

Motion for Immediate Relief

Exhibit 26

GOVERNOR SONNY PERDUE'S

MENTAL HEALTH SERVICE DELIVERY COMMISSION

FINAL REPORT



Delivered: December 4, 2008

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MENTAL HEALTH SERVICE DELIVERY COMMISSION
FINAL REPORT**

Delivered December 4, 2008 to the:

**OFFICE OF GOVERNOR SONNY PERDUE
OFFICE OF LIEUTENANT GOVERNOR CASEY CAGLE
OFFICE OF SPEAKER OF THE HOUSE GLENN RICHARDSON**

Commission Members:



ABEL ORTIZ

JULIE SPORES

STAN JONES

LYNDA HAMMOND

MIKE YEAGER

RICHARD STONE

Judge STEPHEN GOSS

Senator SETH HARP

Senator JOHNNY GRANT

Senator GREG GOGGANS

Representative JUDY MANNING

Representative MIKE KEOWN

BJ WALKER

JAMES DONALD

DEV NAIR

ACKNOWLEDGEMENT

The Governor’s Mental Health Service Delivery Commission (the Commission) gratefully acknowledges the time, effort, and commitment of all those who came forward at the Commission’s public hearings to share their views on improvements that would result in an effective, safe, and more accountable mental health system.

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EXECUTIVE SUMMARY

Following the identification of serious issues in the public mental health system and articulating a strong desire to improve the public mental health service delivery system, Governor Sonny Perdue by Executive Order established the Governor's Mental Health Services Service Delivery Commission (the Commission) in August 2007. It included the leadership of the Departments that primarily serve Georgia's citizens with chronic mental illnesses, addictive disease, and developmental disabilities; the sheriffs, judges and school systems who frequently interact with citizens coping with these issues; legislators who fund services for our adults, children and adolescents; experts in research; consumer representatives of these citizens; and parents of children in our public systems. The Commission focused on principles and practices to guide community-based, recovery-oriented systems as Georgia works through its budget crisis and improves the quality of care of its public programs, while other task forces considered reorganization of the Department of Human Resources (DHR) and the restructuring and improvement of the state inpatient programs, and responses to the Department of Justice (DOJ) investigation.

During the time the Commission was in existence (August 2007 to December 3, 2008), residents from all over Georgia testified or made presentations about the state's mental health system to Commission members. After examining all the information submitted, the Commission determined areas of concern and identified several best practices to be implemented throughout Georgia.

The Commission's recommendations contained in this report are a result of that thoughtful process. During the development of these recommendations, it became clear to the Commission that this effort represents a unique opportunity to examine carefully how Georgians with mental illness are provided services and opportunities to reach their full potential.

After a thorough consideration of all the information presented, the Commission reached the following conclusions that serve as the foundation of all recommendations presented in this report.

Although not directly in its mandated purview, the Commission wishes to endorse the creation of a fully funded and cabinet-level Department of Behavioral Services (DBS) to bring attention, focus and innovation to the mental health and addictive disease programs provided by or through the public sector with its community public and private partners. It believes, with the Presidential New Freedom Commission on Mental Health, that our systems should be based on a recovery model of care and delivered primarily in community settings, with housing, employment, transportation and case management to supplement the crisis stabilization, medical management and counseling services necessary for recovery and safety. It recognizes the need to coordinate services among departments and with our jails, prisons and diversion courts, where many of our citizens access care.

The Commission supports the ongoing appropriate deinstitutionalization and community reintegration, initiated by the Office of the Governor and the DHR, of inpatients and prisoners with mental illness, developmental disabilities, and addictive disease in order to promote better

quality of care, achieve cost savings and stretch the state funds that are necessary to ensure all our citizens with special needs are served. The Commission also supports the efforts of the administration to add treatment resources, appropriately staff and right size the crowded state hospitals. It hopes the public safety net provided by the facilities will be preserved, and a community-oriented focus will guide these processes.

- **Historically, Georgians with mental illness and addictive diseases have been a hidden population whose needs have largely gone unmet.** The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that between 232,000 to 446,000 adults in Georgia have a serious mental illness – not including those who are homeless or institutionalized (in January 2008, Georgia’s homeless population was estimated to be more than 20,000, according to a “point-in-time” count).¹ DHR puts the number of adults with mental illness or addictive disease at nearly 414,000. According to SAMHSA and DHR, about 180,000 of Georgia’s estimated 1.1 million youth aged 9 to 17 are living with a serious emotional disturbance.²
- **According to DHR, Georgia has the capacity, ability and responsibility to develop a public mental health system that is recovery-focused and provides both community-based and hospital-based services established on best and evidence-based practices.** Recent examples of these practices, which are described in full later in this report, include the following:
 - River’s Edge Behavioral Health Center (REBHC), the Macon Housing Authority, and the Georgia Department of Community Affairs (DCA) have created formal agreements to integrate supported housing services for people with mental illness.
 - In 1999, the KidsNet Georgia System of Care model began in Rockdale County through a federal SAMHSA grant to improve service delivery and outcomes for youth with severe emotional disturbances who are at risk for out-of-home placements. KidsNet Georgia now serves as a state oversight committee (chaired by the Governor’s Office of Planning and Budget) and has received funds for targeted expansions to other communities throughout Georgia.
 - The Georgia Crisis Intervention Team (CIT) trains law enforcement officers to better assist and work with people with mental illness. CIT is a collaboration of the National Alliance for the Mentally Ill (NAMI); DHR’s Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD); the Georgia Bureau of Investigation (GBI); Georgia Association of Chiefs of Police; Georgia’s Sheriffs Association and the Georgia Public Safety Training Center. CIT is designed to improve encounters between law enforcement and people with mental illness, increase local community jail diversion programs, improve mental health services and protect the rights of people with mental illness.
- **Georgia’s public mental health system deserves and should receive the same fiscal and legislative consideration as other basic state infrastructure priorities such as education, public safety and public health. It should also take advantage of new mental health parity provisions and community program settings in which Medicaid or other available public funding sources are available in order to stretch state dollars for maximum impact.** If not, individuals with mental illness will continue to

have a devastating impact on the state's basic infrastructure. According to the Department of Education (DOE) 2007 report card, 12 percent of Georgia's students are enrolled in special education and/or have disabilities – a trend that goes back to 2004. In addition, 11.7 percent (186,406) of children in grades K-12 were enrolled in special education, while 10,804 children in Pre-K were enrolled in special education³. The Department of Corrections (DOC) has reported that 250 inmates with mental illness are released from prison every month. Law enforcement officers are estimated to travel over 1.4M miles per year in transporting involuntary commitments, jail holds and forensic consumers. If mileage for these trips were reimbursed, total reimbursement would be nearly \$825,000 per year. This figure does not include the manpower costs incurred by law enforcement agencies providing the transportation.

- **Community treatment, as well as quality support and inpatient services, should be developed, enhanced and funded as part of a comprehensive public mental health system. Historically, these services have been treated separately.** According to the budget office of DHR/MHDDAD, in FY08, \$326,272,487 (33 percent) of total MHDDAD expenditures (\$990,378,401) were spent for mental health services, which includes both adult services and child and adolescent services. Of the \$326,272,487, 76 percent (\$248,405,630) was spent for community services and 24 percent (\$77,866,857) was spent for hospital services. The state needs to determine whether this is the right balance of spending and evaluate these funding benchmarks for the building of community and hospital-based services to ensure the needs of the citizens are being met through system changes and a growth in population.

RECOMMENDATIONS

I. Community-Based Crisis Stabilization Services

Statewide Mobile Crisis Stabilization (MCS) is essential in order to eliminate Georgia's over-reliance on institutional care. For citizens in crisis who are in hospital emergency rooms, jails and other settings, MCS could serve as the central point where their immediate needs are assessed and available community services are identified. Crisis teams can use these assessments to work with such individuals and develop a plan that considers

1. The individual's safety, as well as public safety;
2. What treatment and support services are the safest, least restrictive and promote the individual's recovery close to home; and
3. The individual's connection to longer-term supports.

Short-term Crisis Stabilization Units available throughout the state in local communities can serve 60 percent of those patients currently being served in Georgia's seven psychiatric hospitals. This provides three benefits that will promote recovery and reduce the stigma of mental illness:

1. By serving individuals who need short-term inpatient crisis services in their communities, institutionalization can be avoided; and
2. Natural supports, community supports and treatment providers will adapt their services to handle individuals with more chronic mental illness.
3. Medicaid reimbursement is available in some community settings and can stretch state dollars.

II. Supported Housing

For adults with mental illness, supported housing is vital for promoting recovery and independent living. Supported housing has three components:

1. Available housing integrated into the community,
2. Rental assistance to make the housing affordable and
3. Supported community mental health services to help individuals remain stable in their community.

Developing a comprehensive, statewide supported housing program will help reduce the number of individuals with mental illness in jails, shelters and DOC custody. It will also increase the number of individuals with mental illness who are included as productive citizens in the state's communities.

III. Continuum of Case Management Services

A statewide continuum of case management services will and should serve as the backbone of Georgia's community-based mental health system. This will allow supports and treatment services to be designed and implemented in the least restrictive and most integrated community settings possible. The continuum of case management services should range from intensive case management offered through Assertive Community Treatments, to mid-range services offered through traditional case management services, to services offered through peer specialist programs and Crisis Intervention Teams in the law enforcement field. For children and youth with serious emotional disturbances that can be treated in family or community settings, the new Systems of Care services offered through KidsNet Georgia has been promising in providing case management services that meet individualized needs. All of these supportive services can minimize crises that lead to hospitalization and incarceration.

IV. Common Preferred Drug List

The Commission supports Georgia's efforts to establish an electronic medication exchange that includes a common, preferred medication list and prior authorization processes between departments that fund or provide mental health services. Providing easy access to medication in a way that reduces medical errors and identifies possible allergies and negative medication interaction will enhance community support and treatment. The Commission recognizes that an electronic medication exchange will take time and funding to develop; until this resource becomes available, departments should develop procedures to share paper records to achieve easy, safe access to medication. They should also develop a process to "grandfather" in prior authorizations approved by another state department.

V. Supported Employment

Supported employment offers individuals with mental illness more independence and hope, as well as a daily motivation to continue toward recovery. Supported employment provides an exciting opportunity for private industry to partner with consumers, family members, community

supports and treatment providers to promote inclusion of people with mental illness into mainstream society. Supported employment programs should be developed statewide to work jointly with case management services, housing and treatment services. A comprehensive service and support program will enhance services provided by DHR, DOC, county jails and DOL to individuals with mental illness.

VI. Transportation

Transportation services must be a fundamental component of Georgia's public mental health system. Current services are uncoordinated among different state agencies. For example:

- DCH provides transportation through Medicaid funding when the need is connected to a medically necessary service.
- DHR provides transportation for individuals with mental illness or who are receiving other DHR services.
- Service providers provide transportation to community-based services.
- County authorities and law enforcement transport individuals from hospitals to jail or from community settings to the hospital.

All of these resources are essential to a successful mental health system, but the lack of coordination is costly and confusing for consumers and their families who must make multiple trips with multiple providers. Georgia's transportation funding can and should be spent in a more cost-efficient manner. The Commission encourages state agencies to take advantage of the recent achievements in the use of telepsychiatry as an alternative to transportation and to address mental health professional shortages across the state.

Therefore, the Commission recommends more coordinated and cost-effective transportation services and a broader use of innovative technology such as telepsychiatry.

VII. Uniform Children's Benefit Package

To ensure continuity of care for children who need public mental health services, Georgia should establish a single benefit package that allows children to receive the same service options from the same providers regardless of which state agency provides or funds the service. These services should be community- and family-based and include appropriate and coordinated levels of care for all children who need public support. Currently, how children navigate the state's public mental health system is completely determined by the funding eligibility category that covers their benefits. There are three eligibility categories in Georgia:

- Medicaid managed care
- Medicaid fee for services
- State-funded services

When a child moves from one managed-care organization to another, or from foster care to a permanent home, among residential providers, or from home to state custody, the child's services and providers change even if the child's symptoms remain the same. These changes result in different service and support options, different providers and possibly even different medications. The child is exposed to a potentially upsetting pattern of change that can lead to

crisis situations involving institutional care, as well as the possible involvement of child welfare or juvenile justice systems.

VIII. Adult Services

To fulfill its vision of “a life in the community for everyone,” Georgia must continue to build a statewide network of quality programming that addresses the spectrum of consumer needs. This would include providing case management services that help consumers overcome barriers to community stability. Assistance to consumers may include

- Helping them access benefits;
- Arranging for or providing transportation to mental health, addictive diseases and physical health services;
- Finding safe and secure housing;
- Ensuring their basic needs are met; and
- Helping them reach other individual recovery goals.

IX. Behavioral Health Collaborative

Because behavioral health services are delivered and funded by several state agencies, a Behavioral Health Collaborative is needed to coordinate services between these agencies. The Collaborative would connect the commissioners from departments that fund mental health services to consumers and their families in order to resolve systemic barriers to services that impact individuals served by more than one department. The Collaborative would make recommendations to solve specifically targeted systemic barriers. Its recommendations, which would be presented to the boards of each department for approval, would include funding strategies, policy changes, practice changes and evaluation. The collaborative would also submit a report of its recommendations and evaluation of the implementation to the Governor and members of the General Assembly.

X. Inpatient Services

Inpatient services must be delivered as an integrated part of a community-based system of care that strongly emphasizes person-centered planning and the recovery model. This means moving away from the current practice of using inpatient services in state-operated hospitals as the “front door” to services. Georgia’s inpatient resources should be used only in cases of chronic mental illness after all less-restrictive services and supports are exhausted. Children and individuals who either need short-term crisis services or have physical or developmental disabilities should all be treated in a community-based setting – not a state-run mental health hospital.

Prioritizing Recommendations

Because the Governor’s Commission on Behavioral Health was mandated to view Georgia’s public mental health system as a whole and make recommendations about the system’s overall structure and organization and in the face of a budget crisis, the Commission has not prioritized

the recommendations in this report. However, it became clear to the Commission that Georgia's "silo" approach to managing and funding mental health services (e.g., department by department or community versus hospital) has produced a fragmented set of services that do not meet the needs of most Georgians.

Instead of prioritizing its recommendations, the Commission has chosen to make them from the point of view of consumers and families in need of a comprehensive, interconnected mental health system that delivers quality services. However, the Commission is also aware of the impact current economic realities are having on the state's budget. It has serious reservations about any budget cuts to the mental health, developmental disability and addictive disease programs in the face of the current investigation, the crises identified in this report, and reorganization of a new Department that is to bring leadership, better quality of care and more accountability.

Therefore, the Commission proposes that the recommendations in this report be funded and implemented over a period of five years with DHR or its successor agency completing and publishing an annual assessment of the implementation of these recommendations. The Commission recommends the following steps for implementation:

- **First**, a solid framework of services should be developed that supports the functioning and sustainability of all the services and supports recommended in this report. Such a framework must consist of
 1. Comprehensive case management for children and adults;
 2. Access to a medication management system and
 3. Short-term inpatient and mobile crisis stabilization services.
- **Second**, careful consideration must be given to the appropriate distribution of resources between community and hospital-based or residential services so that these two components can develop at the same pace, but a community focus should be assured. Otherwise, state hospitals will remain the "front door" of the mental health system, where individuals are stuck in institutionalized care without access to comprehensive community services.
- **Finally**, there should be strategic planning around where services are developed when reshaping Georgia's mental health system. Emphasis should be placed on developing a holistic plan that implements rural and urban models of service delivery around the state in phases until statewide coverage is achieved. This method of service development equally respects the needs of individuals with mental illness in both rural and urban areas. To ensure equal access to services for those living in rural areas where services are not based locally, services should be delivered through out-stationed providers, and technology such as telepsychiatry should be used to bring services to rural areas or transportation should be used to bring individuals to services.

Conclusion

The Commission's greatest concern is that the development of a mental health system that truly meets the needs of Georgians with mental illness will be hindered by the state's current economic challenges or the lack of public and political will to implement these recommendations. The Commission is hopeful that the creation of a new Department of

Behavioral Health Services, a new Department of Health and the restructuring of the DHR will manifest and develop that public and political will and bring increased focus and attention to the state's human service programs in all Departments.

The Commission offers these recommendations in the spirit of coordination and cooperation while recognizing three important facts:

1. Georgia has made good progress in the past several years. For example, the state has developed Georgia's first community crisis stabilization programs (5) for children and added significant community-based crisis stabilization program resources for adults, and increased and refinanced child and adolescent programs (*See Inpatient Recommendation System-Wide Improvement for more examples of the state's progress.*)
2. The public mental health system cannot be changed overnight and
3. In these difficult economic times, even though new resources are needed, the cost of improving Georgia's public mental health system must be balanced with other important services and programs needed by the state's citizens.

Regardless of challenges, services and supports for Georgians with mental illness and addictive disease can no longer be treated as optional programs. The needs of these citizens must be elevated to the point that they receive equal consideration with other basic human needs when financial, policy and program decisions are made.

RECOMMENDATIONS

COMMUNITY-BASED CRISIS STABILIZATION SERVICES

CURRENT STATE OF NEED

Currently, the MHDDAD state hospital system is in crisis. This crisis is a direct result of the lack of community-based crisis services such as crisis stabilization programs and mobile crisis services. This has resulted in state hospital overcrowding and overutilization. Adequate community-based crisis services would allow acute crisis services to be provided in community settings, many times at a lower cost. Moreover, crisis services can be more effective in rapid stabilization processes for consumers due to their closer proximity to the community where the consumer lives.

In order to assist consumers in remaining out of inpatient settings in hospitals or jails, there must be adequate infrastructure to accommodate the fluctuating needs of consumers who are living within their communities but require crisis stabilization services from time to time to maintain and increase community tenure. Services must be nimble and convenient and must satisfy the urgent need for intervention in the least restrictive environment.

EFFECTIVE PRACTICE SOLUTIONS

Geographic access to and availability of community-based crisis services 24 hours a day seven days a week is critical to developing an effective infrastructure of acute community-based crisis care in Georgia. Mobile crisis teams are dispatched into the community to triage and de-escalate potentially volatile situations or determine other disposition of a consumer's psychiatric needs. Crisis stabilization programs are community-based facilities where consumers receive 24-hour live psychiatric care without being admitted to a state hospital. Both are widely accepted best practices to break the cycle of readmissions to state psychiatric facilities and to increase the intensity of community-based support when a consumer's continued recovery in the community is in jeopardy.

The combination of mobile crisis services with associated crisis stabilization programs creates a synergy to respond effectively to most psychiatric emergencies without hospital intervention. Interventions in the community frequently result in better linkage to other needed community services and reduce the time before the consumer can move further into a stable recovery journey.

MHDDAD has been working strategically to place crisis stabilization programs in geographically accessible areas, but some areas either have an inadequate number of crisis beds based on hospital utilization data, or are in more remote and difficult-to-reach locations. Mobile crisis services do not touch some of the areas where crisis stabilization programs are located. The following information shows a measured growth plan and the cost to provide geographically accessible crisis stabilization programming throughout the state of Georgia. In FY09, 8 new crisis stabilization beds will open in Glynn County, 24 beds in Chatham County, and 20 beds in Muscogee County. In FY10, 32 additional beds will be needed in metro-Atlanta. In FY12, 8 beds

will be added in Clark County, 16 in Thomas County and 16 in Richmond County. This is the minimum number of beds necessary to support objectives of MHDDAD future planning.

Mobile crisis services should be within close physical proximity to crisis stabilization programs. A strong relationship between these two acute psychiatric emergency community resources must exist for maximum effectiveness. A mobile crisis team costs \$750,000 annualized or about \$54,000 per county. Currently Georgia allocates \$2,175,672 statewide for mobile crisis services. Mobile crisis services are being added in 26 counties in and surrounding Chatham County, Muscogee County and Glynn County in FY09. Georgia can reach the goal of having adult mental health mobile crisis services statewide by systematically adding 31 counties each year in FY10, FY11 and FY12.

Since July 1, 2006, Georgia has had a single toll-free phone number that people can call 24 hours a day, seven days a week, and be connected to local services for mental health, developmental disabilities and addictive disease. The Georgia Crisis & Access Line (GCAL), 1-800-715-4225, was the first statewide access number. It is staffed by trained counselors who do screenings and link people to appropriate services. Georgia's GCAL is unique in that people calling the line are able to get an appointment rather than a referral. More than 168,000 calls are being received on an annual basis with more than 15,000 of those identified as a potential danger to themselves or others. GCAL is managed and operated by Behavioral Health Link. In addition, a Web site, www.mygcal.com, offers a list of providers and services. The Council of State Government identified GCAL in 2008 as an "Innovation in State Government."

Triage Centers are social detoxification programs that offer services for 24 to 72 hours. These services will work in conjunction with homeless and supportive employment services to reach persons for whom substance abuse contributes to unemployment. SAMHSA Treatment Improvement Protocol 45 acknowledges social detoxification as a valuable part of the detoxification service continuum.

Substance Abuse Triage Centers should be established in areas with the highest demand and utilization of AD services in both community and hospital settings. Triage Centers will provide social detoxification, which is a lower-cost means of serving persons with addictive diseases than either crisis stabilization programs or hospitalization. Currently, consumers with addictive diseases are utilizing 60 percent of crisis stabilization beds in Georgia. In 2005, over 14,000 persons were admitted to Georgia hospitals for substance-related issues. Since medical treatment is usually not required for safe detoxification, most of these individuals could be successfully treated in Substance Abuse Triage Centers, thus decreasing the demand for higher-cost inpatient and crisis stabilization program services, freeing them up for use by persons who require psychiatric and medical monitoring. Triage Centers for Substance Abuse Detoxification are being used successfully in other states to divert persons from high-cost inpatient services.

Social Triage and Detoxification Centers (30 bed units) can be added to the crisis array for \$500,000 per program. Georgia funded its first two Social Triage and Detoxification Centers in FY09 in Chatham and Muscogee Counties. Over the next few years, crisis services can be maximized by adding programs in the Richmond County area, in the metropolitan Atlanta area, in the Bibb County area, in the Floyd County area and in the Dougherty County area. A critical

tool for decreasing unnecessary incarceration of persons experiencing a mental health crisis is Crisis Intervention Team Training (CIT) for law enforcement officers. From FY06 – FY08, Georgia trained 1599 officers. By the end of FY09, the state should have 2340-trained officers. DHR can solidify the program, ensuring that Georgia will continue to train its police force to deal appropriately with persons in crisis by funding a training coordinator and administrative support staff member. Currently, the state of Georgia uses the Memphis CIT model.⁴

RECOMMENDATIONS

1. Support an increase in spending for community crisis services that will be offset by decreased hospital costs. Maintaining current funding will not reduce reliance on hospitals to treat acute psychiatric problems and may increase costs to treat acute psychiatric conditions in state hospitals, hospital emergency rooms and jails. Initial estimates indicate that \$5.8 million can introduce intensive case management in the largest areas of the state
2. Create partnerships among crisis stabilization programs, Substance Abuse Triage and Detoxification Centers, Mobile Crisis teams, state hospitals, general hospital emergency rooms, law enforcement and local jails and the Georgia Crisis and Access Line.
3. Recognize that mobile crisis services as the front door to emergent psychiatric events can relieve pressure on hospital emergency rooms, and they should be adequately funded to blanket the state.
4. Build greater capacity for Crisis Intervention Team Training (CIT). It involves teaching the officers crisis intervention and de-escalation techniques, background information on mental illness, developmental disabilities and addictive diseases, as well as taking the officers for site visits to state psychiatric facilities. Georgia NAMI, Fulton County, MHDDAD and the GBI have provided training in locations across the state.⁵
5. Develop a method of determining the need for adolescent detoxification services and develop a plan based upon the need.

SUPPORTED HOUSING

CURRENT STATE OF NEED

According to SAMHSA, approximately 5-8 million individuals in the United States will be homeless for one or more nights within a five-year period.⁶ Furthermore, as many 700,000 Americans are homeless on any given night throughout the country.⁷ In Georgia, a recent point-in-time count estimated that over 20,000 Georgians were homeless on a single night in January 2008.⁸ Over 75,000 experience homelessness at some point throughout the year.⁹ Nationally, as many as 20 to 25 percent of those persons have serious mental illness, while one-half of this subgroup also have a co-occurring alcohol and/or drug problem.¹⁰

In 2004, an Executive Order from the Governor's office creating the Georgia Interagency Homelessness Council stated that "in Georgia, the homeless mentally ill tend to be homeless for an extended period of time, housed only by short confinements in public hospitals, jails, and mental health institutions." The Office of the Governor in a 2004 press release noted that 1,600 Georgians are chronically homeless.¹¹

EFFECTIVE PRACTICE SOLUTIONS

With appropriate treatment and community supports, homelessness among the mentally ill can be reduced.¹² Community supports that promote stability should be offered through an integrated service system. These services include housing, healthcare, mental health services, substance abuse treatment, income supports and entitlements, life skills training, education and employment. SAMHSA's *Blueprint for Change* states "offering an integrated service system reduces barriers, allows for coordination and improvement of existing services and creates new programs that improve the availability, quality and comprehensiveness of services."¹³ Nancy Carter, in a statement to the U.S. House of Representatives, stated that there is research showing that formerly homeless residents who receive supportive housing, for example, show a 50 percent decrease in emergency room visits and inpatient hospital days and an 80 percent decrease in emergency detoxification services.¹⁴ The cost savings are significant. A recent in-depth study of local hospital usage conducted by the Athens Clarke County Department of Economic Development revealed that 891 individuals previously identified as being homeless made 7,000 hospital visits in 2005 to two regional hospitals at a cost of \$12,378,000. Forty-nine percent of those individuals had been diagnosed with a mental illness, addictive disorder or both.¹⁵

In the state of Georgia, River's Edge Behavioral Health Center (REBHC), the Macon Housing Authority, and DCA have implemented formal agreements among their agencies to integrate services for supportive housing for people with mental illness. The REBHC partnership has provided 255 community supported-housing beds for people with mental illness from a seven-county area. Contributing to their success is the philosophy that the Macon Housing Authority and DCA are responsible for the development of housing and providing rental assistance, while REBHC is responsible for developing and/or providing community supports.

REBHC provides community supports that are recognized by SAMHSA as best practices in community mental health services. Some examples of these best practice services are

- Resilience/protective factor identification and promotion
- Recovery-oriented services that are focused on community and consumer integration
- Scientific, strength-based screening and assessments for individuals and co-morbid conditions
- Multidimensional treatment teams, which should include consumers and their families
- Targeted illness self-management education
- Access to new generation psychotropic medication
- Motivational interviewing
- Stage-wise treatment model, which provides treatment targeted to each individual phase of recovery.
- Relapse prevention and intervention
- Cognitive behavioral techniques
- Health promotion services
- An integrated dual disorders treatment tool kit for individuals with a co-occurring mental illness and substance abuse addiction that offers mental health and substance abuse services in one setting.¹⁶

The State Board of Pardon and Paroles, DCA, and DOC have entered into an agreement to accomplish the Reentry Partnership Housing (RPH) for Residence-Problem Inmates (ROI) project. The RPH is designed to provide housing for work-ready convicted felons who remain in prison after the Parole Board has authorized their release due solely to having no residential options. Applicants selected to participate in the RPH program must provide (directly or through written agreement with third parties) parolees with stable housing and food (room and board). In return, the RPH program will provide short-term financial assistance, generally \$1800 for three months of assistance. Expectations are that approximately 300 parolees will be assisted. The goal of the program is to enhance his or her ability to remain crime free once reentering society from prison system. Year to date, DOC has placed 606 inmates in RPH. Out of these 606 inmates, 115 were receiving mental health services. These 606 inmates translate into \$14,637,503 in cost avoidance for DOC. DOC averages 15-20 placements per month. Currently 300+ ex-offenders who were placed in RPH are employed. DOC currently has 33 approved housing providers and is receiving new applications on a weekly basis. DOC also has 15 available beds at River Willow for severely mentally ill inmates.

A variety of federal resources is available to Georgia to provide affordable housing options, including the HOME Investment Partnership (HOME), Housing Choice Voucher (Section 8), Low Income Housing Tax Credit, Shelter Plus Care (S+C), Emergency Shelter Grant (ESG), and Housing Opportunities for Persons with AIDS (HOPWA) programs. These resources are available not only to assist with housing individuals with disabilities and the homeless but also to address affordable housing needs for all low- and moderate-income Georgians. Therefore, current demand for all of these resources outstrips available resources. For instance, it is common that waiting lists for the Housing Choice Voucher are as long as two years. Further

significant barriers exist to coordinating the availability of support services and rental assistance even when sufficient housing options exist within a community.

State resources are also made available to provide low- and moderate-income housing opportunities. Approximately \$3.0 million in FY09 funds is appropriated as match to the federal HOME program, \$3.3 million is allocated for FY09 to the State Housing Trust Fund for the Homeless (HTF), and private equity is raised through the availability of the Georgia Housing Tax Credit. State resources made available to the Housing Trust Fund for the Homeless are utilized to meet the federal match requirements of the Emergency Shelter Grant and Shelter Plus Care programs and to cover costs associated with DCA's Permanent Supportive Housing Program that are not eligible under federal HOME guidelines.

DCA currently makes funding available through its Permanent Supportive Housing Program to develop affordable rental-housing options with supportive services for eligible Homeless Tenants. DCA has broadened the definition of homeless tenants to include not only individuals lacking permanent shelter but also those who are inappropriately housed in institutions. Using an allocation of federal HOME funds, HTF resources, and Section 8 rental assistance, DCA (within its Section 8 service area) provides financing for two of the three legs of the stool needed to create supported housing. Missing from the application process is funding for the support services, which must come through existing service allocations or through new resources made available through the Department of Human Resources.

Due to these federal and state resources, 570 units have been built, and others are under development or have a preliminary reservation of funds through DCA's Permanent Supportive Housing Program. Of these units, 64 percent will be targeted to individuals with mental illness. Additionally, over 1,200 Shelter Plus Care units exist across Georgia, providing sponsor-based rental assistance to eligible homeless individuals with a disability. In testimony to the Georgia Commission on Mental Health, the Macon Housing Authority, DCA and REBHC stated that the lack of community services was one of the largest barriers to expanding supported housing services through new development and set-asides. Specifically, funding is needed to cover those costs that do not fit under medical necessity criteria but are essential for an individual with a mental illness to live independently. These services include, but are not limited to, connecting with shelter and basic needs, learning housekeeping skills, linking to services, and on-going monitoring.

RECOMMENDATIONS

1. Develop a coordinated funding strategy among all departments that serve individuals with mental illness to advocate for state funding and/or dedicated revenue that will help to implement a comprehensive supported housing plan that includes housing resources, including rental assistance, and the necessary supportive community-based services.
2. Develop a strategy to implement services to support individuals without Medicaid and to cover non-Medicaid reimbursable services.
3. Identify the housing needs of individuals with mental illness.

- a. What is the geographic need?
 - b. Are outreach and interim housing supports (e.g., crisis stabilization, shelter, transitional) sufficient?
 - c. What types (i.e., single room only (SRO), one-bedroom, and two-bedroom) of permanent housing options are needed? Is shared housing for individuals with severe mental illness an option?
4. Develop and implement an anti-stigma campaign and educate local government officials to reduce resistance in local communities to the development of housing units for individuals with mental illness.
5. Develop and implement community support services to integrate with housing services.
 - a. Case management services
 - b. Crisis services
 - c. Flexible transportation services
 - d. Medication management
 - e. Peer specialists
 - f. Job training/Supported Employment
6. Develop a strategy to fund operating costs of supported housing.
7. Develop an on-going Housing Workgroup to develop and implement strategies that create partnerships between service providers and housing providers (private not-for-profit, for-profit and public housing authorities) to increase and improve supported housing availability in Georgia.
8. Develop a strategy to increase housing options for mentally ill felons.
 - a. Improve discharge planning and financial preparedness of felons exiting the correctional system and identify housing options existing in community prior to release.
 - b. Identify and implement community services.
 - c. Amend statutes to allow community supervision by correctional staff.
 - d. Develop processes to ensure that tenant selection policies for criminal background screenings are applied fairly and consistently.
9. Support the DCA statewide affordable housing locator system to identify affordable rental units by community.¹⁷ Continue to elicit new housing providers for inmates with mental illness, co-occurring disorders (mental illness along with an addictive disease and/or a developmental disorder), violent mentally ill inmates, and the disproportionate number of mentally ill inmates who are also HIV+.

CONTINUUM OF CASE MANAGEMENT SERVICES

CURRENT STATE OF NEED

According to the National Institute on Mental Health (NIMH), mental illness is the primary source of disability in the United States. As of 2004, approximately 1 in 4 adults, or 26.2 percent of Americans experience a diagnosable mental disorder a year.¹⁸ NIMH estimates that 6 percent, or 1 in 17 adults compose the population with a serious mental illness.¹⁹

Adults do not represent the totality of mental health diagnoses. In *America's Children in Brief: Key National Indicators of Well-Being* (2008), parents reported that in 2005, 4.6 percent of children ages 4-17 have some form of emotional or behavioral difficulty. In 2006, that number rose to 5 percent.²⁰

Georgia's resident population during the 2000 census was 8,186,453. This number is projected to expand to 12,017,838 by 2030.²¹ SAMHSA estimated in 2002 that the number of persons 18 and older with a serious mental illness in the state of Georgia was between 232,000 and 446,000. Notably absent from these numbers are homeless and institutionalized individuals, who were not included in this survey of the state.²² SAMHSA's Office of Applied Studies estimated annual averages of individuals that experienced "serious psychological distress" to be approximately 781 thousand in 2005 to 2006.²³

The Georgia Department of Human Resources estimates that there are approximately 413,756 adult Georgia residents living with serious mental illness. SAMHSA estimates the number of Georgian youth between the ages of 9-17 to be approximately 1,132,114 children, 180,050 of which the Georgia Department of Human Resources estimates are living with a serious emotional disturbance.²⁴

EFFECTIVE PRACTICE SOLUTIONS

The National Association of Case Management (NACM), along with the Community Support Program, Division of Knowledge Development and Systems Change, Center for Mental Health Service at SAMHSA in a 1997 report on case management practice guidelines, defined case management as

A practice in which the service recipient is a partner, to the greatest extent possible, in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. The focus of the partnership is recovery and self-management of mental illness and life. The individual and the practitioner plan, coordinate, monitor, adjust, and advocate for services and supports directed toward the achievement of the individual's personal goals for community living (pg. 22).²⁵

NACM recommends different "levels" of case management for individuals with serious mental illness. While their guidelines suggest three levels of case management intensity, it is advised that at least two of these levels of case management be adopted. Level I (Intensive) case management is the most intense and supports those individuals who are experiencing the greatest

difficulties or problems because of their mental illness. NACM suggests that this population may have frequent hospitalizations or institutionalizations and can include those persons who are homeless or young adults who are aging into the adult system. In contrast, Level II (Basic) case management is suggested for those people who are experiencing recovery or are becoming more stabilized and are able to actively participate and provide direction in their treatment plans.²⁶

Currently, the state of Georgia utilizes Community Support Individual (CSI), to provide community support services for the majority of individuals in the system. Approximate caseloads for a case manager range between 35-50 individuals to whom home visits, phone calls, referrals and coordination between agencies are provided. However, CSI is a Medicaid-billable service, and Medicaid only pays for services that are “medically necessary.” This limitation leads to barriers to comprehensive care because necessary services such as transportation or accompaniment to medical visits or to substance abuse meetings such as Alcoholics Anonymous or Narcotics Anonymous are not considered medically necessary. Providers have to choose services that will be covered through Medicaid, rather than services being chosen to meet the individual’s specific needs. CSI is used to meet many of the needs of individuals in need of Level II case management services, but it needs to be expanded for all patients and all appropriate needs.

Level I (Intensive) case management require small caseloads of approximately 10 to 13 clients, with a single case manager who is receiving clinical supervision. The clinical supervisor should have no more than 10 case managers under his or her supervision at a time. This level of case management necessitates coordination and collaboration with state hospitals and the Department of Corrections to locate and identify those individuals most in need of services. In addition, Level I (Intensive) case management requires flexible funds to support immediate needs such as medical prescriptions, emergency housing or other services. The targeted population would consist of those who are returning to the community after incarceration, those who have been hospitalized at least twice in six months and possess inadequate supports and those whose ability to live in the community requires additional supports.

The top 10 counties in the State of Georgia with the highest number of state hospital 30- and 180-day readmissions and DOC Level III+ releases are Fulton, Chatham, Richmond, Bibb, DeKalb, Muscogee, Cobb, Floyd, Gwinnett and Clayton. These 10 counties account for 46 percent of the state’s consumers in these categories.

RECOMMENDATIONS

1. While continuing to utilize CSI for medically necessary billable services for Level II (basic case management) for consumers, expand and fund wraparound case management services statewide using the Transition and Aftercare for Probationers and Parolees as a template for non-forensic consumers.
2. Build a funding mechanism for activities or services that Medicaid does not reimburse so that the treatment needs of the consumer drive the provision of case management services:

- a. Flexible funding to provide for immediate needs such as medication and emergency housing
 - b. Collaborative funding between agencies and organizations to address longer-term needs
3. Identify and fund in the short-term Level I (Intensive) Case Management population in Georgia for immediate benefit and relief of overcrowding of state facilities considering
 - a. State hospital 30- and 180-day readmissions
 - b. DOC Level III+ releases
 - c. Top 10 counties accounting for 46 percent of consumers in these categories
 - d. The immediate need for case management in rural counties. Build on the model of rural services delivery that already exists in the state.
4. Build greater capacity for Crisis Intervention Team Training (CIT). Doing so would involve teaching the officers crisis intervention and de-escalation techniques, background information on mental illness, developmental disabilities and addictive diseases, as well as taking the officers for site visits to state psychiatric facilities.²⁷ Georgia_NAMI, MHDDAD and the GBI have provided training in locations across the state.²⁸ Georgia utilizes the Memphis CIT model.²⁹

COMMON PREFERRED DRUG LIST

CURRENT STATE OF NEED

The Commission supports the State's efforts to establish an electronic medication exchange to promote continuity of care and the coordination of services when patients move between different state agencies. The Commission also endorses establishing coordinated prior authorization processes that permit reciprocity for patients moving from one health program to another and the use of a common preferred drug list, as measures to support consistent care between different state programs that fund or provide mental health services. Providing easy access to medication in a way that reduces medical errors and identifies possible allergic reactions and negative medication interaction will enhance community support and treatment. The Commission recognizes that an electronic medication exchange will take time and funding to develop. Until these resources become available, the departments should develop procedures to share paper records to achieve easy and safe access to medication and a process to grandfather prior authorizations approved by another department within state government. The system can require individuals to change medication because of different preferred drug lists.

EFFECTIVE PRACTICE SOLUTIONS

The Governor of Georgia issued an Executive Order in 2008 regarding an electronic medication exchange. It states that the use of technology and industry standards has enabled secure and confidential information sharing across healthcare professionals. An electronic medication exchange will enhance the coordination of care across state agencies, to include the Department of Community Health (DCH), Department of Juvenile Justice (DJJ), Department of Human Resources (DHR) and Department of Corrections (DOC). This exchange will have a front-end application that will allow registered healthcare providers to access comprehensive pharmacy-related patient information in a secure environment. The exchange will provide the opportunity to integrate the available pharmaceutical information into the existing information and claims processing systems in each of the agencies. The exchange will also assist in the identification of utilization trends, across state agencies.

RECOMMENDATIONS

1. Create a Georgia Rx Exchange program with multiagency collaboration.
 - a. There should be a provision of continuity of pharmacy benefit care.
 - b. Commissioners from DCH, DOC, DHR and DJJ will advise the Governor on the Georgia Rx Exchange status and activities.
 - c. These efforts shall be coordinated by the Department of Community Health's Office of Information Technology and Transparency.
2. Implement a common preferred drug list and coordinated prior authorization process between the departments that fund or provide mental health services.
3. Develop easier prior authorization processes that are more understandable to the consumer.

4. Convene legal counsel from all the state departments that deliver services to the mentally ill in order to develop a common information-sharing memorandum for treatment, payment, healthcare operation and public safety reasons.
5. Develop a flexible funding mechanism for non-prescription medications that prevents or minimizes side effects of prescription medications.

SUPPORTED EMPLOYMENT

CURRENT STATE OF NEED

Supported employment services and activities have been described as one of the most important strategies to engender empowerment in persons with psychiatric disabilities.³⁰

With unemployment in Georgia (6.2 percent) running higher than the national average (5.7 percent)³¹ the difficulty for any citizen to find gainful employment is daunting. This is especially true for the disabled population who request assistance in acquiring and maintaining employment through supported employment services. DHR's "Strategic Plan for Fiscal Years 2007-2011" states as a five-year goal that "50% of Georgia's mental health consumers will be employed" and includes a two- to three-year goal that "70% of Georgia's mental health consumers enrolled in supported employment programs will be enrolled in services that adhere to fidelity standards of the EBP model for supported employment."³²

As of September 2008, there are 72,971 total unduplicated consumers with serious mental illness, 1,367 (or 1.8 percent) of which are enrolled in supported employment. This is an increase from 1,321 consumers enrolled in March of 2006. The DHR goal to enroll 50 percent of their consumers in supported employment programs (36,485 consumers) requires a minimum of 657 slots to be funded per month.

Supported Employment is not a clinical service but is generally seen as an important social service that enhances the overall quality of life for those who require the structure, support and training necessary to maintain a place in the workforce.

EFFECTIVE PRACTICE SOLUTIONS

In the State of Georgia, AmericanWork, Inc. (AmericanWork) has provided services since 1999. AmericanWork has a contract with DHR to assist mental health consumers who have barriers to employment in finding placements. These consumers vary from those who have a definite mental health diagnosis and are receiving Social Security benefits, to those who are in the process of being declared by Social Security, to those who are not in the process of applying for disability. AmericanWork subcontracts with community service boards (CSB) for the state of Georgia. AmericanWork is able to provide a cost-effective model that scores high on the fidelity scales through SAMHSA's Best Practices for supported employment.³³ Currently, there are four locations in Georgia: Albany, Valdosta, Savannah, and Thomasville.

While the traditional vocational support system focuses on testing and assessment, leading to delays in eligibility for employment, AmericanWork quickly places consumers in a job in the community. While there may be compromises between what consumers may want for a job and the community in which he or she lives, AmericanWork will locate a job as quickly as possible and find the consumer a placement. The goal is to place consumers in meaningful employment as quickly as possible because once employed, many individuals begin seeing the benefits that come with a steady revenue stream, and it resonates with their treatment plan and medication compliance.

AmericanWork provides support to both consumers and employers. The program ensures that consumers are able to get to their jobs, provides support for any concerns that arise for the consumer or the employer and provides assistance as needed for consumers through their employment training process. AmericanWork allows for the flexibility needed for consumers who may leave a job for a few weeks and return for another placement. Consumers are placed in integrated workplaces, with mental health consumers working alongside non-mental health consumers.

Additionally in the state, DOC has developed a work release program to facilitate successful re-entry from prison to the community. Approximately 3,000 inmates who will be released from DOC soon are participating in this program. The program's goals are to develop both employable work skills and good work habits (e.g., punctuality, working for a supervisor, getting along with other employees) and to help them save money which can be used when released from DOC (i.e., for clothing, rental deposit, food, transportation, and the like). Employers consist of fast food establishments (e.g., Wendy's and Burger King), hair salons, dog grooming shops, road and housing construction companies, hotels, dry cleaners, auto-body shops, auto-repair shops, painting companies, roofing companies, restaurants (cooks, dish washers and servers), Tyson chicken plants and local municipalities (e.g., City of Stockbridge). Out of these 3,000 inmates, approximately 200 have been receiving mental health services while living in the general inmate population. In order to expand these supported employment opportunities to more seriously mentally ill inmates DOC has opened a 50-bed transitional unit at the Phillips Transitional Center. These inmates are hand picked by the mental health staff and placed in jobs that have been individualized for them.

RECOMMENDATIONS

Supported employment offers individuals with mental illness or addictive diseases more independence and hope, as well as a daily motivation to continue toward recovery. Supported employment provides an exciting opportunity for private industry to partner with consumers, family members, community supports and treatment providers to promote inclusion of people with mental illness into mainstream society. Supported employment programs should be developed statewide to work jointly with case management services, housing and treatment services. A comprehensive service and support program will enhance services provided by DHR, DOC, county jails and the Department of Labor (DOL) to individuals with mental illness.

TRANSPORTATION

CURRENT STATE OF NEED

In the state of Georgia, one or more of the following methods generally transport MHDDAD consumers to services:

Community Services

Non-Emergency Transportation (NET) – This is a system operated by the Department of Community Health to transport Medicaid-eligible persons to and from Medicaid-covered services. Transportation is an entitlement in this case. Typically, NET is used by adult mental health consumers to access day treatment programs.

DHR Coordinated Transportation – The purpose of this transportation system is to transport DHR consumers to DHR services. The persons using this system are either not Medicaid eligible and/or are not going to a Medicaid-covered service. Aging and developmentally disabled consumers are the primary riders on this system. Mental health and addictive disease consumers make up 10-15 percent of ridership. Total MHDDAD annual expenditures for the DHR coordinated transportation program is \$10M with an estimated \$3.3M devoted to the transportation needs of the mental health and addictive disease population.³⁴

Service Provider Transportation – MHDDAD community service providers were the source of transport for their consumers for many years. These community providers still transport their consumers to and from community integration activities every day. For service providers that are not in the DHR transportation system, they remain the primary transportation source. NET would be the only other source available, if the consumer and the service are eligible. State-operated community service motor vehicle costs were \$471,512 in FY08, \$254,903 of which was for mental health and addictive disease programs.³⁵ For CSBs and private providers, these transportation costs are funded out of total programmatic-funding contracts. The amount community service providers allocate to transportation out of this funding stream is unknown.

Hospital Services

County Governing Authority/Law Enforcement – Georgia law requires that the county governing authority transport individuals that are being sent to a state hospital involuntarily (under a civil court order Form 1013). The county sheriff's department carries out this responsibility. Generally, there is no requirement or expectation that transportation be provided back to the community. If a consumer is returning from a state hospital to a city or county jail, law enforcement (city or county) provides the transportation back to jail upon the consumer's release from the hospital. An individual found Incompetent to Stand Trial or Not Guilty by Reason of Insanity by the courts is transported to the hospital by law enforcement as ordered by the courts. Law enforcement officers are estimated to travel over 1.4M miles per year in transporting involuntary commitments, jail holds, and forensic consumers. If mileage for these trips were reimbursed, total reimbursement would be nearly \$825,000 per year, not including manpower costs incurred by the law enforcement agency providing the transportations.³⁶

Community MHDDAD Service Provider – Some community service providers provide transportation from the hospital back home for persons that are in their community. These transportation costs are funded out of total programmatic-funding contracts. The amount community service providers allocate to transporting consumers from state hospitals to their community is unknown.

State Hospital Transportation – State hospitals maintain vehicles on campus to provide for transportation of inpatient consumers within the campus of the hospital and outside the hospital as needed to meet the consumers’ treatment needs. Hospitals also provide transportation services to carry consumers home upon their release from the hospital. Motor vehicle costs for state hospital in FY2008 were \$1.5M, half of which is estimated to be for the transport of civil mental health consumers.³⁷

Total known MHDDAD annual expenditures for the transport of consumers are approximately \$12.1M. Of this total, an estimated \$4.3M is used to transport MH/AD consumers. In addition, law enforcement officers conduct nearly 15,000 transports per year. At an average of 95 miles per round trip, mileage reimbursement costs would be nearly \$825,000.

EFFECTIVE PRACTICE SOLUTIONS

In 2004, an Executive Order (13330) from the President called for coordination of Federal transportation programs to create greater collaboration and less duplication of services between agencies and services.³⁸

SAMSHA cites that there are five barriers to transportation facing mental health consumers: “affordability, accessibility, applicability, availability, and awareness.”³⁹ In a report from the National Governor’s Association (NGA) Center for Best Practices, several best practices for enhancing existing transportation methods were outlined.

To provide wider access to public transportation, NGA described three effective practices to be expanded: half-fare programs, Medicaid transit passes and travel training. Expanded half-fare programs essentially take those transportation services that are receiving federal funds, and are thereby required to offer half-fare programs for “off-peak hours on trains, subways, and buses to qualified people with disabilities,” and expand the definition of disability beyond the Federal definition, enabling greater access to the program for mental health consumers.⁴⁰ Medicaid transit passes provide “access to people with disabilities who live in areas with a public transit system.”⁴¹ These consumers are given a monthly transit pass with no ride limit, enabling the individual to use the pass for any need. Travel training is often given through local transit authorities or private organizations. The training provides people with disabilities “experiential learning, such as taking the bus or train trips”; schedule reading; and other skills that can give greater confidence in taking public transit.⁴²

NGA recognizes that not all consumers live in areas with public transportation, and that the need for access to transportation is just as great, if not greater, for those in rural communities or those without public transit. Three best practices were described to be consumer-run programs,

volunteer-augmented programs, and travel vouchers. Consumer-run programs are peer-run, and often provide transit to peer services, such as support groups, drop-in centers, and other services. A few of these programs have funding to provide transportation to anywhere the consumer needs to go. Volunteer-augmented programs offer a combination of “paid staff and volunteers, program vehicles and personal vehicles,” in order to provide a greater number of “rides” for consumers.⁴³ Travel vouchers are used frequently in rural areas. A voucher is presented to the taxi driver, public transportation or other service that is used by the consumer. The vouchers are provided by a “sponsoring agency” and can be used whenever necessary.

ENSURING ADEQUATE TRANSPORTATION FOR CONSUMERS OF BEHAVIORAL HEALTH SERVICES

Consolidation of service locations and lack of public transportation in many areas of the state have made transportation to services one of the most pressing issues in the MHDDAD service delivery system. At most consumer/family forums and regional board meetings, transportation is the top issue/complaint. In 2007, the DHR Coordinated Transportation System surveyed MHDDAD community providers about transportation needs of the consumers they serve. This survey found that existing need could support an additional \$11.5M investment in transportation for consumers of MHDDAD services (\$5M additional for developmentally disabled; \$6.5M additional mental health and addictive disease consumers).⁴⁴

As a separate department, Behavioral Health will need to take full advantage of free and low-cost community transportation options. Where there are no reasonable sources of transportation available, Behavioral Health has the option of creating its own statewide transportation system, purchasing the service from existing transportation providers, returning transportation responsibilities to the community service providers, and/or using individualized transportation services. Each of these options has its merits and its place in a comprehensive transportation system. The right transportation will empower the consumer to achieve greater independence and self-sufficiency. The consumer will also have an increased opportunity for successful living in the community.

RECOMMENDATIONS

1. The SAMSHA Transportation recommendations should be adopted in Georgia. This list comes directly from SAMHSA’s Web site and is directed towards states that rely on federal funds.⁴⁵
 - a. States inspired by the Olmstead decision or the New Freedom Initiative should make transportation a central part of any plan to help people with disabilities live in the community.
 - b. Information gathered about the accessibility barriers faced by mental health consumers should be shared with transit providers so that they can better understand consumer needs and ensure appropriate transportation access.
 - c. Projects receiving Section 5310 funding (*Transportation for Elderly Persons and Persons with Disabilities*) should include people with mental disabilities when they provide services to older adults and people with disabilities.
 - d. An assessment tool appropriate for mental disabilities should be developed to aid in determining mental health consumer eligibility for paratransit. Paratransit is flexible in

- that it does not follow a fixed route or schedule and often uses vans or mini-buses as the mode of transport.
- e. The half-fare statute or regulations should incorporate a more inclusive definition of disability so that all people with disabilities who experience hardship would qualify.
 - f. The half-fare statute or regulations should extend reduced fares to rush hour and commuter vehicles, recognizing that many people with disabilities want to work but cannot due to transportation costs.
 - g. Materials should be developed for training travel trainers who want to help mental health consumers use public transit independently.
 - h. State Medicaid agencies should receive technical assistance on implementing Medicaid transit passes and should be encouraged to provide them whenever feasible.
 - i. States should receive technical assistance on using Community Mental Health Services Block Grant funds to provide transportation through innovative programs such as consumer-run, volunteer-augmented and voucher programs
 - j. States should follow the federal lead in coordinating transportation resources to eliminate waste.
 - k. Mental health consumers, family members and advocates should receive technical assistance on becoming involved in transportation planning within Metropolitan Planning Organizations and other planning bodies.
2. The Commission recommends that the state develop a coordinated transportation plan for individuals with mental illness that eliminates the needs for duplicate trips based upon payor source and multiple providers for individual consumers.
 3. Explore legislation to provide immunity to hospitals for when a family or another responsible adult agrees to transport a mentally ill patient when the patient and family agree on the transportation arrangement and are fully informed of the risk.

UNIFORM CHILDREN’S BENEFIT PACKAGE FOR PUBLICALLY FUNDED SERVICES

CURRENT STATE OF NEED

Georgia’s system of behavioral health services for children and adolescents has undergone major changes in the last few years. MHDDAD has gone from a grant-in-aid provider payment system to a fee-for-service system. Children in the custody of the Division of Family and Children’s Services (DFCS), who previously had to have their behavioral health needs primarily met through a large residential treatment system, are now receiving more services in homes and communities through MHDDAD providers. Moreover, Medicaid-eligible children (other than those in DFCS custody) are receiving their behavioral health services through three Care Management Organizations managed by the Department of Community Health.

There have been significant improvements in the MHDDAD-administered system of services to children. Previously there were too many children in the state hospitals and in long-term residential treatment facilities. There was no single point of entry into the system of services. There was little utilization management and inadequate accountability for service provision. There were too few providers of child and adolescent services and therefore limited choice for consumers. The community-based and residential providers are still not all enrolled in the Care Management Organizations (CMO). The office-based and outpatient mental health provider networks provided by the Medicaid CMOs are more robust than the fee for service and MHDDAD waiver programs. While progress has been made, it is not yet clear whether the positive changes have assured that every child or adolescent with behavioral health needs appropriately served by a state-funded program is receiving the necessary and appropriate care.

Now offered:

- Statewide access to basic behavioral health services
- A single point of entry
- Fewer children in state hospitals, staying for shorter lengths of time
- A standard benefit package of “Core” and “Specialty” services
- More Core Service providers and greater consumer choice and access to services
- External utilization review to assure appropriateness of services
- Crisis services, including a crisis and access line, mobile crisis services and crisis stabilization programs

While there has been significant progress, issues remain that must be addressed:

1. Multiple categories of children: Children and youth with serious emotional disturbance (SED) may be involved with and receiving services from one or more of the state’s child-serving departments (MHDDAD, DJJ, DFCS, DCH). Children with SED are often involved with, and served by, multiple systems simultaneously, or they may move from one system to the other. There are now multiple payor sources, each with variations in eligibility criteria. When a child’s eligibility for a particular payor source changes (such as happens when a child is taken into DFCS custody, or when a child’s parents choose to

change CMOs), continuity in their treatment is threatened and may be broken. Parents and providers find it confusing and difficult to navigate the various payors of care.

2. Multiple provider networks: The MHDDAD network of providers of behavioral health services for children and adolescents has grown significantly (from 38 to 102 Core providers and from 69 to 114 Specialty providers). However, this provider base is not shared among the CMOs. Data collected during the first quarter of 2008 indicates that only approximately 55 percent to 66 percent of all child and adolescent providers were enrolled with the CMOs. But of private providers, excluding the CSBs, there were only 30-35 percent of providers enrolled with the CMOs. However, the CMOs have under contract a more robust mental health provider network (i.e., larger volume and variety of the type of mental health providers) than the MHDDAD fee for service network. For children and families, this means that as they move between systems and payors, they may not have access to the same providers.
3. Varied benefits available: It is essential that all Medicaid-eligible children will have the same set of benefits/services available to them through the Medicaid State Plan. While this is true, it is also the case that children and their families need services that are not provided through the Medicaid Rehab Option (MRO) but are known to contribute to positive outcomes for children. These include intensive case management, an array of crisis services and other alternatives to high-end treatment. Currently the availability of these non-MRO services varies depending on the payor.
4. Varied amounts of service provided: Each of the payors of service have different authorization procedures and different authorization criteria and therefore deliver different amounts of the same State Plan MRO services. For providers this means managing multiple utilization-management and billing systems. For children and their families it means that children with the same needs, when served by different systems, may not get the same level of service.

EFFECTIVE PRACTICE SOLUTIONS

Since 1983, there has been a national movement toward a system-of-care philosophy.⁴⁶ As early as 1986, the system-of-care philosophy was defined as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families."⁴⁷

System-of-care services should be "community-based, child centered, family focused, and culturally competent, including linguistically."⁴⁸ These services should be "comprehensive, individualized, provided in the least restrictive setting that is appropriate for the individual, coordinated at both the system and service delivery levels, involve families and youth as full partners, and emphasize early identification and intervention."⁴⁹

Under the auspices of these guidelines, the mental health system operates from an empowering, or strength-based, perspective that incorporates and seeks out the input and preferences of the child and family. The family is involved in each stage of service planning and service delivery, which is grounded in multiagency collaboration and community supports. Services and supports are therefore individualized by the services needed by the individual versus the individual adapting to the services that are offered.⁵⁰ The Surgeon General's Report on Children's Mental Health states that differences in access to services "exists across racial, ethnic, and

socioeconomic groups,”⁵¹ which emphasizes the need for participating agencies and programs to be culturally and linguistically competent with the populations served in their area.

Santa Cruz County Children’s Mental Health published their Seventeen Year Report on their comprehensive interagency system of care for seriously emotionally disturbed children and adolescents. While many aspects of system of care cannot be measured, there are measurable outcomes such as

- Maintaining children safely in their homes if possible
- Placement of children in the least restrictive, clinically appropriate setting
- Reduction in the number and costs of group home and hospital placements
- Reduction in juvenile justice recidivism
- School attendance and educational increases
- Development of family/professional partnerships
- Cultivation of culturally competent services
- Evaluation used as a tool to inform policy and maintain accountability⁵²

In Georgia, KidsNet Georgia System of Care is a “targeted expansion” that began in Rockdale County. KidsNet provides community-based care for youth with severe emotional disturbances who are involved with multiple systems. In 1999, KidsNet received a federal SAMHSA grant for the improvement of service delivery and outcomes for youth at risk for out-of-home placements and their families. Due to KidsNet’s success in developing community-based alternatives that allow the youth to remain in their home communities, they received funds to expand the system of care to additional communities in the state. Currently, KidsNet Georgia serves as a state oversight committee, which is chaired by the Governor’s Office of Planning and Budget. The Phase I expansion pilot sites that are currently operational include Newton, Chatham, Dade, Walker, Haralson, Polk, Bartow, Paulding, Floyd, Gwinnett, Fulton and Douglas Counties.⁵³

DHR, DJJ and the Children and Youth Coordinating Council have committed resources to the expansion of KidsNet. In a 2008 report on the characteristics of children served, KidsNet examined whether children most at risk of out-of-home placement were being identified for intensive support services. In 2007, KidsNet screened 1,519 children. Out of that number, 206, or 14 percent, of those children were referred to KidsNet intensive support. In contrast, 86 percent or 1,313 children were referred elsewhere. The report found that the children referred for KidsNet intensive support were more likely to “be referred by a school, mental health provider, or parent/caregivers; to have severe presenting problems, including physical aggression, property damage, police contact, threat to life of others, sexual assault, self injury, and suicidal ideation and attempt; receive SSI, Medicaid, and food stamps; to have used school-based, outpatient, court-ordered treatment, inpatient, and residential treatment in the past year; be currently using outpatient, school-based, and court-ordered treatment services; be on psychotropic medication;

have a chronic health problem; have a parent with a mental illness; and have a parent who was convicted of a crime.”⁵⁴ According to the research, KidsNet is successfully selecting children most at risk for out-of-home placement and in need of intensive support services.

The use of evidence-based practice (EBP), when informed by the research and evidence, improves the quality of care provided by services and allows for a greater likelihood that specific desired outcomes will be achieved.⁵⁵ Evidence-based practices typically have manuals that guide implementation and that “allow for consistent delivery of the practice and high fidelity to the model.”⁵⁶ In other words, fidelity to the EBP ensures that the treatment administered closely adheres to the original model, thereby increasing the likelihood of success. In Georgia, there is no mandate for EBPs statewide. Included in that is a lack of Multisystemic Therapy (MST) and Trauma Focused Cognitive Behavioral Therapy, and little funding to monitor fidelity.

A promising example of an EBP is Intensive Case Management (ICM). In Georgia, there is a need for ICM that will serve children and adolescents with high needs in order to help these individuals remain in the community and out of residential or psychiatric placements. According to Burns and Landsverk (2007), ICM can lead to “less restrictive placements, increased behavioral adjustment, family functioning, and reduced delinquency” in children and adolescents.⁵⁷ ICM has been described by Santa Cruz County Children’s Mental Health agency as a “whatever it takes” approach.⁵⁸ ICM is a concentrated and targeted service that requires coordination between the family, schools and mental health professionals to provide the supports and services that are individualized to the child or adolescent’s specific needs. The coordination team is often a collaborative effort of interagency staff, which is in line with the system-of-care philosophy. ICM for children and adolescents, as with the adult population, requires small caseloads for case managers in order to be able to respond immediately to changes in needs or circumstances for the individual.

Studies have found that in addition to youth needing less restrictive services, there have been reductions in inpatient hospitalizations for substance abuse; and for children in foster care, there have been findings showing fewer changes in placement and runaway youth.⁵⁹

Currently, ICM services are not paid through Medicaid, along with school-based mental health and substance abuse services. KidsNet does provide school-based services, but they are limited.

Finally, there is a need for increased accessibility statewide for alternatives to high-end treatment. KidsNet and TPA provide Intensive Family Intervention services, crisis stabilization programs and Mobile Crisis and respite-care services, but the accessibility to these services needs expansion.

RECOMMENDATIONS

1. Establish an intensive case management system through the development of a statewide system of care for children (wraparound) with serious emotional disturbances who are at risk for institutional or congregate care or who are inappropriately in institutional or congregate care.
 - a. There are 10 essential elements of wraparound:

- Wraparound must be based in the community.
- Services and supports must be individualized, built on strengths and meet the needs of children and families across life domains to promote success, safety and permanence in home, school and community.
- The process must be culturally competent, building on the unique values, preferences and strengths of children and families and their communities.
- Families must be full and active partners in every level of the wraparound process.
- The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies and community services working together to develop, implement and evaluate the individualized service plan.
- Wraparound child and family teams must have adequate, flexible approaches and flexible funding.
- Wraparound plans must include a balance of formal services and informal community and family resources.
- An unconditional commitment to serve children and families is essential.
- The plan should be developed and implemented based on an interagency, community-based collaborative process.
- Outcomes must be determined and measured for the system, for the program and for the individual child and family.

b. Practice requirements of wraparound are

- Community collaborative structure
- Administrative and management organization
- Referral mechanism
- Resource coordinators to facilitate the process
- Strengths and needs assessment
- Formation of the child and family team
- Interactive team process and formation of a partnership to develop individualized plan
- Development of a crisis/safety plan
- Measurable outcomes monitored on a regular basis
- Review of plans by the community collaborative structure⁶⁰

2. Establish a single benefit package for children receiving publically funded mental health services.

a. Identify and establish a unified population of children regardless of payor source.

Currently continuity of care breaks under the following categories:

- According to the payor source that results in four groups: Medicaid managed care, Medicaid Fee for Service, uninsured, SSI eligible
- Juvenile Court-ordered treatment, court-determined level of care
- Institutionalized youth in DJJ-provided services

b. Georgia needs an agreement among the departments of Behavioral Health, DHR, DCH, DOE and DJJ that ensures that children will have access to essential mental health services regardless of eligibility category. In addition, the benefit package must achieve the following:

- Maximize of EPSDT for Medicaid enrollees
- Use evidence-based practices with fidelity measures
- Utilize and coordinate school-based services
- Ensure adequate services centered in communities with each level of service a child may need, including residential services when appropriate.
- Interagency collaboration/care coordination with mandated participation
- Assure competency re: Limited English Proficiency Sensory Impaired
- Guarantee appropriate, timely, comprehensive assessment in all settings that is transferable from one system to another.
- Work in partnership with families and engage in family activities whenever necessary (family-oriented , strength-based, culturally competent and child and family teams)
- Use and monitor shared outcome measures
- Coordinate transition among levels of care to ensure each child receives the services they need, to include the transition from children to adult services systems
- Develop common definitions of Medicaid rehab option services across all benefits plans and payor categories

c. Establish one unified provider base.

Currently Medicaid managed care, Medicaid fee for service and state-funded treatment providers all have different provider/network requirements. In addition, DHR and DJJ have different provider networks available for non-Medicaid services. Lastly, psychiatric residential treatment facilities (PRTF) providers can choose who they want to serve among the youth who have been pre-authorized by APS, which limits access to some youth with more intensive treatment needs. To ensure continuity of care and to prevent the inappropriate placement of children in institutions and congregate care the State of Georgia must have a common provider network for children with serious emotional disturbances across all state departments providing or contracting for mental health services.

c. The guaranteed benefit package across all funding sources should include PRTF and Medicaid Rehab Option (in child-caring institutions) services available statewide that

- Incorporate system of care principles and values in their operations,
- Ensure that PRTFs participate within a community-based system of care and
- Ensure PRTFs are reimbursed at a reasonable rate that is comparable to other states in the southeast region with equitable payment methodology between profits and non-profits.

ADULT SERVICES

CURRENT STATE OF NEED

Georgia provided core and specialty services to 93,517 adults with serious mental illness or substance abuse in FY08 through a statewide network of over 40 adult core and 20 adult specialty private providers who contract with MHDDAD to ensure that community mental health service needs are met.⁶¹ Adult core customers, based on individual preferences and customized recovery plans, have access to the following services:

- Behavioral health and diagnostic assessments
- Community Support Individual (CSI)
- Crisis intervention services
- Individual, family and group counseling and training
- Nursing assessments and health services
- Day treatment or rehabilitation programs
- Psychiatric treatment and medication management
- Pharmacy and laboratory services
- Substance abuse and co-occurring disorders treatments

In addition, in some areas of the state, consumers also have access to the following specialty services:

- Assertive Community Treatment (ACT)
- Psychosocial rehabilitation (day treatment)
- Mobile crisis services
- Crisis stabilization programs
- Residential services
- Supported employment
- Peer services

Georgia's system of community behavioral health services for adults has many excellent models and is emerging as a recovery-focused, community-based, peer-supported system with a goal of assisting in community re-entry and reducing the inappropriate utilization of hospital beds and 30- and 180- day readmission rates. When consumers need acute care services they should be able to receive them in community settings as close to home as possible. The Georgia Crisis and Access Line is a first point of entry where consumers can receive telephonic triage, which triggers an appropriate referral across the spectrum of care from mobile crisis intervention to a routine appointment within 7 days depending on the services available in the consumer's area.

At the same time, Georgia is facilitating placement into the community of 86 currently hospitalized persons who are on the Olmstead Mental Health Planning List. With adequate intensive case management, flexible funding and residential supports, consumers will make successful transitions into the communities of their choice and maintain their ability to thrive in

those communities where they work, live and socialize. Medicaid funding can often be used to stretch state resources.

Additionally, Georgia has issued a request for proposals to assess the viability of consolidating and managing all of Georgia's in-patient forensics programs. According to Commissioner B.J. Walker, "... we have been encouraged to look at privatization and evaluate whether it offers efficiencies to how we are currently operating our mental health system."⁶² While the Commission has not studied the issue of privatization thoroughly enough for endorsement, it has developed a list of critical questions to be answered prior to awarding a contract. These critical questions are located in Appendix A.

Nonetheless, Georgia's adult community mental health infrastructure is at risk of losing vital ground because of budget reductions. One example where significant losses have occurred is within the network of Supported Employment providers. Some Supported Employment providers have discontinued services altogether while others have had to decrease the number of staff and consumers served. During the current fiscal year, approximately 550 persons will be served in Supported Employment programs. In FY08, 2,241 persons were served in Supported Employment programs throughout the state.⁶³ FY10 looks to be equally challenging for Supported Employment in Georgia.

Other areas of the current service delivery system are also challenged. In rural Georgia, there is an insufficient workforce to meet the growing demands of a community-based mental health delivery system. As a result, there is a lack of a continuum of care that ranges from the most intensive outpatient services to the most basic case management.

NATIONAL RECOMMENDATIONS FOR EFFECTIVE SYSTEM DELIVERY

1. The National Association of State Mental Health Planning Directors has endorsed as a top priority the integration of whole health concepts into person-centered planning. Persons treated for mental illnesses die 25 years younger than those who are not diagnosed with mental illness. Health disparities must be addressed, according to this organization.⁶⁴
2. The Substance Abuse and Mental Health Services Administration (SAMHSA) is focusing attention on increasing availability of evidence-based practices, trauma-informed care and co-occurring disorders treatments.⁶⁵
3. Mental Health advocacy groups, including the National Alliance on Mental Illness (NAMI), Mental Health America and the Georgia Mental Health Consumer Network, list top priorities as increased funding for supported employment, supported housing and intensive community-based programming such as ACT and increased Peer Programming.⁶⁶
4. In 2000, the Institute for Community Inclusion sent surveys to the state mental health authorities in 50 states and the District of Columbia and found that 50 percent use flexible funding for residential and employment supports. It was concluded that persons who have access to flexible-funding spending are more stable in the community and less likely to require institutional support.⁶⁷

RECOMMENDATIONS FOR GEORGIA'S STATEWIDE SYSTEM

For Georgia to reach its vision of a life in the community for everyone, it needs to continue to build a statewide network of quality programming addressing the spectrum of consumer needs. Such a network would include

1. Case management services that help consumers resolve issues that have interfered with community stability. Assistance may include helping consumers access benefits, arranging for or providing transportation to mental health, addictive diseases and physical health services, finding safe and secure housing, ensuring that basic needs are met and helping the consumer to reach other individual recovery goals.
2. Additional interventional services such as mobile crisis and crisis stabilization programs so that the entire state is blanketed with these services.
3. Additional stabilization services to include more Peer Wellness and Respite Centers, Peer Support Programs, Certified Peer Specialist and other Peer run facilities and supports as well as Assertive Community Treatment, Intensive Case Management and Intensive Residential Supports.
4. Increased funding for Supported Employment programs, at least to pre-budget reduction levels.
5. Reasonable flexible-funding allocations that will provide funds that can prevent a consumer from becoming homeless, losing the opportunity to be on medication or experiencing other events that might lead to destabilization and hospitalization or incarceration.
6. That the Mental Health Ombudsman be funded in the FY10 budget.

BEHAVIORAL HEALTH COLLABORATIVE

CURRENT STATE OF NEED

Currently behavioral health services are delivered and funded by several departments. The Behavioral Health Collaborative would bring Commissioners from these departments together with a group of consumers, family members, service providers, advocates, law enforcement and representatives from the executive, legislative and judicial branches to resolve systemic barriers to services that impact individuals served by more than one department. The Collaborative would develop solutions to the systemic issues by making recommendations, which include steps for implementation of funding, policy changes, practice changes and evaluation. The recommendations developed by the Collaborative would be presented to the Board of each department for approval and reported to the Governor and General Assembly. The Collaborative would then evaluate and monitor implementation of the recommendations.

EFFECTIVE PRACTICE SOLUTIONS

New Mexico

On May 19, 2004, Governor Bill Richardson of the State of New Mexico signed HB 271 into law, creating a statutory legal entity charged with overseeing New Mexico's Behavioral Health Delivery System.⁶⁸ This created the Behavioral Health Purchasing Collaborative and the Behavioral Health Planning Council. Various state agencies, local organizations and consumers collaborate to coordinate payment and service delivery for better outcomes and treatment.⁶⁹ According to SAMHSA, New Mexico was the first state in the United States to address "fragmented services, cost, and service access." Current funding includes state-controlled funds from both the federal and state in the approximate amounts of \$200-400 million.⁷⁰ The statutory duties are to identify behavioral health needs statewide; give special attention to regional differences, including cultural, rural, frontier, urban and border issues; inventory all expenditures for mental health and substance abuse services; plan, design and direct a statewide behavioral health system; contract for operation of one or more behavioral health entities to ensure availability of services throughout the state; develop a comprehensive statewide behavioral health plan; and seek and consider suggestions of Native Americans.⁷¹ The creation of the Behavioral Health Purchasing Collaborative, and the Behavioral Health Planning Council, as statutory legal entities, allows the State of New Mexico to replace multiple departments' oversight into one legal entity, the Purchasing Collaborative; replace multiple advisory bodies into one statutory advisory body, the Behavioral Health Planning Council; replace multiple contracting mechanisms and administrative infrastructures with one statewide entity, currently Value Options New Mexico (VO); and address the New Freedom Commission goals and recommendations, as well as New Mexico's own Gap Analysis recommendations (2002) regarding behavioral health programs and services and infrastructure.

Texas

In 2005, Texas received a five-year Mental Health Transformation State Incentive Grant, which supports the development of infrastructure and collaborations at the state level, while also initiating the development of local collaborative at the community level. In 2006, a Comprehensive Mental Health Plan was approved by the Governor and submitted to

SAMHSA.⁷² The “administrative home” of the grant is located in the Texas Department of State Health Services (DSHS). There are 14 state agencies, along with consumers and family members making up the Mental Health Transformation Working Group. The Texas legislature recently appropriated \$82 million for mental health crisis redesign. In addition, over \$500 million related to behavioral health services was appropriated to other state agencies.⁷³ The vision for transformation is that “all Texans will have quick and easy access to early intervention and mental health services and supports of high quality” within a public health framework.⁷⁴

Ohio

Ohio’s Comprehensive Mental Health Plan is centered on the principles of financing reform; cross-system integration and coordination; access to a continuum of services; quality, evidence-based practices and positive outcomes. Ohio’s collaborative stakeholders include the Transformation Working Group, which provides strategy, policy and high-level leadership. State agencies are creating greater “cross-system collaboration” through the sharing resources and designing complementary policies and practices. Consumer and advocacy groups participate in the Transformation Working Groups. The Strategic Advisory Committee (SAC), the Ohio Association of County Behavioral Health Authorities (OACBHA), the Ohio Council of Behavioral Health Providers (OCBHP) and the State Mental Health Planning & Advisory Council provide strategic advice and guidance to the Ohio Department of Mental Health. The Transformation Working Group is responsible for overseeing Ohio’s transformative process.

Oklahoma

On December 12, 2005, Governor Brad Henry authorized the formation of the Governor's Transformation Advisory Board. The purpose of the Board is to advise Oklahoma as it develops a Comprehensive Mental Health Plan. There are 28 members of the board, which include directors of service agencies, senators, representatives, consumers, youth, and family members.⁷⁵ Oklahoma’s vision is that all “citizens will prosper and achieve their personal goals in the community of their choice.”⁷⁶ The Governor’s Transformation Advisory Board serves as the Transformation Working Group as directed by the Governor. The Board is advisory and is represented by consumers, families, youth, state agencies, tribal organizations, Indian Health Services, law enforcement, philanthropy and business partners. Additionally, the Secretary for Health provides a link between the Office of the Governor and the Advisory Board.⁷⁷

Washington

The Mental Health Transformation Project is known as the Partnerships for Recovery Initiative, which is housed in the Office of the Governor, not a state agency. In 2004, a Joint Legislative and Executive Task Force on Mental Health Services and Financing was established to study the delivery of public mental health services. In 2005, the task force submitted a Mental Health Transformation State Incentive Grant application and was awarded the grant in October 2005. Because of partnership between legislative and executive branches in the task force, the Governor established the Partnerships for Recovery and Resiliency Initiative, which is now the Mental Health Transformation Project. Currently, Washington state agencies have completed strategic planning processes, which are being implemented in tandem with the outcomes and strategies that are identified by the Mental Health Transformation Project.⁷⁸ There are two levels of the Transformation Working Group. A senior executive-level group who provide both oversight and direction, while also implementing the transformation, and a 32-member group

that includes state agency directors, adult and youth consumers, family members, local government representatives and mental health providers and advocates. There are also 11 project staff workers and supporting committees.⁷⁹

Connecticut

Governor M. Jodi Rell charged 14 state agencies and the Judicial Branch with the transformation of the mental health system in Connecticut. The Chairs of the Appropriations Committee of the General Assembly have also made a commitment to “sustain effective infrastructure and service delivery enhancements” that will ensue from the transformation work.⁸⁰ An Oversight Committee guides the process, which includes state agency leaders, the Judicial Branch, advocacy groups, family organizations, individuals in recovery, and nonprofit organizations. There are four subcommittees addressing “priority setting and implementation; resource investments strategies; communications; and policy and legislation.”⁸¹

RECOMMENDATIONS

1. **Creation of a Behavioral Health Collaborative.** A statutorily created Behavioral Health Collaborative administratively connected to the Department of Behavioral Health to provide guidance for interdepartmental behavioral health programs, practices, policies and budgets for the purpose of resolving system barriers to service delivery that involve more than one department:
 - a. Collaborative Membership shall include
 - Commissioner of the Department of Behavioral Health
 - Commissioner of the Department of Community Health
 - Commissioner of the Department of Corrections
 - Commissioner of the Department of Juvenile Justice
 - Commissioner of the Department of Human Resources
 - Adult consumer of public behavioral health services
 - A family member of a consumer of public behavioral health services
 - A parent of a child receiving public behavioral health services
 - Member of the House of Representatives
 - Member of the Senate
 - Advisory members as determined necessary by the Collaborative members:
 - Commissioner of the Department of Labor
 - Commissioner of the Department of Community Affairs
 - State Superintendent of Schools
 - Upon request of the Collaborative the following bodies will act as advisory groups to the Collaborative:
 - Governor’s Council on Development Disabilities
 - Council on Aging
 - Governor’s Council on Substance Abuse
 - Governor’s Advisory Committee on Mental Health, Developmental Disabilities and Addictive Diseases
 - Olmstead Planning Committee

- Mental Health Planning Council

- b. Responsibilities:

- The Collaborative will develop solutions to the systemic barriers or problems by making recommendations that implement funding, policy changes, practice changes and evaluation of specific goals designed to improve services delivery and outcome for individuals served by the departments.
- The Collaborative will focus on specific goals designed to resolve issues for service provision that negatively impact individuals serviced by at least two departments.
- For the first three years the Collaborative will focus on the implementation of the following goals:
 1. Implementation of a statewide continuum of case management for both adults and children,
 2. Implementation of the state electronic medication exchange to include a common preferred drug list and common prior authorization process
 3. Implementation of the uniform child benefit package across all department and eligibility categories.
 4. Implementation of the short-term crisis stabilization units and mobile crisis stabilization teams with statewide access.
- The Collaborative will monitor and evaluate the implementation of the four predetermined goals (previously listed), if the Collaborative determines that any one of the initial goals has been effectively implemented and sustained the Collaborative may elect other systemic goals as areas of focus to implement and evaluate.
- Establish common outcome measures
- The Collaborative shall submit reports of their original recommendations and evaluation of their implementation to the Office of Governor and Members of the General Assembly.
- The recommendations developed by the Collaborative shall be presented to the Board of each department for approval or review at least annually.

INPATIENT SERVICES

CURRENT STATE OF NEED

The Commission reviewed the finding letter from the United State Department of Justice (USDOJ) tours of the state hospitals and strongly agrees that the conditions outlined in the letter must be corrected at an aggressive pace. The Commission finds it imperative that the state put in place policies and procedures to ensure that quality of care in the state hospitals are monitored and sustained in accordance with the professional standards of care.

The Commission has identified a clear need for an analysis of state hospital services to determine the current and future bed capacity needed within the state hospital system and to determine who should be served in the state's psychiatric hospitals. This analysis should take into consideration the growth in the state's population as well as current movement towards building community services and supports designed to promote recovery. Georgia's state hospital system currently serves as a safety net and entry point to services, which has resulted in state hospitals becoming all things to all people, operating with no defined mission. For example, a single state hospital in Georgia will provide short-term crisis stabilization services, substance abuse detoxification services, children's services, services to the chronically mentally ill, services to the aging chronically mentally ill and services to individuals with development disabilities. With no clear mission, the hospitals have a difficult time developing effective clinical programming to meet the multiple needs of the individuals being served.

The lack of mental and physical health professionals willing to work for state salaries, which are often less competitive than the private healthcare markets, further impacts the hospitals' ability to provide quality care. This workforce shortage increases operational costs in contracting for temporary staff, as well as continuous recruitment and training of new staff. Consistent staffing is necessary when the individual being treated must receive consistent care in order to develop and maintain stability.

In addition, many of the buildings on the state hospital campuses are old and expensive to maintain, while at the same time structured in an undesirable treatment environment. Therefore, the implementation of new clinical programming, such as treatment malls and person-centered planning, is made more difficult because of the lack of physical space available within the hospitals.

Finally, there is a need for improved coordination with community-based providers for treatment and support services at both admission and discharge. While these processes are beginning to improve, the integration of state hospital services into a comprehensive continuum of recovery-oriented community-based care is essential to quality of care.

While these processes are beginning to improve, integrating state hospitals services into a comprehensive continuum of recovery oriented community-based care is essential to providing quality care.

SYSTEM-WIDE IMPROVEMENTS

Over the past two years, MHDDAD has made many improvements to its hospital system and the services that Georgians receive in its inpatient units. Most of these actions focus on three key areas: treatment, personnel and policy.

MHDDAD reports progress being made on treatment-related issues that focuses on active treatment based on the strengths, needs and desires of the consumer. MHDDAD believes people are more invested in plans that they “own.” Therefore people served in the Georgia State Psychiatric Hospital System are working with staff to complete plans that they had an active part in developing. In addition to making treatment plans individualized, prescriptive and recovery-oriented, DMHDDAD reports to have also

- Developed treatment malls at all seven hospitals to deliver active treatment to inpatient Adult Mental Health consumers
- Partnered with Yale University to bring their Transformation to Recovery initiative to Georgia’s hospital system to support our move to a recovery oriented approach to inpatient services
- Established a “Best Practices Approach” to Medication Management, of which key features include
 - Process improvement to reduce the hospital system’s reliance on benzodiazepines
 - Algorithms for the treatment of chronic medical conditions
 - Algorithms for the prescription of psychotropic medications
 - Eliminated chemical restraints

Healthcare recruitment and retention is a significant challenge across the healthcare industry. MHDDAD competes with all other healthcare providers in Georgia for adequate numbers of qualified staff. Staffing continues to be a challenge for the Georgia State Psychiatric Hospital System. With the support of Office of Human Resource Management and Development (OHRMD) and their commitment of staff to focus on healthcare professional recruitment, MHDDAD is continually looking for ways to be the employer of choice for key staff. MHDDAD reports recent improvements in

- Compressing hiring processes for key direct client care staff
- Compressing and standardizing orientation across the system to assure that hired staff are serving consumers sooner
- Increasing pay for psychiatry, nursing, psychology and pharmacy staff
- Paying longevity bonuses to qualifying direct client care staff to promote retention
- Implementing a “shift differential” for direct care staff working nights and weekends to promote retention
- Improving staff scheduling tools and strategies to assure that core staffing reflects increases demanded by the acuity of patients being served
- Changing traditional approaches to scheduling to be as flexible as possible when scheduling key staff and still meet the staffing requirements for the hospitals
- Establishing statewide contracts for Locum-Tenens
- Establishing statewide contracts for Physician recruitment

Recently MHDDAD reports to have revised some key policies to emphasize quality and drive consistent practice. Policy will continue to be revised to support system improvements. Recent policy changes include

- Standardized admission criteria across the hospital system to include mental health and physical health criteria
- Updated Seclusion and Restraint Policy, increasing the level of clinical oversight
- Adopted the Mandt® Behavior management system across the hospital system and requiring successful certification as a condition of employment this fall

MHDDAD reports that other system-wide improvements that fall outside the categories listed above include

- Implementation of a new information management system called Avatar to manage program data reporting in the hospital system, replacing the 30+ year-old MHMRIS system
- Establishing contracts with private psychiatric hospitals for overflow capacity for adult and child and adolescent inpatient mental health services
- Ensuring that crash carts are available in all usual patient care areas to support staff responses to medical emergencies

RECOMMENDATIONS

1. State Hospital bed analysis

- Complete an analysis of state hospital bed utilization in the metro area to determine how to eliminate the back-up of patients in metro hospital's emergency rooms.
- Complete a needs analysis of state hospital beds and PRTF beds in southwest Georgia.

2. Develop a coordinated, comprehensive and seamless level of care in the community that will relieve the stress on the state hospitals

- Coordinate outpatient, partial hospitalization, and emergency services.

3. Appropriate funds to state hospitals to improve quality of care.

- Georgia's state hospitals pay an average of \$440 per day. The average cost per bed per day in the United States is \$518, with states such as Vermont, Wisconsin, Michigan and Connecticut all showing substantially higher rates of funding, above \$700 per day.

4. Develop a plan to improve primary healthcare in the hospitals.

- Use residents in internal medicine training programs and attendees at university-based programs to rotate through the state hospitals and provide medical psychological care to patients. The four medical schools in Georgia should be approached to help staff training in the basic recognition and management of medical conditions.
- Serious consideration should be given to the establishment of Centers for Excellence at each state hospital. Each state hospital would become a Center of Excellence for a critical subspecialty area, such as substance abuse, treatment and detoxification, management of patients with psychiatric illness and severe medical illness, care of the geriatric patient, etc.

- Three or four associate medical directors should be hired, as is the standard in most other states.

5. Quality inpatient care for children

- The development of quality measures in order to determine the level of care that is provided in the state hospital system is absolutely essential.
- Develop a continuum of community-based crisis intervention, residential and inpatient services to treat children in their home community within a system of care to eliminate the need for children's services within Georgia's state hospital system.

6. Investment in state hospital workforce professional development

- Supported professional growth, education, and career advancement.
- Peer support system should be in place to help employees who have been involved in traumatic events at work to receive the help they need.
- Recruitment of psychiatrists, psychologists and internists/family physicians, behavioral specialists and specialists in nutritional management.

7. State mental health system embrace the recovery model

- Patient advocates, peer specialists for staff education and enhancement of treatment programs, and patients input in treatment and decision-making.

8. Formulary Development

- The availability of medications, typically for the most treatment resistant patients, is essential in order to reduce hospitalization and promote wellness.
- A need for combination pharmacotherapy in many refractory patients demands metrics for monitoring medication response and side effects that are instituted in a standardized fashion.

9. Family Involvement

- A substantial effort to involve families in patient care for both assessment and treatment planning is essential.

MEETING NOTES

The following section contains notes from the Commission's monthly public meetings and conference calls, including public comment. These notes contain information from meetings held from August 2008 through November 2008. It should be noted that these notes are summaries of the public meetings and conference calls, and are not transcribed verbatim.

AUGUST CONFERENCE CALL

August 1, 2008, 9AM-10PM

Attendees on the Call:

Abel Ortiz, Governor/Chair of the Mental Health Commission; B.J. Walker, Commissioner, Department of Human Resources; Judge Steve Goss; Lynda Hammond, Licensed Professional Counselor; Stan Jones, Parent Representative; Dr. Dev Nair; Dr. Charles Nemeroff; Senator Seth Harp; Senator Johnny Grant; Senator Greg Goggans

Non-Commission Members: Don Watt, Department of Community Affairs; Michele Barnett; Melinda Moore, Mental Health Commission staff.

Abel welcomed everyone to the call.

Judge Goss: I won't be able to attend the next Mental Health Commission meeting due to judicial council meetings that I can't miss.

Dr. Nemeroff: Will we be sharing the letter from Georgia Medicaid?

Abel has not seen it himself.

Commissioner Walker will have Dave Statton talk about it.

Abel Ortiz reviewed the last commission meeting.

Abel: You should have received to drafted documents. I'd like to talk about those, and get some feedback on the format. Let's try to look at the answers to the questions asked.

Judge Goss: In terms of Intensive Case Management, I've looked at the drafts. The proposal looks good, but I am concerned it doesn't go far enough. It looks at 10 counties, predominantly metro-Atlanta. DHR has to start somewhere, so I understand the 10 counties. The way I read this is that other counties will have Level 2, which is fine. On the adult outpatient conference call a few weeks, we talked about trying to come up wit ideas for a Level 2 system to bulk up. I've received some contact information for a man who runs the New York State Mental Health.

My concern is that the commission is only looking at 10 counties, and there will be a less expensive and less intensive level statewide for non-forensic consumers.

ACT Team – There needs to be a plan over 2-3 years to beef up the Level 2 to add an additional caseworker. We need to put this into a context of how crisis stabilization will work, pull it all together. How does this fit into the budget context of current budget situation?

Answer: OPB and MH can support these things no matter what budget crisis. It needs to be high priority.

Abel Ortiz: Let's start with what you and Judge Goss started with – lay out where we should start. We probably can't do it all in one year. We need to focus on the highest priority need, request resources based on priorities and why we need them, redirect crucial funds to area most critical.

Dr. Nemeroff: There is a mismatch of availability in some places, and legislators want us to make tough recommendations about the priorities. This needs to be the tough recommendations first. In paper today...

Commissioner Walker: Dave can explain it.

Dave Statton: They received a complaint about Atlanta Regional and issued an immediate jeopardy letter from CMS. It happened when they went in to look at the complaint, and we were still in the original plan of correction in preparation for the DJJ visit. There were still staffing problems, QI problems, and a reporting critical incidences.

We should have a press conference. This incidence might free up a resource, put a silver lining on the work. Do you agree, Greg? (press conference)

Senator Goggans: We've been the paper regularly for several months. We can use this to turn the system around.

Abel Ortiz: I think the comment about PR is that we ought to talk about what we are doing to correct situation. We should use this attention to leverage fact that we are making recommendations to fix the system. We have heard from the two senators that they are expecting us to cut though to tough recommendations and this is what we need first and this is why and this is the impact. Don't give them stuff to sort through. We need to fix the system and make things better.

We have got to be able to argue the funding for this. Lay it out there so legislators understand.

They can take away Medicaid funding if they don't approve of plan; we can use that to take to the funding table.

Lynda: I concur with what Senator Harp just said. About losing funding, that federal mandate is going to cost a lot and have zero control. Keep that in mind. This is not just a situation of we can't afford to do this right now, we have to do something. Either we can drive the boat or someone will do it for us. I would like to add that Judge Goss is right – about 54% will not receive services. I understand that we do things gradually, and this cannot be undone.

Stan Jones: How will we set the priorities?

Abel Ortiz: We are already working on the recommendations that we've already made, we can roll them out quicker than the meetings. Next meetings we will already have children's health benefits, children's mental health. I am working on the Mental Health Collaborative and will have that developed.

The biggest task is that there are a lot of needs. A lot. Needs to child, needs to court, case management, etc. toughest is making priority ratings or someone else will do for us.

Abel Ortiz: At the meetings would it be helpful if we circulated subcommittee recommendations by email so that people can have input?

Yes.

Abel Ortiz: We can do that.

Regarding the Governor: time is of the essence. We are trying to balance budget. Massive cuts. We need to justify and take the priorities to the governor right now. Critical. We are in deep water now, and we don't want the feds to tell us what to do, or lose funding that we already have. We need to prioritize and have recommendations by next week.

Dr. Nemeroff: Can Melinda, Abel, and Michele will create a document on priorities to get feedback to everyone? We can have a conversation via email about priorities, and have it ready by our next meeting?

We need it sooner. I had the impression conferees were going to meet with governor.

Abel Ortiz: I will find out the schedule of when this is needed, and I will include it when we send out the document, so that everyone will know the timelines.

Stan Jones: What is the targeted number, zero sum for MH priorities? SAMHSA package?

Commissioner Walker: SAMHSA grant from feds is strictly confined to pay for planning. It can pay for writing docs, convening meetings. Not used for intervention work at all.

Stan Jones: Does priority depend on funding/money? For example, Atlanta Regional or Case Management or can we afford to do both?

Commissioner Walker: The priority document is the cleanest and best way to convene a conversation. The Governor is out of town. If on the 26th we process, vetted and vote on document, DHR can write an internal point of view doc about what they are seeing that will make everything work together equally. The context or backdrop here; the internal point of view here; here are the 10 things most impediment to calming the system again. We can lay it out with

the priorities. If case management is a way of calming, then our backdrop should help you decide a basis for decisions.

Abel Ortiz: We can't think hospital versus community. How do we prioritize – have to move down the track at the same pace. It would defeat ...part of the hospital is get people from readmitting and to build crucial systems so they aren't hitting the hospital for services.

Dr. Nemeroff: I agree, but if the hospital situation isn't address, there isn't time for CM to address it.

Commissioner Walker: There are problems that will always be systemic, that is true. You can also look at management decisions: people drop ball or don't pay attention to ball and that causes breakdowns that result in this kind of situation. It wasn't just an issue of something you could point at that money can solve. We need to say that carefully.

Judge Goss: Leaving the call.

Abel Ortiz: We will produce a document and circulate priority areas to discuss how to rank them. We can craft it in a way that allows us to look at both hospital and case management; to move at the same pace. The department will put together a list of impediments to those changes that may cause ripple effects, which will put this in context of implementation. We will get this out by the beginning of next week, to be done around when the Governor is meeting with conferees.

Lynda Hammond: Is there a way to guessestimate idea of money that would support case management?

Dave Statton and Commissioner Walker: If there is enough case management on the ground, we can have big impact. Successful in a hospital – don't know what it equates to dollars.

Commissioner Walker: We have to remember there are 2000 beds in our hospitals. Half of those were utilized by DD clients. DD clients bring in Medicaid dollars used to operate hospital. Money follows person that is not going to hospital, so hospital may decrease funding at the same time we are shutting the door and...When you start talking about getting people away from hospital door and the only way to save costs is to shut down unit at a time.

Lynda Hammond: We need a discussion about separating DD out. It waters down everything because we don't have true pictures of mental health; it distorts the whole picture where we can't make projections about anything.

Commissioner Walker: I agree it is a challenge in doing a budget. Separation will finally give opportunity to give us an idea of what we are truly working with.

There are Medicaid costs on the community, too.

Commissioner Walker: It goes back to the 90's, when we were leaning more on federal revenue, and the feds wanted to be leaned on, but now they don't.

Question: If you cut 30% of admissions, you've got it down to 80% occupancy where your staff might be sufficient for quality service.

Commissioner Walker: I don't want a number out there. We are trying to get a reasonable set of conditions out there to get us back to numbers. Overcapacity is the situation. People are leaving because it is tough to work in that environment.

Abel Ortiz: It speaks to the needs to build the community at same time as the hospital.

Lynda Hammond: If we can't focus on the financial, we have to focus on the quality piece. Another talking point.

Abel Ortiz: I would like to talk about what we are doing on the 26th – if you can review and provide reactions in writing so that we all know the feedback, Melinda, Michele, and I can make revisions. And the same for the Intensive Case Management piece.

In summary of today, we need to get the priority pieces out and with the timeline of the Governor's finance discussions.

On the 26th, the agenda states that we will be at Atlanta Regional. We will start the morning with just the Commission going through and looking at corrective action measures put in place. We will have the public meeting in the afternoon.

Lynda Hammond: I can't be there in afternoon, but will be in the morning. Can we swap meeting around?

Abel Ortiz: I will meet with DHR to start to have that discussion about funding consistent with our priorities.

Commissioner Walker: I am submitting the budget to the board for approval and can share some highlights of the funding and some of the challenges that we may have and impacts on budget.

Abel: Agenda on the 26th?

Public Comments

Jim Townsend:

Moving in parallel support for this initiative in getting corrections involved in casework stuff, prepared to brief committee at a later date.

AUGUST PUBLIC MEETING

August 26, 2008, 9AM-12:30PM

Abel Ortiz – opened the meeting, welcomed everyone. He asked the members of the commission to introduce themselves, and went over the agenda for the morning.

Attendees:

Abel Ortiz, Governor/Chair of the Mental Health Commission; B.J. Walker, Commissioner, Department of Human Resources; Jim Donald, Commissioner of the Georgia Department of Corrections; Stan Jones, Parent Representative; Mike Yeager, Law Enforcement; House Representative Judy Manning; Dr. Charles Nemeroff with Emory University School of Medicine.

Julie Spores, President of Georgia Mental Health networks and a Consumer and Registered Nurse, Lynda Hammond, Licensed Professional Counselor.

Summary of Main Points of Discussion

Any discussion around the Governor's announcing on the restructuring of the Department of Human Resources; the Commission Priorities for 2010 and the matrices outlining the priorities; a review of the Housing and Intensive Case Management draft recommendations; CSB Services Review.

Due to the Governor's announcement and time, the discussion of the Children's Case Management and Benefit Packet draft recommendations is tabled for the September 5, 2008 conference call.

Item One – Governor's Announcement

Leadership discussion on restructuring
Budget cuts – no one at this time that they know of

Item Two – Commission Priorities for 2010/Matrices

Abel Ortiz asked the Commission to turn their attention to the Community Priority Matrix.

Discussion:

Crisis Stabilization in Southwest Georgia does not reach Children and Adolescents (C&A) because the nearest regional center is 1 ½ hours away. There is sufficient capacity, but how do you structure crisis stabilization so it is easily accessed by people. In other words, the beds are adequate, but they may not be spread out enough.

In Atlanta, they are using existing beds with different providers, which also provide access to other services at times.

We should set targets for capacity and access, not just budgetary goals. How much can the state actually carry, and what can the communities carry?

We need to look at not just the cost of what is needed, but to be reasonable.

Dr. Nemeroff: North Carolina provides an effective example of transportation systems.

We are spending approximately \$5million in psychotropic drugs on inmate medical care. In addition, when an individual is transported on a 1013/2013, the sheriff has to wait and see if the individual is accepted or not, which takes up valuable time. Communication needs to flow between the jails and mental health services.

Regarding the correctional system, we can reduce numbers coming in by assessing individuals. It is cheaper to provide therapy versus housing them in prison. We need to make sure people are coming in and out of the right door.

We need to look at mandated sentences and legislation that will allow individuals to be supervised in the community when they are released.

Abel Ortiz asked Mike Yeager, Commissioner Donald, and Gwen Skinner: Can you provide measures of success for the population?

Abel Ortiz asked the Commission to turn their attention to the State Hospital Priority Matrix.

Discussion:

Hospitals could each have a general practice, but then each having a different specialized focus, such as Child & Adolescent services, forensics, substance abuse, or a co-medical diagnosis. Some say a specialized hospital for those repeatedly relapse or fail treatment. This keeps hospitals from being all over the map and having to be an expert in all areas of mental illness, which is impossible, just like in general medical practice where you have neurosurgeons or cardiologists.

State prisons have already taken this route. For example, there are some prisons with a cardiac specialist or a orthopedics, so individuals may be assigned according to their condition.

There are 500-800 individuals who will parole, but cannot find housing, so they stay in our prison system.

It sounds like redefining what state hospitals do within the state – Need to reshape our thinking of state hospitals.

The Brunswick area C&A are not taken by hospitals, so they have to go to Central State.

It would be good to map out and present what will be done as we move forward, so that when the report is done, we can show what needs to be accomplished.

Abel Ortiz summarized the conversation for the Commission: So, we try not to have children in state hospitals and shift to only talking about adults. We can service children in the community and private psychiatric care.

It is about accessibility and equality. Can we merge the mandate in with the new department?

The medically mentally ill population are hard to treat.

Question: Regarding the Justice Department letter, can we require a given minimum floor?

Answer: DOJ/Olmstead won't let us run out or exclude.

Item Three – Housing Draft Recommendation Review

Abel Ortiz asked the Commission to turn their attention to the Housing Draft Recommendation. Abel invited Don Watt, Director of the Office of Special Housing Initiatives, and Gwendolyn Skinner, Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases to the front of the room for the discussion.

Gwen Skinner read through the recommendation, and pointed out a few areas that need to be added into the body of the draft. The first item is when looking at the provision of services; the ability of the community to integrate services within the community could be a barrier. This is not in the paper expressively.

Also, there is an error on the first page. The Athens Clarke County data cited is missing a zero in the drafting, making it \$12million.

Feedback from the Commission:

Question: How do you create capital for aggregate living?

Answer: (Abel Ortiz and Don Watt): Looking at other state's strategies, there is typically a dedicated funding source, so it doesn't go through appropriations. The "real estate transfer tax" goes to fund these things. Bonds are another option.

Question: What is the rate of the "real estate transfer tax"?

Answer: Abel Ortiz requested Don Watt to write up the rate, looking at other states and the range of the tax.

We need to find a good target for the number of units based on need. Some preparation work needs to look at which model to use, who should be targeted first, and the number and where.

A lot of people are homeless but are more in need of other resources such as case management.

Question: Can we add a regional breakdown of mental illness and substance abuse in the state?

Commissioner B.J. Walker: We need to remember that it is not just supportive housing, but that there are others things needed, too. We need strong families.

Commissioner Donald: The Day Report Center model shadows people when they come out of prison and provides intensive services such as counseling and substance abuse testing.

There is not a 1:1 ratio of the relationship of mental illness to homelessness, so we cannot say “always”.

We need to establish an on-going work group to look at this issue.

Abel Ortiz summarized the discussion: In the body of the draft, we need to include a discussion of whether the community is ready to integrate. Within the recommendations, we need to add sustainable funding strategies from other states; what is our model and target priority populations; include family reunification; and identify what are the measurements of success.

Item Four – Intensive Case Management Draft Recommendation

Abel Ortiz asked the Commission to turn their attention to the Intensive Case Management draft recommendation. Don Watt, Director of the Office of Special Housing Initiatives, and Gwendolyn Skinner, Director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases remained at the front of the room for the discussion.

Gwen Skinner read through the recommendation, and pointed out a few areas that need to be added or improved in the body of the draft.

The terminology of Level II and Level I are not being used anymore. We are referring to Basic Case Management (formerly Level II) and Intensive Case Management (formerly Level I).

It is recommended that under “case management” that it is stressed that the individual receiving services is a partner in the process through the entire way. “Recovery and self-management”.

CSI is what our current community support services are called. They have to choose between services paid versus the services actually needed.

Question: So, where do you go? Where there is the most impact or variability?

Feedback from the Commission:

Question: Is there is enough CSI?

Answer: No. Not in Glenn County. There is only one, and they cannot take anyone new. Their maximum is 40. Money has to be put into services in the area CSB and private providers.

If you look at Recommendation #3: We should look at peer specialist. You can save money hiring a CPS versus an M.S.W. Can CPS fill this role? We also need more aggressive monitoring of discharges to see who is at risk for readmittance to the hospital or crisis stabilization.

We need to start screen from Day One. What screening tool or instrument can be used to measure risk of readmittance?

Abel Ortiz: We need to look at CPS/CIT resources. We also need to examine an additional recommendation for meaningful discharge planning.

Public Testimony

There was no sign-in sheet.

Talley Wells from Atlanta Legal Aid: Atlanta Legal Aid feels that right now the balance between hospitals and community services is looking good from the drafts. But the Commission needs to consider long-term community services. He also stated that he is concerned that the OCR agreement does not cover nursing homes.

South Cobb NAMI:

People needs services now, not long term planning only.

Meeting adjourned.

SEPTEMBER CONFERENCE CALL

September 1, 2008, 9AM-10PM

Attendees on the Call:

Abel Ortiz, Governor/Chair of the Mental Health Commission; B.J. Walker, Commissioner, Department of Human Resources; Judge Steve Goss; Representative Judy Manning; Commissioner Donald; Department of Corrections; Senator Greg Goggans; Senator Seth Harp

Non-Commission Members: Don Watt, Department of Community Affairs; Frank Barry, KidsNet Georgia; Gwen Skinner; Department of Human Resources; Cynthia Tate; Department of Human Resources; Michele Barnett; Melinda Moore, Mental Health Commission staff.

Abel Ortiz welcomed everyone to the call.

Abel Ortiz: If you are a member of the public, if you could push *6* to mute your phones. On the agenda today, you will see that we are going to review the recommendations on the Detox Centers and the Children's Behavioral Health recommendations. I sent you a revised copy of the Children's Behavioral recommendation this morning, collapsed into one document to make more sense.

Gwen and Cindy, which one would you like to deal with first?

Gwen: The Detox centers.

Abel Ortiz: I am going to walk us through the detox center first, and you can discuss it.

Gwen: For those with a primary diagnostic of substance abuse...not allowed to provide treatment in hospitals. Those should be treated in the community using an evidence-based social detox model. Detox should be provided in an organized, community, non-medical center. Some people need it [medical], but those that don't, we would have these detox programs for them.

These have gotten good results in Nevada, and other states, diverted a lot of people from hospitals, and served other people because it is a more cost effective model. Those with raw symptoms can be treated as outpatients.

Ok, intake assessment and treatment referrals and evaluation in the treatment and outreach referrals. Many are flowing into the hospital...we address the need for 24 hour transportation so we can get people there. There is currently no transportation to get people to wherever they are going after discharge. These individuals are usually on their own after discharge.

Looking at Recommendation #3, there is one in North Metro and South Metro. It would have a 30-bed capacity; and estimated cost for the program is 1.4 million dollars. It would be a co-ed residential setting.

Judge Goss: I was recently in Nevada, and I am heartened by their results. There is a correlation between homelessness and patients in the facility. I am encouraged by the results from court staff in Reno.

And I have a second comment or question: I know it will be a non-medical facility, but will there be a front screening or nurse? I know there is always the question if the individual is decompensated, but we still have to check them out medically.

Gwen: If there is crisis stabilization unit for mental health – it will give relief to the ER and provide more of a centralized place for law enforcement.

Judge Goss: But will a nurse be at the front door and do a quick assessment, and this is the flow? And one more thing while on the line – will you email me a copy of the update on finances?

Representative Manning: Gwen, but about age differential? What will we do about kids –?

Gwen: This is for adult consumers. This does not mean we don't need the same capacity for children. Crisis stabilization does not have as much demand for kids. It is strictly a proposal for adult consumers.

Representative Manning: What are we going to do with children on college campuses who are misusing alcohol?

Gwen: They will be 18 or older and will be in the program

Representative Manning: But the drinking age is 21?

Gwen: But at 18, they are considered an adult. But you are asking good legal question.

Representative Manning: Are we going to be taking 18 year olds in this unit?

Gwen: This window age of 18-21 – it wouldn't be legal charge; it would be a clinical decision.

Commissioner Walker: If a 19 year old presented with a mental health issue, where would you go?

Gwen: You are going to go to our adult crisis stabilization unit.

Commissioner Walker: So the answer is, even if you are illegally drinking it doesn't put you back in the child category. You would be an adult in the adult system.

Representative Manning: I understand. Thank you.

Abel Ortiz: You mentioned at the beginning a statute. Do we need to look at a statute change or something to keep people from showing up at hospital?

Gwen: No.

Abel Ortiz: Do we have the capacity to do this?

Gwen: We have capacity. We have ambulatory in Georgia. One is Gainesville operated by...

Abel Ortiz: Regarding the funding, is any of the crisis stabilization funding going towards this or is the 1 million new funding, or including in the crisis stabilization funding, to model this in two areas of state, and going forward addition, would we be repurposing existing funds or new funds?

Goggans: Where are the two sites?

Gwen: We are putting one in Columbus and one in Savannah.

Senator Harp: How can this thing be anything other than a small band-aid? I perceive that substance abuse is our social problems. Are 2 units a drop in the bucket? It is a huge burden on law enforcement to transport individuals.

Commissioner Walker: We will do as we did with the other commission issue. If it turns out to be a major recommendation, we'll have to consider funding and coverage. A price tag with repurposed dollars or new dollars at some point. We to prove the concept that if you have a couple of places with a rich array of services, you need to keep people from inappropriately being in hospital beds and the different needs that come up – try to load it up as a concept and drive funding to it.

Senator Harp: My admonition is to for gosh sakes call it a “pilot”. If we paint it as a broad brush, we'll get banged around a bit by the federal courts.

Commissioner Walker: I agree. Call it a pilot or demonstration.

Representative Manning: Is the admit going to be voluntary only? Is there any kind of release that the state will use to protect from a lawsuit or liability? If there are sites in Columbus and Savannah, what are we doing in Metro? Is Metro going to cost the same as the other two?

Gwen: The decision will be made by a physician, who can hold you even if you are not willing to be held, for a specified period. But once you are through the detox process and can make decisions, then it becomes your decision unless you are a threat to yourself/others.

Regarding Metro Atlanta, right now, the proposal for Metro would still, we have to look at the demand at Atlanta Regional and other places like Grady, but the 30-bed model is what we are looking at - the number of 30 bed models is not determined.

Manning: Cobb has a good community program that uses this model.

Gwen: Yes, they do, they are good.

Abel Ortiz: Any other questions on this? Gwen, do you have anything further to say?

Gwen: I will edit this and get back to you.

Abel Ortiz: Now let's look at the new children's behavioral health system – we'll have Gwen, Cindy, and Frank discuss it.

Cindy: How do you want to do it? How much of the background do you want to go over?

Abel Ortiz: Go through the background so they know problems and history.

Cindy: There have been major system changes in the past few years. MDDHAD going to fee for service; DFCS unbundling of LOC; Medicaid-eligible children covered by large CMOs. We have also had significant accomplishments that improved: statewide access to basic services; new core and specialty CCNA providers; single point of entry; external review process; more crisis services in place.

But nonetheless, we have new challenges: Multiple categories of children. Children with SED can be served through DFCS, DJJ, MHDDAD, etc. and can move through systems or serviced by multiple agencies at the same time. It is confusing for providers and parents.

And a multiple provider network which has grown significantly over period, not necessarily same as that shared by CMO. Preliminary data on overlap on 30-35% on private providers, 50-60% on providers including CSBs.

If you are seeing a provider in the MHDDAD and eligibility shifts and you become a CMO child, you may not be able to see same provider as before.

The third issue is around the variability of benefits. Medicaid not Rehab option that children and families need that are not covered to keep them out of the system – it includes Intensive Case Management and crisis services and other alternatives.

The fourth issue is the varied amounts of services provided. All have criteria for how much and which services kids can get. No parity around services is provided.

Abel Ortiz: Can we walk through Systems of Care and the target population. Frank?

Frank: Can you hear me?

Abel Ortiz: Yes.

Frank: Starting with the historical perspective. From the mid to late '90's, SOC Phase I funding really put an emphasis on keeping children in communities. There was the grant that Georgia received in 1999 for the Rockdale Board of Commissioners. In 1999, the first one that put a

tremendous amount of services into one site in Rockdale County. It was called PeachNet, not KidsNet, and was utilized old MATCH communities that were designed to describe community placement plans, but there was no funding to do it. This gave them the resources to do it, and gave flexible funding for non-traditional mental health services. Historically, there was no way to get this stuff paid for.

This allowed KidsNet to happen. The biggest part was emphasis on intensive service coordination. Family advocates who made sure that the family was getting all they needed, and then behavioral aide support for those kids who needed 24 hours support. A team was presented. The Federal grant lasted for 4 years, doing this intense level of support. It showed tremendous reduction in out of home care, going into Juvenile Justice Systems, those sent home from school with suspensions and expulsions, graduation rates, school performance, RYDC utilization, out of home placement, and improvement in overall community functioning. It has expanded with lapsed federal funds, and has targeted statewide initiatives in Northwest Georgia and Savannah. That's 15 years in 3minutes.

Abel Ortiz: We wanted a recommendation that addressed both issues. Recommendations that would provide an intensive case management designed for SED kids at risk for institutionalized care or those who are in institutions who could be successful in community; and then address the issue of kids switching between eligibility categories. So the recommendations we are making in this document are to use System of Care/Wraparound services as our ICM for children in the state. What that means is that we begin to target communities that establish a team around the child made of law enforcement, therapists, schools, etc. that can improve the child's daily functioning. It is family and community driven. The idea is that family and community can care for most children, even the most severe, and they can be successful. Data shows it works and it works across the country.

The first recommendation of SOC as our ICM, and our second is to develop a single benefit package for children's mental health services. We would have an agreement between DHR, DJJ, and others regardless of who pays, and they would offer the same types of services.

Secondly, we do that with providers. If the child moves from Medicaid managed to Medicaid Fee for Service, or state funding, they don't switch providers. We insure that all children have access to the same types of services.

Questions?

Commissioner Walker: It's beautiful! It's a beautiful thing!

Representative Manning: I am trying to figure out how this will be work. I hope someone smarter than me can figure this out. I cannot navigate the system as it is. It would be wonderful, especially reauthorization. Are we also looking at the higher end of care?

Abel Ortiz: Psychiatric residential treatment. The concept is that we don't want to put children in state hospitals. The high end would be the acute hospital. Then regional or localized residential treatment facilities. The high end provider would be a part of the local SOC, so if go into

residential treatment, that provider works with community support to make sure there is a way out and they don't stay longer than necessary, so that when the child goes back into the community, the supports stay there.

Senator Harp: Do we envision a competitive market? Not only the state but also providers can bid on it?

Commissioner Walker: It is set up for the private sector to do. Closing children units at the hospital in order to get those dollars out to the community

Abel Ortiz: In states that have done this, the mental health dept become contract, QI, and training for providers, so that we stay on the cutting edge. The state becomes a purchaser of services rather than provider of services.

Senator Harp: I think there is an advantage to do this. In Columbus, we have agencies that could do this and would do it with a smile on their face.

Abel Ortiz: It keeps this close to school and family

Senator Harp: How would we do this for rural communities? That is my concern. Ya'll help me. Is the market such that people would spring up and do this?

Representative Manning: I think there are those who would like the opportunity. As to whether it will save state dollars, if it is competitive it might.

Senator Harp: I think it would save us a lot of money. Better provision of services. At end getting children back in our community. Great idea.

Gwen: There are providers who will provide residential and wraparound services in rural communities. You will see them adjusting to the new provider environment, and many of them are doing that as they become MRO providers. Rural areas are our challenge, but we have many providers through the state that will and have already risen to this challenge. We have a provider in Reynolds, Savannah...that will stretch out. I think if business...will stretch out into these areas.

Commissioner Walker: I think that is what we've tried. There are former LOC providers who are going to make the shift to this environment. They can convert to a business model. We can see if perhaps some of the hospitals will put in a small unit for children with several beds. I am not sure if that is totally doable but they may look at it. I think we'll see people convert.

Gwen: What we refer to is a federally funded psychiatric team – what will it take to keep children in the community versus in residential. They are great funds to have because they help you actually build capacity instead of just planning. Southwest Georgia is the first two areas of the state, and then it builds out. It is not just state dollars, but federal dollars.

Cindy: Case management for these children...we have 120 local interagency planning teams across the state. Some of these are former MATCH communities, and are the front gate to the LOC system. We could launch a training to redirect and retrain.

Frank: To follow up on the interagency planning... the interagency planning is really where folks are coming together and taking ownership of going to collaborate and helping communities buy into this(SOC). The other piece is in the KidsNet SOC site – it is in the Northwest, rural area. We are starting to demonstrate that SOC can be done in a regional model as well. We have always talked about better outcomes for kids, and that is what we are now really starting to see. I think the recommendation is really nice. And thank you for your support of this.

Abel Ortiz: Are there any other comments

Representative Manning: Is the Department of Education buying into this as much as we are?

Abel Ortiz: I think that in areas where SOC sites are located, they see a benefit. On a local level. I know that Cathy Cox is very open to discussion. Actually, she is on the First Lady's Children Cabinet, and is aware and supportive on that level.

Representative Manning: In our study committee, we've tried to get DOE to talk about how they are identifying and treating children.

Gwen: The school system has approached us on the state level – they need systems in place to address kids in what was called their psycho educational programs. They are quite honest about the fact that the psyched programs did not provide....they are ready to partner, but it will be an education process on what we can and cannot do, and what we can bring to the table.

Representative Manning: It is stepping in the right direction.

Frank: The benefit in SOC is that Masters level clinicians are housed in the schools. In Rockdale and Newton County, you have two superintendants who say the only reason they made AYP is because they have the SOC model, because people know whom to call 24/7. If it would be beneficial for them to speak to the group, they would be happy to do so.

Abel Ortiz: In terms of the agenda for next commission, meeting...what is still leftover is an update from hospitals on what they have done since DOJ.

I would propose that I will work Melinda, the Division and DHR to develop recommendations on transportation and to develop recommendations on the mental health coordinating council.

Commissioner Walker: If we can restore the visit to Atlanta Regional and use that as our meeting space, I would like to do that.

Abel Ortiz: Ok, let's plan on that.

Gwen: What will be the length of the meeting, so I can plan the presentation?

Abel Ortiz: We'll take an hour for a tour of the hospital, ½ hour for CSB; we can circle up on the transportation.

On this one, we were going to see what they had implemented at hospital. Then we can have a longer discussion on other two recommendations as well. How does that sound?

Representative Manning: Can we get more input from DOE as well? And also maybe an update on federal bill for parity?

Abel Ortiz: OK. We'll put together an agenda and put it out to you for input.

Julie: Did you send out the recommendations?

Abel Ortiz: I sent them out early, at 6:45 this morning.

Question: Where are we going to meet? At the Capitol?

Abel Ortiz: We will meet in Decatur. We will send directions out. The meeting will be at Atlanta Regional.

SEPTEMBER PUBLIC MEETING

September 30, 2008 at Atlanta Regional Hospital

Attendance:

Commissioner Walker; Senator Harp; Michael Yeager; Larry Gellerstadt; were unable to attend the meeting.

Abel gave a welcome.

Abel Ortiz: ...have toured three hospitals, and are currently in settlement. We are going to see an update on what the hospital has done since the Department of Justice investigation letter, and then talk about the other issues that have come up that are priorities in our mental health system, and have a period of public comment. Then the Commission will take a lunch break and will have an opportunity to tour the hospital to see the implementation steps that have been put in place. We will take feedback on what you saw on the tour at the hospital on Friday. Melinda has compiled a draft on what other states have done with their Behavioral Coordinating Councils, and we will give you a chance to look at it and will go over it on Friday. DHR has received the counter data and are going to talk about how we want to present that data.

Atlanta Regional Hospital Update:

Gwen: Our expert is trapped behind a wreck on the interstate; so I am going to present for him. I am going to approach this by telling you specific things we did in Atlanta, things we extended throughout the system, and things we [missed section]. The A-Team – service delivery administration budget, and what we could be doing differently. They were embedded in the hospital for several months and made sure that the recommendations were implemented. There is no magic to this – you didn't have to be the brightest or best to know what needed to be done. Increased staffing was a top priority; bringing additional staff and putting funding here for direct care positions. New administrative and clinical leadership and various other leadership in personnel and nursing quality assurance...all beefed up to sustain changes in the hospital. Medical records and the management processes were a problem; all of us are getting older and they don't necessarily like to keep or have the time to keep meticulous records. There is a real emphasis on accurate and good records. A high acuity unit. The Department of Labor is working with us to provide eligible working opportunities to consumers. These are changes to the Atlanta hospital, I would not say Atlanta is out of whitewater, but we have made changes. This hospital gets more turnover – the amount of people coming through the hospital is immense. Just the physical plant gets a lot of wear and tear, and it is one of the largest challenges we have; this is from the seventies and is one of our newest ones. What we started is a compressed hiring process for the direct client staff. We were using the normal hiring process, and that now it is more about the credentials we need – expedited hiring processes. Our DHR HR is focused on professional recruitment through conferences. Our orientation is the compressed – but there is still training that you have to have. It is not as protracted. Increased pay for certain positions, but not any different from what other facilities are paying. I like to point out that even if I pay what Emory University pays, it doesn't have the prestige that working for Emory does. Marketing ourselves as a training facility to those schools so they see this as a place where you train with the most complex cases and have experiences that you don't get in other facilities. The salary is the salary.

Paying longevity bonuses, shift differentials, staff scheduling tools and strategies to ensure that we look at people on the unit depending on the needs of the 10 consumers on the unit should determine the staffing on that unit. Contracts with private psychiatric hospitals – when we need a bed we can pay them for a bed. However, we pay them more and you have to be very careful because if those hospitals run ER's that feed this hospital then there is an incentive to direct people to the state hospital from their ER and make state hospital buy beds from them because the state hospital will be full. We are looking at safeguards for that and increased crisis stabilization capabilities. If you walked about our facilities 18 months ago, there was a lot of dead time on the units. People waiting to go lunch, etcetera. The Treatment Mall model keep doesn't keep people waiting around. It was a culture change for our staff – it required them to come out from behind their desk and engage with the consumer. The standardized admission criteria across the hospital include physical health data, because we were getting people they couldn't treat physically. We now have a screening criteria that is consistent across all hospitals. A best practices approach to medication management...replaced 30-year data system.

Representative Manning: What is the Yale University?

Gwen Skinner: An approach where they come in and look at all of your treatment planning. They work with staff on culture change, and the whole hospital environment. Everything from signage to treatment planning process.

Representative Manning: So is this a team from Yale, and they leave you suggestions? You do the work while they are there, and they leave suggestions also? I would like to see the data. What is the occupancy rate? I know all of these things are the right things to do, but I need more data.

Gwen Skinner: We assumed that you would tell us which data you wanted so it could be targeted.

Abel Ortiz: A lot of the concern was around appropriate medical care on the unit: PRN medications, seclusion and restraint. Can you talk more specifically around those? How do you change the seclusion and restraint policy? And appropriate staff on the unit?

Gwen Skinner: I'll keep it specific to Atlanta, but it is carrying over. PRN – Dr. Don Manning is new, and has worked closely with Atlanta Regional. There is really good data that we can provide – physician training and monitoring and justification – in the medical records. For us, the training and monitoring, and Dr. Manning is making an initiative.

Julie Spores: We have two models: Traditional crisis stabilization units and a peer wellness center (in Decatur) which I think is more consumer friendly and is run by peers versus nurses and doctors. The treatment model, is it focused on the Wrap?

Gwen Skinner: Yes. The biggest problem with the treatment model is the facilities weren't constructed for active treatment.

Julie Spores: On the use of medications, is that open access or unrestricted? If I come in here and I am on ephexor, if I come in here will I stay on here?

Gwen Skinner: We have open access. I can Dr. Manning in here to talk about it – it might be really good to have him talk.

Julie Spores: We have gotten rid of chemical restraints?

Gwen Skinner: When we talk about chemical restraint, and a doctor prescribes Haldol [spelling]...we don't use medication for the intent of restraining.

Julie Spores: You are not going to keep me like a zombie all day.

Gwen Skinner: We have made significant progress in this area.

Dev Nair: We've eliminated PRN use of medications?

Gwen Skinner: Doctors can order them, but it has to be well documented and ordered by the doctor, it is not routine.

Julie Spores: Well, if you are on 2mg of Xanax, you aren't going to remember your treatment, but if you are on a smaller dose, you will.

Gwen Skinner: It really is all about partnership between consumer and clinical director of the physician.

Julie Spores: And they are talking with them not at them?

Gwen Skinner: I will say it is a real focus and we are trying to get better at this. It's a lot easier to get that treatment plan written when it is just one person; it is time consuming when it is a team working on it. But when you have a reasonable number of people to work with, it works.

Julie Spores: What is the minimum length of stay now?

Gwen Skinner: NO minimum or maximum. After 60 days you go on a planning list to pull team of people together to see what it is that is keeping someone from going back into community? Is it a clinical need or community resource need?

Julie Spores: What about community resources need as a result of the budget?

Gwen Skinner: Yes, budget cuts are affecting it. If you look how budget cuts were made in mental health, state dollars – a 6 percent cut in state dollars is different than those with less than state dollars. Huge cuts have happened to us. On top of that, 6% of approximately 775 million – can't take it from the hospitals, because it is not there. So what you had to turn around do is take it out of the community programs. Yes, the hit is being taken in the community programs.

Julie Spores: But it is going to cost more. It is going to take more money to pay for hospitalizations for people who belong in the community, or those who wind up in DJJ and local jails...and..thank you.

Stan Jones: If we are going to have a discussion about privatization, it needs to be public and we need to have baseline data. I know there is a meeting tomorrow that may be on the topic. But for example at Atlanta regional we talked about 60% of patients...Georgia has more hospitalizations than the national average. The next 35-45% were relatively short term and below length of stay than the Florida model. The Georgia model does not have that issue except in the DD units. I'd like to see the actual results of what we've already started. It is a good list, but we don't know the results yet. Until we know what we've accomplished on our own, I don't know that we can talk about closing Atlanta, Central...etc. I know all of this relates to DOJ report at some point, but I don't know quite yet what to do – we are in a mental health commission, so we should be able to talk about it.

Gwen Skinner: Abel, Stan is talking about having an open conversation about privatization to talk about work that has been done and informed recommendations about privatizations.

Stan Jones:and to have enough data to compare with the other states that have done it.

Gwen Skinner: Georgia is unique compared to Florida because Georgia stays are shorter than Florida.

Julie Spores: How would you monitor hospitals if you allowed privatization to occur? How would you know they are doing what they should be doing?

Gwen Skinner: 60% of our community providers are private, just not the hospitals. When Rick talks to us, you'll see how important contracts are.

Julie Spores: If you don't or are not doing what you are supposed to be doing under a recovery model and you don't have someone monitoring that, and in a lot of places it is not happening that well, then we wouldn't have hospital usage all the time.

Abel Ortiz: I think you look at how they set up monitoring. There are two ways: contract and then quality assurance monitoring. I think that if we look at privatization we would need both contract monitoring ways in place. If the commission wishes to talk about privatization we can do it, but it is a sensitive issue to have the data and to get really deep into data from potential providers. Some of that information will be proprietary and not open to the public. WE need to acknowledge that and accept that, and structure it to protect the providers so that the commission could say we accept the recommendations.

Stan Jones: I think having our own data is a starting place. I know there are proprietary issues involved. To accept this is to say there is a certain level of trust about leaders. I don't mean that in a negative way. And the RFI process would be better than an RFP process first. I personally...also, it doesn't make sense to make that decision before you have a new department. If so, you have prejudged one of the major decisions that the new department should form – the

timing doesn't seem right to me, without having heard more of the discussion that has occurred. I was trying to think of a practical way to collect information that doesn't prejudge. I would like know some of the data on getting DD out of facilities, I am sure you have had successes. It all seems relevant and as we talk about what hospital needs.

Mike Keown: By the time we get through this commission, the whole landscape could have changed and we are still working on a plan from last year. These decisions are changing the whole look.

Abel Ortiz: If you look at the priority areas we are working on, the discussions here have been taking into consideration the privatization discussion and the new department discussion, because our recommendations are more community-based focused, i.e. intensive case management, transportation, housing, a common benefit package for children - which actually set up the new department with a road map of what to do. They are the key to the hospital reform – it says those that come into hospital are those who truly need to be there. The work is continually being fed to OPB, the Governor, and the Department. For example, we sat with OPB yesterday to say this is what commission is looking at in the face of the budget. How are we going to make this consistent with Governor's budget and timeframe and how to do that so decisions don't have the benefit of the commission's recommendations? So all of that has been happening. It isn't two parallel processes. I continually provide updates during the budget talks, so it is consistent.

Stan Jones: To me it feels like there are four– the budget, DOJ, privatization, Olmsted, and us. We haven't had a discussion...I think you also forfeit resources in privatization; and it affects morale. But until more of that is out loud...

Abel Ortiz: You mentioned the budget, DOJ...while they are different process, the recommendations address all of them. I think the big discussion is what it is going to look like. I am asking what kind of forum we should have, how we should structure it so that commission feels that it is getting more of the information it needs.

Stan Jones: I think a status report on the three other activities.

Abel Ortiz: We've had the status reports on the development of the department – the legislation hasn't been written yet. DOJ has sent the letter, but there isn't much else that has opened yet. Olmstead we can give you a report on and on the privatization we can sit down and have that conversation.

Stan Jones: If our problem is the labor cost and retention here, on its surface that doesn't necessarily seem believable [Missed part]. We should have fewer beds, probably. I like the states that only have forensic beds.

Abel Ortiz: Do others want to have that conversation and if yes, when?

Dev Nair: I think it is an important conversation to have. I struggle with the amount of time we have left, what is our role and what are we going to be able to do. It doesn't sound like we will

be able to say yay or nay in the amount of time we have left. What do we think are the values that should guide the privatization or the new department after the commission expires?

Stan Jones: Maybe compare what we have done – the papers have been a dramatic shift and are allowing us to discuss things at a higher level of detail.

Abel Ortiz: If we can do brief snippets here...It worked well to get feedback via email. I don't know how it was for you, but it was good for us. And we can roll it all up and put it together. And I think there are ways we can structure it, now that we have a system of getting Melinda and the department to get the writing on the recommendations. If we want to choose to do that type of stuff on a smaller scale and monthly calls, we can use the meetings on other stuff.

Representative Manning: I saw Senator Harp and talked about how it was an underlying conversation – the issue of privatization. It appears to me we need to have a conversation about it before legislation appears and it is our job to look at that. Maybe I am a little out of the loop because I didn't know it was so fast coming.

Mike Keown: I think it is important to get our information from elsewhere besides the AJC. When my constituents say what is going on, and my response is "I don't know what is going on", I would like to know where we are headed.

Abel Ortiz: What I am hearing is that maybe we look at the October meeting at having a discussion on privatization, knowing there are limitations on information that could be a disadvantage to the state at the bid process. We could still have that conversation and have Michele and Melinda send out an email asking what the real questions you want answered are, and provide that to the Division and have a conversation around the privatization issue. How does that sound?

Julie Spores: Will we devote part of time on privatization and then other conversation after or...

Abel Ortiz: Today we will finish up the community-based recommendations, and in October, we will discuss the budget portion, the need and program concepts. The Division is working with OPB. In October we are saying these are recommendations on (ICM, etc) and this would be the cost in the next five years and how state would need to invest so you could mull it over and then in November form the final recommendations. We can look at the need and the concept and devote October meeting to privatization and looking at those numbers on the recommendations and stay on track for December.

Stan Jones: That sounds sensible. So we will see numbers attached to the recommendations?

Abel Ortiz: On some of these you will see current budget impact, but not projected costs for the next five years just yet. And then having the conversation with the Governor on this work and how we can continue to grow it...so the numbers have to be accurate as possible. We are targeting having this by the end of October for him.

Julie Spores: When Gwen presented the Case Management Level I & II, I think the projected cost is 5 million dollars? How are we going to have that money?

Abel Ortiz: That's why we want all of these laid out at end of October, so that if we want to roll this out statewide over five years, what is it going to have to look like?

Julie Spores: We can't just roll this out in metro Atlanta, it has to be statewide. There are a lot of people all over the state of Georgia. Is this work that we've done – are we going to get the money to cut down on hospitalizations and return people to community, is this work we've done going to happen? I am concerned that the money is not there to do this.

Judge Goss: That segue ways into report I am going to hand out from adult outpatient subcommittee.

Abel Ortiz: This is from the adult outpatient committee. Let's turn to CSBs, go through Transportation, Supportive Employment and collaborative information and then talk about adult outpatient recommendations. That should get us through to lunch.

CSB

Rick Dunn: I have some caveats regarding the data – it is based on encounter-data. You submit a form per day to the state to let them know who you served; there is a lag and the data is not complete until 6 months past. So data this year won't be ready until January 1. And CSBs are still encountering barriers to encounter reporting, and especially in cases where you are not being paid, there are barriers to getting the information in. Also, there are external barriers in getting things submitted to external vendors. For example: I hear from providers that what they report to counters and what is actually submitted to our system and sometimes discrepancies can be quite large.

Gwen Skinner: Remember the Division went through a big shift from counting enrolled consumers and are now counting encounters. This is a major shift in the Division.

Rick Dunn: What I have done is the following – I've pulled encounter from end of December through May '08. Reporting has improved with time, remember. It is not a 100% complete.

Abel Ortiz: Is the data lag for CMOs the same?

Dev Nair: CMOs actually file the claim, but there is a lag to file the claim and for it to get to DCH.

Abel Ortiz: It would be good to see these two next to each other to get the big picture and compare apples to apples.

Rick Dunn: And this is only looking at CSBs. We wanted to tie this to dollars, and we had to bunch this into categories of services that are bundled in our contracts. For example, we contract

for core services, or crisis, or residential services. Once we pulled encounters, we aggregated them by categories.

Stan Jones: Is it APS who collects this data?

Rick Dunn: What I tried to do is to give you the CSB provider – you cannot necessarily double these numbers by a 12-month period depending on the services. And for those with the Medicaid Rehab option, and there is a price attached, what I've done is project out if these providers were delivering services on a fee for services basis so this is what the Medicaid rate would look like. And remember these caveats, this is just a slice of reality. [walking through first column] "earnings for state funded services" is what they would have earned fee for service Medicaid rate over 6 months, and next column is what is in their contract.

Dev Nair: Right now they get the contract dollars regardless?

Stan Jones: MRO is not a separate subset.

Abel Ortiz: So if you would take Douglas – they served 294 state funded individuals, and they would have collected \$48...

Commissioner Donald: For the ex-offenders released into the community, are you able to separate those out?

Rick Dunn: If I were to work with Jim and match those up with our database, we could easily pull them out, but there is nothing that tags this specifically.

Commissioner Donald: We should because the recidivism rate will be higher. I thought we had a incentive process to have CSBs serve more of that population.

Rick Dunn: We have the TAPP programs.

Gwen Skinner: We have tagged ex offenders as one of our core customers.

Commissioner Donald: So we are tracking?

Gwen Skinner: Individual CSBs track, but we don't.

Jim: I will be sure to get you that data.

Commissioner Donald: You know what, of the factors we have to talk about the fact that the TAPP program is victim of budget cuts, and how to manage those working together. It is a serious potential problem.

Lynda Hammond: Is the first column those who have zero funds – no Medicare, Medicaid, private insurance?

Rick Dunn: They meet our core customer criteria and have no other sources of payment.

Lynda Hammond: Will this include those under insured?

Greg Hoyt: It will include those who have exhausted their policy or are underinsured.

Gwen Skinner: When you look at some of these numbers, remember in defense of your CSBs that they do not get reimbursed for a lot of the work they do – for example going to court, transporting consumers so you do have to keep in mind they have to pay for it some way. So it is not as clean because there are a lot of services and it is one of those recommendations that case management is reimbursed in some way. But that is critical to remember when looking at CSBS.

Lynda Hammond: So what about folks working way over [missed section].

Gwen Skinner: You may see they are over providing in one category and not enough in another.

Greg Hoyt: Fulton has such a tremendous amount of local money they report everyone and max out their money.

Gwen Skinner: Just simple things: if you are a CSB Executive Director, you are expected to be at rotary club so often, meet with hospital people so often and they just have to pay for it.

Dev Nair: So the dollar amount is totally based on those services with a Medicaid rate, right?

Rick Dunn: Yes.

Lynda Hammond: In looking at everybody, is there ever a time that you compare on a per consumer charge and isolate your top performers to help those who maybe aren't doing as well?

Rick Dunn: This data is so new to us we have not gotten that sophisticated yet. But we will be able to.

Greg Hoyt: A lot of things that have been said are what is going on. Cobb Douglas, for example is not being paid to report data. But you'll find another CSB who has a data wonk who is great about reporting every single thing they are doing – this doesn't reflect whether they are getting paid or not.

Abel Ortiz: Unless we get our systems actually looking at data we are not going to get the performance we want. And we need capacity building. Unless it is a requirement, only those with a passion to report will do it. It needs to be a cultural shift. Until payment is contingent on data reporting, that needle won't shift. But we will have to provide support and training to do it.

Commissioner Donald: It is amazing to me that these are private.

Stan Jones: Actually they are not, in the 2002 they decided to be public agencies.

Greg Hoyt: They are quasi-governmental agencies. They are not state employees, but are in the Merit system

Gwen Skinner: Their encounters, they are also having to – even if you move adult to fee for service – there are larger questions such as Emergency Preparedness like Katrina, it took state office staff to the airport and it worked, but while doing that we are not manning the state office – so there is a question about questions to be answered: do you pay CSBs to stand ready in the event you need to call them for something? It is a larger systems issue so you can stand up when needed?

Commissioner Donald: Are there other states that are providing best practices in this area?

Gwen Skinner: Yes, sure.

Commissioner Donald: My problem is everything we do according to programmatic should have an outcome attached to it. When you start looking at huge variances, how do we know that we are getting the delivery we ask for?

Abel Ortiz: Utah and Colorado have a good privatized system.

Commissioner Donald: One of the challenges we have is to incentivize the process. When you walk into any of my private prisons, they want to know about security...so the issue is as we move forward we see that the private system may be offering some best practices to look at as we move forward.

Abel Ortiz: Private CSBs – their 3rd party payers – they provide community employee assistance programs to generate private dollars and this is just a part of their business, and it helps them to even out their dollars and pay higher wages. I think Utah and Colorado get state benefits and retirement but are considered private employees so they don't do the state pay structure.

Lynda Hammond: If you cannot account for your dollars, the basics of being able to account for what it costs you to do a business you cannot develop a budget and stick to it. It seems to me until you can get that started, you don't know what you are doing really. There are probably CSBs in the state who really know how to run a business, but I don't see how you could know.

Julie Spores: On the projected percent of state contracted dollars earned, if a CSB is contracted for 331K and they haven't used but 64% of that now, right? What if they only use 10%? Where does that money not used, where does it go? Does it shift to another place?

Abel Ortiz: Some of the services are not covered, so some of that money can be used to pay for services that are non-reimbursable, for example training. We can't answer that question. They are running a business.

Julie Spores: And the CSBs are getting that money...under residential services...

Gwen Skinner: Keep in mind when you look at this data what Georgia is doing is pulling out of a historical system where you had a certain number of CSBs, money divided between them with no data to support what they were doing. We know this isn't pretty. What you are looking at is the beginning of trying to track encounters and services like children systems moving to fee for services – that's why this commission is addressing how to cover services, because we are forcing providers by contract to do it. You wanted the honest real data – it is not perfect data. You have a system where effort has been put in developing alternatives to hospitalizations such as crisis stabilizations and a crisis line...

Julie Spores: You know how we shifted children to adult dollars? I wonder if the CSBs are shifting dollars among programs.

Gwen Skinner: With children's dollars, there are restrictions. Children dollars have to be spent on children, adult have to spent on adults. You can change from spending money on – if you have a fabulous supported employment program, you could move it from another program (\$) to the supported employment program.

Judge Goss: In our recommendation, we talk about TAPP as a template for case management, and looked at NY. A key marker for data in my judgment for those coming in and out of jail, prison, hospitals is cost avoidance: how much have we saved preventing recidivism? That would be data needed not just in Georgia, but in all states. If you spend X here you spend XYpercentage down the road.

Commissioner Donald: It seems to me too, that yalls accountability to hold CSBs... because it is a shared relationship. We have all gotten letters from the legislative government to create a 0-balance budget. We need a zero balance mission based on these CSBs.

Stan Jones: We are talking about accountability and how to get better data and I think you have articulated that. I think discussions doesn't really mean they have too much money, I hate to beat up on DHC again, but they lost dollars, and these columns on the left are less than the money they gave up. We don't know how much of it comes back to providers and what is better used in CMO system. And this is an old debate between wholly private, wholly state, or wholly mixed. We actually need more services in the community and not less. Which is what Gwen, Abel, and Steve have been articulating.. I would rather them use more private providers in their communities, myself, but this is an old debate.

Judge Goss: I can't lose sight of the fact that this is a diverse state and that just because we have funds doesn't mean that we don't have providers to buy services from. I think we have to recognize that we have different issues in different places in the state. For example transportation to treatment is easier in Atlanta than the mountains or south Georgia. And frankly that is what a lot of these CSBs are doing. Getting people to the clinic and they can't bill for it. We need to recognize that.

Commissioner Donald: But we don't know what we don't know so we need to take a good look at the process so make sure taxpayers are getting resources. I think we should look at best

practices to look at how to best to get our arms around a system that denies our comfort of accounting where money is going.

Abel Ortiz: what if we look at a recommendation paper on CSBs – a 0 balance perspective, best practices from other states and with funding that we provide states dollars we look at these populations () and services provide are the ones the commissions identifies as the priority ones (ICM, etc) and down the list and when we do this we need to take into consideration what they need for infrastructure development. Give allowances to allow them to train staff in these things and how they can support state in emergency situations for next time. And then ask Dev Nair to see if he can pull a similar spreadsheet for CMOs.

Dev Nair: You probably want CMO plus Medicaid that DCH pays.

Gwen Skinner: Two things: I don't think you'll do for much if you look at our core consumer definitions. When you talk about best practices when you talk about that is – well, there are best practice for individuals with DD, or schizophrenia...if you want to be specific. Rates are an issue – they gravitate towards – if you are a CSB and you are struggling to survive if one service reimburses at a better rate, then they may – they do have business sense some of them – but you can't look at it without looking at rate structure too, without looking at how much you want to pay for it. You'll hurt us if you just say you should do best practices, but there is not enough money to say that is all they are going to do. Strengths on what they can do in different communities.

Dev Nair: Do you have the ability to track other services like case management?

Rick Dunn: We only track the defined services.

Lynda Hammond: How do you budget for it if you don't track it?

Gwen Skinner: We don't reimburse for it, so we don't track it. We are not the CSBs, and they may track the services they don't reimburse for...

Lynda Hammond: He doesn't need to speak to us, he needs to speak to others in the state.

Gwen Skinner: But it is the recommendation of the state that needs to define the services [Missed part].

Supported Employment:

Gwen Skinner: We know it is critical to success....in our budget cuts, we held onto medically necessary services. [missed part]

Abel Ortiz: One of my concerns is that it would be perceived that this is moving people to public employment, but it actually moves it to private employment, and creates livable SSI.

Stan Jones: What is the cash used for?

Greg Hoyt: It goes to support the provider. If the employee is not providing good support in the organizations...people who are committed to maintaining their employment, and frequently become a preferred candidate. Private companies knows that a job coach can come in if there is an issue with the employee.

Julie Spores: Top priority at Georgia consumer conference is employment and it is a real issue for consumers to be able to be a part of employment. If a person doesn't have a place to stay, a job and a way to get to the job where are they going to be. And I know it is about money, but it is the right thing.

Abel Ortiz: Gwen, can you talk briefly about transportation?

Gwen Skinner: With transportation in community services there are three different types. Hospital services has three different types as well. LE transport – 1013s. It is an 11 ½ million investment made in transportation in general. We recommend to you that you might consider this as one of your recommendations. How do you integrate all of these systems? Or if you run a bus specified for a particular consumer?

Mike Keown: What was the issue with not sharing the information?

Abel Ortiz: The vendor doesn't report the data to DCH, so vendors are going back to subcontractors to get the data. This and employment will be our discussion on the call on Friday.

Stan Jones: We should ask Mike Yeager about how to transport folks in rural counties, there may be another piece added to the dollar list.

Housing

Don Watt: Real Estate Transfer taxes are the primary way of providing money.

Stan Jones: Is a real estate transfer fee used for anything else right now?

Abel Ortiz: Can we look at the Commission for a New Georgia money?

Don Watt: We'll check.

Adult Outpatient Subcommittee:

Steve Goss: Community-based mental health case management services - it is the little things: transportation, linkages to other agencies such as social security and helping fill out forms. I looked at some other states. Virtually all have websites that do case management in some form. I talked to NY state. One thing that is interesting about New York is that they have the major metro area and small cities and rural areas. Very much like Georgia. And they have a blended case management delivery system. One thing they do according to New York – is intensive case management and they have a 2nd tier they call supported, what we call basic case management

which really utilizes peer support specialists not only because of the value of someone who has been there but it is also cost effective. One thing I have put in here and I am simply making a recommendation - I don't appropriate or make legislation. TAPP program is case management, and utilized by corrections, DHR, etc. and could use same model with other mentally ill with no brushes with the law. We could be using a template not reinventing the wheel. CIT recommendations are to at least continuing to fund at the level it is funded at now. To keep program alive, feel it is working, and certainly as the budget picture improves there are recommendations to expand that program. Support development of jail mental health protocols in all counties – we've tried to get basic protocols in place and would include things like linking people to services when they come out of jail, better services for jail staff. Finally, to develop community triage detoxification – there are other states with non-medical detox centers. From non-clinician standpoint there has to be medical involvement because there may be someone who comes in who needs that attention (ex. Diabetic crisis while in mental health crisis). There again, the key is case management, it goes back to case management. Also, we should look at sheriff's association survey.

Two public comments:

Bridgette Jackson – nurse practitioners: I have read about your recommendations. Are you thinking about psychiatric nurses? It would be cost effective in terms of meeting problems of access in rural areas or hospital reductions. That might be something you would like to look into.

Lynda Hammond: We love psychiatric nurses, we'd love for them to come to Albany.

Bridgette Jackson: The problem there is a shortage of training. GSU is putting a program out this fall. Emory eliminated it. I see the need nationwide, and there are not enough of them. State may want to invest into his.

Lynda Hammond: What are the differences between nurse practitioners and clinicians?

Bridgette Jackson: It is more a medical model versus staffing – schools are starting to blend those roles and get both. Psychiatry is a subpractice. There is a need in that they are not being churned out, it may be worthwhile for states to think about how to promote the education of nurse practitioners and to get them into rural areas, more incentives. It is a long-term thing because there is no professional organizations. And they tried to have one and it dissolved. Reimbursement is a problem because it is not something medical. Thank for letting me put that in there.

Nora: Thank you for confidences in CIT program. We need a mental health system bailout. The legislature – I don't care where the money comes from – we are already really poor and now you are taking 6% and taking money from nothing is nothing. I echo what Mike said – We don't need to read it in the AJC, so Gwen I am asking you and DHR to let people in the grassroots to provide input on how to transport the system.

Julie Spores: The Georgia mental health advisory council – oversees federal dollars. A GMCH member should be appointed as a liaison and maintenance of current director to stay with staff

while they are creating a new department. Support of a new behavioral health coordinating council

Abel Ortiz: Our conference call is on Friday from 9-10am. We will discuss supportive employment and transportation in more detail and you received outline of what other states have done. Be ready with ideas of what we put into interim report on the collaborative. Thank you.

Meeting Adjourned.

OCTOBER CONFERENCE CALL

October 3, 2008, 9AM-10PM

Attendees on the Call:

Abel Ortiz, Governor/Chair of the Mental Health Commission; Senator Seth Harp; Representative Judy Manning; Julie Spores; Lynda Hammond, Licensed Professional Counselor; Stan Jones, Parent Representative; Commissioner B.J. Walker, Department of Human Resources.

Non-Commission Members: Don Watt, Department of Community Affairs; Gwen Skinner; Department of Human Resources; Melinda Moore, Mental Health Commission staff; Michele Barnett, Department of Human Resources.

Abel Ortiz welcomed everyone to the call.

Abel Ortiz: Why don't we go ahead and get started. What we wanted to do today was talk about supportive employment, transportation, housing, and the state collaborative and then get feedback on thoughts that we can include the recommendations. Senator Harp, since you weren't at the last meeting, I sat down with OPB over the recommendations and priorities that the Commission has discussed and the Division is working with OPB in looking at costs and numbers from the recommendations, and making sure what we come up with is part of the Governor's process as he develops his budget recommendations. We want to have this by the end of October. That way the Commission will have a chance to look at it and approach it as a five-year implementation plan to get where we are going in light of the recommendations.

Gwen, can you give a quick snapshot of the supportive employment recommendation?

Gwen Skinner: Abel, give me just a quick second, I am putting my hands on my paperwork now.

Abel Ortiz: Are there any comments on supported employment?

Representative Manning: I went to a Department of Labor Open House in Cobb County, and they were very interested in cooperating with us, as far as working with us to help folks get employed. They have a whole career center there, and jobs available. I would suggest we get Michael Thurmond on board, and see if we can collaborate with DOL.

Abel Ortiz: Can you give us an update, Gwen?

Gwen Skinner: We have actually, because of our budgets cuts, had an ongoing conversation – they believe they will be able to offset supportive employment services with the budget cuts. We are meeting with them aggressively, and should know something next week. Some of our providers are providers with them, as well.

Representative Manning: That's what Michael had indicated.

Abel Ortiz: Can I ask, Gwen and Judy, are these state or federal funds?

Representative Manning: Evidently, they must be federal funds, but they do include individuals with disabilities in those criteria. It was quick and a broad brush, but it seems like Mike and Peggy would look positively on having a collaborative relationship with us.

Gwen Skinner: This is something from our perspective that is going to move forward – it is an ongoing project we are aggressively moving forward on.

Abel Ortiz: Can you work with Melinda to revise this to reflect the steps with DOL?

Gwen Skinner: I'll run through supportive employment. We know this is one of the most important issues. Employment and housing consistently come out on top as important issues. Now, I provided data at the mental health meeting, so I won't go over that. The before budget, 6.6 million combined state and mental health block grant funds allowed us to serve (missing number). After the 6% budget reduction, 552 annualized – only mental health block grant funds. We are having ongoing conversations with the DOL and we hope they can pick up some of these consumers through FY '10, and request new dollars in FY '11. Basically, it is costing \$410 per month or \$5K a year to serve someone in supportive employment.

Representative Manning: My take is that it includes money for things other than supportive employment? Transportation, housing, non-medical necessities? Is that right?

Gwen Skinner: Currently, there is a separate funding category for that, and where we pay for that but it is a small part in the budget, yes.

Lynda Hammond: Can you repeat those numbers? Does mental health block grant design dollars for function?

Gwen Skinner: Yes.

Abel Ortiz: It is one of the things we can spend money on, but don't have to. One thing Georgia has done really well is use money for really effective services.

Lynda Hammond: Are we working with other non-profits who do this well? Non-profits like Easter Seals or Volunteers of America? I am just wondering, have we looked to partner with someone who knows how to do that well and economically effectively?

Gwen Skinner: Easter seals is a provider of ours too.

Lynda Hammond: I meant for mental health and substance abuse.

Gwen Skinner: Not for substance abuse. Typically, we see supportive employment dollars serve mental health and developmental disabilities, unless it is co-occurring.

Lynda Hammond: I didn't know what they were doing for mental health, but just knew about DD and folks out of transition centers.

Gwen Skinner: You are right, but whenever you try to make a clean cut, there is someone who is picked up like that. The lines get a little blurred.

Lynda Hammond: I just wondered if they could help out with that. DOL isn't happening for free there either.

Gwen: If you want to see a breakdown in where the dollars are spent, I will pull it together.

Abel Ortiz: That is a good idea.

Gwen Skinner: if you want to see breakdown in where dollars spent, I'll pull together

Abel Ortiz: good idea. Same good idea about the block grant. I went through block grant spending with the Division to see how money is being used, and came away seeing what is being used for effective services. Can we provide a summary of how the block grant is being used, Gwen? We are using it for non-Medicaid reimbursable services really well.

Gwen Skinner: I am happy to provide that information. When you look at other states, a lot of them use block grant funds not in direct service delivery.

Abel Ortiz: Utah is using theirs to support long lasting relationships as general assistance grants, not core services, but more partnership building. IT was only in Utah, but in a lot of states, the biggest criticism on block grant states. It is found to be just the opposite in Georgia.

Is there anything else on supportive employment?

Stan Jones: A two-page reference to the chart is not in here?

Abel Ortiz: We don't have the chart finished yet. We will have the final by the end of the month.

Stan Jones: OK.

Abel Ortiz: Let's go to the transportation recommendations. It is more confusing because there are different funding sources.

Commissioner B.J. Walker joined the call.

Gwen Skinner: I broke it down into two broad categories first. Within the community, there are three different types of non-emergency transportation (NET) run through DCH. It takes Medicaid eligible consumers to Medicaid services. DHR coordinated is transportation for DHR consumers to DHR services. Non-Medicaid eligible and non-Medicaid services, as well as aging and DD consumers tend to be the primary riders.

Lynda Hammond: If the whole thing is 10 million, 3.3 million is about a third?

Gwen Skinner: It might be dependant on the length of trip or the frequency. However, it is followed in a structured way, so this is a good number.

Community service transportation provides services particularly in the area of children's services. They have to provide the service and it behooves to provide transportation.

Abel Ortiz: Is that built into their rate structure as a part of doing business? How do we actually – do we look at cost reports with Fee for Services?

Gwen Skinner: I can check with the budget people. When these providers separated and became quasi, they took the vehicles with them. There is recognition of transportation expenses in their budgets. I will have to get the breakdown.

Lynda Hammond: So there is not a specific line in their budgets? They just find the money somewhere in their budget?

Gwen Skinner: I want to be exact, so I will check. That is part of when we were looking at encounter data, and it looked like they were under-providing. It is part of their flexibility to cover expenses.

Abel Ortiz: Let's break it out.

Gwen Skinner: I've made a note of it. Do you want to see it in the paper?

Abel Ortiz: Yes, that would be helpful, so we know that we in fact considering that.

Representative Manning: The service provider transportation system – they don't really understand the funding stream. Can we pull out that funding stream? They say consumers go into activities every day, are some of those provided by DOE or DOL or assisted transportation services – can we identify where that money is coming from?

Gwen Skinner: Do you want to know if others are contributing?

Representative Manning: I am looking at the last three lines – and continuing on the last. I wonder if we can find out who is providing them and what is the cost so we will know the total?

Abel Ortiz: And I think Representative Manning is asking if any of it is paid for by Community Affairs, or CSBs, or DJJ.

Representative Manning: I'd like to know where those pockets of money are coming from to see if we can utilize what is already existed. They used to transport children back and forth to schools. It's just a question; I'm looking for anything that can help.

Gwen Skinner: We appreciate it. Okay, hospital transportation is broken into three types, as well. One is Law Enforcement, where they transport people back and forth to the hospital. It is estimated at 1.4 million miles per year. Looking at today's mileage reimbursement, this is

(missed number). Community mental health service providers will provide transportation for those in their services. Hospital transportation is for different services and appointments while in the hospital, as well as the return to the community.

The community has also been outspoken about getting relief to transportation provision.

Senator Harp: I think this is a sticking point with our sheriffs, because it takes two to transport. I hope we can arrive at some means of transporting people with our mental health folks being responsible for that.

Commissioner Walker: We had the Sheriff's Association come in from around the State. One they said is most problematic is the waiting because there are times when they go to an ER where someone is tearing up the ER Room, and the person may be combative. They don't mind the transporting, but the wait. I think what we have to do is think about ways where we don't need that kind of wait, or transportation back after the person is non-combative. I think that is something we need to look at as a system design problem, not just a money problem.

Senator Harp: It is all tied up together – short personnel, all of this is cumulative.

Lynda Hammond: Senator Harp, and Commissioner Walker, when at the Commission meeting on Tuesday, Judge Goss brought his outpatient services report. In his handout, there are the results of a survey in 139 counties. Questions 14, 15, 16 provide information that says almost 22,000 transpirations take between 30 minutes and 12 hours. 2.2 million dollars. And this was without Fulton County. I think we ought to quantify that.

Representative Manning: And Number 19 includes juveniles, so that is another million.

Abel Ortiz: As this is developing, keep in mind system design and to look at both adult and juvenile.

Representative Manning: Is it the law that you have to have two staff folks? I was wondering.

Abel Ortiz: I don't know if it is the law.

Senator Harp: I don't think it is a law; it is a matter of safety of the law.

Lynda Hammond: I believe there is legislation somewhere that if there is a female person being transported, you must have a female in the vehicle.

Senator Harp: If there is a recommendation for a law change, it ought to be included in some way.

Lynda Hammond: A family can transport them, but there needs to be language to protect the hospital, so that when we release to transport, we take the risk away from the hospital. Some protection for that when we are in good faith after a good assessment. I can tell you now that is why we won't do it, in case of something happening to the patient.

Senator Harp: What I was primarily talking about was the forensic transportation. I am talking about a murder or aggravated assault, and they are mentally ill or showing signs of mental illness.

Representative Manning: I wonder how many of those we have, versus the total number of community transport.

Abel Ortiz: OK, we need to separate out the truly forensic, and how we design the transportation systems so that sheriff's aren't waiting for long hours.

Julie Spores: Who is actually doing these assessments at the hospital? The CSB? There used to be a system that made the whole situation a lot quicker. Someone would come in and the officer could leave. If it was necessary, they could contact them to come back or to notify the family. Who is doing the assessing? ER or providers?

Gwen Skinner: ER is doing the initial assessment and communication with the state hospital. The Sheriffs do not understand the ER is the initial assessment, but the state hospital does the actual evaluation.

Julie Spores: So, why no the CSB?

Gwen Skinner: It has to be a psychiatrist and meet the clinical criteria for admission. Not to say you can't do that, we are trying to do that in Columbus and Savannah.

Abel Ortiz: I think Gwen brings up a good point. While you need a psychiatrist to clear a person, you could actually have a social worker or psychologist sit and do the contracting of behavioral interventions to get the person stabilized enough so that the psychiatrist can make the call. That way the sheriff doesn't have to sit, and a clinician is with the person.

Julie Spores: OK thanks, exactly.

Representative Manning: Would community detox centers eliminate some of this?

Gwen Skinner: I agree. It will take care of some of it. Detox will depend on how are established, also.

Representative Manning: I thought our recommendation was for three pilots through the state.

Gwen Skinner: Right.

Abel Ortiz: That is the recommendation. Anything else on transportation? What we can do is have Melinda and Gwen can pull together information we asked for and get out for one more look. Let's move through housing and the work they have done.

Don will walk us through it one more time, and then we can have a discussion.

Don Watt: Let me pull that up. OK – again just basically, Georgia currently provides ...however, other states have a legislative authority to fund stably. Real estate transfer tax as a dedicated fund source, unclaimed property funds, recording fees with real estate transactions. The second page put together information based on other states and how their fees are associated. I've provided research on a handful of that states just to give you an idea on how these are structured.

Exhibit B is the amount of resources that have been generated from these sources. Most of them well exceed the general appropriation put in place by the state of Georgia. Any questions regarding the information>?

Question: Is Georgia generally to be cut?

Don Watt: We actually increased by 300,000 for this state Fiscal Year '09 to fund housing support specialists. The actual amount is 3.3 million dollars.

Abel Ortiz: You are saying that is not part of the DCA recommendation in the cut.

Abel Ortiz: If we come up with more state dollars or are we capped on federal?

Don Watt: We are capped on federal. HUD allocates an appropriation of funds, so it depends on their appropriation every year. We are capped in a certain way due to how allocation process works.

Stan Jones: Are state money rental or capital?

Don Watt: It is used as match to emergency shelter grant providers who provide shelter and services to homeless. We use a portion to fund part of our supported housing programs.

Stan Jones: Do you still have tax credits?

Don Watt: Yes. 18 million tax credit annually.

Abel Ortiz: During our meeting Representative Manning brought up a Commission for a New Georgia, One Georgia money. I was wondering if it would be possible to get with River's Edge. Could you get with them and look at One Georgia to use as seed money to do work in this area?

Don Watt: I can actually do that.

Representative Manning: Is there any possibility for any incentive to use foreclosures as a tax incentive to state housing trust fund, to ask for a percentage or something?

Abel Ortiz: I don't know. Anyone?

Don Watt: The allocation that the state of Georgia has received, and regulations, came out of Monday. Money has to be used for homes foreclosed upon vacant or blighted - it can't just be a vacant or blighted, it also has to be foreclosed upon. 25% of that money benefits households at

less than 50% of the area income. A lot of mental health consumers should qualify. We have been discussing whether we can use some of these as group homes.

Representative Manning: I would be interested in more details on that. Could you give us a white paper on that?

Abel Ortiz: That would be great.

Stan Jones: I had the impression that capital costs have been the hardest to come by. Once a project is up and going, you can find an array of services to help support the rent. But the problem is finding enough capital to support the renovation and construction of a new project. I guess that is why the charts are here in that regard. I feel like we need to say something about the capital issue.

Don Watt: There certainly are provisions to provide funding for consumers with special needs. But traditionally developers go after family or elderly housing.

Abel Ortiz: I want to be respectful of people's time. To summarize on housing - what I have heard we want is to really look at issue of capital expense, is that an issue or use more tax credit with private investment. If you can also look at one Georgia for possible seed money for housing programs, too.

Melinda will send out the state mental health collaborative recommendation. Let's look at the document on what other states have done. Give her some feedback on some of those other ideas that you would like to see incorporated into those recommendations. Have the feedback to her by the 15th, to give her time to incorporate them into our next meeting.
Any other questions?

OCTOBER PUBLIC MEETING

October 28, 2008, 9AM-12:00PM

Attendance: Dev Nair, Lynda Hammond, Lynda Hammond, Julie Spores, Mike Allen, Stan Jones, BJ Walker, Steve Goss, Lee Johnson, Gwen Skinner, Melinda Moore, Michele Barnett

Welcome and Intro:

Abel Ortiz opened the meeting and welcomed the Commission. Abel Ortiz went over the agenda.

Abel Ortiz: The next steps for our conference call...we will have proposed format for the paper, and will get something to the Commission by the 10th for feedback. Before our next meeting, if decide we need to meet, we will. There will be room at the end of this meeting for public comment.

Representative Judy Manning: I did not get the state mental health collaborative email.

Abel Ortiz: We will resend the email. Now, let's start with the privatization packet.

Lee Johnson: I will go through both documents, both from the Vinson Institute background web search and the interviews. The purpose of doing the background research was to get some sense of privatization and to demonstrate why we feel that looking at privatization for hospitals is a viable option. The operation of hospitals in every state looks different in every state. We first looked at Oklahoma, which did privatization around the DD population and looked very carefully at what can be gleaned from their efforts, and we also looked at Florida's forensic and [missed section] hospital beds. What we heard from then and when we looked and talked to these folks is that there is some real savings that can be reinvested into communities. For example, Florida converted homes on campus for folks on campus...to transition back into the community. Doing casework in the community was a better investment than when it was in the homes. The second – infrastructure was addressed in privatization in ways that were very creative and did not put a burden on the state. Privatization works if you have a tight performance contract and monitoring system in the state. The Vinson Institute research shows that strong leadership is important to be successful. It talked in lessons learned about the importance of strong performance contracts and monitoring again, and the challenge of staff and professionalization in privatization. And is talked about privatization as something that can be reversed. In summary, GA has unique resources and populations that need to be served in the best way possible. We are going to try to consolidate our forensic services, and trying to remove children from hospital campuses. As we move along, we will try to keep you abreast of what is happening. An RFP should be online hopefully by the end of the week, and we will let you know when it is happening.

Lynda Hammond: So, is the RFP is for the forensic piece?

Judge Goss: I am a little concerned to know there is an RFP going out. I have concerns about consolidating forensics. Our jails are full of folks with mental illness, and sheriffs are faced with horrid costs to transport people. Lynda [Hammond] was telling me there was a 16-year-old sitting in an ER for 24 hours because there was no available transportation. It's a push to haul to

people sixty miles, and I can only imagine what the distance will be to wherever you are planning consolidating. We've had a lot of support with people in the state hospital in Thomaston, but they cover a lot of ground. When all of a sudden, you've consolidated and you need someone to come testify, and they have to be in Atlanta at the same time, it is going to back up the system. I think this needs to be discussed. I think we could have talked about this issue...about the privatization for a year and not have come to consensus. I don't think we can talk about this in the next to the last meeting and come up with a recommendation. I don't know why we are talking about this...

Stan Jones: I did request that we talk about this...I don't think the writing has been transparent on this topic. We've talked around some of these issues. Crisis stabilization, more acute care in community hospitals makes more sense to me. It allows federal matching dollars with services covered 100% in state facilities. I think that doing these things with the state hospital...I don't know enough to make those decisions. I think it makes more sense to do a request for information and let them discuss the issues. You will get a whole sense of the whole range of privatization issues that occur. I agree that the sheriffs are going to have transportation issues. Later in time, if folks have a longer term sentence or a prognosis for longer term care, and really get back to competency to stand trial of complete treatment phase or see what they are capable of, those might be more appropriate for additional management and I think sometimes you find energy from privatization, where the state gets burned out and beat up politically. But I think you need to look closely and slowly at things like length of stay and making sure case management actually gets performed in order to monitor. The Georgia and Florida model is different from our experience here. It is very important what the criteria and the contract contain. I think a two-minute summary on that is a mockery of what we are doing here. I think a few people have seen and been a part of more conversations than we have. I think we should wait for the new Department, before making a pre-judgment on something the new Department is responsible for. I don't think we have a situation where that we have enough money in mental health that if we took people out of the hospital and put them into the community it would be same. Turning it over at this point in time doesn't makes sense, or at least across the board. I think that if we set up PRTF in two units, we could have better outcomes than we do now. I think we need more than a summary, I think we need to see contractual terms – staffing ratios, accreditation. It needs to be proved that it is a better alternative than what we have now.

Commissioner Walker: You've said a lot but I'd like to get in and say a few words: an RFP is just that. A request for a proposal. We have to get to the point where we have a proposal and contract that is in the best interest of Georgia. We will continue what we are currently doing until that time. If we do not get a proposal and contract that our [missed word] say will be in the best interest of Georgia, we will not do it. One thing that we are not doing well right now is not removing people from jails that need to be removed. We did bring in the sheriffs to talk to them about transportation because it is a huge issue. The issues in the transportation in forensics in not as big a deal as transport on the civil side. If we are able to generate savings to invest in transport on when it comes to the civil side. They prefer to transport folks in the criminal justice system to the facility is they can drop them off and move on. Transport back is another matter and we are going to have to work it out on a contractual basis. And that work is what we are going to continue to do on the public side. I don't know that we are asking for a privatization recommendation. What we are doing is looking for another strategy to see if an RFP brings a

solution, and we are proceeding with caution. Is it a panacea? Will it solve all of the problems? No. But rather than continue to struggle or to not function at the optimal level [missed section]...and new facilities, the oldest hospital is 149 years old. We've spent multi-million dollars just patch working those facilities. We could get to the end of this road and think that none of it is viable. The worst-case scenario is that we do nothing different. Gwen and her staff are working very hard, so that if we don't change anything at all, we are still doing things at the highest level possible. We are not giving the whole system to anyone; we are talking about small pieces of the system.

Gwen Skinner: I would add that in the four years that I have been doing this, there have been inquiries about whether we have looked at privatization. And I think the Department was reluctant to look it. And this a good faith effort to look it, if it is a better system. Part of it is to finally say, we are going to write the best RFP that can be written and put it out there based on the needs of a variety of people.

Abel Ortiz: I want to clarify two things: I am not sure we intended to write a recommendation on this issue, it was to be a conversation. I think maybe a list of critical questions could be helpful.

Stan Jones: I think we need it for the RFP.

Commissioner Walker: It is not a transparent process. You cannot make it a public document while it is in the procurement process. It is tainted.

Stan Jones: What is contestable is the private conversations between the bidders and the [missed word].

Commissioner Walker: How do I know if I provide information to someone if they are friends with someone related to putting in a contract for bid? And if that information becomes available to the bidder...

Stan Jones: The criteria needs to be [missed word]. It is also discretionary whether you think something illegal happened or not. The process is litigious by nature. You can manage that carefully.

Abel Ortiz: I am not sure we are going to be able to do anything about the RFP release. I want to ask about the critical questions...we are getting our populations entwined. We are hearing forensic, civil-committed, length of stay, case management...

BJW: How do I know if I provide info to some that they are friends, etc with someone related to putting in contract for bid? And information becomes available to bidder.

SJ: The criteria needs to be...? It is also discretionary whether you think something illegal happened or not. Process is litigious by nature. You can manage that carefully.

AO: I'm not sure we are going to be able to do anything about the RFP release. I want to ask about critical questions. We are getting populations entwined. We are hearing forensic, civil

committed length of stay, case management. Forensic and civil committed are two very different populations in terms of length of stay. Gwen, can you inform the Commission? What is the clear picture between forensic and non-forensic consumers? I think that unless you understand that, I can't conceptualize the RFP.

Gwen Skinner: The easiest way to explain is that forensic are those court-involved. They may be there waiting for evaluations, incompetent to stand trial, reason of insanity. Forensic is criminal allegation. There are approximately 590 beds. Civil self-committed come through probate court. They are often there because the family intervened. Many of the people at the hospital are self-admits and can leave when they are ready to leave. It is a totally separate population.

Commissioner Walker: That length of stay is...

Gwen Skinner: ...moving upward to 300 days. Many times it is restoring them to competency, or to accommodate the court calendar. All of these contribute to the length of stay. Our civil committed are different than the rest of the country. Our civil population cycles through very rapidly. We are trying to stop the rapid cycling. That's why you read that they come to the hospital 10, 20 times, because the community does not have services for them.

Lee Johnson: We have the rapid cycling because we are the front door of our system. At same time, we have a residual population that gets added into that front door revolving that is more long term. I don't want to mislead anyone – when we talk about length of stay it is an average of all.

Abel Ortiz: Is the mission of the Division in forensic the same as non? Getting back into community? What happens after they are restored to competency? What is the outcome in forensic?

Gwen Skinner: Those are typically those who are presented back to the court for a decision. But I would also tell you on the residual population – that too can be attributable to the lack of community-based services. They are there because there is not housing or support services available. So, even though they are different populations, they are heavily influenced by a lack of community-based services.

Stan Jones: How many beds are in the new building at central?

Gwen Skinner: 184.

Stan Jones: 97 beds at state hospitals move into a smaller unit.

Commissioner Walker: Only some of them.

Steve Goss: I don't know that I am qualified to make a statement if privatization is a good or a bad decision for the state. I don't have good information. I don't want this to go into a written report and it later come back that the Commission said this was a good decision. I'm not comfortable with this subject matter, and is way bigger and way broader than we can say we've adequately covered.

Julie Spores: How many forensic units are across the state?

Gwen Skinner: NW Regional – 76; Atlanta - 90, west central - 80, central state - 184; east central - 71; South West -19; Savannah -70.

Julie Spores: And this RFP is only for forensics?

Abel Ortiz: Yes.

Stan Jones: Is this the only one?

Commissioner Walker: We've been talking about the possibility of privatization of an individual hospital but have not stated a process. We need new physical infrastructure, and use privatization as a new creative way to get new infrastructure through privatization and a long-term leasing agreement.

Steve Goss: When the RFP is out, will there be a dialogue with judges and others?

Commissioner Walker: Once it is public, we can talk about it.

Julie Spores: I have another question: if we contract to do this, will it take forensic money and a contract with them to start up? Will it cost the state extra money?

Commissioner Walker: I can't talk about it now, but I can when it is released.

Julie Spores: Say it will cost the state additional money, then it won't be cost effective. There are family members that are also going to be involved. The distance for travel in these economic times for families will be hard.

Commissioner Walker. Any proposal that will cost more money will defy the reason for doing it. The second issue, we should not have an average of 300 days in a forensic bed. We should be turning around our forensic population. Yes, for those in longer term stay, there will be challenges around transportation. Does it serve the best interest of Georgia? Even what we do now, it is inconvenient to someone somewhere.

Mike Allen: I think we need to keep in mind it is a long way from Thomaston to Atlanta. We don't want to be left out. We hear the southwest is on the list to be closed completely. I don't even know if those decisions have been made or are in the RFP.

Commissioner Walker: There is not.

Mike Allen: We don't want to lose the ability to serve people in southwest Georgia.

Representative Manning: Where are we going to get the money from without taking away from services?

Commissioner Walker: We are already spending money in places where we are talking about doing it. And it costs more because our infrastructure is old. A new hospital does not look like ours – sprawled out in separate buildings, which is harder to manage and it is inefficient. A modern building has more efficiency. We have sewer needs at Central State Campus, for example. It is a difficult conversation to have. It was difficult to have internally. We know the cost of running each individual hospital.

Lynda Hammond: How much does it cost?

Commissioner Walker: I don't have that number.

Gwen Skinner: Forensic is approximately 47.6 million. But there are a few things not calculated in that...this is just for services, not the infrastructure.

Commissioner Walker: We have spent 68 million since 2003 on the infrastructure issue alone. I think that was a-ha moment. A brand new building is about 25 million.

Representative Manning: I am concerned about the folks in the hospital. This could be an economic engine for some communities, and some communities will not be able to provide local support. I am concerned we are out on a limb.

Mike Allen: There is the privatization question and there is the location question. Privatization isn't as big of a question as where it will be. If you think there is political influence now, wait until private corporations start, it will be flooded with political influence.

Commissioner Walker: We operate a privatized system in other areas. All of our thinking is based on zero-based funding. [Missed section]...would have crisis stabilization, ACT Teams, mobile units, things to help people stay in community. So if we had 17-bed crisis stabilization program, would it suffice if you had ACT, detox, etc. funding services in the communities. We decided it was worth the risk of putting out an initial RFP to see if it is a viable option for us. That is what we are trying to get done. You are a level of what if? We are at a level of what can?

Lynda Hammond: Is anyone helping from outside?

Commissioner Walker: We have a consultant with a long history [missed].

Lynda Hammond: Who is not able to be a vendor or...

Commissioner Walker: That's right. And external legal help because we are dealing with corporate entities. We need that kind of expertise at the table as well if we get to that point. We took our realities and tried to spin them differently and decide what we could do. We decided that if we got this piece done, it could be the first piece of many pieces to get things done.

Lynda Hammond: If I can state a fear, the idea of someone coming in...if they come in and develop a facility and it doesn't work, who suffers? Us, and those in hospitals. It is always a risk.

And think about those in the hospitals. If you are spending this much money and someone else can come in and spend less...what happened to leadership? When you are not taking care of your own house...it's a basic thing. You are going to fix your roof. I have a hard time getting my head around that. I can tell you that money going back into the communities has been said before and if past performance has not done that, then how do you know that it will do that now? Gwen, you are struggling with the little CSBs, and you can't get them to change their labs, I mean, how are we going to manage this...this is my concern, and it is serious. And one thing I am an advocate for is southwest Georgia, and the other concern is the paucity of leadership in hospitals. It isn't there. The evidence demonstrates it to me. I haven't seen it.

Gwen Skinner: We have excellent hospital administrators. What you see if no different anywhere else. Changes in governors, legislators, DHR Commissioners, Mental Health Directors and what happens to hospitals – they have been protected at the expense of those served in there, because of economic viability in the communities. At the Central State hospital – they said your water usage is up, decrease your water usage. OK. Get the leadership to decrease the water usage. Central State stays the same. They go back and find a leak in the water pipes and are told to fix it. And there are 25 miles plus of underground piping, because it is so old. Somehow we have to hire a company to find the leak in the piping. WE are going to have to find a way to deal with several things. Economic drivers in community – Georgia is going to have to decide what is important to them. Recognize what is – if you want to keep the seven hospitals you've got, because it is 140 some odd years old and it will cost you. The Director of Mental Health cannot do anything about it. How much money do you want to spend on it? I can run the best hospital system in the country if you give me the resources. You can't continue what it is doing and be frustrated because we are not getting the outcomes. And I do take polite offense, because we have excellent mental health administrators. They don't get the right tools, and a lot that has to do with stigma, etc.

Commissioner Walker: And whether or not we are going to address original question we started with? If the goal is to provide appropriate care and treatment, right now we have seven hospitals and they are the go-to place. All of us have to change our minds on how, where and when the system should do what it should do. How do we get there? We don't suggest that we have the answer, we don't. We are struggling with what we have to make answers. We are just saying there is another way to look at it and maybe do it more appropriately. We understand it is a road we're on.

Lynda Hammond: The lesson to take forward is to learn from what we've seen, if it is the 100-year-old parts, or whatever. Making sure you've got up to date what you need as you go along. Any organization needs a mission, and a good, strong sustaining mission will outlive everyone if it is there.

Julie Spores: I have a couple of comments – I saw where September revenues were up \$70 million more than last September.

Stan Jones: that is not how it works.

Commissioner Walker: It is based on a projection of revenues; it would have to be future. It is a projection issue.

Julie Spores: While on subject of revenue – how do we propose to look for money to be able to fund behavioral health services at the level of now and better? Because now isn't doing it. Is that what we care about, that we want our children to have quality services? Because now it is not there. I am concerned we spent all this time to come up with a plan for Georgia, and a lot of us are tax payers, how are we going to make sure things are going to happen? You asked us to prioritize, but a lot of those got stuck in the back file somewhere. Case management...I guess I am asking for legislators to find revenue resources. If we are going to provide it, it is up to you guys to figure a way to do that. Other wise we are spinning wheels talking about a system that we're never going to fund. Also , we need an advisory board to oversee this new behavioral health system. We need people on this commission to be on that commission, we are the ones who've worked hard to find the services we need. We have to have people on this committee to carry this forward. If not, what have I done for the past year?

Mike Allen: I am an advocate for southwest Georgia, but I am trying to look from a statewide perspective, too. I just don't want us to be left without.

Abel Ortiz: The prioritization that we have done was communicated to OPB and the Governor, and it is a part of the planning process. We don't know what the budget is going to look like yet, and that is the process we are going through right now. My suggestion for privatization is to write up a list of critical questions. Not a recommendation, because of the complexity of the issue. There are questions the state should address in the process, based on what we have heard here today. And we can repeat back through them to hear what they be – and if you are comfortable with it, we can put it in the final report, and if not, we'll leave it out.

Representative Manning: I think we need it, but I'd like answers.

Abel Ortiz: Are people comfortable with that?

Stan Jones: But it cannot precede the RFP?

Commissioner Walker: It will not precede it, but it will inform the process. If the critical questions will influence the RFP in a positive way, there are options. There are lots of opportunities....once the RFP is public we can talk about it...there are plenty of opportunities to use critical questions and answers in the process. And we will do that based on the questions received from the commission.

Abel Ortiz: From my notes and Melinda's notes, we can try and get this out to you quickly, so that we can get them to the Department by Monday. So, we will have them out by Friday, and a response by Monday. Let's move on to housing.

Doug Scott: Let's look at the neighborhood stabilization first. There is new funding that has come out, a substantial amount of money statewide, totally 150 million dollars approximately.

[Doug Scott walked the Commission through the Neighbor Stabilization paper.

Abel Ortiz: It is not just for special needs housing? Is there going to be a set aside amount where there will be a set amount for programs?

Doug Scott: They have not specified program set-asides. They haven't figured out if it will be a set aside, or a first come first serve basis. It hasn't been determined, but we should have decided by the first week of December.

Stan Jones: Is there any discussion on zoning restrictions that can be overcome for this issue? Can you use this money for mental health purposes?

Doug Scott: There could be eligible use, but it must comply with local regulation. Next [Doug Scott walked the Commission through the General Obligation Bonds]...There seems to be difficulty in whether GOB can be used for supportive housing. If you look at item "c", we might be able to use that. I also want to highlight that rental assistance funding for permanent supportive housing is on the same page. A key component of it is rental assistance. [Doug Scott walked the Commission through the Low Income Housing Tax Credit program document].

Abel Ortiz: Has anyone in Georgia done this?

Doug Scott: Yes. This is the simplest explanation of what can be done.

Stan Jones: Is there any set aside for mental illness or substance abuse?

Doug Scott: There is not.

Stan Jones : I've had the impression that tax credits are easily used by for profit agencies, but that there is not enough knowledge yet in non-profit agencies.

Doug Scott: We have some very experience developers in permanent supportive housing. And a few with experience in managing permanent supportive housing.

Stan Jones: Do you have any feel for demand or need?

Doug Scott: Um, there are roughly 10 thousand homeless with disability, and 8 thousand in prison that might be a source for demand and issues around community placement and Olmstead, and money following the person...all are potential sources. As for supportive housing, there are those in investment that specialize in this, but it takes more work. But it is doable.

Abel Ortiz: Are there any questions on this one?

Doug Scott: [Walked the Commission through the One Georgia document]. It was felt by the staff of One Georgia that they were looking for commercial jobs, and the creation of housing would not be for industrial or commercial purposes. WE made the argument that housing in

some areas of rural areas might be a way of creating jobs and types of support service personnel that would be there –

Representative Manning: What about hospitals?

Doug Scott: I don't know if they could use it for a public hospital. You would have to ask the One Georgia Authority.

Representative Manning: Are they not responsible to anybody?

Doug Scott: The Board of Directors are appointed by the Governor.

Julie Spores: How would consumers know this assistance is out there past Atlanta? Any kind of...CSBs getting the word out?

Doug Scott: Through CSBs or various referral networks that we have. CSBs, support service providers in region, courts...

Julie Spores: And this is for DD and MH and AD? How many are available – there is not a set aside slot?

Doug Scott: There is no special set aside of resources.

[Missed section]

Abel Ortiz: Who makes the decision?

Doug Scott: The document for the qualified allocation plan is available for public comment – it does come out in the next month. We accept recommendations, then it is approved and sent to Governor.

Abel Ortiz: So it is influenced on the department level?

Stan Jones: Is there any pending federal discussion?

Doug Scott: No. There is a new tax credit modernization that will allow flexibility in the use of the tax credits.

Stan Jones: Do you have a backlog in resource allocation ?

Doug Scott: There is an annual process where the allocated is based on our [missed word] structure. Last year there were 60 plus applications, and we awarded the top 65.

Abel Ortiz: The available tax credits are being used.

Dev Nair: Is there an overall planning structure in what is being developed, or does individual developers come to you?

Doug Scott: [missed]

Abel Ortiz: Would it be possible under structure – if DHR established a housing committee to make sure good development is going on in the state? Could they partner with DCA?

Doug Scott: There is nothing that prohibits that type of strategic understanding of those resources. We wrote a MOU between DHR and DCA to look at exactly that. We were combining rental assistance and tax credits and combine with tax credits, but it fell by wayside. It is on hold due to budget.

Gwen Skinner: The agreement is on paper.

Abel Ortiz: Can we see it?

Gwen Skinner: Yes.

Stan Jones: Abel, any thought on taking these good efforts and expanding them?

Abel Ortiz: That is why I am interested in that plan.

Gwen Skinner: When we first started working on this, 570 were built and of those about 64% were targeted for people with mental illness, from DCA.

Doug Scott: Although we have concentrated our future on the homeless with mental illness, substance abuse, etc. going forward, that is where we'd like to concentrate our efforts.

Abel Ortiz: It is in one of our recommendations, to package it. Turning our attention to the state mental health collaborative...what is here is a shorter version of what was sent over email. I'll have Melinda re-send it. These are best practices in other states. All of the states started their process through a federal grant from SAMHSA. The most radical one is New Mexico, where they put all of their funds in one bucket, and one vendor does all of the services. And the rest have a range. The last page and half are recommendations. Do you want to make any recommendation changes to this?

Question: How does it relate to the alliance and the restructuring? And I can explain my understanding. This would be connected to the new Department and focus on the tasks listed here. It relates to the alliance in that it deals with human services broadly across all human service agencies. This would focus only on behavioral health. It will be attached to the new Department of Behavioral Health.

Next Steps and Next Meeting

Public Comment

Meeting Adjourned.

NOVEMBER CONFERENCE CALL

November 7, 2008, 9AM-10AM

On the call:

Abel Ortiz, Governor/Chair of the Mental Health Commission; B.J. Walker, Commissioner, Department of Human Resources; Judge Steve Goss; Lynda Hammond, Licensed Professional Counselor; Stan Jones, Parent Representative; Dr. Dev Nair, Julie Spores; Jim DeGroot, representing Commission Donald, Department of Corrections; Representative Judy Manning;

Non-Commission Members: Don Watt, Department of Community Affairs; Michele Barnett; Melinda Moore, Mental Health Commission staff; Doug Scott; Department of Community Affairs; Gwen Skinner, MHDDAD; Mary Eleanor Wickersham, new Health and Human Services

Agenda

1. *Welcome and Introductions*
2. *Privatization Discussion*
3. *Behavioral Health Collaborative*
4. *Encounter Data*
5. *Final Report Draft*
 - **Title Page*
 - **Table of Contents*
 - **Executive Summary*
 - **Recommendations (Review and Comment by 11/12)*
 - **Statement of the Problem*
 - **Effective Practice Solutions*
 - **Recommendations*
 - **Meeting Notes*
 - **Appendix (Power Points and Handouts)*
(Receive complete draft of report by 11/17 review and comment by 11/21)
6. *Next Meeting 11/25*

Welcome and Introductions

Abel Ortiz opened the meeting.

Abel Ortiz: What I wanted to start with is, you got the agenda, I hope. What we wanted to cover was the privatization questions that were sent to the Commission for input or feedback.

Privatization

Judge Goss: I have concerns about the privatization questions. I do not want this to come as a recommendation from the Commission. I also noticed that the Adult Subcommittee document is not reflected in the email sent out. I will resend this by the end of the day.

Abel Ortiz: I was thinking that I would include this [privatization questions] as a part of the executive summary, but not include it in the recommendation section. That way it is not a part of the recommendation section. I would like feedback from the Commission on whether they want it –

Stan Jones: I think it is a fair portrayal of the things we talked about, but I am hesitant to endorse it. But I am happy to shoot everyone an email after I have had a chance to think about it.

Abel Ortiz: Maybe we could refer to it as not an endorsement, but a list of questions. And then we can put the questions in the appendix.

Representative Manning: Is the RFP still going to be out?

Commissioner Walker: The RFP is going to be released on Friday, so it is out at this time. Let me add to this, my understanding about the questions is that once we are in the process, these are questions that the Commission was asking would be asked and answered as we proceed toward a contract.

Representative Manning: BJ, one thing I am concerned about is that the response to a RFP... [missed] it is costing them money to even apply for the RFP. So, if the Commission is not going to recommend it, should we do it or not?

Commissioner Walker: To get business, you have to spend money to get business. That is the nature of the beast. But the efforts to privatize is a business decision we are making in conjunction with the Governor and the Governor's office as a business decision. While the Commission may recommend or not recommend, we are making a decision based on the dollars on the table and the resources that we have, and what is the best decision that we have to offer. That's kind of where we are at with that. As I understood it, you were asking us to use these questions as we proceeded and if we proceeded to any kind of contractual process.

Abel Ortiz: Is it clear to the Commission that we are saying this is not an endorsement?

Lynda Hammond: I am.

Stan Jones: I think it is implicit because it is in the report.

Abel Ortiz: If you would prefer it not be in the report, then say you don't want it in the report. After you review it, please state that.

Stan Jones: All right, I will not dodge that.

Abel Ortiz: And it does say these questions should be considered, and I do not know if we need to use stronger language.

Stan Jones: I have heard some compliments about the strength of the RFP. But my immediate concerns are the same ones that Steve expressed, and how they can get what they need close to home. I don't know how there is enough space in Milledgeville that they can put in forensic beds. The two issues sort of run together that way in my mind. I think that people will write in during the RFP process, and that is fine.

Dr. Dev Nair: Maybe we need to make an explicit statement that the Commission did not have enough time to view the pro's and con's on the issue, but with the time we did have, these were the questions that we have.

Abel Ortiz: I will add that language. Please give feedback by the 12th, that would be great.

Behavioral Health Collaborative

Abel Ortiz: Is there any feedback on the previous recommendation that was handed out at the meeting? We had a conversation around whether it is advisory, and what its capacity will be, and how to work into a plan. The question we grappled with is what does "guidance" mean, and how much teeth do we want it go have? And to remember that each department involved has a board, and the new Behavioral Health department – what and how will this interface with that board? What do the members think about, you know, what would the recommendation be from the Commission on how we would phrase the power of the guidance of the collaborative?

The recommendations are located at the end of the section on the other states.

[Melinda Moore resent the document to the Commission]

Stan Jones: I think it ought to be able to make a recommendation to OPB that it should be staffed. It should be an intermediary between DHR, Corrections, etc. The Governor's Advisory Council [missed section].

Commissioner Walker: Is the collaborative is going to be making the recommendations to OPB and not to the board of the agency?

Stan Jones: I think both. If they don't they don't have clout to serve any function. Not that the boards do not have the legal responsibility to say how they use they resources.

[Missed]

Abel Ortiz: If the Department of Health Services are...and that this is going to be used so that they break down the silos and building and leveraging for each other.

Commissioner Walker: I think it is really important to be realistic about what can happen. I've been responsible for 4 ½ years for silos and I have struggled to blur the lines between the silos. Some of it is easier and some it's not. All the child and mental health dollars – some of it was effective on the DFCS side and one of them was ineffective about CSBs because they are not serving children. In consolidating they are creating one set of [missed] to serve children. I can't

tell you how difficult it has been to get it done. As a silo buster, it is not easy work with so many people at the table. There will be so many opinions and the people at the agencies - it will be frustrating doing the work they are trying to do and we need to be specific about what problems we want them to solve. What do we want them to do exactly?

Representative Manning: Do the recommendations go to the various boards and then to general assembly and the governor?

Commissioner Walker: I don't know, we need to decide that.

Abel Ortiz: I think that is the most logical way to envision it happening. We can't take the authority away from the...

Lynda Hammond: I agree, there is a lot of jockeying back and forth and who is to be served. Children get left behind every time. And it is a lot of hard work, and I appreciate it. We need that system for the state as a whole.

Jim Detroit: From where I sit we are doing the best we can to facilitate re-entry. Our primary function is to provide a constitutional ... my hope a collaborative can help us build bridges with the community.

Commissioner Walker: I think the hardest things we try to do is to create a reasonable and consistent system of care, and our policies are specific to our agencies and we don't have one unifying set up policies. That would be a problem that needs to be solved, and it would drive budgets, etc. towards solving it.

Jim Detroit: One set of policies and procedures.

Dawn Randolph: We sat down and talked about operationalizing it where medication and data warehousing is an operative goal. Now it is getting down to what do you want this look at? This is where we were at a year ago.

Jim Detroit: And I feel like we are slipping a little, where we are providing a 14-day supply of meds, and not 30 days, and it won't cut it.

Abel Ortiz: So, I wonder if we could take what BJ, Dawn, and Jim said – it is almost like if the collaborative could bring Department heads together and have them on two or three critical issues that are interdepartmental departments, and get them resolved. So, you don't look at the entire world of mental health, but at critical issues like the transition of mentally ill inmates out of corrections and jails, could be one, or the medication issue. And the collaborative is a place where you work on those issues until they are resolved, and then the collaborative determines when they move on and what the next issue is going to be.

Commissioner Walker: That makes a lot of sense, because at least you are working on real problems.

Stan Jones: If it isn't real it will be a waste of time.

Representative Manning: If it doesn't have teeth to it, then we are wasting time. It needs to be something we get our teeth into and can get collaboration. On my study committee, I am having a hard time even getting someone to come speak to us from a CMO standpoint because they fear retaliation, but I cannot get an answer. I wonder if we can get direction as to what we can do next and move on.

Abel Ortiz: So, involve three departments, and the charge is to find resolutions to a problem and a monitoring plan of the implementation and those be formed in the recommendations that include practice policy and budget recommendations that go to the individual boards. Sort of like we take the case management piece that touches corrections, DBH, DHR, DCH – that is a problem they can target on. They would be charged with a plan for implementation and a monitoring plan for implement and developed into a recommendation plan that includes policy, fiscal...that they can then take to their individual boards, and this how we are proposing resolving the problem and then how they would solve the problem.

Stan Jones: Let's put that on paper and we can react to it.

Abel Ortiz: That makes it very targeted and they can see it is an issue that needs to be resolved. The call is about to end, and I want to talk about things on the agenda. We have encounter data. In the agenda is an outline as a proposal for the setup of the final report. We sent you the recommendations and we will go back and double check that you have got all of them, and we would like you to review and make sure that you have the most recent copies of everything. And the executive summary for you to review. And then get to you a full layout of what the final report will look like for your review.

Question: Will you send them out so they are identified in order so we can print out in the correct order?

Stan Jones: There is some lack of the consistency.

Abel Ortiz: We'll reorder so you don't confuse handouts with recommendations. And then whole report back together for your review. The big question is we have a meeting scheduled for the 25th, do we want to have another call in the interim?

Lynda Hammond: I don't know when you could have that call. I have a little concern that we haven't been able to go over everything.

Representative Manning: I've got to get off the call. I am not comfortable with budget piece either.

Stan Jones: What's missing from encounter data is the period of time...

Dr. Dev Nair: The request was for us to look at the same data that Rick Dunn pulled. But Stan, you are asking to look at how things change over time.

Abel Ortiz: Does anyone have any time on the 20th or 21st for a conference call?

- Set up a new conference call on MHC at 1:30 on the 14th.
- Recommendations are to be sent to Representative Manning's capitol office.

NOVEMBER PUBLIC MEETING

November 25, 2008, 9AM-12PM

Attendance: Gwen Skinner, Dev Nair, Lynda Hammond, Representative Manning, Stan Jones, Julie Spores, Mike Keown, Jim Donald, Abel Ortiz, BJ Walker, Senator Johnny Grant

Welcome/Intros

Abel Ortiz: Go through draft recommendations – what was sent yesterday morning, in addition to Stan and Judge Goss’s feedback. Then talk about timeline and getting final report released. Setting aside time for public comment.

Why don’t we start at beginning and walk through – not so much grammar, but concentrate on content.

Stan, can you explain content of changes?

Stan Jones: Put what we’ve been working on in the context, tried to accent more of what folks have been doing, and down at bottom of page to accent that we had looked mostly at principals and not in mandate to look at privatization and other issues.

Abel Ortiz: And more of the impact of the parity bill which we hadn’t put in here very much. Came up in Olmsted planning as well, had we done an impact statement.

Representative Manning: does that just go to 51 employees? Does not count for little families...

Abel Ortiz: In talking to dr. meadows, have they done analysis planning for Medicaid and s-chip to see if they are in compliance?

Representative Manning: I wonder how many of these (missed)...

Dev Nair: does it exclude self-funded?

Stan Jones: I think there is provision for self-funded plans. Doesn’t cover Medicaid explicitly. Larger number of small businesses.

Representative Manning: I don’t know how you check that.

Stan Jones: there is data though

Lynda Hammond: Many people will work for a small business though

Stan Jones: public system more care delivered – CSBs, etc get some insurance.

Representative Manning: thought it was going to be a big thing

Abel Ortiz: need to know how it is going to impact

Lynda Hammond: it will help those who had lost their benefits

AO: as we go down recommendations

More on quality of care (SJ);

Commissioner Walker: are you willing to say confidently that you believe if we don't have \$ that there aren't things we may be funding in current budget that if reduced or eliminated would not present a threat to – that which you are spending dollars on which is not a good spent on your money . The money the public has to give us is what we are obligated to operate in, little or big. The question is with the monies we have what is the prioritization for spending

Julie Spores: do we own the land the hospital sits on? The state?

Commissioner Walker: I believe so.

Julie Spores: why don't we lease the land to a private, environmentally safe – got to be something we can do with that land other than just sit there, when the state is hurting for...do something proactively with that land? Seems logical to me that you would think about long-term around that area, because the land is just sitting there, and why not use that? I am sure we could probably put some money, generate revenue off that to put back into the budget.

Commissioner Walker: one of the things I've learned is how expensive it is to tear down a building

Gwen Skinner: two issues at central state – one is some having historical significance, and the other is at best the abatement has been done, which costs more than to raze the building.

Abel Ortiz: can we get back to walking through this

Commissioner Donald: there is a master plan to look at this whole community. Therefore, that issue is being looked at.

Stan Jones: corrections and DHR?

Commissioner Donald: yes. It does cost more to tear down.

Point in time look at budget. We don't know that this is the right balance of funding right now; we know exists. This is the historical way dollars have been used, but we should continually evaluate on a year-to-year basis, because if it is in proportion to need right now, need for hospital may be higher or lower – b/c we have an imbalanced system. It could be we need more or less, but we don't know which now. Hate this to be driver of what we think it ought to be.

Gwen Skinner: Need to have clarity about where you draw that line – when it becomes a community service. Some things that are considered community program are paid out of a hospital program. Even if you are going to look at how money is spent today, need decisions on what's community? Who is funding or who is running?

Commissioner Walker: This is benchmark, ongoing evaluation of whether this is the right proportion and definitions driving it.

Abel Ortiz: actually, you wrote the comment that we are making the assumption that we want to make MH services community-based. I think when you talk about hospital beds and you look at our current utilization and our customers in there that are non-forensic. I'm sure we can say we need more hospital beds for non-forensic patients, and I don't know that we can say that – when we can take care of them in community settings. So think we need to be careful about walking the line

Stan Jones: I wasn't going that far. 85-90% staffed, which is acceptable for maximum number of people in hospital.

Commissioner Donald: I would recommend that we don't get too prescriptive right now. We are looking at a conceptual framework right now. So my thoughts are that we might find we have sufficient beds, but it is how we manage those beds. As we get more information from new commissioner of that department, a master plan of what we really need in beds. Is it forensic beds, etc? Temptation is how to fix the problem. I love the way Abel wrote the last paragraph that gives us the flexibility to look at the issues. That when we formed this it was with idea that the commissioner would bring the information. (Missed)....bring better quality

Stan Jones: In the MH system, though people ebb and flow closer to home. I don't think it quite the same thing in the forensic population. Not everyone in forensic unit fits that category...

Gwen Skinner: forensic pop- what are the laws that currently exist that drive people into the hospitals, b/c there are certain things we know...

Abel Ortiz: so we are going to make a statement this is the current status, and state needs to determine what the right formula should be and it should change as system and population grows.

Stan Jones: See regional on page 3

..... (Missed section, while editing document)

Commissioner Walker: Right now before we have a change in legislature, and Gwen is doing the statewide leadership role for MH, we are sitting here right now doing what we think needs to be done. We still have a whole lot of hoops; we can't wait until next July.

Representative Manning: that's my point.

Commissioner Walker: that is my point too that we are doing what we think needs to be done today to put tools in place for leadership to move things forward.

Representative Manning: you know there will be struggles between the departments.

Commissioner Walker: But right now, there is only one. If there is a problem tomorrow, AJC is here – they are going to write about problems with the group here now.

Abel Ortiz: Can I ask that we really do need to get through this and stay task oriented?

(Discussion of transportation – telepsychiatry on page 4).

Commissioner Donald: for our rural sheriff's especially, for transportation – it seems to me we've doubled our telepsychiatry. It ought to be a postmark at the end – something to the effect: increased consideration to using telepsychiatry used to transport those who don't need to be.

Lynda Hammond: Minimal costs in what it costs to transportation (in comparison).

Gwen Skinner: keep in mind court-hearings; keep respectful that that needs to be accomplished as well.

Abel Ortiz: BHC – decided on call what the collaborative would actually look like. The longer BHC recommendation has more information on that. (Abel walked the commission through the longer recommendations – staff, etc.) More targeted, more focused. Thought this was better way to make sure something is done by the larger group.

Representative Manning: that means boards the boards have the ability to approve what the collaborative suggest. I thought we were going to the governor with what is suggested. I think the general assembly needs to be on there as

Abel Ortiz: recommendations from collaborative would be incorporated into the budget.

Representative Manning: that is one more skin on the onion. That is the problem we have already. That's not how I would like to have this approached, it looks like more beaurocracy.

Commissioner Donald: our budgets have to be voted on by our boards. Ultimately, the governor makes the decisions.

Representative Manning: that's why I think it should be presented to the governor.

Stan Jones: why don't we say all three?

Commissioner Walker: If a board doesn't approve your budget and says they won't, then by statute the submission has not been accepted, and it sounds we are asking governor to act independent of his appointees.

Representative Manning: the general assembly doesn't see through the same glass as governor.

Abel Ortiz: A report goes to both assembly and governor – so even if not approved, you will have information on the original proposal.

Representative Manning: I just think there is a hierarchy of beaurocratic power.

Abel Ortiz: I think that is just how it set up. It is interested to see what comes out in board to budget approval...not all of it stays the same. I think it would be helpful to see the original proposal.

Representative Manning: I think it would be cleaner if it were the other way.

Commissioner Walker: Common room in the middle of this – a collaborative would say this is our report and what we think needs to happen, could go to general assembly to governor and to board. The commissioner would take funding/policy pieces to get board to pass off on; but they are just the first point of decision, and then the Governor and the General Assembly already have pure recommendations. So when budget makes it way from my board to the governor and they look at it and decide what they are receiving is what the collaborative is putting out there, and then onto the general assembly and the final opportunity to say I don't see what I see in the original report. General assembly is the last point of contact before it goes out the door.

Lynda Hammond: concern that I have is that issues are not watered down passing through different people.

Commissioner Walker: that is democracy in action.

Lynda Hammond: I know, but... (Missed)

Commissioner Donald: but we have something we didn't have before in a new commissioner in this new department.

Representative Manning: It is about the money and who has it and what programs and what department. I think it would be a good thing to involve general assembly at that point in the process. I would hope not just as advisory.

Commissioner Donald: interesting in what has evolved. Speaking to house appropriations committee – in Georgia at least, we have gotten out ahead of this. I've done it a similar way at the senate. So there is an opportunity to see what is in my budget before January.

Lynda Hammond: speaks to importance of who is going to lead the BH department. Needs to not be a yes person. A gadfly, need to be someone with guts to speak to the truth of what has happened to those in the sate.

Stan Jones: some compromise in there somewhere. A requirement exerted by oral authority of the governor that I am not going to spend any money on inpatient forensic services until they get together and figure out best way to spend \$ on MH in each system. We need a bit more to say that the departments need to get together more. If going to have something like this, needs to have pizzazz or some independent reporting and monitoring authority (missed) and make recs that are made to governor and GA to make up how well they do, especially to deal with silo issues. It needs to have more independence and oomph so that there is more accountability to the boards, etc. – serve function to pull out of narrow roles to work more broadly. Kind of what we've gotten to now. And resembles what the collaborative did in other states – cross-agency activities with endorsement of governor.

Abel Ortiz: what I have captured so far: "Need to have members of GA involved in process as member or advisory in collaborative. And a desire to have to maintain legal requirement of

boards but that collaborative would submit directly to governor and G assembly and monitor what it recommends”>

Section on page 8 – significant progress: BJ and Gwen outlined the efforts that have taken place, and how to do more with same amount of money.

Lynda Hammond: probably should add that in there. We wouldn't say that based on what we've learned and happened.

Next progress report comes out in February.

Commissioner Walker: we move 33 million dollars of DFCS money to the MHDDAD 2 years ago. We moved it in the budget for FY '08, we were making a guess of how much \$\$ would be need for kids in foster care. Number dropped in care, there was \$7 – 8 million about 6.2 was moved back to DFCS b/c money was not spent on kids in foster care. That money came from DFCS in the first place. We have to make tough choices about money – started in DFCS and had to move it back. We left it in the '09 budget because we think that as the system gets more sophisticated. That money was not taken from MH.

Julie Spores: why are they closing services everywhere? Honeycreek.

Gwen Skinner: DJJ's program. DJJ budget cuts.

Lynda Hammond: I don't mean it disparagingly.

Commissioner Walker: Over a long period of time, we have not done what we needed to do in this area. When I asked Gwen to head MH 4 ½ years ago, we looked at how to turn the money over and invest in what we needed it to do. All I am saying is that we don't need to dishonor her work to make point that more work needs to be done. We don't take it personally, or we wouldn't be able to get up in the morning. But we take it professionally.

Lynda Hammond: we need to all bear this, it just so happens the leaders get the hit. This is an indictment of citizens of Georgia and what we have not done for our citizens, so we need to be sure we are using and doing things in the right way.

Stan Jones: My kid died in the last 6 years because oversight led to his finger being bitten off. I think people thought because the deaths happened in that period of time and because the DOJ report identified things after the AJC report. And we have made changes but to have a statement is credible – it should say something like, “Been good recent progress in these areas, everything cannot be done overnight and there is a need to keep working.”

Commissioner Donald: GRIP program, too. 700,000 in housing for returning ex-offenders and stood up six 11-day reporting centers with MH and SA diversion capabilities; and steelwork – 8 different sites (doubled sites for telepsychiatry)

Stan Jones: DO we know ho much more money need for mobile –

Abel Ortiz: I wonder if we could determine need for adolescents. DJJ determine what the need is.

Dev Nair: because you won't have the medical need

Gwen Skinner: rick can do this – assessment of need and develop a plan based on the need for detox.

Abel Ortiz: I am trying to think where we can this data from –

Lynda Hammond: Pediatricians or somewhere before DJJ?

Stan Jones: Cost to do Columbus, Savannah at other state hospital or regions?

Gwen Skinner: Yes, we have that costed out. Little different based on specific sites.

Abel Ortiz: be careful when we talk about dollars that legislature is not committed if the numbers don't match what is in the recommendation.

Julie Spores: if we can make an easier way to get into the medication system. It's bad. It's very uncomfortable, and you often feel like you are crawling out of your skin with the wrong medicine.

Commissioner Donald: Medical provider needs to do that. I don't think this mandates a formulary. It makes it transparent so they can retain medication as they come out of one system, so you can see all of those drugs and what has worked and hasn't as an ex-offender comes back into the community.

Abel Ortiz: you would need to look at

Abel Ortiz: Technical assistance plan helping getting people on SSI – there is a process in your state programs that you are actually maximizing SSI and Medicaid. And the Feds have been asked to help bring this person to Georgia.

Gwen: You currently have the Soar program that does outreach to the homeless population.

Julie Spores: Is there any money in the state budget for non-billable Medicaid services –

Commissioner Walker: Which services are going to be most helpful to the consumer to keep them out of the hospitals? I believe we use some of the CSI for that now. Money there to do it, just not more money there to do it.

Transportation

Stan Jones: Are sheriff's presenting anything specific in their community to address this? We don't want to leave something out if they are addressing it or discussing it – we should acknowledge or support it. Maybe shoot Steve and Mike an email to see if there is a piece missing on the sheriff's side? (Mike Yeager)

Uniform Children's Benefit Package

Commissioner Walker: CMS firewall between CCI functioning and medically necessary core providing or function that provides those services. CCI being operated a whole other set of guidelines.

Stan Jones: Talk about Rehab option.

Abel Ortiz: What would we say about the Rehab Option? I'm not sure how aggressively Georgia has gone after MRO for case management. It's statutory, it can't drop out of Medicaid but a state can opt not to provide it.

What is the best practice out there that all children should have access to? If MRO has it, then MRO provides it, but if not state resources have to assist.

Public Comment:

As I see that most of these proceedings are about the fiscal issues addressing mental illness. I would hope that you would remember the civil rights of our citizens; the ombudsman is a needed component to this system, being violated especially as they to children. I am mental health consumer, a member of NAMI, a facilitator for NAMI, and educator in DeKalb Co School System as in school suspension facilitator. Watching many of children be neglected by school system and doe and I have written doe on how many children have fallen through cracks and how they are falling into the school system but there are so many teachers who don't understand mental illness is, and I am watching children including my own son (bi polar) acquire a rap sheet for behaviors that are attributed to his diagnosis. I am hoping the governor and you understand importance of education because if people don understand mental illness and what it is it will not be looked upon as a serious issue when children can be served better in the school system. Our children cannot help themselves – a child who has a mental illness that is undiagnosed and untreated will grow up to be an adult who is still undiagnosed and untreated and it will take over society and we don't have enough jails, hospitals etc. to help. I am behind your support because I felt it was important to be here and speak. Teachers need to be here and be aware of what mental illness is and what we can do to help change the future.

APPENDIX A

CRITICAL QUESTIONS ON THE ISSUE OF PRIVATIZATION

On October 28, 2008, the Mental Health Commission heard a presentation on the Department of Human Resources' plan to release a request for proposal to privatize forensic hospital services. The Commission has not endorsed the plan for privatization, but has raised the following questions to be considered prior awarding a contract.

1. How will the issue of transportation be addressed?
2. What impact will the consolidation of the forensic units have on rural areas of the state and how will concerns raised by patients, families, law enforcement and community providers be addressed?
3. How will the privatization assist with the backup of the mentally ill in the jails?
4. How will it affect the courts?
5. What are the contractual terms going to be?
6. How will the contract measure performance?
7. Will the contract address length of stay?
8. What type of accreditation will the private hospital provider have?
9. Will the private hospital provider provide case management and how will they interface with community-based providers (case management, treatment and support services)?
10. Will this process pull resources away from Southwest Georgia?
11. How will the management of services be monitored?
12. What is plan "B" if privatization does produce the positive clinical outcomes or if privatization is or becomes too expensive?
13. Has the RFP been developed with as much transparency as possible according to state procurement regulations and laws?
14. Where is the money coming from to privatize forensic hospital services?
15. What the difference between "forensic" patients and "non-forensic" patients?
 - a. Do they require the same hospital services?
 - b. Does the Division have the mission with forensic and non-forensic patients
 - c. Will forensic and non-forensic patient require the same type of community-based services
16. Is the Division considering privatizing other state hospital services or populations?
17. Will the new privatized forensic hospital include those serviced by the Department of Corrections?
18. Are GDC inmates going to have access to forensic beds at the Culver Kidd and Cook Buildings?
19. If so, how many beds will be allocated for GDC inmates?
20. If not, aren't we maintaining agency silos that resulted in creating a fragmented public mental health system?
21. In addition, why aren't convicted felons who are mentally ill and/or who have a co-occurring disorder included in DHR's definition of a forensic population?

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⁵ As noted, these CIT training sessions have been offered in various geographic locations in order to facilitate the training to officers and to hold down travel expenses for the law enforcement agencies. One concern that has been voiced is that some smaller agencies are not availing themselves of the training due to manpower issues. The training is provided in five business days in a forty- hour block. Most officers that have completed the training and the trainers believe that such focus is needed to obtain the maximum benefits. However, some small police and sheriff's departments have difficulties in losing an officer for work for an entire week in a block of time, even if the training is nearby. GBI Director Keenan has advised that he will confer with the Sheriffs' Association and the police chiefs' organization to see if some informal manpower arrangements can be worked out to further facilitate the training opportunities for smaller agencies.

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- ²⁷ *Note*: The Commission received a presentation on the program from Georgia NAMI President Nora Lott Haynes and a number of CIT law enforcement officers on April 29, 2008.
- ²⁸ As noted, these CIT training sessions have been offered in various geographic locations in order to facilitate the training to officers and to hold down travel expenses for the law enforcement agencies. One concern that has been voiced is that some smaller agencies are not availing themselves of the training due to manpower issues. The

training is provided in five business days in a forty- hour block. Most officers that have completed the training and the trainers believe that such focus is needed to obtain the maximum benefits. However, some small police and sheriff's departments have difficulties in losing an officer for work for an entire week in a block of time, even if the training is nearby. GBI Director Keenan has advised that he will confer with the Sheriffs' Association and the police chiefs' organization to see if some informal manpower arrangements can be worked out to further facilitate the training opportunities for smaller agencies.

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