THE CHANGING CONTEXT OF MENTAL HEALTH STATISTICS AND INFORMATICS

The purpose of this short paper is to outline several mega trends that will influence the future contours of the mental health statistics and informatics fields. The intent is to provide a framework for discussion at the upcoming Mental health Statistics Improvement Program (MHSIP) retreat later in 1999. Topics are presented in synoptical form in order to provide a quick overview. The views expressed are those of the author, based upon a broad range of discussions with representatives of the mental health, substance abuse, and primary care fields.

The role of both Federal and State Government is receding; this trend will continue. The failure of the Clinton health care reform effort, the Congressional elections of 1994, and the general movement away from government intervention have all fostered efforts toward reinvention, downsizing, and consolidation of public programs at the federal and State levels. The charge is to do more with less, to network among like programs in different fields, to consolidate "stove pipes" whenever possible, and to diffuse operational and financial responsibility to other entities. The Federal Government is doing this with States; States are now moving risk to counties, not for profit entities, and managed care firms. What are the implications for the MHSIP? For the past quarter century, the MHSIP has been operated as a Federal-State partnership, with input from other groups, i.e., private hospitals, consumers, etc. If one were to make the assumption that the Federal and State roles will end in the future, how will the MHSIP be operated?

The role of mental health is receding in favor of behavioral healthcare and, now, primary health care; this trend will continue. The rapid expansion of managed care, the growing concern with duplication of function and related costs, the recognition of the stigma associated with mental health care, and the recent impetus given to primary care as opposed to specialties have all led to efforts to combine (or subsume) the mental health field a more generic field of behavioral healthcare and, recently, into primary care. A major concern in the mental health field is how these consolidations will be accomplished, i.e., will mental health providers be incorporated in an orderly fashion; will their functions simply be taken over by primary care; will the field disappear entirely? In this changed environment, a real question must b raised about the viability of the MHSIP qua MHSIP. Should the MHSIP be developing a joint effort with substance abuse and primary care? Would such an effort further erode the position of the mental health field? Will the MHSIP disappear entirely? What would be an effective response?

The role of statistics and informatics has changed dramatically; this trend will continue. Since the founding of the MHSIP effort in 1976, and continuing as recently as the early 1990s, the underlying MHSIP concept was that improved data would lead to improved services and improved consumer quality of life. Data were viewed as a social good; governmental entities recognized this and provided support (even if modest) for data efforts. Since the early 1990s, data have come to be viewed as a commodity with particular financial value since data can be used to predict and reduce service resource consumption; data can be sold as any other commodity; data transfers can be accelerated due to improved informatics to speed service reimbursement. Money rather than the concepts of social good or improved quality is a driving force. For similar reasons, a strong focus has developed on outcome data (a desire for brief services at low cost) and population data (a desire for early interventions to reduce later costs). How should the MHSIP respond to these developments? Should cost and outcome data drive the entire enterprise? What about the human rights concerns that are being jeopardized?

The input received from constituents has multiplied during the past decade, yet many groups still feel left out, while others don't even yet know of the mental health statistical enterprise; the trend toward diversification will continue. Over the pat decade, considerable effort has been expended to incorporate the consumer point of view into the MHSIP. These efforts have had a good degree of success. However, consumer activities have moved into a second generation in which representation is being replaced by equal participation. Similarly, efforts are underway to bring the family, child, minority, and disability points of view to the table. Beyond these groups, there is also need to reach out to the private for profit sector, to providers, and to the managed care industry, among others. How can MHSIP continue to incorporate broad-based diversity without fragmentation? Will consumers go their won way with the new consumer informatics? Can the private sector actually be brought to the table, or will parallel activities continue?

Internet technology is revolutionizing the statistical field, and a new informatics endeavor has arisen, spurred by the private sector; these trends will continue. Over the past decade, MHSIP has focused almost exclusively on data standards to the relative exclusion of technology and informatics. This strategy was probably appropriate during that period. However, new technology and informatics will soon be driving decisions about the nature and focus of data standards. Should MHSIP engage the question of new technology, new software, and new approaches to data standards? How can this be done effectively? How can MHSIP keep abreast of the rapid developments taking place?

Concluding Observation: As should be clear by this point, the context in which MHSIP will operate in the future will be dramatically different than that in which the current MHSIP came of age. Because these differences are so dramatic, it also seems clear that the MHSIP will need to make a dramatic response in order to adapt to this new world.

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