



RE-INVENTING THE MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM

Prepared by Steven Davis, Ph.D., April 1999

Introduction.

It is critical that MHSIP move to capitalize on the progress made in the past 15 years by securing resource support. An infrastructure needs to be created that is capable of carrying out the many functions currently performed and those that will be added as demand for information expands. In the absence of such a structure, it will be difficult for MHSIP to expand in the needed direction, or even maintain its current gains. It will be especially difficult, because, even at the present, there are insufficient staff dedicated to MHSIP-related activities and because most of the current financial support (i.e., the MHSIP implementation grants) is time limited.

While this sounds like an accurate assessment of the current status of MHSIP, it is a statement taken from another MHSIP document written eight years ago (MHSIP Ad Hoc Advisory Group, 1991).

It seems that infrastructure development is an ongoing concern for the MHSIP Policy Group. The issue was raised again at a meeting of the group held in February, 1999, in Alexandria, Virginia. Following is a brief review of some of the background, discussion and output of that meeting. References in this review are currently available, or will soon be made available, in the MHSIP website "library" at www.mhsip.org.

MHSIP Mission. The mission of MHSIP is "to foster and enhance the quality and scope of information for decisions that will improve the quality of life and recovery of people with mental illness" (MHSIP Ad Hoc Advisory Group, 1994). An underlying assumption of the mission statement is that users will apply comparable data, i.e., data based on standard definitions, to make better decisions. Two elements of the "MHSIP approach" or philosophy that have been behind the implementation of the mission from the outset of the MHSIP enterprise are the emphasis on collaboration and voluntary participation. A third element that has evolved is an emphasis on inclusivity of perspectives. The MHSIP vision, then, is one of all mental health stakeholders working together to develop data standards and information systems that will be used to improve the service system and, thus, the lives of those in need of mental health treatment.

MHSIP History. The Mental Health Statistics Improvement Program began in the late 1970s as a collaborative data standards development effort between the federal government and state mental health agencies. Over the years, local treatment providers, consumers, their families, and representatives of related interests were added to the "MHSIP community." Members of this community, with federal financial support, have helped produce a long line of documents that have contributed significantly to the MHSIP mission. Those reports and related MHSIP activities are described in "The Mental Health Statistics Improvement Program: Background Information for MHSIP Focus Groups," prepared by Cecil Wurster, consultant to the MHSIP Policy Group and the person who started the MHSIP endeavor while at NIMH. In his review, he notes the most significant change in MHSIP has been "the introduction of the consumer orientation into the program and the MHSIP Advisory Group" (see the discussion of this change and other environmental influences below). In the past few years, another change in the group has been to remove the term "advisory" from its title because of the federal

requirements for designating advisory groups; MHSIP Policy Group was selected as the new group name.

MHSIP Model. *Data Standards for Mental Health Decision Support Systems (FN-10)* has been a standard reference for the MHSIP community since its publication (Leginski, *et al.*, 1989). The model for developing and implementing standards described in FN-10 was of "An ad hoc advisory group [that] shapes the policy and direction of the MHSIP and selects the projects and operations to be carried out" (p.8). From the outset, task forces and work groups were convened and charged with reconsidering existing standards and recommending proposed changes in light of environmental changes. Results of task force efforts have been shared with attendees of the annual National Mental Health Statistics Conference, and more recently with state representatives at MHSIP Regional User Group meetings, to receive feedback on proposed changes. CMHS (and previously, NIMH) provided resources for MHSIP Group and task force members to travel, hold meetings and publish results. Task force members have been federal, state and local agency staff, consumers, academicians and others who have contributed their time and efforts to MHSIP projects. This process has worked effectively in the past. However, down-sized state and federal government, change in government funding priorities and other factors have reduced resources and staff time that have made this model successful.

Environmental Changes. At the September, 1998, MHSIP Policy Group meeting, a discussion of future projects led members to conclude the need to re-state the MHSIP mission, goals and objectives. Holding a retreat with a variety of contributors was proposed as the means for achieving that purpose. However, in phone conversations among planning group members, more preliminary activities were deemed necessary. Ron Manderscheid, CMHS, agreed to write a brief paper describing the current context of mental health data. "The Changing Context of Mental Health Statistics and Informatics" identified five areas of dramatic change: (1) the receding role of state and federal government, (2) the integration of mental health care with other disciplines, (3) the view of data as a commodity with financial value, (4) the expanded participation and diversification of constituents, and (5) the increased use of Internet and other technological advances. Responses to the environmental description were solicited from representatives of consumers, state and federal government, private industry, and technology specialists.

Options. In the February, 1999, MHSIP Policy Group meeting, the environmental statement and responses were discussed, along with Dr. Manderscheid's proposal to adopt a public health approach to managed care, the current status of MHSIP Policy Group membership (the significant turnover in the past year), and the status of MHSIP projects. The picture painted by this review was a somewhat gloomy one. Although the MHSIP Consumer-Oriented Mental Health Report Card provided the basis for work on the Five-State Performance Indicator Study and is being used by grantees of the CMHS State Indicator Pilot grants, MHSIP did not have a direct role in designing these projects. The HSRI-directed Report Card Toolkit and the Abt Associates contract with CMHS to develop a model of clinical and system data standards are other examples of projects that involve MHSIP group members, but for which the MHSIP Policy Group did not have the role of shaping policy and direction described in FN-10.

Members agreed the changing environment had led to an eroded power base for MHSIP, and the old MHSIP model for accomplishing objectives was no longer effective. Alternatives for the future of MHSIP were enumerated:

- * Leaving the organization, its relationships and support as they have been did not seem a viable option, given the negatives already discussed.
- * Conceding that the time for MHSIP had passed and that it no longer held value in the current environment was raised as a possibility. Although there was agreement that MHSIP

would not be effective without significant changes, the ongoing need for data standards development of the sort MHSIP has provided was recognized.

* A membership group was also mentioned as a direction to choose. The MHSIP Association was created a few years ago in response to anticipated reductions in federal grant funding. However, the entrepreneurial interest or other guidance needed to extend this effort beyond its infant stages has not been forthcoming.

* A congress-type organization, in which members come together once or twice a year to discuss and vote on issues was also proposed.

* Creation of a technical or coordinating center that would have a core group of advisors that represented MHSIP values was the fifth option considered. A "Mental Health Informatics Coordinating Center" would have the advantages of an ongoing infrastructure to support activities as do organizations like NASMHPD, HSRI and Abt. Paying participants for their contributions, as has been the model used in some recent CMHS contracts, would insure more commitment of resources to projects than is possible for MHSIP members who have contributed their spare time to MHSIP projects.

Three of the options would require the financial and staff support of CMHS to succeed.

Plans. It was agreed that diverse input was needed to make the plans for a "re-invented MHSIP" both workable and applicable in the current environment. The decision was made to hold two focus group meetings, the first in early May and the second at the time of the National Conference to solicit ideas and recommendations. Both groups will be asked to recommend a structure (one of the options describe above or another) and content (define scope and enumerate specific activities) for MHSIP in the future. Prospective invitees were identified with the intent that one group has more members with broader system and organizational interests, while the other includes more people with interests in technology applications. A facilitator is to be arranged for both meetings.

The proposed format for the meetings includes the following:

- * Introductions
- * Review of background papers and MHSIP mission
- * Consideration of organizational options (including structure, constituents, participants, funding and other issues group members may propose),
- * Consideration of project/content options (including Stage 2 Report Card Healthy People 2010, Surgeon General's report, developing a public health model for managed care, Abt system/clinical guidelines model development, 16-state indicator pilot grants extension and expansion, recovery definition and measure, integration of mental health and other disciplines, application of technology to mental health, or group members' alternatives)
- * Development of recommendations for structure and content options.

Output from the two focus groups will be summarized and presented at the MHSIP plenary session of the National Mental Health Statistics Conference in June. Feedback will be solicited from attendees as has been the past practice. The recommendations from the focus groups and the national conference

feedback will then be considered by the MHSIP Policy Group at their summer meeting. The Group will develop a "white paper" describing the "new vehicle" to carry forward MHSIP projects and present the report to CMHS.

References

Leginski, WA, Croze, C, Driggers, J, Dumpman, S, Geertsen, D, Kamis-Gould, E, Namerow, MJ, Patton, R, Wilson, NZ, and Wurster, CR. Series FN No. 10, *Data Standards for Mental Health Decision Support Systems*. National Institute of Mental Health, DHHS Pub. No. (ADM) 89-1589. Washington, DC: Supt of Documents, US Govt Printing Office, 1989.

Manderscheid, RW. "The Changing Context of Mental Health Statistics and Informatics." Paper prepared for the MHSIP Policy Group, January 1999.

MHSIP Ad Hoc Advisory Group. *MHSIP in the Year 2000 and Beyond*. Mental Health Statistics Improvement Program, October 4, 1991.

MHSIP Ad Hoc Advisory Group. *Mental Health Statistics Improvement Program--Current Status and Directions for the Future, 1994*. Mental Health Statistics Improvement Program, May 1994.

Wurster, CW. "The Mental Health Statistics Improvement Program: Background Information for MHSIP Focus Groups." Paper prepared for the MHSIP Policy Group, April 1999.