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## IN THIS ISSUE

Message from the Deputy Commissioner for Behavioral and Community Health Services ..... 2

Question from the Assistant Commissioner for Mental Health and Substance Abuse Services: "What have you done for clients today using data?"  
Answer: Cheryl Purnell (Contract Manager, Substance Abuse Contracts Management) ... 4

Hospital Data Highlights  
DSHS State Hospitals Section Implements Forensic Plan ..... 1

Community Mental Health Data Highlights  
Assessment Driving Treatment with DSHS Resiliency and Disease Management ..... 2

Substance Abuse Data Highlights  
DSHS Substance Abuse Treatment Helps Reduce Days Sick Due to Health Problems ..... 3

What the Research Literature Teaches Us:  
Lifetime Risk of Suicide in People with Schizophrenia Lower than Commonly Reported ..... 4  
Alcohol and Risk for Injury ..... 5

Upcoming Events ..... 5

Clinical Management for Behavioral Health Services (CMBHS) Project Update ..... 6

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# Behavioral Health NEWS BRIEF

Informing policy and practice in mental health and substance abuse services through data

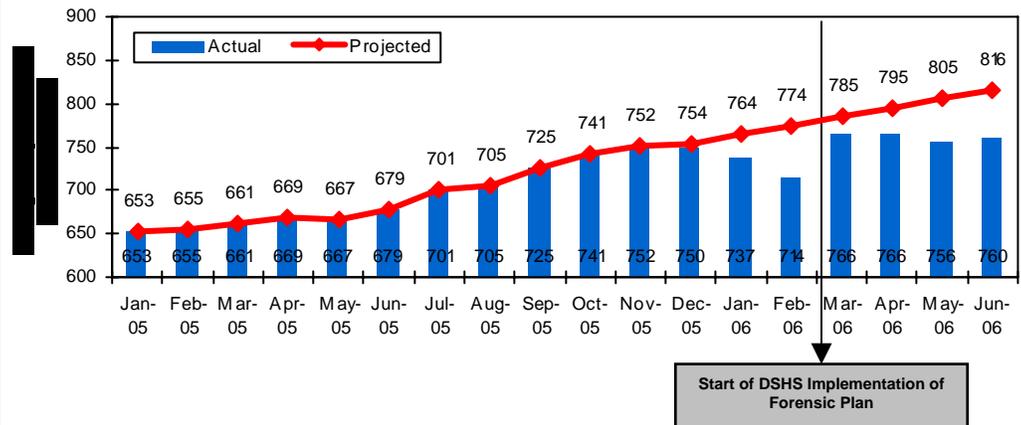
Volume 1 ■ Issue 4 ■ August 21, 2006

## HOSPITAL DATA HIGHLIGHTS

### DSHS State Hospitals Section Implements Forensic Plan

Until recently, more and more patients were being admitted to Texas State Mental Health Hospitals (SMHHs) through criminal courts. This SMHH forensic population increased from 16% in 2001 to 27% in 2005. Since space is limited, the growing number of forensic patients meant that fewer patients could be admitted through the civil commitment process. Indeed, the SMHH civil population decreased from 84% in 2001 to 73% in 2005. Concerned about the shortage of SMHH beds, the Texas Legislature authorized the DSHS State Hospitals Section to implement a *Forensic Plan*. The Plan required the addition of 96 beds for patients admitted through criminal courts, and the addition of 103 beds for patients admitted through the civil commitment process, all beginning in March of 2006. As a result, the SMHH system now has 738 forensic beds and 1,739 civil beds. To ensure a cap of 738 forensic beds, no new forensic patients were admitted during January and February of 2006. But what effect has this Plan had on the SMHH forensic population since DSHS began implementation in March of 2006? To answer this question, Bill Manlove (State Hospital Management Data Services) examined the *actual* average daily number of forensic patients from January of 2005 through June of 2006 vs. the number *projected* during this same period had DSHS not implemented the Forensic Plan. As *Figure 1* shows, the number of forensic patients in Texas SMHHs would have continued to increase considerably had DSHS not implemented the Forensic Plan in March of 2006, suggesting that this intervention holds promise for success.

Figure 1. Number of forensic patients in Texas State Mental Health Hospitals (SMHHs) would have continued to increase considerably had DSHS not implemented the *Forensic Plan* in March of 2006.



Source: DSHS Client Assignment and Registration (CARE) system, 08/17/06.

As part of the Forensic Plan, a standardized curriculum was also implemented for the treatment of forensic patients to assure uniform, quality treatment across the SMHH system in Texas. Moreover, the committee responsible for the Plan continues to explore additional methods for managing this growing population.



## MESSAGE FROM THE DEPUTY COMMISSIONER FOR BEHAVIORAL AND COMMUNITY HEALTH SERVICES

Dave Wanser, PhD

In his bestselling book, *Good to Great*, Jim Collins (2001) explains that one of the ways good organizations become great is by using technology as an accelerator of momentum. The Clinical Management for Behavioral Health Services (CMBHS) project is just that — a technology accelerator. It is critical that we use technology to accelerate the transformation of the behavioral health delivery system in Texas. The goal of CMBHS is to integrate existing Information Technology (IT) systems to better manage client information and billing/claims for community mental health and substance abuse services. By doing so, we will improve access, care, coordination, and be responsive to the needs of Texans with behavioral health problems. As we work together to build this new IT system, please accept my sincere appreciation for all the time and effort that DSHS staff and other stakeholders are devoting to this important project. Your knowledge and ideas will serve as the foundation for what will surely be a great IT system.

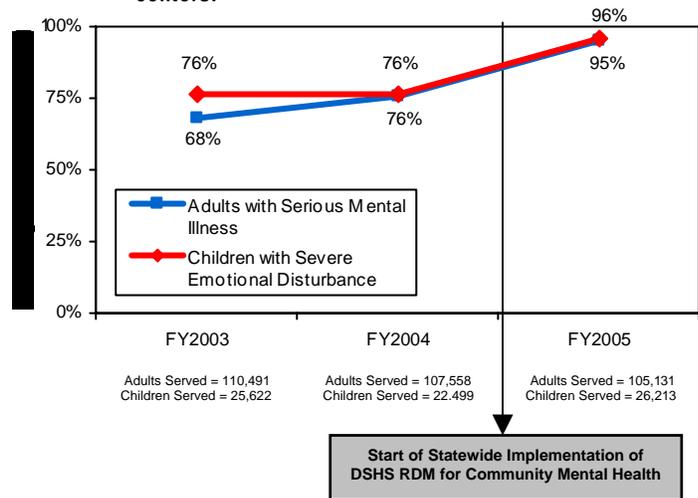
Collins, J. (2001). *Good to great: Why some companies make the leap...and others don't*. New York, NY: Harper Collins.

## COMMUNITY MENTAL HEALTH DATA HIGHLIGHTS

### Assessment Driving Treatment with DSHS Resiliency and Disease Management

In a system constrained by limited resources, such as the community mental health system in Texas, it is critical to distribute services according to clinical need. However, the Texas community mental health system has been fraught with examples of apparent inequities in care. There has been great variability in the types and amounts of community mental health services provided to adults with serious mental illness and children with severe emotional disturbance that could not be explained by differences in specific needs for care. Indeed, the DSHS Resiliency and Disease Management (RDM) initiative for community mental health in Texas requires that clients be assessed before being served, so that services are distributed according to clinical need. But are more served clients being assessed since RDM was implemented statewide in Fiscal Year 2005? A data analysis conducted by Mark Mason (Mental Health and Substance Abuse Data Analysis and Information) and Karen Ruggiero, Ph.D., (Community Mental Health Program Services) seems to indicate that this is the case. As *Figure 2* shows, the percentage of served adults with serious mental illness who were assessed has increased substantially from Fiscal Years 2003 and 2004 to Fiscal Year 2005, when RDM was implemented statewide at DSHS-funded community mental health centers. The same is true among children with severe emotional disturbance who were served at DSHS-funded community mental health centers, with a greater percentage being assessed in Fiscal Year 2005, when RDM was implemented throughout Texas, compared to Fiscal Years 2003 and 2004. It does seem, then, that assessment is driving treatment with RDM.

Figure 2. Percentage of served clients who were assessed increased substantially from Fiscal Years 2003 and 2004 to Fiscal Year 2005, when Resiliency and Disease Management (RDM) was implemented statewide at DSHS-funded community mental health centers.



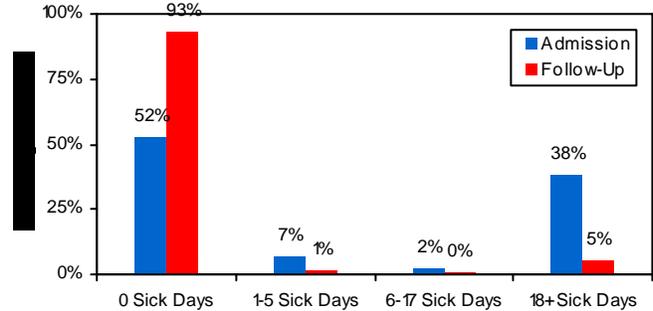
Sources: DSHS Client Assignment and Registration (CARE) system, 02/27/06; DSHS Mental Retardation and Behavioral Health Outpatient Warehouse (MBO), Business Objects *PM UM Completion Rate for FY2005*, 07/13/06.

## SUBSTANCE ABUSE DATA HIGHLIGHTS

## DSHS Substance Abuse Treatment Helps Reduce Days Sick Due to Health Problems

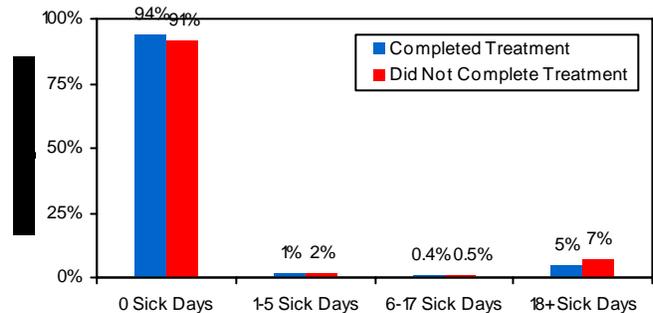
It is well known that the consumption of alcohol and/or drugs is related to health problems. For example, individuals may suffer from memory lapses, blackouts, tremors, and other withdrawal symptoms. Indeed, the nature of these health problems has been linked to the type of substance consumed. Whereas alcohol might become an intestinal irritant, substances that are smoked may induce respiratory problems. Indeed, of the 22,244 clients admitted for DSHS-funded substance abuse treatment in Texas during September of 2004 through July of 2006 who were unemployed, 52% reported not working due to health problems related to their substance use. And health problems like these are bound to increase the number of days that individuals feel sick. For this reason, at DSHS-funded substance abuse clinics in Texas, clients are assessed at admission and after treatment for the number of days that they have felt sick because of health problems related to their substance use. But does DSHS substance abuse treatment help to reduce days sick due to health problems? To answer this question, Martin Arocena, Ph.D. (Mental Health and Substance Abuse Data Analysis and Information), examined the percentage of clients at DSHS-funded substance abuse treatment clinics who reported experiencing sick days because of drug-related health problems during the past 30 days at admission and at a 60-day post-treatment follow-up. *Figure 3* shows that 52% at admission vs. 93% at follow-up reported 0 sick days due to drug-related health problems. Furthermore, 7% at admission vs. 1% at follow-up reported 1-5 sick days. Similarly, 2% vs. 0% reported 6-17 sick days. And 38% at admission vs. 5% at follow-up reported 18 or more sick days due to drug-related health problems. In all, whereas 47% of the 15,019 clients who received DSHS-funded substance abuse treatment during September of 2004 through July of 2006 reported 1 or more days of feeling sick due to drug-related health problems at admission, only 9% reported days sick at the 60-day post-treatment follow-up. In fact, *Figure 4* shows that the likelihood of experiencing sick days due to drug-related health problems was reduced among individuals who completed DSHS-funded substance abuse treatment compared to those who did not. Since the relationship between alcohol and drugs and ill health is so well established, it was expected that many clients admitted for substance abuse treatment at DSHS-funded clinics in Texas would report physical health problems. However, substance abuse treatment is not a medical intervention, per se. Therefore, the finding that DSHS substance abuse treatment helps to reduce days sick due to health problems is especially noteworthy.

**Figure 3.** Percentage of clients at DSHS-funded substance abuse clinics between September of 2004 through July of 2006 who reported days sick due to drug-related health problems significantly lower at 60-day post-treatment follow-up than at admission.



Source: DSHS Behavioral Health Integrated Provider System (BHIPS), 08/18/06.

**Figure 4.** Likelihood of experiencing days sick due to drug-related health problems reduced among individuals who completed DSHS-funded substance abuse treatment between September of 2004 through July of 2006 compared to those who did not.



Source: DSHS Behavioral Health Integrated Provider System (BHIPS), 08/18/06.

**QUESTION FROM THE ASSISTANT COMMISSIONER FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES: “What have you done for clients today using data?”  
(Joe Vesowate)**

**ANSWER: Cheryl Purnell (Contract Manager, Substance Abuse Contracts Management)**

I use data in many aspects of my job as a contract manager. I review data reports to ensure that substance abuse contractors are meeting key performance goals and expenditures in treatment, prevention, and intervention programs, and that they are submitting program and financial information in a timely manner. I also use data from the Texas Education Agency and the Substance Abuse and Mental Health Services Administration’s model programs when reviewing school requests submitted by contractors. I participate in contract oversight meetings that may be initiated because of data acquired during a site visit. I also make funding recommendations based on historical and current data to ensure that substance abuse services for adults, youth, and women are provided according to need.

## **WHAT THE RESEARCH LITERATURE TEACHES US**

### **Lifetime Risk of Suicide in People with Schizophrenia Lower than Commonly Reported**

For several decades, the literature has quoted lifetime risk of suicide among people with Schizophrenia as 10 to 15%. The most frequently cited review is that of Miles (1977) who examined mortality reports published between 1931 and 1975, and estimated lifetime risk to be 10%. This figure was substantially challenged by Inskip, Harris, and Barraclough (1998), who analyzed 29 studies and estimated lifetime risk of suicide to be substantially lower at 4%. The systematic review by Brian Palmer, M.D., M.P.H., and his colleagues published in the March 2005 issue of *General Archives of Psychiatry*, provides the most accurate estimate to date of lifetime risk of suicide in individuals with Schizophrenia. Studies were included if they involved people diagnosed with Schizophrenia, had a follow-up of at least two years, and did not lose more than 10% of participants at follow-up. Studies limited to a particular age group or among people diagnosed with Schizoaffective disorder (in whom risk of suicide is thought to be particularly high) were excluded. Moreover, studies enrolling people at the onset of Schizophrenia or first admission for Schizophrenia were analyzed separately, since they cover the initial period of illness when risk of suicide is highest, thereby providing a more accurate estimate of lifetime risk of suicide. Case fatality rates (i.e., the proportion of the cohort — alive and dead — that committed suicide) and proportionate mortality rates (i.e., the proportion of deaths in the cohort that were due to suicide) were determined for each study. The authors then computed the point where the case fatality rate and proportionate mortality rate were equal — a theoretical point when all participants have died that provided an estimate of lifetime risk of suicide. Using this methodology, Palmer et al. found that lifetime risk of suicide in those observed from first admission or illness onset was 5.6%, whereas those at various illness points showed a rate of 1.8%. In general, the researchers estimate that 4.9% of people with Schizophrenia will commit suicide during their lifetimes, usually near illness onset. The estimate of lifetime risk of suicide in people with Schizophrenia is therefore lower than was formerly thought, with the greatest risk in the first few years of illness. This information, together with knowledge of risk factors for suicide in individuals with Schizophrenia (i.e., previous depression, previous suicide attempts, drug misuse, agitation, fear of mental disintegration, poor adherence to treatment, and recent loss; see Hawton, Sutton, Haw, et al., 2005), should help DSHS mental health services focus on those at highest risk. Targeting affective symptoms, substance misuse, and compliance, particularly in the first few years of the illness, would appear to be important in suicide prevention.

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Palmer, B.A., Pankratz, V.S., & Bostwick, J.M. (2005). The lifetime risk of suicide in Schizophrenia: A reexamination. *Archives of General Psychiatry*, 62(3), 247-253.

## Alcohol and Risk of Injury

Numerous articles have documented the association between alcohol consumption and the risk of injury. (See DSHS Behavioral Health News Brief, Volume 1, Issue 3, June 19, 2006, *DSHS Substance Abuse Treatment Helps Reduce Emergency Room Costs*.) To examine whether specific patterns of alcohol consumption affect this risk, Gerhard Gmel, Ph.D., and his colleagues assessed 8,736 patients admitted to a hospital Emergency Room (ER) in Switzerland, with 5,077 having an injury. Measures included usual volume of drinking, past-month heavy episodic drinking (i.e., more than 4 drinks for men and more than 3 drinks for women, on at least on occasion), and recent drinking (i.e., in the 24 hours before the ER visit). The study, published in the March 2006 issue of *Alcoholism Clinical and Experimental Research*, indicated that heavy episodic drinking and recent drinking increased the risk of injury. And as the volume of usual and recent drinking increased, the risk of injury increased. Risk of injury was highest in patients who usually drank moderately (i.e., less than 14 drinks per week for men, and less than 7 drinks per week for women), and reported both past-month and recent heavy episodic drinking. Past-month heavy episodic drinking was associated with a higher risk in patients who usually drank moderately than in patients who usually drank heavily. Also, almost half of the alcohol-related injuries among women were suffered by those who usually drank moderately, did not have past-month heavy episodic drinking, and drank between 1 and 3 drinks in the 24 hours before their ER visit. This study indicates that patterns of drinking, particularly heavy episodic drinking, influence the risk of injury. Therefore, interventions and treatment to reduce alcohol-related injury in Texas and elsewhere should focus on preventing episodic drinking among both moderate and heavy drinkers.

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Gmel, G., Bissery, A., Gammeter, R., et al. (2006). Alcohol-attributable injuries in admissions to a Swiss emergency room: An analysis of the link between volume of drinking, drinking patterns, and preattendance drinking. *Alcoholism Clinical and Experimental Research*, 30(3), 501-509.

### UPCOMING EVENTS

August 22, 2006 (1:30-4:30pm)

*Mental Health Transformation Workgroup*

DSHS, Robert E. Moreton Building, M-739, 1100 West 49<sup>th</sup> Street, Austin, Texas

For more information, visit <http://www.dshs.state.tx.us/mhtransformation/>

August 31, 2006 (9:30am-1:30pm)

*DSHS Joint Budget Hearing with Governor's Office of Budget, Planning, and Policy and Legislative Budget Board*

John H. Reagan Building, Room 140, 105 West 15<sup>th</sup> Street, Austin, Texas

For live stream broadcast, stay tuned to <http://www.house.state.tx.us/media/welcome.php>

September 7-8, 2006

*Texas Council of Community Mental Health and Mental Retardation Centers, Inc.*

*Behavioral Health Consortium Meeting*

Park Plaza Hotel, 6000 Middle Fiskville Road, Austin, Texas

For more information, visit <http://www.txcouncil.com/behavioral/calendar.html>

September 7-8, 2006

*Texas Council of Community Mental Health and Mental Retardation Centers, Inc.*

*Quality Management Consortium Meeting*

Embassy Suites Hotel, 9505 Stone Lake Boulevard, Austin, Texas

For more information, visit <http://www.txcouncil.com/qmgmt/calendar.html>

September 29, 2006

*Drug Demand Reduction Advisory Committee*

Time/location pending

For more information, keep checking <http://www.dshs.state.tx.us/sa>

# CLINICAL MANAGEMENT FOR BEHAVIORAL HEALTH SERVICES (CMBHS) PROJECT UPDATE

Diana Mortensen, CMBHS Program Project Manager

## ABOUT THIS PROJECT

Currently, DSHS uses different Information Technology (IT) systems to manage client information and billing/claims for community mental health and substance abuse services contracts in Texas. The IT systems include:

- *CARE/WebCARE* (Client Assignment and REgistration) — a central client database for mental health and mental retardation services used by the Department of Aging and Disability Services (DADS) and DSHS;
- *BHIPS* (Behavioral Health Integrated Provider System) — a web-based on-line application for DSHS substance abuse services, clinical management, and billing; and
- *Medicaid Translator* — a system that converts mental health services data into a format that can be used for Medicaid payments.

DSHS initiated the Clinical Management Behavioral Health System (CMBHS) project to integrate these systems with \$1.1 million in capital authority appropriated by the 79<sup>th</sup> Texas Legislature. Benefits include:

- Presenting mental health and substance abuse service providers a more complete and accurate treatment history of clients;
- Reducing administrative burden by creating a single billing and claims processing system;
- Compiling client data to provide a comprehensive view of behavioral health services;
- Eliminating inefficiencies for providers and the state in managing separate databases for behavioral health services;
- Accommodating to changes in software application technology by replacing obsolete technology and aging hardware; and
- Complying with state and federal mandates to integrate processes and procedures that guide the delivery of health and human services.

## STAKEHOLDERS

Many individuals have been involved in gathering the information necessary to analyze the mental health and substance abuse IT systems. These include staff at DSHS and the Health and Human Services Commission (HHSC), the Executive Committee of the Information Management Consortium of community Mental Health and Mental Retardation (MHMR) centers, as well as substance abuse service contractors. DSHS has also met with representatives of other MHMR center consortia, and individual community MHMR leaders at a number of venues.

## NEXT STEPS

1. High-level system requirements specified (complete by end of August of 2006).
2. DSHS Executive determines scope of work (begins in September of 2006).
3. Detailed system requirements specified.
4. Beta system developed.
5. Beta test.

## GET INVOLVED

A CMBHS project website is under construction and will be located at [www.dshs.state.tx.us](http://www.dshs.state.tx.us). Look for the new link in the next issue of this News Brief. You may also contact Joe Vesowate, Assistant Commissioner for Mental Health and Substance Abuse Services, at (512) 206-5797 or [Joe.Vesowate@dshs.state.tx.us](mailto:Joe.Vesowate@dshs.state.tx.us).