THE MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM:

BACKGROUND INFORMATION FOR MHSIP FOCUS GROUPS

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Introduction

This paper has been prepared to provide information for use in planning for the future of the Mental Health Statistics Improvement Program (MHSIP) or in planning for a MHSIP-like entity to replace MHSIP. The author of the paper introduced the MHSIP concept over 20 years ago to assist the state mental health agencies and the NIMH, provided NIMH staff support for MHSIP until 1989, and continues to provide consultant services, and institutional memory, to MHSIP through participation in activities of the MHSIP Advisory Group, regional user groups, and the National Conference on Mental Health Statistics. The views expressed in this paper are those of the author and do not necessarily reflect the views of the MHSIP Advisory Group or its members, the participants of the MHSIP regional user groups, or the Center for Mental Health Services. It has been prepared in brief format to ensure that it is read and, hopefully, used by participants of MHSIP focus groups and the MHSIP Advisory Group in the development of a vision for the future of mental health statistics, information systems, and decision support systems.

A Brief History of MHSIP

Historically, the purpose of the Mental Health Statistics Improvement Program (MHSIP) has been to upgrade decision support systems and statistical programs in local mental health service provider organizations, within state and federal government agencies, and among national mental health organizations so that these systems and programs are responsive to needs for data to administer and manage mental health services. An essential feature of the MHSIP has been the development of standards for data content and a common language to assure comparability of data across the entire mental health services delivery system. Other features of the MHSIP have included:

- advocating for adoption and implementation of data standards
- developing guidelines for the design of information and statistical systems
- enhancing the field through technical assistance and training
- developing a community of data users
- encouraging the use of statistical information in administrative, management, clinical, and research activities

The MHSIP has its origins in the Model Reporting Area (MRA) for Mental Hospital Statistics, which

was established by NIMH and 11 state mental health agencies in 1951. The MRA was formed to address the need for uniform definitions among state mental hospital statistical systems. By the mid-1960s, 34 states had met MRA statistical standards and had been admitted into the Model Reporting Area. However, with the expansion of outpatient and community-based mental health services in the late 1950s and early 1960s, the MRA was no longer sufficient for setting data standards for mental health services, because it continued to focus only on the state hospital systems. Consequently, in 1966 the MRA was essentially abandoned and the annual meetings of the MRA, supported by NIMH, were modified and expanded into a National Conference on Mental Health Statistics; and all states were invited to participate.

During the next few years, the use of standardized definitions for mental health statistics decreased and the participants in the meetings of the National Conference appealed for the restoration of a mechanism to develop and promote standardization. At the 1976 meeting of the National Conference, NIMH proposed a cooperative mental health statistics program in the form of the Mental Health Statistics Improvement Program. The participating state representatives endorsed the concept of a cooperative system and agreed in principle to a collaborative relationship among the States and NIMH.

In the collaborative relationship, the states agreed to work together with NIMH to develop standardized minimum data sets for mental health statistical systems and implement the data sets and data standards as statistical systems were developed or modified. NIMH agreed to continue to support:

- annual meetings of the National Conference on Mental Health Statistics
- meetings of necessary advisory groups and work groups
- technical assistance to states for implementation of MHSIP data standards

NIMH also agreed to revise ongoing national statistical surveys to become consistent with the accepted minimum data sets.

NIMH maintained an organizational unit devoted to technical assistance and training in statistical programs, information systems, and MHSIP activities. This unit was staffed with two professionals and support staff.

The first version of the minimum data sets was completed in 1979 (FN-8) and endorsed by the state representatives at the 1980 meeting of the National Conference on Mental Health Statistics. Initially, the focus of the MHSIP was to design and implement a system for recording information about mental health service provider organizations, with standardized data elements to facilitate reporting of statistical information to meet data needs at the various governmental levels--local, state, and federal.

A later version of the MHSIP data standards, published in 1989 (FN-10), represented a major shift in scope and perspective, and addressed the need for a broadly conceived system of information to support decision-making at the service provider level and throughout the public and private mental health services system, including local, state, and federal governments, providers of services, and national organizations. As a result, the revised MHSIP standards formed the minimum data elements for decision support systems for the mental health field, broadly defined.

Oversight and management of the MHSIP has been provided by an Ad Hoc Advisory Group, which includes representatives of the state mental health agencies, the National Association of State Mental Health Program Directors (NASMHPD), consumers, community-based mental health programs, and the Center for Mental Health Services (earlier NIMH). Specific developmental work for the MHSIP has

been accomplished through ad hoc work groups and task forces with membership representing public, private, and national perspectives and experience. Work of the Advisory Group has been guided by an ongoing planning process, and progress reports are provided to the states at annual meetings of the National Conference on Mental Health Statistics and periodic meetings of MHSIP regional groups. Financial and staff support for MHSIP activities and management was provided initially by the NIMH, and later the Center for Mental Health Services (CMHS).

Participation in the development of the MHSIP and in the implementation of national mental health data standards recommended by the MHSIP has been voluntary. During the early history, the NIMH sought to obtain federal funds to support enhancements of state mental health statistical programs through grants to state agencies. However, major funding for the program did not materialize until 1989 when Alcohol, Drug Abuse, and Mental Health Services Block Grant set-aside funds were allocated to the support of grants to states to enhance information systems and implement MHSIP recommended data standards. State mental health commissioners advocated for this use of set-aside funds by NIMH.

The accomplishments of the MHSIP have been many. Early in its history, the MHSIP Advisory Group provided leadership in areas of mental health statistics and information systems. The group developed projects that anticipated information needs in the field and contributed to the readiness of mental health provider organizations, states, and the federal government to meet their information needs. MHSIP also produced many critical products. Chief among these products are:

- The Design and Content of a Mental Health Statistics System, FN-8.
- Data Standards for Mental Health Decision Support Systems, FN-10.
- Enhancing MHSIP to Meet the Needs of Children
- Performance Indicators for Mental Health Services: Values, Accountability, Evaluation and Decision Support
- The MHSIP Consumer-Oriented Mental Health Report Card

Changes in MHSIP Over Time

The Mental Health Statistics Improvement Program and the role of the MHSIP Advisory Group have changed over their 23-year history. To fully understand these changes, it is essential to view MHSIP's history through five major perspectives: the MHSIP mission and purpose; the mental health services system and its data needs; resources to support MHSIP; leadership within MHSIP; and the power base which supports MHSIP contributions and activities.

The MHSIP Purpose and Mission

The mission of MHSIP-----to enhance mental health decision support systems----has not changed significantly over time; however, there have been changes in the operation of the program and in approaches to achieve the MHSIP mission. Uppermost among these changes has been the introduction of the consumer orientation into the program and the MHSIP Advisory Group. This change has infused the program with much greater insight into why enhanced decision making is important----to ensure that persons with mental illness receive the quality care and treatment they need. MHSIP played a leading role in the mental health field in the involvement of recipients of mental health services in state and federal mental health program activities.

Although the MHSIP Advisory Group has continued to focus on the technical aspects of decision support enhancement, such as data standards and performance measures, its approaches to the technical assistance and training mission of MHSIP have changed. Initially, technical assistance and training were integrated into the MHSIP program at NIMH as part of its statistics technical assistance program. With the reorganization of NIMH in 1989, the separate organizational focus of MHSIP was eliminated, and MHSIP was assigned to the Survey and Analysis Branch of CMHS without dedicated staff, and the MHSIP function was shared with the office of the Division director. Also, earlier in the 1980's the statistics technical assistance program at NIMH lost two major training resources, the Applied Statistics Training Institute (ASTI) of the National Center for Health Statistics and the NIMH Staff College.

Currently technical assistance, for the most part, is decentralized to regional MHSIP user groups and is associated with a variety of grants to states from the Block Grant set-aside funds. It is appropriate to ask if this approach actually provides an adequate infrastructure to sustain technical assistance and if it delivers technical assistance of the quality and intensity needed in MHSIP. It is also appropriate to ask if the grants reinforced the importance of data standardization that is fundamental to MHSIP. For the most part, the state grantees have not been held accountable for their commitments under the MHSIP grants, and there have been no attempts to assess the level to which MHSIP recommended data standards have been implemented as a result of the grants.

The Mental Health Services System

When MHSIP was initiated in 1976, systems of mental health services consisted primarily of state mental hospitals, community mental health centers, private psychiatric hospitals, and mental health services in general hospitals. At that time, the multi-service community programs and the linkages between community programs and state hospitals posed major new problems in the collection and reporting of mental health statistical information. The development of recommended data standards and information systems designs in the MHSIP report, Data Standards for Mental Health Decision Support Systems, was an innovative effort to address these problems, and the state mental health agencies quickly endorsed these recommendations and, through MHSIP grants, made efforts to implement the MHSIP recommendations.

Beginning in the 1990s, the environment in which MHSIP functions has become far more complex. The financing and delivery of mental health services have changed dramatically. What seemed like daunting problems in data collection and reporting through the 1980s now seem minor by comparison. The emergence of managed care organizations, the development of many small and specialized community service providers, the blending of mental health and physical health services, demands for accountability and performance monitoring, and the need to integrate clinical data, management data, and billing information, as well as other forces, all place new demands on statistical programs and information systems.

Resources to Support MHSIP

Resources to support MHSIP have always been limited. Initially, NIMH operating funds were used to financially support the meetings and work of the MHSIP Advisory Group and its task forces and work groups. Funds were also made available to support a program of technical assistance and training to state and local mental health agencies in areas of data standards and information systems technology. Although federal funds to support MHSIP were limited, these funds were significantly augmented by contributions from state mental health agencies and community programs through the time and effort their staff made available to participate in meetings and work on MHSIP projects. MHSIP, from the start, was a collaborative effort among the states and NIMH.

Currently, MHSIP is funded from Block Grant set-aside funds and must compete for funds with other

programs within the Center for Mental Health Services and SAMHSA. While it can be argued that funding of grants to states has been quite good, funding to support long range MHSIP Advisory Group planning and MHSIP program development has been poor.

Also, because of the increased demands on the staff of state and local mental health agencies, very little state staff time can be allocated to MHSIP projects and activities, further limiting expertise resources for MHSIP development and projects.

MHSIP Leadership

Early in its history, MHSIP leadership came primarily from the staff of NIMH, working with the MHSIP Advisory Group. However, to ensure a sense of equal partnership between the states and NIMH, the NIMH staff worked to shift leadership to the state members of the advisory group. This shift in leadership was not easy, but was accomplished over time. State MHSIP leaders met frequently with NIMH leadership about statistical systems needs and directions. The MHSIP Advisory Group's disengagement from the MHSIP grants program, for whatever reasons, has somewhat isolated the group from important developments and has brought into question its leadership role.

More recently, it is not clear where MHSIP leadership rests. Advisory Group activities are guided to a large extent by CMHS funding priorities.

The MHSIP Power Base

In its beginning, the MHSIP power base emanated from the National Institute of Mental Health and the state mental health agencies; and MHSIP focused almost exclusively on the data needs and information systems capabilities of these two levels of government. At both levels, there was a need to collect and report data about state mental hospitals and community-based services, including outpatient clinics and comprehensive community mental health centers (CMHCs).

NIMH needed data to document changes occurring in the delivery of mental health services through the comprehensive community mental health centers construction and staffing grants; however, in the early years of the centers program, NIMH did not require or fund information systems capabilities within the centers or within state mental health agencies. For the most part, data simply were not available, and the MHSIP movement was seen by NIMH as a mechanism to stimulate and develop information capabilities that would support its collection of comparable national data through the Inventory of Mental Health Organizations and special surveys.

Most state mental health agencies, on the other hand, had long histories of collecting data on mental health services, starting with the state mental hospitals. They recognized the importance of comparable data across states, supported the Model Reporting Area for Mental Hospital Statistics, felt a loss of comparability of data when the MRA was discontinued, and felt the need for a mechanism to develop national standards for data content and definitions. The states, therefore, welcomed a collaborative effort among the states and NIMH, such as the MHSIP, to meet these needs.

The MHSIP Advisory Group was formed to provide leadership to the MHSIP; however, in its earlier years, the Group also provided expert advice to the NIMH on issues relating to its National Reporting Program and data collection from funded community mental health centers. The advisory group also assisted the state mental health commissioners in their planning for the development of the NASMHPD research program.

Now, in the late 1990s, the MHSIP power base in not at all clear. CMHS leadership appears to

demonstrate little interest in MHSIP, except possibly for MHSIP products it might claim as it own, such as the MHSIP Consumer-Oriented Report Card. MHSIP seems supported by CMHS and SAMHSA in order to justify its use of Block Grant set-aside funds. The MHSIP Advisory Group is now rarely consulted for advice on CMHS programs.

Perhaps the MHSIP community can be faulted for not fully demonstrating to CMHS and SAMHSA the contributions MHSIP and MHSIP grants have made in enhancing information systems capacities within the states and expanding data resources to meet federal, as well as state, needs for comparable and timely mental health statistical data. Even with its major investment in the MHSIP grants program, CMHS has never created an opportunity or demand to showcase MHSIP accomplishments. Perhaps the MHSIP grants have not been very product-oriented, and as a result have not produced the expected results of nationally comparable statistical information.

Because of the limited funding and staffing to maintain its leadership role, the MHSIP Advisory Group has been unable to keep pace with changes occurring in the financing and delivery of mental health services. Data standards have not been revised and updated in 10 years and the MHSIP Report Card has not been revised and enhanced based on experience gained from its implementation. While the MHSIP recommendations are still highly valued by the states, new demands for data have resulted in the state mental health agencies, through the National Association of State Mental Health Program Directors (NASMHPD), proceeding with the development of performance monitoring systems and new data standards and definitions that go beyond the MHSIP recommendations.

Initially, MHSIP was the only "kid on the block" concerned with mental health data standards. Now scores of agencies are developing and recommending standards for data collection and performance monitoring. Many of these agencies do not have a primary concern for, or knowledge of, the unique data requirements of mental health patients or services; and rarely do they appreciate or acknowledge the long history of work on data standards in the mental health field. Efforts on the part of the MHSIP Advisory Group to expand its presence into, and involvement with, many of these agencies have been relatively unsuccessful.

The MHSIP power base has eroded.

The Future of MHSIP

The Mental Health Statistics Improvement Program has survived over 20 years, and during those years has made major contributions to the mental health field. The long-term survival of MHSIP, as a federal/state health statistics collaboration, is unprecedented. While there have been efforts to undermine this collaboration, commitments to MHSIP, especially from the states, have ensured its survival.

A critic once asked "What is MHSIP?", and the gut response, without really thinking, was "It's like a religion. There are those of us who believe that quality data and information, based on accepted and implemented data standards, are critical to the success of decision making to meet the service needs of persons with mental illness; and the best approach to developing and fostering data standards is through collaboration, rather than through mandate."

The future of MHSIP will depend upon our ability to continue to anticipate the data needs and information required to make sound decisions that ensure quality services are available to all persons with mental illness. Equally important, in planning for the future of MHSIP, is the need to address the factors that have contributed to MHSIP's past success. The challenge is to focus equally on both of these critical areas in planning for the future of the Mental Health Statistics Improvement Program.