MENTAL HEALTH REFORM ACTION PLAN

GEORGIA GOVERNOR'S OFFICE OF HEALTH STRATEGY AND COORDINATION (OHSC)

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Prepared by accenture

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1. REPORT INTRODUCTION

1.1 BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

Over the past twenty months, as we faced the COVID-19 pandemic together, Georgians have become acutely aware of their own mental health, as well as that of their family, friends and neighbors, coworkers, and community. As a result of that awareness and the increased need for services that it brings, the mental health service landscape across Georgia is challenged.

From a lack of mental health service personnel to an inadequate number of treatment facilities, the State of Georgia is in a position that many, including those in elected and appointed leadership, recognize needs improvement. Correctional facilities have become the top mental health service provider.[1] More than 60% of Georgians who need treatment for their mental illnesses are deprived of that treatment because they simply cannot find the care: with only 236 treatment facilities across the State, and an estimated 360,000 citizens who need care, simply finding an affordable nearby location with capacity is a challenge.[2]

Georgia has 77 counties who do not have dedicated full-time psychiatrists. Moreover, with only 53% of psychiatrists accepting Medicaid, the lack of access transcends lines on a map and includes one's ability to pay for the services.[3] For these and other reasons, Mental Health America ranks Georgia 51st in the United States for access to mental health care.[4]

In response to these challenges, the Georgia General Assembly created, and Governor Kemp signed into law, the Behavioral Health Reform and Innovation Commission (BHRIC). Through the collaborative work of five subcommittees, this Commission has submitted an initial set of key recommendations for change to Georgia's mental health system.

In October 2021, Accenture was contracted to evaluate these recommendations and, in turn, to develop an action plan for the Office of Health Strategy and Coordination, part of the Governor's Office of Planning and Budget.

Specifically, we were asked to:

1. Prioritize the order of implementation for BHRIC's recommendations;
2. Determine the best route for implementation (i.e., via legislative codification, executive action, or both);
3. Indicate which recommendations implicated an appropriation and, if so, estimate the amount of that appropriation, whether it would have to be annualized, and under which agency's budget it would fall;
4. List other considerations that the General Assembly or Executive agencies should note during implementation; and
5. Note who should be responsible for, accountable for, consulted on, and informed of the execution of these recommendations to ensure that the desired outcomes are achieved.

To answer these questions in preparation for the upcoming legislative session, Accenture engaged with the State for six weeks. Section 2 of this report describes our approach. Section 3 details our findings and recommendations.

[1] To read the full article regarding the mental health service providers in GA and specifically Cobb county: https://www.axios.com/local/atlanta/2021/11/17/georgia-cobb-jail-mental-health-care-detainees?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axioslocal_atlanta&stream=top
[2] Substance Abuse and Mental Health Services Administration (SAMHSA) 2019 National Mental Health Services Survey: https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2019-data-mental-health-treatment-facilities
[3] Attachment O-GS Workforce and System Development_10.26.20, p.11
[4] Attachment P-The State of Mental Health in America, p.13

Of note, our original process was to be a simple look at the BHRIC recommendations. During the course of our work, though, we saw the need for additional and in-depth conversations with Executive agency heads, leadership, and professionals, as well as members of the Commission itself. We take into account their thorough and detailed feedback and, at the conclusion of this report, use that feedback to outline a series of next steps for the Office of Health Strategy and Coordination to consider.

At the outset of our report, though, we want to acknowledge what we learned from our conversations and research. We used these as our guiding principles as we considered how to present the Commission's various calls for action.

1. Some challenges are fully understood by all and at the most intrinsic level:
    a. Access to care is a crippling issue across Georgia, no matter the reason.
    b. In particular, the Departments of Juvenile Justice and Families and Children are "points of last resort" when families simply surrender their children to the State because they cannot get them adequate care.
    c. The criminal justice system needs more options and flexibility in how it handles cases involving persons with mental illness.
    d. Access issues often mean that people with mental health issues are treated in the most expensive and least appropriate places, i.e., emergency rooms or jails.
    e. Timely medical attention during a mental crisis is imperative and often a determining factor in ultimate success in treatment.

2. Some challenges complicate, if not exacerbate, other ones:
    a. If residential bed capacity is increased, who will service them? Workforce is clearly a known issue, but no cohesive strategy exists on how we might recruit and then remunerate a strong pipeline of professionals.
    b. Proactive preventative mental health care can often lessen the need for repeat care. However, preventative care is most acutely needed in local jails, which generally have expensive or inaccessible care.
    c. Because Georgia's reimbursement rates are some of the lowest in the country, patients from neighboring states come here for care, reducing the number of residential beds and mental health services that are available to Georgians.

3. Some challenges are less understood, in part because of poor measurement:
    a. Agencies repeatedly bemoaned a lack of transparent and available data on the most basic of metrics – how long Georgians wait for care, what it looks like by zip code or census tract, how it varies by type of illness, how comorbidities impact treatment and outcome, etc.
    b. Social determinants of health – including access to transportation, childcare, or technology – clearly impact mental health, but the quantification of that impact is incomplete.

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In short, we heard repeatedly that Georgia's mental health system is less of a coordinated system and more of a loose confederation of state and local agencies and partners, often using different processes and technologies. A system necessarily implies coordination, connection, and defined and measurable outcomes. Here, though, service provision is often disjointed and disparate, which can lead to ineffective outcomes.

When taken in concert with the BHRIC report, our conversations with multiple agencies and Commission leadership yielded one central theme: **Georgia needs a centralized mental health system, designed to serve its residents with appropriate care when and where they need it.**

Though it was outside our initial scope, we provide in Appendix 1 a series of questions and guiding principles to consider as Georgia's leaders contemplate how best to reform and/or redesign the system.

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Finally, both momentum for and capacity to enact meaningful reform are significant. State leaders could and should capitalize on it.

- COVID-19 has made more people more aware of mental health.
- A National 988 Mental Health Crisis hotline will be implemented across the country in July of 2022. This will both improve access to mental health services and help to facilitate a needed conversation regarding mental health service provision.
- The Coronavirus Relief Fund (CRF) and American Rescue Plan Act (ARPA) provide federal funding for key areas of concern related to mental health. This presents a major opportunity for states to strategically address key needs with the support of federal funding.
- Immense societal and technological changes will only aggravate the need.

1.2 COMMENTARY ON TERMINOLOGY

In acknowledgement of the existing industry conversations related to mental health and behavioral health services, this report will refer to mental health challenges and mental illnesses broadly as "mental health."

The relevant service needs that fall under the Department of Behavioral Health and Developmental Disabilities, Department of Juvenile Justice, the Georgia Department of Corrections, and other related agencies will be referred to as mental health services rather than behavioral health services. While the current term behavioral health encompasses the behaviors that impact an individual's well-being, mental health specifically addresses the individual's psychological state of being. Most recommendations provided relate specifically to mental health challenges. Substance use disorders will be similarly categorized.

2. PROJECT INTRODUCTION

2.1 REVIEW AND ANALYSIS OF BHRIC YEAR ONE REPORT

Following the publication of the Behavioral Health Reform and Innovation Commission (BHRIC) First Year Report in January 2021, the Governor's Office of Health Strategy and Coordination (OHSC) and Accenture collaborated to charter a path forward based on the recommendations found in the 26-page report. Over the course of six weeks, the team reviewed the Year One Report recommendations, analyzed the level of effort, next steps for implementation (including ownership for ultimate execution), and developed and sequenced the recommendations. We augmented our own work through conversations with Commission members and key State agency leadership and personnel.

This implementation action plan will identify key policy and budgetary focus areas for the upcoming legislative session, provide a recommended path forward, and note important considerations for the State as it moves forward.

2.2 INTERVIEWS WITH SUBCOMMITTEE CHAIRPERSONS

To gather a clear understanding of the recommendations, the Accenture team coordinated with the chairpersons of the five subcommittees in addition to its chair, the Honorable Kevin Tanner. In each of the meetings Accenture posed questions to the subcommittee heads to gain clarity on the intention behind and anticipated next steps for each recommendation. These interviews allowed the subcommittee chairs to provide additional context, update information or considerations, and suggestions or adjustments for steps to implement. Throughout the course of two weeks, we spoke with:

- **Dr. Brenda Fitzgerald** - Hospitals and Short-Term Care
- **Ms. Gwen Skinner** - Workforce and Systems
- **Judge Brian Amero** - Involuntary Commitment
- **Justice Michael Boggs** - Mental Health Courts and Corrections
- **Dr. Sarah Vinson** - Child and Adolescent Behavioral Health

Our report takes into consideration each chairperson's suggested course of action.

2.3 INTERVIEWS WITH RELATED AGENCIES

We also engaged in a series of conversations with the Executive agencies that will ultimately be responsible for implementation of any legislative or executive action. Agency personnel were given the opportunity for candid feedback, including the addition of historical context, potential challenges to implementation, and budget estimates.

- Department of Behavioral Health and Developmental Disabilities
- Department of Community Health
- Department of Public Health
- Department of Juvenile Justice
- Department of Community Supervision
- Department of Human Services-Department of Family and Children Services
- Department of Operations and Administrative Services
- Criminal Justice Coordinating Council
- Community Service Boards *(meeting not completed at time of report publication)*
- Georgia Student Finance Commission
- Office of Insurance and Safety Fire Commissioner
- Georgia Department of Corrections

2.4 ACTION PLAN DEVELOPMENT

With a goal of operationalizing the recommendations from the BHRIC Year One Report, the Accenture team held interviews to understand key considerations, upstream and downstream influences, and relevant context for the various recommendations. To arrive at this plan, we considered the following:

- Anticipated timeframes for recommendation execution
  - Initial action: addressable actions for prioritization in 2022
  - Future action: needs that require further investment to understand, and/or intentional consideration for sustainable, continuous improvement in Georgia
- Anticipated action required
  - Legislative
  - Executive
  - Budget
- Anticipated appropriation and budgetary impact (if applicable)
- Key stakeholders
  - State agencies
  - Related organizations
  - Boards or other entities

3. INITIAL ACTION

Our analysis sought to identify the initial actions the State of Georgia could take to address the needs identified by the Commission, agency personnel we interviewed, and supplemental research we conducted. The recommendations were divided into categories based on the type of action required (i.e., legislative change, executive action, and/or budget/appropriations requests) and then prioritized based on their potential impact, level of difficulty to achieve, and time sensitivity. The items listed below have been identified as addressable through legislative or budget action in the upcoming 2022 session of the General Assembly, including in the AFY22 or FY23 budgets, or through executive action in the coming year. Information regarding needed budget allocations are in red font.

3.1 2022 LEGISLATIVE PRIORITIZATION[5]

This section prioritizes legislative action during the 2022 Session of the General Assembly. The recommendations that carry budget implications are noted (specific budget details and an explanation of how they were derived can be found in Section 3.3 below). We also include additional context or pertinent commentary provided by agencies or subcommittee chairs.

L1. Remove requirements that a tragic outcome be "imminent" before an individual in crisis can qualify for civil commitment for mental illness[6]

- *Georgia is one of only seven states as of September 2020 that has not removed "imminent" language within their laws for civil commitment.[7] This update will move Georgia to the country-wide standard, which enables more timely intervention and treatment to individuals experiencing a psychiatric crisis, reducing the "consequences of non-treatment on them, their families and their communities."[8]*
- *Note: this action, as well as actions named in L2 and L3, relate to civil commitment laws for Georgians experiencing a psychiatric crisis. The goal of this update is to provide a more timely treatment for individuals experiencing severe mental illness (SMI), which is currently 5-6% of Georgia's population[9]. While 1013 forms are available, the process can be prohibitive to timely medical intervention.[10] This delay contributes to the reality that individuals with SMIs are 5.1 times more likely to be incarcerated vs hospitalized[11]. This is both an expensive and inappropriate path to medical treatment for those with mental illness.*
- *Note: if enacted, this change will likely require additional resources in the future to satisfy increased demand for services. Furthermore, greater workforce development support will be needed to provide the requisite practitioners to treat the individuals. Though a potential increase in service demand will likely further strain the over-capacity service network, that should not prevent the legislature from improving access for mental health care through this mechanism. Access should be enabled where possible, and workforce capacity will be separately addressed to adjust for the existing demand across the State.*

[5] We number these priorities and actions independent of how BHRIC numbered its recommendations. Some recommendations come directly from the BHRIC report, and we cite accordingly; others come from our conversations throughout this work. Our recommendations for legislative action start with the letter "L." Recommendations for executive action start with the letter "E." Our recommendations for budgetary action start with the letter "B."
[6] See Georgia BHRIC Year One Report (BHRIC Report), p.17
[7] Attachment Q: State Standards for Civil Commitment, p. 15
[8] Treatment Advocacy Center's Georgia Statistics as of 2017 https://www.treatmentadvocacycenter.org/browse-by-state/georgia
[9] National Institute of Mental Health Prevalence Statistics: https://www.nimh.nih.gov/health/statistics/mental-illness#part_2541
[10] Attachment N: 2019_ICJE Orders to Apprehend
[11] Attachment R: More Mentally Ill Persons Are in Jails and Prisons Than Hospitals, p.10

Section 4 of this report addresses the needs related to workforce and service provision shortage with short-term, mid-term, and long-term approaches.

L2. Allow psychiatric deterioration as a basis for inpatient commitment[12]

- *Note: according to the BHRIC Year One Report, individuals experiencing "psychiatric deterioration" are defined as, "those who are powerless due to lack of insight (ability to recognize their own illness and need for treatment) to volunteer for care and protect their minds from harm that could be irreparable in the absence of timely medical aid."[13] Recommended legislative language can be found on Page 18 of the report.*

L3. Allow peace officers to transport persons in a mental health crisis to a psychiatric evaluation without evidence of a penal offense[14]

- *Note: For individuals experiencing psychiatric crisis, the police are often called to respond when symptoms are being exhibited that cause concern to an observer. Often it is clear to the officer that the individual needs medical care but based on current law they are not able to transport the individual to an emergency receiving facility unless a penal offense is committed. The officer is unable to intervene to unless and until the individual commits a penal offense, resulting in delay of care and risk of psychiatric deterioration, as well as a risk to public safety depending on symptoms exhibited.*

L4. Permit the expenditure of fees collected for the Drug Abuse Treatment and Education Fund to be expended to support mental health court divisions where they exist[15]

- *Note: the Drug Abuse Treatment and Education Fund is a statutory program funded by the collection of fees imposed on individuals charged with certain crimes. In every case in which a court imposes a fine for offenses related to certain activities regarding marijuana, controlled substances, and noncontrolled substances, there is imposed an additional penalty that is equal to 50 percent of the original fine. That money is collected by the clerk or court officer charged with the duty of collecting moneys arising from fines and forfeited bonds and is to be paid over to the governing authority of the county in which the court is located upon receipt of the fine and assessment if paid in full at the time of sentencing or upon receipt of the final payment if the fine is paid in installments. The money is then placed in the "County Drug Abuse Treatment and Education Fund." Currently, those funds can be expended by the governing authority of the county solely and exclusively: 1) for drug abuse treatment and education programs relating to controlled substances, alcohol, and marijuana; 2) for purposes of the "drug court division," if one has been established in the county; 3) for the purposes of the "operating under the influence court division," if one has been established in the county; and, 4) for the purposes of the "family treatment court division," if one has been established in the county. This legislative change would simply add the above potential use to this list as the fifth allowable use of the funds.*

L5. Create and promote a loan forgiveness/repayment program for behavioral health professionals[16]

- The estimated FY23 appropriation to implement this recommendation is: TBD *(additional information on this budget request can be found at item B7 in Section 3.3 below)*

[12] *BHRIC Report, p. 17.*
[13] *Ibid.*
[14] *Id.,* p. 18
[15] *Id.*, p. 19
[16] *Id.,* pp. 13 & 24

- *Important Consideration: If this new loan program is established, there are critical details that should be addressed in the legislation or by the regulatory authority granted to the administering agency (the Georgia Student Finance Commission), including:*
  - ***i.*** *What list of behavioral health occupations will be covered by the program?*
  - ***ii.*** *Will the program be prospective, meaning only available to newly-enrolled students who begin their training after the grant is enacted, who would commit to a term of service at the time of applying for the loan ("pre-qualified service cancelable loans")? Or would it be available to currently enrolled students or recent graduates as well to incentivize work in the field in high-need areas?*
  - ***iii.*** *What's the required term of service to qualify for the program benefits?*
  - ***iv.*** *Will the program prioritize service in high need areas, such as rural and/or socioeconomically distressed parts of the state?*
  - ***v.*** *Will the program only be available to graduates of training programs in the state of Georgia? Or could out-of-state graduates who choose to work in the state qualify as well? If in-state only, will it only apply to public institutions?*
  - ***vi.*** *Note: the best approach when developing the new loan program may be to utilize the framework currently used for existing similar programs, such as the Georgia Physician Loan Repayment Program (GPLRP), Physicians for Rural Areas Assistance Program (PRAA), or Advanced Practice Registered Nurse Loan Repayment Program (APRNLRP).*

L6. Require minimum data set surveys (MDSS) for licensed behavioral health providers to help understand the workforce landscape and plan for solutions[17]

- *Note: MDSSs are intended to collect data from behavioral health providers during their annual certification or re-certification process to help understand the behavioral health workforce and plan for solutions. Depending on the clinical profession, it may be required to be completed every year or only every two years. The types of data to be collected, as to be determined by GBHCW and partners, could include: who is actively taking patients, or practicing, and where; do they have specialized training in treating children and adolescents; what proportion of their practice is children and adolescents; types of insurance accepted; certifications and specialties; telehealth offered; and retirement plans.*
- *Note: though some providers update their information with license renewal, many do not. Because it is not codified, the Georgia Board for Health Care Workforce (GBHCW) does not have the ability to collect data consistently across providers. Because of this, there is an inability to perform a meaningful assessment of workforce capacity. By requiring a minimum data set survey, Georgia enables visibility to the true workforce capacity for various mental health services. For example, there is currently no data to indicate if a provider serves multiple counties. Such data is especially important in rural areas where providers are both limited and difficult to retain.*
- *Important Consideration: this legislative change would require coordination by the Georgia Board for Health Care Workforce (GBHCW) with the Georgia Composite Medical Board (GCMB), Georgia Board of Nursing (GBON), the Georgia Department of Community Health (DCH), and any other relevant administrative entities responsible for the behavioral health workforce to complete the required actions if codified. GBHCW would work with these partners to determine which data points would be included. The surveys could be designed to avoid adding a time-consuming task to practitioners, by making them short Yes/No answer or short free response inputs. The MDSS would need to be collected separately by*

[17] *Id.,* pp. 7, 23, & 24

each governing entity; or alternatively, a single survey platform could be developed and utilized by all entities to streamline the collection and sorting of the survey data. Currently, this data is not collected for all occupations in the behavioral health workforce. Some occupations currently have the option to complete a survey; however, it is not required. This legislative proposal would codify a statutory mandate for all behavioral health workers to complete the survey during their licensing process, for which GBHCW was very supportive.

L7. Mandate DCH to include clear parity provisions in renewed Medicaid managed care contracts and require Care Management Organizations (CMOs) to submit complete parity compliance analyses and data to demonstrate compliance[18]

- *Note: in conversations with DCH, the representatives present did not express concern with or opposition to this recommendation's implementation. They stated that it would be re-stating what is already mandated by federal statute; however they would be happy to do so if that is what is preferred. They noted that some conversations regarding this potential change have involved adding independent review organizations to the process; if that is implemented, they stated that it would have budget implications and would have to be approved by the Centers for Medicare and Medicaid Services (CMS).*

L8. Mandate Georgia Office of Insurance and Safety Fire Commissioner (OCI) to perform annual data calls for parity compliance and produce an annual report with results[19]

- *Important Consideration: the BHRIC recommended mandating OCI to perform "regular market conduct exams"; however, OCI strongly believes that this would be problematic and that the public release of those exam results would be prohibited by existing state law that is required to be in place as part of OCI's charter. OCI instead recommend that a mandate be created for "annual data calls" accompanied by public reporting, as this process would provide the information the Commission is seeking without creating legal/reporting issues. Regular market conduct exams are very involved (akin to an IRS audit) and are currently only conducted when there is a suspected or alleged concern. They are staff intensive and produce a large amount of confidential information that could not be shared publicly. Data calls are not nearly as involved, but they would still produce adequate data to determine if parity issues exist that warrant more specific analysis into the areas of concern.*

L9. Mandate DCH and OCI to report annually on methodology used to ensure compliance with federal and state parity laws[20]

- *Note: neither agency with whom we spoke expressed concern with or opposition to this recommendation's implementation.*

L10. Establish and fund within the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) a multi-year grant program to foster the creation of new county-level Assisted Outpatient Treatment (AOT) programs across the state[21]

- *Note: AOT is court-ordered treatment (including medication) for individuals with severe mental illness who meet strict legal criteria, e.g., they have a history of medication noncompliance. Typically, violation of the court-ordered conditions can result in the individual being hospitalized for further treatment.*

[18] *Id.,* p. 4
[19] *Ibid*.
[20] *Ibid*.
[21] *Id.,* p. 16

- The estimated FY23 appropriation to implement this recommendation is: $4,500,000 *(additional information on this budget request can be found at item B8 in Section 3.3 below)*

3.2 2022 EXECUTIVE ACTIONS

The following section prioritizes executive actions for the upcoming calendar year (including executive orders and agency directives). The recommendations with budget implications are noted (specific budget details and an explanation of how they were derived can be found in Section 3.3 below). Additional context or pertinent commentary provided by agencies or subcommittee chairs is also provided, where necessary.

E1. AGENCY DIRECTIVE: Direct the Georgia Department of Behavioral Health and Developmental Disabilities (DHBDD) to implement the following:

a. Increase the number of Certified Peer Specialists (CPSs), adult and youth/parent and forensic specialists.[22]

i. Note: CPSs provide interventions which promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are individual motivated, initiated and/or managed, and assist individuals in living as independently as possible.

ii. Note: all stakeholders engaged were supportive of increasing the number of available CPSs.

iii. The estimated FY23 appropriation to implement this recommendation is: $5,629,391.67 *(additional information on this budget request can be found at item B9 in Section 3.3 below)*

b. Work with the Georgia Department of Corrections (GDC), DJJ, and other relevant stakeholders to agree on the use of a standard definition of "Serious Mental Illness" (SMI) and/or "Serious and Persistent Mental Illness" (SPMI) to ensure access to services is consistent, there is a common metric for measuring prevalence rates, and changes can be tracked over time.[23]

i. Note: based on conversations with the involved agencies, there does not appear to be too large of a disconnect here. All agencies claimed to use standard definitions for SMI or SPMI. However, a coordinated conversation between the agencies could help alleviate any existing confusion. Each agency expressed that they have no flexibility when it comes to definitions that are used for eligibility purposes for federal programs. Additionally, consideration should be given to the fact that the SPMI definition that DBHDD uses is set by the DOJ Settlement Agreement; there are issues in connecting those in GDC or DCS custody to DBHDD services because DBHDD requires an independent diagnosis by a physician and GDC and DCS often use self-attestation. The existing issues identified by the BHRIC may not be related to the definitions being utilized, but instead due to who makes the determination. Nonetheless, synchronization and agreement among the involved agencies could be useful in terms of data collection and reporting.

[22] *Id.*, p. 12
[23] *Id.*, p. 19

c. Develop a universal consent form in English and Spanish and an electronic process for sending/receiving consent forms via the electronic Georgia Crisis and Access Line (GCAL) platform.[24]

i. Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.

E2. AGENCY DIRECTIVE: Direct the Georgia Department of Community Health (DCH), in coordination with DBHDD and other key stakeholders, to work to submit a State Plan Amendment (SPA) for the current Georgia Medicaid State Plan to the Centers for Medicare and Medicaid Services (CMS) for review and approval to implement the following changes:

a. Allow Licensed Marriage and Family Therapists (LMFTs) and Certified Licensed Professional Counselors (LPCs) to become independent providers.[25]

i. Note: according to DCH, this change is already in the works in GAMMIS and will be live for enrollment on 1/1/2022; however, it would be helpful to state this publicly so that the Commission can know that their recommendation has been addressed.

b. Allow Psychiatric Mental Health Nurse Practitioners (PMHNPs) to practice to the full extent of their training and grant full prescriptive authority.[26]

i. Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.

c. Allow Psychiatric Mental Health Nurse Practitioners (PMHNPs) in psychiatric residential treatment facilities to lead treatment team meetings without the presence of a psychiatrist or physician.[27]

i. Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.

d. Suspend rather than discontinue youth Medicaid benefits upon admission to a secure juvenile facility.[28]

i. Important Consideration: DJJ recommends continuing with annual reviews and redeterminations during the youth's incarceration. For youth who become ineligible during incarceration, assure that application is made prior to the youth's discharge within a sufficient time period to allow coverage to be in place at the time of discharge, or as soon as possible thereafter.

e. Extend parity of extended Medicaid coverage that is in place for youth aging out of the custody of the Georgia Division of Family & Children Services (DFCS) to youth 18-21 who are discharging from the Georgia Department of Juvenile Justice (DJJ) secure facilities.[29]

i. Note: this recommendation was put forth by DJJ as an extension of the broader recommendation proposed by the BHRIC on page 21. DJJ strongly urges implementation.

[24] *Id.,* pp. 6 & 7
[25] *Id.,* p. 8
[26] *Id.,* p. 12
[27] *Ibid*.
[28] *Id.,* p. 21, and Attachment G: DJJ_BH Recommendations
[29] BHRIC Report, p. 21, and Attachment G: DJJ_BH Recommendations

f. Add justice involved youth to the definition of "eligible youth" as authorized in the At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act).[30]

i. Note: Section 1001 of the SUPPORT Act section 1902(nn) defines "eligible juvenile" for purposes of section 1902(a)(84) of the Act. An eligible juvenile is defined as an individual who is under 21 years of age, or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (referred to as the mandatory eligibility group for former foster care children) who was determined eligible for Medicaid before becoming an inmate of a public institution or who is determined eligible for Medicaid while an inmate of a public institution.

ii. Note: this recommendation was put forth by DJJ as an extension of the broader recommendation proposed by the BHRIC on page 21. DJJ strongly urges implementation.

E3. AGENCY DIRECTIVE: Direct the Georgia Department of Community Affairs (DCA), in coordination with GDC, DJJ, the Georgia Sherriff's Association, and the Georgia Association of Chiefs of Police, to establish a standardized process and reporting system for increased screening upon admission to jail for mental illnesses, substance use disorders, and homelessness in order to collect and track more accurate and reliable data regarding these issues for the individuals incarcerated around the state.[31]

- *Important Consideration: in cooperation with the Georgia Crime Information Center, DCA currently compiles and publishes a Monthly Jail Report for the Georgia Sheriff's Association and the Association County Commissioners of Georgia. As an extension of that effort, DCA should explore how to standardize the collecting and reporting of the above data points at all correctional facilities across the state and include it in the monthly report that is currently compiled. This effort could include the creation of a centralized reporting platform where all correctional facilities could be required to report monthly on the requested data points. Given the potentially broad nature of this request, it is likely the first year will involve planning and strategy efforts among the involved organizations, with potential legislative, executive, or budget implications next year.*
- *Note: we did not have the opportunity to consult with DCA regarding this recommendation's implementation. DCA was identified later in the review process after several other agencies recommended they be the lead agency given their existing Monthly Jail Report.*

E4. AGENCY DIRECTIVE: Direct OCI to establish a landing page on their website for consumers to easily understand parity requirements and file complaints for violations, and establish a process for publicly reporting how consumer complaints were addressed.[32]

- *Note: the OCI representative with whom we spoke did not express concern with or opposition to this recommendation's implementation. An existing complaint portal exists on their agency website that they said could be updated to satisfy the recommendation.*

E5. AGENCY DIRECTIVE: Direct the Georgia Composite Medical Board, in consultation with the BHRIC and other relevant boards and agencies, to determine the need and appropriateness of preferred training topics/curriculum and the development of tracking and training calendars across agencies with administrative authority over clinicians and practitioners.[33]

[30] *Ibid*.
[31] BHRIC Report, p. 19
[32] *Id.*, p. 4
[33] *Id.,* p. 13

- *Note: the BHRIC highlighted the existing issue related to the multiple different oversight agencies and boards with administrative authority over the behavioral health workforce often scheduling conflicting and/or similar trainings. This issue has caused frustration among practitioners and can create an undue burden. All the agencies consulted suggested the Georgia Composite Medical Board was the best entity to consult with the other relevant entities to coordinate these trainings and to develop a shared training calendar to help avoid duplication or scheduling conflicts. We did not have the opportunity to consult with the Georgia Composite Medical Board regarding this recommendation's implementation.*

E6. EXECUTIVE ORDER: Direct DOAS, in partnership with OHSC, to create a statewide behavioral/mental health training to better inform State employees about general behavioral health, trauma-informed care, and the resources available to assist them if needed.[34]

- The estimated FY23 appropriation to implement this recommendation is: $13,440.00 *(additional information on this budget request can be found at item B15 in Section 3.3 below)*
- *Important Consideration: DOAS expressed several challenges and considerations to be addressed prior to the statewide training being developed. The agency's feedback is provided in the document that can be found at Attachment H: DOAS_HRA Training Challenges.*

E7. EXECUTIVE ORDER: Supporting the criminal justice system as it relates to behavioral health reform and innovation. To further support reform, authorize the following actions to be implemented:

a. Creation of a new grant administered by Criminal Justice Coordinating Council (CJCC) for increased crisis intervention training for local law enforcement personnel[35]

i. The estimated FY23 appropriation to implement this recommendation is: TBD *(additional information on this budget request can be found at item B13 in Section 3.3 below)*

ii. Important Consideration: for this grant, CJCC should consider including post-credit certification for officers who participate in the training to incentivize and reward officers to complete.

iii. Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.

b. Creation of a new grant administered by CJCC for inmate mental health transfers for 1013/2013 transports, including overtime comp, shift coverage, and vehicle maintenance[36]

i. The estimated FY23 appropriation to implement this recommendation is: TBD *(additional information on this budget request can be found at item B14 in Section 3.3 below)*

ii. Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.

[34] *Id.,* p. 3 and Attachment H: DOAS_HRA Training Challenges
[35] BHRIC Report, p. 20
[36] *Ibid.*

c. **Creation of a new grant administered by CJCC to provide supplemental funding to counties to permit the expansion of existing or new contracts with medical care providers to pay for mental health and substance use disorder treatment to individuals in correctional facilities, including increased funding for psychotropic medication costs to Sheriff's departments**[37]
   i. The estimated FY23 appropriation to implement this recommendation is: TBD *(additional information on this budget request can be found at item B15 in Section 3.3 below)*
   ii. *Important Consideration: for each of these newly created grants, CJCC will need to coordinate with relevant stakeholders (GDC, DHBDD, the Council of Accountability Court Judges (CACJ), Community Service Boards (CSBs), Georgia Sherriff's Association, Georgia Association of Chiefs of Police, Georgia Public Safety Training Center, etc.) to develop appropriate guidelines, requirements, and strategic mandates for proper and effective implementation. These grants could be used to strategically direct the desired outcomes at the local/county level as it relates to best practices for behavioral health within the criminal justice system. CJCC will also need to develop strategies and processes for proper administration, management, and oversight of the grant funds once they are dispersed.*
   iii. *Note: the agency representatives with whom we spoke did not express concern with or opposition to this recommendation's implementation.*

d. **Directive to all relevant state agencies to remove language in any of their policies, or reform any of their processes, as they relate to excluding youth who are in the custody of DJJ from accessing behavioral health services for any of the following reasons: having been diagnosed as having "Conduct Disorder" or "Oppositional Defiant Disorder;" having a dual diagnosis of a behavioral health disorder and a developmental disability; or for having legal charges against them. Furthermore, all state agencies should monitor contracted providers to assure that no youth who qualifies for services is being excluded solely on the basis of any of these classifications.**[38]
   i. *Currently, existing policies and operational processes cause many of these youth to be excluded from/denied access to services, even though the qualify for those services otherwise.*
   ii. *Note: we did not have the opportunity to consult with all of the affected agencies regarding this recommendation's implementation. This recommendation was put forth by DJJ as an extension of the broader recommendation proposed by the BHRIC on page 21. DJJ strongly urges implementation.*

e. **Directive that youth released from restrictive custody or residential placement with any prior psychiatric hospitalizations (e.g., PRTF, 1013) be automatically referred to Intensive Case Management services, known as IC3 services, to ensure successful coordination for youth and families who have multi-systems involvement upon re-entry to the community.**[39]

[37] *Ibid*.
[38] BHRIC Report, p. 21, and Attachment G: DJJ_BH Recommendations
[39] *Ibid*.

i. *Note: DBHDD is currently working on expanding the IC3 network from two CSBs to four.*

E8. EXECUTIVE ORDER: Stating the importance of the Governor's Office of Health Strategy and Coordination (OHSC) and its central role in driving the reform and innovation efforts of the behavioral health system in the state. As part of that responsibility, OHSC would be tasked with the following actions over the next calendar year:

a. Direct OHSC, in partnership with the Georgia Data Analytics Center (GDAC) and the Behavioral Health Coordinating Council (BHCC), to evaluate the ability to share mental health data across agencies.[40] This effort should also include:

i. Working with the relevant agency(s) to develop and issue state guidance, tools, and templates to facilitate sharing information across the behavioral health and criminal justice systems.[41] The engaged agencies should include, but not be limited to: DBHDD, DCH, the Georgia Department of Public Health (DPH), the Georgia Department of Human Services (DHS), DJJ, GDC; and,

ii. Determining the best methodology for collecting and reporting relevant data across the respective state boards and agencies that oversee the behavioral health professional workforce and establishing processes for implementation.[42] This effort should be conducted in collaboration with the Georgia Board of Healthcare Workforce (GBHCW) and the Georgia Board of Nursing (GBON);

b. Direct OHSC, in partnership with DCH, to explore a unified Medicaid formulary to decrease wasteful spending and administrative hurdles; evaluate best practices for community health service reimbursement to improve access to care across the state[43]; and, explore having state plans, including Medicaid, cover integrated care billing codes[44];

i. *Note: the Ohio Department of Medicaid implemented a Unified Preferred Drug List (UPDL) on January 1st, 2020 that encompasses the entire Medicaid population regardless of enrollment in Managed Care or Fee for Service (FFS). ODM pharmacy staff and leaders from the Managed Care Plans collaborated together in clinical, technical, and communications-based workgroups to help ensure a smooth transition.[45]According to the Ohio Department of Medicaid, the benefits experienced by this change include: reducing the administrative burden for providers by streamlining the prior authorization process across FFS and managed care; consolidating six preferred drug lists into one; facilitating coordination of care for approximately three million covered Medicaid lives; and, minimizing member movement between the Ohio Medicaid Managed Care Plans.*

ii. *Note: when consulting with representatives from DCH, they remained agnostic toward the merit of the recommendation as a whole; however, they said they would be happy to engage in a discussion to explore the potential change. They said a number of factors would have to be considered regarding how it would be*

[40] BHRIC Report, p. 20
[41] *Id.,* p. 19
[42] *Id.,* p. 13
[43] *Id.*, p. 23
[44] *Id.,* p. 25
[45] pharmacy.medicaid.ohio.gov/unified-pdl

structured, including the potential implications around flexibility and competition within the system.

c. Direct OHSC, in partnership with GBHCW, to examine salary disparities between medical and behavioral health practitioners across the state and make recommendations for parity improvements[46];

i. Note: some previous work has been conducted by OPB in this area. It is possible that this effort could be a continuation or extension of what has already been started or completed at OPB. GBHCW was consulted on this recommendation, and they stated that they did not believe it fell within their scope of work to complete; however, they are happy to assist and consult in any way needed. This item was assigned to OHSC instead of BHRIC because it involves efforts that require dedicated staff time as opposed to facilitated discussion among stakeholders. OHSC is better positioned to accomplish that, in conjunction with other partners and/or contractors.

d. Direct OHSC to promote the new statewide telehealth contract for the expansion of access to behavioral health services across the state.[47] These efforts should include:

i. Partnering with the Georgia Department of Administrative Services (DOAS) and DPH to promote the newly awarded statewide telehealth contract to all eligible agencies and entities;

ii. Partnering with DPH's Office of Telemedicine to promote communication and knowledge sharing among relevant agencies regarding telehealth best practices;

iii. Partnering with DBHDD, DPH, and the Georgia Department of Education (GaDOE) to promote statewide telehealth parity for schools to expand and support behavioral health services; and,

E9. EXECUTIVE ORDER: Recognizing the importance and impact of the BHRIC thus far, acknowledging the influence of the first year's report on the policy and budgetary priorities, and requesting the Commission focus its 2022 agenda on:

a. A comprehensive review of prior commissions and establish strategies for implementation;[48]

b. In coordination with DBHDD, DJJ, DPH, DCH, and any other relevant stakeholders, explore targeted and specific strategies for expanding the capacity of residential programming beds for youth across the state;[49]

i. Important Consideration: this effort should include a review of the proposed Crisis Respite Program proposed by DBHDD as outlined in Attachment D: DBHDD_Crisis Respite Program, an evaluation of the challenges currently experienced by DJJ and DFCS with getting their youth placed in care in a timely manner, the potential of having DJJ and DFCS contract directly with vendors for behavior health services for their youth, the suggested "level system" of care to simplify provision of services as outlined in Attachment G: DJJ_BH

[46] BHRIC Report, p. 13
[47] *Id.,* p. 5
[48] *Id.,* p. 12
[49] *Id.,* pp. 6, 7, & 21, Attachment D: DBHDD_Crisis Respite Program, and Attachment G: DJJ_BH Recommendations

Recommendations, and the challenges outlined by DPH regarding youth with developmental disabilities who struggle to get access to residential programming despite being eligible for Medicaid.

c. In coordination with DCH, DBHDD, and the Georgia Office of Insurance and Safety Fire Commissioner (OCI), explore how other states address parity and whether such solutions might be applicable in Georgia;[50]

d. In coordination with the DCH, DBHDD, DHS' Division of Family and Children Services (DFCS), the Georgia Collaborative Administrative Services Organization, private insurers, Children's Healthcare of Atlanta (CHOA), Care Management Organizations (CMOs), acute psychiatric hospitals, and Crisis Stabilization Units (CSUs), explore how to best support the needs of children who are high utilizers of crisis care;[51]

e. In coordination with DBHDD, the Georgia Department of Community Supervision (DCS), and the Community Service Boards (CSBs), evaluate the need for continuity of care and a seamless collaboration with local CSB and behavioral health providers for treatment and housing, to include impediments and solutions to shorten the wait-time for individuals referred for services;[52]

i. Note: this appears to be already happening with GDC facilities; however, this effort should include a discussion regarding how to better implement best practices within county correctional facilities.

f. In coordination with GBHCW, GBON, the Statewide Area Health Education Center (AHEC) Office, and other relevant stakeholders, explore the opportunities and need for targeted training program support to feed the pipeline of clinicians and improve graduate retention, as well as ways to create more accessible and cost-effective supervisory opportunities for new graduates;[53]

i. Note: conversations with stakeholders revealed that one of the major challenges in this area involves out-of-state private training providers paying large sums for access to the limited supervisory opportunities within the state; consequently, many of the graduates of in-state programs are pushed out of those opportunities or forced to pay large sums in order to access them. Therefore, this effort should involve a comprehensive analysis of the existing problems creating challenges for graduates and an evaluation of potential ways to solve the problems (e.g., subsidizing the payment needed to access the supervisory slots).

g. In coordination with DCH, DHBDD, and OCI, evaluate the impact to workforce expansion management of the providers network if private practitioners are allowed to bill Medicaid Fee-for-Service;[54]

[50] BHRIC Report, p. 4
[51] *Id.,* p. 6
[52] *Id.,* p. 21
[53] *Id.,* p. 24
[54] *Id.,* p. 13

h. In partnership with GDC, DCS, and the CACJ, evaluate the viability of expanding integrated treatment within GDC facilities for those offenders with mental health dual diagnoses;[55]

i. In partnership with the Behavioral Heath Coordinating Council (BHCC), evaluate the expansion of mental health wrap-around services and the connectivity to local mental health resources across the state;[56]

j. In partnership with GDC, DBHDD, CJCC, the Georgia Sherriff's Association, Georgia Association of Chiefs of Police, Georgia Public Safety Training Center, develop strategies for strategic expansion of the pilot co-responder model where trained mental health professionals are teamed with (or available to assist) law enforcement officers in mental health related emergency calls;[57]

i. Important Consideration: the first year of work will likely be spent analyzing the best approach for expanding the pilot to the best-suited areas of the state. This should include a thorough analysis of the existing pilot programs to determine what was successful and what should be improved with the model prior to expansion. That effort could lead to legislative and/or budget changes in future years. This effort should also include a broader review of relevant policies and suggestions of changes to support crisis response instead of traditional/sole law enforcement response.[58]

ii. Note: Attachment E: DBHDD_Co-Responder Pilot provides an overview of the programming and budget included in the eight-county pilot program underway. This information should be consulted when developing the pilot expansion plan.

k. In partnership with GDC and DBHDD, evaluate the viability of a long-term acute care psychiatric facility for Level VI inmates requiring one-to-one oversight/intensive treatment;[59]

l. In partnership with DBHDD, evaluate the viability and impact of a child and adolescent access phone consultation program to provide on-going support for primary care providers in the provision of children's mental health services;[60]and,

i. Important Consideration: the first year of work will be spent analyzing the need, feasibility, and best route of execution for this plan. That analysis should include a consideration for any needed legislative and or budget requests for future years to support or enable the full implementation.

m. In partnership with the Georgia Rural Health Innovation Center and Mercer Rural Health Innovation Center, identify needed ECHO topics, create innovative ECHOs to bridge existing gaps, and explore the viability of creating a communication channel to promote existing ECHOs to providers and SMEs and determine how it would best be operated and managed;[61]

[55] *Id.,* p. 20
[56] *Ibid*.
[57] *Ibid*. and Attachment E: DBHDD_Co-Responder Pilot Program
[58] BHRIC Report, p. 19
[59] *Id.*, p. 20
[60] *Id.,* p. 25
[61] *Id.,* p. 5

i. *Note: Project ECHO (Extension for Community Healthcare Outcomes) was founded by Dr. Sanjeev Arora at the University of New Mexico. ECHO's mission is to disseminate knowledge and amplify the capacity to provide best-practice care to broad geographic areas. The program facilitates virtual clinics, linking specialists with care providers in local communities through videoconferencing. Participants become part of a learning community where they receive mentoring and feedback from specialists as they manage complex patient cases.*

3.3 BUDGET IMPLICATIONS

The following section outlines the recommendations that involve budget requests. The list includes the legislative and executive actions from sections 3.1 and 3.2 that have budget implications, as well as any standalone recommendations that are strictly budget related. The appropriation amounts listed below were solicited directly from the impacted agency(s) or derived by Accenture using information provided by key stakeholders. For the items listed as "TBD," estimations from the tagged agencies are still pending, or in some cases, the identified agency is uncertain how to accurately estimate the proper allocation request.

B1. Funding for one (1) new Treatment Fidelity Monitor (TFM) position[62]

- *Note: State Standards require that accountability courts deliver evidence-based treatment curricula to program participants. CACJ has created a process to monitor fidelity to evidence-based treatment models to ensure that participants are receiving effective interventions and education. The TFM conducts trainings and site visits and provides targeted feedback to improve treatment delivery.*
- Type of Funding: Annualized
- Recipient: Council of Accountability Court Judges (CACJ)
- FY23 Amount: $83,945

B2. Funding for a dedicated CACJ position to provide technical assistance to 169 courts to interpret the per/court data analysis reports to support policy and procedure changes[63]

- Type of Funding: Annualized
- Recipient: Council of Accountability Court Judges (CACJ)
- FY23 Amount: $122,250
  i. *Note: this line item was included in CACJ's budget submitted to the House.*

B3. Funding for gender-specific trauma treatment modalities and 22 curriculum court trainings for judges and mental health court professionals (Moral Reconation Therapy (MRT) Trauma and Trauma Recovery and Empowerment Model (TREM))[64]

- *Note: Moral Reconation Therapy (MRT) is a cognitive-behavioral treatment program for substance abuse and offender populations. MRT is a cognitive-behavioral treatment system that leads to enhanced moral reasoning, better decision making, and more appropriate behavior. Over 200 published outcome studies have documented that MRT-treated offenders show significantly lower recidivism for periods as long as 20 years after treatment. Trauma Recovery and Empowerment Model (TREM) is a fully manualized 24- to 29-session group intervention for women who survived trauma and have substance use and/or mental health conditions. This model draws on cognitive behavioral, skills training,*

[62] *Id.*, p. 19
[63] *Ibid.*
[64] *Ibid.*

and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse.

- Type of Funding: One-Time & Annualized
- Recipient: Council of Accountability Court Judges (CACJ)
- FY23 Amount: $222,500 (One-Time); $97,800 (Annualized)
    i. *Note: a request for funding to support this effort was submitted by CACJ in their ARPA funds request. A full breakdown of this funding request can be found in Attachment S: CACJ Funding Request*

B4. Funding to facilitate implementation of gender-specific trauma treatment in accountability courts[65]

- *Note: gender-specific trauma treatments are drug and alcohol addiction programs designed for women and men separately. These programs address the many fundamental differences men and women have when dealing with substance and alcohol abuse. Some of those differences include rates of dependence, choice of substance, brain response to substance, rate of exposure, ability to break down alcohol, or speed of addiction progression. This new funding would allow the accountability courts serving the mental health and/or co-occurring population to provide this type of programming.*
- Type of Funding: Annualized
- Recipient: Council of Accountability Court Judges (CACJ)
- FY23 Amount: $1,682,837
    i. *Note: a request for funding to support this effort was submitted by CACJ in their ARPA funds request. A full breakdown of this funding request can be found in Attachment S: CACJ Funding Request*

B5. Funding to support the Crisis Stabilization Units (CSUs) to have an on-call physician after hours to review pending patients[66]

- *Note: Crisis Stabilization Units (CSU) are small inpatient facilities of less than 16 beds for people in a mental health crisis whose needs cannot be met safely in residential service settings. CSUs try to stabilize the person and get him or her back into the community quickly.*
- *Important Consideration: just before report submission, we received the following feedback from DBHDD: "While we of course always support more funding for CSUs and anything that boosts the workforce, we're not sure about this particular solution. CSUs already are required to have access to an MD; if the MD is not available on-site, they are available by phone." It is their understanding that this recommendation came from one hospital but wasn't identified as a widespread issue. They believe more helpful support for the CSUs would be to provide support for the system as a whole by increasing the rates for the CSUs to help with retention of workforce (like MDs, Nurses, Clinicians), which is compromised in a way these days that results in about 10 percent of available beds being offline due to workforce shortages each day; or, to modernize CSUs into the Behavioral Health Crisis Center model, which does have a more robust staffing model and an on-site pharmacy. With this in mind, OHSC should potentially reconsider advancing this recommendation and should instead consult with the BHRIC and DBHDD on pursuing one of the alternatives mentioned above.*
- Type of Funding: Annualized

[65] *Ibid.*
[66] *Id.,* p. 6

- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: TBD

B6. Supplemental funding to increase availability of Forensic Peer Mentors (FPMs) for offenders preparing for release[67]

- *Note: FPMs currently work in several Georgia Department of Corrections (GDC) and Georgia Department of Community Supervision (DCS) facilities and the Family Reunification, Education, and Empowerment (FREE) Program at Metro to assist identified adults receiving psychiatric inpatient care, or receiving psychiatric care within a correctional facility, with their transition back into community living.*
- Type of Funding: Annualized
- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: $1,036,050
  i. *A detailed plan for increasing the FPM program can be found in Attachment B: DBHDD_FPM Expansion.*

B7. Funding to make needed improvements/upgrades to the Georgia Crisis and Access Line (GCAL) system[68]

- *Note: GCAL provides telephonic crisis intervention, clinical triage, and referral for Georgians in need 24/7/365.*
- Type of Funding: One-Time
- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: $302,505.15
  i. *A detailed breakdown of the planned GCAL upgrades included in this request can be found in Attachment C: DBHDD_GCAL Improvements. Please note, the attachment explains that additional funding will likely be needed in the near future to support the mandated 988 additions that are currently being rolled out.*

B8. Supplemental funding to restore Apex programs and school-based health centers budget to the pre-cut funding level[69]

- *Note: the Georgia Apex Program strives to build capacity and increase access to mental health services for school-aged youth, Pre-Kindergarten to 12th grade, throughout the state. The program promotes collaboration between community mental health providers and schools to provide school-based services and supports, including training for school staff, in hopes of facilitating the right care at the right time for children, young adults, and families.*
- Type of Funding: Annualized
- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: additional $5,855,446, bringing total program annual allocation to $18,000,000
  i. *A detailed explanation of previous allocations for the APEX programs and the justification for this request can be found in Attachment I: DBHDD_Apex Funding.*

***B9. (Connected to L5)* Create and promote a loan forgiveness/repayment program for behavioral health professionals[70]**

[67] *Id.*, p. 20
[68] *Id.*, pp. 6-7
[69] *Id.*, p. 25
[70] *Id.*, pp. 13 & 24

- Type of Funding: Annualized
- Recipient: Georgia Student Finance Commission (GSFC)
- FY23 Amount: TBD

B10. (Connected to L10) **Establish and fund within DBHDD a multi-year grant program to foster the creation of new county-level Assisted Outpatient Treatment (AOT) programs across the state[71]**

- *Note: AOT is court-ordered treatment (including medication) for individuals with severe mental illness who meet strict legal criteria, e.g., they have a history of medication noncompliance. Typically, violation of the court-ordered conditions can result in the individual being hospitalized for further treatment.*
- Type of Funding: Annualized
- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: $4,500,000
  i. *This amount was derived using the current funding for the existing pilot program with two CSBs over four years ($1.46MM). The pilot has revealed that additional funding is needed to support the programs to allow for hiring staff on the judicial side to aid the AOT efforts. An estimated amount of $3MM was developed to provide this additional support, or roughly $1.5MM per CSB. Therefore, a $4.5MM allocation would allow for the expansion to 3 additional CSBs each year. The funding details provided by DBHDD can be found in Attachment A: DBHDD_AOT Expansion.*

B11. *(Connected to E1.a)* DHBDD shall increase the number of Certified Peer Specialists (CPSs), adult and youth/parent and forensic specialists[72]

- *Note: CPSs provide interventions which promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, are individual motivated, initiated and/or managed, and assist individuals in living as independently as possible.*
- Type of Funding: One-Time & Annualized
- Recipient: Department of Behavioral Health and Developmental Disabilities (DBHDD)
- FY23 Amount: $2,860,950.17 (One-Time); $2,768,441.50 (Annualized)
  i. A detailed budget spreadsheet for this request was provided by DBHDD and can be found in Attachment F: DBHDD_Capacity Increase Budget.

B12. *(Connected to E6)* Direct DOAS, in partnership with OHSC, to create a statewide behavioral/mental health training to better inform State employees about general behavioral health, trauma-informed care, and the resources available to assist them if needed[73]

- Type of Funding: Annualized
- Recipient: Georgia Department of Administrative Services (DOAS)
- Consulted: Resilient Georgia
- FY23 Amount: $13,440.00

B13. *(Connected to E7.a)* New grant administered by CJCC for increased Crisis Intervention Training (CIT) for local law enforcement personnel[74]

- *Note: CIT is designed to train law enforcement personnel to effectively assist individuals with mental illness and other brain disorders who are in crisis, therefore advancing public safety and reducing the stigma commonly associated with mental illness. The training also*

[71] *Id.,* pp. 16
[72] *Id.*, p. 12
[73] *Id.,* p. 3
[74] *Id.,* p. 20

aims to ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases.

- Type of Funding: Annualized
- Recipient: Criminal Justice Coordinating Council (CJCC)
- FY23 Amount: $3,000,000
    i. *Note: The Georgia Public Safety Training Center stated that the cost per officer for CIT is $392.75. This allocation would allow roughly 7,600 law enforcement officers to be trained each year. If Georgia has approximately 26,551 sworn police officers (according to the 2008 Census of State and Local Law Enforcement Agencies), that would allow nearly all officers to have access to the training in 3.5-4 years. At that point, the annual allocation could likely be reduced to only cover the costs of newly hired officers. If the budget allows, the initial allocation could be higher to expand immediate access to existing officers. It would take nearly $10,500,000 to sufficiently cover all 26,551.*

B14. ***(Connected to E7.b)*** **New grant administered by CJCC for inmate mental health transfers for 1013/2013 transports, including overtime comp, shift coverage, and vehicle maintenance[75]**

- Type of Funding: Annualized
- Recipient: Criminal Justice Coordinating Council (CJCC)
- FY23 Amount: $700,000 to $1,250,000
    i. *Note: Attachment T - 2021 MH Transport Costs for Sheriffs outlines the data provided by the Georgia Sheriffs' Association. Please note, this data only represents 76 counties that provided information. Therefore, the range in allocations represents the potential to cover roughly those counties, or the larger allocation could help potentially cover all 159 counties.*

B15. ***(Connected to E7.c)*** **New grant administered by CJCC to provide supplemental funding to counties to permit the expansion of existing or new contracts with medical care providers to pay for mental health and substance use disorder treatment to individuals in correctional facilities, including increased funding for psychotropic medication costs to Sheriff's departments[76]**

- Type of Funding: Annualized
- Recipient: Criminal Justice Coordinating Council (CJCC)
- FY23 Amount: $10,000,000

    i. *Note: Attachment U - Jail Population Mental Health Data outlines the data provided by the Georgia Sheriff's Association. Please note, this data only represents the 13 counties that provided information. While there is no way to know exactly how much would be needed to cover all 159 counties that are applicable, the above recommendation is to provide at least some supplemental funding to the counties in need. Using the limited data to calculate for all 159 counties would result in an extremely large budget request. We believe this is a strong starting point, and future year allocations can be re-evaluated based on availability of funds and grantee responses after implementation.*

B16. Supplemental staff funding for CJCC to support increased bandwidth for administration of newly created grants administered by the entity

- Type of Funding: Annualized
- Recipient: Criminal Justice Coordinating Council (CJCC)
- FY23 Amount: $247,500

[75] *Ibid.*
[76] *Ibid.*

i. *Note: this amount was derived using information provided by the CJCC. It is difficult to fully determine the extent of needed staff improvements without knowing the final size of each of the new grant allocations and the number of grant recipients. However, it is estimated if all proposed grants are implemented, the CJCC would need approximately three (3) new staff members, which would cost approximately $82,500 each (for salary & benefits).*

4. ENABLING FUTURE ACTION

We reiterate the consistent theme that emerged during our report review, our conversations with agency leadership and other key stakeholders, and our time in preparing this action plan: **the State of Georgia needs a truly coordinated, connected behavioral health system**. And that need is critical.

To be certain, Georgia has extraordinarily dedicated professionals working in this field, caring for those who need mental health services and helping them, and their families navigate and find care. However, because service provision in Georgia is fragmented and difficult to navigate, state and local agencies, service providers, and allied organizations act more as a loose confederation rather than an intentionally designed mental health system that is coordinated and effective.

To design a system for everyone in Georgia – whether it is a mother with postpartum depression, a middle schooler struggling with school and at home, an incarcerated person who allegedly committed a crime while suffering from mental illness, or just a regular citizen dealing with the trials and tribulations of everyday life – requires an immense amount of work and time. But the investment of that work and time – and the resources to match – is critical to both our present and future.

The recommendations detailed in Section 3 of this action plan are both necessary and timely. Collectively, if enacted, they will address many of the acute mental health challenges and needs faced by Georgians. But reform cannot stop there.

At the outset, we note a refrain we heard multiple times while preparing this plan: Georgia has seen its fair share of reports, agency efforts, legislative initiatives, and working groups in the past. The leaders of the BHRIC and of the agencies with whom we interacted, though, shared a common and explicitly stated goal: that their work would not result in just another report to sit on a shelf and gather dust.

For that to become reality, Georgia must approach mental health reform as more than a singular moment in time, more than an omnibus piece of legislation, more than one executive order, and more than line items in one year's budget. Instead, Georgia must plan for a logical, multi-year effort, solving some of the most critical access, quality, and affordability needs initially and then turning to the more nuanced issues.

We strongly recommend that approach.

Such an approach is **action-oriented**, allowing patients, families, caregivers, and policy leaders to see encouraging results and steady progress in the months ahead. Part of the frustration with reform is when people must wait years to see tangible progress. Quick wins are more than just a catchphrase; they demonstrate action and leadership. They create and sustain momentum. And they set the stage to tackle even greater obstacles.

Therefore, we recommend that, no matter the ultimate plan it adopts, the State should think about this as **a series of serial reforms over multiple years** that, taken together, reshape Georgia's mental health to be a national model for patient care and service delivery.

Finally, **that multiyear approach must be coordinated**. If the constant critique of the present system is true – i.e., it is not a unified, coordinated system across all agencies and with local partners – then the effort to reform it must not follow that same path. Put more succinctly, the State needs someone or a team whose sole job when they wake up in the morning is to advance reform in the mental health system.

One may naturally point to various leaders in relevant State agencies, but each of them already has a "day job" with significant responsibility. The likelihood of sustained, driven reform lessens without a team or a partner whose mission it is to do that and only that.

4.1 RECOMMENDED NEXT STEPS

We recommend the following next steps:

1. **A Fresh Start for the System: Redesign the State's mental health agencies and create a single, coordinated, true system that is centered on the patient.**

   This recommendation, while bold, is unsurprising given how many times this issue was raised during our 2020 work with the BHRIC and our 2021 work with the OHSC.

   We stress that this recommendation is explicitly action oriented. We are *not* recommending that the issue of redesign be merely studied. Instead, we advocate for the State conducting a current-state analysis and full organizational assessment – including of roles, responsibilities, office and reporting structures, budget and administration, technology, etc. – and launch changes directly from that report.

   When State agency personnel, members of the judiciary, and local partners repeatedly and consistently say that the current system is bureaucratic, difficult to navigate, antiquated in approach and technology, and not patient friendly, a band-aid approach is inadequate. The system needs to be designed in such a way to meet the needs of a 21st century Georgia, prioritizing patient care, technological advances, and policy approaches.

   To accomplish this, the State will need the following:
   - A clear, articulate, compelling mental health strategy that places the patient, not the government or the service provider, at the center;
   - A reliable, real-time, and accessible source of data that all stakeholders can access;
   - Transparent expectations and key performance indicators (KPIs) and a mechanism to hold people accountable to meet them;
   - A governance model that is easily understood and likewise holds people accountable;
   - An open communication system that fosters collaboration, accountability, and system improvement; and
   - Continued partnership with and involvement of all relevant stakeholders in the mental and behavioral health systems, including those in the educational and criminal justice systems.

   In a full system redesign, the State should strongly consider the need for a centralized approach to care, policy, and direction. To that end, any reform should clearly articulate the role of a lead agency that does the following:

   - Sets mental health strategy and policy initiatives for the State based on the existing challenges;
   - Identifies those challenges – whether new or existing ones that have changed in nature or still require attention – to delivering accessible, high-quality mental health care in the State;

- Outlines recommendations to address existing challenges based on leading practices, evidence-based approaches, and stakeholder input;
- Identifies resources needed to execute approved recommendations and provides an annual report to the Governor outlining legislative, budgetary, and executive action recommended for the upcoming legislative session; and,
- Coordinates efforts across multiple stakeholder groups in a consistent and longitudinal effort that transcends existing political influences.

To effectuate this recommendation, the State will have to appropriate an amount of money for the redesign and retooling effort, as well as likely partner with an outside organization to ensure that the process is thorough and fair and runs at an appropriate pace. However, the long-term return on this investment may be significant as an organization and a system is designed to be more effective, more efficient, and more patient-centered.

States such as Indiana, Ohio, and Michigan have established programs for wraparound services that can serve as leading practice models. These programs focus specifically on the high-risk, high-complexity population and design services to ensure the care needed is provided with specific consideration of continuity of care. When considering system redesign, focus should be placed first on the areas of greatest impact opportunity.

2. Data and KPIs: Identify, define, and measure key performance indicators indicative of successful provision of and access to mental health care.

One frequent critique of Georgia's present mental health landscape centers on around *data*. Data exists in various places and comes from various channels, but it is incomplete and, at times, difficult to share. Insufficient data makes it difficult both to set goals and then measure success against those goals. This must be rectified.

But the identification what data sources the State needs is directly correlated to how it measures success within the system.

In any effective system, key performance indicators are thoughtfully defined, measured, and regularly reviewed by accountable parties to measure the performance of the system against the defined objectives of the system.

To enable this in Georgia, the State must:

- Develop key performance indicators centered around thematic areas fundamental to mental health care[77];
- Identify essential underlying data used in KPI measurements; and
- Identify appropriate frequency of data collection and review relevant to each measurement.

Once KPIs and underlying data are identified, the State will need to perform a data inventory assessment that identifies and outlines:

- The existing data currently available to the State, indicating if the current data is both sufficient (i.e., collected consistently, with enough detail and at an appropriate frequency) and accessible (i.e., both secure and accessible at appropriate level of detail and in a usable format for both the State and relevant stakeholders); and

[77] Recommended KPI categories are listed in Appendix 1.

- Any required data currently unavailable to the State, indicating if data is currently not collected, or if it is collected but unavailable (i.e., unavailable because of security issues, the lack of a partnership agreement, an existing but unenforced agreement, etc.).

If data gaps are discovered, the State can then take steps to address them. In addition, this recommendation is complementary to the next. While many with whom we spoke advocate for technological improvements within the system, good data is paramount to doing so. The State needs a technological system that meets its needs, but it must first quantify those needs.

3. A Technology Overhaul: Improve the system through a technology assessment and new technology systems friendly to the patient, the provider, and the government.

Any modern-day mental health system consists of people, processes, and technology. Our first two recommendations consider both people and processes. This recommendation addresses technology.

Redesigning and reforming the system without doing the same for the platform that services it would create additional problems. The present system is ill-suited to a modern mental health care system.

At this juncture, our recommendation about any specific platform is agnostic. We believe that the technological system follows the organizational redesign, rather than vice-versa. This is both logical and ensures stewardship of taxpayer dollars. The redesign will determine what a platform needs to function at its best for everyone in the process, including partners in the educational and criminal justice systems.

To that end, the State should engage in a technological inventory of incumbent assets and case management systems, their functionalities, gaps and limitations, annual costs, ability to be customized, etc. Conducting this inventory now will save valuable time and allow the State to move more quickly into technological transformation after it redesigns the people and process side of the house.

4. Concurrently, empower the BHRIC to continue its work.

We stress that BHRIC service is voluntary. While all these professionals want to be a part of the Commission's work, most have demanding "day jobs." They serve as subject-matter experts but rarely have time to engage in the meaningful research, preparatory work, and drafting and follow-up work that turns their knowledge and passion into actionable items for the Governor and General Assembly to consider.

In Executive Recommendation 8, we suggested the next set of policy items that the Governor should direct and encourage the Commission to study. To supply both the executive and legislative branches with meaningful, substantive, and action-oriented recommendations for the 2023 Session and the AFY23 and FY24 budgets, the Commission needs professional assistance. We recommend OHSC staff the BRHIC with a dedicated project management partner.

5. Restructure and revitalize the objectives and authority of the Behavioral Health Coordinating Council (BHCC).

This recommendation, as put forward by Dr. Garry McGiboney, a BHRIC member and member of the Child and Adolescent Behavioral Health Subcommittee, would make the following changes to the BHCC:

- Expand the membership to add the:
  - Commissioner of the Georgia Department of Early Care and Learning (DECAL)
  - Commissioner of the Technical College System of Georgia (TCSG)
  - State Child Advocate
  - Behavioral health expert appointed by the Chancellor of the University System of Georgia (USG);
- Appoint an independent (meaning not from one of the member agencies) Governor-appointed Chair, to serve a four-year term; and,
- Revise the duties and responsibilities (as outlined in OCGA § 37-2-4) for the purpose of coordinating behavioral health services across all state agencies and to provide continuity of ongoing efforts to improve access to prevention, intervention, and treatment services.

We recommend that the State adopt those particular points in Dr. McGiboney's proposal. The full details of the recommendation may be found *in Attachment J: Garry McGiboney BH Recommendations*.

5. COUNCIL OF STATE GOVERNMENT (CSG) REPORT

CSG supported the Mental Health Courts and Corrections Subcommittee and the Involuntary Commitment Subcommittee throughout the duration of the project. The recommendations below represent specific, action-oriented initiatives that strengthen the foundation of providing services for individuals who interact with the criminal justice system. The full report presented on November 19th, 2021 during a joint subcommittee meeting is included in Attachment K, with highlights below.

5.1 RECOMMENDED NEXT STEPS

1. Participate in the States Supporting Familiar Faces Initiative.

The State should participate in an initiative facilitated by national experts to improve outcomes for people who have frequent contact with criminal justice, homeless, and behavioral health systems termed “familiar faces.” This initiative will address member-identified priorities, including:

- Improving data collection across mental health and criminal justice systems
- Expanding and improving comprehensive crisis systems, including non-law enforcement community responder models
- Expanding housing opportunities for people with mental health needs who have regular contact with the criminal justice system.

Note: This specific population of individuals with severe and persistent mental illness is the same focus area that the Department of Justice settlement agreement is focused on identifying and serving.

2. Advance co-responder programs across the State.

To increase access to pre-arrest diversion and improve connection to community-based services for people with behavioral health conditions who come in to contact with law enforcement, the State should implement a network of local co-response teams.

- To increase access to pre-arrest diversion and improve connection to community-based services for people with behavioral health conditions who come in to contact with law enforcement, the state shall implement a **network of local co-response teams**.
- Subject to the availability of funding, the state shall implement a minimum of 3 to 5 teams in local jurisdictions with the goal of implementing additional teams across the state.
- The development of this program will be overseen by the Mental Health Courts and Corrections Subcommittee in consultation with relevant law enforcement and mental health experts.

3. Continue Focus on Mental Health Caseloads.

The Mental Health Courts and Corrections Committee should continue its exploration of community supervision strategies for people with mental illnesses. This should include the charge to:

- Explore opportunities to expand equitable access to MH specialized caseloads to reach a larger share of the supervision population with MH needs.
- Qualitatively assess the quality of MH supervision and adherence to evidence-based standards to determine how MH supervision could be improved.
- Develop new approaches for officers to utilize non-arrest and non-custodial responses to technical violations for people with MH needs, especially since they appear no more likely to commit other crimes or violent crimes while on supervision.
- Assess the availability of mental health treatment providers by supervision district to estimate the access to treatment across the state.

4. Continue Focus on Mental Health Courts.

The subcommittee should understand budgetary needs for mental health courts so that these may be considered in the grant program, evaluating the following funding requests:

- Supportive housing for participants
- Additional funding to increase number and pay of case managers
- Additional funding to support treatment in rural communities with low census
- Funding for staff overtime for additional training.

APPENDIX 1: ADDITIONAL CONSIDERATIONS

A. QUESTIONS TO CONSIDER IN REFORM OR REDESIGN OF THE SYSTEM

1. What patient outcomes determine if mental health provision is sufficient in Georgia? What other outcomes should be considered in determining the effectiveness of service provision in Georgia? *Note: existing SAMHSA grants collect data related to specific programs and intervention methods, but additional analysis will be required to identify data collection specific to patient outcomes.*
2. What measurements indicate successful care provision? What do we measure to ensure outcomes are reached?
    a. Who determines related key performance indicators?
    b. Who measures related key performance indicators?
    c. How are these measurements collected across various system entities?
    d. How is data used to inform decision making for Georgia's leaders?
    e. Who monitors key performance indicators?
3. Who determines mental health policy for the State?
4. Who executes and monitors mental health policy across the State?
5. Who holds the mental health system – public and private - accountable for outcomes?

B. GUIDING PRINCIPLES FOR SYSTEM REDESIGN

1. Channels of communication and coordination between system entities
2. Prioritization of services for Georgians with the highest need
3. Incentivization for proactive, collaborative, and coordinated care
4. Prioritization of the patient – a human-centered view:
    a. Consider the patient by lifetime challenges and holistic success rather than separate interventions with service providers
    b. Support Georgians that they are in the best position to be their most successful self
5. Defined and measurable success criterion for patient outcomes
6. Clear lines of accountability when patient outcomes are not met
7. Systematic identification of and mechanisms to solve for barriers to access
    a. For example, leveraging and modeling remote mental health services, such as DPH's Home Visiting Program that exists for improving lives during pregnancy and early children & families (see Attachment M in Appendix 2).

C. RECOMMENDED GROUPINGS OF KEY PERFORMANCE INDICATORS

1. Risk Factors and Prevention – enables predictive analytics for future demand based on current-state realities (i.e. adverse childhood experiences, number of foster care placements, interactions with the criminal justice system, etc.). These risk factors vary based on life stage, and can be developed from the perspective of a patient – from birth to old age:
    a. Maternal and Infant Health
    b. Early Childhood and Education
    c. Adolescence and Early Adulthood
    d. Adulthood and beyond
2. Workforce and Professional Education – enables measurements of existing workforce capacity, as well as visibility to the workforce pipeline via professional education and career path development
3. Facilities and Service Providers – enables visibility of facilities that house service providers, as well as any exclusionary factors that act as barriers to service
4. Social Determinants of Health – enables visibility of non-health related factors that impact health outcomes for a given population, such as access to nutritious food and language and literacy
    a. Considerations of access to service can be housed in this categorization
5. Criminal Justice and Mental Health Courts – enables visibility of interactions between Georgians with mental illness and the criminal justice system
6. Coordinated Case Management – enables holistic, citizen-centric view of services for “frequent faces” of mental health services, foster care, the criminal justice system, public assistance, and other key groups to coordinate care for high-need and high-cost Georgians

APPENDIX 2: ATTACHMENTS

ATTACHMENT A: DBHDD_AOT EXPANSION

ATTACHMENT B: DBHDD_FPM EXPANSION

ATTACHMENT C: DBHDD_GCAL IMPROVEMENTS

ATTACHMENT D: DHBDD_CRISIS RESPITE PROGRAM

ATTACHMENT E: DBHDD_CO-RESPONDER PILOT PROGRAM

ATTACHMENT F: DBHDD_CAPACITY INCREASE BUDGET

ATTACHMENT G: DJJ_BH RECOMMENDATIONS

ATTACHMENT H: DOAS_HRA TRAINING CHALLENGES

ATTACHMENT I: DBHDD_APEX FUNDING

ATTACHMENT J: GARRY MCGIBONEY BH RECOMMENDATIONS

ATTACHMENT K: COUNCIL OF STATE GOVERNMENT (CSG) REPORT

ATTACHMENT L: GA SENATE_HOUSE STUDY COMMITTEE RECOMMENDATIONS 2013-2019

ATTACHMENT M: DPH GEORGIA HOME VISITING PROGRAM

ATTACHMENT N: 2019_ICJE ORDERS TO APPREHEND

ATTACHMENT O: GS WORKFORCE AND SYSTEM DEVELOPMENT_10.26.20

ATTACHMENT P: 2021 STATE OF MENTAL HEALTH IN AMERICA

ATTACHMENT Q: STATE STANDARDS FOR CIVIL COMMITMENT

ATTACHMENT R: MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS

ATTACHMENT S: CACJ FUNDING REQUEST

ATTACHMENT T: 2021 MH TRANSPORT COSTS FOR SHERIFFS

ATTACHMENT U: JAIL POPULATION MENTAL HEALTH DATA