

MHSIP Updates

Newsletter of the Mental Health Statistics Improvement Program

May
2003

MESSAGE FROM THE CHAIR

Welcome to what we hope will be a new and improved MHSIP Updates newsletter. It will be new because, as many of you know, David Brown, the former part-time newsletter editor and contract support staff person for CMHS Survey and Analysis Branch for several years, has moved on to a job as Senior Research Associate with the CARF organization in Arizona. We wish David success, but we've missed his assistance as we've put this issue together.

The 'new' newsletter will be improved, we hope, because part of what we plan to offer is the ability to receive the newsletter as an email attachment, or through notification to download it from the MHSIP website. We're still cobbling together the resources and process to edit, produce and disseminate the Updates, so please let us know through which medium you'd like to receive it, and send us your ideas for format and content, or specific notices or reports you'd like us to consider for inclusion in future editions.

This is a time of great excitement and activity for the field. As many of you know through your participation, we are currently engaged in a number of important activities. These include the development of Version 2 of the MHSIP Consumer-Oriented Report Card; collaboration with others in the field to develop HIPAA behavioral health transaction codes; and collaboration with CMHS and Abt Associates on the development of modules for Decision Support 2000+. The need for the continued development, refinement, and use of data standards is more important than ever, because in the absence of these basic building blocks, there can be no accountability.

This volume of MHSIP Updates includes articles about projects and activities in the MHSIP regional user groups, some poetry reflecting consumer concerns, news about several initiatives of the MHSIP Policy Group supported by CMHS, and other topics we think will be of interest to you, the MHSIP community.

--Mary E. Smith, Ph.D.
Chair, MHSIP Policy Group

New MHSIP Report Card In the Works

The MHSIP Consumer-Oriented Report Card was published by the Center for Mental Health Services in April of 1996 (MRC, Version 1). Since then, more than 45 states and territories have implemented various aspects of the Report Card. Additionally, a variety of initiatives implemented across the public and private sector, have been derived from the content of the Report Card. We have learned a lot from these initiatives, but the constant changes occurring in the field, as well as the need to address issues that weren't addressed in Version 1, have led to the convening of a Task Force to develop Version 2 of the Report Card.

The purpose of this revision is to consolidate the lessons and experiences of those who have developed and implemented mental health performance measures and to compile a set of measures that reflect key concerns of stakeholders who want to improve the performance of mental health systems or organizations. MHSIP Report Card Version 2.0, like Version 1.0, is value-based. A central tenet of the MHSIP Report Card Version 2.0 project is that a mental health performance measurement system should be designed and built to be consumer-centered and help consumers move towards recovery.

MHSIP Report Card 2.0 will:

- Address report card requirements for both adults and children and is intended to apply to the entire mental health field, both public and private;
- Build on the work of the Recovery Advisory Group and the Recovery Measurement Group and will incorporate the common measures developed by the Adult and Child Mental Health Performance Measurement Workgroups of the Performance Measurement Forum;
- Emphasize the implementation, reporting and uses of performance measures;
- Give special attention to developing a second generation of consumer survey instruments building on the work done on the MHSIP Consumer Surveys and Experience of Care and Health Outcomes (ECHO) Survey;

- Be modular, based on the recognition that different sets of measures may be needed for different populations in different settings. However, a major emphasis of this work will be to develop consistency and commonality across these settings and populations.

Additionally, a toolkit related to methodological and implementation issues related to the proposed measures will be developed by the Human Services Research Institute (HSRI) in collaboration with the Task Force and released in conjunction with Version 2. Efforts will also be made to incorporate new technologies for the implementation of performance measures and for the dissemination and distribution of reports.

The Task Force is chaired by Vijay Ganju, Ph.D., who is a member of the MHSIP Policy Group, and who was the chair of the MHSIP Report Card Version 1 Task Force. In addition to several members of the MHSIP Policy Group, the task force includes representatives from the following organizations: the National Mental Health Association (NMHA), the National Association of Consumer/Survivor Mental Health Administrators NACSMHA), the National Association of State Mental Health Program Directors (NASMHPD), the National Council of Community Behavioral Healthcare (NCCBH), the American Managed Behavioral Healthcare Association (AMBHA), the National Alliance for the Mentally Ill (NAMI), the National Association of Mental Health Planning and Advisory Councils (NAMHPAC), the Federation of Families for Children’s Mental Health, the Outcomes Roundtable for Children and Families (ORCF), the American College of Mental Health Administrators (ACHMA), the Human Services Research Institute (HSRI), State Mental Health Authority Planners and Data Policy representatives and the Center for Mental Health Services State Planning and Systems Development and Survey and Analysis Branches.

**State Report – Colorado
Western States Decision Support Group**

Richard H. Ellis, Ph.D.
Colorado Mental Health Services
Data & Evaluation

Monitoring Program Quality

Colorado Mental Health Services (MHS) is responsible for quality care in its contracting agencies, both Medicaid and non-Medicaid. One of the ways this is accomplished is

through annual Site Visits to each agency for the purpose of surveying the agency’s records and reviewing charts. Site Visits may also include program reviews such as a children’s service or an acute treatment unit (ATU). These vary from year to year and site to site.

Procedure – Before the 1.5 day Site Visit, files of Colorado Client Assessment Records (CCAR) for an agency are sampled for the IDs of clients whose charts are to be reviewed. The sample is designed as a profile of the agency’s case-mix. The ID list is sent to the agency so the charts are available when the Site Team arrives. Each Team may have up to 3 reviewers. Upon arrival, after the opening session, charts are reviewed. A formal protocol is used along with a score sheet to record the results for each chart reviewed.

Protocol & Scoresheet – The Protocol is a complete description including definitions of what is to be reviewed. The Scoresheet is scannable (Teleform) and includes identification, demographics and additional information. The following sections contain items that may or may not be completed depending on what type of case is being reviewed. Each item on the Scoresheet is scored S = Satisfactory, U = Unsatisfactory; or N = Not Applicable.

Content – In general, reviewers look for evidence of service planning, treatment objectives, consumer input to the process; if Medicaid, evidence of medical necessity, and evidence of sensitivity to cultural issues (cultural competency).

The first check is to see if the data on the CCAR is congruent with what’s in the chart. Other assessment information is also reviewed. A Plan of Service is required. It has a number of characteristics. The remaining sections only apply in specific cases.

- Section 3: Regular review of service plan and assessment.
- Section 4: Consent forms – release of information; consent valid only for 1 year.
- Section 5: Psychiatric Services only – a meds only service plan with rationale and frequency of reviews.
- Section 6: Care and Treatment: 27-10 (involuntary treatment).
- Section 7: Contractual: OBRA / PASARR – This refers to a Memo of Understanding between MHS and the Colorado Department of Health Care Policy and Financing (HCPF) and Colorado Department of Public Health and Environment (CDPHE).
- Section 8: Contractual: HCBS – This refers to compliance with Cooperative Agreement between MHS and Colorado Department of Health Care Policy and Financing (HCPF).

Scoresheets are returned to Data & Evaluation, scanned and results provided to the Review Team to be incorporated in the final report.

Criteria – Requirements are 80% of charts reviewed are Satisfactory for each completed Section. If there are areas out of compliance, a Plan of Correction is required for each, a copy to go to MHS and a copy to the agency Board within 30 days.

Wrap up and Final Report – At the end of the Site Visit, a wrap up is held for presentation of preliminary findings and discussion. The reviewers attempt to give a balanced summary with emphasis on program strengths as well as areas needing improvement. The final report also provides a balanced perspective including Commendations, Recommendations and any need for a Plan of Correction.

Future – There is some administrative dissatisfaction with chart review as a general method for assessing quality care. At a minimum, it is hoped these reviews can be supplemented or replaced with more of a focus on outcome and indirect measures of quality such as performance indicators. For now, a multi-year data base is being assembled and, where elements exist in common across years, some generalizations about adequacy of sampling and overall findings will be made.

ONE-MHSIP NEWS UPDATE

Roundtables, Factoids and a Traveling Road Show

The Northeast Regional User Group of MHSIP (aka ONE-MHSIP) has led an active and transient life since our last report. We continue to rotate the locations of our semi-annual meetings among the Northeast states. Recent meetings in Portsmouth, New Hampshire and Burlington, Vermont, for examples, offered different venues but each provided a wealth of presented material on state mental health authority data initiatives. To maximize the time available for the regional user group meeting, ONE-MHSIP has initiated an optional Wednesday afternoon "Roundtable" discussion. Focused on but one topic of interest to northeast state representatives, the roundtable allows numerous states to share their findings and thoughts in a round-robin fashion. More recently we have begun to intersperse into the meeting agenda a handful of "Five Minute Factoids" - small bytes (yes, the pun was intended) of information designed to permit states to briefly introduce interesting mental health data findings to the group. Beyond the meetings themselves, ONE-MHSIP has also been busy in producing a cross-state comparison of northeast consumer

survey activities. Results of the study, along with other ONE-MHSIP information can be found on our Internet web site at:

<http://www.angelfire.com/ga3/mhsip1/home.html>

By the way, did we mention that ONE-MHSIP meetings are open to visitors from the other regional user groups?

WSDSG Update

The WSDSG welcomed Dennis Mohatt as the new Director of the WICHE Mental Health Program. Dennis has broad experience ranging from directing the Nebraska Medicaid Managed Care to working in the private sector on integrated information systems. He has served on the National Advisory Committee on Rural Health and published on access to mental health services in frontier America. We look forward to his leadership.

The WSDSG meets 3 times a year (two supported by CMHS and the third by fees). Meetings focus on development of performance indicators. The WSDSG includes two consumer representatives who present at each meeting (one supported by CMHS and another by fees). Each meeting includes updates on DS2000+, HIPAA, State DIG grant activities, and MHSIP Policy Group activities.

The Director of the hosting State SMHA usually welcomes the group to meetings and talks about issues relevant to decision support from their perspective. Most meetings include local consumer participation and many meetings include representatives from service sectors other than mental health. A few highlights of WSDSG meetings include:

Cultural competence was a focus in the meeting in Santa Clara. Presentations were made by a consultant (Josie Romero), a County Program Evaluator (Amamdo Cablas) and a consumer panel (Andrew Phelps, Tom Jergensen, Lorre Mendelson, Barry Fultonberg, Jose Rangel).

(go to:

<http://www.wiche.edu/mentalhealth/WSDSG/index.htm>)

Colorado Population In Need (PIN) study. The PIN study was designed to estimate the difference between the population in need of mental health services and the number served. The study defined need as the prevalence of serious mental disorder in the population (operationalized via synthetic prevalence estimates generated by Dr. Charles Holzer, University of Texas Medical Branch). Service utilization was estimated across mental health and several additional sectors utilizing the Probabilistic Population Estimation technology developed

by the Bristol Observatory. You can see the Executive Summary at <http://www.cdhs.state.co.us/ohr/mhs/>.

Consumer Educational Interaction With Law Enforcement. Lynne Stewart, a client advocate from Riverside, CA, showed a powerful video and discussed the preparation. A County Sheriff introduces the video and consumers discuss their positive and negative experiences with law enforcement officers.

Public Health surveillance was explored by the Western States Decision Support Group in the Montana meeting. The Behavioral Risk Factor Surveillance System (BRFSS) was discussed by Pete Feigley and Joanne Oreskovich from the Department of Public Health and Human Services. The BRFSS is an ongoing, state-based, random-digit-dialed telephone survey of non-institutionalized adults. One of the core four health related quality of life questions on the survey is a measure of mental health: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days in the past 30 days was your mental health not good?"

The measure of recent mental health correlates well in a general population comparison with the widely used and clinically validated Medical Outcomes Study Short Form 36. (Self-Reported Frequent Mental Distress Among Adults – United States, 1993-1996. Morbidity and Mortality Weekly Report. May 1, 1998. 47(16))

The WSDSG was unanimous in its opinion that the BRFSS is a useful instrument which provides invaluable information on the physical and mental health status of the general population, statewide and nationwide. The group also observed that the instrument has not been tapped as a principal source of mental health data. The group made recommendations regarding:

- MHSIP coordination with BRFSS workgroups to add mental health questions
- MHSIP using the four core BRFSS health related quality of life questions

Regarding MHSIP coordination with BRFSS workgroups, the WSDSG recommended specific questions to add to the BRFSS. Please refer to Minutes of the WSDSG August meeting on public health at www.wiche.edu/mentalhealth.

MHSIP could pilot the four core BRFSS health related quality of life questions right away in some state consumer surveys. We could also explore including the questions in the DS2000+ enrollment data set: the questions may be valuable enough to ask of all consumers.

Consumer Group. Six active current and past WSDSG consumer representatives led by Max Dine are creating an E-mail group to increase consumer involvement in

WSDSG activities. The group will have a web presence where participants explain their reasons for participating in MHSIP and the value of consumer input. Sylvia Caras has set up a listserv for the group.

Mortality Data. Several mortality measures were reviewed and comparisons made across a number of states by Craig Colton, Utah Division of Mental Health. In eight states across all years the standardized mortality ratio (actual deaths/expected deaths) was greater than 1, i.e., higher than the general population of the state. The average number of years of life lost was 25 to 32 years of life in every state except Virginia. Most mental health clients die of natural causes, only at younger ages than the general population.

Consumer Voices in Montana. Vicki Stull offered an assessment of the MHSIP consumer survey. Among her observations was this:

*(WSDSG August 2002 Minutes
www.wiche.edu/mentalhealth have more).*

"The MHSIP is okay but needs to include a specific evaluation of Peer-to-Peer support:

Do you have access to someone who has the same kind of symptoms as you have and who is successfully living in the community with a job? Can you relate to this person on a personal basis? Would you like someone else to relate to who is closer to your cultural perspective, educational level, or severity of symptoms?

Has anyone told you of the peer-to-peer programs available in your area? Are there any peer-to-peer programs in your areas?

Have you been trained in WRAP or any other consumer run program? Do you have access to the internet? Have you been shown how to use the internet to access peer support?"

Other Presentations on "Integration of Primary Care and Mental Health", Dennis Mohatt; "CCAR Client Typologies", Jack Wackwitz; "National Recovery Project", Bernadette Phelan, Judy Hall, Denny Geertsen; "NAMI Training Programs", Mary Robson; "California Consumer Survey", Jim Higgins, Kathy Styc; "Compare State Definitions of SMI/SPMI with Federal", Chuck McGee; "HIPAA", Vijay Ganju; and "COSP Multi-site Study", Bonnie Shell.

Decision Support 2000+ (DS2K+) Updates

Over the past year, the DS2K+ Initiative has made considerable progress on the development of new data standards for the field, including the transition to the electronic transaction requirements of the Health Insurance

Portability and Accountability Act (HIPAA); and the development and testing of Web Internet technology for processing data (DS2K+ IT Prototype). User-friendly handbooks and master data sets have been completed for all eight of the required HIPAA transactions and are currently posted on the MHSIP website at www.mhsip.org/ds2k+.htm. The DS2K+ IT Prototype now has its own website and can be accessed and tested at www.ds2kplus.org.

The MHSIP community has been instrumental in pushing forward the agenda of the DS2K+ Initiative. The MHSIP Policy Group has formed a liaison group to work with the DS2K+ team on an ongoing basis and to provide information to and solicit input from the Regional User Groups. The liaison group has regularly scheduled monthly calls with CMHS and the DS2K+ team from Abt Associates to discuss latest developments, issues and concerns.

In partnership with MHSIP, DS2K+ has completed the data standards for the Core and Stakeholder-Specific (State) Person and Encounter data sets. Drafts of core data standards exist for the population, organization, human resources, financial, clinical and system guidelines, outcome, report card and performance indicator data sets. Over the next several months, further work will be undertaken to refine these core data standards and to work with stakeholder groups to draft three parallel stakeholder-specific data sets: for State public mental health systems, providers, and consumers and families. Drafts are targeted for completion and review prior to this year's National Conference on Mental Health Statistics.

The DS2K+ IT Prototype will be tested over the next several months to assess how it can perform a number of basic functions: receiving data from different types of software platforms; mapping and translating input data into required HIPAA formats; aggregating data and providing benchmarks; completing routine and ad hoc analyses; providing an online capacity for completing the MHSIP Consumer Survey; and linking with other software, all while meeting privacy and security standards. Results of testing will guide the development of the Blueprint for building the full-scale system. Input and collaboration is critical throughout this process. The team will be working actively with MHSIP, the Data Infrastructure Grant Coordinating Center, the National Association of State Mental Health Program Directors and the Research Institute, the Behavioral Healthcare Software and Technology Vendors Association (SATVA), the Forum on Common Performance Measures, private sector groups, such as the American Managed Behavioral Healthcare Association (AMBHA) and the National Association of Psychiatric Health Systems (NAPHS),

consumers, families, providers, and allied fields, such as substance abuse and child welfare. We welcome your input and suggestions as we move ahead with this important initiative to adopt common data standards.

MHSIP Contracts with CMHS Branch of Planning and Block Grants to Create a Use of Data for Planning Toolkit

Last year, in an unprecedented action, the 2002 Annual National Technical Assistance Mental Health Block Grant Conference was held in conjunction with the 51st Annual Meeting of the National Conference on Mental Health Statistics. The effect of this convergence was that a venue was created in which state planners, members of state planning councils, state data policy personnel, consumers, family members, mental health advocates, CMHS Block Grant Branch staff and CMHS Survey and Analysis Branch staff explicitly conversed about the linkage of planning efforts and the use of data. During the last day of the conference, a Town Hall Meeting sponsored by CMHS was held which focused on the following question: "How can the statistical and planning communities work together in the future to make the vision (Mr. Curie's vision for SAMHSA, consisting of priorities and cross-cutting principles) a reality?" Two major underlying themes emerged from the dialogue that followed: (1) There is a need for better communication between the planning and data community regarding the use of data for decision support, and (2) There is a need to provide a vehicle for systematically addressing all aspects of data use from presentation-- to interpretation-- to analysis-- to discussion of such pragmatic issues as "what can data tell us and what can't it tell us?"

In response to the identification of these issues, the MHSIP Policy Group submitted a proposal and obtained a contract from the SAMHSA CMHS State Planning and Mental Health Block Grant Branch, led by Marie Danforth, MSW, to develop a toolkit that will focus on using data for planning purposes. The MHSIP community is particularly well-suited to take on this task since it has developed valuable expertise during its 26-year history of implementing strategies for using data for planning. The project has two phases:

- (1) Develop a "user-friendly" toolkit focusing on data use and interpretation that includes a training curriculum and presentation materials (videotapes, PowerPoint presentations, etc.) customized specifically for targeted mental health stakeholders (see below) and

- (2) Test the materials developed with targeted audiences, market and disseminate toolkit materials, and provide training in targeted venues.

The audiences to be targeted under this contract are the following:

- ❖ State Mental Health Planners
- ❖ Members of the National Association of Mental Health Planning and Advisory Councils (NAMHPAC), including State Block Grant Planning Council members

IT'S NOT ABOUT PATHOLOGY, IT'S JUST ABOUT LIFE

When we talk about recovery
I see a distinction
Between recovery of my mental health
As opposed to recovery from my mental illness.
The fact that I have a diagnosis of mental illness
Does not exclude the possibility that I, too,
Can achieve a pretty high level of mental health.

Regaining control over my life, having a say
Finding a balance and stability
Access to medications
Access to try different drugs
Access to a psychologist
All these help me find direction in life.

A sense of structure helps me live with a purpose
Attainable goals that help me to focus
Non-judgmental peer support
Spirituality
Organized physical group activities
My cat
Are things that give me better control of my life.

What do I need to keep that control in my life?
I need family support
Case management
Counseling
Vocational Rehabilitation
Connections
Transportation
And being invited to the table and being asked the question.

I need a system that does not assume
That if you're a consumer, you have a problem.
A system that does not jeopardize my recovery
By having layers to go through too many.
A system that is proactive (not reactive)
One that does not say you can't but you can
For these tendencies no doubt will support me.

The most beneficial relationships for me
May have sprouted out of the fact that I have
A psychiatric disorder and needed to make connections.
It's easier to reach out
To people who have been there
Than to depend on a system
That is not always there.

The support system that we build for ourselves
Brings awareness of the resources that are out there
This is a system that understands my difficulty
And not one that thinks of medication adjustment.

It's a shame if a system doesn't teach us
To learn what is a symptom from a normal life
Misguided dependence is to my detriment
For it takes away my sense of independence.

You know I've now moved on (but the system has not)
With self determination, self esteem and self confidence
I've used the opportunity to say that I, too, have value
For the honest responsibility of recovery is on me
Nobody else can do that for me.

The poem was developed by Bernadette E. Phelan, PhD, using words lifted verbatim from the focus group discussion on consumer recovery held on February 9, 2001 at the Arizona Department of Health Services, Division of Behavioral Health Services, Phoenix, Arizona.

**2003 National Conference on
Mental Health Statistics**

Technology Track

The MHSIP Policy Group will be working in collaboration with the Center for Mental Health Services Survey and Analysis Branch, which is led by Dr. Ronald Manderscheid, to sponsor a technology track at the National Conference on Mental Health Statistics held in conjunction with the National Conference on Block Grant Planning, May 27th through May 30th, 2003. The technology track is designed to highlight partnerships between mental health and information technology professionals to develop and implement applications that support data based decision making. This year six presentations have been selected which feature **currently used and successful applications** specifically developed for the mental health field.

Vendor Display

The MHSIP Policy Group is also sponsoring a Vendor Display at the National Conference. The focus is on Information Technology Vendors who are actively working with states to implement technological solutions that support data based decision making. Solutions that will be featured address the following areas:

- ** Data Mining
- ** Web-Based Applications
- ** Analytic Solutions (Various applications used to analyze data)
- ** Automated Data Capture Applications (including survey data)
- ** Computerized Outcome Measurement Systems
- ** Applications to address HIPAA requirements for behavioral health
- ** Data Warehousing/Data Integration (e.g. combining Medicaid and Mental Health Information)

Announcements – “Save the Dates”

SRCMHS Fall Conference “Dialogues on Behavioral Health Care”

Embassy Suites Hotel, October 19 –22, 2003, New Orleans

The SRCMHS will hold its 45th annual meeting in New Orleans, Louisiana. The Conference which is titled “Implementing Effective Services for Persons with Co-Occurring Disorders: Strategies, Models and Tools” will focus on strategies for treating persons with co-occurring mental health and substance abuse disorders. An emphasis will be placed on providing participants with information regarding factors that have been identified as common among programs cited as dealing effectively with co-occurring disorders.

MHSIP Policy Group Member Updates

Cecil Wurster

Cecil Wurster, as most of you know, has been a tireless supporter of the Mental Health Statistics Improvement Program. In fact, it was under Cecil’s tenure that MHSIP was created. After retiring from the SAMHSA, Center for Mental Health Services, Cecil served as a consultant to the MHSIP Ad Hoc Group (which is now known as the MHSIP Policy Group) continuing to provide leadership and support with regard to the development and use of data standards. Cecil tendered his resignation to the Policy Group in 2002 after devoting many years to the field and the pursuit and advocacy of MHSIP values and ideals. We wish him the best as he pursues other endeavors!

Randy Koch, Ph.D.

Dr. Randy Koch, who previously was the Director of Research and Evaluation for Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, recently resigned from the Policy Group. Dr.

Koch has accepted a new position as the Executive Director of the Institute for Drug and Alcohol Studies at Virginia Commonwealth University. We wish Dr. Koch the best of luck and look forward to collaborating with him in his new role.

James Dennis

James Dennis, who is employed by Value Options Behavioral HealthCare in New Mexico, resigned from the Policy Group during the last year. We also wish Mr. Dennis the best and success in his future endeavors.

MHSIP Policy Group Members

Mary E. Smith, Ph.D.

Illinois Dept of Human Services
Office of Mental Health
Chair

Neal Adams, M.D.

California Dept of Mental Health

Steven Davis, Ph.D.

Oklahoma Dept of Mental Health and Substance Abuse Services
Past Chair

Herbert (Chip) Felton, M.S.W.

New York Office of Mental Health

Vijay Ganju, Ph.D.

NASMHPD Research Institute
Past Chair

Judy Hall, Ph.D.

Washington Dept. of Social & Health Services
Mental Health Division

Cynthia Hopkins

Texas Department of Mental Health and Mental Retardation

Ted Lutterman

NASMHPD Research Institute

Ronald Manderscheid, Ph.D.

Center for Mental Health Services

Marla Smith, M.A.

Wyoming Dept. of Health
Mental Health Division

Boyd Tracy, M.Ed.

New Hampshire-Dartmouth
Psychiatric Research Center

Leslie Tremaine, Ed.D.

Jefferson Parish Human Services Authority

Olinda Gonzalez

Center for Mental Health Services
Survey & Analysis Branch

Regional Users Group (RUG) Chairs

ONE-MHSIP (Northeastern Users Group)
Jerry Goessel, M.S, Pennsylvania

SoSmug (Southeastern States' MHSIP Users Group)
Senyoni Musingo, Florida

MUG (MHSIP Midwestern States Users Group)
Jim Harvey, Nebraska

WSDSG (Western States Decision Support Group)
Jon C. Collins, Ph.D., Oregon

MHSIP Policy Group
c/o Masimax Resources
1375 Piccard Drive, Suite 175
Rockville, MD 20850

Give us some feedback please!

Let us know how you would prefer to receive this newsletter: (1) printed and sent in US Mail, (2) sent a notice that a .pdf version has been posted on the MHSIP website, or (3) sent a MS-Word or .pdf copy as an attachment to e-mail. If your address has changed, or you received this in circulation, but you are not on our e-mail or US Mail list, please send your preferred method for receiving the newsletter and your correct address information to Deidre Evans at devans@masimax.com or c/o Masimax Resources, 1375 Piccard Drive, Suite 175, Rockville, MD 20850, or call at 240-632-5629.

MHSIP Updates newsletter composed by Zina Arnold, Oklahoma Department of Mental Health and Substance Abuse Services.