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Behavioral Health NEWS BRIEF

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

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HOSPITAL DATA HIGHLIGHTS

Texas State Mental Health Hospitals Reduce Seclusion Use

Texas State Mental Health Hospitals (SMHHs) have long been minimal users of seclusion compared to the national public average, especially when you consider that Texas uses the strictest definition of "seclusion". Virtually any incident is counted when an individual is restricted to an area for behavioral reasons and egress is prevented (either physically or by implied consequences for leaving).

However, the use of seclusion at Texas SMHHs has leveled off in recent years. That observation led to the formation of a committee chaired by James Smith (Superintendent, North Texas State Hospital) with the goal of reducing, and possibly eliminating, the use of seclusion at Texas SMHHs. The committee first met in November 2004. Although far from meeting its charge, the committee's work has already led to measurable results.

As *Figure 1* shows, the percentage of persons secluded from July 2005 to June 2006 was much lower at Texas SMHHs (1.3%) than the national public average (2.4%), as maintained by the National Association of State Mental Health Program Directors' Research Institute. Moreover, *Figure 2* indicates that from July 2005 to June 2006, individuals at Texas SMHHs spent substantially less time in seclusion per 1000 inpatient hours (0.05) compared to the national public average (0.43).

Figure 1. Much lower percentage of persons secluded from July 2005 to June 2006 at Texas State Mental Health Hospitals (SMHHs) than national public average.

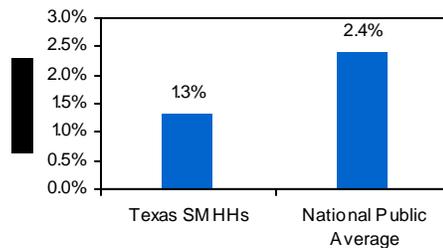
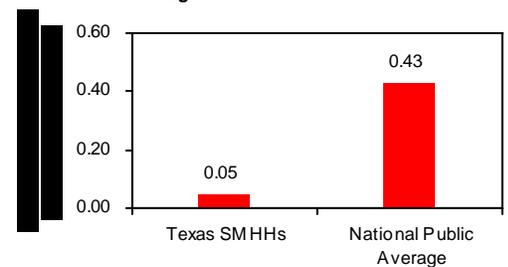


Figure 2. Individuals spent substantially less time in seclusion from July 2005 to June 2006 at Texas State Mental Health Hospitals (SMHHs) than national public average.



Source: National Association of State Mental Health Program Directors' Research Institute.

In addition, there has been a steady reduction by month of the percentage of individuals secluded at Texas SMHHs from 2.0 percent in July 2005 to 0.7 percent in June 2006. The average time spent in seclusion has also decreased at a steady pace by month from 0.09 per 1000 inpatient hours in July 2005 to 0.05 per 1000 inpatient hours in June 2006.

Clearly, Texas SMHHs will continue to seek ways to reduce, and eventually eliminate, the use of seclusion throughout the system.



MESSAGE FROM THE DEPUTY COMMISSIONER FOR BEHAVIORAL AND COMMUNITY HEALTH SERVICES

Dave Wanser, PhD

As we approach the beginning of another Texas legislative session in January, I am reminded of the quote, "In God we trust; everyone else must supply...data" (Ross, 1997, p. 318). It is the responsibility of DSHS to remain accountable to the Texas Legislature and the people of Texas. The Mental Health and Substance Abuse Services Division is responsible for quarterly measures that the Texas Legislative Budget Board uses to judge its performance, given the State appropriations we receive. Mental Health and Substance Abuse staff are also responsible for partnering with DSHS Budget staff to ensure that the Legislative Appropriations Request for each biennium accurately reflects the needs of Texans with mental health and/or substance use disorders. We are also responsible for responding to special requests for data and information from Texas Legislators. Indeed, these are just a few of the many responsibilities that we have when it comes to the Texas Legislature. And it is with data that we must meet them. So, rest and enjoy the holidays, for there will be plenty to do during the upcoming session!

Ross, E. C. (1997, June). Managed behavioral healthcare premises, accountable systems of care, and AMBHA's PERMS. *Evaluation Review*, 318–321.

COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE DATA HIGHLIGHTS

Behavioral Health Issues and Juvenile Justice Involvement in Texas: A Vicious Cycle?

Children continue to be at risk for juvenile justice involvement in Texas. The number of new commitments to the Texas Youth Commission (TYC), as the State's most serious or chronically delinquent offenders, increased almost 14 percent from 2001 to 2006. In 2002, 18 percent of all arrests in Texas involved individuals under the age of 18 (Snyder, Puzanchera, & Kang, 2005). Moreover, being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59 percent (Kelley, Thornberry, & Smith, 1997). Research also shows that co-occurring mental health and substance use disorders among youth are the norm, not the exception, in the juvenile justice system (Hoffmann, 2006).

Recognizing the need to investigate behavioral health risk factors for juvenile justice involvement in Texas, a multi-state-agency, data-matching project was conducted. In addition to the Texas Department of State Health Services (DSHS), participating state agencies included the Texas Department of Family and Protective Services (DFPS), the Texas Education Agency (TEA), the Texas Health and Human Services Commission (HHSC), and TYC. A cohort of 12,331 youth, confirmed by DFPS in Fiscal Year (FY) 2003, to be victims of child abuse or neglect, was examined. They were between the ages of 10 and 16, and most were female (62.8%).

Data-matching by Mark Mason (Decision Support Unit, Mental Health & Substance Abuse Services, DSHS) revealed that, of the 12,331 DFPS youth, only 176 or 1.4 percent had contact with TYC between FY2004 and FY2005. Most youth with TYC contact were male (76.1%), and between the ages of 13 and 16 (71.0%). In contrast, those without TYC contact were mostly female (63.3%), with an almost equal number between the ages of 10 and 12 (50.3%) as between 13 and 16 (49.7%).

Importantly, as *Figure 3* shows, among FY2003 DFPS youth with TYC contact (60.8%), a much greater percentage had a *behavior problem* than those without TYC contact in FY2004 or FY2005 (18.3%). Also, a considerably higher percentage with TYC contact (19.3%) had a *substance abuse issue* than those without TYC contact (3.3%). And among youth with TYC contact (66.5%), a much greater percentage had *family with criminal history* compared to those without TYC contact (47.6%).

In fact, a subsequent data-match by Perry Weirich (Information Analysis Division, PEIMS Ad Hoc Reporting, TEA) showed that a much greater percentage of the FY2003 DFPS youth cohort who had a behavior problem (46.0%) also had an *earlier school discipline problem* from FY1999 to FY2003 than the FY2003 DFPS youth cohort in general (27.2%), with student misconduct being the most common form of discipline problem.

Taken together, the findings of this multi-state-agency data-match suggest that there might be a vicious cycle involving behavioral health issues and juvenile justice involvement among at-risk youth in Texas. As *Figure 4* suggests, family involvement with the criminal justice system and youth's early school discipline problems, behavior problems, and substance abuse issues may work together to increase their risk for juvenile justice contact. Furthermore, when at-risk youth become parents themselves, the cycle may repeat itself.

Figure 4. A vicious cycle?

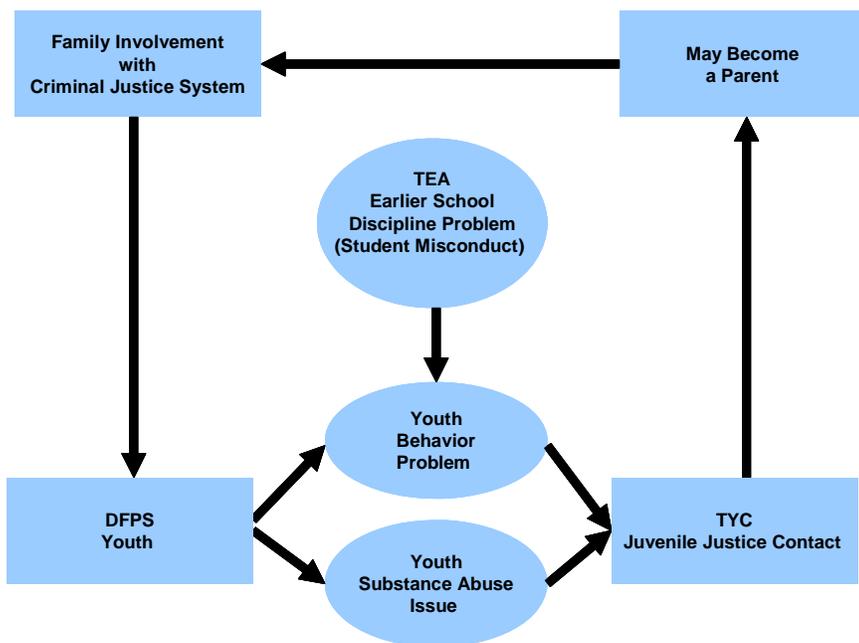
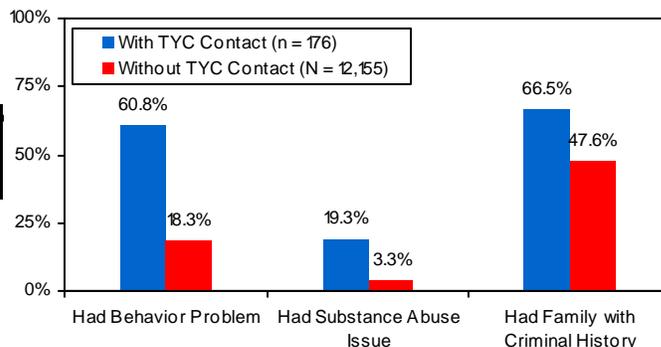


Figure 3. Much greater percentage of FY2003 DFPS youth cohort with TYC contact had a behavior problem, substance abuse issue, and/or family with criminal history than those without TYC contact in Fiscal Year 2004 or 2005.



Source: DFPS Child Protective Services and TYC client databases.

The challenge, then, is to design, fund, and implement early behavioral health interventions to break this seemingly vicious cycle. After all, data-matching revealed that less than half of the FY2003 DFPS youth with TYC contact who had a behavior problem (38.3%), a substance abuse issue (41.2%), or family with criminal history (35.9%) received mental health or substance abuse services funded by the State of Texas in FY2003. Yet, research shows that community mental health and substance abuse services do reduce the risk of juvenile justice involvement (e.g., Durlak & Wells, 1998; Farabee et al., 2001).

Therefore, well-timed, evidence-based, family-focused behavioral health services may help to break the cycle of juvenile justice involvement in Texas. The present findings also underscore the importance of data-sharing for informing policy and practice in children's behavioral health. Indeed, "exchanging health information through secure means...will make important data

available at the right times and places to support optimal care and recovery for consumers" (New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, Final Report, 2003, p. 83).

Durlak, J. A., & Wells, A. M. (1998). Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology*, 26(5), 775-802.

Farabee, D., Shen, H., Hser, Y. I., Grella, C. E., & Anglin, M. D. (2001). The effect of drug treatment on criminal behavior among adolescents in DATOS-A. *Journal of Adolescent Research*, 16(6), 679-696.

Hoffmann, N. (2006). *Case-mix and outcomes: Keys to improving and descending treatment*. Presentation at the Texas Institute on Substance Abuse and Mental Health, Austin, Texas.

Kelley, B. T., Thornberry, T. P., & Smith, C. A. (1997). *In the wake of childhood maltreatment*. Washington, DC: National Institute of Justice.

Snyder, H., Puzanchera, C., & Kang, W. (2005). *Easy access to FBI arrest statistics 1994-2002*. Retrieved July 17, 2006 from <http://ojdp.ncjrs.org/ojstatbb/ezaucr/>

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

ANSWER: Candis Guidry (Program Specialist, Quality Management)



As the Fidelity Coordinator, I frequently use data to evaluate how the Local Mental Health Authorities (LMHAs) are performing in Resiliency and Disease Management implementation, as well as in meeting performance contract measures. We now have the capability to drill down into the date, time, amount, and type of community mental health service a person receives from a LMHA. When there is a complaint or question that arises about service delivery, we can often conduct preliminary investigations using data. My goal is to make a difference by improving community mental health services through continuous quality improvement.

WHAT THE RESEARCH LITERATURE TEACHES US

Obesity Linked to Mood and Anxiety Disorders

Most research on obesity has focused at the physical consequences, such as heart disease, type II diabetes, arthritis and cancer. In the first major study to examine the association between obesity and psychiatric consequences, Gregory Simon, M.D., M.P.H., and his colleagues completed a cross-sectional epidemiologic survey using a nationally representative sample of U.S. adults. A total of 9,125 respondents completed an in-person interview, where they were assessed for a range of mental disorders using the World Health Organization Composite International Diagnostic Interview, along with their height and weight by self-report. The results, published in the September 2006 issue of *Archives of General Psychiatry*, indicated that Obesity (defined as body mass index [calculated as weight in kilograms divided by the square of height in meters] of ≥ 30) was associated with significant increases in lifetime diagnosis of Major Depressive Disorder, Bipolar Disorder, and Panic Disorder or Agoraphobia. However, obesity was associated with significantly lower lifetime risk of Substance Use Disorder. Subgroup analyses found no difference in these associations between men and women, but the association between obesity and mood disorder was strongest in non-Hispanic whites and college graduates. In short, obesity is associated with an approximately 25 percent increase in odds of mood and anxiety disorders, and an approximately 25 percent decrease in odds of substance use disorders. Moreover, variation across demographic groups suggests that social or cultural factors may moderate or mediate the association between obesity and mood disorder. More than ever, the need to integrate physical with behavioral health is upon us in Texas.

Simon, G. E., Von Korff, M., Saunders, K., Miglioretti, D. L., Crane, P. K., van Belle, G., & Kessler, R. C. (2006). Association between obesity and psychiatric disorders in the U.S. adult population. *Archives of General Psychiatry*, 63(7), 824-830.

Abstinence from Alcohol Saves Lives

A long-term follow-up study of substance abuse treatment graduates found that those who stayed sober one year after treatment for an Alcohol Use Disorder were much more likely to be alive 15 years later than those who reverted to drinking. Researchers led by Christine Timko, Ph.D., of the Veterans Affairs Health Care System, tracked 628 people who entered treatment for Alcohol Use Disorders, examining the percentage that died of alcohol-related causes one year after completing the program and again 15 years later. The study, published in the October 2006 issue of the journal *Alcoholism: Clinical and Experimental Research*, found that 68 percent of the individuals had died of alcohol-related causes within a 15-year period, a rate 40 percent higher than would have been expected among the general population. Those who had spent three weeks or longer in inpatient or residential care were more likely to have died, most likely because they had more serious drinking problems to begin with, the study suggests. Other high-risk groups included older individuals, those with more symptoms of alcohol dependence, and those who were not married. However, people who had been abstinent one year after a combination of a short duration (less than 3 weeks) of inpatient or residential treatment and having no drinking-related problems or being remitted were less likely to have died. Also less likely to have died, were individuals who spent eight weeks or more in outpatient care, or four months or longer attending Alcoholics Anonymous meetings. These findings suggest that efforts should be made to help substance abuse treatment providers in Texas identify individuals who are not responding positively to inpatient or residential treatment and intervene to motivate participation in continuing outpatient care and community self-help groups to reduce the likelihood of a chronic and fatal Alcohol Use Disorder course.

Timko, C., De Benedetti, A., Moos, B. S., & Moos, R. H. (2006). Predictors of 16-year mortality among individuals initiating help-seeking for an alcoholic use disorder. *Alcoholism: Clinical and Experimental Research*, 30(10), 1-10.

UPCOMING EVENTS

December 10-12, 2006

National Association of State Mental Health Program Directors (NASMHPD) Winter 2006 Commissioners Meeting

Driskill Hotel, 604 Brazos Street, Austin, Texas

For more information, visit <http://www.nasmhpd.org/>

December 11-15, 2006

15th Texas HIV/STD Conference

Renaissance Hotel, 9721 Arboretum Boulevard, Austin, Texas

For more information, visit <http://www.dshs.state.tx.us/hivstd/conference/2006/default.shtm>

January 18-19, 2007

DSHS Council Meeting

Robert E. Moreton Building, M-739

1100 West 49th Street, Austin, Texas

For agenda, stay tuned to <http://www.dshs.state.tx.us/council/agenda.shtm>

January 18-19, 2007

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

Quality Management Consortium Meeting

Embassy Suites Hotel, 9505 Stonelake Boulevard, Austin, Texas

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

January 24-25, 2007

February 21-22, 2007

March 28-29, 2007

DSHS Employee Advisory Council Meeting

Austin, Texas

For more information, visit <http://online.dshs.state.tx.us/wpimprovement/deac/>

CLINICAL MANAGEMENT FOR BEHAVIORAL HEALTH SERVICES (CMBHS) PROJECT UPDATE

Bill Senters, CMBHS IT Project Manager
Diana Mortensen, CMBHS Program Project Manager

ABOUT THIS PROJECT

Currently, multiple computer systems are used for managing community mental health and substance abuse clinical information and services. For example, the Client Assignment and Registration (CARE) system is used for community mental health, whereas the Behavioral Health Integrated Provider System (BHIPS) is used for substance abuse. House Bill 2292 directs Texas Health and Human Service (HHS) agencies to eliminate duplicative administrative systems. Moreover, the Substance Abuse and Mental Health Services Administration (SAMHSA) has listed as a core priority the development of a single system for co-occurring mental health and substance use disorders.

In response to these directives, the Texas Department of State Health Services (DSHS) initiated the Clinical Management for Behavioral Health Services (CMBHS) project

to design new business processes and a new software application to provide a more holistic approach to behavioral health treatment. Not only will CMBHS track co-occurring mental health and substance use disorders, it will also provide a more complete picture — an electronic health record of a client's progress through the community mental health and substance abuse system to show continuity of care, and to more effectively evaluate the success of services provided. Leading the way is the *CMBHS Business Development Team*, pictured above.



CMBHS Business Development Team. Top row, from left to right: *Mike Hastie* (Program Implementation Unit), *Valerie Shown* (Quality Management Unit), *Charles Thibodeaux* (NorthSTAR & Special Initiatives Unit), and *Glenn Richardson* (Training & Technical Assistance Unit). Bottom row, from left to right: *Diana Mortensen* (CMBHS Program Project Manager), *Charlie Lee* (Application Development Unit), and *Kevin Davis* (Decision Support Unit). Absent: *John Keppler, M.D.* (Program Design Unit), *Beatrice Sager* (Program Design Unit and former Team member), and *Bill Senters* (CMBHS IT Project Manager).

STAKEHOLDER MEETINGS

Several stakeholder meetings have been conducted, covering:

- Client registration;
- Screening;
- Evaluation and admissions;
- Transfers;
- Discharges; and
- Data standards.

NEXT STEPS

1. System requirements and prototyping (complete by December 2006).
2. Detailed system requirements (begins in January 2007).
3. Beta system developed.

GET INVOLVED

The CMBHS project website is located at <http://www.dshs.state.tx.us/cmbhs/default.shtm>