (eight, or 22%) offered Permanent Supportive Housing, which helps individuals secure and maintain safe housing; or MedTEAM (five programs, 14%), also called Medication Management, which uses best practice coupled with patient input to make medication management decisions.

The percent of CCS programs offering IDDT and Family Psychoeducation rose substantially in 2014 (from the year before) while the percent that offered Supported Employment rose modestly. Meanwhile, the percent of CCS programs offering IMR, MedTEAM, and Permanent Supportive Housing each dropped for the second year in a row.

Chart 8 shows that almost three-quarters (72%) of programs offer at least one EBP; this is up from 2013 when 66 percent offered one or more EBPs. However, only 11 percent of programs offered five or more EBPs in 2014 (compared to 17% in 2013), so a greater percentage of programs (61%) are now offering one to four EBPs (up from 49% last year). Fewer programs (28%) offer no EBPs at all, down from 34 percent in 2013.

Chart 8: Number of Evidence-Based Practices Offered by CCS Programs, 2014

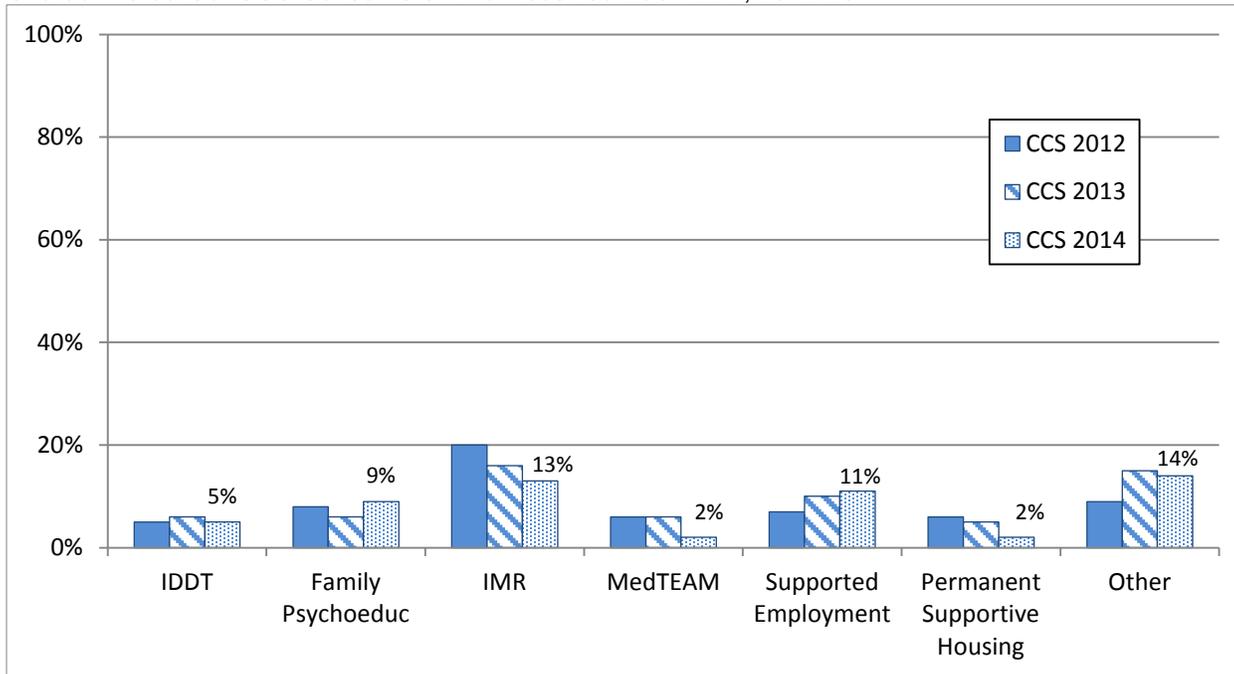


Source: 2014 Comprehensive Community Services (CCS) Program Surveys.

EBPs Delivered

While most CCS programs are familiar with and offered at least one EBP, those CCS programs that did offer EBPs actually delivered these services to only a small fraction of their consumers. As seen in Chart 9 (below), the most widely available practice was Illness Management and Recovery (IMR), which was provided to only 13% of consumers. With the exception of the “Other” category (described in further detail below), all other EBPs specified on the survey were offered to only between 5%-10% of consumers. These proportions are very similar to those seen in 2012 and 2013.

Chart 9: Percent of CCS Consumers Who Received Each EBP, 2012-2014



Source: 2012-2014 Comprehensive Community Services (CCS) Program Surveys.

Among the CCS programs that reported using “other” EBPs (not listed on the survey, but found on the SAMHSA website), five provided Motivational Interviewing (MI) and four delivered Cognitive Behavioral Therapy (CBT), including “Coping Cat” (in essence a CBT-based intervention designed for children). Dialectical Behavioral Therapy (DBT) and Person-Centered Planning were each provided by three programs, and two programs used WRAP. Several other EBPs were each provided by one program: Coping/Problem Solving Skills Training, Relapse Prevention Therapy, Applied Behavioral Analysis, Eye Movement Desensitization and Reprocessing, Family Behavioral Therapy, Dialectical Behavior and Mindfulness Training, and Therapeutic Mentoring.

Table 5: Other Evidence-Based Practices (EBPs) Used by CCS Programs, 2014

Other Evidence-Based Practices	Number of Programs
Motivational Interviewing (MI)	5
Cognitive Behavioral Therapy (CBT)	4
Dialectical Behavioral Therapy (DBT)	3
Person-Centered Planning	3
WRAP	2

Source: 2014 Comprehensive Community Services (CCS) Program Surveys.

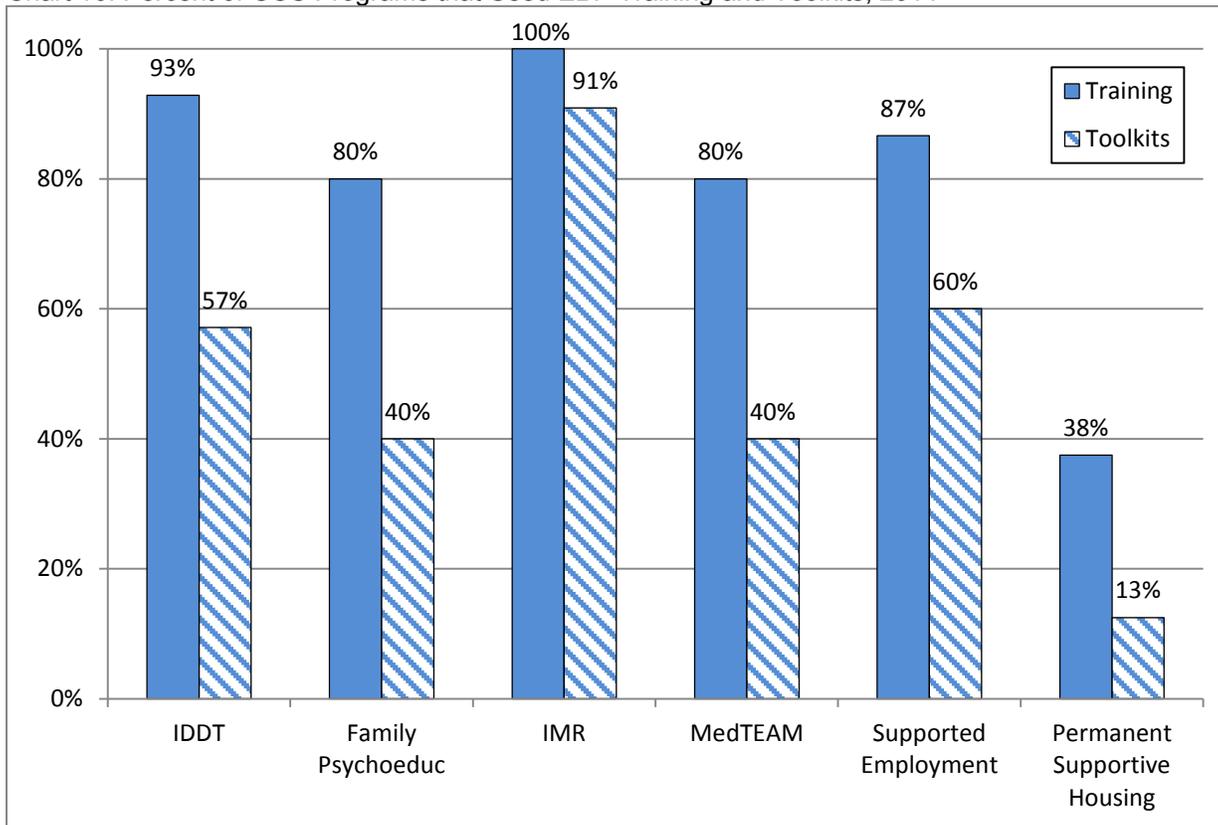
EBP Training and Toolkits

The program survey included a series of questions asking whether CCS staff had been specifically trained to implement each EBP (of those they utilized in 2014), and whether they used EBP toolkits to guide their implementation. Chart 10 displays the responses to the questions about training and toolkit usage.

For five out of the six EBPs listed, most of the programs that used that EBP (between 80% and 100%) reported that their staff had been trained in that method; however, only 38 percent of the programs that offered Permanent Supportive Housing said they had trained their staff to implement that EBP.

Almost all (91%) of the programs that offered Illness Management and Recovery (IMR) reported using a toolkit to aid implementation, but only about half (40% to 60%) used toolkits for IDDT, Family Psychoeducation, MedTEAM and Supported Employment. Very few (13%) used a toolkit to implement Permanent Supportive Housing.

Chart 10: Percent of CCS Programs that Used EBP Training and Toolkits, 2014



Source: 2014 Comprehensive Community Services (CCS) Program Surveys.

Monitoring EBP Fidelity

Table 6 shows the percent of CCS programs that monitored the fidelity with which they implemented each EBP (measured the degree to which the EBP was being implemented as intended) and whether they used an outside monitor to review fidelity.

Supported Employment was more likely to be monitored for fidelity than any other EBP; more than half (53%) of the programs using this EBP evaluated how well they were implementing this practice. IDDT was monitored by about one third (36%) of the programs, while fidelity of the other EBPs were monitored in about one quarter of the programs (20% to 27%).

With the exception of Supported Employment (almost half of the programs that offered this EBP used an outside monitor to gauge implementation), few if any of the programs that used an EBP employed an outside monitor to measure fidelity.

Table 6: Fidelity Monitoring Practices among CCS Programs Offering Each EBP, 2014

Evidence-Based Practice (EBP)	Number of Programs Using EBP	Percent of Programs Using EBP that Monitor Fidelity	Percent of Programs Using EBP that Use Outside Monitor
IDDT	14	36%	7%
Family Psychoeducation	15	27%	13%
IMR	11	27%	9%
MedTEAM	5	20%	0%
Supported Employment	15	53%	47%
Permanent Supportive Housing	8	25%	0%

Source: 2014 Comprehensive Community Services (CCS) Program Surveys.

Waiting Lists

Only seven (19%) of the 36 CCS programs who responded to the 2014 Program Survey said they had a waitlist for CCS services during 2014. Of those seven programs, only two had individuals on their waitlists at the end of 2013 (one with 18, the other with three). Collectively, the seven programs added an additional 140 individuals to their waitlists during the year and still had 123 individuals waiting for services at the end of 2014 (an average of almost 18 per CCS). Programs reported that the average length of time individuals spent on the waitlist ranged from 1 to 10 months.

Programs offered various interim services to those on the CCS wait list. All seven programs provided outpatient mental health services, psychiatric services, and assistance with locating community resources to those on their waitlist. Another six programs also offered outpatient substance abuse services and crisis intervention services to individuals while they waited. Five programs provided case management and another four provided medication management. One CCS had a drop-in center available. These results suggest programs were more likely to link waitlist consumers up with clinical services than informal (or peer-based) resources, such as clubhouses and drop-in centers. While the linkages to clinical services are indeed crucial, programs may also want to consider strengthening their ties with less formal resources (including peer-run respites, where they are available).

Suicide Risk Assessment

For only the second time on the program survey, programs were asked to report whether or not they had a policy or standard practice for assessing suicide risk among their consumers and, if so, what tools they used. Thirty-one of the 36 CCS programs (86%) said they did assess their consumers for suicide risk, a sizable increase over the 68 percent who reported conducting suicide assessments in 2013.

Many of the 31 programs who assessed suicide risk (seven, or 23%) indicated they evaluated consumer risk during a clinic session or home visit (simply using clinical judgment as part of their regular clinical practice). Another seven programs (23%) reported conducting a crisis assessment (either administering the Northwest Connection evaluation or their own mobile crisis assessment tool) and working with crisis intervention services or mobile crisis teams to assess and manage suicide risks. Five programs (16%) reported using the Columbia Suicide Severity Rating Scale (C-SSRS), and three (10%) specified SAMHSA's SAFE-T tool; one program reported using the ASIST training, and another said they used a "Suicide Assessment Checklist." Three programs (10%) said they conduct suicide screens at admission and at least every six months (to determine if a consumer has suicidal thoughts); then, if the screen is positive, use the suicide risk assessment tool found in their electronic health records (EHRs). Finally, four programs (13%) said they have a system in place for managing suicide risk, but do not use any particular tool.

CONSUMER DISCHARGE REASONS AND OUTCOMES

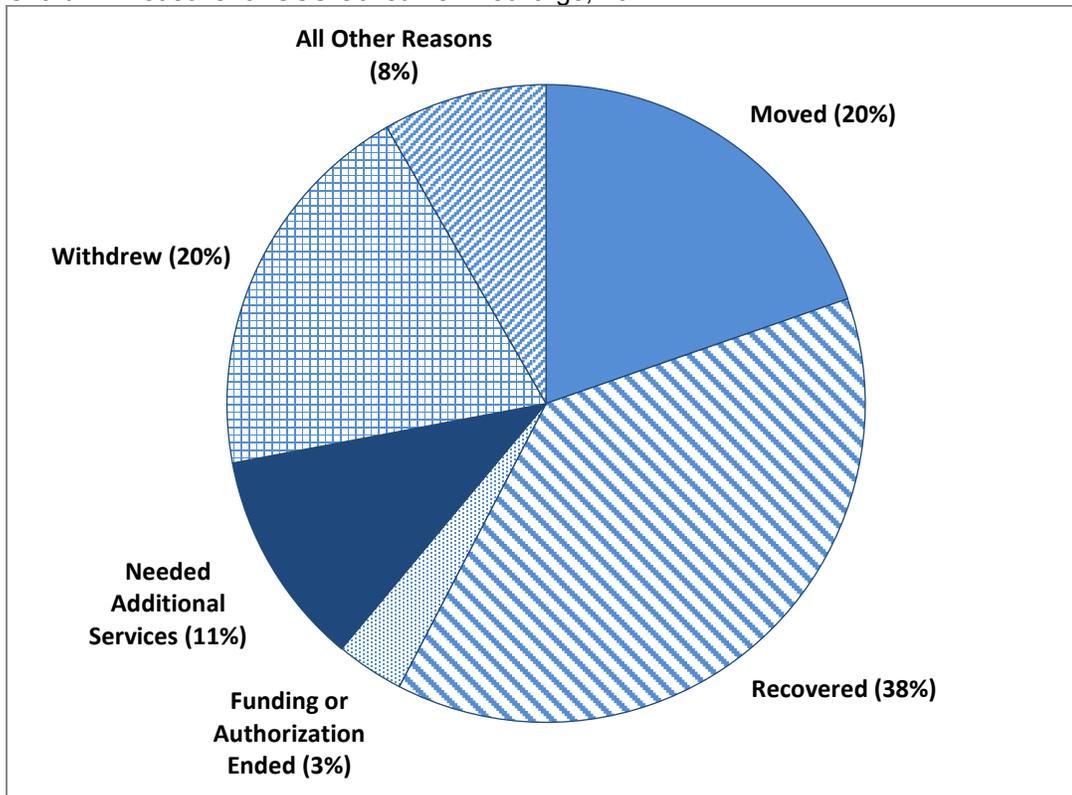
This section of the report provides information answering questions such as, “What were the reasons consumers were discharged from CCS services?” and “What are the quality of life outcomes of CCS services?” Information about discharge reason can be useful for planners, policy makers, evaluators, service administrators, and clinicians because if consumers aren’t receiving appropriate services or remaining in CCS long enough to benefit, then their chances of attaining recovery and improved quality of life are greatly reduced. This information can assist these stakeholders in identifying areas for service improvement. Similarly, information about consumer outcomes is critical to the overall evaluation of CCS by determining whether the program is meeting consumer needs and program goals.

Consumer Discharge Reasons

In 2014, 501 out of 2,438 consumers served (21%) were discharged from CCS. In general, CCS services are considered to be fairly long-term, medium-intensity services. However, a substantial proportion of consumers receiving CCS services (about one in five) are discharged from CCS services each year for a variety of reasons.

Chart 11 reflects 2014 CCS Program Survey responses that, of the 493 consumers for whom a discharge reason was reported, 187 (38%) indicate they left because they had recovered to the extent that CCS-level services were no longer needed. Ninety-seven consumers (20%) moved out of the CCS area, and another 20 percent withdrew from the program. Fifty-four consumers (11%) were reported to need additional services beyond what CCS could offer, and 17 consumers (3%) lost their funding or authorization. Another 41 consumers (8%) were discharged for some other reason: six left because they went to jail or prison, 11 were reported to have died, 20 gave some other reason (including “noncompliance” with the program), and four consumers were discharged for an “unknown” reason.

Chart 11: Reasons for CCS Consumer Discharge, 2014



Source: 2014 Comprehensive Community Services (CCS) Program Survey.

Discharge Reasons by County

Table 7 displays the percent of consumers in each county who were discharged from CCS in 2014 for each listed reason (for those counties that reported CCS services in the PPS data system for the year).

Table 7: Discharge Reasons for CCS Consumer Discharge, by County, 2014

County	Completed Services w/ Improvement	Completed Service No Change	Transferred to Another Service	No Probable Cause to Commit	Referred	Administrative or Noncompliance	Funding or Authorization Expired	Withdrawn	Incarcerated	Transferred to Institution	Client Passed Away
Adams	22.2%	0.0%	0.0%	0.0%	11.1%	55.6%	0.0%	11.1%	0.0%	0.0%	0.0%
Brown	0.0%	1.5%	22.1%	30.9%	0.0%	11.8%	25.0%	2.9%	2.9%	0.0%	2.9%
Calumet	26.0%	0.0%	32.9%	1.4%	8.2%	13.7%	0.0%	16.4%	1.4%	0.0%	0.0%
Columbia	14.8%	3.7%	18.5%	0.0%	44.4%	0.0%	7.4%	3.7%	0.0%	7.4%	0.0%
Dodge	13.3%	0.0%	60.0%	0.0%	13.3%	6.7%	0.0%	6.7%	0.0%	0.0%	0.0%
Fond du Lac	25.6%	2.3%	14.0%	0.0%	46.5%	2.3%	0.0%	7.0%	0.0%	0.0%	2.3%
HSC	16.0%	0.0%	40.0%	0.0%	8.0%	12.0%	0.0%	20.0%	0.0%	4.0%	0.0%
Green	0.0%	0.0%	14.3%	0.0%	42.9%	42.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Green Lake	11.5%	3.8%	7.7%	0.0%	69.2%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%
Jackson	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Jefferson	0.0%	0.0%	66.7%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Juneau	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Kenosha	90.9%	0.0%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Kewaunee	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	33.3%	0.0%	33.3%	0.0%	0.0%
La Crosse	6.4%	45.7%	28.3%	0.0%	2.9%	1.2%	12.7%	0.6%	0.0%	0.6%	1.7%
NCHC	29.6%	3.8%	18.2%	11.3%	6.3%	2.5%	0.0%	25.8%	0.0%	0.6%	1.9%
Manitowoc	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Marinette	12.1%	2.2%	57.1%	1.1%	6.6%	8.8%	1.1%	9.9%	0.0%	0.0%	1.1%
Marquette	20.0%	0.0%	20.0%	0.0%	0.0%	20.0%	0.0%	30.0%	0.0%	10.0%	0.0%
Outagamie	44.8%	1.7%	19.0%	0.0%	5.2%	24.1%	0.0%	1.7%	0.0%	1.7%	1.7%
Portage	0.0%	0.0%	0.0%	0.0%	0.0%	91.3%	0.0%	4.3%	4.3%	0.0%	0.0%
Richland	31.0%	3.4%	17.2%	0.0%	6.9%	24.1%	3.4%	6.9%	0.0%	6.9%	0.0%
Sauk	15.6%	1.1%	21.1%	0.0%	32.2%	12.2%	5.6%	11.1%	1.1%	0.0%	0.0%
Shawano	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Sheboygan	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Walworth	23.5%	0.0%	0.0%	0.0%	64.7%	5.9%	0.0%	5.9%	0.0%	0.0%	0.0%
Washington	15.6%	0.0%	68.8%	0.0%	0.0%	6.3%	0.0%	6.3%	3.1%	0.0%	0.0%
Waukesha	14.7%	0.6%	9.8%	0.0%	72.4%	0.0%	0.0%	0.6%	0.0%	0.6%	1.2%
Waushara	13.4%	1.0%	24.7%	5.2%	28.9%	7.2%	0.0%	17.5%	0.0%	2.1%	0.0%
Winnebago	10.6%	0.0%	17.7%	0.0%	2.7%	64.6%	0.9%	0.9%	1.8%	0.0%	0.9%
Wood	25.8%	7.6%	24.2%	0.0%	13.6%	12.1%	1.5%	15.2%	0.0%	0.0%	0.0%
State	17.3%	7.1%	24.2%	3.2%	20.1%	13.4%	3.5%	8.8%	0.6%	0.8%	1.0%

Source: Human Services Reporting System (HSRS) and Program Participation System (PPS) Mental Health Modules.

HSC = Health Services Center (includes Forest, Oneida, and Vilas counties)

NCHC = North Central Health Care (includes Langlade, Lincoln, and Marathon counties)

Discharge Reason Type

In order to provide local service managers with information that could be used to increase service quality, it is also helpful to further evaluate the reasons for discharge from CCS. This part of the discharge analysis considers data as reported in the HSRS and PPS data systems between 2012 and 2014.

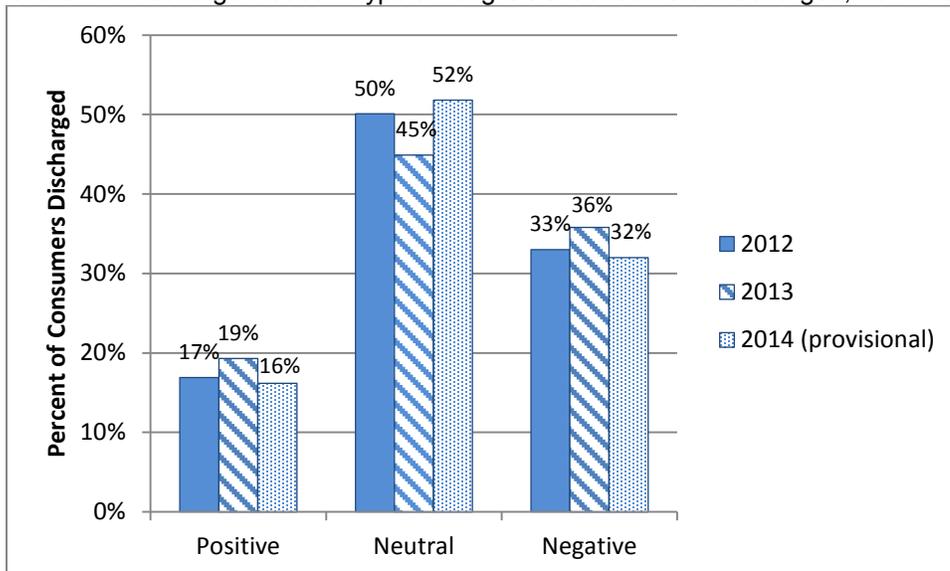
In this analysis, consumers are grouped by whether they experienced:

- A “positive” discharge (completed services with improvement).
- A “neutral” discharge (referred, transferred, no probable cause).
- A somewhat “negative” discharge (withdrew, behavioral reasons, no change, incarcerated, discharged to a nursing home, or funding expired).

Chart 12 below tracks trends in discharge reason type between 2012 and 2014; there does not appear to be any discernable trend up or down across the three-year period among these discharge reason types. The percentages of all consumers discharged who left for positive or negative reasons increased in 2013 then dropped back in 2014 to levels seen in 2012. The percent of those discharged for neutral reasons first declined in 2013 then rose in 2014.

The group of consumers discharged for neutral reasons (about half of all discharges from CCS) was substantially larger than either the positive or negative discharges. Because the category of neutral discharges covers a variety of reasons that might include more positive or negative reasons consumers left CCS (such as referral, transfer, and no probable cause), the size of this group of consumers might be overstated. Further data would need to be collected and analyzed to determine whether or not these consumers benefited from CCS services.

Chart 12: Discharge Reason Type among CCS Consumers Discharged, 2012-2014



Source: Human Services Reporting System (HSRS) and Program Participation System (PPS) Mental Health Modules.

Discharge Reason Type by Consumer Characteristic

The follow analyses look at differences in discharge reason by various consumer characteristics: gender, race, ethnicity, age, presenting problem, primary diagnosis, commitment status, or service intensity level during the three-year period. The distribution of each characteristic (among consumers in the discharge sample) is noted in parentheses next to the corresponding category in the tables below. Where applied, a “proportions difference” test is run to assess whether there is a statistically significant difference (at the $p < .05$ level) in the proportions discharged for positive, neutral, or negative reasons, meaning the observed difference could not have occurred by chance.

Gender

A slightly, but not statistically significant, higher proportion of females than males had negative discharges from CCS.

Table 8: Discharge Reason Type, by Gender, 2012-2014

<i>Discharge Reason Type</i>			
Gender	Positive	Neutral	Negative
Female (46%)	16.7%	45.9%	37.4%
Male (54%)	19.1%	47.2%	33.8%

Race/Ethnicity

A significantly higher proportion of Hispanic/Latino persons discharged from CCS (61%) had a negative discharge reason. Persons of color have lower rates of positive discharges than Whites.

Table 9: Discharge Reason Type, by Race/Ethnicity, 2012-2014

<i>Discharge Reason Type</i>			
Race/Ethnicity	Positive	Neutral	Negative
Asian (0.4%)	0.0%	100.0%	0.0%
African American (5.0%)	12.8%	53.2%	34.0%
Native American (2.2%)	4.8%	57.1%	38.1%
Hispanic/Latino (2.4%)	4.3%	34.8%	60.9%
White/Caucasian (90.0%)	18.7%	45.6%	35.7%

Age Group

Persons between the ages of 30 and 45 years had the highest rate of positive discharges (23%), while children under age 12 and persons age 60 and older had the lowest rate of positive discharges (16% each). Persons between the ages of 18 and 29 years and persons age 60 and over had the highest rates of negative discharges (37% and 36%, respectively).

Table 10: Discharge Reason Type, by Age Group, 2012-2014

<i>Discharge Reason Type</i>			
Age Group	Positive	Neutral	Negative
<12 (9%)	15.8%	54.4%	29.7%
12 – 17 (28%)	19.1%	50.3%	30.6%
18 – 29 (20%)	17.4%	45.9%	36.6%
30 – 45 (18%)	23.3%	52.7%	24.0%
46 – 59 (17%)	17.0%	55.6%	27.4%
>59 (8%)	15.5%	48.3%	36.2%

Presenting Problem

At the time of admission to an episode of CCS services, intake staff document the consumer's presenting problem—the consumer's perspective on the reason or circumstances that prompted them to seek services.

Three presenting problems with the highest levels of positive discharge (reported by 22% to 25% of consumers) were some of the most common problems at admission: coping with daily roles (representing 34% of consumers at intake); social/interpersonal issues (12%); and disturbed thoughts (9%). While consumers with alcohol and drug use problems at admission also had high levels of positive discharge (23.5%), only 3 percent of consumers presented with this problem at intake. Persons seeking services due to victimization and emergency detention had the lowest rate of positive discharges (and together only represent 3% of CCS consumers). The presenting problems with the highest level of negative discharge reasons were victimization and marital/family (50% and 41%, respectively).

Table 11: Discharge Reason Type, by Presenting Problem, 2012-2014

Presenting Problem	Discharge Reason Type		
	Positive	Neutral	Negative
Marital/family (11%)	17.8%	41.1%	41.1%
Social/interpersonal (12%)	24.7%	45.5%	29.9%
Coping with daily roles (34%)	22.2%	51.9%	25.9%
Medical (2%)	18.2%	45.5%	36.4%
Depressed or anxious (20%)	19.8%	48.4%	31.7%
Suicide attempt (6%)	16.2%	54.1%	29.7%
Alcohol/drug use (3%)	23.5%	41.1%	35.3%
Disturbed thoughts (9%)	25.4%	49.2%	25.4%
Victimization (2%)	0.0%	50.0%	50.0%
Emergency detention (1%)	11.1%	55.6%	33.3%

Primary Diagnosis

CCS service workers and managers can use information about how a consumer's diagnosis affects the outcome of care. The most prevalent primary diagnoses among consumers in the discharge sample (percentages noted next to the diagnosis category) are listed in Table 12 (below); together, depression and schizophrenia make up 60 percent of the primary diagnoses among discharged consumers.

The data confirm that persons with alcohol or drug use problems, relative to consumers with other diagnoses, have a higher rate of positive CCS discharges (32%) and a lower rate of negative discharges (26%), although they represent only 2 percent of all diagnoses. Persons having adjustment or ADHD disorders have relatively low rates of positive discharges (15% and 13%) and the highest reported rates of neutral discharges (56% and 63%, respectively), possibly because these issues are primarily childhood disorders. Persons with personality disorders (1% of the consumers served) have the lowest rate of positive discharges (9%) and highest rate of negative discharges (63%) among all consumers discharged.

Table 12: Discharge Reason Type, by Primary Diagnosis, 2012-2014

<i>Primary Diagnosis</i>	<i>Discharge Reason Type</i>		
	Positive	Neutral	Negative
Alcohol/drug use (2%)	31.8%	42.1%	26.3%
Schizophrenia (21%)	19.1%	47.8%	33.1%
Depression (39%)	19.6%	41.6%	38.9%
Anxiety (9%)	25.0%	39.1%	35.9%
Personality (1%)	9.1%	27.3%	63.6%
Adjustment (13%)	15.3%	56.1%	28.6%
ADHD (11%)	12.8%	62.8%	24.4%
Defiant (4%)	21.9%	40.6%	37.5%

Commitment Status

By Wis. Admin. Code ch. DHS 36, all consumers who are served in CCS have to participate voluntarily in the program (including CCS consumers who are under a civil commitment). The vast majority of discharged CCS recipients (82%) were not under a civil commitment at intake; only 18 percent received services under various forms of civil commitment (including a settlement agreement before or after court proceedings, an involuntary civil or involuntary criminal commitment, or guardianship). Among consumers discharged from CCS, most of those with a civil commitment at intake (14% of the total 18%) were involuntary civil commitments (under Wis. Stat. § 51.20). Table 13 shows mixed results as it pertains to commitment status being related to positive or negative discharges. However, persons receiving service episodes while being under a civil commitment have a significantly higher rate of neutral discharge reasons (60%) than persons receiving services without a civil commitment (44%).

Table 13: Discharge Reason Type, by Commitment Status, 2012-2014

<i>Commitment Status</i>	<i>Discharge Reason Type</i>		
	Positive	Neutral	Negative
Not Civil Commitment (82%)	18.9%	43.7%	37.4%
Civil Commitment (18%)	13.8%	60.2%	25.9%

Service Intensity Need

PPS collects data on the consumer's service intensity level needs at intake, although this level of need may change during episodes of care. Among the discharge sample, 22 percent needed short-term situational services when they first came into CCS, 35 percent needed low intensity ongoing services, and 43 percent needed high intensity ongoing services. Table 14 displays the percent of consumers with each type of discharge reason among those with different service intensity levels of need at admission. Findings confirm that persons needing higher intensity services had lower rates of positive CCS discharges and higher rates of neutral CCS discharges than consumers with either of the other two levels of need at intake. Consumers with short-term situational needs had the highest rates (40%) of negative CCS discharge; however, since CCS is not primarily designed for clients with short-term situational needs, this result suggests the possibility of inappropriate placement in the program. Overall, these findings suggest CCS was not as helpful as it might have been, resulting in more neutral or negative discharges.

Table 14: Discharge Reason Type, by Service Intensity Need at Intake, 2012-2014

<i>Service Intensity</i>	<i>Discharge Reason Type</i>		
	Positive	Neutral	Negative
Short-term situational (22%)	18.4%	41.7%	39.8%
Low intensity ongoing (35%)	22.2%	41.9%	35.9%
High intensity ongoing (43%)	14.3%	52.8%	32.8%

Current research evidence and Wisconsin evaluation support a policy of funding psychosocial rehabilitation services such as CCS because of its acceptance among consumers and its ability to reduce hospitalizations and improve recovery outcomes.¹¹ This analysis of CCS discharge reason and consumer profile data supports this policy as well, but also points to the need for some improvements. The purpose of quality improvement is not necessarily to resolve a service issue completely, but rather to begin to put in place one or more small beneficial changes that begin to reduce a problem or improve a situation. The analysis indicates that among the one-third of consumers who are discharged from CCS services each year, there is no increasing trend in the rate of positive discharges and no decreasing trend in the rate of neutral or negative discharges. The analysis also shows that females; Hispanic/Latino persons; persons over age 60; persons seeking services due to victimization; persons having adjustment, ADHD, or personality disorders; persons receiving services by coercion; and persons needing higher intensity services could benefit from more individualized or modified care plans and interventions or other consumer-centered service improvements to increase positive discharges and reduce neutral and negative discharges for these person groups.

Consumer Outcomes

Prior to enrollment in CCS, a Functional Screen (FS) is completed by a trained professional screener for counties and providers via interview with the consumer, with information verified where appropriate through other documentation and collateral sources. Functional Screens are used to assess an individual's mental health and substance abuse needs (including significant life stressors), to determine if an individual has an appropriate level of need and is eligible for the CCS program, and if so, to establish a crisis prevention and management plan. For consumers enrolled in CCS for at least one year, an updated FS is completed annually to assess the consumer's progress during program enrollment. An FS is also completed at CCS discharge.

This section analyzes FS data (separately for adults and children) to evaluate whether consumer status changed on a range of measures between the consumer's initial enrollment in CCS and their most recent FS update. Consumers included in this analysis were enrolled in CCS for at least one year at some point between 2005 and 2014 and completed at least two FSs (so their progress could be analyzed across time). Notes on the data used for this analysis appear in Appendix III.

Adult Outcomes

The functional screen for adults (Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services, web-based form [F-00258](#)) determines functional need for CCS (along with other programs) among individuals 18 years of age and older. Of the 2,142 adult consumers who received CCS services between 2005 and 2014 and for whom an "initial" FS was completed, 1,657 (77%) also had an "update" FS, providing adequate data to be included in this analysis.

Adult consumer progress was assessed across various status measures:

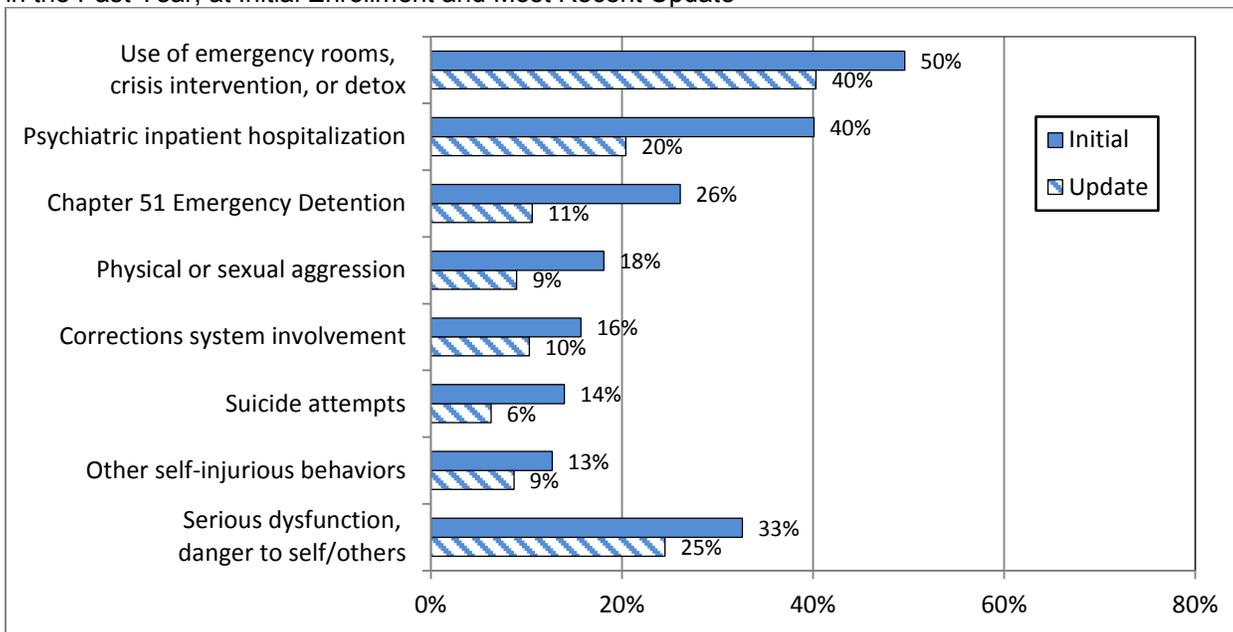
- Crisis/Situational and Risk Factors – use of crisis and psychiatric services, Emergency Detentions (EDs), physical aggression, corrections system involvement, substance use, suicide attempts, and other injurious behaviors;
- Community Living Skills – assistance needed to manage physical and mental health, taking or monitoring medications;
- Vocational Information – current work status; and
- Living Situation – current residence.

¹¹ Barton, R. (1999). "Psychosocial rehabilitation services in community support systems: a review of outcomes and policy recommendations." *Psychiatric Services*, 50(4): 525-534.

Crisis/Situational and Risk Factors: Stabilizing Acute Needs

A significant percentage of adult consumers (who were both considered eligible for and enrolled in CCS) had high-risk needs reflected in their initial FS and still experienced acute care episodes at the FS update. For example, the initial FS indicated 50 percent of adults had used an emergency room, crisis intervention, or detox unit within the past year; a smaller but still significant fraction of CCS consumers (40%) had used these services in the past year. Another 40 percent had a psychiatric inpatient stay (voluntary or involuntary) in the year prior to CCS enrollment, but this percentage dropped in half (fell to 20%) after enrollment. While about one quarter (26%) of adult consumers had experienced an ED in the year prior to enrollment, less than half as many (11%) had an ED once they were enrolled. A third of consumers (33%) had a “serious sudden onset of dysfunction” or were a danger to oneself or others in the year before being enrolled in CCS; somewhat fewer (25%) reported the same at update. The incidence of other crisis/situational and risk factors (including physical or sexual aggression, corrections system involvement, suicide attempts, and other self-injurious behaviors) were all less common (experienced by under 20% of adults prior to CCS enrollment), but also declined markedly after being enrolled in CCS.

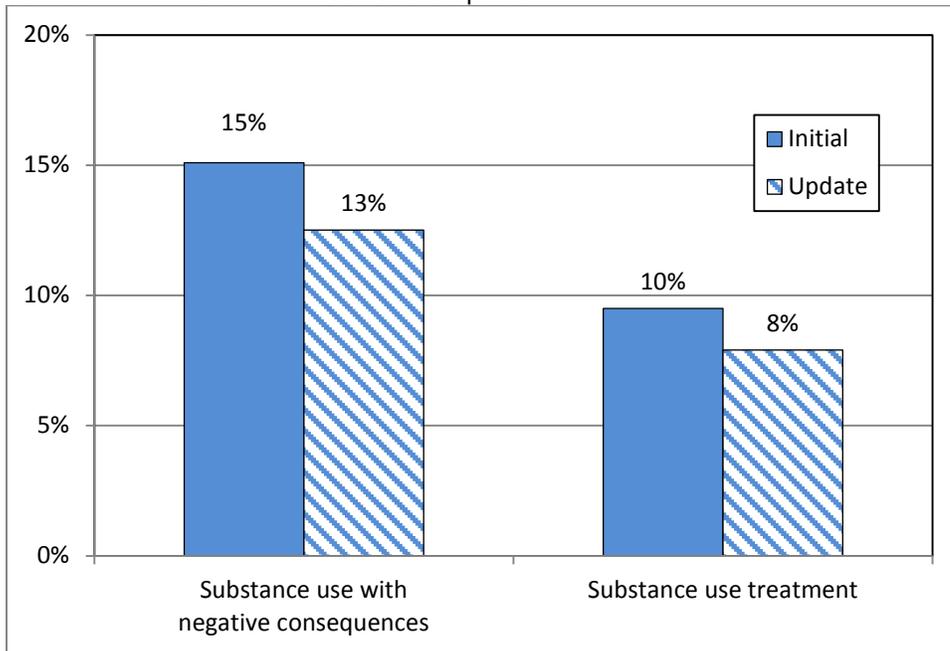
Chart 13: Percent of Adult Consumers with Crisis and Risk Behaviors in the Past Year, at Initial Enrollment and Most Recent Update



Source: Mental Health Functional Screen.

After one year of CCS enrollment, the percentage of adult consumers who either had experienced substance use problems (negative legal, financial, family, relational, or health consequences) or had received substance use treatment in the past year both declined.

Chart 14: Percent of Adult Consumers with Substance Use Problems and Substance Use Treatment in the Past Year, at Initial Enrollment and Most Recent Update



Source: Mental Health Functional Screen.

Community Living Skills: Self-Management of Health Conditions

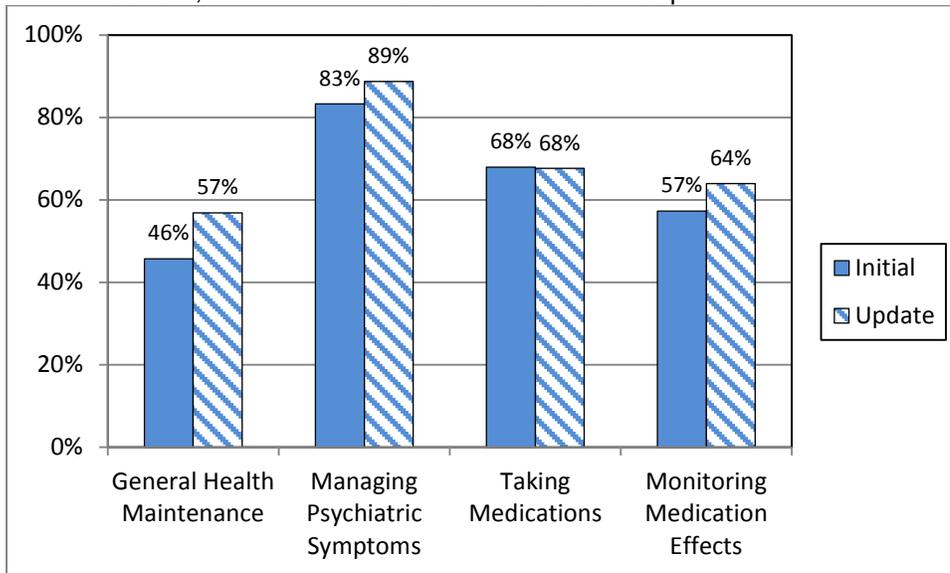
CCS recognizes the interaction of mental health disorders with physical and substance abuse disorders and how all areas of health may need to be addressed in some cases in order for the consumer to experience significant progress. As a result, the CCS assessment process is designed to cover physical, mental, and substance abuse care needs. Any trauma history is also assessed to determine its potential impact on the consumer's health care needs.

Chart 15 illustrates consumers' ability to manage different aspects of their own health (based on the percent who reported needing assistance on at least a monthly basis with the following tasks):

- General health maintenance – ability to care for one's own physical health and recognize symptoms, including tasks such as scheduling and keeping medical appointments.
- Managing psychiatric symptoms – ability to manage one's mental health symptoms.
- Taking medications – ability to schedule medication administrations and take mental health medications.
- Monitoring medication side effects – ability to monitor possible medication side effects, report them to a doctor, and follow dose changes as prescribed.

Perhaps contrary to expectations, the percent of CCS consumers in need of assistance actually increased in three out of four areas of health management between initial enrollment in CCS and their most recent update screen. For example, prior to CCS, 46 percent of adults were reported to have needed help caring for their physical health and managing medical appointments, while this number increased to 57 percent after being enrolled; those reported as needing help monitoring their medications also increased (from 57% to 64%) during this time. Likewise, more adult consumers needed help managing their psychiatric symptoms once they were enrolled in CCS.

Chart 15: Percent of Adult Consumers in need of Assistance in Managing Health Issues in the Past Year, at Initial Enrollment and Most Recent Update



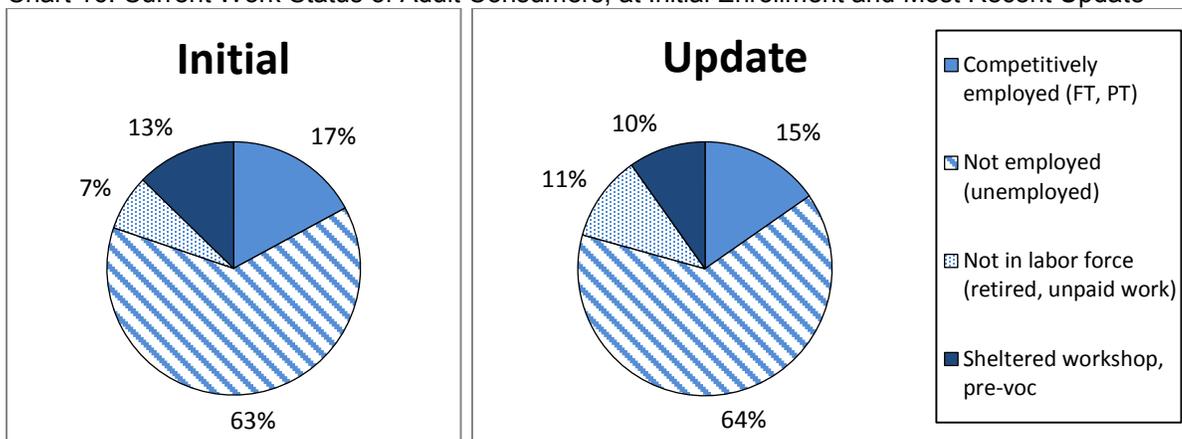
Source: Mental Health Functional Screen.

Vocational Information: Employment

CCS activities are intended to assure successful community living and help consumers reach their best possible functional level, allowing them to live with maximum independence in community-integrated settings. Employment-Related Services help individuals overcome the symptoms, manage the behaviors associated with their mental illness or substance use disorder, and restore functioning such that they may obtain and maintain competitive employment. This in turn promotes recovery through a community-integrated socially valued role and increased financial independence.

PPS data show the percent of CCS consumers who were unemployed, the largest group, stayed the same (63-64%) after enrollment, while the percent who were competitively employed (either full- or part-time) declined slightly (from 17% to 15%). Fewer consumers were in “sheltered” (non-competitive) employment, from 13 to 10 percent, perhaps reflecting CCS’s encouraging consumers to be in competitive employment rather than pre-vocational workshops. The percent of adults not in the labor force (either retired or with unpaid work) increased from 7 to 11 percent.

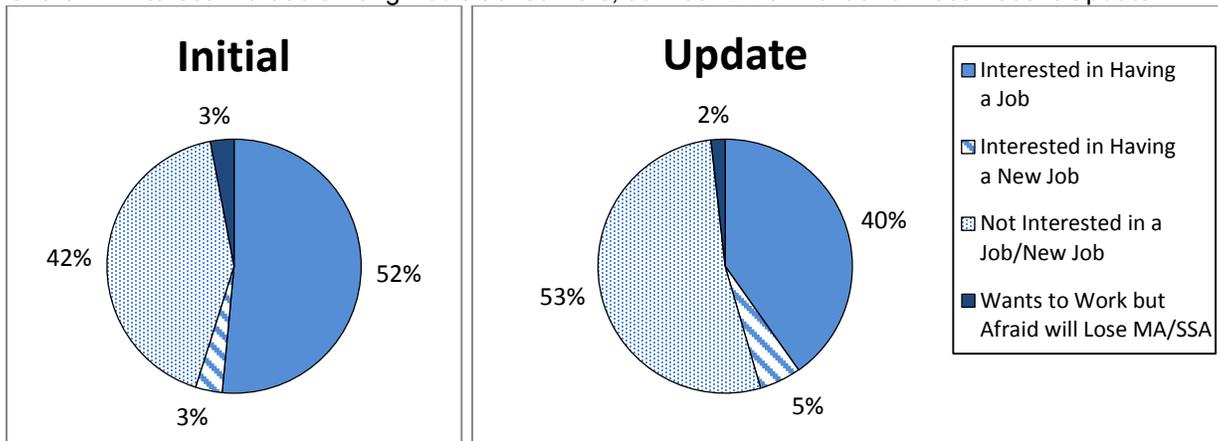
Chart 16: Current Work Status of Adult Consumers, at Initial Enrollment and Most Recent Update



Source: Mental Health Functional Screen.

Likewise, the percent of adult consumers who were reportedly interested in having a job declined (from 52% to 40%) while the percent who were not interested in getting either a job or a new job increased by about the same amount (from 42% to 53%).

Chart 17: Interest in a Job among Adult Consumers, at Initial Enrollment and Most Recent Update



Source: Mental Health Functional Screen.

Living Situation: Adult Living Stability

Through psychosocial rehabilitation, CCS providers work with consumers to address their basic needs such as employment and a stable living situation. Not only can mental health and/or substance use issues interfere with one’s job and living situation, but unemployment and uncertainty about one’s living situation can lead to stress about meeting one’s basic needs and can be a barrier to effective treatment.

The living situation of many adults appeared to improve during CCS enrollment. For example, there was a substantial increase between initial and update screens in the percent of consumers who lived in their own home or apartment (up from 63% to 72%), while fewer consumers lived in someone else’s home (falling from 12% to 8%). Fewer adults lived in community-based residential facilities (CBRF’s) and transitional housing, while more lived in residential care apartment complexes. Also fewer were homeless, lived in shelters, or various other living situations.

Table 15: Current Living Situation among Adult Consumers, at Initial Enrollment and Most Recent Update

Living Situation	Initial	Update
Home Setting		
Own Home or Apartment	63%	72%
Someone Else's Home or Apartment	12%	8%
Residential Assisted Living		
Adult Family Home	3%	4%
Group Home – Community-Based Residential Facility	13%	9%
Residential Care Apartment Complex	1%	4%
Transitional Housing	3%	1%
Institutional Facility		
Mental Health Institute, Nursing Home, IMD, ICF-MR	1%	1%
Other Living Situation		
Homeless, Shelter, Other	4%	1%

Source: Mental Health Functional Screen.

Child Outcomes

The functional screen for children (Functional Eligibility Screen for Children’s Long-Term Support Programs, web-based form [F-00367](#)) determines functional need for CCS services among youth from birth to age 21. Of the 914 child consumers who received CCS services between 2005 and 2014 and who completed an “initial” functional screen, 581 (64%) of them also completed an “update” functional screen, providing adequate FS data to be included in this analysis.

Child consumer progress was assessed across various status measures:

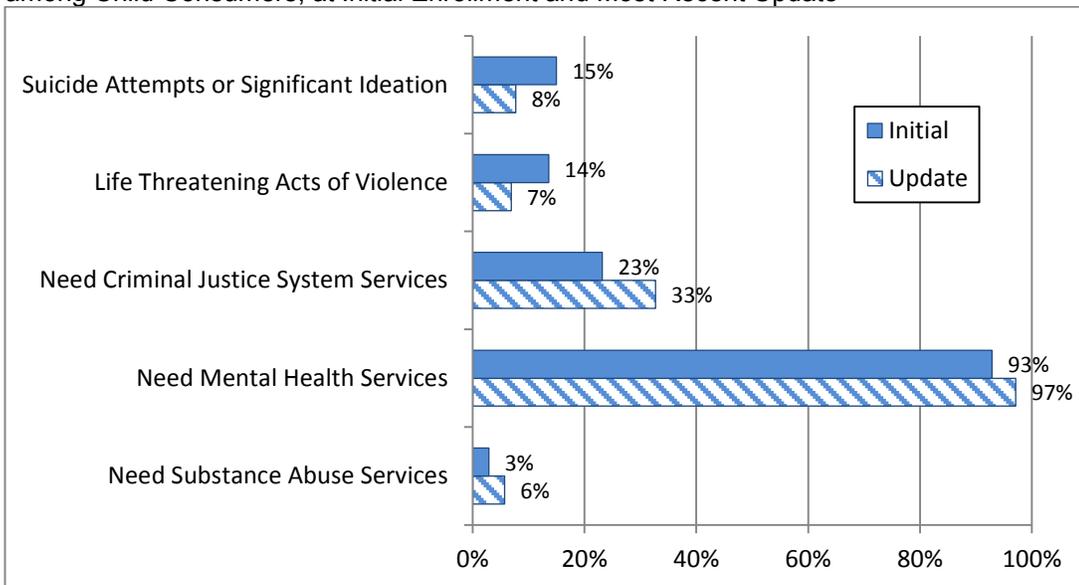
- Mental Health and Substance Abuse – symptoms and service needs.
- Behaviors – high-risk, self-injurious, aggressive or offensive behaviors, and lack of behavioral control.
- School/Work Information – employment status, academic and behavioral needs.
- Living Situation – current residence.

Mental Health, Substance Abuse, and Behaviors: Stabilizing Acute Needs

Mental health services were needed by the great majority of youth in CCS (93% at baseline, and 97% after being enrolled in CCS). Substance abuse services were reported as needed by 3 percent at their initial screen, and 6 percent at their most recent update. These increases may be due to more comprehensive assessment information becoming available as providers continue to work with youth consumers after the Initial Screen.

Similar to adult CCS consumers (shown above), the percent of children who reported suicide attempts or serious acts of violence decreased markedly after being enrolled in CCS. The percentage who reported needing criminal justice system services actually increased somewhat over this time.

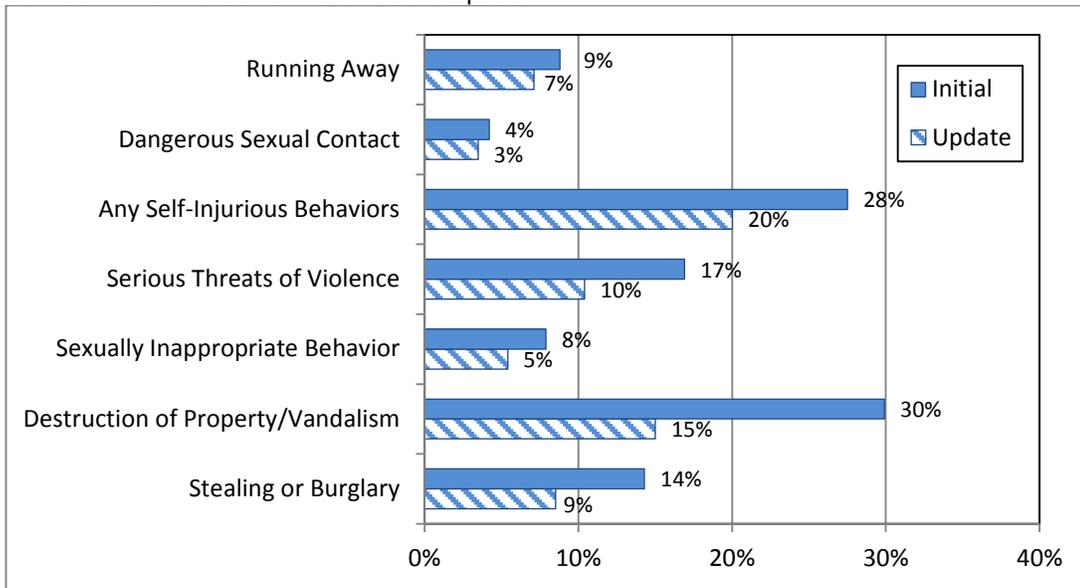
Chart 18: Mental Health and Substance Abuse Symptoms and Service Needs among Child Consumers, at Initial Enrollment and Most Recent Update



Source: Child Mental Health Functional Screen.

Various behavioral risk factors were assessed for youth consumers (shown in the chart below). The percentage of children who reported exhibiting a behavior declined between initial and update screens for each of the risk factors shown. There were substantial reductions in the percent of youth who reported destruction of property (30% to 15%), self-injurious behaviors including head banging, and cutting, burning or biting oneself (from 28% to 20%), serious threats of violence (17% to 10%), and stealing or burglary (14% to 9%).

Chart 19: High-Risk, Self-Injurious, Aggressive Behaviors, and Lack of Behavioral Control among Child Consumers, at Initial Enrollment and Most Recent Update



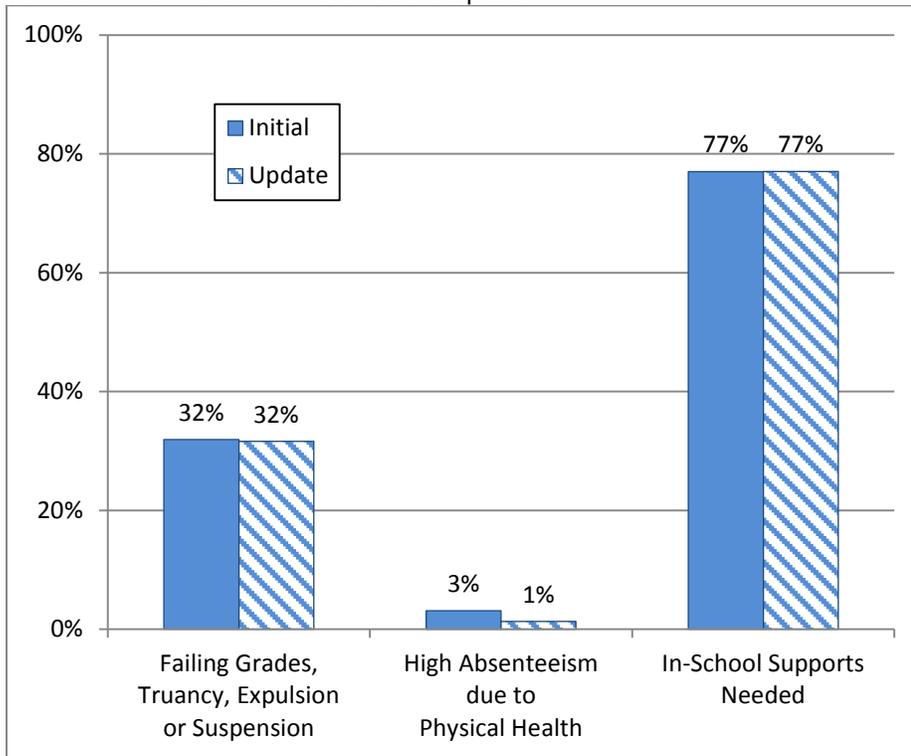
Source: Child Mental Health Functional Screen.

School and Work Information: Youth Educational Status and Employment

Of the CCS youth in this analysis, 2 percent were employed at their initial screen and 11 percent were employed at their most recent update. All but a handful of those youth were employed part-time. The CCS focus on increasing vocational skills and assisting with job search efforts appears to be more evident among youth consumers than adults.

There was little change in academic status or behavioral needs between initial and update assessments. At both baseline and follow-up, 32 percent of youth consumers in CCS had behavior or emotional needs that caused failing grades, repeated truancy or expulsion, suspension, or an inability to conform to a school or work schedule over half the time. In-school supports for emotional or behavioral problems were needed for 77 percent of youth both before and after CCS enrollment. However, there was a slight decline in the percent of youth (from 3% to 1%) who reported their physical health caused them to miss over half their classes or to require home education.

Chart 20: Academic and Behavioral Needs among Child Consumers, at Initial Enrollment and Most Recent Update



Source: Child Mental Health Functional Screen.

Living Situation: Youth Living Stability

By far, more child consumers lived in a home setting than in any other living situation. Between baseline and follow-up, the percent of children in CCS who reported living with their parents declined from 72 to 67 percent; however, there was a slight increase in the percent living with a legal guardian (from 5% to 6%). At baseline, 10 percent lived in a residential foster care setting, declining to 8 percent at update; fewer children lived in group foster homes (2%) or treatment foster homes (3%), increasing to 4 and 6 percent, respectively, at their most recent status. Only 2 to 3 percent of youth in CCS were living in an institutional facility (mental health institute or child caring institution) at either baseline or follow-up.

Table 16: Current Living Situation among Child Consumers, at Initial Enrollment and Most Recent Update

Living Situation	Initial	Update
<i>Home Setting</i>		
Parents	72%	67%
Legal Guardian	5%	6%
Other Unpaid Family	2%	2%
<i>Residential Assisted Living</i>		
Community-Based Residential Facility (CBRF)	1%	1%
Group Foster Home, Paid Adult Family Home	2%	4%
Foster Care	10%	8%
Treatment Foster Home	3%	6%
<i>Institutional Facility</i>		
Mental Health Institute	2%	1%
Child Caring Institution	1%	1%
<i>Other Living Situation</i>		
No Permanent Residence, Home Leased by Other, Non-Relatives, Alone	0%	2%
Other	1%	3%

Source: Child Mental Health Functional Screen.

CONSUMER SATISFACTION

The CCS Administrative Rule prescribes that programs have some way of gauging consumer satisfaction. Specifically, Wis. Admin. Code § DHS 36.08 states: “The CCS shall develop and implement a quality improvement plan to assess consumer satisfaction and progress toward desired outcomes identified through the assessment process.”

In past years, the annual CCS Program Survey has asked programs whether they used a survey or other tool to measure consumer satisfaction during the previous calendar year. In 2013, 89 percent of programs reported using a consumer satisfaction survey, an increase from 2012 when 85 percent reported using a survey to collect data on consumer satisfaction. However, CCS programs had the discretion to utilize any tool of their choice and were not required to report the outcomes of their survey to the state.

As part of the state’s efforts to measure the satisfaction of consumers of public mental health and substance abuse services across the state, DMHSAS’s Bureau of Prevention Treatment and Recovery (BPTR) identified three satisfaction surveys that met with the approval of the CCS Advisory Committee, then developed data entry and reporting tools (based on these surveys) to help agencies become independent in their use of the collected data.

Starting in the fall of 2014, all CCS programs (counties and tribes) were required to administer one of three satisfaction surveys to consumers who have had at least six months of CCS service history during the previous calendar year. These surveys ask CCS consumers to provide feedback on their level of satisfaction with the mental health and/or substance abuse services they received through CCS during the past six months. With the implementation of universal and standardized survey instruments, future CCS reports will be able to provide valuable information on how well CCS programs are serving their consumers.

Each consumer receives one of three surveys, depending on their age:

- The Recovery Oriented System Indicators (ROSI) Adult Satisfaction Survey is completed by adult consumers (ages 18 years and older) about their own experience with CCS services and interactions with staff. The ROSI Survey assesses the extent to which consumers experience the CCS program as recovery-oriented.

The ROSI Adult Satisfaction Survey evolved from collaborative efforts among a number of State Mental Health Authorities (SMHAs) and national organizations through a project called *Mental Health Recovery: What Helps and What Hinders?* Through an extensive process that included the use of consumer focus groups followed by pilot testing the survey, the instrument was developed as one means to assess the performance of state and local mental health systems and providers. Five Wisconsin counties began using the ROSI Adult Survey with grants from BPTR to implement recovery principles within evidence-based practices for mental health consumers.

- The Mental Health Statistical Improvement Project (MHSIP) Youth Satisfaction Survey, filled out by adolescent consumers (ages 13-17 years), asks about their own experience with services and interactions with staff.
- The MHSIP Family Satisfaction Survey, filled out by the parent or guardian (caregiver) on behalf of child consumers (ages 12 years and younger), asks about their child’s and family’s experience with services and interactions with agency staff. The MHSIP Family Survey is of particular interest for CCS programs because of their focus on including family in the recovery team.

Both MHSIP surveys used here are variations of the standardized MHSIP survey used by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for state-by-state comparisons. Both the MHSIP Youth Satisfaction Survey and the MHSIP Family Satisfaction Survey are aimed at

younger consumers with serious mental health conditions (Serious Emotional Disorder) or substance abuse concerns.

CCS programs collect satisfaction data using one (or some combination) of three methods of survey administration: in-person interview, phone interview, and self-administered survey. After collecting Adult, Youth and Family Satisfaction Surveys from as many consumers as possible and entering all survey responses into Data Entry and Reporting Workbooks (developed and provided by DHS, one for each of the three surveys), programs returned completed Adult, Youth and Family workbooks to DHS for analysis. CCS programs also are encouraged to use these workbooks themselves by evaluating automatically generated scales and summary statistics (calculated across all survey items and respondents based on data entered into the workbooks) to gauge and improve satisfaction among their own consumers. Copies of the 2014 ROSI Adult Satisfaction Survey, 2014 MHSIP Youth Satisfaction Survey, and 2014 MHSIP Family Satisfaction Survey are provided in Appendices IV, V, and VI, respectively.

Survey Responses

In the fall of 2014, all 28 CCS programs (in counties and regions that were both certified, and had enrolled consumers for at least six months during 2014) administered satisfaction surveys to their consumers. These programs returned a total of 421 ROSI Adult surveys, 85 MHSIP Youth surveys, and 64 MHSIP Family surveys to DHS (Table 17).

Table 17: Number of CCS Consumer Satisfaction Surveys Returned, 2014

County/Region	Family	Youth	Adult
Adams	3	2	7
Brown	0	0	24
Calumet	0	4	10
Columbia	3	2	1
Dodge	1	0	4
Green	0	0	18
Green Lake	0	1	2
Health Services Center	2	3	3
Jefferson	1	5	9
Juneau	0	0	1
Kenosha	5	3	31
Kewaunee	0	1	9
La Crosse/Jackson/Monroe	0	0	23
Manitowoc	3	4	6
Marinette	3	6	7
North Central Health Care	5	5	62
Outagamie	2	2	27
Portage	5	4	5
Richland	2	2	13
Sauk	8	13	10
Shawano	1	0	0
Sheboygan	3	4	36
Walworth	5	4	7
Washington	0	3	33
Waukesha	0	0	33
Waushara	5	6	3
Winnebago	4	9	23
Wood	3	2	14
TOTAL	64	85	421

Source: CCS Consumer Satisfaction Surveys, 2014

Health Services Center includes Forest, Oneida, and Vilas counties

North Central Health Care includes Langlade, Lincoln, and Marathon counties

In the following three sections, Tables 18, 19, and 20 summarize adult, youth, and family satisfaction with CCS services during 2014. These three tables present several summary statistics:

- Results presented in the row labeled “Average Score for All Consumers” provide a summary measure of satisfaction (calculated for all respondents combined).
 - For each of the three surveys, “Overall Mean” represents the average level of satisfaction (recovery-oriented experience) reported across all survey questions for all consumers who responded to the survey.
 - “Scale” scores (for the six ROSI Adult Scales, six MHSIP Youth Scales, and six MHSIP Family Scales) are calculated across all respondents from a combination of different measures in each of the three surveys (described in their respective sections, below).
- The following three rows show the satisfaction distribution among respondents (the percent who are more, moderately, and less satisfied with their CCS services). For these three rows, “Overall Mean” reflects the percent of all consumers who had a more positive, mixed, and less positive experience; the percentages for each of the six Scales reflect how many consumers reported high, medium, or low scores.

- For the ROSI Adult survey, the “Percent with Mostly Recovery-Oriented Experience” indicates what percent of consumers were *more* satisfied with the CCS services they received (both overall and for each scale); the “Percent with Mixed Experience” were *moderately* satisfied; and the “Percent with Less Recovery-Oriented Experience” indicates what percent were *less* satisfied with their CCS services.
- For the MHSIP Youth and Family surveys, the “Percent with More Positive Experience” shows what percent of consumers were *more* satisfied with the CCS services they received (both overall and for each scale); the “Percent with Mixed Experience” were *moderately* satisfied; and the “Percent with Less Positive Experience” were *less* satisfied with their CCS services.

Adult Satisfaction

This section (including Table 18) describes the level of satisfaction with CCS services reported by adult consumers who responded to the ROSI Adult Survey during the fall of 2014.

The ROSI Adult Survey asks 44 questions about their satisfaction with the mental health and/or substance abuse services they received in the past six months. Summarizing this large number of items to assess consumer satisfaction can be difficult. Using factor analysis, a statistical technique that identifies groups of related items based on their high correlation (or association) with each other, researchers reduced the number of measures needed to understand consumer responses by combining items together into six scales. Appendix VII provides a brief description of the general concept of each scale and illustrates the groups of items used to create each scale in the ROSI Adult Survey.

Overall Adult Mean

On average, adult respondents to the ROSI survey ranked their satisfaction with CCS services over the past six months as 3.3 out of 4.0, indicating that most adult consumers agreed or strongly agreed that the services they received were recovery-oriented. This conclusion is supported by the finding that over three-quarters (76%) of adult consumers had a “mostly” recovery-oriented experience (i.e., were more satisfied) with the CCS services they received.

Table 18: Average Scale Scores and Percent of Adult Consumers Reporting a Mostly, Mixed, and Less Recovery-Oriented Experience in CCS, 2014

	Overall Adult ROSI Mean	Scale 1 - Person Centered	Scale 2 - Barriers Exist	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Negative Staff Approach	Scale 6 - Basic Needs
Average Score for All Consumers	3.3	3.5	3.1	3.5	3.1	3.5	3.1
Percent with Mostly Recovery-Oriented Experience	75.7%	83.5%	49.1%	89.7%	63.3%	77.6%	72.4%
Percent with Mixed Experience	23.5%	14.3%	44.0%	9.4%	29.8%	17.3%	20.9%
Percent with Less Recovery-Oriented Experience	0.7%	2.2%	6.8%	1.0%	6.9%	5.2%	6.7%

Source: CCS Consumer Satisfaction Surveys, 2014

Note: Scales 1, 3, 4 and 6 are positively worded, with scores ranging from 1.0 (Strongly Disagree) to 4.0 (Strongly Agree). Questions used to calculate Scales 2 and 5 were negatively worded but these two scales have been recoded, so for this analysis, higher values (closer to 4.0) reflect a more positive, recovery-oriented experience in CCS.

Adult Scales

Responses to the questions that make up Scales 1 and 3 (with average scores of 3.5 out of 4.0) indicate adult consumers felt even more strongly that the CCS services they received were person-centered and empowering. Over 8 out of 10 adults felt the CCS clinical staff had a person-centered focus (staff saw them as an equal partner in their treatment, stood up for them to get the services and resources they needed, or treated them with respect regarding their cultural background). Nearly 9 out of 10 adults felt empowered by staff and others (at least one other person believed in them, or the staff respected them as a whole person).

Scores for Scale 5 indicate adults also felt the CCS staff approach provided a recovery-oriented experience. The high average score (3.5) shows most consumers disagreed with the sentiment that staff used a paternalistic and/or coercive approach when working with consumers. Over 77 percent disagreed (and only 5% agreed) that staff used pressure, threats or force in their treatment, interfered with their personal relationships, or treated them as a psychiatric label rather than a person.

A large majority (72%) of consumers also felt they currently had the financial ability to meet their basic needs (had enough income to live on, had housing they could afford) as reflected in Scale 6, although over one in five (20%) had mixed responses to these questions, and nearly 7 percent did not agree. Scale 4 indicated that less than two-thirds of consumers (63%) believed they had a chance to advance their education, that mental health services helped them get or keep employment, or that consumer peer advocates were available or worked as paid employees in the agency where they received services.

By far, Scale 2 had the lowest proportion of consumers reporting a positive experience in CCS, indicating many consumers felt barriers to recovery existed. Only about half of adult consumers (49%) agreed (and nearly as many had mixed experiences, 44%) that they had enough good service options to choose from, got the services they needed when they needed them, or staff understood their experience as a person with mental health problems.

Overall, adult consumers reported being quite satisfied with the CCS services they received. The majority reported their experiences with CCS services were person-centered and empowering, and the staff approach was recovery-oriented. However, while many felt their basic needs were being met, fewer felt educational or employment opportunities were available to them and barriers to recovery were a common experience among many adult consumers.

Youth Satisfaction

This section (including Table 19) describes the level of satisfaction with CCS services reported by youth (adolescent consumers aged 13 to 17 years) who responded to the MHSIP Youth Survey during the fall of 2014.

The MHSIP Youth Survey contains 26 questions about their satisfaction with the mental health and/or substance abuse services they received in the past six months. Summarizing this large number of items to assess consumer satisfaction can be difficult. Using factor analysis, a statistical technique that identifies groups of related items based on their high correlation (or association) with each other, researchers reduced the number of measures needed to understand consumer responses by combining items together into six scales. Appendix VII provides a brief description of the general concept of each scale and illustrates the groups of items used to create each scale in the MHSIP Youth Survey.

Table 19: Average Scale Scores and Percent of Youth Consumers Reporting a More, Mixed, and Less Positive Experience in CCS, 2014

	Overall Youth MHSIP Mean	Scale 1 - Satisfaction	Scale 2 - Participation	Scale 3 - Access	Scale 4 - Culture	Scale 5 - Outcomes	Scale 6 - Social Connectedness
Average Score for All Consumers	4.2	4.3	4.2	4.3	4.6	3.9	4.2
Percent with More Positive Experience	92.9%	86.9%	89.4%	90.2%	96.0%	75.6%	90.5%
Percent with Mixed Experience	7.1%	13.1%	7.1%	4.9%	4.0%	22.0%	7.1%
Percent with Less Positive Experience	0.0%	0.0%	3.5%	4.9%	0.0%	2.4%	2.4%

Source: CCS Consumer Satisfaction Surveys, 2014

Note: All Youth Scale scores range from 1.0 (Strongly Disagree) to 5.0 (Strongly Agree) with a higher value (closer to 5.0) reflecting a more positive experience in CCS.

Overall Youth Mean

In general, adolescent consumers were very satisfied with the CCS services they had received during the past six months. On a scale of 1.0 to 5.0 (5.0 representing a more positive experience), youth reported an average score of 4.2. Almost all (93%) said they agreed or strongly agreed with statements that expressed satisfaction with CCS services (indicating that most of the time they had a more positive experience in CCS).

Youth Scales

Generally, adolescents were very satisfied with the CCS services they received in the past six months. Scale 1 shows 87 percent said they agreed or strongly agreed that the services they received were right for them, they got the help they wanted and as much help as they needed, they had someone to talk with when they were troubled, and the staff stuck with them no matter what. All but a few youth (96%) were especially satisfied with the cultural sensitivity of their CCS providers (Scale 4), agreeing or strongly agreeing that the staff treated them with respect, respected their family’s religious or spiritual beliefs, were sensitive to their cultural or ethnic background, and spoke with them in a way that they understood. Nearly as many youth (91%) reported a high score on Scale 6: they felt socially connected and had family and friends to help bolster and sustain recovery (people who will listen when they need to talk, people with whom they can do enjoyable things). Youth also agreed the access to services was good (Scale 3: location of services was convenient and services were available at convenient times) and that they were integrated into treatment services (Scale 2: they helped choose their services and treatment goals, and participated in their own treatment).

The youths’ assessment of their treatment outcomes (Scale 5) was somewhat less positive: only three-quarters of adolescent respondents (76%) felt their life had improved as a direct result of the mental health or substance abuse services they had received. Many had a mixed experience with regard to being better at handling daily life, getting along better with family or friends, doing better at school or work, or being better able to cope when things go wrong.

Overall, youth consumers reported being very satisfied with the CCS services they received. The great majority said their experiences with CCS services were culturally sensitive, that they had access to the services they needed, and had the support they needed to support their recovery. At the same time, many felt the services they received did not necessarily have as much impact on their lives as they might have wanted.

Family Satisfaction

This section (including Table 20) describes the level of satisfaction with CCS services reported by family (caregivers of child consumers aged 12 years and younger) who responded to the MHSIP Family Survey during the fall of 2014.

The MHSIP Family Survey contains 26 questions about a caregiver’s satisfaction with the mental health and/or substance abuse services their child consumer received in the past six months (the same questions as those in the Youth survey, but from the caregiver’s perspective.) Summarizing this large number of items to assess consumer satisfaction can be difficult. Using factor analysis, a statistical technique that identifies groups of related items based on their high correlation (or association) with each other, researchers reduced the number of measures needed to understand consumer responses by combining items together into six scales. Appendix VII provides a brief description of the general concept of each scale and illustrates the groups of items used to create each scale in the MHSIP Family Survey.

Table 20: Average Scale Scores and Percent of Family Consumers Reporting a More, Mixed, and Less Positive Experience in CCS, 2014

	Overall Family MHSIP Mean	Scale 1 - Satisfaction	Scale 2 - Participation	Scale 3 - Access	Scale 4 - Culture	Scale 5 - Outcomes	Scale 6 - Social Connectedness
Average Score for All Consumers	4.2	4.3	4.4	4.4	4.7	3.6	4.2
Percent with More Positive Experience	89.1%	87.5%	92.2%	95.3%	98.2%	57.8%	84.4%
Percent with Mixed Experience	9.4%	9.4%	4.7%	3.1%	0.0%	29.7%	10.9%
Percent with Less Positive Experience	1.6%	3.1%	3.1%	1.6%	1.8%	12.5%	4.7%

Source: CCS Consumer Satisfaction Surveys, 2014

Note: All Family Scale scores range from 1.0 (Strongly Disagree) to 5.0 (Strongly Agree) with a higher value (closer to 5.0) reflecting a more positive experience in CCS.

Overall Family Mean

In general, caregivers were very satisfied with the CCS services their child had received during the past six months. On a scale of 1.0 to 5.0 (5.0 representing a more positive experience), parents and guardians reported an average score of 4.2, and almost 9 out of 10 (89%) said they agreed or strongly agreed with statements that expressed satisfaction with their child’s CCS services (indicating that most of the time they had a more positive experience with CCS).

Family Scales

Generally, Scale 1 scores indicate that caregivers were very satisfied with the CCS services their child received in the past six months: 87.5 percent said they agreed or strongly agreed that the services their child and/or family received were right for them, they got the help they wanted and as much help as they needed, the child had someone to talk with when they were troubled, and the staff stuck with them no matter what. All but a few caregivers (98% on Scale 4) were especially satisfied with the cultural sensitivity of their child’s CCS providers (agreeing or strongly agreeing that the staff treated them with respect, respected their family’s religious or spiritual beliefs, were sensitive to their cultural or ethnic background, and spoke with them in a way that they understood). Most parents also agreed the access to services was good (Scale 3: location of services was convenient and services were available at convenient times) and that they participated with their child’s treatment (Scale 2: they were integrated into treatment services, helped choose their child’s services and treatment goals).

Not quite as many parents (84%, compared with 91% of youth) felt socially connected, had family and friends to help bolster and sustain their child's recovery (people who would listen when they need to talk, people with whom they felt comfortable talking about their child's problems, or had the support they needed from family or friends).

The families' assessment of their children's treatment outcomes was much less positive: only about half (58%) of caregivers felt their child's life had improved as a direct result of the mental health or substance abuse services they received. Many (30%) had a mixed experience and more than 1 in 10 (13%) had a less positive experience with their child's outcomes (with regard to their child being better at handling daily life, getting along better with family or friends, doing better at school or work, or being better able to cope when things go wrong).

Overall, family consumers reported being very satisfied with the CCS services their child received, but were less satisfied with the impact of these services on their children's lives. The great majority of parents said their children's experiences with CCS services were culturally sensitive and their child had access to the services they needed. However, somewhat fewer felt CCS provided the services they needed to support their child's recovery, and a substantial proportion (more than 4 in 10) did not believe CCS services had directly improved their child's life.

APPENDIX I – SOURCES FOR NATIONAL HEALTH ESTIMATES

National rates of various health issues (for the analysis of physical health conditions) were drawn from the following sources:

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

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

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

Diabetes, Type I: National Diabetes Education Program. “The Facts About Diabetes: A Leading Cause of Death in the U.S.” <http://ndep.nih.gov/diabetes-facts/>. Note that the prevalence rate was calculated based on the fact that diabetes overall affects 8 percent of the adult population, and Type I makes up 5 percent 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 II – 2014 CCS PROGRAM SURVEY

This worksheet is provided to assist you in completing the 2014 CCS 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 your CCS is certified as part of a region (multi-county behavioral health collaboration), please complete a separate survey for each county individually. Also, if you manage more than one CCS, 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 27th. If you have questions or difficulties with the survey, please contact Laura Blakeslee at Laura.Blakeslee@wisconsin.gov. Thank you!

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

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

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

_____ County employees only
_____ County employees and contractors

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

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

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

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

page 2

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

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

page 3

10. Number of active CCS 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 CCS consumers discharged in 2014 were in Family Care? *

page 4

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 CCS 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 CCS-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 CCS 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 CCS-level services were no longer needed?	
funding or authorization ended for the consumer?	
the consumer needed services beyond what CCS 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 CCS consumers who were discharged in 2014 for each 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 CCS	
Outpatient therapy / psychiatry	
Targeted Case Management (TCM) or other CM program	
Community Support Program (CSP)	
Nursing Home	
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 CCS-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	
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.

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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	
Community Support Program (CSP)	
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 CCS can offer, how many went to each of the following destinations? *

	# of Consumers
Nursing Home	
Community Support Program (CSP)	
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 CCS can offer), please describe where these consumers went.

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

	# of Consumers
Outpatient therapy / psychiatry	
Targeted Case Management (TCM) or other CM program	
Community Support Program (CSP)	
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.

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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:

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Demographic Information

Please provide information about the full group of CCS 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	

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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)	

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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? *		
<i>[Please answer "Yes" or "No" for each EBP.]</i>		
	YES	NO
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? *	
<i>[Please count a consumer multiple times if they received more than one EBP during 2014.]</i>	
	# of Consumers
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 SAMHSA 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
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
Integrated Treatment for Co-Occurring Disorders						
Family Psychoeducation						
Illness Management and Recovery (IMR)						
MedTEAM						
Supported Employment						
Permanent Supportive Housing						

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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
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
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. Integrated Treatment for Co-Occurring Disorders *

	Yes	No
Have CCS 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 Integrated Treatment for Co-Occurring Disorders, what fidelity measure did you use?

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41. Family Psychoeducation *

	Yes	No
Have CCS 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 Family Psychoeducation, what fidelity measure did you use?

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43. Illness Management and Recovery (IMR) *

	Yes	No
Have CCS 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 Illness Management and Recovery (IMR), what fidelity measure did you use?

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45. MedTEAM *

	Yes	No
Have CCS 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 MedTEAM, what fidelity measure did you use?

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47. Supported Employment *

	Yes	No
Have CCS 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 Supported Employment, what fidelity measure did you use?

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49. Permanent Supportive Housing *

	Yes	No
Have CCS 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 Permanent Supportive Housing, what fidelity measure did you use?

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51. 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

52. Did your CCS 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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53. 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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CCS Waiting List Information

54. Were there times during 2014 when there was a waiting list for CCS 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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55. How many individuals were on the CCS waiting list on 12/31/2013? *

56. How many *additional* individuals were placed on the CCS waiting list during 2014? *

57. How many individuals were on the CCS waiting list on 12/31/2014? *

58. How long was the average wait (in months) during 2014 before individuals on your waiting list received CCS services? *
[Please provide an average number of months, not a range of months.]

59. Which of the following interim services did individuals receive while they were on your CCS 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 (please describe): _____	

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Suicide Risk Assessment

60. Does your CCS 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

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

62. 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 III – NOTES ABOUT OUTCOMES DATA AND ANALYSES

How are CCS participants identified?

- Consumers were eligible for the Outcomes analysis if they were recorded as having received CCS services in the HSRS and PPS data systems.
- Since consumers who had completed a Mental Health Functional Screen were not necessarily enrolled in CCS, Functional Screen data by itself could not be used to identify CCS consumers.
- Service (SPC) start and end dates in HSRS and PPS were used to identify dates of CCS participation.
- CCS consumers were eligible for the analysis if data from both an initial screen and a follow-up (either annual or discharge) screen were available.

What outcome data were used?

- Functional Screen data was used to measure outcome indicators because it has a wider array of indicators available.
- All screens were eligible to be included in the analysis.

How were Functional Screens identified (to represent a consumer's initial and update status)?

- If more than one initial screen was identified, the first screen was selected for analysis (based on Screen Completion Date).
- If more than one follow-up screen was identified, the last screen was selected for analysis (based on Screen Completion Date).
- The most recent FS was selected to measure a CCS consumer's most recent status independent of whether a consumer was still enrolled in CCS or not.

APPENDIX IV – 2014 ROSI ADULT SATISFACTION SURVEY

Recovery Oriented System Indicators (ROSI) ADULT SATISFACTION SURVEY

To provide the best possible mental health and substance abuse services, we want to know what you think about the services you received in the last 6 months. Do not write your name or address on this survey. Your answers are confidential and will not be linked to any of the mental health and/or substance abuse services you receive.

Section One: Please indicate how much you disagree or agree with each of the following statements. Read each statement and circle the number (from “1”=Strongly Disagree to “4”=Strongly Agree) that best represents your situation in the past 6 months. If the statement is about something you did not experience, circle the last response “N/A” to indicate this item does not apply to you.

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
1. There is at least one person who believes in me.	1	2	3	4	N/A
2. I have a place to live that feels like a comfortable home to me.	1	2	3	4	N/A
3. I am encouraged to use consumer-run programs (support groups, drop-in centers, etc).	1	2	3	4	N/A
4. I do not have the support I need to function in the roles I want in my community.	1	2	3	4	N/A
5. I do not have enough good service options to choose from.	1	2	3	4	N/A
6. Mental health and/or substance abuse services helped me get housing in a place I feel safe.	1	2	3	4	N/A
7. Staff do not understand my experience as a person with mental health and/or substance abuse problems.	1	2	3	4	N/A
8. The mental health/substance abuse staff ignore my physical health.	1	2	3	4	N/A
9. Staff respect me as a whole person.	1	2	3	4	N/A
10. Mental health and/or substance abuse services have caused me emotional or physical harm.	1	2	3	4	N/A
11. I cannot get the mental health/substance abuse services I need when I need them.	1	2	3	4	N/A
12. Mental health/substance abuse services helped me get medical benefits that meet my needs.	1	2	3	4	N/A
13. Mental health/substance abuse services led me to be more dependent, not independent.	1	2	3	4	N/A
14. I lack the information or resources I need to uphold my client rights and basic human rights.	1	2	3	4	N/A
15. I have enough income to live on.	1	2	3	4	N/A
16. Services help me develop the skills I need.	1	2	3	4	N/A
17. Substance abuse services help me be better able to deal with my alcohol or drug problem.	1	2	3	4	N/A
18. Substance abuse services help me have a better understanding of my addiction.	1	2	3	4	N/A

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Section Two: Please read each statement and circle the number that best represents your situation *during the past 6 months*. The responses range from “1”=Never/Rarely to “4”=Almost Always/Always. If the statement is about something that you did not experience, circle the last response “N/A” to indicate this item does not apply to you.

	Never/ Rarely	Sometimes	Often	Almost Always/ Always	N/A
19. I have housing that I can afford.	1	2	3	4	N/A
20. I have a chance to advance my education if I want to.	1	2	3	4	N/A
21. I have reliable transportation to get where I need to go.	1	2	3	4	N/A
22. Mental health/substance abuse services helped me get or keep employment.	1	2	3	4	N/A
23. Staff see me as an equal partner in my treatment program.	1	2	3	4	N/A
24. Mental health/substance abuse staff support my self-care or wellness.	1	2	3	4	N/A
25. I have a say in what happens to me when I am in crisis.	1	2	3	4	N/A
26. Staff believe that I can grow, change, and recover.	1	2	3	4	N/A
27. Staff use pressure, threats, or force in my treatment.	1	2	3	4	N/A
28. There was a consumer peer advocate to turn to when I needed one.	1	2	3	4	N/A
29. There are consumers working as paid employees in the mental health/substance abuse agency where I receive services.	1	2	3	4	N/A
30. Staff give me complete information in words I understand before I consent to treatment or medication.	1	2	3	4	N/A
31. Staff encourage me to do things that are meaningful to me.	1	2	3	4	N/A
32. Staff stood up for me to get the services and resources I needed.	1	2	3	4	N/A
33. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc)	1	2	3	4	N/A
34. Staff listen carefully to what I say.	1	2	3	4	N/A
35. Staff lack up-to-date knowledge on the most effective treatments.	1	2	3	4	N/A
36. Mental health/substance abuse staff interfere with my personal relationships.	1	2	3	4	N/A

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Please circle the number that best represents your situation <i>during the past 6 months</i> .					
	Never/ Rarely	Sometimes	Often	Almost Always/ Always	N/A
37. Mental health/substance abuse staff help me build on my strengths.	1	2	3	4	N/A
38. My right to refuse treatment is respected.	1	2	3	4	N/A
39. My treatment plan goals are stated in my own words.	1	2	3	4	N/A
40. The doctor worked with me to get on medications that were most helpful for me.	1	2	3	4	N/A
41. I am treated as a psychiatric label rather than as a person.	1	2	3	4	N/A
42. I can see a therapist when I need to.	1	2	3	4	N/A
43. My family gets the education or supports they need to be helpful to me.	1	2	3	4	N/A
44. I have information or guidance to get the services and supports I need, both inside and outside my mental health/substance abuse agency.	1	2	3	4	N/A

Section Three: Are there other issues related to how services help or hinder your recovery? Please explain.

Section Four: Please answer the following questions to let us know a little about you. We are asking you to provide this information so we are able to have a general description of the participants taking this survey. Please circle the answer that best fits your response to the question or write in your answer on the line provided.

45. What is your gender?
1 = Female 2 = Male

46. What is your age? _____ years

47. What is your race or ethnic background? (Circle the one that applies best.)
1 = American Indian/Alaska Native 5 = White/Caucasian
2 = Asian 6 = More than one race or ethnic group
3 = Black/African American 7 = Other (describe: _____)
4 = Native Hawaiian/Pacific Islander

48. Do you consider yourself Hispanic or Latino/a?
1 = Yes 2 = No

49. What is your level of education? (Circle the highest level you reached or currently are in.)
1 = Less than high school 3 = College/Technical Training 5 = Other (describe: _____)
2 = High school/GED 4 = Graduate School

50. Are you currently receiving mental health and/or substance abuse services?
1 = Mental Health only 2 = Substance Abuse only 3 = Mental Health and Substance Abuse services

51. How long have you been receiving mental health and/or substance abuse services?
1 = Less than 1 year 3 = 3 to 5 years
2 = 1 to 2 years 4 = More than 5 years

52. Which services or program have you used in the past six months? (Circle all that apply.)
1 = Community Support Program (CSP) 2 = Comprehensive Community Services (CCS)

53. What type of place do you live in? (Circle the one that applies best.)
1 = My own home or apartment 4 = Boarding house
2 = Supervised/supported apartment 5 = Homeless or homeless shelter
3 = Residential facility 6 = Other (describe: _____)

54. What Wisconsin county do you currently live in? _____ County, WI

55. Do you have any other comments about the services you received in the last 6 months?

Thank you for your time and cooperation in completing this survey!

[This survey was adapted from the instrument developed by Dumont JM, Ridgway P, Onken SJ, Dornan DH & Ralph RO.]

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**APPENDIX V –
2014 MHSIP YOUTH SATISFACTION SURVEY**

**Mental Health Statistics Improvement Program (MHSIP)
YOUTH SATISFACTION SURVEY**

To provide the best possible mental health and substance abuse services, we want to know what you think about the services you received in the past 6 months. Do not write your name on this survey. Your answers are confidential and will not be linked to the mental health and/or substance abuse services you receive.

Please indicate how much you agree or disagree with each of the following statements by circling the number (from "1"=Strongly Agree to "5"=Strongly Disagree) that best represents your opinion. If the statement is about something you have not experienced, circle "N/A" to indicate that this item does not apply to you.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
1. Overall, I am satisfied with the services I received.	1	2	3	4	5	N/A
2. I helped to choose my services.	1	2	3	4	5	N/A
3. I helped to choose my treatment goals.	1	2	3	4	5	N/A
4. The people helping me stuck with me no matter what.	1	2	3	4	5	N/A
5. I felt I had someone to talk to when I was troubled.	1	2	3	4	5	N/A
6. I participated in my own treatment.	1	2	3	4	5	N/A
7. The services I received were right for me.	1	2	3	4	5	N/A
8. The location of services was convenient for me.	1	2	3	4	5	N/A
9. Services were available at times that were convenient for me.	1	2	3	4	5	N/A
10. I got the help I wanted.	1	2	3	4	5	N/A
11. I got as much help as I needed.	1	2	3	4	5	N/A
12. Staff treated me with respect.	1	2	3	4	5	N/A
13. Staff respected my family's religious or spiritual beliefs.	1	2	3	4	5	N/A
14. Staff spoke with me in a way that I understood.	1	2	3	4	5	N/A
15. Staff were sensitive to my cultural or ethnic background.	1	2	3	4	5	N/A

Questions 16-22: As a direct result of the mental health and/or substance abuse services I received ...

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
16. I am better at handling daily life.	1	2	3	4	5	N/A
17. I get along better with family members.	1	2	3	4	5	N/A
18. I get along better with friends and other people.	1	2	3	4	5	N/A
19. I am doing better in school and/or work.	1	2	3	4	5	N/A
20. I am better able to cope when things go wrong.	1	2	3	4	5	N/A
21. I am satisfied with my family life right now.	1	2	3	4	5	N/A
22. I am better able to do things I want to do.	1	2	3	4	5	N/A

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Questions 23-26: Please tell us about the current relationships you have with persons other than your mental health and/or substance abuse provider(s).						
	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
23. I know people who will listen and understand me when I need to talk.	1	2	3	4	5	N/A
24. I have people that I am comfortable talking with about my problems.	1	2	3	4	5	N/A
25. In a crisis, I would have the support I need from family or friends.	1	2	3	4	5	N/A
26. I have people with whom I can do enjoyable things.	1	2	3	4	5	N/A

Questions 27-35: Please answer the following questions to let us know a little about you.

27. Are you currently receiving mental health and/or substance abuse services?
 1 = Mental Health only 2 = Substance Abuse only 3 = Mental Health and Substance Abuse services

28. How long have you received these services?
 1 = Less than 6 months 3 = 1 year to 2 years
 2 = 6 months to 1 year 4 = More than 2 years

29. Do you currently live with one or both parents?
 1 = Yes 2 = No

30. What is your gender?
 1 = Female 2 = Male

31. What is your age? _____ years

32. What is your race or ethnic background? (Circle the one that applies best.)
 1 = American Indian/Alaska Native 5 = White/Caucasian
 2 = Asian 6 = More than one race or ethnic group
 3 = Black/African American 7 = Other (describe: _____)
 4 = Native Hawaiian/Pacific Islander

33. Do you consider yourself Hispanic or Latino/a?
 1 = Yes 2 = No

34. What Wisconsin county do you currently live in? _____ County, WI

35. Do you have any other comments about the services you received in the last 6 months?

Thank you for your time and cooperation in completing this survey!

[This survey was created by the Mental Health Statistics Improvement Program (MHSIP) in 2001.]

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APPENDIX VI – 2014 MHSIP FAMILY SATISFACTION SURVEY

Mental Health Statistics Improvement Program (MHSIP) FAMILY SATISFACTION SURVEY

To provide the best possible mental health and substance abuse services, we want to know what you think about the services your child received *in the past 6 months*. The parent or guardian who had the most contact with your child's service provider(s) should fill out this survey. Do not write your name on this survey. Your answers are confidential and will not be linked to the mental health and/or substance abuse services your child receives.

Please indicate how much you agree or disagree with each of the following statements by circling the number (from "1"=Strongly Agree to "5"=Strongly Disagree) that best represents your opinion. If the statement is about something you or your child have not experienced, circle "N/A" to indicate that this item does not apply to you.

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
1. Overall, I am satisfied with the services my child received.	1	2	3	4	5	N/A
2. I helped to choose my child's services.	1	2	3	4	5	N/A
3. I helped to choose my child's treatment goals.	1	2	3	4	5	N/A
4. The people helping my child stuck with us no matter what.	1	2	3	4	5	N/A
5. I felt my child had someone to talk to when he or she was troubled.	1	2	3	4	5	N/A
6. I participated in my child's treatment.	1	2	3	4	5	N/A
7. The services my child and/or family received were right for us.	1	2	3	4	5	N/A
8. The location of services was convenient for us.	1	2	3	4	5	N/A
9. Services were available at times that were convenient for us.	1	2	3	4	5	N/A
10. My family got the help we wanted for my child.	1	2	3	4	5	N/A
11. My family got as much help as we needed for my child.	1	2	3	4	5	N/A
12. Staff treated me with respect.	1	2	3	4	5	N/A
13. Staff respected my family's religious or spiritual beliefs.	1	2	3	4	5	N/A
14. Staff spoke with me in a way that I understood.	1	2	3	4	5	N/A
15. Staff were sensitive to my cultural or ethnic background.	1	2	3	4	5	N/A

Questions 16-22: As a direct result of the mental health and/or substance abuse services my child received ...

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
16. My child is better at handling daily life.	1	2	3	4	5	N/A
17. My child gets along better with family members.	1	2	3	4	5	N/A
18. My child gets along better with friends and other people.	1	2	3	4	5	N/A
19. My child is doing better in school and/or work.	1	2	3	4	5	N/A
20. My child is better able to cope when things go wrong.	1	2	3	4	5	N/A
21. I am satisfied with our family life right now.	1	2	3	4	5	N/A
22. My child is better able to do things he/she wants to do.	1	2	3	4	5	N/A

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Questions 23-26: Please tell us about the current relationships you have with persons other than your child's mental health and/or substance abuse provider(s).						
	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	N/A
23. I know people who will listen and understand me when I need to talk.	1	2	3	4	5	N/A
24. I have people that I am comfortable talking with about my child's problems.	1	2	3	4	5	N/A
25. In a crisis, I would have the support I need from family or friends.	1	2	3	4	5	N/A
26. I have people with whom I can do enjoyable things.	1	2	3	4	5	N/A

Questions 27-35: Please answer the following questions to let us know a little about your child.

27. Is your child currently receiving mental health and/or substance abuse services?
 1 = Mental Health only 2 = Substance Abuse only 3 = Mental Health and Substance Abuse services

28. How long has your child received these services?
 1 = Less than 6 months 3 = 1 year to 2 years
 2 = 6 months to 1 year 4 = More than 2 years

29. Does your child currently live with one or both parents?
 1 = Yes 2 = No

30. What is your child's gender?
 1 = Female 2 = Male

31. What is your child's age? _____ years

32. What is your child's race or ethnic background? (Circle the one that applies best.)
 1 = American Indian/Alaska Native 5 = White/Caucasian
 2 = Asian 6 = More than one race or ethnic group
 3 = Black/African American 7 = Other (describe: _____)
 4 = Native Hawaiian/Pacific Islander

33. Do you consider your child Hispanic or Latino/a?
 1 = Yes 2 = No

34. What Wisconsin county does your child currently live in? _____ County, WI

35. Do you have any other comments about the services your child received in the last 6 months?

Thank you for your time and cooperation in completing this survey!

[This survey was created by the Mental Health Statistics Improvement Program (MHSIP) in 2001.]

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APPENDIX VII – SATISFACTION SURVEY SCALES

ROSI Adult Scales

For each question on the ROSI Adult Survey, the adult consumer was given a range of response options (from “1”=Strongly Disagree to “4”=Strongly Agree). The adult’s responses then were summarized across six satisfaction domains: whether services are person-centered (*Person-Centered*), whether consumers experience barriers to recovery (*Barriers*), the degree to which consumers feel empowered by staff (*Empower*), the degree to which the consumer has educational/employment opportunities (*Employ*), the degree to which agency staff are paternalistic and/or coercive (*Staff Approach*), and the consumer’s financial ability to meet basic needs (*Basic Needs*). All the questions on the ROSI Adult Survey either fall into one of these six domains (with all of the items correlated with each scale grouped in lists below) or are not correlated with any of the scales (so are not included in any scale).

Scale 1 – Person-Centered: These items describe whether clinical staff have a person-centered focus and allow for person-centered decision-making. The Person-Centered scale was constructed for all individuals who responded to at least six of the following items, identified by question number (q#):

- q23. Staff see me as an equal partner in my treatment program.
- q24. Mental health staff support my self-care or wellness.
- q30. Staff give me complete information in words I understand before I consent to treatment or medication.
- q31. Staff encourage me to do things that are meaningful to me.
- q32. Staff stood up for me to get the services and resources I needed.
- q33. Staff treat me with respect regarding my cultural background (think of race, ethnicity, religion, language, age, sexual orientation, etc.).
- q34. Staff listen carefully to what I say.
- q37. Mental health staff help me build on my strengths.
- q38. My right to refuse treatment is respected.

Scale 2 – Barriers: These items describe passive barriers to recovery that consumers may experience. The Barriers scale was constructed for all individuals who responded to at least four of these items:

- q4. I do not have the support I need to function in the roles I want in my community.
- q5. I do not have enough good service options to choose from.
- q7. Staff do not understand my experience as a person with mental health problems.
- q8. The mental health staff ignore my physical health.
- q11. I cannot get the services I need when I need them.
- q14. I lack the information or resources I need to uphold my client rights and basic human rights.

Scale 3 – Empower: These items describe the degree to which consumers feel empowered by staff and others. The Empower scale was constructed for all individuals who responded to at least two of these items:

- q1. There is at least one person who believes in me.
- q3. I am encouraged to use consumer-run programs (support groups, drop-in centers, etc.).
- q9. Staff respect me as a whole person.

Scale 4 – Employ: These items describe the degree to which educational/employment opportunities are available to the individual consumer or consumers in general. The Employ scale was constructed for all individuals who responded to at least three of these items:

- q20. I have a chance to advance my education if I want to.
- q22. Mental health services helped me get or keep employment.
- q28. There was a consumer peer advocate to turn to when I needed one.

q29. There are consumers working as paid employees in the mental health agency where I receive services.

Scale 5 – Staff Approach: These items describe the degree to which agency staff use a paternalistic and/or coercive approach working with consumers. The Staff Approach scale was constructed for all individuals who responded to at least three of these items:

- q27. Staff use pressure, threats, or force in my treatment.
- q35. Staff lack up-to-date knowledge on the most effective treatments.
- q36. Mental health staff interfere with my personal relationships.
- q41. I am treated as a psychiatric label rather than as a person.

Scale 6 – Basic Needs: These items describe the consumer’s current financial ability to meet his/her basic needs. The Basic Needs scale was constructed for all individuals who responded to both of these items:

- q15. I have enough income to live on.
- q19. I have housing that I can afford.

Other ROSI Items Not Included in Scales: These items were not strongly correlated with any of the above items in the six scales, but could be important recovery indicators on their own:

- q2. I have a place to live that feels like a comfortable home to me.
- q6. Mental health services helped me get housing in a place I feel safe.
- q10. Mental health services have caused me emotional or physical harm.
- q12. Mental health services helped me get medical benefits that meet my needs.
- q13. Mental health services led me to be more dependent, not independent.
- q16. Services help me develop the skills I need.
- q17. Substance abuse services help me be better able to deal with my alcohol or drug problem.
- q18. Substance abuse services help me have a better understanding of my addiction.
- q21. I have reliable transportation to get where I need to go.
- q25. I have a say in what happens to me when I am in crisis.
- q26. Staff believe that I can grow, change and recover.
- q39. My treatment plan goals are stated in my own words.
- q40. The doctor worked with me to get on medications that were most helpful for me.
- q42. I can see a therapist when I need to.
- q43. My family gets the education or supports they need to be helpful to me.
- q44. I have information or guidance to get the services and supports I need, both inside and outside my mental health agency.

Because the ROSI Adult Survey allows responses on a scale from 1 (Strongly Disagree) to 4 (Strongly Agree), with no middle response option for being “Undecided” (as the MHSIP surveys have), the Overall Mean and six Scale values range from 1.0 to 4.0. In the Adult Survey, wording on statements used to create Scales 1, 3, 4 and 6 are positively phrased, so a value closer to 4.0 on these scales represents a more positive experience (meaning the consumer felt services were more recovery-oriented); meanwhile, wording on statements used to create Scales 2 and 5 are negatively phrased, so a value closer to 1.0 on these scales represents a more positive experience (meaning the consumer felt services were more recovery-oriented).

Note: The percent of adult consumers with a Mostly, Mixed and Less Recovery-Oriented Experience have been adjusted for the negative scales (2 and 5), so the percent reported for these measures have the same meaning as the other (positive) scales.

MHSIP Youth Scales

For each question on the MHSIP Youth Survey, the adolescent was given a range of response options (from “1”=Strongly Agree to “5”=Strongly Disagree). The youth’s responses then were summarized across six satisfaction scales (different from the six ROSI Adult Scales): general satisfaction with services (*Satisfaction*), satisfaction with participation in treatment planning (*Participation*), satisfaction with access to services (*Access*), satisfaction with the cultural sensitivity of providers (*Culture*), satisfaction with treatment outcomes (*Outcomes*), and their level of social connectedness (*Connectedness*). All the questions on the MHSIP Youth Survey fall into one of these six scales.

Scale 1 – Satisfaction: These items describe a youth’s overall level of satisfaction with their services. The Satisfaction scale was constructed for all individuals who responded to at least four of the following items, identified by question number (q#):

- q1. Overall, I am satisfied with the services I received.
- q4. The people helping me stuck with me no matter what.
- q5. I felt I had someone to talk to when I was troubled.
- q7. The services I received were right for me.
- q10. I got the help I wanted.
- q11. I got as much help as I needed.

Scale 2 – Participation: These items describe how well a youth was integrated into treatment planning. The Participation scale was constructed for all individuals who responded to at least two of these items:

- q2. I helped to choose my services.
- q3. I helped to choose my treatment goals.
- q6. I participated in my own treatment.

Scale 3 – Access: These items describe the perceived ease with which a youth obtained their mental health and/or substance abuse services. The Access scale was constructed for all individuals who responded to both of these items:

- q8. The location of services was convenient for me.
- q9. Services were available at times that were convenient for me.

Scale 4 – Culture: These items describe the perceived cultural sensitivity of providers. The Culture scale was constructed for all individuals who responded to at least three of these items:

- q12. Staff treated me with respect.
- q13. Staff respected my family’s religious or spiritual beliefs.
- q14. Staff spoke with me in a way that I understood.
- q15. Staff were sensitive to my cultural or ethnic background.

Scale 5 – Outcomes: These items are prefaced with the following phrase: “As a direct result of the mental health or substance abuse services I received,…” and describe the perceived treatment-related improvements in a youth’s life. The Outcomes scale was constructed for all individuals who responded to at least five of these items:

- q16. I am better at handling daily life.
- q17. I get along better with family members.
- q18. I get along better with friends and other people.
- q19. I am doing better in school and/or work.
- q20. I am better able to cope when things go wrong.
- q21. I am satisfied with my family life right now.
- q22. I am better able to do things I want to do.

Scale 6 – Connectedness: These items describe the extent to which youth are socially connected, have “natural supports” in place—family, friends, and acquaintances—to help bolster and sustain recovery. The Connectedness scale was constructed for all individuals who responded to at least three of these items:

- q23. I know people who will listen and understand me when I need to talk.
- q24. I have people that I am comfortable talking with about my child’s problems.
- q25. In a crisis, I would have the support I need from family or friends.
- q26. I have people with whom I can do enjoyable things.

Because the Youth Survey allows responses on a scale from 1 (Strongly Agree) to 5 (Strongly Disagree), the Overall Mean and six Scale values range from 1.0 to 5.0. Wording on all statements in the Youth Survey are positively phrased, so a value closer to 1.0 represents a more positive experience (the consumer was more satisfied) while a value closer to 5.0 represents a less positive experience (the consumer was less satisfied).

MHSIP Family Scales

For each question on the MHSIP Family Survey, the caregiver (parent or guardian) was given a range of response options (from “1”=Strongly Agree to “5”=Strongly Disagree). The caregiver’s responses then were summarized across the same six scale domains used in the Youth Survey (*Satisfaction, Participation, Access, Culture, Outcomes, and Connectedness*), but from the perspective of the caregiver. Again, all of the questions on the MHSIP Family Survey fall into one of these six scales.

Scale 1 – Satisfaction: These items describe a caregiver’s overall level of satisfaction with their child’s services. The Satisfaction scale was constructed for all individuals who responded to at least four of the following items, identified by question number (q#):

- q1. Overall, I am satisfied with the services my child received.
- q4. The people helping my child stuck with us no matter what.
- q5. I felt my child had someone to talk to when he or she was troubled.
- q7. The services my child and/or family received were right for us.
- q10. My family got the help we wanted for my child.
- q11. My family got as much help as we needed for my child.

Scale 2 – Participation: These items describe how well a consumer’s family members were integrated into treatment planning. The Participation scale was constructed for all individuals who responded to at least two of these items.

- q2. I helped to choose my child’s services.
- q3. I helped to choose my child’s treatment goals.
- q6. I participated in my child’s treatment.

Scale 3 – Access: These items describe the perceived ease with which mental health and/or substance abuse services were obtained. The Access scale was constructed for all individuals who responded to both of these items.

- q8. The location of services was convenient for us.
- q9. Services were available at times that were convenient for us.

Scale 4 – Culture: These items describe the cultural sensitivity of providers. The Culture scale was constructed for all individuals who responded to at least three of these items.

- q12. Staff treated me with respect.

- q13. Staff respected my family's religious or spiritual beliefs.
- q14. Staff spoke with me in a way that I understood.
- q15. Staff were sensitive to my cultural or ethnic background.

Scale 5 – Outcomes: These items are prefaced with the following phrase: “As a direct result of the mental health or substance abuse services my child received,…” and describe the perceived treatment-related improvements in consumers' lives. The Outcomes scale was constructed for all individuals who responded to at least five of these items.

- q16. My child is better at handling daily life.
- q17. My child gets along better with family members.
- q18. My child gets along better with friends and other people.
- q19. My child is doing better in school and/or work.
- q20. My child is better able to cope when things go wrong.
- q21. I am satisfied with our family life right now.
- q22. My child is better able to do things he/she wants to do.

Scale 6 – Connectedness: These items describe the extent to which consumers' family members are socially connected, have “natural supports” in place —family, friends, and acquaintances—to help bolster and sustain recovery. The Connectedness scale was constructed for all individuals who responded to at least three of these items.

- q23. I know people who will listen and understand me when I need to talk.
- q24. I have people that I am comfortable talking with about my child's problems.
- q25. In a crisis, I would have the support I need from family or friends.
- q26. I have people with whom I can do enjoyable things.

Because the Family Survey allows responses on a scale from 1 (Strongly Agree) to 5 (Strongly Disagree), the Overall Mean and six Scale values range from 1.0 to 5.0. Wording on all statements in the Family Survey are positively phrased, so a value closer to 1.0 represents a more positive (more satisfied) experience while a value closer to 5.0 represents a less positive (less satisfied) experience.