Georgia Behavioral Health Reform and Innovation Commission

Appendix A: Subcommittee on Children and Adolescent Behavioral Health

APPENDIX A: SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS

The Subcommittee on Children and Adolescents was created to explore behavioral health issues in children, adolescents, and young adults. It also aims to understand how untreated behavioral health illness can impact children into adulthood and the role of the education system in the identification and treatment of behavioral health issues. The subcommittee was chaired by Dr. Eric Lewkowiez in 2022.

The following report includes information from the numerous presentations to the subcommittee from experts, substance abuse and mental health providers, researchers, advocates, parents, educators, and others with a vital interest in children and adolescents. It also includes the priority recommendations of the subcommittee, which align with the commission's 2022 Annual Report. Finally, in Appendix B, the subcommittee has compiled additional recommendations relevant to improving the behavioral health system for children and adolescents.

Subcommittee Members

Eric Lewkowiez, M.D. (Chair)
Garry McGiboney, Ph.D.
Gwen Skinner
Miriam Shook
Sen. Donzella James
Commissioner Tyrone Oliver
Sarah Vinson, M.D.

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Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas including the Subcommittee on Children and Adolescent Behavioral Health chaired by Dr. Sarah Vinson (2020-2021) and by Dr. Eric Lewkowiez (2022-2023).

During 2022, the Subcommittee on Children and Adolescents held five public meetings on topics vital to the mental health of children and adolescents, including substance abuse, infant and early childhood mental health, autism, Medicaid for children and adolescents, mental health in the juvenile justice system, school-based mental health, mental health access, and refugee and immigrant mental health.

The Behavioral Health Reform and Innovation Commission's Subcommittee on Children and Adolescents believes that the following recommendations will help Georgia build capacity and improve access to mental health services for infants up to 18 years of age and into adulthood. Research shows that untreated mental health issues in infancy, childhood, and adolescence transfer to adulthood and become significantly more difficult to treat.[1] Therefore, the members of the Subcommittee on Children and Adolescents believe it is imperative for the State of Georgia to develop an implementation plan that provides access[2] to a wide range of mental health support services for infants, children, and adolescents regardless of their economic status, complication of need, or where they live.

This report includes information from numerous presentations from experts, substance abuse and mental health providers, researchers, advocates, parents, educators, and others with a vital interest in children and adolescents.

[1] Copeland WE, Wolke D, Shanahan L, Costello EJ. Adult Functional Outcomes of Common Childhood Psychiatric Problems: A Prospective, Longitudinal Study. JAMA Psychiatry. 2015;72(9):892–899. doi:10.1001/jamapsychiatry.2015.0730.

[2] Access: affordable, accommodating, and appropriate.

List of Presenters to the BHRIC Subcommittee on Children and Adolescents 2022

BHRIC Subcommittee on Children and Adolescents Members **Dr. Eric Lewkowiez (Chair), Miriam Shook, Dr. Sarah Vinson, Gwen Skinner, Commissioner Tyrone Oliver, Dr. Garry McGiboney**
Support to the BHRIC Subcommittee on Children and Adolescents **Ashley Dickson (United Way), Dr. Ann DiGirolamo (Georgia State University), Ann Marie Mukherjee (Georgia State University)**

Presenters to the BHRIC Subcommittee on Children and Adolescents 2022

Date	Topic	Presenter
July 28, 2022	Substance Use and Abuse	**Dr. Paula Riggs** Professor of Psychiatry, University of Colorado School of Medicine Director, Division of Addiction Science, Prevention, and Treatment
July 28, 2022	Substance Use and Abuse	**Jill Mays** Director Office of Behavioral Health Prevention, Georgia Department of Behavioral Health and Developmental Disabilities
July 28, 2022	Substance Use and Abuse	**Cassandra Price** Director Office of Addictive Disease, Georgia Department of Behavioral Health and Developmental Disabilities
August 25, 2022	Infant Mental Health	**Honorable Judge Peggy Walker** Senior Judge
August 25, 2022	Infant Mental Health	**Dr. Emily Graybill** Clinical Associate Professor, Director of the Center for Leadership in Disability, Principal Investigator for the Georgia Association for Infant Mental Health (GA-AIMH)
August 25, 2022	Infant Mental Health	**Dr. Terri McFadden, MD, FAAP** Pediatrician, Professor in the Department of Pediatrics of the Emory University School of Medicine, Medical Director of Primary Care at the Hughes Spalding Campus of Children's Healthcare of Atlanta

Date	Topic	Presenter
August 25, 2022	Infant Mental Health	**Teresa Wright-Johnson** Parent Peer Support Specialist Founder of Zaria's Song
August 25, 2022	Infant Mental Health	**Laura Lucas** Infant and Early Childhood Mental Health Director, Georgia Department of Early Care and Learning (DECAL)
August 25, 2022	Infant Mental Health	**Callan Wells** Senior Health Policy Manager, Georgia Early Education Alliance for Ready Students (GEEARS), Policy Advisor for the Georgia Association for Infant Mental Health (GA-AIMH)
August 25, 2022	Infant Mental Health	**Arianne Weldon** Strategic Innovation Manager, Georgia Family Connection Partnership
September 22, 2022	Autism and Related Disabilities	**John N. Constantino MD** Chief of Behavioral and Mental Health, Children's Healthcare of Atlanta Professor - Departments of Psychiatry and Pediatrics, Emory University
September 22, 2022	Autism and Related Disabilities	**Michael Ellis, MD** Psychiatrist St. Francis Hospital Columbus, Georgia
September 22, 2022	Autism and Related Disabilities	**Synita Griswell, MPH** Autism and Developmental Disabilities Program Manager, Children and Youth with Special Healthcare Needs, Maternal and Child Health Section Division of Health Promotion, Georgia Department of Public Health
September 22, 2022	Autism and Related Disabilities	**Maliha Haider-Bardill** Autism Project Manager, Georgia Department of Behavioral Health and Developmental Disabilities

Date	Topic	Presenter
September 22, 2022	Autism and Related Disabilities	**Wendy White-Tiegreen** Director, Office of Medicaid Coordination & Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities
October 27, 2022	Medicaid & CMO Services for C&A Mental Health	**Caylee Noggle, MA** Commissioner, Georgia Department of Community Health
October 27, 2022	Medicaid & CMO Services for C&A Mental Health	**Lynnette Rhodes, JD** Executive Director, Medical Assistance Plans, Georgia Department of Community Health
October 27, 2022	Medicaid & CMO Services for C&A Mental Health	**Bhavini Solanki, MA** Director, Behavioral Health, Amerigroup
October 27, 2022	School-Based Mental Health	**Ann DiGirolamo, PhD** Research Associate Professor, Director-Behavioral Health, Georgia Health Policy Center, Director-Center of Excellence for Children's Behavioral Health, Georgia State University
October 27, 2022	School-Based Mental Health	**Layla Fitzgerald, MS** Director of Community Programs, Office of Children, Young Adults and Families, Georgia Department of Behavioral Health and Developmental Disabilities
November 17, 2022	Children and Adolescent Mental Health in DJJ	**Margaret Cawood** Deputy Commissioner of Support Services, Georgia Department of Juvenile Justice
November 17, 2022	Children and Adolescent Mental Health in DJJ	**Christine Doyle, PhD** Director of the Office of Behavioral Health, Georgia Department of Juvenile Justice

Date	Topic	Presenter
November 17, 2022	Data Sharing to Improve Behavioral Health Outcomes for Youth in Foster Care	**Melissa Haberlen DeWolf, JD** Research & Policy Director, Voices for Georgia's Children
November 17, 2022	Data Sharing to Improve Behavioral Health Outcomes for Youth in Foster Care	**John N. Constantino, MD** Chief, Behavioral & Mental Health, Children's Healthcare of Atlanta
November 17, 2022	Mental Health Needs of the State's Refugee and Immigrant Children	**Darlene C. Lynch, Esq.** Head of External Relations, The Center for Victims of Torture Georgia
November 17, 2022	Embedding Mental Health Supports for Georgia's Refugee Youth and Families into Everyday Settings: A Community Response	**Davielle Lakind, PhD** Assistant Professor, Department of Clinical Psychology, Mercer University
November 17, 2022	Embedding Mental Health Supports for Georgia's Refugee Youth and Families into Everyday Settings: A Community Response	**Amber McCorkle** Director of Education and Programs, Clarkston Community Center

Summary of Presentations to Subcommittee

July 28, 2022

Substance Use and Abuse

Substance abuse and problematic patterns of substance use among youth can lead to problems at school, cause or aggravate physical and mental health-related issues, promote poor peer relationships, cause motor-vehicle accidents, and place stress on the family. They can also develop into lifelong issues such as substance dependence, chronic health problems, and social and financial consequences.

Substance Abuse: Lessons Learned

Dr. Paula Riggs, Professor of Psychiatry, University of Colorado School of Medicine Director, Division of Addiction Science, Prevention, and Treatment

The future well-being of our country depends on how we support and invest in the next generation. Even before the pandemic, mental health challenges were the leading cause of disability and poor life outcomes in young people with up to 1 in 5 children ages 2 to 17 having a mental, emotional, developmental, or behavioral disorder.

From 2009-2019: During this time period, there was a 40 percent increase in high school students who reported persistent feelings of sadness or hopelessness; 26 percent increase in suicidal behaviors; 44 percent increase in suicide planning; 16 percent had made a suicide plan in the past year; and a 57 percent increase in suicide rate. These are troubling statistics for children and adolescents and the trajectory into adulthood should be a concern for everyone.

Deaths associated with alcohol, drugs, and suicide took the lives of 186,763 in 2020, a 20 percent increase in one year, which is the highest number of substance misuse deaths ever recorded in a single year. The overall drug-induced death rate increased by 30 percent, largely driven by increases in deaths due to continued increased use of synthetic opioids and psychostimulants, as well as pandemic-related anxiety, stress, grief, disruption to substance treatment/recovery and financial hardship. The largest increases were in underrepresented communities among youth 17 years and younger and adults 19-34, as well as in the South and West.

Factors that contribute to the youth mental health crisis include the COVID-19 pandemic, critical clinical workforce shortages, mental health stigma, opioid crisis, expanding legalized cannabis environment, disparities and poor treatment access, and systemic barriers such as lack of mental health payment reform despite federal parity legislation (2008), and separate funding streams for mental health and substance abuse treatment services. Other systemic barriers include that addiction treatment services are reimbursed at a lower rate than mental health services.

Most childhood-onset psychiatric disorders increase the risk for adolescent-onset substance use. Adolescent-onset substance abuse increased the risk for psychiatric illness and progression to other substance use disorders. Eight to 10 percent of youth ages 12 and older

are addicted to drugs/alcohol with most starting as adolescents. Substance abuse during adolescence interferes with brain development and increases the risk of chronic addiction and mental health problems. What adolescents do, whether it's playing sports or playing video games, can affect how their brains develop. Environment and activities during the adolescent years guides selective synapse elimination during a critical period of adolescent development.

The national trends in cannabis potency are alarming. The THC content percentage has increased from three percent in 1960 to 23 percent in 2016. Concentrates such as Shatter, wax, dabs, butane hash oil contain as much as 70-90 percent THC. Crystalline cannabis is 99 percent THC. Cannabis concentrates equaled 21 percent of the market share in 2016 and increased by 154 percent in only two years, from 2014-2016. A study in New Zealand found that cannabis use in adolescents resulted in worse social outcomes by age 25, with an increased likelihood of welfare dependency, unemployment, low income, and lower percentage of college completion. The impact of cannabis use on adolescent brain development includes persistent neurocognitive deficits; reductions in adult IQ; and higher risk of psychosis, anxiety disorders, suicidality, paranoia, and amotivational syndrome. Even more troubling is that these disorder effects may not be fully reversible even with later abstinence. Cannabis use also raises the risk of hyperemesis (persistent vomiting and dehydration) and vaping.

There needs to be a universal recognition that addiction and mental illness are brain diseases and are neurobiologically based medical illnesses. Psychiatry needs to fully function as a medical subspeciality. The evaluation and treatment of substance use disorders should be fully integrated within psychiatry. Clinical and medical management should be similar to other chronic diseases such as diabetes, asthma and other medical conditions with universal treatment access. There should be an expansion of evidence-based treatment for co-occurring disorders with integrated treatment models, co-located treatment services, and coordinated care models. The access to telehealth should be expanded especially in rural areas and with underserved minority populations. Telehealth could offer access to direct patient care, clinician training, clinical consultation, and x-waiver training (outpatient use of buprenorphine for the treatment of opioid use disorder). There should be an increase in access to evidence-based integrated mental health and substance abuse treatment, which could be accomplished by leveraging existing community-based resources to extend the continuum of care. There needs to be a concentrated effort to increase the mental health and substance abuse treatment provider pay to bring more therapists into the service networks. It could be value-based, outcome-based care. Legislators and policy makers need to cautious about expanding the legalization of cannabis due to the resulting negative impacts on adolescents, where states that expanded the legal access to cannabis have seen increases in adolescent cannabis use and emergency room admissions.

The evidence-based substance and psychiatric treatments for adolescents with conduct disorders includes family-based treatment and CBT (cognitive); for depression it is CBT and pharmacotherapy; for ADHD it is CBT and pharmacotherapy; for substance abuse it is family-based treatment, abstinence, and behavioral/contingency management as well as CBT. The standard SBIRT (screen, brief intervention, referral to treatment) model does not work effectively. Only 10 percent of adolescents that could benefit from treatment receive any type

of treatment. SBIRT can be augmented by SBIRE (screen, brief intervention, and referral to evaluation) because opportunities to effectively treat substance abuse depend on a thorough evaluation first.

Role of the Georgia Department of Behavioral Health and Developmental Disabilities and Community Service Boards in Addressing Children and Adolescent Substance Abuse

Jill Mays Director for the Office of Behavioral Health Prevention Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)

Prevention

In Georgia 7 percent of 12–17-year-olds report using drugs in the last month while 6 percent reported have a substance use problem within the past year. Seven percent reported using illicit drugs (including marijuana) in the past month, and among middle and high school students, 6 percent reported marijuana use in the past month. It is reported that 17 percent of high school students reported using an electronic vapor product in the last month. Among middle and high school students, 4 percent reported consuming 5+ alcoholic beverages over the span of a couple of hours in the past month.

Prevention is part of a Continuum of Care that includes Promotion, Prevention, Treatment and Recovery. Prevention focuses on promotion of universal, selective, and indicated components of the prevention services. Prevention is science based and data driven using the logic model of (1) assess the problems and related behaviors; (2) prioritize and select the associated risk and protective factors; (3) select the appropriate interventions; and (4) measure the outcomes.

Georgia has three Prevention Clubhouses (Norcross, LaGrange, Dawson County) that provide intense, intentional, and supportive services and activities aimed to prevent youth substance use and abuse. Each Prevention Clubhouse can serve up to 75 youth. Plans are being developed to add three more Prevention Clubhouses using federal funds.

DBHDD and DOE partner to sponsor the Sources of Strength suicide prevention program that combines community work with school efforts to empower children and adolescents and to provide support for mental health and recognition of the importance of family support, access to services, spirituality, generosity, mentorship, and health activities.

School-based mentoring for prevention includes the Peer Assisted Student Transition (PAST) program that provides information and activities for teenagers to avoid opioids and other risky behaviors. There are six university partners located in high-need areas that adopt a nearby middle or high school. College students are recruited and trained as mentors to work through skill-building curriculum and skill-building activities with middle and high school students referred by school counselors. Another school-based prevention strategy is the Governor's Red Ribbon Campaign which is aimed at building universal awareness of the importance of a drug-free lifestyle. The Red Ribbon Week brings all K-12 level schools, colleges, and universities together to celebrate awareness. The Georgia Teen Institute Project is a targeted initiative for developing youth leaders and building capacity in Youth Action Teams that includes a residential youth camp to build leadership skills, strategic

prevention framework skills, and to develop customized community prevention plans. At the college and university level, the College Prevention Partnerships is active at 14 colleges/universities. This program addresses the misperceptions, attitudes, and behaviors of college-age youth toward prescription drug abuse and to promote drug-free lifestyles.

In partnership with Let's Be Clear Georgia, marijuana prevention activities include an accessible website for youth so they can learn about the misinformation regarding marijuana use: (1) benefits of not using marijuana; (2) what to do if offered marijuana; (3) feelings and marijuana; (4) motivation and marijuana; and (5) how marijuana can negatively affect grades. To address underage tobacco use and vaping, there is an annual vaping prevention campaign, and annual Synar[3] compliance checks are conducted to reduce the sale and distribution of tobacco products to youth under the age of 21.

Cassandra Price Director for the Office of Addictive Disease Georgia Department of Behavioral Health and Developmental Disabilities

Treatment

Best practices for youth substance use disorders include person-centered planning; family-based therapy; and cognitive behavioral therapy. Additionally, multicomponent psychosocial therapy is offered that involves family-based therapy with cognitive behavioral therapy and motivational interviewing. Adjunctive interventions are also available, such as exercise, Yoga, and Mindfulness.

The Georgia Crisis and Access Line (GCAL) is available 24/7 for mental health crisis support and provides telephonic crisis intervention services and has access to dispatch a mobile crisis team, as well as assist individuals in finding an open crisis or detox bed across the State. Additionally, GCAL can link individuals with urgent appointment services and help individuals to access a State Funded provider in their area in a non-emergency as well. The nationally accredited Behavioral Health Link Crisis Call Center operates GCAL. GCAL includes a text messaging system for individuals who are reluctant to make a phone call.

The framework for mental health treatment changed when the State moved to the Managed Care Model that presently includes Amerigroup, Amerigroup Foster Care (Georgia Families 360), CareSource, and Peach State Health Plan, which left DBHDD with the responsibility to cover non-Medicaid supported mental health needs, with Medicaid fee-for services falling between both systems of care.

Four Crisis Stabilization Units (CSU) are operated by Community Service Boards, which are a residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and withdrawal management services. The programs provide medically monitored residential services for the purpose of providing psychiatric stabilization and/or withdrawal management on a short-term basis. Specific services include psychiatric, diagnostic, and medical assessments; crisis assessment, medication administration and

[3] In July 1992, congress enacted the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (P.L 102-321), which included the Synar Amendment (named for its sponsor, Congressman Mike Synar of Oklahoma) that requires states to prohibit the sale of tobacco products to minors. In Georgia, the Synar Amendment is codified as O.C.G.A.16-12-171.

management, psychiatric/behavioral health treatment; nursing assessment and care; brief individual, group, and/or family counseling; and linkage to other services as identified. Additionally, the Child and Adolescent Substance Abuse Intensive Outpatient Program is an approach to treatment services for adolescents 13-17 years old who require structure and support to achieve and sustain recovery while focusing on early recovery skills using a multi-disciplinary team, medical, therapeutic and recovery supports that can be delivered during the day or evening hours to enable youth to maintain residence in their community and continue work or attend school. The treatment is based on an individualized treatment plan that utilizes the best/evidence-based practices.

Substance use disorder intensive residential treatment is provided by one Community Service Board (CSB) and one non-profit provider: Highland Rivers @ Hartmann Center (Cobb County) and WestCare (Carroll County). The average length of stay is six months.

Non-intensive outpatient programs are provided by 22 Community Service Boards (CSB) and 97 Medicaid-only providers. These services include behavioral health assessments; psychological testing; diagnostics; interactive complexity; crisis intervention; psychiatric treatment; nursing services; medication administration and management; individual outpatient treatment; group and family outpatient services; community transition planning; case management; youth peer support; and parent peer support. Additionally, 9 Clubhouse Programs are provided by 7 CSBs. The Clubhouse Programs are a continued care program for adolescents recovering from substance use issues where they are engaged with their families in recovery. The average length of participation is 7 months.

One facility offers transition aged youth services, which serves 10 youth in the Westcare Guidance Center in Barnesville. There are plans to develop a substance abuse intensive residential treatment program.

August 25, 2022

Infant Mental Health

Infant mental health is a critical component of a comprehensive mental health system. It is critically important that experts in infant mental health be included in the identification and development of best practices and policies to aid the State's efforts to improve access to prevention, intervention, and treatment for our most vulnerable population – infants.

Honorable Judge Peggy Walker, Senior Judge

Judge Walker provided three case studies that illustrate the need to engage more in the mental health of infants through direct interactions with infants as well as teaching parents of infants how to talk and interact with their babies in order to help them develop skills necessary to live and thrive socially and educationally. Judge Walker sought training to teach her how to interact with juveniles and families with infants. She received the national certification "Zero to Three" Training. She then trained her juvenile and family court staff. By way of case studies, Judge Walker illustrated the need for early intervention and access to

mental health services for infants, their parents, and their families because the unmet needs will result in higher rates of mental health problems, delayed reading attainment, increased likelihood of juvenile court involvement, and reduced quality of life.

Dr. Emily Graybill Clinical Associate Professor, Director of the Center for Leadership in Disability, and Principal Investigator for the Georgia Association for Infant Mental Health (GA-AIMH); Dr. Terri McFadden, MD, FAAP, Pediatrician, Professor in the Department of Pediatrics of the Emory University School of Medicine, Medical Director of Primary Care at the Hughes Spalding Campus of Children's Healthcare of Atlanta; Teresa Wright-Johnson, Parent Peer Support Specialist and Founder of Zaria's Song; Laura Lucas, Infant and Early Childhood Mental Health Director, Department of Early Care and Learning (DECAL); Callan Wells, Senior Health Policy Manager, Georgia Early Education Alliance for Ready Students (GEEARS) and Policy Advisor for the Georgia Association for Infant Mental Health (GA-AIMH)

Infant and early childhood mental health is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn all in the context of family, community, and culture.

Signs and symptoms of mental health concerns in infants and toddlers (0-3 years old) include chronic eating or sleeping difficulties; inconsolable "fussiness" or irritability; incessant crying with little ability to be consoled; extreme upset when left with another adult; inability to adapt to new situations; easily startled or alarmed by routine events; inability to establish relationships with other children or adults; excessing hitting, biting, and pushing other children; or very withdrawn behavior and flat affect (shows little or no emotion at all). Signs and symptoms of mental health concerns for preschoolers (3-5 years old) include engaging in compulsive activities; throwing wild, despairing tantrums; withdrawn behavior; showing little or no interest in social interaction; displaying repeated aggressive or impulsive behavior; having difficulty playing with others; little or no communication – lack of language; loss of earlier developmental achievements; and being anxious and fearful in most situations.

Adverse childhood experiences impact infants, particularly with physical, emotional, and sexual abuse; physical and emotional neglect; caregiver mental illness; incarcerated relative; mother treated violently; parental substance abuse; and divorce. Almost 10 percent of Georgia's children had a guardian with substance abuse; 21 percent live in poverty; 30 percent live in housing that is more than 30 percent of the household income; and 10 percent of children had a parent serve jail time. Atlanta is the #1 city in the United States for income inequality.

There are three levels of stress: positive stress; tolerable stress; and toxic stress. Toxic stress that is persistent can change the brain architecture of infants and children by damaging neurons thus restricting the development of neural connections. The diminished neural

connections have an adverse effect on the prefrontal cortex and hippocampus which drives the development of executive functioning/decision-making and self-regulation.

Promotion and prevention at the universal level means policies and practices that can benefit large numbers and/or individuals. Targeted early intervention addresses an emerging infant-parent challenge or provides initial services after a challenge or delay is suspected. Intensive treatment includes assessment, diagnosis, consultation, and/or therapy aimed at optimizing individual/dyadic functioning.

The Georgia House Study Committee on Infant and Toddler Social and Emotional Health offered the following recommendations: establish a set of core competencies to address infant and toddler mental health; increase the mental health workforce to include professionals trained in serving children birth to 4 years of age; and provide infant and early childhood mental health (IECMH) training for state employees. IECMH workforce priorities include childcare and school; health care and public health; Part C early intervention; child welfare; home visiting; justice system; mental health; Head Start and Early Head Start; and Part B Special Education.

The Georgia Association for Infant Mental Health (GA-AIMH) was created with the mission to promote family, infant, and early childhood mental health as foundational by raising awareness of young children's social and emotional needs; building culturally-responsive preventive and therapeutic professional capacities; fostering interdisciplinary and cross-system collaboration by supporting professionals working with and on behalf of infants, young children, and their families; and advocating for and supporting policies in the best interest of infants, young children, families, and communities. Ga-AIMH provides training for mental health professionals that includes standardized competencies with an endorsement. The endorsement is intended to recognize experiences that lead to competency in the infant, early childhood, and family fields. Also, the endorsement is cross-sector and multidisciplinary (psychologists, educators, social workers, psychiatrists, child and/or human developmental specialists, nurses, and others). The endorsement does not replace licensure but indicates that the professional has received training on infant and early childhood mental health. There are four career pathway endorsements: Infant Family Associate Promotion (early care and education, administration, case management, wraparound, and child welfare); Infant Family Specialist Prevention/Early Intervention (Part C, Early Head Start, 0-3 home visiting, mental health consultation); Infant Mental Health Specialist Intervention (infant mental health home visiting, infant/child parent psychotherapy, minding the baby, interaction guidance); and Infant Mental Health Mentor MACRO (research, faculty, reflective supervision, policy, advocacy, administration).

It is important to note that treatment is not about medicating young children and does not include separating them from their parents. For young children who are at risk of a mental health concern, especially young children who have experienced trauma, the focus is always on the child and the caregiver. One of the evidence-based treatments is dyadic therapy or caregiver-child therapy while another is child-parent psychotherapy (CPP). A pilot project

trained 15 clinicians on CPP who will be receiving referrals from Babies Can't Wait, Head Start, and others. Private funders supported the training of 30 clinicians and the Department of Early Care and Learning (DECAL), and the Department of Public Health expanded the CPP training to include 60 clinicians, which includes three Community Service Boards. By 2023, approximately 100 clinicians will have been trained and will significantly improve access to CPP across the state.

The Infant and Early Childhood Mental Health (IECMH) Taskforce convened by DECAL brings together child-serving state agencies and stakeholders to address the mental health needs of young children and their families. The Taskforce created a billing matrix for all children's mental health services for children under the age of 6, and all CMOs are reimbursing for family therapy for children under the age of 4. The Taskforce is working to address confusion about Medicaid billing codes for IECMH treatment-end services. State Medicaid has plans to recognize DC:0-5, which is the diagnostic manual for children under the age of 5. It is important to note that GA-AIMH is providing DC:0-5 training for clinicians, agencies, and payors.

DECAL is fully committed to IECMH, as evidenced by the creation of the IECMH Director, the IECMH Taskforce and support for the GA-AIMH and CPP training. DECAL's goal is to "Build Georgia's Early Childhood System of Care Together" because it is critical for infants and young children to form close and secure adult and peer relationships, to experience, manage, and express a full range of emotions, and explore the environment and learn in the context of family, community, and culture. The work touches pediatric health care, early care and education, home visits, the judicial system, policy, child welfare, and early intervention.

Neonatal Intensive Care: A Two-Generational Opportunity

Arianne Weldon, Strategic Innovation Manager Georgia Family Connection Partnership

When comprehensively addressing the needs of children and adolescents experiencing mental health disorders, questions arise regarding the root causes and origins of these concerns. Notably, children and adolescents who were admitted to a NICU at birth are nearly two times more likely to have a mental health disorder or more than one mental illness and remain at high risk for a range of mental and behavioral health disorders from ages 4–17 years. By taking an epidemiologic approach — studying the how, when, where, and why of a disease or illness — we may identify underlying factors. Considering the experiences of infants during the neonatal period (the first 4 weeks of life) helps inform evidence-based approaches to care that improve infant mental health and later outcomes. If understood and noticed early, factors that influence mental health challenges may be mitigated or prevented all together and if we understand early life experiences, we have the opportunity to implement approaches to care that fully support relationships early in an infant's life.

The number of infants admitted to NICUs is increasing at a substantial rate. In the US, overall NICU admissions increased by 37% from 2008 to 2018, and increasing trends were observed among all racial and ethnic groups. Additionally, infants born substance-exposed represent a growing population of babies admitted to a NICU. Georgia's NICU admission rate is 11%, which is higher than the national average of 6-9%. In Georgia, every year from 2016 – 2020, over 11,500 infants were admitted to a NICU. Reasons included low birthweight (<2500 grams; >50%) and pre-term (<37 weeks; 60%), with the average gestational age at 35 weeks. At 35 weeks, an infant's brain weighs only two-thirds of what it will weigh at 39 to 40 weeks (full-term).

The circumstances of early life in the NICU can lead to serious negative consequences on the emotional well-being and the quality of the relationship between infants and families. Infants admitted to a NICU have higher rates of behavioral and self-regulation problems in early childhood and higher rates of emotional and mental health problems later in life. For example, infants born before 34 weeks have over 3 times the risk for later diagnosis of attention-deficit hyperactivity disorder (ADHD). However, by taking a closer study of these conditions, we can find ways to mitigate outcomes. Higher maternal milk intake among infants admitted to a NICU has a demonstrated protective effect against the development of ADHD symptoms at 7 years of age. Hospitalization in the newborn period is a significant form of toxic stress for infants during a crucial period of brain development that can have lifelong, adverse effects and is considered an adverse childhood experience. Infants admitted to a NICU are repeatedly exposed to painful, multisensory stimuli, unfamiliar odors and sounds, and multiple periods of handling by unfamiliar care givers. One study found that infants in a NICU endure as many as 16 painful procedures a day. The constant exposure to stressors has the potential to alter infants' brain structure and function through chronic dysregulation of stress responses. Without the buffering provided by families' responses to their infants' behavioral cues, this frequently results in traumatic infant stress within the NICU environment. As a result, many infants admitted to a NICU have difficulty regulating their systems in an organized way and may display behaviors that many parents cannot understand, so they cannot meet the needs of their infant. Infants who show this type of disorganized attachment are at high risk for later mental health disorders. Research indicates that even full-term infants admitted to a NICU are 6 times more likely to develop a disorganized attachment with their families. This finding yields immediate implications for integrating families in the care of their infants in the NICU.

The NICU experience and subsequent stressors are crucial elements that influence future family-infant relationships. Interrupted interactions between infants and their families and subsequent social isolation hinders formation of an emotional connection. Consequently, the natural learning of rhythms and behaviors is disrupted and the relationships between infants and their family members during critical early postpartum moments are placed in jeopardy. Unfortunately, families often lack support and opportunities to engage with their infants' while in the NICU, which leads to frequent misperceptions of their infants' behavioral cues and even labeling of them as 'difficult.'

Families face an unknown situation with their infant's hospitalization. The highly specialized care their infant may require often leaves families struggling as they cope with parenting from a distance, not feeling like adequate parents, and hesitating to become involved due to a myriad of barriers. This is where opportunity lies for approaches that integrate families as part of the care team for their infants through observing and responding to their behavioral cues.

Responsiveness between families and infants in the NICU is vital to infants learning to regulate, communicate, and respond to stimuli. Parents, in turn, increase their confidence through holding and engaging with their infant. Postpartum depression, anxiety, and other stress-related conditions negatively impact the family–infant relationship. Mothers of infants admitted to a NICU are over 3 times more likely to experience post-partum depression that often persists up to 6 – 12 months after discharge from the hospital. Each of these conditions can disrupt family–infant relationships and negatively impact childhood outcomes. Families of infants admitted to a NICU have the opportunity to be better prepared if they are encouraged and supported to engage in the care of their infants. It is critical for families to frequently engage in responsive, reciprocal, and meaningful interactions with their infants. It is through these interactions that communication, co-regulation, bonding, and attachment occur. For example, preterm infants whose mothers see them within 3 hours after birth are nearly 5 times more likely to establish a secure attachment relationship than preterm infants with no early contact. The simple effect of just seeing her infant alters the mother's behavior and emotions which facilitates a more secure attachment relationship. Relationship-based care for parent-infant dyads in the NICU can significantly reduce traumatic stress and maternal depression and improve infant weight growth and development.

The positive impacts of relationship-based care include the significant benefits of parental voice in the NICU and reading aloud on infants' cognitive, social, and emotional development. Reading aloud to infants is also associated with reductions in parenting stress and increases in early relational health as measured by parental warmth and parent sensitivity, from infancy to toddlerhood. Parents of infants admitted to a NICU describe reading to their infants as a positive experience leading to an increased sense of control and normalcy, a source of comfort, and a practice that has helped them cope in difficult moments.

September 22, 2022

Autism and Related Disabilities

Michael Ellis, M.D. Psychiatrist, St. Francis Hospital, Columbus, Georgia

In Georgia, 1 in 46 children (about 1 in 27 boys in the US) have Autism Spectrum Disorder (ASD) based on the Metropolitan Atlanta Developmental Disabilities Surveillance Program (2018). Schools are overwhelmed, especially with limited Early Education Programs (EEPs)

to develop. Primary Care Practices (PCPs) struggle to diagnose and refer to appropriate specialists, therapists, or other providers. Problems include recognition of diagnosis, availability of providers/therapists, various artificial delays in treatment, poor knowledge of resources, and scarcity of resources. ASD is a whole community burden and responsibility. Parents are often overwhelmed before a diagnosis and lost as to what to do after a diagnosis of ASD. In the first place it's difficult to get a diagnosis. There are very few resources and guidance for parents, which makes it difficult to start evidence-based treatment. Parents are forced to fight for their child constantly; for example, trying to get an Individualized Education Program (IEP) at school, and then if an IEP is developed, teachers don't know how to follow the IEP. Also, parents must wait for an Applied Behavioral Analysis (ABA) therapist, wait for the Katie Beckett program, wait for a Medicaid waiver, and while the ASD child's behavior deteriorates, parents must deal with daily issues and basic needs while trying to control tantrums or even violent outbursts.

Insurance companies require a psychological evaluation when pediatricians and other professionals can make the diagnosis of ASD. This insurance requirement can cause delays of 6 months to a year for ABA treatment. ABA is the only evidence-based treatment shown to improve ASD behavior. Early diagnosis is crucial, but pediatricians must refer a child suspected of having ASD to a psychologist which further delays treatment and few psychologists have had proper training to make a diagnosis. There are a lot of inconsistencies and variability in the thresholds for diagnosing ASD at the community level. If there is not a psychologist available in the family's home area, children with suspected ASD are referred to the Marcus Center in Atlanta. There is a six to 12 month wait at the Marcus Center.

Primary care practices (PCP) often do not include the Modified Checklist for Autism in Toddlers (M-CHAT; standard care screening form), which should be required as a standard of care. PCP training should include awareness of ASD and how to diagnose and refer. Pediatricians, PCPs, child psychiatrists, pediatric neurologists, developmental pediatricians and others are qualified to diagnose ASD, but insurance companies only recognize a psychological evaluation from a psychologist for the purpose of starting and paying for ABA. This causes delays of 6 months to a year to start ABA, which is critical because ABA is the only evidence-based treatment shown to improve prognosis of ASD. Delays in care equal poorer outcomes and harm is caused. Legislation needs to address this unnecessary and harmful practice by insurance companies.

Schools have inexperienced teachers, which means ASD accommodations are slow to start and are typically poorly followed. IEPs are often not given to children with ASD. The Federal government "froze" funding of IEPs. Paraprofessionals in schools have virtually no ASD training. There should be Registered Behavioral Technicians (RBTs) which would require a standard level of training that requires only two weeks of training. Board Certified Behavior Analysts (BCBAs) should be required in schools because the northern school districts use them, and they are effective. Funding is an issue for schools but perhaps they could have some BCBAs available for teachers. ABA therapists should be allowed into

schools, which they are not currently because of liability issues. Teachers who are experienced with ASD deliver "watered down" services due to large classroom sizes. There should be lower student-teacher ratios so more one-to-one instruction is available. Functional skills are often taught instead of basic educational goals which oftentimes leads to a certificate of completion instead of a high school diploma.

Even psychiatrists do not feel well trained in ASD and very few offer treatment in Georgia. Too many ASD patients are taken to emergency departments (ED) where they linger without intervention or treatment. Sometimes the families tire of waiting and just go home. There are essentially no emergency services for ASD. Emergency responders are not trained on ASD and therefore take ASD patients to the ED. There is only one residential treatment facility in Georgia for acute ASD, which is Laurel Heights and they do not accept females. There needs to be more than one of these facilities, because the current one has a 6 month to one year waiting list and does not serve females. Parents sometimes must make a decision based on financial constraints or treatment, especially while waiting for a diagnosis or verification of the diagnosis. The Medicaid waiver process is long and can result in years of waiting. Georgia needs to continue to give more resource to the Medicaid waiver program to get ASD patients off the waiting list.

John N. Constantino MD. Chief of Behavioral and Mental Health, Children's Healthcare of Atlanta, Endowed Professor, Departments of Psychiatry and Pediatrics, Emory University

States have the opportunity for nuanced insurance reform, based on several studies: Expediting clinician assessment in the diagnosis of autism spectrum disorder; Billing Code for MD/NP/PhD Participation in IEP; The Autism Inpatient Collection; Autism-Related Variation in Reciprocal Social Behavior: A Longitudinal Study. Professionals are learning more about ASD, but the treatment is difficult because of social behavior, rigid behavior and repetitive behaviors. A longitudinal study did not show a decrease in core ASD symptoms, but the adaptive functions can be improved – not the condition but the social functions – motor skills, language, executive functioning, IQ, academic functioning. Our best outcomes are in the adaptive functions, such as working and developing friendships. It is very important to combat the notion that ASD cannot be treated. The most important necessary function to teach ASD patients is language development. The best predictor of life outcomes is language – the capacity to communicate. A CDC MMWR reported that the overall ASD prevalence per 1,000 children aged 8 years became equal across race in a 2006 birth cohort, but a disproportionate burden of cognitive impairment has been consistent across 2006, 2008, and 2010 cohorts. For the 2010 cohort, the percentage of children with ASD with IQ scores less than 70 were 49.8%, 33.1%, and 29.7% among Black, Hispanic, and White children, respectively. There are long delays between the time parents raise concerns about their children and some type of assessment, which delays the treatment and is a major factor in the disproportionate number of minority ASD patients that do not develop the functional skills necessary to thrive socially which impairs their quality of life. A total of 31.3% of parents cited availability of professionals as a barrier to diagnosis.

There should be a re-evaluation of Medicaid reimbursement rates for ASD diagnosis and the restrictions on who is qualified to make a diagnosis should be removed, as is recommended by the American Academy of Pediatrics (AAP). A smartphone-based app has been developed to learn about dual diagnoses; it is called the Clinical Decision Support App that is available to the public and to mental health practitioners.

Synita Griswell, MPH. Autism and Developmental Disabilities Program Manager, Children and Youth with Special Healthcare Needs, Maternal and Child Health Section Division of Health Promotion, Georgia Department of Public Health

The Georgia Autism Services Initiative is a service delivery system to improve Georgia's capacity for early identification, screening, diagnosis, intervention, and transition planning for children and youth birth to 21 years of age with ASD. The services are implemented in Babies Can't Wait. The core of the services is based on educational outreach. Annually the program screens 4,000 children for ASD at 18 months and 24 months using the Modified Checklist for Autism in Toddlers (ASD M-CHAT-R/F). The screening recommendations from AAP are used for the screening process. There has been an increase in the number of professionals trained to provide the ASD assessment within 18 public health districts. Children who receive a negative result on the ASD assessment are referred for a diagnostic assessment within 90 days. The Georgia Autism Service Initiative collaborates with the other entities, including the Marcus Autism Center. The Autism Navigator is a self-paced online resource guide on autism and supportive practices. It provides four guidebooks on: Social Communication Milestones; Collaborating to Make Early Intervention Work; Getting Started on Early Intervention; and Addressing Challenging Behaviors. Project Impact is a parent coaching program for children with social communication delays. Individual Transition to Adulthood Plan is an interactive model that supports adolescents and young adults with ASD, who are exiting the school system.

Maliha Haider-Bardill. Autism Project Manager, Georgia Department of Behavioral Health and Developmental Disabilities

Wendy White-Tiegreen. Director, Office of Medicaid Coordination & Health System Innovation, Georgia Department of Behavioral Health and Developmental Disabilities

Georgia Department of Behavioral Health and Developmental Disabilities Centers for Medicare and Medicaid Services (CMS) Guidance sent a memo to states to allow the use of Medicaid benefits in states for use with ASD. DBHDD, DPH, DCH, DFCS, and OPB came together. The Medicaid State Plan Services begins with ASD-specific screening, diagnosis, comprehensive assessment, ASD behavior therapies, ASD group and family skills and supports, and ASD skills building. With limited funds there is a mobile crisis capacity, ASD crisis support and homes (6 beds), and ASD crisis stabilization units (10 beds). BCBAs assess behavioral functions and create a behavior support plan (BSP), but the guardians

must be willing to participate in family training on the BSP. The ASD Crisis Support Homes provide case management services to connect with local resources, but there are some exclusionary criteria, including that they cannot provide psychiatric stabilization; cannot provide medical stabilization, and individuals must meet elopement assessment criteria. The ASD CSU is operated by ViewPoint in Rockdale County. It serves youth with ASD from 10-14 years of age, and they may have co-morbid behavioral health conditions. Services include crisis-related needs assessments, therapeutic services to provide behavioral and psychiatric stabilization and caregiver training. Planning - CMO foster care, fee for services not in a CMO, IDEA school-covered supports, payer of last resort.

October 27, 2022

Medicaid & CMO Services for C&A Mental Health

Caylee Noggle, M.A. Commissioner, Georgia Department of Community Health

Department of Community Health (DCH) mission: We will provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight. We are dedicated to a Healthy Georgia.

Commissioner Noggle introduced the current directions at DCH and shared that Lynette Rhodes (Medicaid expert) will be taking the lead in presenting exciting updates and progress, including a new grant partnership with DBHDD to fund Community Service Board services. There are also several studies with behavioral health providers in the works, with findings to be shared out in December.

Lynette Rhodes, J.D. Executive Director, Medical Assistance Plans Division, Georgia Department of Community Health

DCH is the single state agency that administers and supervises the state Medicaid and Children's Health Insurance (CHIP) programs. There are two service delivery models: Fee-for-Service and Managed Care. Aged, blind, and disabled members receive services under the fee-for-service model, as well as 1915-C waiver recipients and children enrolled under the Georgia Pediatric Program (for skilled nursing services). Low-income families, children who qualify for PeachCare for Kids, newborns, children under 19, and pregnant/postpartum mothers fall under the Managed Care model. There are three Care Management Organizations (CMOs) in Georgia: Amerigroup, CareSource, and Peach State Health Plan, all of which administer the Georgia Families Program for the state. Amerigroup administers the Georgia Families 360 Program, which serves the foster care, adoption assistance, and DJJ-involved populations. DCH follows broad federal guidelines for eligible groups, types of ranges of services, payment levels for services, and administrative and operating procedures. DCH works closely with the Department of Education, Department of Juvenile Justice, Department of Early Care and Learning, Division of Family and Children Services, Department of Behavioral Health and Developmental Disabilities, and Department of Public

Health to administer Medicaid and PeachCare for Kids programs. DFCS helps determine program eligibility, and DBHDD helps with determining behavioral health services. DPH provides many services out of county public health facilities. DOE is helping to identify Medicaid-eligible children to receive free or reduced lunch.

The scope of services provided by the Medicaid and CHIP programs are outlined in two separate State plans. These serve as contracts with the Centers for Medicare and Medicaid Services (CMS). The State plans need to evidence compliance with federal law, including the Mental Health Parity and Addiction Equity Act. This Act prohibits discriminatory practices that limit coverage for behavioral health treatment and services; they must be no more restrictive than coverage for medical/surgical conditions. In FY22, PeachCare for Kids children and adolescents were primarily paid for by CMO services. Although most Medicaid members receive care through CMOs, over half of Medicaid expenditures go towards those enrolled in fee-for-service. As of September 2022, 2.7 million members were enrolled in Georgia Medicaid; 2.1 million enrolled in CMOs (remainder enrolled in fee-for-service).

Early Periodic Screening, Diagnostic and Treatment Services (EPSDT) benefits provide comprehensive behavioral and mental health services for children under 21 who are enrolled in Medicaid. EPSDT services required by federal law include vision, hearing, and mental health screening and treatment services. EPSDT also requires services that correct, reverse, or ameliorate defects and physical and mental illnesses and conditions discovered by screening services. Annual EPSDT reporting is required. As of last year, CMS has started managing EPSDT data and reporting.

As of 2018, Autism Spectrum Disorder (ASD) services are offered to children with an Autism or Autism-related diagnosis under the age of 21, including ABA therapy. Children's Intervention Services (CIS) and Children's Intervention School Services (CISS) programs offer coverage for restorative and/or rehabilitative services. CIS services are provided in the home or community settings, and CISS services are provided in school settings. To be eligible, children must have a written service plan, such as an IEP or Individualized Family Service Plan (IFSP). Counseling services include rehabilitative treatment for social, mental, cognitive, emotional, and behavioral problems. Community Behavioral Health Rehabilitation Services (CBHRS) are provided by outpatient mental health centers to anyone 4 years and older that are emotionally or mentally disturbed or have drug or alcohol abuse disorders; these include crisis intervention and crisis stabilization services. CBHRS also provides psychiatric treatment, addictive disease support services, intensive family intervention (IFI), intensive customized care coordination (IC3), and peer support, among other services.

Children under the age of 21 with severe and complex behavioral or mental health issues may also be eligible for Psychiatric Residential Treatment Facilities (PRTF), which is a short-term intensive inpatient treatment program. There are 12 PRTF facilities, and each have their own structure and level of treatment acuity. PRTFs also provide occupational, physical, and speech therapy, and are responsible for establishing discharge planning.

A new service is being added to the state plan, called Behavioral Support Services (currently undergoing approvals with CMS). This program will be similar to the Georgia Pediatric Program (GAP), which provides in-home skilled nursing supports. A behavioral support aid will assess and assist children with behavioral health issues in their homes, with the goal of preventing the need for PRTF admittance. DCH is collaborating with DBHDD and DFCS to develop and administer this program.

Another new service being implemented through a collaboration with DBHDD is the Certified Community Behavioral Health Centers (CCBHC). SAMHSA is funding 11 facilities to provide comprehensive behavioral healthcare via community-based mental health and substance abuse treatment, including 24/7 crisis services. Services will be provided to any adults, children, or adolescents with severe behavioral health issues. The program will be presented to CMS in the beginning of 2023. The sustainability of these programs will be dependent on billing for services once the grant funding period is over.

Several quality measures are used to evaluate PeachCare for Kids, Georgia Families 360, and Georgia Families populations throughout the fiscal year. DCH also measures and tracks behavioral health service availability statewide on a county basis, including the number of psychiatrists (and where they are located) and the number of Medicaid and CHIP members, as well as their distance from mental and behavioral health professionals and facilities. These geo-access reports and "secret shopper" analysis can help to identify who does not have access to behavioral health providers and services.

In rare cases, children with high acuity needs and co-occurring behavioral health diagnoses are sent out-of-state for treatment. Often, these are children diagnosed with Autism, Attention Deficit Hyperactivity Disorder (ADHD), and/or Oppositional Defiant Disorder (ODD) (or other developmental disabilities) with low IQs. This is because not all PRTF models are equipped to serve these children—they may not have the staffing capacity or expertise level. This problem is escalated due to federal regulations that do not allow room and board Medicaid reimbursement. DCH leaders recognize that this poses challenges as far as providing inpatient care.

Bhavini Solanki, M.A., LPC. Director of Georgia Families 360, Amerigroup Georgia

The Georgia Families 360 (GF360) vision is: To have healthy members in a new and ever-changing world. Their mission is: To improve the health of their members through advocacy, accountability, coordination, training and high-quality preventive care and treatment. There is a new digital early intervention program with GOMO Health to provide ASD services. There are two levels to the program: Early Intervention and Early Detection.

The Early Intervention program has approximately 4,000 members with a 90.5% program retention rate. It is an opt-in program in which eligible members choose to participate or not. Some are enrolled in additional support tracks, such as those who lack reliable transportation. The program is designed to promote caregiver confidence to support their

child with autism and to reduce concerns about their child's overall health. Additionally, the program is aimed at reducing crisis events.

The Early Detection program seeks to aid in the early detection of autism (children 0-4 years). Approximately 58,000 member caregivers have enrolled in the program. The goal is to assist caregivers in detecting autism and ensuring they are aware of and receive appropriate services before a diagnosis is made.

Amerigroup is tackling the issue of hoteling of foster care children by collecting data on members who are subjected to unnecessary PRTF or hotel submission, with the goal of avoiding children being in this situation. (Ms. Solanki emphasized that a PRTF is not a punishment but is not an appropriate setting for children who need a placement outside of a foster care home).

The Triage Team will conduct internal and external assessments once a family is enrolled in Families 360 to explore clinical and non-clinical support services. Services will be provided through DFCS Regional Pods which are coordinated with DJJ pods.

School-Based Mental Health

Ann DiGirolamo, Ph.D. Research Associate Professor, Director-Behavioral Health, Georgia Health Policy Center, Director-Center of Excellence for Children's Behavioral Health, Georgia State University

Layla Fitzgerald, M.S. Director of Community Programs, Office of Children, Young Adults, and Families, Georgia Department of Behavioral Health and Developmental Disabilities

School-based mental health (SBMH) is a mechanism for promoting access to behavioral health services and awareness of mental health. Mental health needs are common, with 1 in 5 children having a diagnosable mental health disorder. One in 8 teens suffer from depression, and in 2019, ~40,000 Georgia children reported attempting suicide. Half of mental health disorders start by age 14. Children and youth are often unable to access mental health services: about 50% of children who need services do not receive them due to transportation issues, provider shortages, and stigmatization. Importantly, untreated mental health problems can cause significant problems for young people, including educational attainment. Students with mental health disorders have higher rates of disengagement from the learning environment, academic failure, behavior problems, discipline referrals, and truancy. Behavioral problems in the school setting can negatively influence the overall school climate.

School is where children spend the most time during the year, and school settings are often the only place where children can receive behavioral health services. Robust SBMH has been shown to increase school attendance and academic performance, as well as engagement in academic activities, school climate, and access to services. Additionally, SBMH programs can decrease discipline referrals, course failure rates, inpatient hospitalizations, classroom disruptions, and mental health stigma.

Most SBMH programs follow a three-tiered approach. Tier 1 is universal prevention provided by all school staff to 85-90% of students, which can include Mental Health First Aid training, bullying prevention training, and mental health awareness events. Tier 2 services are those that target early intervention and are administered by counselors, social workers, or mental health providers to approximately 7-10% of students considered at risk for mental health challenges; these services include group therapy, targeted screening, and skills training. Tier 3 are services, which are delivered by mental health providers, are for children with more serious mental health problems (~3-5% of students), and include individual therapy, crisis intervention, and behavioral assessment.

There are also several different types of models for SBMH service delivery. First, there may be therapists hired as employees within schools (e.g., Dublin City Schools in Central GA). Second, schools may have school-based health centers, which eliminates barriers such as transportation, access to providers, costs of health care services; mental health treatment is integrated within treatment for physical health treatment and prevention. Finally, there may be community-based mental health providers embedded within the school setting, partnering closely with the school in the delivery of mental health services; the Georgia Apex program is an example of this.

The Georgia Apex program is a SBMH program in which funding is provided to community mental health providers to provide mental health services for students who are uninsured or underinsured. There are various Apex stakeholders who are integral to the program's success, including DBHDD, Apex providers, youth and families, Apex school partners, the Center of Excellence for Children's Behavioral Health, and the Georgia Department of Education.

There are three programmatic goals of Apex: Detection, Access, and Coordination. Detection refers to providing early detection of child and adolescent behavioral health needs; access refers to improving access to mental health services for children and youth; and coordination refers to sustaining increased coordination between Georgia's community mental health providers and local schools and school districts in their service areas.

Apex representation is in 6 regions, 129 counties, 147 school districts, and 738 schools, across 42 Tier 1 and Tier 2 providers. Most frequent Tier 1 services include staff meetings, faculty consultation or classroom observations, and parent education. Most frequent Tier 3 services include individual outpatient services, Community Supports/Individual Supports (CSIS), group therapy, psychiatric treatment, and family therapy. Medicaid and CMOs account for 84% of billable students; other billing goes to the Apex grant, DBHDD FFS, PeachCare for Kids, WellCare, or other funding avenues.

The presenters played this Apex informational video, which includes information about the program as well as provider, staff, student, and family testimonials.

The Apex Internship Program has been implemented as a pilot program to address the behavioral health provider workforce shortage as well as provide additional training on

school-based mental health services. The internship program is for Social Work or Mental Health Counseling graduate students, in which they participate in a supervised, one-year, paid internship with an Apex provider agency. Agencies are provided with support to recruit, support, and retain interns.

The Center of Excellence for Children's Behavioral Health (COE) at Georgia State University has rigorously evaluated the Apex program and its influence on school climate, which has involved matching 359 Apex schools with 359 non-Apex schools.[4] When exploring school climate indicators over time (from 2015-2019) between the Apex and non-Apex schools, it was found that Apex schools had significantly greater increases in positive school climate overall and in student attendance rates, and fewer disciplinary incidents (more positive discipline rating) relative to non-Apex schools over time.

This research and similar research show that SBMH promotion and prevention efforts can build resilience in children. SBMH programs enhance awareness around mental health, identify risk and protective factors, decrease mental health stigma, positively change mental health trajectories for youth, and protect against adversity. Factors associated with youth resilience include social support and strong relationships; providing experiences that promote productive decision making, engagement, youth voice and personal responsibility, and development of self-regulation and adaptive skills; sources of faith, hope, and cultural traditions; and health-promoting activities.

Several prevention initiatives were presented, including Positive Behavioral Interventions and Supports (PBIS), Sources of Strength, Mental Health First Aid, Mindful Schools, Project AWARE, Peer-Led Efforts (e.g., teen MHFA, Certified Peer Specialists), and Movement (e.g., yoga, dance, activity breaks).

Several resources for working with children and families were provided: first, the National Child Traumatic Stress Network (NCTSN): Resilience and Child Traumatic Stress; second, a systematic review titled "Posttraumatic Growth in Children and Adolescents: Clinical Implications of an Emerging Research Literature;" third, First Aid for Feelings: A Workbook to Help Kids Cope During the Coronavirus Pandemic; and fourth, Free Your Feels (Mental Health Campaign hosted by DBHDD and Voices for Georgia's Children). Finally, two additional programs in Georgia available to youth and families to promote resilience were described: Resilient Teens – Supported by Resilient Georgia and the Pittulloch Foundation, and Raising Resilience – Teaching Kids to Be Resilient, supported by the Strong4Life group at CHOA.

Opportunities to consider in Georgia include exploring funding opportunities for prevention initiatives within school settings (and providing training and necessary infrastructure); expanding youth-informed and youth-led mental health initiatives in more schools; exploring opportunities for licensing counselors and social workers within schools and

[4] Ann M. DiGirolamo, Dimple Desai, Deana Farmer, Susan McLaren, Ani Whitmore, Danté McKay, Layla Fitzgerald, Stephanie Pearson & Garry McGiboney (2021) Results From a Statewide School-Based Mental Health Program: Effects on School Climate, School Psychology Review, 50:1, 81-98, DOI: 10.1080/2372966X.2020.1837607.

agencies; considering the Certified Community Behavioral Health Clinic model to support SBMH programs; and promoting training programs to prepare students and therapists for working in the school setting.

In response to a question from the Subcommittee members regarding the scope of SBMH programs in the state including and in addition to Apex, the presenters noted that currently, there are 738 schools with the Apex program, and 104 schools that have a school-based health center (41 of which participate in Apex). Right now, members of the Inter-agency Directors Team are working to determine how many schools and providers are participating in SBMH outside of those models. All CSBs provide Apex services to at least one school or school district. The primary barriers to providing Apex services in more schools include funding and workforce shortages/retainment issues. Investments that Georgia has made in SBMH programs are likely similar to those in South Carolina; the COE can do a scan to determine how other states are investing in SBMH programs and services.

Children and Adolescent Mental Health in DJJ

Margaret Cawood. Deputy Commissioner of Support Services, Georgia Department of Juvenile Justice.

Christine Doyle, PhD. Director of the Office of Behavioral Health, Georgia Department of Juvenile Justice.

High acuity of mental health needs has been an issue in the juvenile justice population for many years. In the past year, 20 youth from DJJ secure facilities had to be sent to local emergency departments for mental health emergences. Situations included youth experiencing severe psychosis or suicidal attempts. Only one of these resulted in the youth being admitted into a higher level of care. There are many barriers within the state's systems that present challenges in getting these youth the services they need. The presenters highlighted their recommendations to address these barriers, which are included amongst the committee's recommendations. They also shared additional details on the barriers in the system that these recommendations will address.

Often times, youth involved with DJJ have mental health needs that exceed the capability of the DJJ facility to treat and manage the care of these youth. Barriers are faced when attempting to get children in these circumstances into a higher level of care. There is a common misunderstanding of DJJ's role and a belief that their facilities are a crisis stabilization placement facility. There are also misconceptions that because they have protocols to prevent suicide, that it equates to suicide treatment. These misunderstandings equate to difficulties in getting youth the service they need.

There are also challenges getting youth admitted to Psychiatric Residential Treatment Facilities (PRTFs) or Max+ Room, Board, and Watchful Oversight (RBWO), two of the highest levels of care. PRTFs will not accept referrals from DJJ clinicians, creating a barrier requiring youth to be reassessed by a community clinician in order to get the referral

processed. The portal site for PRTF referrals is also a challenge because it is not structured to allow DJJ staff to register. When placements are not available, youth often end up in the YDC until placement can occur. This also leads to youth with high levels of mental health needs, but low risk from a justice perspective, being sent to YDCs. These challenges ultimately lead to a lack of placement for youth with high mental health needs in the appropriate settings.

The admissions structures, including Medicaid processes, also present barriers in referrals, placement, and other process challenges. Medicaid CMO care coordinators cannot communicate with DJJ clinical staff creating barriers in youth accessing crisis services. CMOs also do not have the ability to compel placement even if clinically appropriate. Community providers regularly exclude or deny placement of DJJ youth, and DJJ youth are ejected from care at higher rates than other youth. Community vendors have also indicated that reimbursement rates are not sufficient to hire staff who can meet the youth's behavioral health needs.

Increasingly, DJJ is seeing more youth with developmental disorders such as autism or cognitive disability. The appropriate interventions for these youth are typically environmental, which is difficult or impossible to implement in DJJ facilities. Youth may be sent to DJJ secure facilities to secure some level of safety and services for these youth.

DJJ is also not immune from the staffing, recruitment, and retention challenges heard by many other presenters. Due to the recession in 2008, positions were cut that have never restored over a decade later. However, legislative mandates have required the department to implement more rigorous evidence-based services and treatment. DJJ is expected to do more with less staffing. The competitive behavioral health market has also made it harder to retain seasoned clinicians and recruit new clinicians leading to the department operating at a 40-50 percent clinician vacancy in the past year.

Data Sharing to Improve Behavioral Health Outcomes for Youth in Foster Care

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John N. Constantino, MD. Chief, Behavioral & Mental Health, Children's Healthcare of Atlanta.

Data sharing on youth in crisis, particularly those in foster care, is a challenge in the state and creates barriers in the provision of care to these children. Lack of available information on a youth's medical and personal history significantly hinders healthcare worker's ability to provide high quality care to youth in foster care. Twenty-five percent of youth in DFCS custody are in care for 12 to 24 months and one third of these youth have had 3 or more placements.

HIPAA does allow covered entities to use and disclose Protected Health Information (PHI) without individual consent for a variety of activities, including behavioral health

conditions. However, Georgia has more strict confidentiality laws when it comes to mental health treatment, which is a key reason why behavioral health providers may be more hesitant in sharing information. For data sharing in Georgia, there are three main tools healthcare providers use: Private EHR Software, GAMMIS, and GA HIN.

Many states have information sharing systems to improve care coordination of youth receiving child welfare services. Texas' Health Passport System is designed to improve care coordination for children in foster care in Texas by reducing duplication of services for these youth. Ohio's IDENTITY System is a bidirectional data sharing system that merges child welfare data with EHR data. Participating healthcare providers can then match the data to create one unified record for each child and pull that information into a web-portal that is accessible by case workers. Missouri's Synchrony is a program which houses information on all infants in St. Louis protective custody to review and address any unmet mental health needs of the families in order to strengthen the likelihood of families being safely reunified. Their Surround project delivers the same intervention as project Synchrony but for families who were at risk for foster care placement or instances of child-abuse.

The presenters identified several recommendations to facilitate data sharing initiatives in Georgia to better support youth in foster care receive the services they need. They include facilitation of data sharing by relevant state agencies through sharing of guidance, requiring portable health record technology, and developing a system that joins data from multiple relevant sources including the medical community. The full set of recommendations are included in the recommendations section of this report.

Mental Health Needs of the State's Refugee and Immigrant Children

Darlene C. Lynch, Esq. Head of External Relations, The Center for Victims of Torture Georgia.

Georgia's population is increasingly diverse, ranking among the top 10 states for racial and ethnic diversity in the U.S. One in ten Georgian's is foreign-born and roughly 50 percent of foreign-born Georgians are naturalized citizen. An estimated half a million people in Georgia have limited English proficiency and limited access to mental health care due to language barriers.

Georgia is also one of the leading states welcoming refugees from around the world. Georgia has a long history participating in the refugee resettlement program, and typically resettles 2,500 to 3,000 refugees per year, including many families. Georgia has supported these individuals and families through a successful public-private partnership including the DCFS Refugee Program, DPH Refugee Health Program, and numerous community organizations and volunteers.

The refugee population experiences unique behavioral health concerns due to the circumstances which led them to resettling in the U.S. This is called the "Triple Trauma Problem," describing the traumas experienced from fleeing one's home and the three

distinct stages of that flight, pre-flight, flight, and post-flight. Each stage encompasses new and unique challenges and increase risk of trauma exposure and corresponding behavioral health concerns. Additionally, up to 44 percent of refugees are torture survivors requiring responsive and sensitive behavioral health treatment.

Better supporting Georgia's refugee and immigrant communities requires building systems that emphasize mental health equity and culturally responsive care. Systems must address trauma among children and parents, cultural and language barriers, stigma, underuse of existing programs, and insurance barriers. A full list of recommendations can be found in the recommendations section of this report.

Embedding Mental Health Supports for Georgia's Refugee Youth and Families into Everyday Settings: A Community Response

Davielle Lakind, PhD. Assistant Professor, Department of Clinical Psychology, Mercer University.

Amber McCorkle. Director of Education and Programs, Clarkston Community Center.

Refugee families face systematic, logistic, and perceptual barriers to enrollment and sustained engagement in traditional mental health services. Community-based settings and workforces can enhance engagement in services by meeting the family in a setting they already access and that is familiar with the culture of the community. These settings also minimize social distance and stigma, and house community advocates and "boundary spanners" to help navigate systemic barriers. The Clarkston Community Center (CCC), one of these community-based settings, provides unique experiences, educational resources, and valuable tools that foster community while celebrating diversity. CCC's youth programs include STEAM-Plus Summer Camp, CCC Quiet Zones 1.0, Afterschool Quiet Zones 2.0, and Leaders of Tomorrow. CCC also provides English classes, computer literacy classes, a food pantry, community garden, and other community-based classes and resources.

CCC is currently piloting a project to enhance youth mental health promotion in community-based organizations. The program includes a collaborative service model and a three-tier stepped care support model. Tier 1 includes training for all staff and volunteers on culturally-responsive trauma-informed care, positive interaction support strategies, and identification of mental health and academic concerns. Tier 2 connects families and youth with Liaisons to assess mental health and academic concerns, provide emotional support, psychoeducation, and basic interventions. In Tier 3, Liaisons counsel youth and families on mental health support options, refer to partner organizations, and maintain regular communication to promote continued engagement in services. The presenter recommends continued and new funding for piloting similar initiatives in community-based organizations.

Behavioral Health Reform and Innovation Commission

Subcommittee on Children and Adolescents

Recommendation Priorities

The Child and Adolescent Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

1. Increase the mental health and substance abuse treatment provider pay to bring more therapists into the service networks, which would build more community-based resources and improve access for rural areas and other underserved populations.
2. Seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health - children from lower income families are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards, that increase the need for health care interventions.
3. Include coverage through health insurance to address social determinants of health (transportation, parking/lodging/meals costs, missed work pay, lack of child-sitting for siblings) to increase families' ability to engage in the care of their infants while in the NICU.
4. Re-evaluate Medicaid reimbursement rates for ASD diagnosis and remove the restrictions on who is qualified to make a diagnosis, as also recommended by the American Academy of Pediatrics.
5. Increase the capacity of Child and Adolescent Substance Abuse Intensive Outpatient Programs.
6. Expand the number of DBHDD Clubhouse Programs that provide continued care for adolescents recovering from substance use issues.
7. Develop and support strategies and an implementation plan to expand the state's capacity to provide access to Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH (Georgia Association for Infant Mental Health) statewide to CSBs and other mental health providers.
8. Create an executive leadership position (i.e., Assistant Commissioner) at the Georgia Department of Behavioral Health and Developmental Disabilities that focuses on children and adolescent mental health and substance abuse.
9. The Georgia Department of Community Health (DCH) and the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) should revise their policies and practices to recognize the Georgia Department of Juvenile Justice (DJJ) as referral sources for PRTFs.
10. DCH and DBHDD should work with DJJ and emergency receiving facilities to develop a direct referral process for DJJ secure facilities to refer DJJ juveniles to crisis stabilization placements.

11. Leverage guidance provided by the Center for Medicaid & Medicare Services to expand Medicaid coverage for Justice involved youth to include those 18 to 21 (congruent with DFCS foster children).
12. The Department of Community Health (DCH) should be strongly encouraged to consider reimbursement for 90791 for Medicaid patients in Georgia.

The Child and Adolescent Subcommittee identified the following recommendations as priorities needing additional study for future consideration.

1. Study the use of the 1115 waiver to allow a portion of Medicaid funding to address social determinants of health, such as poverty, violence, unsafe living conditions, and environmental health hazards, which increase the need for health care interventions.
2. Study how to create incentives to open more residential treatment facilities and crisis stabilization units for acute ASD funded by a combination of federal and state funds and reimbursements from Medicaid and insurance carriers.
3. Study how to close the gap in the continuum of care of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, Peach State, and DBHDD.
4. Study how to sustain the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) that provides training for primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs.
5. Study how to include family-integrated approaches to care in the NICU as part of university and professional training for practitioners who provide care in NICUs, including nursing, medicine, social work, counseling, and allied health.
6. Study reimbursement options for room and board when residential placement is necessary for children's behavioral health treatment.
7. Study the feasibility of requiring insurance companies to recognize a diagnosis of ASD from a PCP or child psychiatrist while waiting for the psychological evaluation which would allow immediate access to ABA treatment.
8. Study the feasibility of developing a department or section at DBHDD that identifies the mental health needs of immigrants and refugees.
9. Study how to amend the State Medicaid Plan to extend Medicaid/CHIP coverage to all legally residing immigrant children.
10. Study the feasibility of coordinating a DBHDD FTE with the State Refugee Health Program.
11. Study how to expand residential providers and residential bed capacity statewide to include justice involved youth. (This may require addressing Medicaid rates and plan and would benefit foster children too).

A full list of recommendations is included in the appendix of this report.

Georgia Behavioral Health Reform and Innovation Commission

Appendix B: Additional Recommendations from the Subcommittee on Children and Adolescent Behavioral Health

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health and Substance Abuse - General	Create an executive leadership position (i.e., Assistant Commissioner) at the Georgia Department of Behavioral Health and Developmental Disabilities that focuses on children and adolescent mental health and substance abuse.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand access to telehealth for mental health and substance abuse issues. Telehealth could offer access to direct patient care; clinician training, clinical consultation, and x-waiver training (outpatient use of buprenorphine for the treatment of opioid use disorder).	X	X		X
Mental Health and Substance Abuse Treatment and Resources	Increase the mental health and substance abuse treatment provider pay to bring more therapists into the service networks, which would build more community-based resources and improve access for rural areas and other underserved populations.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Expand the Certified Peer Support Specialist (Specialist) program and increase the compensation for the Specialists to exceed the minimum wage.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Close the gap of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, PeachState, and DBHDD by developing a coordinated plan of continuum of care.	X		X	
Mental Health and Substance Abuse Treatment and Resources	Legislators and policy makers need to be cautious about expanding the legalization of cannabis due to the resulting negative impacts on adolescents. States that expanded the legal access to cannabis have seen increases in adolescent cannabis use and emergency room admissions.	X			

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health and Substance Abuse Treatment and Resources	Expand evidence-based substance abuse and mental health treatment for co-occurring disorders with integrated treatment models, co-located treatment services, and coordinated care models so that community-based resources can provide the essential services.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Explore avenues for continued funding for the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) with Georgia State University, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Children's Healthcare of Atlanta, Emory University, Georgia-AAP, and the Medical College of Georgia. The purpose of GaPPCAP and GMAP is to support primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs. GaPPCAP also provides education for core mental health competencies in pediatric behavioral health support. *(1)*		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Schools should explore the use of telehealth for medical and mental health services. The Georgia Department of Administrative Services has a statewide contract with approved telehealth providers.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Schools and Regional Education Service Agencies (RESA) should work with local CSBs to develop coordinated mental health access for students (i.e., expand the APEX program).		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Crisis Stabilization Units to cover more regions of the state and provide information about the CSUs to CSBs, pediatricians, emergency room physicians and others.		X	X	X

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health and Substance Abuse Treatment and Resources	Expand the availability of Child and Adolescent Substance Abuse Intensive Outpatient Program to more regions of the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Study the possibility of expanding the number of substance use disorder intensive residential treatment centers from the present two facilities to more locations in the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Clubhouse Programs that provide continued care for adolescents recovering from substance use issues.		X	X	
Mental Health and Substance Abuse Treatment and Resources	There is only one facility in the state offering residential substance abuse treatment and recovery services to uninsured and under-insured transition aged youth (18-26 years old). A second facility is in the process of being developed. Study the feasibility of expanding these programs to more regions in the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand juvenile drug courts to more jurisdictions and link to community-based resources.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Operationalize the Georgia Student Health Survey data, for use by stakeholders, decisionmakers, and Georgia citizens by making it a queryable database (Georgia Tech's Center for Health Analytics and Informatics capable of creating and request sent to Acenture to consider as part of their community service/pro bono programs).		X	X	
Mental Health and Substance Abuse Treatment and Resources	Continue funding for the Mental Health Training Initiative that provides mental health and trauma awareness training for educators.		X		X

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health and Substance Abuse Treatment and Resources	Seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health - children from lower income families are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards, that increase the need for health care interventions.			X	
Mental Health and Substance Abuse Treatment and Resources	Public and private schools should consider establishing school-based plans and toolkits that help eligible students and family members enroll in health insurance that include mental health coverage.			X	X
Mental Health and Substance Abuse Treatment and Resources	Study the impact of requiring TB and RPR (rapid plasma reagin) testing on the child and adolescent admission process for substance use treatment.			X	X
Mental Health and Substance Abuse Treatment and Resources	Schools should partner with Federally Qualified Health Centers to offer integrated health services in schools.			X	X
Mental Health and Substance Abuse Prevention	Expand Prevention Clubhouses to add more regions of the state to broaden the reach of this successful program.		X	X	
Mental Health and Substance Abuse Prevention	Expand the Sources of Strength suicide prevention program that combines community work with school efforts to empower children and adolescent and to provide support for mental health and recognition of the importance of family support, access to services, spirituality, generosity, mentorship, and health activities.		X	X	X
Mental Health and Substance Abuse Prevention	Expand substance abuse prevention activities in schools and colleges and include community resources to aid the development of and expansion of prevention programs and activities, such as the Peer Assisted Student Transition program, College Prevention program, and Let's Be Clear program.		X	X	

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health and Substance Abuse Prevention	Study how Certified Community Behavioral Health Centers (CCBHC) currently being funded by SAMHSA can be sustained once the grant funding period is over.		X	X	X
Mental Health and Substance Abuse Prevention	Expand the Certified Student Peer Support Specialist program to include more schools and link to community-based resource programs.		X	X	
Infant Mental Health Prevention, Intervention, and Support	Enact policies that support infant and child caregivers who are experiencing stress related to housing and income support. Consider case management services.	X	X	X	
Infant Mental Health Prevention, Intervention, and Support	Support and expand high-quality early childhood programs that give children a safe, stable environment.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Support evidence-based home visiting models that can provide information and support for parents.		X	X	
Infant Mental Health Prevention, Intervention, and Support	Provide funding for training on early childhood trauma to members of the child-serving workforce.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Develop and support strategies and implementation plans to expand the state's capacity to provide access to Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH (Georgia Association for Infant Mental Health) statewide to CSBs and other mental health providers.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Ensure Medicaid reimbursement for prevention and treatment for infant mental health and dyad treatment.			X	
Infant Mental Health Prevention, Intervention, and Support	Add Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH to workforce training programs.			X	X

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include coverage through health insurance to address social determinants of health (transportation, parking/lodging/meals costs, missed work pay, lack of child-sitting for siblings) to increase families' ability to engage in the care of their infants while in the NICU.	X	X	X	
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources through private-public partnerships that support hospitals to provide on-site childcare facilities for siblings to help remove the barrier of securing and paying for sibling childcare while infant is in NICU.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand access to training and implementation of NICU Peer Recovery Coaching to reach families impacted by substance use and to improve coordination and monitoring of plans of safe care.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Support efforts like Reach Out and Read in the pediatric setting so families will continue to be encouraged and supported to read with their infants and throughout early childhood.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand implementation of NICU peer-to-peer support provided by parents who have experienced having their infant in a NICU to those who currently have an infant in a NICU.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Provide resources for hospital systems to proactively develop innovative solutions that facilitate and support the family's presence in the NICU. These solutions could include providing a place for parents to stay and take care of their basic needs, such as eating, bathing, laundry, and sleep. Vouchers for lodging and meals would significantly reduce the financial burden of staying long periods in the NICU.		X		X

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources so technology-based approaches can be implemented to supplement families' physical presence in the NICU, which may include text messaging updates, web-cam footage of infants, FaceTime and Skype updates, virtual visitation, and virtual rounding.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand support for NICUs by investing in the Regional Perinatal Center Neonatal Outreach Educators, coordinated by the Georgia Department of Public Health.		X	X	
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Develop and implement case and care management during and after the NICU stay to create a plan of safe care with families impacted by substance use.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include family-integrated approaches to care in the NICU as part of university and professional training for all types of practitioners who provide care in NICUs, including but not limited to nursing, medicine, social work, counseling, and allied health.				X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Embed practices in the NICU that encourage and support families to read aloud with their infants while in the NICU and promote private-public partnerships with hospitals to help with the cost of books.				X
Autism Spectrum	There should be a re-evaluation of Medicaid reimbursement rates for ASD diagnosis and remove the restrictions on who is qualified to make a diagnosis, as also recommended by the American Academy of Pediatrics.	X	X	X	X
Autism Spectrum	Study how to create incentives to open more residential treatment facilities for acute ASD.		X	X	
Autism Spectrum	The state needs to give more resources to the Medicaid waiver program to get ASD patients off the waiting list.		X	X	

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Autism Spectrum	Study how schools and universities could train more teachers and paraprofessionals on ASD awareness, interventions, and support.		X		X
Autism Spectrum	Develop medical and psychosocial protocols as immediate follow-up after an ASD diagnosis, which should include respite care.				X
Autism Spectrum	Study how the state and school districts could provide more Board-Certified Behavior Analysts to work with teachers and ASD students.				X
Autism Spectrum	Provide case managers from Medicaid or commercial insurers to parents to help them find and best utilize services.		X	X	
Autism Spectrum	Insurance companies should be required to recognize a diagnosis of ASD from a PCP or child psychiatrist while waiting for the psychological evaluation which would allow immediate access to ABA treatment.	X		X	X
Autism Spectrum	Develop more acute autism crisis stabilization units funded by a combination of federal and state funds and reimbursements from Medicaid and insurance carriers.		X	X	
Autism Spectrum	Study the feasibility of school paraprofessionals receiving training as a Registered Behavioral Technicians.	X		X	X
Psychologist Billing	The Department of Community Health (DCH) should be strongly encouraged to consider reimbursement for 90791 for Medicaid patients in Georgia.			X	X
School-Based Mental Health (SBMH)	Explore funding opportunities/grants for prevention initiatives within the school setting, providing training and necessary infrastructure to support SBMH and SBMH coordination with other mental health providers and systems (i.e., CSBs, universities, private providers).		X	X	X
School-Based Mental Health (SBMH)	Expand youth-informed and youth-led mental health initiatives in more of Georgia's schools.		X	X	X

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
School-Based Mental Health (SBMH)	Explore more opportunities for licensing counselors and social workers within schools and agencies.		X	X	X
School-Based Mental Health (SBMH)	Consider the feasibility of linking Certified Community Behavioral Health Clinic (CCBHC) Model to SBMH programs.			X	X
School-Based Mental Health (SBMH)	Promote training programs to prepare students and therapists for working in the school setting.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Expand and promote funding sustainability for Certified Community Behavioral Health Centers (CCBHC), which are currently funded by a SAMHSA grant.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to sending children with severe and complex behavioral health issues out-of-state for inpatient treatment while increasing the number of in-state inpatient options.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Explore reimbursement options for room and board when residential placement is necessary for children's behavioral health treatment.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to hoteling of foster care children for whom traditional placements are not an option.		X	X	X
C&A Mental Health in DJJ	Operationalize The MATCH Committee as outlined in HB1013 by convening and staffing referrals on children with complex and unmet treatment needs.		X	X	X
C&A Mental Health in DJJ	DCH & DBHDD revise policies and practices to recognize DJJ as referral sources for PRTFs.			X	X
C&A Mental Health in DJJ	DCH and DBHDD work with DJJ and emergency receiving facilities to develop direct referral process for DJJ secure facilities to crisis stabilization placements.			X	X
C&A Mental Health in DJJ	Develop communication and referral pathways for services for DD youth in DJJ care.			X	X

BHRIC Subcommittee on Children and Adolescents

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
C&A Mental Health in DJJ	Expand residential providers and residential bed capacity statewide to include justice involved youth.		X	X	X
C&A Mental Health in DJJ	Develop service capacity and resources for 18 y/o + youth.		X	X	X
C&A Mental Health in DJJ	Leverage guidance provided by the Federal Center for Medicaid & Medicare Services to expand Medicaid coverage for Justice involved youth to include those 18 to 21 (congruent with DFCS foster children). (January 19, 2021, letter)			X	X
C&A Mental Health in DJJ	Earmark budget increase specifically for competitive salaries for clinical staff.		X	X	X
C&A Mental Health in DJJ	Earmark budget increase to sustain evidence-based treatment interventions and practices.		X	X	X
Data Sharing for Children in Foster Care	In upcoming Medicaid foster care CMO RFP and contract, include requirement for portable health record technology.			X	X
Data Sharing for Children in Foster Care	Create a system among all relevant agencies and the medical community that joins robust medical data (EMR/EHR) and child welfare data for multiple users across the system.		X	X	X
Data Sharing for Children in Foster Care	DBHDD and DCH continue to regularly and broadly disseminate data sharing guidance for medical and behavioral health providers and their attorneys.			X	X
Data Sharing for Children in Foster Care	DPH should leverage existing data to drive access to social supports for participants in evidence-based home visiting programs.			X	X
Data Sharing for Children in Foster Care	DCH/CMOs should facilitate reimbursement for all service components of two-generational maltreatment prevention interventions.			X	X
Data Sharing for Children in Foster Care	Create and fund an interagency home visiting commission overseen by DPH to develop a comprehensive statewide strategy to increase access to home visiting.	X	X	X	

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Mental Health Needs of Refugee & Immigrant Children	Establish DBHDD Division of Cultural & Linguistic Competency to identify cultural/linguistic subpopulations as DBHDD priority groups, such as refugee and immigrant children and families. The Division should continue collection of data and implement strategies addressing disparities (per SAMHSA) and adopt national CLAS standards.		X	X	X
Mental Health Needs of Refugee & Immigrant Children	Build culturally & linguistically responsive workforce through streamlining of the licensure process for qualified foreign-born professionals and requiring cultural competence training & certification for all providers (as required by CCBHCs).	X		X	X
Mental Health Needs of Refugee & Immigrant Children	Amend State Plan to extend Medicaid/CHIP coverage to all legally-residing immigrant children.			X	
Mental Health Needs of Refugee & Immigrant Children	Improve utilization of DBHDD services by immigrant and refugee families by funding DBHDD FTE to coordinate with State Refugee Health Program, piloting a specialized Apex program to serve refugee/immigrant students with high rates of trauma, providing targeted funds to refugee/immigrant-serving CSBs and Apex programs to build cultural/linguistic competence (training, interpretation, navigation, outreach), training community members as paraprofessionals & peers, and authorizing reimbursement for interpretation and navigation services.		X	X	X
Mental Health Needs of Refugee & Immigrant Children	Include providers specializing in care of refugee and immigrant children within DBHDD Tier 3 category for specialized community providers.			X	
Mental Health Needs of Refugee & Immigrant Children	Support community nonprofits that are filling in gaps in the continuum of care for refugee and immigrant children and families.		X		

Identified Needs/Recommendations

Topic	Identified Need/Recommendation	Legislation Considerations	Budget/Grant Considerations	Administrative Considerations (State Agency)	Practice Considerations
Community Response to Mental Health Supports for Refugee Youth and Families	Fund or expand funding to community based organizations to pilot youth/adolescent innovative, evidence based mental health programs for refugee and immigrant children and their families.		X		X

Note: *(1)* On May 17, 2022, Colorado Governor Jared Polis signed Senate Bill (SB) 147 with provisions intended to improve integrated access to pediatric behavioral health care services. It appropriates $4.6 million in state support for growth of the Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP) at the University of Colorado. More than 85% of primary care practices have difficulty finding medication advice and appropriate services for children with behavioral health care needs. Overall, 85.9% of primary care practices said that it was difficult to find medication advice, 86.8% said it was difficult to find evidence-based psychotherapy, and 88.5% said it was difficult to find family-based treatment for this population. (Chien AT, Leyenaar, JA, Tomaino, M., Woloshin, S., Leininger, L., Barnett, E., McLaren, J., and Meara, E., "Difficulty Obtaining Behavioral Health Services for Children: A National Survey of Multi-physician Practices", National Library of Medicine, (January 12, 2022) https://www.annfammed.org/content/20/1/42).

Georgia Behavioral Health Reform and Innovation Commission

Appendix C: Subcommittee on Involuntary Commitment

APPENDIX C: SUBCOMMITTEE ON INVOLUNTARY COMMITMENT

Involuntary Commitment Subcommittee

The Subcommittee on Involuntary Commitment was created to explore the legal and systemic barriers to treatment of mental illness. The subcommittee was chaired by Judge Brian Amero in 2022.

Included in this appendix are the recommendations compiled by the subcommittee. These recommendations were presented to the BHRIC during its meeting on November 16, 2022, at the capitol. These recommendations align with those included in the commission's 2022 Annual Report. Additional information on these recommendations can be found in the meeting packet from the November meeting (pages 126-356).

Subcommittee Members

Judge Brian Amero (Chair)
Judge Sarah Harris
Judge Stephen Kelley
Nora Haynes
Representative Don Hogan
Chief Justice Michael Boggs
Judge Bedelia Hargrove
Dr. Karen Bailey
Dr. DeJuan White

1. **Remove California Criteria for Admission into AOT program**

On July 15, 2022, we received an AOT grant program implementation update from Carol Caraballo, the DBHDD Director of Adult Mental Health, at which time we were alerted to the fact that an Advisory Committee had been formed which included Senior Superior Court Judge David Sweat and our subcommittee member, Probate Court Judge Sarah Harris. While Ms. Caraballo didn't state that they needed any legislative assistance to implement the program as passed in 2021, she identified low enrollment as an AOT challenge.

To aid in enrollment, we should consider the recommendations made by Brian Stettin from the Treatment Advocacy Center in the waning hours of last year's legislative session:

> "There are three major ways in which [the AOT grant] … criteria interfere with the optimal practice of AOT:
>
> a. ***These criteria do not allow AOT unless "the person's condition is substantially deteriorating." ([Line 953 of the current version of the bill as passed].)***
>
> The right time to place a person under an AOT order is not when their "condition is substantially deteriorating." On the contrary, AOT has been designed as a discharge planning tool upon a person's release from a hospital, at a moment when they are doing (tenuously) *well*. It is precisely because the person is *not* substantially deteriorating that they are eligible for return to the community. By pairing their outpatient treatment plan with court oversight, we seek to ensure that they *remain* on a stable path. Imposing AOT at this juncture, at which the person is typically embracing the court's involvement, maximizes our chances of success. We take that precious opportunity away if the judge is required to deny AOT to a person who is presently in a psychiatrically stable condition. Fortunately, California has come to recognize this huge problem, and in 2021 amended their AOT criteria to remove current substantial deterioration as a requirement.
>
> b. ***These criteria do not allow AOT unless "the person has been offered an opportunity to participate in a treatment plan … and such person continues to fail to engage in treatment." ([Lines 949-952 of the current version of the bill as passed].)***

As reasonable as this may seem on the surface, it has in practice led to an unfortunate approach to AOT in California (sometimes called "AOT Lite") that should not be replicated in Georgia. It is of course appropriate for AOT eligibility to hinge on clear and convincing evidence that the person is unable to engage with treatment on a voluntary basis (as Georgia's already do[es]). But in California, the "offered opportunity" criterion is generally interpreted to require not merely a history of *prior* unsuccessful voluntary opportunities offered, but an unsuccessful or refused offer *right before the filing of an AOT court petition*. This has led to nominal AOT programs in California in which the great majority of participants are not under court order or court supervision at all, with court orders reserved only for hardcore refusers of services and those who fare very poorly on the initial voluntary track.

It should not be surprising that most potential participants in California accept the initial offer [to participate in a treatment plan] to avoid a court proceeding. Even in programs elsewhere that go directly to court with those who meet the legal criteria, it is very common for respondents to stipulate to AOT rather than challenge the petition. But research tells us that those with stipulated court orders will have better outcomes in AOT, by virtue of experiencing the "black robe effect" imparted through the ritual of a court hearing and a personal connection with a caring judge. There is good reason to believe that AOT outcomes in California would be significantly better if programs were securing court-ordered treatment for all whose histories and condition indicate the need for it.

c. In requiring the person to have been hospitalized twice in the prior 36 months or to have committed violence in the past 48 months, these criteria…exclude from consideration any period of hospitalization or incarceration "immediately preceding the filing of the petition." ([Lines 942-943, 947-948 of the current version of the bill as passed].)

Many states, like California, have AOT criteria requiring two hospitalizations in the last 36 months or a violent incident in the last 48 months as a specific history of failure in voluntary treatment. I have no problem with that. Where California goes weird here is in excluding from these "look-back" periods any hospitalization "immediately preceding the filing of the petition," as well as any violent incident that occurred during such a hospitalization. In effect, if the person happens to be hospitalized on

> the date the petition is filed, the California law actually requires *three* hospitalizations in 36 months, or potentially *two* violent incidents in 48 months.
>
> I have yet to hear a rational basis suggested for these exclusions. Why on earth should a hospitalization not count, just because it happened to "immediately precede" the filing of the petition? Same question for a violent incident that happened to occur during an immediately preceding hospitalization: Why not?? These seemingly random exclusions serve only to disqualify some individuals who clearly need AOT. Knowing the history of the California AOT law, I do not believe this was ever the legislative intent. They appear to be inadvertent consequences of re-phrasing New York's AOT criteria, which very clearly exclude *the time period* of an immediately-preceding hospitalization – not the qualifying incidents -- from the retrospective review. (In other words, in New York, if the respondent has been hospitalized for the three months immediately preceding the filing of the petition, the 36-month look-back for a second qualifying hospitalization is extended to 39 months.) In any event, Georgia should not repeat this absurdity."

Brian Stettin offers a solution to these problems:

> "The solution here is very simple: delete [Lines 929 to 960 in the Bill as Passed] and replace with the following:
>
> *(2) A description of the population the applicant proposes to serve through assisted outpatient treatment, including the number of patients anticipated to participate in the program over the course of each year of grant support;*
>
> As someone deeply steeped in this area, I know that having these eligibility criteria imposed upon the grantees threatens the efficacy of the AOT grant program itself. A key to making AOT work is getting the people who need it most into the program. These extra criteria will make that exceedingly difficult."

2. **Fund Criminal Justice Coordinating Council research into data sharing between criminal justice and behavioral health.**

On July 15, 2022, Stefanie Lopez-Howard, the Statistical Analysis Center Director of the Criminal Justice Coordinating Council, recommended that we develop an

overview of the magnitude of interaction among i) people with mental illness in treatment, ii) people with mental illness in jail, and iii) people with mental illness in crisis in the community to see how many people are interacting with multiple systems at or about the same time. Additionally, Ms. Lopez-Howard recommended that we engage in a business process analysis and data map to match data across systems to see how people travel through multiple systems with an eye toward reducing arrests, hospitalization, and incarceration. Finally, she is recommending that we invest in the kind of business process and analysis and technology implementation that allows for on-going data sharing.

3. **Fund Opening Doors to Recovery (ODR) state-wide.**

On August 25, 2022, Nora Lott Haynes, Bill Curruthers, and Dr. Michael Compton presented on the efficacy of the Opening Doors to Recovery initiative in DBHDD Region 5. Their work showed how participants coming out of local hospitals benefited from community navigators and how a partnership between the GCIC and program participants reduced participant arrests by almost two-thirds while at the same time improving their quality of life and connection to treatment. One of the key features of this program is that a participant consents to having their participation made part of the GCIC so that the police would be able to see an alert when they encountered a participant in crisis. Wouldn't it be fantastic if every person coming out of a state mental hospital or participating in an accountability court was included in this program and all of it was integrated into the co-responder model that is beginning to be rolled out! Imagine all of these folks having executed a psychiatric advanced directive as well. The outcomes would reduce arrest and give deference to the care that the participant wants to receive.

4. **Recommend that competency restoration be limited to only the most serious offenses and that diversion "off ramps" be created during initial contacts with criminal justice and at every stage of the competency restoration process.**

Dr. Karen Bailey, subcommittee member and a forensic psychologist with 30 years' experience in the field, presented to the subcommittee on September 28, 2022, and nationally renowned mental health/criminal justice reform leader Judge Steve Leifman presented to the committee on October 11, 2022. Both distinguished presenters agree that we should limit the use of what's known as competency restoration to only the most serious offenses.

> "Treating a person with mental illness simply to make it possible for them to stand trial, and for no additional purpose, is a shocking misuse of desperately needed resources. The funds saved by minimizing the practice could go instead to front-end, community-based prevention and treatment services."
>
> *Source:* Locking People Up Is No Way to Treat Mental Illness, Norm Ornstein and Judge Steve Leifman, The Atlantic, May 30, 2022.

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial. Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder.

In Georgia, more than 870 persons are awaiting evaluations to determine their competency to stand trial on criminal charges. More than 350 persons are awaiting mental health competency restoration services so that they may then stand trial. The time spent waiting for evaluation or restoration services is measured in months.

These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

There are, however, alternatives to the current scenario, and these alternative approaches often work better for the individual as well as the community and use limited resources and available dollars more wisely.

Because jails and courts struggle to effectively address serious mental illness (SMI), moving individuals in and out of these systems can make people with SMI worse.

Diverting people who experience mental health symptoms to a system where treatment can be addressed at the right level of need as something more akin to our physical health processes and facilities is a better option. Trained 911 dispatchers, mobile crisis units, co-responder models, CIT trained law enforcement who have access to psychiatric advanced directives and provider contact information through the GCIC, community navigators, and well-designed crisis stabilization facilities

that interact appropriately with criminal justice are likely more effective and humane alternatives.

These diversion opportunities also arise at each point in the competency process, and off-ramps from the criminal justice system to treatment and civil alternatives, including voluntary treatment, the use of Psychiatric Advance Directives, and even involuntary civil commitment when appropriate — such as the use of Assisted Outpatient Treatment (AOT) — should be considered at each of these points. Interventions should be tailored to the needs of the individual and the community at the evaluation stage, prior to restoration, upon return from restoration, and prior to and as a part of sentencing or other case disposition. Even individuals found incompetent to stand trial and unrestorable could take advantage of the right "offramp" opportunities for diversion and be linked to appropriate community services to reduce their risk of offending and returning to the competency system.

Source: Leading Reform: Competence to Stand Trial Systems, a resource for state court systems authored by the National Judicial Task Force to Examine State Courts' Response to Mental Illness

5. **Develop Piedmont Healthcare Systems, Inc.'s Recommendations.**

On September 1, 2022, Fiona Hall, the Behavioral Health Service Line Executive Director of Piedmont Healthcare, Inc., stated plainly in her first slide that "Emergency Departments are the central intake point for patients who need transport to an Emergency Receiving Facility pursuant to a 1013 certificate. Due to lack of available beds for evaluation and treatment, patients are commonly held days or weeks in emergency rooms awaiting an appropriate placement. This result delays necessary care for those patients and impairs hospitals' ability to care for other patients in need." In 2021, Piedmont had 18,751 encounters with behavioral health patients resulting in $18.7 million in uncompensated care and over $3 million spent on contracts with private providers to care for these patients. They believe that the strain on local hospitals in this way is not sustainable. Dr. Dejuan White, psychiatrist and subcommittee member, indicated in a comment during the presentation that Piedmont's experience appears to be not that different from his experience at Grady.

Ms. Hall presented the following recommendations: 1) increase in-patient bed availability; 2) improve the continuum and coordination of care; and 3) provide alternate treatment or expanded acceptance criteria for medically compromised patients.

Perhaps we could consider partnering with the consortium of private healthcare providers that are meeting regularly in the Atlanta area to address these issues. Additionally, we could try and reach out to the state behavioral health institution in Tallahassee, Florida mentioned by Ms. Hall in her presentation which has been shown to reduce the medical clearance burdens that hospitals face here. In the end, we need to do a deep dive into these topics before we can make more specific recommendations.

6. **Research the extent to which local jurisdictions are experimenting with mental health diversion and create a state-wide data base for information sharing**

Anecdotally, there appears to be some diversion related experimentation on an ad hoc basis throughout the state at the intersection of mental health and criminal justice. One such example is the Misdemeanor Diversion Court founded in Henry County in 2018 by Senior State Court Judge Jim Chafin. This program diverts people with severe and persistent mental illness from traditional court processes to treatment, but it is not a mental health court and can result in the dismissal of the misdemeanor charge within 6 months of arrest. This program was created without funding through the cooperation of the local superior and state courts, the police and sheriff's departments, misdemeanor probation, the community service board and a nearby behavioral health crisis center (See attached Memorandum of Understanding for Diversion from Jail for Misdemeanor Offenders).

An effort should be undertaken to collect information from the courts regarding their diversion efforts with the goal of evaluating them and sharing best practices.

7. **Recommend a legal review of The Equitas Project and The CARES Act**

As part of his presentation to the subcommittee, Judge Steve Leifman shared the findings of the Equitas Project. The call to action of the Equitas Project was *Care, not Cuffs*. From May of 2019 to August of 2022, Judge Leifman led a blue-ribbon panel of experts from across the country who set out to disentangle mental health from criminal justice and create modern legal processes. Additionally, Judge Leifman introduced us to a framework the Equitas Project developed entitled Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society.

The work group aimed to produce legislative language that reflects cutting edge brain and behavior research, the civil liberties and patient's rights advocacy of

consumers and families, as well as health provider and public safety innovations and efficiencies. The work group of nationally recognized experts in mental health law, psychiatry, and advocacy aspired to create model law which would set the gold standard for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety.

A legal review of this project should be done to consider whether and how to incorporate these proposed reforms into our body of law.

Furthermore, in 2022, the Community Assistance, Recovery and Empowerment Court Program (SB-1338) was enacted in the State of California as a form of Assisted Out-Patient Treatment. Legislative Counsel's summary of the bill in section 3 states as follows:

"Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning the defendant to competency. Existing law suspends a criminal action pending restoration to competency. This bill, for a misdemeanor defendant who has been determined to be incompetent to stand trial, would authorize the court to refer the defendant to the CARE process."

This particular diversion point should be considered as a possible off ramp from the criminal forensic side to treatment in Georgia.

8. **Revise O.C.G.A. 17-7-130(c) to permit superior courts to exercise discretion to determine whether to transfer a violent offender to the department for in-patient restoration services or to outpatient restoration services pursuant to *Carr v. State*, 303 Ga. 853 (2018) and *McGouirk v. State*, 303 Ga. 881 (2018).**

Proposed Legislative Change to O.C.G.A. § 17-7-130(c):
"(c) If the court finds the accused is mentally incompetent to stand trial, the court may order a department physician or licensed psychologist to evaluate and diagnose the accused as to whether there is a substantial probability that the accused will attain mental competency to stand trial in the foreseeable future. The court shall retain jurisdiction over the accused and ~~shall~~ **may** transfer the accused to the physical custody of the department~~.~~ **if, after a hearing, the court in its discretion determines the evaluation should be performed on the accused as**

an inpatient. At its discretion, the court may allow the evaluation to be performed on the accused as an outpatient ~~if the accused is charged with a nonviolent offense~~. Such evaluation shall be performed within 90 days after the department has received actual custody of an accused or, in the case of an outpatient, a court order requiring evaluation of an accused. If the accused is a child, the department shall be authorized to place such child in a secure facility designated by the department. If the evaluation shows: [SUBSECTIONS OF STATUTE OMITTED]."

Reasoning and Background:
O.C.G.A. § 17-7-130(c) permits the court to order a department physician or licensed psychologist to evaluate and diagnose as to whether there is a substantial probability a defendant will attain mental competency to stand trial in the foreseeable future, if the court finds at present that the defendant is mentally incompetent to stand trial. However, the current version of O.C.G.A. § 17-7-130(c) only allows the court to use its discretion to permit outpatient evaluation if the accused is charged with a nonviolent offense. Otherwise, "[t]he court shall retain jurisdiction over the accused and shall transfer the accused to the physical custody of the department." O.C.G.A. § 17-7-130(c) (emphasis added). The Supreme Court of Georgia has found this automatic inpatient commitment provision to be unconstitutional. See *Carr v. State*, 303 Ga. 853 (2018); *McGouirk v. State*, 303 Ga. 881 (2018).

In *Carr*, the defendant was arrested and charged with rape, aggravated sexual battery, two counts of child molestation and a criminal attempt to commit a felony, which are considered violent offenses by the statute. See O.C.G.A. § 17-7-130(a)(11)(i)-(iv). He was released on bond, and a doctor from the department found the defendant to be not competent with a strong probability he could not be restored; nevertheless, the doctor concluded that restoration attempts should be made and recommended that the restoration occur in an outpatient, community setting.

Similarly, in *McGouirk*, the defendant was arrested and charged with the offenses of aggravated child molestation, child molestation, cruelty to children, and arson in the first degree. 303 Ga. 881 (2018). These are also violent offenses as defined by the statute. O.C.G.A. § 17-7-130(a)(11)(A)(ii) and (ix) (sexual offense and arson in the first degree). He was released on bond. A doctor from the department performed a competency evaluation on the defendant and found him not competent at the time of her evaluation, but that she might be able to provide a better sense as to his restorability after providing restoration services. She found no indication the

defendant was in need of inpatient care, and she recommended outpatient commitment.

Nevertheless, in both cases, the trial court automatically transferred custody of the defendants to the department for inpatient evaluation pursuant to the statute.

This automatic inpatient commitment solely on the basis of a defendant's mental incompetence and the nature of his charges impermissibly infringes upon a defendant's due process rights. See *Carr*, supra; *McGouirk*, supra. Although there is a "legitimate and important government interest" in accurately evaluating whether a defendant's competency can be restored for trial, *Carr*, 303 Ga. at 859, there must be a reasonable relation between this interest and the deprivation of the defendant's liberty. *Id.* at 860. The Supreme Court of Georgia held that the mere facts of a defendant's crimes, of which he must be presumed innocent, and his incompetency to stand trial were, alone, insufficient to deprive him of his liberty. *Id.* at 868. Further, depending on the defendant's needs, inpatient evaluations could work against the government's purpose of accurately evaluating whether the defendant's competency could be restored. *Id.* The Supreme Court of Georgia concluded that, absent any other lawful reason to be detained, the "automatic commitment for all those defendants [who are accused of a violent crime and found incompetent to stand trial] does not bear a reasonable relation to the State's purpose of accurately determining the restorability of individual defendants' competence to stand trial[.]" *Id.* at 869. Thus, "that aspect of O.C.G.A. § 17-7-130(c) violate[d] due process when applied to defendants who have been deprived of their liberty based solely on that statutory provision." *Id.*

The two cases provide a framework by which O.C.G.A. § 17-7-130(c) might be constitutionally applied. In *Carr*, the Supreme Court of Georgia counseled that the court should consider all relevant evidence and make a finding as to whether the evaluation required by O.C.G.A. § 17-7-130(c) should be conducted on an inpatient or outpatient basis. A defendant who is not already lawfully detained should be committed to the department only if the court finds that such confinement is reasonably related to the purpose of accurately evaluating whether that particular defendant can attain competency. A hearing on this issue should be held at the same time or promptly after the court initially determines the defendant's competency to be tried. To the extent the prosecutor or the defendant wishes to present or contest evidence that speaks to the detention determination, that should be permitted.

Id. at 869-70. In *McGouirk*, relying on *Carr*, the Supreme Court of Georgia affirmed that "the court must exercise its discretion to make an individualized determination of whether [the defendant's] confinement reasonably advances the government's purpose of accurately determining whether there is a substantial probability that [the defendant] will attain mental competency to stand trial in the foreseeable future." 303 Ga. at 883. In making such a determination, the court "should proceed as it does in determining how to evaluate mentally incompetent defendants accused of nonviolent offenses." *Id.* at 883-84.

Georgia Behavioral Health Reform and Innovation Commission

Appendix D: Subcommittee on Hospital and Short-Term Care Facilities

APPENDIX D: SUBCOMMITTEE ON HOSPITAL AND SHORT-TERM CARE FACILITIES

Hospital and Short-Term Care Facilities Subcommittee

The Hospital and Short-Term Care Subcommittee was created to explore the behavioral health and facilities available in Georgia, the systemic barriers to treating those with mental illnesses, and the role of payers in access to behavioral health services and supports for those experiencing mental illnesses. The subcommittee was chaired by Dr. Brenda Fitzgerald in 2022.

The following report includes information from the numerous presentations to the Subcommittee from experts, researchers, advocates, and others with a vital interest in improving the behavioral health system. The report also includes the priority recommendations of the subcommittee, which align with the commission's 2022 Annual Report. In Appendix E, the subcommittee has compiled additional recommendations relevant to improving the behavioral health system. A full list of the presenters to the subcommittee can be found in Appendix F.

Subcommittee Members

Brenda Fitzgerald, Ph.D. (Chair)
Emily Anne Vall, Ph.D.
Senator Brian Strickland
Dr. Lucky Jain
Commissioner Candice Broce
Dr. Mark Johnson
Jason Downey
Kim Jones
Donna Hyland
Commissioner Caylee Noggle

Introduction

House Bill 514 (2019 Session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former-Representative Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact on how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees to review these focus areas including the Subcommittee on Hospital and Short-Term Care (called Access for short) chaired by Dr. Brenda Fitzgerald. The first annual report was submitted to the Governor in December of 2020, and since then the Access subcommittee held 13 public meetings and heard testimony from 46 subject matter experts from across the state and nation. The recommendations outlined below were identified as priorities by the Access Subcommittee. For the full list of recommendations presented to the Access subcommittee, please see Appendix F.

1. **Georgia's Reimbursement Rates**

Multiple subject matter experts have testified to the Hospital and Short-Term Care Committee reporting that as many as 60% of Georgia's inpatient beds are filled by out of state patients due to Georgia's low reimbursement rates and practices. The results of Georgia's inability to compete with other states reimbursement rates has been heard and seen consistently from numerous testimonies across all subcommittees over the last three years. Although H.B. 1013 has made headway through the study that requires DCH to look at this issue, additional actions need to be taken immediately. If reimbursement practices do not improve quickly, it will be difficult to make real progress. This issue is negatively impacting the neediest adult and pediatric populations in our state.

It is recommended that upon immediate receipt of the DCH Reimbursement report (December 30, 2022), a small study is completed in partnership with a diverse group of representatives from the provider community to determine if the suggested rate increases will create an impact. It is strongly suggested that this take no longer than 30-60 days to complete. Coverage specifications regarding what services will be covered to meet the needs of patients, and steps to simplify administrative processes related to reimbursement practices should be included.

2. **Georgia Crisis Bed Tracking**

In recent years, additional emphasis is being put on states to ensure they have a robust crisis continuum to meet the growing demand for behavioral health crisis services. One common challenge states face is

boarding behavioral health patients in emergency departments (EDs) as they await admission to a crisis facility or inpatient bed.[1]

The role of bed tracking systems in making bed availability transparent and facilitating the referral process for getting emergency department patients transferred to the most appropriate level of care is imperative for the state. A robust continuum of care is needed that includes capacity and services beyond inpatient beds so that these high acuity services remain available for those most in need of them. According to SAMSHA, Georgia is one of 32 states that has a bed tracking feature in place ("The Georgia Crisis and Access Line (GCAL Board)"). While no state has excelled at streamlining the process of referring and admitting patients into available inpatient beds and limiting ED boarding times, there are several steps Georgia can take to improve the current situation.

Through multiple testimonials, the following improvements are suggested to enhance and streamline Georgia's current bed tracking system. These updates will allow the state to better understand the current crisis care population, bed needs, and care continuum barriers, facilitators and needs.

- Create a reporting feature that shows how many beds are utilized at any given point in time by in state patients and how many are out of state patients
- Create a reporting feature that collects when a patient is turned down for a bed, that facility must report the reason why
- Create a reporting feature that collects outpatient follow up care information to identify what patients are receiving outpatient services and who are not

3. Build a Robust Crisis System with A Full Continuum of Services

The Substance Abuse and Mental Health Administration defines the core elements of a crisis system as including: (1) a regional crisis call center, (2) crisis mobile team response, and (3) crisis receiving and stabilization facilities. These services have been coined, "someone to talk to, someone to respond, and a safe place to go," and they make up a no-wrong door integrated crisis system. Fully building and funding these core elements can help direct persons experiencing a behavioral health crisis to the appropriate level of care and divert people from high-cost inpatient services when another level of care is appropriate.

There is an identified need for immediate action in building Georgia's crisis services system. The Access subcommittee heard from a coalition of Atlanta hospitals over summer 2022 indicating there is a need for an additional 150 inpatient beds in the Atlanta region alone, before the closure of Atlanta Medical Center in October 2022. Inpatient capacity by itself will not address the challenges identified by the subcommittees. Capacity building is needed throughout the continuum of crisis services to ensure persons experiencing a behavioral health crisis can be seen in the least restrictive environment that is appropriate for the crisis they are experiencing.

The subcommittees heard testimony on overburdened inpatient services, long wait times for placement, and challenging processes for accessing behavioral health beds. While testimony focused on the highest acuity services, building the system's full continuum will help relieve these stress points on the system in

[1] Inpatient Bed Tracking: State Responses to Need for Inpatient Care, August 2019,

addition to adding capacity for high acuity services. Overall, there was an identified need for immediate action in capacity building paired with further study to ensure Georgia's long-term system reflects the needs of the state.

- Building a full and robust crisis system can relieve capacity issues on inpatient beds, decrease wait times for placement to services, and streamline care connections while keeping folks in the community when that is the most appropriate setting for them.[2,3]

4. Care Coordination

Through multiple testimonies a common theme that emerged was that for effective care management and coordination of care to occur, care coordination should continue to be paid for Managed Care Organizations, but care coordination and case workers should not be employed by Managed Care Organizations. Reimbursement rates should be at a minimum approximate to the cost of providing the function. Given the severity of some patients, it was identified that there should be several levels based on acuity.

- Throughout 2023, state agencies and key stakeholders should create a strategy that outlines what group(s) can work to build capacity and create the case management work force that will effectively provide care coordination in partnership with the Managed Care Organizations to better serve Georgians, specifically those most in need. DCH, DFCS and DBHDD will be key drivers and contributors in this strategy.

5. Expand Insurance Coverage to People with Mental Illness and Substance Use Disorders Using Medicaid 1115 Waivers

15.2% of Georgia adults with mental illness are uninsured, and nearly 70,000 Georgians with mental illness and substance use disorder currently do not qualify for affordable health coverage. According to the Kaiser Family Foundation, as of November 2, 2022, 23 states, including Arkansas, Florida, North Carolina, Virginia, and West Virginia , have expanded Medicaid coverage to individuals with serious mental illness through an 1115 waiver. These waivers include wrap-around benefits that also provide social supports, such as housing support and peer counselors, to enrollees, on top of health care services. Enacting a similar 1115 waiver in Georgia would expand Medicaid coverage to adults with behavioral health conditions, thereby improving access to care. This change would leverage Medicaid funds to provide health benefits to a discrete group of uninsured Georgians.

- It is recommended that Georgia pass legislation directing DCH to submit an 1115 waiver to expand Medicaid coverage to Georgians with serious mental illness to CMS and support DCH in the development and submission of the waiver.

[2] Inpatient Bed Tracking: State Responses to Need for Inpatient Care, August 2019,
[3] Psychiatric Bed Registries, September 2017

6. Waiving the Medicaid IMD Exclusion (via HB 610)

SB 610, sponsored by Senators Harrell, Burke, Dugan, Butler, Watson, and others and signed into law by the Governor, requires DCH to submit an IMD exclusion waiver request to CMS no later than December 31, 2022. Obtaining the waiver will provide more care for Georgia's citizens at less cost to Georgia's taxpayers. The FY2022 federal match percentages for services provided under the waiver are 66.85% for Medicaid and 76.80% for PeachCare. This compares to a 0% federal match for the costs of providing inpatient psychiatric beds to affected Georgians.

IMD stands for "institutions of mental diseases", terminology that comes from the Social Security Act of 1965. The IMD exclusion prohibits the use of federal Medicaid funds to pay for inpatient treatment delivered to individuals ages 21 through 64 at psychiatric facilities with more than 16 beds. The IMD exclusion waivers are intended to address the acute lack of inpatient psychiatric beds due to the 16-bed limit. The limit restricts access to necessary inpatient and residential behavioral health services, particularly for individuals in acute psychiatric distress; deprives states of federal funding for critical services; and undermines mental health parity by treating mental health differently than physical health. The 16-bed limit restricts state options to treat individuals in acute psychiatric distress, which in turn can lead to these individuals boarding in emergency departments, being held in jails, and/or being discharged from these settings without appropriate linkages to community-based care.

According to the Kaiser Family Foundation, as of November 2, 2022, 34 states, including Arkansas, Kentucky, Louisiana, North Carolina, Oklahoma, Virginia, and West Virginia, have approved IMD Payment Exclusion waivers for Substance Use Disorder Treatment, and another 5 states are pending approval. In addition, 10 states, including Alabama and Oklahoma, have approved IMD Payment Exclusion waivers for Mental Health Treatment, and 6 states are pending approval.

- While the December 31, 2022, waiver submission deadline will not be met, the recommendation is to continue to encourage and support DCH and Georgia in the submission of the IMD exclusion waiver to CMS.

7. Network Adequacy

Network adequacy means that health plans have a sufficient number of in-network primary care and specialty providers and included benefits to offer access to all medically necessary services within a reasonable period of time. Persistent and growing disparities in the rates paid to health providers by Medicaid, Medicare, and commercial insurance are a key issue for strengthening access to care. Rates alone do not determine provider participation in Medicaid, but they are a key lever to ensuring access. Medicaid rates are generally well below Medicare rates, which are themselves well below commercial rates. Some of the most impoverished and medically vulnerable persons, disproportionately children, persons of color, and persons with disabilities, are covered disproportionately by the program – Medicaid - that pays the lowest rates.

Health providers that rely principally on Medicaid revenues face greater workforce recruitment challenges than those primarily serving commercial patients. Relatively low Medicaid base payment levels put providers who primarily serve Medicaid and uninsured patients at a disadvantage, not only with respect to attracting and retaining a robust and qualified workforce, but also in terms of investing

in innovative care models and making critical and ongoing capital investments that can strengthen quality.

A critical parity measure is the frequency plan members must go out-of-network for behavioral health care as compared to medical/surgical care. Georgia's children are forced to go out-of-network for behavioral health care 10 times more often than for medical/surgical care, and Georgia's adults are forced to go out-of-network 4 times more often. When health plans do not have sufficient numbers or types of behavioral health providers, Georgians are forced to wait, travel long distances for care, or pay out-of-pocket to receive care from an out-of-network provider. Many Georgia families lack the financial resources to go out-of-network, so they must forego necessary medical care.

- Implementing strong network adequacy standards to ensure consumer access to quality, affordable care and achieving greater equity in health care is strongly suggested. Enforcement of the standards must be robust and the results transparent. Aligned legislation that improves network adequacy through simplifying existing processes for the consumer to make appointments and find providers is supported. Aligned legislation that improves the application process for healthcare providers to become in-network for various plans is supported including any willing provider legislation.
- The creation of one portal that all Managed Care Organizations utilize will help streamline and modernize current practices and improve network adequacy. The Hospital and Short-Term Care Subcommittee recommends identifying how the following measures and services can be accomplished through this suggested portal.
    - Put standards in place for patients to receive mental and behavioral health care without specialized referrals when they are unnecessary and obstructive in nature
    - Allow patients to see available providers and select appointments directly through the portal
    - Allow Managed Care Organizations a set amount of time to respond to a request for appointments that cannot be met on the portal (for example 3 days)
    - Track data when a demand is not met
    - Allow mental and behavioral health specialists and providers to easily apply to become in network with all Managed Care Organizations at once

8. Workforce

Many subject matter experts provided testimony about Georgia's mental and behavioral health workforce. A common theme that was identified was that to better meet the demand, Georgia must identify ways to immediately break down barriers and streamline the licensing of Marriage and Family Therapists (LMFTs) and Associate Marriage and Family Therapists (AMFTs) by the Georgia Secretary of State's Composite Board of Professional Counselors, Social Workers, and Marriage Therapists. The Georgia Association of Marriage and Family Therapy (GAMFT) provided the following recommendations to the Hospital and Short-Term Care Subcommittee.

- Develop grant program for University's with LMFT programs (Mercer, Valdosta State, UGA) to bolster and/or build satellites throughout the state to expand LMFT workforce.

- Statutory requirements for LMFT licensure are outdated and in need of revision. Post graduate clinical experience required in OCGA 43-10A-13 is out of line with other states, making it difficult for out of state licensees/MFT graduates to receive licensure in Georgia. Georgia must update Licensure Requirements for MFTs and support licensure requirements proposed in HB 1599 33 9142 (2022).

- The volume of applications to the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists has increased by approximately 65% since 2017 with no commensurate increase in staffing. There are currently five staff members supporting multiple separate licensure boards. The shortage of staff causes delays in the processing of applications. Georgia must increase Staffing and Board Capacity to Review License Applications and provide increased funding within the state budget for the Secretary of State Professional Licensing Division for additional staff support. In addition, Georgia should increase representation on the Composite Board by one person for each of the three professions governed by the Board.

- The applications for AMFTs and LMFTs are out of date, unnecessarily complex, and often redundant. The applications are at a minimum 17 pages long and must be printed and completed by hand unless the applicant owns special software. Georgia should shorten Simplify, and Computerize License Applications**, c**reate an online application that can be completed electronically and can log and store applicant information throughout the applicants' training and application process, and replace snail mail communications regarding applications with email communications in most instances, unless unavailable to the applicant. In addition, Georgia should create a direct online process for applicants to check their application status to easily identify errors and reduce the time staff uses to respond to applicant inquiries and provide for automatic approval of an applicant's educational and internship/practicum experiences for applicants who completed COAMFTE programs with a simplified and standardized method for Board staff to verify a program's COAMFTE accreditation based on information available on the COAMFTE website.

- Georgia currently limits Medicaid eligibility for behavioral health providers who are MFTs, LPCs, LCSWs to serve patients only to children ages 0-21. This change was made by an amendment to the state plan in January 2022. Legislative action was not required. However, these behavioral health professionals are not authorized to bill Medicaid for providing services to adults. Georgia should expand eligibility for LMFTs, LPCs, and LCSWs to provide services to Medicaid eligible adults to increase access to mental health care for this population.

9. Bolster Training Opportunities

In most areas of the state, Georgian's do not have sufficient access to MBH providers and specialists and rely on primary care providers and pediatricians for treatment and diagnosis. It is suggested that Georgia increase training opportunities and grant opportunities for primary care and pediatric providers to increase clinicians' comfort with assessing, diagnosing, and treating adult and pediatric mental health concerns.

- One suggestion is to expand the REACH Institute's training opportunities in under-resourced areas of the state through physician and clinician training scholarships and work with organizations like the Georgia Chapter of the American Academy of Pediatrics and Resilient Georgia to host, promote and implement trainings.

10. H.B. 1013 Mental Health Parity Annual Comparative Analysis

The Hospital Short-Term Care Subcommittee identified the following categories of information that should be included in annual comparative analyses between medical and mental health benefits of insurance companies mandated by H.B. 1013. The template below is used as an example to showcase how these measures would effectively show violations of mental health parity as parameterized in the 2020 Strengthening Behavioral Health Parity Act, SBHPA, H.R. 7539.

Which condition?	*How often does this condition occur in a population?*	*What is the sequence of evidence-based outpatient treatments for this condition?*	*How often should this service be rendered to keep the population mentally healthy?*	*Is the service occurring as often as would be expected for known prevalence*	*Are there adequate numbers of providers in-network to meet the need?*	*Does the insurer cover the cost of this service?*
Diagnostic Indication for Medically-Necessary (Evidence-based) Service	**Annual Incidence (Per 1,000 Covered Lives)**	**Medically-Necessary Service**	**Expected Encounters/Yr Per 1,000 Covered Lives**	**Proportion of expected encounters per 1,000 covered lives that were ACTUALLY DELIVERED**	**Proportion of provider slots (work RVUs) necessary to meet expected demand that are actually available**	**Proportion of true cost of service, inclusive of care coordination, that is covered by insurer**
Major Depressive Disorder, F32	71	Initial Psychiatric Evaluation, 90801	142			
		Cognitive Behavioral Therapy, 90836	550			
		Psychopharmacology, 99214	426			
		Transcranial Magnetic Stimulation, 90868	35			
		Electroconvulsive Therapy, 90870	28			
Anxiety Disorder	120	Initial Psychiatric Evaluation, 90801	240			
		Cognitive Behavioral Therapy, 90836	720			
		Psychopharmacology, 99214	480			
Alcohol Use Disorder	60	Drug / Alcohol Specific Assessment, H0001	60			
		Individual Therapy, H0004	240			
		Group Counseling, 96164	360			
Hypertension	30	Hypertension Management, 3077F	120			
Reactive Airway Disease	40	Assessment, 1039F	80			
		Management, 99211	160			
Type II Diabetes	15	Diabetes Management, G0108	180			

Additional Recommendations

Many additional recommendations have been made to the Hospital and Short-Term Care (Access) Subcommittee over the last several months. Recommendations can be found in Appendix E.

Georgia Behavioral Health Reform and Innovation Commission

Appendix E: Additional Recommendations from the Subcommittee on Hospital and Short-Term Care Facilities

Organization	Identified Need	Recommendation	Supporting Information
Georgia Department of Juvenile Justice	Substance Use Treatment in RYDCs	•DJJ received federal grant to expand Seven Challenges substance use program in 14 RYDCs (19 RYDCs in the state).	•53.5% of cases in RYDCs have substance use disorders
Georgia Department of Juvenile Justice	• Recruitment and retention of qualified staff • Aging staff and professionals •Difficulty time recruiting child and adolescent professionals •DJJ cannot offer competitive salaries	• Offer competitive compensation • Desired workforce would be well-versed in trauma, family systems/family conscious therapists • DJJ has internships and clinical placement available. Welcomes interns	• Position for Psychologist or clinical director took over 2 years to recruit, other job postings are open for months. • DJJ involved children are clinically and psychologically complicated. Community providers may not have been trained to work with complicated children.
Georgia Department of Juvenile Justice	Treatment Gaps in Rural Areas	• Include support for clinicians providing services for youth; rural treatment resources; improved insurance and funding for treatment.	•Because of the significant gaps in rural treatment resources, lower risk youth are pushed into more expensive residential or secure confinement.
Georgia Department of Juvenile Justice	• Funding for treatment services • Need for evidence-based services	• Earmark budget increase specifically for residential & community treatment services • Evidence-based trainings are possible through partnerships • Offer competitive compensations and ongoing funding to implement and sustain evidence-based practices	• No specific resources (budget) allocated to support evidence-based practices. • Treatment services budget was cut in 2010-11. The 2014 Juvenile Justice Reform was focused on public safety & community services, not treatment.

Organization	Identified Need	Recommendation	Supporting Information
Emergency Services and Residential Treatment Facilities	• Difficulty finding services for children that meet 10-13 criteria or children facing extreme psychosis • Insufficient residential programming bed capacity	• Identify residential providers committed and equipped to serve DJJ involved youth • Develop service capacity and resources for 18+ youth • Evaluate the Emergency Psychiatric Hospitalization and PRFT admission processes and revise/enhance to ensure timely access to all of Georgia's high need children • Implement a mandatory state-level staffing for high needs youth with unmet needs with DCH, DBHDD, DKK, DFCS, Child Advocate Office, and DOE that has authority to act. • Leverage guidance provided by CMS and CHIP in SMD #21-002, "Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions" (https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf) • Ensure Medicaid coverage for eligible justice involved youth to include those from age 18-21 (The SUPPORT Act, Pub L. 115-271) • Explore expansion of wraparound services (IC3-intensive customized care coordination) for automated opt-in process for justice involved children and young adults	• No DJJ specific emergency psychiatric hospital • Denials are based on justice involvement rather tha nclinical need. There's a perception that justice involvement makes the child in need "less serviceable" • Often competing with DFCS for residential beds • Waitlists for medium-risk/need youth • Placement failures and disruptions • Children that meet 10-13 criteria or facing extreme psychosis are often restrained or sedated • YDC and RYDC's are not designed or staffed to provide intensity of services required by children that need PRTF • There is a perception that DJJ children are "too dangerous" for placement in PRFT • DJJ associated youth are able to receive emergency care for acute health issues. DJJ is payor of last resort - the hospital treats the child and then deals with insurance/payment. But for mental health/clinical concerns, the child is not seen until the payor source/insurance is finalized.

Organization	Identified Need	Recommendation	Supporting Information
Showcase Group	Youth Incarceration Rate • 2,000 youth currently incarcerated in Georgia • Black and Brown youth are disproportionally involved in the juvenile justice system. • 50% will return to a detention center within 2 years	• Establish a psychosocial determinant of youth reentry to develop an evidence-based tool for treatment planning • Support community-based organizations that can support youth after release • Work with youth prior to release to meet them as they are reintroduced to the community • Refine justice model from the perspective from Black and Brown boys and men • Form partnerships between private, government, and philanthropic institutions to improve community vitality and workforce development.	• Showcase group works with youth at the systemic, community, and individual level. Systemic incarceration causes trauma.
Showcase Group	Mental Health Treatment for Incarcerated Youth • 30% of incarcerated youth receive mental health treatment, while 70% require it.	• Need to understand the scope of justice involved youth requiring care. Showcase Group reported different data than the DJJ - See Source.	• DJJ reports that 70% of youth involved with the justice system will have mental health needs • DJJ reports 72.3% in YDC & 49.1% in RYDC receive mental health care in 2019.

Organization	Identified Need	Recommendation	Supporting Information
Medical College of GA	Human Resources • Hiring and retaining staff in rural health care practices; providers are not able to pay competitive wages ("inability to pay acceptable salaries")	• Enhance trauma informed knowledge base statewide; including training across communities • Improve graduate medical education • Increase residency opportunities for medical doctors in Georgia by engaging Community Service Boards (using a CSB residency being developed in Moultrie as an example) • Develop a survey to understand "how bad the workforce is" to measure the deficit across mental health providers in the state • Independent provider status for licensed Marriage and Family Therapists and other licensed professional counselors • Implement Project ECHO to create learning opportunities for communities and to train mental health providers	
Medical College of GA	School Based Mental Healthcare • Workforce issues	• Expand Georgia APEX Program	• https://dbhdd.georgia.gov/georgia-apex-program • Through APEX, Community Service Boards receive funding to provide care in schools, but the need exceeds the funding. One CSB in SW Georgia receives funding for two schools, but provides APEX in four.
Medical College of GA	Transportation • Distance to care and lack of transportation is a barrier to care, which is exacerbated in rural areas.		

Organization	Identified Need	Recommendation	Supporting Information
Medical College of GA	Broadband • Telehealth is the answer to overcome transportation issues, but there is a lack of broadband access in rural communities	• Understand the broadband access for rural patients	• https://gov.georgia.gov/press-releases/2022-02-01/gov-kemp-announces-almost-408-million-awards-provide-broadband-access
Rural Hospital CEOs: Emmanuel Medical Center and Dodge County Hospital	Hospital Finances • Emmanuel Medical Center - Hospital operates with 0-5 days cash on hand. To hire the sitters (for mental health cases in the ER) and security, it added $25,000 to the monthly expenses of the hospital • Dodge County Hospital - Sitters cost about $32,400 • Dodge County Hospital - Operating at lower capacity due to COVID and social distancing. • Medicaid and commercial payers are not paying enough for hospital services	• Emmanuel Medial Center operates with 0-5 days of cash on hand. To expand services or implement programs, the hospital must be confident that the service/program has a "solid reimbursement mechanism" • Patients with a payor source get placed faster • Hospital departments close because of increased liability and financial losses. Dodge County Hospital was losing $500,000 per year for a department, Emmanuel losing $100,000 on Labor and Delivery department so they had to close	• A CEO suggested looking to Utah's payment methodology, which favors rural hospitals. •https://www.beckershospitalreview.com/quality/the-rise-of-the-patient-sitter-one-of-healthcare-s-most-undervalued-safety-tools.html • https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R176SOMA.pdf

Organization	Identified Need	Recommendation	Supporting Information
Rural Hospital CEOs: Emmanuel Medical Center and Dodge County Hospital	Mental Health Patients in ER • "Dual diagnosis and uninsured is a disaster because developmental disability places don't want you [the patient] because of the behavioral health and behavioral health places don't want you [the patient] because of the developmental disability."	• Improve Crisis Access Line to allow groups outside of the region to accept patients • Request from Dr. Fitzgerald: provide data from the hospital detailing the length of stay for mental health patients in the emergency room.	• "Georgia the state with the lowest mental health expense per capita in the country. We compare $50 or $60 per capita to $400 - $500 range in many other states. Then you take a payer mix as these two CEOs describe in our rural areas and you see the perfect story that they are dealing with." BHRIC Member
Rural Hospital CEOs: Emmanuel Medical Center and Dodge County Hospital	GCAL • "the board is bureaucratic and clunky and it's labor intensive for my staff to participate with that."	• Update the board for more efficiency	• Emmanuel Medical Center developed a Mental Health Collaborative that includes CSB, providers, hospital staff - provides training and shares resources.
Rural Hospital CEOs: Emmanuel Medical Center and Dodge County Hospital	Workforce • Pay for entry-level positions (CNAs, registration, reception) is a barrier to maintaining workforce. CNAs for mental health checks "probably our highest needs."		

Organization	Identified Need	Recommendation	Supporting Information
Dept Counseling and Psych. Services, GSU	Suicidal Ideation among Older Adults	• Skills training for those that work with older adults to provide "CPR" to those experiencing mental health/mental distress • Evaluate current resources to see if those resources are being used effectively and to increase the value of current resources (recommendation of sub-committee member)	• An evidence-based intervention ASIST (Applied Suicide Intervention Skills Training) trains people to help somone experiencing mental health/mental distress/crisis by adding a third option to suicide outcomes. In addition to life and death, adds "stay safe for now" and centers the person at risk. • Homebound older adults were 2.69 times more likely to have depression than non-homebound older adults. Socialization is a buffer against the effects of isolation. • Dr. Laura Shannonhouse and her team at GSU are in the evaluation phase of developing a knowledge-based, suicide prevention training for those who work with older adults. not available at the time of testimony

Organization	Identified Need	Recommendation	Supporting Information
Agency on Aging, Atlanta Regional Commission, Metro Atlanta	Psychiatric and Behavioral Disorders - Public and Affordable Housing (Older Adults) • Without treatment, symptoms of these disorders put residents at increased risk of nursing home placement (at the expense of Medicaid), loss of housing/termination of lease and eviction. • Most of those living in public housing that needed mental health care did not receive treatment and that mental health was the biggest concern for residents and staff in affordable health complexes	• Develop coaching services and a centered approach that promotes individual engagement and self-determination that supports access to treatment. • Addresses unmet social determinants of health (transportation, adequate housing and nutrition) to create more lasting behavioral change • Preserve independence and housing • Add behavioral health coaches to (low-income and affordable) housing providers	• Advocacy for behavioral health/housing issue from leadership - Chairwoman Penny Houston and the House Appropriations subcommittee (the General Assembly). Funds were provided to the Department of Community Affairs to expand the work to Tifton and Albany this fiscal year.
DBHDD	Workforce	• Development of psychiatry residencies • Support technical colleges that have programs health care assistant, health care aides • Training Pipelines: Development of a program that includes core hours, plus behavioral health specialists or intellectual development disorder specialists. • Address the nursing shortage • Train nurses and medical staff in suicide awareness trainings like MHFA or ASIST	

Organization	Identified Need	Recommendation	Supporting Information
DBHDD	Access to Care • Identifying the barriers and challenges to accessing care. • Defining access - what does access include? • Parity	• Must identify the access challenges and barriers for individuals, providers, and networks • Develop common language around access (includes way to measure) • Understanding the role of the third-party payer, particularly when discussing children, like Medicaid. Understanding how the payer and the reimbursement model impacts access • Explore telemedicine and the home-based care as ways to overcome the barriers and challenges • Access map - are the networks adequate to provide care?	• Access to care has three components - individuals, providers, and the network. For the Individual - what determines whether or not an individual is able to access what they need. For Providers - What role does a provider play in facilitating access for individuals. For hte Network - Is the network organized, arranged, and equipped to deliver the kind of services needed in Georgia? • Access is more than the physical access to services. includes affordability and the ability to get valid assessments, appropriate diagnosis, and response to treatment. • Behavioral healthcare requires the coordination between individuals, providers, families, and networks to be successful. Those services must be coordinated and connected.

Organization	Identified Need	Recommendation	Supporting Information
Brookhaven Police Department	Law Enforcement And Access to Care • "what we end up doing, unfortunately, is babysitting we will take someone into custody that's evidently a mental crisis, sometimes there's a criminal act involved, sometimes, there's not." • Providers sending juveniles out of state for care because "they can't get hospitals that will accept them." • Drug use and homelessness also need to be addressed	• Develop something similar to the Baker Act in Florida, where with a signed affidavit police could take someone into custody and take them for an evaluation. • NAMI and crisis intervention training for police (Georgia is at 70% of police forces trained at the time of the testimony) • Co-Responder model to have clinicians on staff (Chief Yandura shared that there is a clinician on staff for 40 hours as a test period and "that's been working great.")	• "last year, we tried adopting legislation simiar to…" • Police are working around the system to get care for people with mental health crisis. Currently, if someone is having a mental crisis, the police will take someone into custody and take them to the hospital to try to get a 10-13. If If that doesn't work, they post criminal charges against the person to force a 10-13 then drop the charges. Then the charges are dropped.
Behavioral Health Link	Divert from Law Enforcement to GCAL Services	•The goal is to divert psychiatric issues from emergency departments and jails to a Behavioral Health Coordinating Council • Currently 2 available in Atlanta and 1 in Savannah	
Behavioral Health Link	Nursing Workforce • Not able to compete with hospitals and can't pay bonuses/travel. If a nurse calls out, they might have to close referrals and intakes for the day		

Organization	Identified Need	Recommendation	Supporting Information
Behavioral Health Link	Bed Capacity (specifically in the youth sector) • low capacity for youth aged 14-18, specifically for those with Autism • because of payer source (Peach Care or Medicaid) 89% of children in Georgia would not be eligible for the beds.	• Develop Autism specific units • understand how the Georgia system works - multiple payers with multiple responsible authorities.	• currently at a 96% occupancy rate. A lot of patients tend to have dual diagnosis or be violent or older. • privately insured are often referred to private options
Behavioral Health Link	Parity • Problem with parity after hearing from rural hospitals, hospitals in urban areas, providers, etc. • The payment system needs to be updated • Parody for behavioral and medical issues	• Report cards on parody laws should be accessible in GA • To have parity for behavioral and physical health, the recording systems must be checked so that you're able to make observations • With an updated recording system denied length of stay, difficult placement, and patients that came back within 30 days will be seen	

Organization	Identified Need	Recommendation	Supporting Information
Behavioral Health Link	Hospital EDs and inpatient units being used for last resort housing • Limited support for patients with complex needs to access behavioral services from hospitals • Increase in hospital care coordination discharge resolutions • Increase in patient length of stay • Increase in patients/families utilizing hospital EDs	• Support that interfaces with hospital services for complex patients • Temporary housing options for patients waiting for behavioral health services or permanent placement • Full transparency, communication, and coordination between health facilities, DBHDD, and other service providers offering care Services that address need gaps for complex patients	• This issue occurs often enough where the health and safety of GA residents with disabilities are compromised; a structural solution is needed • Multiple diagnoses can mean no facility provides services leaving patients as frequent visitors to the ER or an extended stay • Limited support for complex patients to access behavioral health services from hospital facilities
Behavioral Health Link	Expanding access to care • Meeting the needs of Georgia's increasingly diverse population regardless of race, gender, ethnicity, socioeconomic status, geographical location, etc. • Assisting providers in becoming more culturally competent	• Provide programs that are linguistically and culturally relevant • Be careful with frequent virtual services • Beware of the use of interpreters • Provide more programs in group settings • Pay attention to individual literacy levels • Understand your communities' immigration laws, policies, and issues	• DBHDD Has noted an increase in the ethnic and Racial diversity of the state and of the consumers serve by DBHDD provider • Barriers to utilizing CSBs • There are limited resources for people in crisis • Lack of qualified interpreters • A presence of stigma specifically strong in certain cultures

Organization	Identified Need	Recommendation	Supporting Information
GA Association for Infant Mental Health	Infant and Early Childhood Mental Health (IECMH)	• Focus on building the clinical mental health workforce to keep more children with their families • Shortage of mental health workforce to support families of young children who have had trauma • Establish an agreed-upon set of core competencies • Grow the labor pool of mental health professionals serving children from birth to 4 • Determine how to provide IECMH training to existing state agency employees	• Young children who reside in families where parental loss, substance use, or mental illness exist are at a heightened risk for developing mental health disorders • 2016 Georgia Behavioral risk factor surveillance system: Georgians who reported four or more adverse childhood experiences were likelier to have poorer mental health, depression, difficulty making decisions, etc. • Young children are at a heightened risk for adversity • Rates of child abuse and neglect are highest in children under the age of three (USDHHS, 2018)
Pediatric Healthcare Improvement Coalition (PHIC)	• Improved data sharing	• Standards are needed for providers/organizations to have data available and accessible through GaHIN • Looking at the current law regarding the confidentiality of mental health records • With the consent of the patient or his/her representative • Without the consent of the patient or his/her representative when mandated by law	

Georgia Behavioral Health Reform and Innovation Commission

Appendix F: List of Presenters to the Subcommittee on Hospital and Short-Term Care Facilities

Appendix F: Hospital and Short-Term Facilities Subcommittee Presenters

Date	Topic	Organization	Presenter
4/22/2021	Juvenile Justice Behavioral Health Treatment Needs & Services	Georgia Department of Juvenile Justice	Tyrone Oliver, Commissioner Margaret Cawood, Deputy Commissioner Dr. Christine Doyle, Director of Office of Behavioral Health
	Juvenile Justice Behavioral Health Treatment Needs & Services	The Showcase Group	John Kennebrew, Founder/Executive Director
5/27/2021	Barriers & Opportunities in Rural Georgia	Medical College of Georgia, Department of Surgery	Douglas Patten, MD, Associate Dean, Associate Professor
	Barriers & Opportunities in Rural Georgia	Emanuel Medical Center	Damien Scott, Chief Executive Officer
	Barriers & Opportunities in Rural Georgia	Dodge County Hospital	J. LaDon Toole, Chief Executive Officer
7/22/2021	Behavioral Health & Housing for Older Persons	Aging & Independent Services, Area Agency on Aging	Becky Kurtz, Director
	Behavioral Health & Housing for Older Persons	Georgia State University, Dept. of Counseling & Psychological Services	Laura R. Shannonhouse, Ph.D., Associate Professor
8/26/2021	Georgia Crisis and Access Line	Georgia Department of Behavioral Health & Developmental Disabilities	Debbie Atkins, Director of Crisis Coordination
	Georgia Crisis and Access Line	Behavioral Health Link	Michael Claeys, Executive Vice President
9/23/2021	Access to Care	Georgia Department of Behavioral Health & Developmental Disabilities	Judy Fitzgerald, Commissioner
	Access to Care	Brookhaven Police Department	Gary Yandura, Brookhaven Police Chief
2/24/2022	Continuum of Care for Hospital Patients with Complex Medical Needs	Atlanta Regional Collaborative for Health Improvement (ARCHI)	Carrie Oliver, Senior Project Manager
	Continuum of Care for Hospital Patients with Complex Medical Needs	Northside Hospital	Lisa Mize, Behavioral Health Services Coordinator Melissa Harris, Manager of Complex Cases Nikeisha Whatley-Leon, Director of Behavioral Health Services
	Continuum of Care for Hospital Patients with Complex Medical Needs	Grady Health System	Anne Hernandez, Administrative Director of Behavioral Health Marci Tribble, Director of Psychiatry
4/28/2022	Justice, Equity, Diversity and Inclusion	The Center for Victims of Torture, Georgia	Darlene C. Lynch, Esq., Head of External Relations
	Justice, Equity, Diversity and Inclusion	Ser Famila, Inc	Belisa M. Urbing, Chief Executive Officer
	Justice, Equity, Diversity and Inclusion	Georgia State University Prevention Research Center College of Education & Human Development School of Public Health	Mary Helen O'Connor, Ph.D. Johnathan Orr, Ph.D. Ashli Owen-Smith, Ph.D.,

Date	Topic	Organization	Presenter
5/26/2022	Infant and Early Childhood Mental Health	Georgia Association for Infant Mental Health (GA-AIMH)	Emily Graybill, Ph.D., Principal Investigator
	Infant and Early Childhood Mental Health	Hughes Spalding Campus of CHOA	Terri McFadden, MD, FAAP, Medical Director of Primary Care
	Infant and Early Childhood Mental Health	Zaria's Song	Teresa Wright-Johnson, Founder and Parent Peer Support
	Infant and Early Childhood Mental Health	Department of Early Care and Learning	Laura Lucas, MS., Infant and Early Childhood Mental Health Director
	Infant and Early Childhood Mental Health	Georgia Early Education Alliance for Ready Students (GEEARS)	Callan Wells, MS, Senior Health Policy Manager
6/23/2022	Patient Confidentiality and the Exchange of Health Information	Pediatric Healthcare Improvement Coalition of Georgia (PHIC)	Kathryn Cheek, MD, Chairperson
	Patient Confidentiality and the Exchange of Health Information	Georgia Health Information Network	Denise Hines, DHA, PMP, FHIMSS, Executive Director
	Patient Confidentiality and the Exchange of Health Information	Amerigroup	Vanderlyn Sewell, MD, Medical Director Shane Savage, MD, Medical Director
	Patient Confidentiality and the Exchange of Health Information	Whites Pediatrics	Jeoffrey White, MD, Board-Certified Pediatrician
	Patient Confidentiality and the Exchange of Health Information	Pediatric Healthcare Improvement Coalition of Georgia (PHIC)	Pamela Mason, RN, BSN, Executive Director
7/28/2022	Farmer Mental Well-Being	Georgia Foundation for Agriculture	Lily Baucom, Executive Director
	Farmer Mental Well-Being	Georgia Rural Health Innovation Center	Anne Montgomery, Ph.D., Biostatistician Stephanie Basey, Research Assistant
	Farmer Mental Well-Being	University of Georgia, College of Public Health	Christina Proctor, Ph.D., Assistant Professor Noah Hopkins, Research Assistant
8/25/2022	Mental Health and Substance Use Services	Georgians for a Healthy Future	Laura Colbert
	Infant and Early Childhood Mental Health	Georgia Family Connection Partnership	Arianne B. Weldon, MPH
9/22/2022	Network Adequacy	GA Chapter American Foundation for Suicide Prevention	Roland Behm
	Network Adequacy	Oregon Health and Sciences University (OHSU)	Jane Zhu, MD, MPP,
10/27/2022	Network Adequacy	Georgia Association of Health Plans	Jesse Weathington, President & CEO
	Network Adequacy	Evernorth Behavioral Health	Douglas Nemecek, MD, MBA, BA, CHIE, Chief Medical Officer

Georgia Behavioral Health Reform and Innovation Commission

Appendix G: Subcommittee on Mental Health Courts and Corrections

APPENDIX G: SUBCOMMITTEE ON MENTAL HEALTH COURTS AND CORRECTIONS

Subcommittee on Mental Health Courts and Corrections

The Mental Health Courts and Corrections Subcommittee explores the impact the behavioral health system has on the courts and corrections system and aftercare for persons exiting the criminal justice system. The Mental Health Courts and Corrections Subcommittee convened the Familiar Faces Advisory Committee during 2022 and consulted with the Council of State Governments Justice Center to craft their subcommittee's recommendations. The subcommittee was chaired by Chief Justice Michael Boggs in 2022.
Included in this appendix are the recommendations compiled by the subcommittee with the support of The Council for State Governments Justice Center. These recommendations were presented to the BHRIC during its meeting on November 16, 2022, at capitol. Those slides are included here and align with the recommendation in the commission's 2022 Annual Report.

2022 Subcommittee Members

Chief Justice Michael Boggs (Chair)
Judge Brian Amero
Sheriff Andy Hester
Chief Louis Dekmar
Judge Brenda Weaver
Judge Kathleen Gosselin
Stan Cooper
Commissioner Timothy Ward
Commissioner Michael Nail

Justice Center
THE COUNCIL OF STATE GOVERNMENTS

Familiar Faces Advisory Committee

Mental Health Courts and Corrections Subcommittee
Behavioral Health Reform and Innovation Commission

November 16, 2022

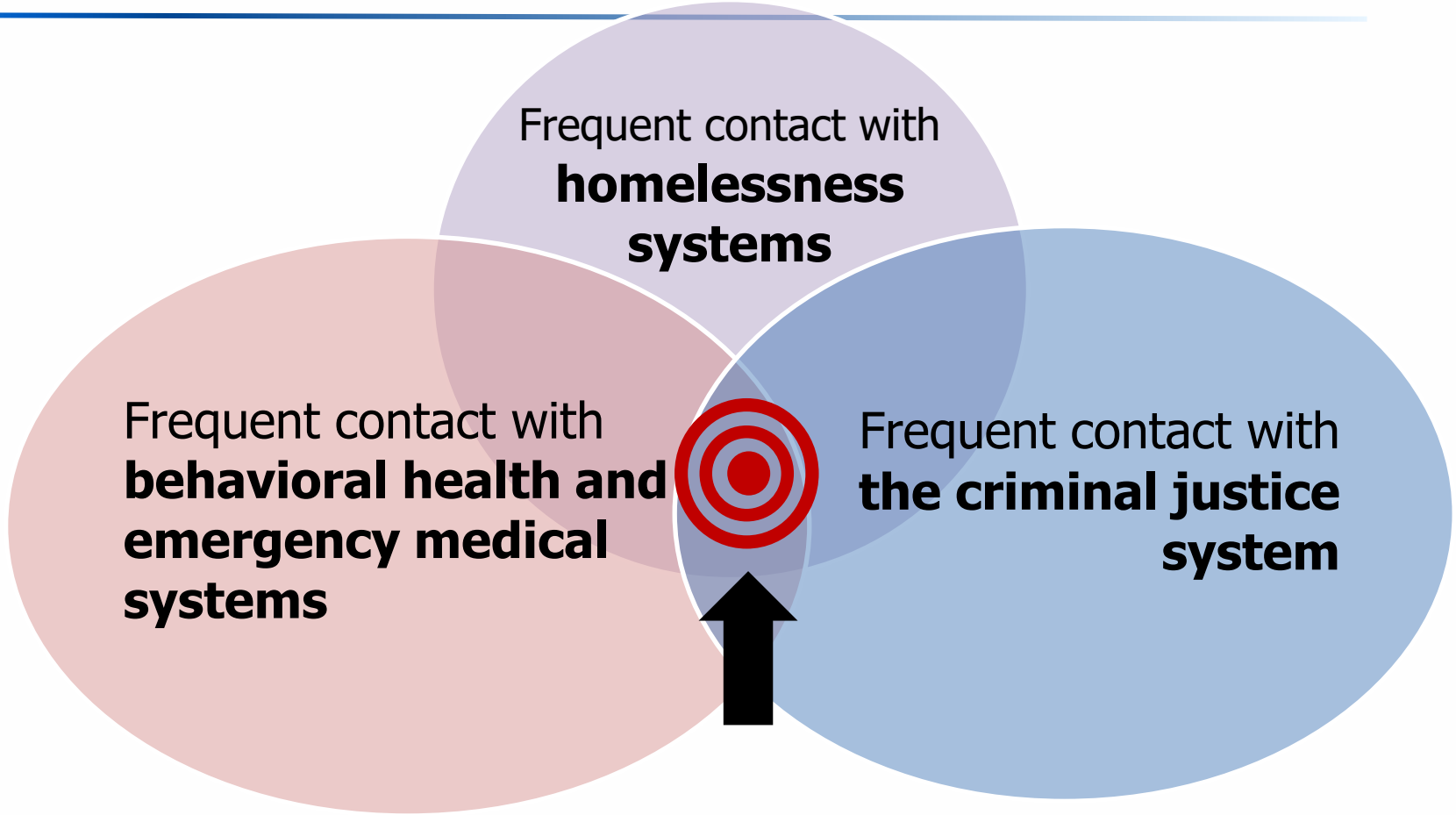
Agenda

- "Familiar Faces" and the Georgia Familiar Faces Advisory Committee
- Recommendations of the Mental Health Courts and Corrections Subcommittee
  - Priority Area 1: Bolster Capacity to Identify Familiar Faces
  - Priority Area 2: Improve Community Response to Familiar Faces
  - Priority Area 3: Expand Access to High-Quality Care and Supports
  - Priority Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in GA

Familiar Faces

Very Small Population with a High Volume of Contact with Health and Justice Systems

"Familiar Faces"

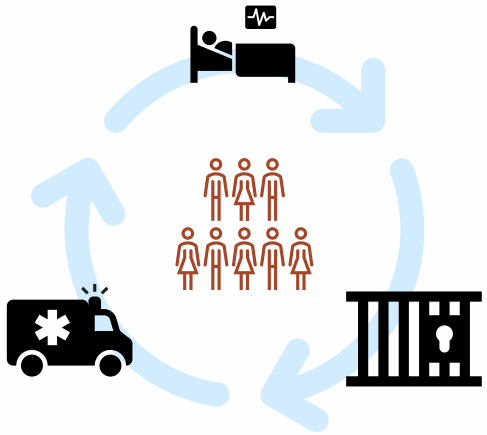


People with mental illness incarcerated in Georgia jails

2020 Study of incarcerated people with mental illness in 9 Georgia jails, 2013-2018

Familiar Faces: **the top 1% of booking episode counts**

- Total Familiar Faces population = **2328**
- **Familiar Faces with mental illness = 649**



	Familiar Faces	Familiar Faces w MI
Average # Arrests	21	51
Average Days Community Tenure	394	172

John Speir, Sharon C. Johnson, Stefanie Lopez-Howard, Taylor Gann, Stephen Okala, Identifying Predictors of Mental Illness in County Jails (Atlanta: Criminal Justice Coordinating Council, 2022).

Familiar Faces Advisory Committee

Mental Health Courts and Corrections Subcommittee of the Behavioral Health Reform and Innovation Commission

The Advisory Committee

Behavioral Health Reform and Innovation Commission
Kevin Tanner, Chair

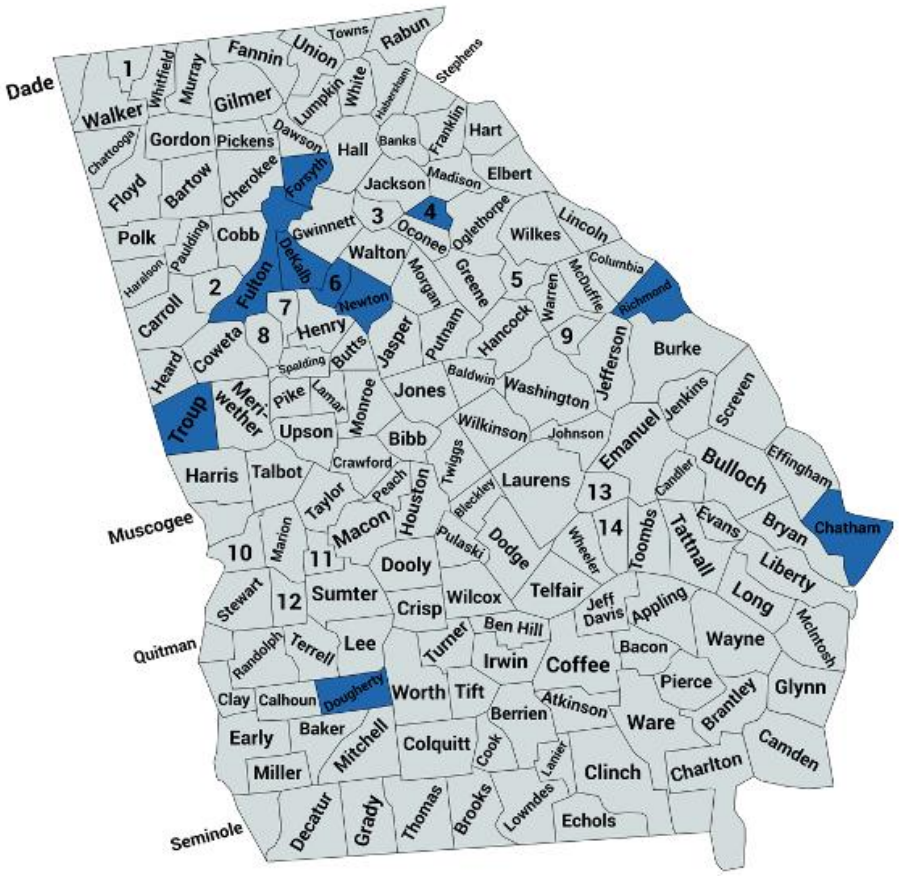
Mental Health Courts and Corrections Subcommittee
Presiding Justice Michael J. Boggs, Chair

Familiar Faces Advisory Committee

Georgia Familiar Faces Advisory Committee

Judge Brian Amero	Chief Judge Henry County Superior Court	Henry County Superior Court
Chief Justice Michael Boggs *	Mental Health Courts and Corrections Subcommittee Chair	Georgia Supreme Court
Stan Cooper	Director, Probation Operations (Retired)	Georgia Department of Corrections
Chief Louis Dekmar	Chief of Police	LaGrange Police Dept
Kathlene Gosselin	Chief Judge	Northeast Circuit of Georgia
Andy Hester	Sheriff	Turner County
Chris Johnson	Interim Executive Director	Georgia Mental Health Consumer Network
Monica Johnson	Division Director, Behavioral Health Interim Commissioner	Georgia Department Behavioral Health and Developmental Disabilities
Kristyn Long	Deputy Chief Operating Officer, Deputy Executive Counsel	Office of GA Governor Brian P. Kemp
Stefanie Lopez-Howard	Statistical Analysis Center Director	Criminal Justice Coordinating Counsel
Evan Mills	Director of Development and Housing Programs	Advantage Behavioral Health Systems (Athens-Clarke)
Clint Mueller	Legislative Director	Association of County Commissioners of GA
Commissioner Michael Nail	Justice Courts Steering Committee Member	Georgia Department of Community Supervision
Kristin Stoycheff Schillig	Court Support Manager II, Justice and Mental Health Projects	Superior Court of Fulton County
Senator Brian Strickland	Georgia State Senator	Senate District 17
Kevin Tanner	Forsyth County Manager; Chair, Behavioral Health Innovation and Reform Commission	Forsyth County
Cordaryl Turner	Deputy Division Director	Georgia Department of Community Affairs
Judge Brenda Weaver	Chief Judge	Appalachian Circuit of Georgia

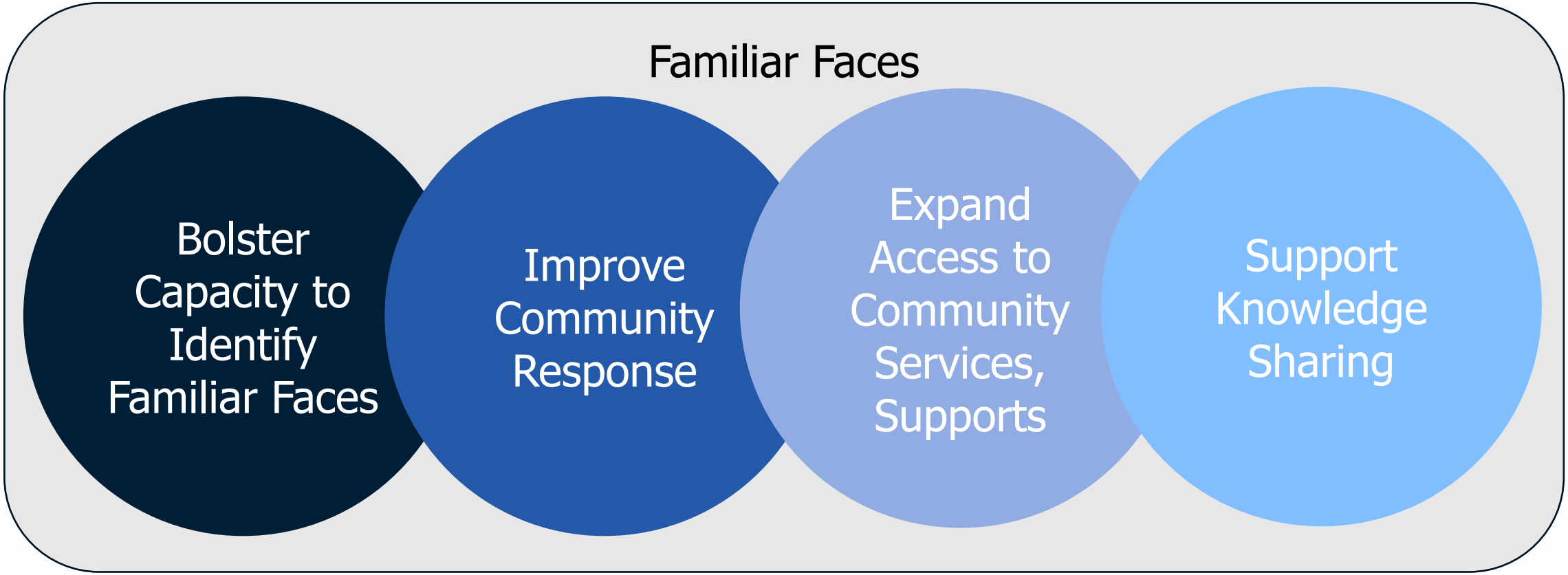
County Teams



County	Familiar Faces	Stepping Up	JMHCP**
Athens-Clarke County		✓	✓
Chatham County		**Innovator**	✓
DeKalb County		✓	✓
Dougherty County		✓	
Forsyth County		✓	✓
Fulton County	✓	**Innovator**	✓
Newton County		✓	✓
Richmond County		✓	
Rockdale County		✓	✓
Troup County	✓		

**Justice & Mental Health Collaboration Program

Framework for Policy Ideas



Policy Area 1: Bolster Capacity to Identify Familiar Faces

Policy Area 1: Bolster Capacity to Identify Familiar Faces

1.A. Develop state level guidance to standardize and streamline information-sharing that local system partners can opt to implement.

- Standardized definitions across state agencies for serious mental illness and
- Fund a pilot to test and scale local implementation

1.B. Implement validated behavioral health screening in jails.

- Provide pilot funding for jails to implement validated housing stability and behavioral health screening
- Support Georgia Sheriffs' Association and local sheriffs in expanding use of best practice behavioral health screening in jail credentialling and standards

Policy Area 2: Improve Community Response to Familiar Faces

Policy Area 2: Improve Community Response to Familiar Faces

2.A. Expand access to crisis and other resources

- Fund a small number of county-based, dedicated coordinator positions to build collaboration between criminal justice and behavioral health partners, and to work with co-responder protocol committees under SB 403.
- Support for DBHDD to conduct / contract for analysis of need for non-crisis beds for Familiar Faces: short-term housing/diversion options; Psychiatric Respite Centers, etc.

2.B. Reduce wait times for state hospital beds and competency evaluation/restoration services

- Empower a task force to address long wait times for competency evaluation and restoration services in Georgia.

Policy Area 3: Expand Access to High-Quality Care and Supports

Policy Area 3: Expand Access to High-Quality Care and Supports

3.A. Expand jail in-reach services in Georgia

- Build local capacity with competitive funding and technical assistance for a few diverse counties to create or expand collaborative jail in-reach and reentry programs
- Increase funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) case managers, pilot program in jails

Policy Area 3: Expand Access to High-Quality Care and Supports

Recommendation 3.B. Increase housing access and availability for Familiar Faces

- Establish Tenant Selection Plans through DCA that do not create criminal record-related barriers to housing unrelated to fitness as a tenant, similar to North Carolina and Louisiana
- Assess feasibility of housing set-asides for the Familiar Faces population, inventory current DCA programs (e.g., HOME-ARP and the Housing Choice Voucher program)
- Increase supportive housing development for Familiar Faces by establishing incentives through DCS in the 2024 LIHTC Qualified Allocation Plan (QAP), such as implementation of a supportive housing set-aside.
- Seed a Landlord Incentive Fund with federal funding to be matched with private funds and allocated regionally, to recruit more landlords to serve this population (e.g., leasing incentive payments and risk mitigation funds)

Policy Area 3: Expand Access to High-Quality Care and Supports

3.C. Address behavioral health workforce shortages

- Endorse the recommendations of the Workforce and Systems Development Subcommittee, including consistency in credentialing standards for managed care organizations in Georgia

3.D. Strengthen Georgia's Peer Support Specialist capacity.

- Add peer members to Behavioral Health Innovation and Reform Commission and authorize it to lead a comprehensive, multi-year plan to further expand the number of forensic peer support specialists

Policy Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in Georgia

Policy Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in GA

4.A. Assist counties working with Familiar Faces

- Establish a statewide public-private partnership to be a clearinghouse for best practices, information, and resources that support developing and sustaining practices for Familiar Faces: data collection, use, and sharing; diversion; community-based services
- Draw on expertise and administrative capacity of a designated state agency, university system, and/or other entity

Thank You!

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For more information, please contact Marilyn Leake at mleake@csg.org or Amy Button at abutton@csg.org

The presentation was developed by members of The Council of State Governments Justice Center staff. The statements made reflect the views of the authors, and should not be considered the official position of The Council of State Governments Justice Center, the members of The Council of State Governments, or the funding agency supporting the work.

Appendix: Key Contributing Stakeholders

Subject Matter Experts and Stakeholders Who Contributed to Dvelopment of Policy Recommendations

Key Stakeholders: Policy Area 1- Bolster Capacity to Identify Familiar Faces

- 10 county teams
- Association of County Commissioners of Georgia
- Department of Behavioral Health and Developmental Disabilities
- Georgia Sheriffs' Association
- Office of Georgia Governor Brian P. Kemp
- Chair, Workforce and Systems Development Subcommittee
- Strong support from the Familiar Faces Advisory Committee

Key Stakeholders: Policy Area 2 Improving Community Response to Familiar Faces

- 8 county teams
- Department of Behavioral Health and Developmental Disabilities
- Advisory committee/county coalition members with subject matter expertise

Key Stakeholders: Policy Area 3 – Expanding Access to High-Quality Care and Supports

- 10 county teams
- Atlanta Legal Aid
- Department of Behavioral Health and Developmental Disabilities
- Department of Community Affairs
- Dr. Sam Tsemberis, Pathways Housing First Institute
- Georgia Association of Community Service Boards
- Georgia Supportive Housing Association
- Peer listening session
- Workforce and Development Subcommittee
- Housing advocates

Key Stakeholders: Policy Area 4 – Cross-Systems Knowledge Sharing in Georgia About Familiar Faces

- 10 county teams
- Association of County Commissioners of Georgia
- Georgia Sheriffs' Association
- Georgia Association of Community Service Boards
- Advisory Committee subject matter experts

Georgia Behavioral Health Reform and Innovation Commission

Appendix H: Subcommittee on Workforce and System Development

APPENDIX H: SUBCOMMITTEE ON WORKFORCE AND SYSTEMS DEVELOPMENT

Subcommittee on Workforce and Systems Development

The Workforce and Systems Development Subcommittee was created to explore the workforce shortages that impact delivery of care. This subcommittee was chaired by Representative Mary Margaret Oliver in 2022.

Included in this appendix are the recommendations compiled by the subcommittee. These recommendations were presented to the BHRIC during its meeting on November 16, 2022, at the capitol. These recommendations align with those included in the commission's 2022 Annual Report. Additional information on these recommendations can be found in the meeting packet from the November meeting (pages 357-390).

Subcommittee Members

Rep. Mary Margaret Oliver (Chair)
Renee Johnson
Dr. Nicoleta Serban
Wayne Senfeld
Cindy Levi
Michael Polacek
Polly McKinney
Sallie Coke

Summary of 2022 Activities

July 7, 2022 - Student Cancellable Loans and Behavioral Health Data Surveys by Professionals

Polly McKinney- Voices for Georgia's Children

Chet Bhasin- Georgia Board of Healthcare Workforce

The agenda and witnesses at the July 7, 2022, focused on Section 2-2 of HB 1013 relating to the creation of a Behavioral Care Workforce Data Base for the purpose of collection and analyzing minimum data set survey of the behavioral health care professionals, and Section 2-1 that creates additional types of service cancelable educational loans.

Witnesses for the Subcommittee agenda included for the tasks relating to the data surveys ----from Voices, and Chet Bhasin, the newly appointed Executive Director of the Georgia Board of Health Care Workforce-----described his initial contacts with the licensing boards directed to collect data from behavioral health care provides, and his timetable for compliance with HB 1013. The specific types of survey information required to be collected and the purposes were discussed. For Section 2-1 of HB 1013 creating new cancelable education loans, there have been discussions and questions ongoing on when the loans administered by the Georgia Student Finance Commission might be granted for eligible students and how to define underserved or geographic areas under 20-3-374(b)(3). These questions require clarification.

September 15, 2022 - Data Sharing Among State Agencies, Data Sharing Platforms, and SB 374

Elizabeth Holcomb, Legal Counsel for the Office of Health Strategy and Coordination (OHSC)

Kanti Chalasani, Director of Georgia Data Analytic Center (GDAC)

The Subcommittee heard from Dr. Kanti Chasalasani, Director of the Georgia Data Analytic Center (GDAC) and Elizabeth Holcomb, Legal Counsel for the Office of Heath Strategy and Coordination, and her research paper on Compilation of Data Sharing Issues and Research. Ms. Holcomb's paper surveyed the efforts of other states to share data by either legislation, Executive Order, or Memoranda of Understanding (MOUs).

In addition, the Subcommittee reviewed SB 374, legislation introduced and passed in the Georgia Senate in 2022, but not passed by both Chambers, that incorporated some of the ideas to enforce data sharing described in Ms. Holcomb's paper. The subcommittee Chair has talked with the Senate sponsor of SB 374, Senator Blake Tillery, about the specific elements of his legislation, and also conferred with Ms. Holcomb on our anticipated proposal to reintroduce data sharing legislation in the 2023 General Assembly Session.

October 27, 2022 - Issues of Licensure, Credentialing, and Certification that Create Unnecessary Obstacles

Melissa Haberlen-DeWolf, Research and Policy Director, Voices for Georgia's Children

Lesley Kelley, Senior Policy Analyst, Voices for Georgia's Children

Carol Caraballo, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)

Judge David Sweat

Leslie Austin, Provider Enrollment Manager, Georgia Department of Community Health (DCH)

Brig Zimmerman, Executive Director, Georgia Composite Board of Professional Social Workers and Marriage & Family Therapists, Secretary of State's Office

Anita Brown, Georgia Psychological Association

Dr. Shannon Mullins, Georgia Psychological Association

Dr. Stephen Livingston, Association of Marriage and Family Therapists

Gail Macke, Executive Director, Georgia Licensed Professional Counselors

The Subcommittee solicited from a variety of Behavioral Health professional recommendations for changes to the Secretary of State Office of Georgia Composite Board of Professional Counselors. A specific review of SB 403 relating to co-responder programs was discussed to determine whether any amendments are necessary to facilitate or clarify the status of mental health providers who are part of a co-responder team.

Recommendations

1. **Loan Repayment Assistance Program for Mental Health and Substance Use Disorder Professionals**

HB 1013 called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals, which will be administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students which can later be repaid through service once they are licensed and practicing in the field. Based on the subcommittees review of other states programs and related workforce data and it would be worthwhile for Georgia to incentivize its current workforce to practice in mental health professional shortage areas through a loan repayment assistance program for individuals who are no longer students but actively practicing in the workforce as a licensed mental health or substance use professional.

Participants in the program would receive loan repayment assistance that is conditioned on five consecutive years of service in a facility with a Health Professional Shortage Area (HPSA) designation that serves the Medicaid and PeachCare for Kids population. This loan repayment program would be administered of the Georgia Board of Healthcare Workforce. The concept of a loan repayment program has been discussed previously with HB 1013, but new language is necessary to ensure such loan assistance can be offered to licensed professionals in addition to the service cancelable loan program available to eligible students.

The Workforce and Systems Development Subcommittee recommends the establishment of loan repayment assistance programs for individuals who are practicing as a license mental health or

substance use professional, conditional on five consecutive years of services in a facility with a HPSA designation that serves both Medicaid and Peachcare for Kids.

2. Data Sharing

Several states have recognized the important role data can play in enhancing delivery of services and improving overall efficiencies by establishing frameworks for an overarching system and policies for data sharing between agencies and "interagency data sharing" – any exchange of data between or among two or more state agencies. The legal framework of information sharing is an important piece of responsible data sharing that sometimes translates into barriers, but other states have had success in balancing privacy laws and optimizing data exchanges, effecting a cultural shift in attitudes around interagency data sharing. In Georgia, there is no uniform statewide process or system by which interagency data sharing occurs, nor is there a statewide protocol for agencies to submit requests for data from another agency or coordinating entity.

The Georgia Data Analytic Center (GDAC) created by HB 197 in 2019 has established an integrated data system with the authority to seek out data from state agencies to further research and inform policy decisions to support the health, safety, and security of Georgia citizens. There was legislation introduced by Senator Tillery in 2022, SB 374, which would have removed some barriers to data sharing by making GDAC an agent of all executive state agencies for sharing government information and an authorized receiver of government information.

The Workforce and Systems Development Subcommittee recommends revisiting SB 374 this session with enhancements that serve to further empower GDAC by designating it as the entity responsible for facilitating and overseeing data sharing between state agencies, and the central data repository for the state from which data can be released to requesting agencies.

3. Increase Psychiatric Residency Programs

Georgia has a mental health workforce shortage. The low number of psychiatrists in Georgia is a large contributing factor to access issues. Georgia has fewer psychiatric residency programs than neighboring states and data suggests that psychiatrists are more likely to practice in the state where their residency training is located. The Workforce and Systems Development Subcommittee recommends a pathway to increase residency programs in the state, and funding pathways that serve promising.

4. Behavioral Health Workforce Study

Understanding gaps and challenges among the existing behavioral health workforce will allow for targeted solutions to address shortages impacting Georgians most in need of behavioral health care. Studying salaries of the public behavioral health workforce, including DBHDD providers and the Community Service Board workforce, will help the state better understand recruitment and retention challenges among these professionals.

The Workforce and Systems Development Subcommittee Recommends Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complete a study on current wages of behavioral health providers at all levels, including recommendations on how to increase wages for providers. HB 1013 required a study of reimbursement rates for mental health services. This workforce

wages study would be a next step to ensuring behavioral health practitioners in the state are compensated fairly.

5. Increasing Medicaid Reimbursement Rates as findings in the DCH Reimbursement Rate Study Indicate

Department of Community Health (DCH) is slated to complete their reimbursement rate study by December 31, 2022, to compare Georgia's reimbursement rates to other states. It is anticipated that this report will show similar results to the Accenture Report that noted that Georgia has some of the lowest reimbursement rates in the country.[1] The Workforce and Systems Development Subcommittee recommends an increase of Medicaid reimbursement rates as the DCH reimbursement rate study indicates.

6. Examine Issues of Internships, Practicum Requirements, and Supervision for Service Providers

There are several challenges to granting behavioral health licensure in Georgia. First, there has been approximately an 80% increase in applications from 2017 to 2022; however, the number of Board members to review applications has not increased to meet this growing demand. There are three members from each licensing association on the Georgia Composite Board of Professional Social Workers and Marriage & Family Therapists who review applications, and two of the three members are required to review and approve each application. Board membership is a volunteer position, and members are spending approximately 10-12 hours per week reviewing applications and complaints. Additionally, Georgia's application requirements are generally more stringent than those of other states. Adjusting these requirements would streamline the application and approval processes.

For example, there are unique challenges to obtaining a Marriage and Family Therapist (MFT) license in Georgia. The application process is complicated and has not been updated in over 25 years. The application is over 17 pages and needs to be completed on paper. The Association of Marriage and Family Therapists has recommended that the application be shortened and simplified and transitioned to an online process. Additionally, as noted above, there are currently too few staff reviewing applications – more reviewers are needed to accommodate a growing workforce. Moreover, there are currently greater direct clinical and supervision hour requirements to obtain MFT licensure in Georgia relative to neighboring states.

The Workforce and Systems Development Subcommittee recommends examining the issues that service providers face for completion of internships, practicum requirements and supervision and create a pathway to overcome these issues.

7. Enhancing Opportunities for Foreign Trained Behavioral Health Professionals

The state of Georgia is continuing to increase in ethnic and racial diversity, which also increases the need for culturally competent and equitable health services/providers. Furthermore, Georgia's population has shown an exponential increase in foreign-born people who now reside in the state, contributing to 10% of Georgia's population. In addition to facing a behavioral health workforce shortage, fewer minority and foreign-born behavioral health providers are accessible and readily

[1] Accenture. (2021, December 2). *Mental Health Reform Action Plan.* Prepared by Accenture for the Georgia Governor's Office of Health Strategy and Coordination.

available to serve these communities. There is a need for Foreign Trained Behavioral Health Professionals, however, there are barriers that may impede this process. Other states have reduced these barriers through temporary licensure, the creation of task force, and pathways for Foreign Trained Behavioral Health Professionals for making licensure easier to navigate, obtain, and use. Other activities that may support this work include establishing culturally competent divisions within state agencies such as DBHDD, creating incentive programs, implementing National CLAS Standards, improving coordination between agencies and programs, and culturally-responsive crisis services.

The Workforce and Systems Development Subcommittee Recommends changes to Georgia's licensing practices to reflect cultural competencies, and create a pathway for foreign trained behavioral health professionals to establish a license in Georgia.