

WSDSG

Western States Decision Support Group

The western user group for the national Mental Health Statistics Improvement Program is sponsored by the Center for Mental Health Statistics, SAMHSA

Meeting Minutes August 15-16, 2002

The regular meeting of the WSDSG was called to order at 8:30 in Helena, Montana by Denny Geertsen, Chair. Those present included:

State Representatives

Greg Brock, **Vice Chair**,

Alaska Dept of Health & Soc Serv

Bernadette Phelan

Arizona Dept of Health Services

Holly Johnson,

California Dept of Mental Health

Nancy Johnson Nagel,

Colorado Mental Health Services

Michael Wylie,

Hawaii Dept of Health

Don Corbridge,

Idaho Dept. of Health and Welfare

Bobbi Renner,

Montana DPHHS

Kevin Crowe,

Nevada Div of Mental Health DD

Carol Thomas,

New Mexico Behavioral Health

Chad Ihla,

North Dakota Dept of Human Ser.

Dennis C. Geertsen, **Chair**

Utah Division of Mental Health

Marla Smith,

Wyoming Dept of Health

Consumer Representatives

Sheila Cooper,

Alcalde, **New Mexico**

Bonnie Jo Schell,

Santa Cruz, **California**

WICHE Liason

Chuck McGee,

WICHE Mental Health Program

Presenters and Others

Craig Colton,

Utah Div of Mental Health

Pete Feigley

Montana Dept of Public Health and HS

Joanne Oreskovich,

Montana Dept of Public Health and HS

Vicki Stull,

Montana M H Advisory Council

Lou Thompson,

Montana Dept of Public Health and HS

Mary Smith,

MHSIP Policy Group (phone)

Phillippe Gross,

Hawaii Dept of Health

Presenters and topics may be seen on the Agenda ([link to 2002_08_Agenda.doc](#)).

Contact information may be found on the participants list ([link to](#)

[2002_08_Participants.doc](#)). This document provides an overview of presentations and links presentations when provided electronically.

The State of Montana Mental Health

Lou Thompson, Chief, Mental Health Services Bureau

An overview of the mental health system and changes since reorganization to managed care in FY 1995 was provided. The managed care organization changed hands a couple of times. The contract was cancelled June 30, 1999 and the state has gone to a managed fee-for-service arrangement. They do not contract with providers so much as prior authorize services.

The number of providers has increased from 4 to 17. The number of individuals served has actually increased though the budget continues cuts. Services are being cut, including a school based program, and more cuts are on the way.

The State is pursuing a Medicaid 1115 B waiver. They are also moving toward regional authorities though there is resistance from providers.

CDC Survey and Discussion - The Behavioral Risk Factor Surveillance System (BRFSS)

Pete Feigley, Department of Public Health and Human Services, Montana

A bibliography was distributed prior to the meeting (many reference are available on the web at <http://www.cdc.gov/brfss/>) and available as a handout (link to brfss_references.doc). Background information on the CDC annual BRFSS was provided including the reasons for the BRFSS; the method using state level sampling; data collection; questionnaire design and content; BRFSS strengths; point-in-time surveys; uses of data; BRFSS funding; and the process for adding questions. (link to BRFSS0816.doc)

A paper was referenced indicating the value of using SUDAAN software to analyze BRFSS data: Pitfalls of Using Standard Statistical Software Packages for Sample Survey Data Donna J. Brogan Brogan, D. (1998). (Available on the SUDAAN website.)

Joanne Oreskovich, Department of Public Health and Human Services, Montana

Health People 2010 goals were reviewed and data sources for goals (the BRFSS covers 11 objectives). Mental Health objectives were reviewed along with examples of monitoring indicators over time. Other topics included: validity issues and how to gain access to the BRFSS survey in your state.

Four core questions include one specifically targeting mental health:

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

This question can be analyzed several ways: average days poor mental health; average days positive mental health; grouping of people into the number of days with poor mental health; and a measure of mental distress (14+ days poor mental health).

An optional module has 14 questions on Quality of Life and Caregiving.

CDC Survey Review and Discussion

Denny Geertsen, Utah Division of Mental Health, Chair

Additional description of the BRFSS and findings including:

Estimates of individuals without telephones (5.5% nationwide, ranging from 1.98% Maine to 12.17% Mississippi)

“Not good” mental health days (33% nationwide)
(28% males and 37% female) (also by age group, income, race/ethnicity)

“Not good” mental health days: State comparisons
(ranging from 41.5% Utah to 23.3% Montana, median 37.5%)

“Not good” physical health days (34.3% nationwide)

There are also youth risk behavior surveys conducted of high school students.

Discussion. Participants were intrigued with the potential in the BRFSS to quantify the effects of mental distress in terms used by public health. This allows demographic comparisons, geographic comparisons; and comparisons of mental distress among people with different health conditions. Two specific ideas were raised:

- 1.) Mental health should become more involved with the BRFSS and
- 2.) MHSIP could use BRFSS questions in the mental health system (e.g.s consumer surveys, and potentially in core)

Denny Geertsen proposed the WSDSG recommend mental health increased involvement with the BRFSS. The group strongly supported the idea. He and Chuck will send a letter to CMHS and the MHSIP Policy Group. (After the meeting we discovered that MHSIP discusses links to the BRFSS as part of the DS2000+ population data in a chapter . (link to sect2.pdf”)

MHSIP Report Card ver.2 Feedback

Mary Smith, MHSIP Policy Group

Mary reviewed the public and private effort going into a consolidated report card. The modular approach will include recommendations from the recovery workgroup and the children’s outcome roundtable. HSRI is developing a parallel process with toolkits on risk adjustment, data presentation, and methods. A focused survey and focus groups are being developed.

Comparisons of Mortality, Causes of Death, and Diagnoses for Public M. H. Consumers Craig Colton, Utah Division of Mental Health (link to “Mortality comparisons – Montana presentation 2002.ppt).

The presentation used mortality as an indicator of the health status of clients served by public mental health organizations. Several mortality measures were reviewed and comparisons made across a number of states. 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.

Health Status Indicators - Montana Mortality Data

Bobbi Renner, Mental Health Services Bureau

Mortality data from Montana were presented with similar findings to the previous presentation.

MHSIP Policy Group

Denny Geertsen, Utah Division of Mental Health, Chair

DS2000+ is requesting volunteers for workgroups for the various data sets. Denny walked through the data sets and will send an E-mail requesting volunteers.

Cecil Wurster aka "A voice from the desert" has resigned from the MHSIP Policy Group as well as the WSDSG. He was a father to MHSIP and has been involved in MHSIP for 26 years. His association with the WSDSG dates back to 1962 in Hawaii. We will miss him. Denny and Chuck will write a letter of thanks.

Steering Committee Report (Saturday morning)

Denny Geertsen, Utah Division of Mental Health, Chair

2003 Meetings: San Francisco, January; Boise, April; and Santa Fe, August.

The agenda for January will include integration of mental health and substance abuse, and the integrated database project. Utah has just consolidated substance abuse and mental health; Alaska is considering it; Idaho expressed interest; and while the Divisions were separated in Wyoming the data base was integrated. Additional topics include reports from the recovery workgroup and the children's outcomes roundtable.

Prevention was raised as a topic. Cat distributed information on a primer used that the NY State Office of Mental Health for internal presentations related to prevention and early intervention (including slow down the progression; prevent comorbidity; prevent relapse; and decrease disease burden) (contact Dr. Isaac Koilpillai (518) 408-2139).

We have had only one consumer representative at each meeting this year. This is the only meeting for Bonnie Shell, and Sheila Cooper is missing this meeting with health problems. A motion was passed to continue the current consumer representatives into the next year (M Greg Brock). We will invite the new consumer representative to the August, 2003 meeting.

Consumer Update

Bonnie Schell, Consumer Advisory Panel for COSPM

The California network of mental health clients has 8,000 members; 1,800 individuals pay \$5 for a newsletter; the State provides funding. Clients prefer assistive case management to the current bill for involuntary commitment.

The memorial project to restore cemeteries has restored over 20,000 graves. (See the California Network of Mental Health Clients website www.cnmhc.org).

The Consumer Operated Service Program (COSP) started in 1998 and ends August, 2002. An evaluation was conducted to determine if it was effective. The plan was to randomly assign individuals to traditional services vs traditional plus participation in COS. Random assignment didn't work, especially in the education programs. Less than 30% of individuals were engaged in COS. That doesn't mean the services weren't effective, but that the evaluation plan didn't work.

With the end of the COSP, programs lose enhancement money and have to lay off staff and reduce consumer participation. There is pressure to develop the capability to bill Medicaid as day rehabilitation.

A Multi-site Research Initiative for COSP is on a web site developed by Jean Campbell at the Missouri Institute of Mental Health (<http://www.cstprogram.org/>)

Consumer Voices in Montana

Vicki Stull, Vice-President, Montana Mental Health Advisory Council

A. What is happening with consumers in Montana;

As part of planning for regionalization of mental health services the advisory council is generating more involvement from consumers. Vicki has been conducting focus groups, and gotten information from a planning group, conferences and people contacting her, and her private practice.

Samples for adults (contact cmcgee@wiche for the full list). Adult consumers see recovery and consumer involvement as a process. Different people have different needs. Consumers want the opportunity to be responsible for the management of their illness. They need a way to meet other people who have had similar experiences and who are successfully managing them.

Samples for children. We are tired of having to turn our children over to the state (give up custody) in order to get treatment. We need support to help jus keep children in the home. Parents are tired of being seen as the bad guy when they have a child with mental illness.

B. Increase consumer to consumer programs.

Wellness Recovey Action Planning trained teams state wide. A list serve, chat room, bulletin board system just for consumers in Montana.

C. How to evaluate the effectiveness of this program.

The MHSIP is ok but need to include other concerns including:

Specific evaluation of treating professionals

Does your psychiatrist listen to your concerns. Do you feel you have a collaborative relationship. Do you feel that if you decide to do something different than he/she is advising that you will be punished in some way.

Evaluation of Peer to Peer support

Do you have access to someone who has the same kind of symptoms that 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, 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.

WSDSG Consumer Email Committee

Chuck McGee for Sheila Cooper who could not attend

Max Dine and current and former WSDSG consumer representatives propose creation of an E-mail group to increase consumer activity. The intent is to have each state represented and WSDSG representatives will be asked to identify potential participants. The name of the group will be the Western Consumer E-mail Committee (WSEC). WSEC participants can learn more about performance indicators; inform the WSDSG of consumer concerns; and provide feedback on WSDSG issues. Draft rules were reviewed and the WSDSG recommended support for the group (M: Don Corbridge, S: Bernadette Phelan – passed unanimously).

Sylvia Caras has set up a listserv for the WSEC at <http://www.topica.com/lists/wcec/prefs/info.html>. Chuck will get the draft rules posted on the WSDSG web site and make space for our consumer representatives to publish information on the WICHE website.

State Reports (*2 Minute Updates from all States*)

Facilitator: Greg Brock, Alaska, Vice-Chair

Budget cuts for most states. A couple of states looking at integrating substance abuse with mental health (AK and ID). Utah has just integrated. Wyoming has just disintegrated (no that's not quite the way to say it – they separated mental health and substance abuse). DIG grants are proceeding well, some discussion of ways to make the match requirements.

Alaska is breaking ground for a new 72 bed state hospital.

Nevada passed out a 35 page document on mortality analysis done by Health.

Nevada is also in the process of replacing AIMS on their AS400.

New Mexico just completed a needs assessment: Behavioral Health Needs and Gaps in New Mexico, July 15, 2002 (Technical Assistance Collaborative, and the Human Services Research Institute). Cat passed out the table of contents. See the document at www.health.state.nm.us.

Wyoming has a web site for the Mental Health Planning Council and has started a needs assessment project.

Idaho is reorganizing toward more centralization and requiring prior authorization of services. They are integrating data with child protection and later substance abuse.

Arizona is automating the performance indicator reporting process started with the 16 State Pilot. It will be web-based.

North Dakota is moving from a mainframe to web based server, and having meetings around data linking MH, SA, Medicaid.

Hawaii is still working on a quality of care law case in the state hospital that has implications for community services. They are trying to define an "at risk" population for hospitalization.

California is looking at a 20% funding cut (on top of a cut already taken).

Providers are not being paid; hiring freeze. Jim Higgins and Holly have made career moves leaving 2 performance indicator staff vacant. Performance outcomes is changing from a longitudinal method to sampling. They are losing too many people in the longitudinal analysis.

Utah is updating MHSIP variables including diagnosis, employment and living situations, and identification of individuals with SED or SMI. Employment and mortality have increased visibility in the state.

Meeting was adjourned at 12:30 by Denny Geertsens, chair.