Georgia's Mental Health Gap Analysis: Building an Action Agenda

Eleventh Annual Rosalynn Carter Georgia Mental Health Forum
May 19, 2006

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Opening Remarks

Rosalynn Carter
Chair, The Carter Center Mental Health Task Force

For a long time, there has been disagreement over the demand for mental health services in Georgia. Advocates statewide have been crying out for help, but legislators and policy-makers have been turning down requests for funding and services, citing inadequate proof of unmet needs.

In 2004, the Mental Health Planning and Advisory Council, which works with the state Division of Mental Health to plan how to use federal block grant funds, requested a "gap analysis" of the mental health delivery system that serves Georgia. APS Healthcare was contracted to conduct the Mental Health Gap Analysis and published its final report in 2005. The analysis examined seven key areas and found that: (1) Georgia's public mental health services reached less than one-third of those estimated to have a serious mental illness or a serious emotional disturbance; (2) community-based crisis services are woefully inadequate, and to fill the void, state hospitals are dramatically overutilized; and (3) there is a fragmented vision for an improved mental health system.

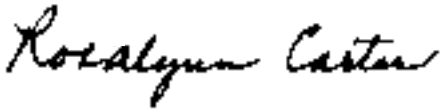
The planning committee for the 2006 Rosalynn Carter Georgia Mental Health Forum decided to publicize the report in an attempt to educate advocates about its contents and encourage its use to address a now-documented need for mental health services. This Georgia-specific tool is a useful complement to our arsenal of information that includes the U.S. Surgeon General's Report on Mental Health and the President's New Freedom Commission on Mental Health's report. Our objective today is to call attention to the inadequacy of Georgia's mental health services and to develop an advocacy agenda around three of the report's principal findings.

In order to provide different perspectives, two panelists will speak on each of the three topics. Then participants will meet in smaller working groups to develop their advocacy plans.

Please note about the second topic regarding hospitals: During the 2006 legislative session, a bill was introduced proposing the privatization of one of the state's public mental health hospitals. The legislation specified the company to receive the contract and that the term of contract be for 25 years. The bill was defeated, but the issue of privatization is sure to come up again in the future. Therefore, we are tailoring the panel presentation to address the privatization of hospitals.

And through the third topic, we hope to present our vision for a transformed mental health system for the citizens of our state.

The Georgia Mental Health Gap Analysis gives us a valuable instrument for advocating on behalf of people with mental illnesses and their families. Hopefully, we can reach consensus and speak with one voice on these issues. By working together, we can support each other and effect change for the better.



Child and Adolescent Mental Health in Georgia

Patrice Harris, M.D.
Medical Director
Fulton County Department of Mental Health, Developmental Disabilities and Addictive Diseases

What is the service need for child and adolescent mental health in Georgia? Our children are in crisis, and if our children are in crisis, we are in crisis. Nationally, 15-20 percent of all children suffer from a diagnosable mental or emotional behavior disorder. And we have 4.5 million youths aged 9 to 17 who have serious emotional disturbance (SED), so the numbers are astounding. Twenty percent of our children in the United States are served by Medicaid, and 55 percent of those are in managed Medicaid programs.

Currently, there are dozens of federal class-action lawsuits against state agencies for failure to meet the needs of our children. Mrs. Carter mentioned the wonderful report that APS Healthcare did, the Mental Health Gap Analysis. Approximately 160,000 children and adolescents in Georgia are diagnosed with a SED. The prevalence of youth under age 17 with a mental illness is 7.4 percent, and all these numbers probably are low, because sometimes people still are hesitant to talk about the fact that they or a family member has a mental illness or brain disorder. Also from the report, 23.8 percent are youth in need of receiving services.

We have some particular special populations of youth we need to focus on, and one is transitional youth. In private practice, some of the most heartbreaking stories I encounter are those children who turn 18, leave our public system, and have nowhere to go. There is no transition. We need to make sure in our planning that we take this particular population into account.

Certainly we know that children of color have elevated rates of mental illness. People of color are underserved and do not have the same access to services. Past data has shown that even when insurance coverage is taken into account, there are still barriers to access to care for people of color in general and children in particular.

Three hundred thousand children in Georgia are without health insurance.

Three hundred thousand children in Georgia are without health insurance. Some are covered by Medicaid. Even for the children who have private insurance, greater than one-half of the outpatient specialty mental health needs, or psychiatric needs, are out of plan. There are probably reasons for that, at least reasons that have surfaced in my practice.

One reason is that physicians are opting out of these plans. It is burdensome for physicians to be involved in some of these plans. Usually, physicians have to hire people to handle the paperwork and the preauthorization calls. For someone like me, in practice by myself, I cannot afford to do that. The other reason is stigma, which happens more with adults. I recently attended a meeting at which some legislators were concerned. They said, "You doctors are diagnosing these kids with attention deficit/hyperactivity disorder and putting them on Ritalin, and then they cannot get into the military." So you have some families deciding not to use their private insurance but to pay out of pocket to avoid stigma and future problems. Even when you have private health insurance, that still does not ensure you are going to get adequate care.

We can provide a full continuum of services if we partner.

I would like to present work from Dr. Andy Pumariega, who heads the American Academy of Child and Adolescent Psychiatry's work group on systems of care. Much of my data is from that group's work. It is not yet published, but you will be able to get it soon. From the academy's standpoint, this work is not "the answer," but it is a system of care that can be a foundation for many answers. Medication is not one-size-fits-all, and there is not one system that fits everyone. You must have a flexible system that can move and change quickly as new needs and issues arise.

What is the philosophy? It is a comprehensive array of services: individualized services, treatment planning, services in the least restrictive environment with families and consumers as full participants, and, underlying all of the issues, the recovery model. The recovery model is key. Actually, it is now so pervasive that we do not have to highlight it anymore – at least I hope it is. When I interview physicians in Fulton County, they have to define the recovery model, and I will tell you I do not hire those who do not understand it. But I will say we have to get away from that medical recovery model and the question of which one is right. The medical model was doctor-fix-the-patient. Symptoms got better and that was it. I say that is the first part of the recovery model. We get our patients better, so they can go on to fuller lives of work and play. These are some of the important areas of a community-based system of care.

We can provide a full continuum of services if we partner. We get into turf battles, and we all know that funding is shrinking, but it is going to take everyone stepping back and saying, "If you do this well, you can do this part, and I will do that part." The child and family are at the center of any framework of care we develop. This is a must – non-negotiable. We have to have multidisciplinary teams, case management,

flexible services, and dollars. And again, evidence-based interventions are very important.

In the past, we have not been able to prove a lot of things. Most of us have been going around saying, "I do it and it works for my

The therapeutic orientation is recovery and wraparound. We have the bio-psychosocial model, and the idea of individualization is key. One size does not fit all, and we have to look at the particular child and the family involved and see what works best for them. Culturally competent services also are non-negotiable. Families and consumers have to be at the center of our treatment, and they have to be involved in all levels of care. Through case management service provision and governance, we want to get them involved in political advocacy and research and evaluation as well.

patients," but there has really been no good evidence. We can no longer say that. We can say proudly that lots of research has gone on. We still need more – we are in our infancy – but we do have some data. There is data about in-home, therapeutic, and early childhood interventions. All of these services have shown to improve outcomes in the community. We know that medications and cognitive behavioral therapy have been shown to be particularly helpful with adults and children. We had studies for adults, but we did not have those same studies for children.

Some studies, including one in Ventura, Calif., and one in Vermont, have looked at systems of care and have done some evaluation. Some data showed reduced out-of-home placements, decreased juvenile justice recidivism, and decreased negative behaviors on the child behavior checklist. So we do have the data to show that when we use these evidence-based, community-based practices, we can have good outcomes regarding their symptoms, their increased level of functioning, improved strengths, improved family function, reduced level of out-of-home placement, improved school attendance, and significant system-of-care implementation.

Because many studies use middle-aged white adults and white children, more and more people understand that some of the interventions that may work with white children and families may not work with nonwhite children and families. Of course, we do not have to reinvent the wheel here in Georgia. Once we know that these programs are working, we can learn from them.

I want to speak briefly about psychopharmacology, my area of expertise. Medication is still controversial. As I said, I went to that legislative meeting, and they said, "You are putting these kids on Ritalin, and then they cannot get into the military." You know what? I was embarrassed that I did not know that. That is something you have to tell your families of young kids. So we want to educate more, and we want to be educated.

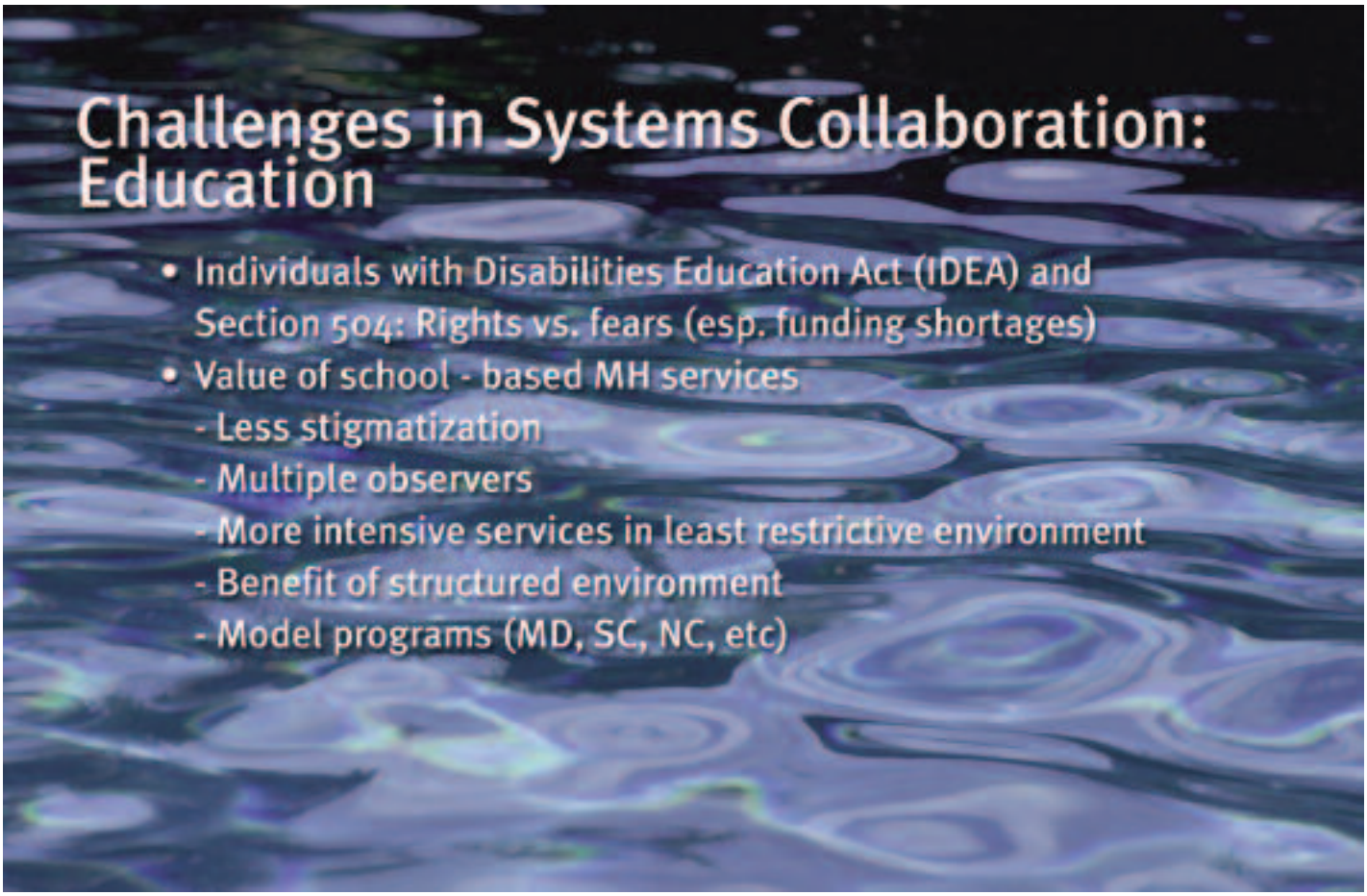
Because children cannot legally consent, I tell parents that if a child, especially an older child, does not want to take the medicine, I do not want to give it to them. Maybe when a child is 2, you can force her to take her antibiotics, but you cannot force it down a 15-year-old. We need to make sure that children, and especially older adolescents, are on board with their

medication. We need to do a systematic assessment of the medications we use, assess benefits and risks in the community, and, again, pay particular attention to the issue I call "ethno-psychopharmacology." We are learning more and more that people of color metabolize medications differently, and this has to be taken into consideration.

As we look to the future, child and adolescent psychiatrists are going to have to take on new roles – more consultation, more team leadership, more system-quality roles. In Fulton County, utilization management has come under my leadership. Child and adolescent psychiatrists are going to have to focus on the more seriously ill children. We may need new clinical skills for child and adolescent psychiatrists, and what about the other nonpsychiatric mental health professionals? The role of social work, case management, psychology, information management, testing, and behavioral consulting is very important. We just passed legislation in Georgia that allows advanced practice nurses to prescribe. I think that is going to go a long way toward improving access to care. Also, we have to make sure we are including recreational and occupational therapists, as well as schools.

More and more people understand that some of the interventions that may work with white children and families may not work with nonwhite children and families.

We have some challenges in working with folks from Juvenile Justice, but again, the data has shown that when we use these evidence-based practices, we can get good outcomes. Working with school systems is key. I remember that when I was doing my training in child and adolescent psychiatry, we had a 50 percent no-show rate in the clinic – some days higher. I remember saying, "We have to go to where they are." The old days of the nurse, social worker, or psychologist sitting in the office and waiting for the patient are over. I think school-based



mental health care is the way for us to go. We are working with one school, and while you think one project is a good idea and it will be simple, it can become complicated working in a school system.

We have managed care in Georgia now, and managed care, in theory, is not necessarily a bad thing. Some of the risks to managed care include restricting services, having arbitrary service limits, and lack of attention to special needs. If the managed care companies, all the partners of the state, the Department of Community Health, and all of us providers work together, benefits can be realized. But we definitely have to have our managed care partners on board, and managed care partners have to answer to shareholders, and there is a bottom line they sometimes have to deal with. We, however, cannot let them use that as an excuse. The Center for Mental Health Services and the Substance Abuse and Mental Health Services Administration (SAMHSA) started their children's system-of-care program, Starting Health Starting Smart. Now that we have some evidence, federal and state agencies have been responding. (I know we are working on a system of care for children here in Georgia.) I talked about the AACAP, the American Academy of Child and Adolescent Psychiatry, and the work group's recommendations. The new data should be out soon.

What does the future look like? A good system of care would have good organization. Care would be coordinated. Regional organization would avoid potential duplication. Interagency

collaboration is important. We need community and consumer governance and participation. Private, public, and academic collaboration and participation are key. And we need to define the roles for our stakeholders clearly. We believe that school-centered services are at the core of this good system, and the continuum of services has to be there. I submit to you that we will always need a few hospital beds. There will always be folks who need every level of care. It may not be forever, but we have to ensure we have that full continuum of services.

Child and adolescent psychiatrists are going to have to take on new roles – more consultation, more team leadership, more system-quality roles.

One agency, one community service board, one county system does not have to provide it all, but we have to make sure that all levels of care are there in our systems. We must emphasize early access and prevention, coordination, and integration with the child health system – if you will, the medical system that I call "medical below the neck." I do "medical above the neck." Provider participation, function, and co-locating services are great ideas, as are culturally competent services and flexible service delivery. These days, we have to be nimble, and once a system is in place, we should be able to make a quick change if it is not working.

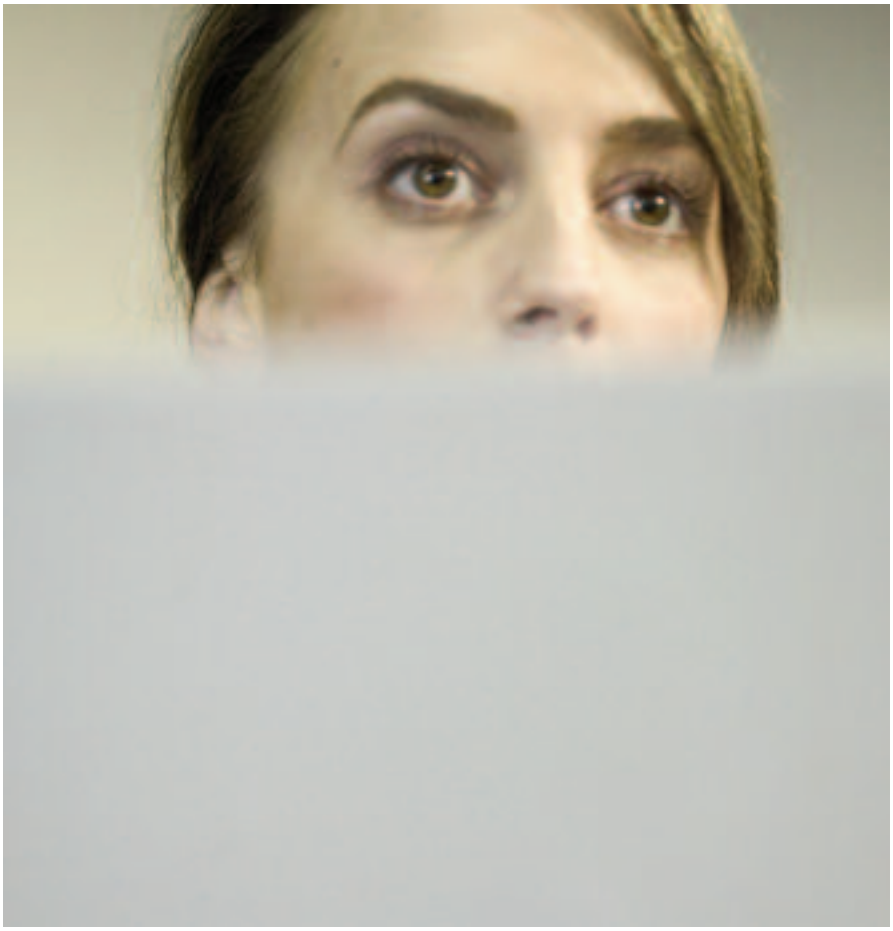
Financing is an important key. New Mexico was going to a blended, noncategorical funding system, and I think that is going to be a great experiment. We need to look at new technologies. Georgia is a rural state, and I see we have a lot of psychiatrists, psychologists, and social workers in Atlanta. We need to be able to communicate with our providers in the rural areas using telemedicine, an exciting area for the future. What about having kids who enjoy computers sit at the computer and do some self-assessments? These are new and innovative ideas that we need to take toward the future. It is that whole "virtual staffing" thing. What about guided interventions, again on the computer? Electronic clinical records are coming and are very important, and a lot of research is looking at genetic markers with the newer chemicals involved in brain disorders so we can improve medications.

I hope I have been able to tell you a little bit about what I believe is a good foundation for the future of systems of care for children in Georgia and across the country.

Adult Mental Health in Georgia

Linda Buckner
Community and Consumer Relations Manager
APS Healthcare, Inc.

The President's New Freedom Commission states, "We envision a future when everyone with a mental illness will recover, a future when mental illness can be prevented or cured, a future when mental illnesses can be detected early, and a future when everyone with a mental illness, at any stage of life, has access to effective treatment and supports essential for living, working, learning, and participating fully in the community." The interim report concluded that the system is not oriented to the single most important



goal of the people it serves – the hope of recovery. Science has shown that having hope plays an integral role in an individual's recovery. Recovery begins with hope.

The prevalence rate for mental illnesses in Georgia is 6.7 percent. With adults, there is a somewhat lower rate at 6.43 percent. Approximately 94 percent of adults living with mental illness are living without much, if any, hope of having access to mental health services. This picture is even bleaker in special populations – for instance, the aging and Latinos. Fifteen to 20 percent of older adults in the United States live with a mental illness, yet the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases provided services to less than 1 percent of the total population of adults over the age of 65. And only 2 percent of consumers receiving mental health services were identified as Latino in fiscal year 2004. Without access to quality recovery-based services, for most there is no hope; therefore, recovery cannot begin.

I want to point out a few of the more important issues with reference to gaps in the Georgia mental health system. Research has shown that one of the most effective treatment components to improve recovery outcomes is providing services within the community. In stakeholder surveys, it was revealing that many believe community-based services are one of the top five strengths in Georgia. In fiscal year 2004, only 7 percent of individuals who were eligible for community-based services were actually receiving them. That means 93 percent of human beings living with mental illness – 93 percent of my brothers and sisters – are not getting this essential service to aid them in the recovery process. We must take providers' offices away, give them a laptop and a cell phone and a car, and push them to meet individuals where they are, even if it is under a bridge, living in a car, or on a park bench, as I have done in the past.

I believe the gap in the availability of community-based services along with the lack of crisis stabilization units in all communities are major reasons Georgia has a 55 percent higher readmission rate to the hospital within 30 days of the individual's last admission than anywhere else in the nation. Even though in the last 15 years of Georgia Mental Health Consumer Network's annual conferences, consumers have identified transportation as a top priority, to date a majority of consumers, in order to have access to services, must

somehow find a way to get to a mental health clinic. We are not being met where we are.

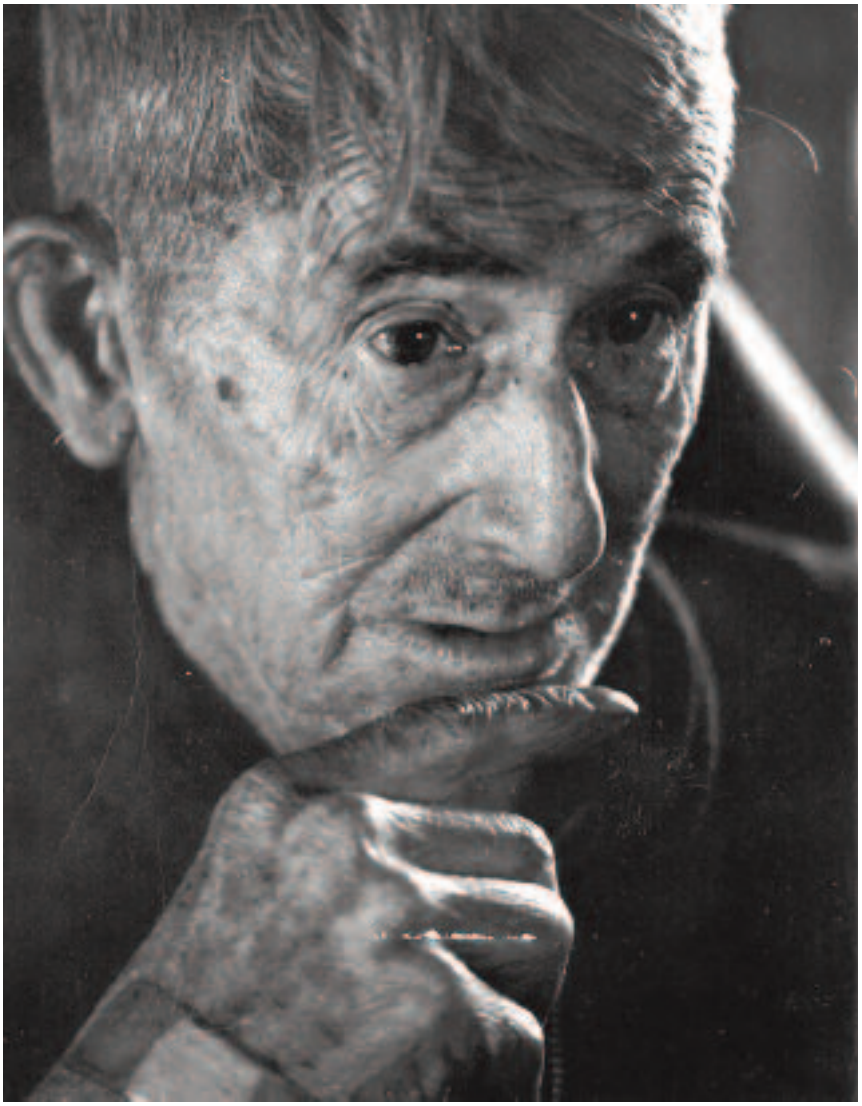
Georgia is ranked somewhere between 43rd and 46th in the nation in spending per capita for mental health services. The pay rate for our professionals and paraprofessionals is significantly lower than any other state in the nation. Put this on top of the outcries of providers across the state of continually increasing stress, paperwork load, and working in the system, and our ability to maintain and recruit staff is horrendous. I want to give you an example from a personal experience of just how hard it is to keep staff. A couple of years ago, I was doing a training in northwest Georgia, and I was told that one agency lost 16 of approximately 24 staff members, both professionals and paraprofessionals, who went to work at the local new Super Wal-Mart.

Georgia is recognized throughout the nation and world for its peer support and certified peer specialist programs.

Georgia is recognized throughout the nation and world for its peer support and certified peer specialist programs. Stakeholders rank them as two of the top five strengths in the system, yet estimates show approximately 65 percent of certified peer specialists are not even working. In talking with those during the trainings that we conduct of the certified peer specialist, I have found that one of the major reasons for individuals not going to work is because the starting pay rate averages less than $17,000 annually. This makes it virtually impossible to pay for their medications, mental health services and physical needs and still survive.

We must come together as an advocacy community with a solid voice saying, "This can go on no longer." Human beings have the right to have access to quality, effective, recovery-based services in the communities of their choosing. We must challenge legislators to fund the services needed for those of us living with a mental illness to live full, productive, and contributing lives in our communities. We must cry out that we will no longer tolerate the segregation and institutionalization of human beings and that we will decriminalize mental illness. We must demand access to medications that work and services that enhance the quality of lives of individuals living with mental illness. It is up to us to educate our communities and destigmatize mental illness. We must push the state to fund innovative services such as the Peer Mentor project in Milledgeville, a group of consumers working for an independent agency, not connected to the hospital or to any providers, to help assure a smooth transition for those hospitalized long term, many over 20 and 30 years, back into the community.

We must push legislators to pass a bill supporting advanced directives, giving consumers and family members a choice of treatment services while in crisis. We must demand that every individual in services in Georgia be given the opportunity to create a wellness and recovery action plan, giving back the control of managing illness to the individual. We must push the state to demand that all providers provide services that are individualized and person-centered. We must increase consumer and family choice and honor the principles of self-determination. We must push the state toward person-centered planning. We cannot tolerate any more one-size-fits-all. Day programs must be pushed to offer more than one group at a time that everyone must attend, even if it is not about a subject or something they have identified as a need. We must offer programs that support individuals getting and keeping jobs that bring us out of poverty. We must hold the



state accountable to ensure that every human being is given the basic right to live the life they choose in the communities they want to live in, in the least restrictive and intrusive environment.

The Constitution says all have the right to the pursuit of happiness. I am here to tell you from personal experience, happiness cannot be found locked away in a state institution, in a group home, or in a life sentence to a day program at a local community mental health center. We must push the state to train providers on best and innovative practices that will enhance the recovery process. We must pay our work force that retains them. We must support and enhance peer supports. They work. I am living proof. It is up to us. We must lead the way in pushing the state toward system transformation to meet the gaps.

Although we all may have different ways of going about it, let's put our differences aside and come together as a unified voice, fill the gaps, and meet the needs of individuals living with mental illness. My brothers and my sisters are looking to you to help, to help us live full and productive lives in the community. If I did not have a good job with good insurance and decent pay, I would not be here today. I would still be in day treatment. I would not be the happy individual that I am. I would not be out contributing to my community. Remember, recovery begins with hope. I am asking you to come together. Let's address the gaps in mental health services, and let's make that hope again.

Questions and Answers

Q: **Dr. [Patrice] Harris, you indicated that you were going to be more provocative. Would you give those comments now?**

A: I glazed over the recovery model versus the medical model just a little bit. As a physician, maybe I am extra-sensitive to this. Some people believe that a doctor and the nurses and other members of the medical team do not belong in the recovery model. That is a continuum model, if you will. Certainly the medical piece of getting folks stabilized in the beginning is key to their working, playing, loving, and leading fuller, productive lives. Managed care is always provocative. We have managed care coming up in Georgia. I am intimately involved as part of our senior management with some of the issues, and I wondered aloud why, in the planning of this whole managed care deal, the state did not bring the managed care companies in the room and say, "Look, we do not need more burdensome paperwork for our providers. We do not need X, Y, and Z; so you can come into the state, but you have to be user friendly to both the consumers and the providers." So I was a bit less provocative than you thought about managed care.

Q: **Dr. [Patrice] Harris, the key to primary, secondary, and tertiary prevention is early diagnosis. And the key to early diagnosis is screening in our elementary schools. How do we go about breaking down the barrier in the Department of Education in our local school districts so we can get screening of children before they get into trouble in schools, just as we do for other health needs?**

A: That is a difficult question, and I am sure many of you have been following the legislation advocated by some groups in this country that are anti-psychiatry and anti-mental health. They have been able to convince some federal legislators to pass laws saying that teachers cannot even ask about these issues or cannot discuss these issues with parents, so that is an additional barrier. Certainly it is a multifaceted problem, but I believe that sometimes when you cannot get action on the big level, you start on the micro level. What we need to start doing is partnering with individual schools – finding and talking to principals and school districts, school counselors, and school psychologists who want to work with this. This is going to start at the grassroots level, because there are too many barriers from the top down. Providers should find the schools in their neighborhood and partner with them. We know that it works, and once we show that it works and that we are not trying to put everyone on medication and that we are not trying to do bad things to children, then there will be a groundswell, and we will get more people to appreciate that.

Q: **I am with the Georgia Mental Health Consumer Network, and I am also a certified peer specialist. I heard you, Dr. [Patrice] Harris, speak on the use of computers to engage youth. I also can see the possibility of using that computer for an individual to access rural areas to talk with a person – to share their experience, strength, and hope with them and to encourage them to take their medication. I hope you will use the model that shows how peers can be a big help when it comes to accessing services and recovery. I also want to make a challenge to you for your organization to continue to work with youth, and I encourage you to use the idea of the computer, especially in sharing with encouragement and support with peers.**

A: The difficulty in the past was no one wanted to pay for that, but I think federal officials are getting on board. It was not a traditional visit where the consumer came into the office to see the social worker, the nurse, or the doctor. I think there is some payment structure involved.

Q: **Two years ago, there was a bill in the House that would have allowed screening. The bill did come out of committee but never got past the committee process. The National Mental Health Association of Georgia did try to get that bill passed, and we will try again this year. When the legislator says to you, "Why do you want to put a label on these children?" it is important that you are able to say quickly, "These children have a label. The label is 'bad,' 'disruptive' – all kinds of labels that have a negative impact but cannot have a positive result, because what do you do with a 'bad' child?" They look at the issue as a discipline issue, and we have to turn that around and make sure that people understand children can have a mental illness. It is not about medication. It is about treatment.**

There were two main oppositions to the bill the past two years. The first was money, and the second was a conservative view from some who do not believe the school should infringe at that level. However, two legislators who spoke at a recent meeting of Voices for Georgia's Children, Senator Renee Unterman and Representative Kathy Ashe, made a commitment to a question asked about screening for mental health.

A: I [Dr. Patrice Harris] absolutely agree with that. Lots of folks try to block this legislation on the national and the federal level. There are all kinds of groups out there that are covert in their opposition to these bills. The legislators are not hearing enough from us, so we need a groundswell to say, "You are probably getting inaccurate information; let me tell you why this is important." Recent research has shown that these mental illnesses actually cause brain damage. The longer you let them go untreated, the more damaging they are to the brain. That is the other reason it is critical we get folks diagnosed and get them into appropriate treatment early, whether that be medication or psychotherapy.

Q: **Ms. [Linda] Buckner, I would like to ask you about returning to work, if you can share with us whether you were on Social Security disability and how hard it was to get off. It has been my experience that Social Security has acted like a benevolent bully. They would give you a certain amount, but if you even tried to get more, they would cut off what they gave you, and you would be back to square one. Has that happened for you?**

A: That has probably been one of the hardest things that I did in my entire life: coming off the stability and safety of having Social Security and having my medication available. When you apply for and get a new job, even if it is a good job with good insurance, most companies will require you to wait six months before you get insurance. And you have already lost your Social Security and lost your medication. Most of us cannot go six months without our medication and be stable. I was very fortunate. I got into a program that immediately started my insurance. Most people I know that have been successful have either gotten into something like that or have done it gradually and have been able to save back money so they had access. They had the money to pay for their medication until their insurance kicked in. Three to six months is a long time to wait.

Q: **If I am not mistaken, Social Security now has a program titled "Ticket to Work," and if you get off Social Security, you are allowed to have your Medicare for five years. Therefore, you can get medication for that period of time. After the five years, then you will not have medication. So they have allowed for that transition.**

A: Thank you for that information on a positive note.

Panel Discussion

Ellyn Jeager, Moderator
Interim Executive Director
National Mental Health Association of Georgia

The Mental Health Gap Analysis is an incredibly wonderful opportunity because it gives us the information we need to go to our legislators. In the past, we have gone to legislators with, "It is about this percentage; it is about this number; we do not think…" Those are not facts; those are opinions, and we needed facts. When Cynthia Wainscott and I were on the Mental Health Planning and Advisory Council, we both recognized that without real facts, we were not going to make any progress with our legislators. They do not understand mental health and often confuse it with physical disabilities, developmental disabilities, or mental retardation. So when they look at the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases, they look at the division as a whole. If something positive comes from the division, their expectation is that as mental health advocates, we should be happy. I am always pleased to see anybody advance in the legislative arena in terms of budget increases, but although I strongly support everyone we share the division with, that does not mean mental health has advanced. It is important that we recognize that the first problem is lack of education and that we should spend time looking at how we educate our legislators. The Gap Analysis is a perfect way to do that.

Each panel member will talk about a subject addressed in the Gap Analysis. Every one of these subjects is important, and every one is about a need that is not being met. We want you to think about how we use this information to our advantage.

Topic: There Is a Fragmented Vision for an Improved Mental Health System

Larry Fricks
Director
Appalachian Consulting Group

One of the most exciting things I have the opportunity to do right now is work in seven states that want to start the peer support program. The Center for Mental Health Services and the Substance Abuse and Mental Health Service Administration, with which I am contracting, have decided that Connecticut is probably ahead of everybody else in the country on how you systemically transform according to the President's New Freedom Commission on Mental Health Report, and we are working mostly with Connecticut. They started in 2000 before the commission report came out. According to the National Alliance on Mental Illness scoreboard that came out nationally, they were one of the highest states. They had a B+. I do not think any state had above a B+, and they are doing it. They did not have strong training and certification for peers, so we [will soon] start the first training there of 35 peers. What makes them so transformative is that they believe that the concept of recovery and resiliency has to be the overarching theme for the whole department. Commissioner Tom Kirk has said that to be a provider in the Connecticut system, you must grasp strength-based recovery.

If you do not understand the social justice issues that poverty and stigma bring, then you cannot grasp what recovery is all about.

Here is an example of what strength-based recovery is not. When I was hospitalized for the third time, I rode in the back of a police car from Forsyth County. I was going to Peachford, and the Forsyth County deputy had never been to Peachford before. I was sitting in the back, and he was on the radio, trying to get instructions on how to get to Peachford. He could not find it. So I said, "I can get you to the hospital." You know, he could not accept that. He would have had to reshape his belief system to believe the guy in the back seat could get him to Peachford. So he kept circling and circling because he did not want to believe I could have insights. He did not want to believe I had strengths.

I believe that with anybody else, he would have said, "I'm lost." But finally he slammed down the microphone and said, "All right, where's the hospital?" And I got him right there. Now that may be an indicator that I needed to be hospitalized. But the bottom line is he could not see my strength. He could not understand that we would not have ridden around DeKalb County for an hour if he would have honored that I had strengths and started with those strengths. That is strength-based recovery, person-centered planning. It is starting with the strengths of the consumer and the families because we have the lived experience.

One of the things I love about Larry Davidson in Connecticut is that he understands the civil rights piece of recovery. In other words, if you do not understand the social justice issues that poverty and stigma bring, that being treated as a second-class citizen brings, then you cannot grasp what recovery is all about. Davidson talks about (a) developing core values and principles based on the input of people in recovery, (b) establishing a conceptual and policy framework based on this vision, (c) building

work force competencies and skills, (d) changing programs and service structures, (e) aligning fiscal and administrative policies, and (f) monitoring, evaluating, and adjusting these efforts.

We should not forget our strengths. Just like person-centered planning, Georgia has some great strengths. Georgia just won a national battle with Medicaid. Medicaid across the country is sending out a letter that you can bill for peer support under the rehab option with the state plan amendment. The future is wellness. Peer-to-peer wellness is going to be huge. Judith Cook was awarded $6.4 million to study Georgia's peer support as an evidence-based practice. It will be a two-year randomized control study. We have a lot to celebrate. Let's focus on what we are going to build, not on what we are going to change, and by building, we will change it.

Anna McLaughlin
Co-Director
Georgia Parent Support Network, Inc.

Seven initiatives are going on now in children's mental health reforms for the state of Georgia. Concerning the Mental Health Gap Analysis, we are looking at the statement "The fragmented infrastructure of the state's many offices involved in financing, accounting, and information management does not support the division goals for measuring utilization, trending, and planning for system needs." That is how it was written in the Gap Analysis. So if we are looking at that, and we are looking at seven separate reform issues, and we are looking at reform issues happening inside the system, that is already fragmented.

When we talk about a vision and where we could go dealing with the fragmented system, recovery, wellness, and resiliency need to be the guiding forces for every change. Some of these changes are guided by what is commonly called the Bruce Cook Task Force. Some of these changes are guided by new leadership at the Department of Human Resources. Some of these changes are guided by financial issues. So each of these seven changes has a different guiding principle. As we look at them, we have to be aware that these changes are happening in a previously fractured system. These changes are not fracturing the system. The system already exists in silos.

I want to thank Dr. Patrice Harris for discussing the system of care and the evidence around that. When we look at a vision for children, it is important that we include the system of care principles: a wraparound, full continuum; and screenings. My husband was diagnosed with diabetes as an adult. Why is it that the entire medical profession was up in arms because he wasn't diagnosed sooner, but no one was up in arms when my older sister was finally diagnosed with manic depression or bipolar disorder at the age of 40, after she had gone through massive substance abuse and treatment programs and had done things in her life that hurt her? I am outraged with a system that did not do early screening to detect her bipolar disorder, not because I think we could have stopped the illness (because that technology is not here), but we could have treated some symptoms to make her life better, and we did not do that. I believe that if you have a disease, you need to name, treat, and recover from the disease – period.

Regarding transitioning kids: Yesterday I went to my staff and said, "Who wants to make a private arrangement with a 20-year-old, and who has a room they would be willing to rent until I can find appropriate placement?" When it comes to transitioning kids, we cannot get involved because they are 20. So we have to look at transitional services as children move in. We have to look at parity, which is not the word we said, but it is what we mean when we say we can get treatment for some things through care management organizations and not others. And we have to look at stigma. Is it stigma that kept my sister from being diagnosed? Is it stigma that keeps many people from being diagnosed? If you say "one in five," how many people are walking around not knowing what their real condition is?

When we look at a vision for children, it is important that we include the system of care principles; a wraparound, full continuum; and screenings.

We acknowledge that change is necessary, and our system for children's mental health is fractured, siloed, and in some places, just completely broken. We agree that this change has the potential to create a system that will benefit our children and families, and right now there is a lot of change happening. The seven separate initiatives that are going on will all have a significant impact on our children. Let's focus on changing what we intend to change. What goal and outcome do we want from each change? Let's not focus on blaming each other about how we wound up with a fractured, siloed system. Let's look at where we want to go and how we are going to get there.

Let's have a transparent system and be open and honest. If the changes are not coming from us, let's share where those changes are coming from and how they are coming down the pipeline. Let's start building trust that will sustain us through this transition. Let's have a team approach with inclusion. There are many of us who wish to participate in the planning of these changes, who understand the goals, and who may have some possible solutions to help implement these changes. Let's have an open forum where the community can have the best- and worst-case scenarios of possible changes. That way, we can better understand what the change impact is going to be. Let's address the human and technological challenges before they occur, not after. Let's be honest about what our capacity is, what our work force development and training needs are, and what technological supports we do and do not have.

Lastly, what our children and families need are solutions. We have to define the message we want to send to the changing system. The Gap Analysis was clear: Change is needed. Let's accomplish that change with our eye on a bigger picture that has cross-sector networking with humor and transparency, knowing that the thing we are creating is something that will have an impact on our children, their families, our community, and our state.

Topic: State Hospitals Fill the Void of Community-based Crisis Services: Does Privitization Work?

Andrea Bradford, M.D., M.M.M.
Medical Director
Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases

I have been asked to provide an update on the hospital system in the state and whether privatization will work, given our particular system. The answer is, "It depends." We should never doubt, as Margaret Meade wrote once, that a small group of dedicated people can change the world. Indeed, nothing else ever has. So I do believe that advocacy is an essential piece to improving our system, whatever improvement we decide upon. We have a tremendously dedicated staff of individuals in our hospitals. We have seven hospitals across the state, serving consumers every day in large numbers. Last month, our utilization on adult mental health was at 108 percent, and it reached 130 percent for some hospitals for some days.

We have an acute-care mission in our hospitals. We do not, as in many other hospitals, only serve chronic-care patients. That probably explains a large part of the higher utilization rate of beds in our hospitals than in other states. For example, a person in Florida cannot apply for admission to the state hospital until he/she has been hospitalized for 30 days. Our state hospitals are on the front line, along with our crisis stabilization units. It is important to identify that there is a need for both inpatient care and crisis stabilization and that the missions are different. Crisis stabilization has a focus on stabilizing systems so individuals can receive their care on an outpatient basis. Inpatient psychiatric care focuses on stabilizing illnesses that cannot be stabilized on an outpatient basis.

We have a challenge in providing care where people are. We have a challenge in providing appropriate care. We need more crisis stabilization, and crisis stabilization is appropriate for many of the people we serve in our state hospitals. Our crisis stabilization units need to increase. However, under an agreement with the Georgia Hospital Association, our crisis stabilization units can be operated only by the state or by a community service board. So privatizing crisis stabilization would require certificates of need for inpatient psychiatric beds. It is not possible in our state under our current rules to just privatize crisis stabilization.

Our state facilities do operate some community services where we have had difficulty identifying private providers who were willing to provide those services. We do have a crisis stabilization program for children and adolescents in the Savannah area in addition to our two child and adolescent units in the Atlanta and Central State hospitals. We also have an assistive community treatment team in the southwest area of the state out of the Thomasville hospitals. And we have a crisis stabilization unit there as well that is state-operated because we have been unable to find willing community providers to provide those services.

We are working diligently to improve our hospitals. We recently implemented a contract with APS Healthcare as an external review organization to collect data and look at inappropriate hospitalizations and what community services are needed to

be able to prevent those inappropriate hospitalizations. We are implementing an electronic medical record, which will give us access to data about the care we provide and how well we are doing and will enable us to improve our care. We are using the treatment model approach at many, if not all, of our hospitals to ensure we can individualize care and that we have many different groups and classes offered at the same time and people can go to the treatment that they need. We are among the lowest in the nation in the use of seclusion and restraint at our hospitals, and we are proud of the efforts that we have made and the response we have gotten to those initiatives to decrease seclusion and restraint. We are implementing evidence-based practices. We are implementing algorithms, and we are working on replacing treatment plans with an individual recovery plan that will belong to the consumer and will go with the consumer into the outpatient setting. That planning process has to be person-centered.

I believe that advocacy is an essential piece of improving our system, whatever improvement we decide upon.

We have seven hospitals in five administrative regions. These regions are aligned to match the regions for the departments of Juvenile Justice and Family and Children's Services so that we can improve collaboration with our sister organizations.

It is important for people to understand and recognize, as we begin to consider privatization, what the Georgia Code has to say about the difference between public and private facilities. Public facilities must take all comers at all times. A private facility that agrees to become an emergency receiving facility under Georgia law may decline to accept any patient who is unable to pay it for hospitalization or for whom it has no available space.

When we have someone sent on a 1013 [involuntarily committed] to one of our state hospitals, these are the three things we do: We are an emergency receiving facility, and we do assessments. We are an evaluating facility, and we evaluate the health of people. And we are a treatment facility treating people with mental illnesses.

We also have a responsibility to accept those individuals who have substance abuse problems; however, we currently do not provide active substance abuse treatment. We are working to provide education, and we are working to integrate with substance abuse facilities external to our hospitals so we can hook people in. That is another challenge that we have.

Again, according to code, we have to accept those who are brought to our facilities, and we have to take custody of any patient that a private facility requests to transfer to our facilities. We have been studying privatization, trying to do some cost-benefit analyses and looking at options in terms of privatizing. The first option we came up with was to privatize a state facility or facilities. As we have worked to develop our seven hospitals into a hospital system rather than seven hospitals, we would lose some of our flexibility to move beds, to collaborate, and coordinate care. Some of the proposals we have seen include increasing salaries for our hospital staff as part of privatization. Increasing salaries is a needed action. However, if we privatize one facility, or one or two facilities, and increase salaries at those facilities, that is going to increase pressure on the state salary scale for professionals at our other hospitals.

Contracting may need to include an option to bid on the provision of essential community services. The integration of the hospital and community services and the

flow across the continuum of care are extremely important issues. One of the things we struggle with is how to build community services that are needed in order to keep people out of the hospital and to get people out of the hospital. Can we require a privatized facility to accept all comers and not say "no," just like our state facilities? We can certainly write that into a contract, but such a privatized facility could decide to challenge that portion of a contract because of the state law. A private contractor, however, may bring ideas and innovations to our hospital system that are needed and may bring some flexibility in terms of financing and in terms of quick responses to immediate needs that are more difficult in a bureaucracy such as the state.

The second option we looked at is to privatize a service or a system of care. We have variable types of management and different service lines at our different hospitals. Might it be a better option to privatize child and adolescent care, to privatize forensics, to privatize any number of different service lines across the state rather than privatizing a single facility with all of the service lines? There are these systems of care that need to be developed where the monies are in different departments and divisions across the state. Is this an opportunity to save and improve consistency of care? Aside from the systems of care, we also have looked very actively at – and, in fact, have a request for proposal out – for privatizing services such as pharmacy within our hospitals. We also are investigating whether or not privatizing food service across all the hospitals might be an option. So privatization does not necessarily have to focus on a single facility or facilities but may make more sense if you are privatizing particular services across facilities.

The third option we have looked at is doing both. Why not privatize one or more facilities and a service or system of care? Services do not exist at all facilities. There are some services that have a particular hub where it might make sense to privatize that hospital and the service of care where they serve as a primary. The division is interested in receiving input from the community as we move forward.

Stan Jones Jr., J.D., M.A.
Partner
Nelson Mullins Riley & Scarborough LLP

I got started in 1971 working for Mrs. Carter's Mental Health Commission when Jimmy was governor. That Mental Health Commission was actually run and chaired by John Moore, who was a lawyer who had worked for the Medical Association of Georgia when he was invited by Governor Vandiver to investigate surgeries on patients at Central State Hospital in the late 1950s.

My son ended up in the state hospital two-and-a-half years ago, and I want to say a bit about some of the things that happened. My son had depression and serious drug problems and, after 15 or 16 particular incidents, landed in the Fulton County Jail in the fall of 2004. The city jail had suspended its mental health programs for a period of time because they did not have enough money to run them. So if he acted out, he ended up in an isolation cell, which was difficult for somebody who was claustrophobic and withdrawn.

Sometimes we need that protection, but you also need pressure to socialize so you can learn through peers the kinds of things that we are talking about.

Eventually, he went to a camp and managed to escape the second day. He walked eight miles to the interstate and hitchhiked home, so I took him back to the jail the next day, which was hard. He served the first part of his sentence, and the psychiatrist working with the jail was very helpful and said, "I think he needs to be in a safe place for a while." We worked it out that he would go to the forensic unit at Atlanta Regional. I admire very much the capability of the treatment personnel there, but it was not an easy thing. Tom tried to climb the fence the first day to get out, so the first couple of times we saw him, he was in leggings. They were chrome, and they were not the mental health bell iron, but that is hard to watch. I also knew it was necessary.

Things were progressing relatively well until an incident occurred one night about five weeks into the session in which another inmate bit off the tip of Tom's finger. That inmate had the same public defender as Tom did, but the court did not tell the staff of the hospital that the other person had acted out, so he and Tom got into a fight. The hospital took Tom to Grady [Hospital], and they sewed up his finger. This is one of the funny things that happened: They were sitting outside waiting for the cab to the hospital, and Tom took off up the street in leggings and managed to get ahead of the orderly up to the MARTA turnstile, jump over the turnstile, and head for the train. The orderly said, "He's a patient at Atlanta Regional." Tom said, "He is too!" I think the orderly had been afraid to tackle him because he had his finger bandaged.

Eventually, after the period of evaluation about whether he was competent to stand trial, the Fulton County judge decided that he needed to go to the adult unit instead of the forensic unit at the hospital because there were 25 other people in the jail waiting for evaluation at the forensic unit. The department actually told the judge, "The adult unit is not as secure as the forensic unit." In fact, I learned later, there had been three escapes in the previous year or so. The judge said, "I do not think it is fair for you, because the division worked out something for your son when there are other people waiting for the competent services that were there." I agreed with that, but that was tough. I knew it was a bad decision to make a change for somebody who has been in that circumstance for a fairly long period of time.

Try to talk about how to make hospitals responsive to community programs instead of vice versa.

There were seven languages being spoken on the adult unit. It was very chaotic, which is a reflection of the occupancy rates recited in this forum. The doors were not being locked properly, in the proper sequence. So about two weeks into this, Tom walked out with my dad. He said to my dad, "Where are we going?" Dad said, "You're going back in there." But I had watched the sequencing of the locking and the unlocking of the doors, and it was not good. There were many visitors, so many that letting people out was not actually secure. Later, Tom called up my father, his mom and me, and three or four friends, and he said (and I think this is funny), "Would you guys mind bringing me a Gatorade with some vodka in it, because there is an older man here on the unit and his family is bringing him a drink every afternoon at visiting time." And I thought to myself that might be a good idea. I do not really think that, but it is a reflection of how hard it is to maintain a kind of energy in your institutional systems.

Tom was on line-of-sight observation. One day he did not return from lunch break in the yard, and we learned the next day that he had gone under the fence, which is hard to do on line-of-sight observation. He went to Piedmont Park and killed himself the next day. It was clear that he intended to do that from things he said to other people in the preceding four or five days. And it is also clear that he was getting better. One thing we know is that as people get better, they are strong enough to do things like that. I admire the kind of stubborn courage to say, "I have had enough of all of this, and here is one way I can take control of it." I think it is awful but understandable at many levels. I tell that story to humanize the issues of how we talk about our hospitals. I have to be able to respond to the legislator who calls me and says, "Can you help Mrs. Jones' son have a place to be, because he is acting out so much at home that we cannot handle him." And you know that is better than letting someone be unsafe.

I remember, too, the first time we went to Central State Hospital in 1971. There were people on beds, on mattresses, on the floor naked. I do not know to this day whether the superintendent staged that to get more attention to the hospitals. There were 8,000 people at Central State then. There had been 12,057. I looked at the data for the single-point-of-entry request for proposal. We now again have 12,000 people. Of course, our state population has doubled since 1970, and we do need to ask the question and figure out how many inpatient beds we need. Those are legitimate things to investigate.

Ellyn [Jeager] and I were involved in a bill that required that by October 2006, the division had to privatize one or more state hospitals. The bill had strong support from the leadership in both houses – not all the leaders, but several critical ones – and it was coming up from a company that had been doing forensics in state care in Florida. We looked at the pro forma, the cost report that was available for that Florida hospital. It was a couple of years old, so it might not have been accurate, but it reflected a payer mix that was 50 percent Medicare and 50 percent private insurance. As [Andrea] Bradford pointed out, that really is not a state hospital. That is, in effect, a private facility. (Note: In the legislature, I represented two private psychiatric hospitals that were concerned about competition.)

I believe that sometimes our consumers need "safe havens" instead of hospitals.

I also think it is a fair question to say that if the department is spending about $403 per inpatient day, what is the best range of services we can buy for our patients who need inpatient care on a more extensive basis? I know that some facilities operating in the private sector are selling services at $300 or $350 a day to private insurance companies. So there is a gap, so to speak, and some opportunity to do things better. That is why I say regarding questions about whether we should privatize or how we should privatize, "Which" is a more appropriate question and a fair one.

Here are a few things I think are important in this discussion. One is that our system should be community-based and not institutional. Over the last 40 years, we have struggled to get the hospitals working for the community system instead of the hospitals being independent in their own right and having a certain level of power so that in the system, they were unto themselves. They got in the way of the de-institutionalization movement that we have been involved in for a long time. I believe that sometimes our consumers need "safe havens" instead of hospitals. Somehow that communicates a better way to think about what we need. I do think we deserve choices and our system should include a mix of services. It is incumbent on the advocates to understand exactly what is being proposed – I guess this is the lawyer in me – and I say to people, "Stop whining, understand the finances and the administrative issues, and then let's talk about practical solutions that maximize our services."

Finally, when we talk about how to do things outside of the hospital, try to talk about how to make hospitals responsive to community programs instead of the other way around. We need not lose any state dollars in that process. There are opportunities to generate Medicaid reimbursement, at least for the crisis stabilization offered in the public sector and even in general hospitals too. We can cut our inpatient costs by 40 percent and get the federal government to pay for it. What has happened too often, though, is that when you do things like that, you lose state money. So rather than ending up with a system that has more resources, you end up with a system that has fewer resources at the state level. We need to think about how we take advantage of matching opportunities to expand our services.

Topic: Public Mental Health Services Reach Less Than One-Third of Those Estimated to Have a Serious Mental Illness or Serious Mental Disturbance

Michael Claeys, M.S., M.B.A.
Executive Director
APS Healthcare

Today, Georgia ranks 43rd in per capita expenditures for mental health, and yet we are the 10th most populous state in the nation. People generally do not retire up North; they retire down South where the weather is warm. So, as Georgia's population grows, mental health certainly is going to be an issue in the future. The Mental Health Gap Analysis group looked at several different dimensions across the state.

The report is lengthy because it is detailed. We looked at the hospital systems. We looked at the community system: who is providing what and where it is being provided. We partnered with the University of Texas Medical Branch to look at the prevalence of people in each county, all 159 counties within Georgia, who have severe to persistent mental illness or SED. We were able to come up with concrete numbers and compare those numbers to how many people are getting services. During FY04, more than 500,000 people in the state of Georgia needed services. Thirty-two percent were served by the public mental health system, so there is a huge gap between those who have needs and those who are actually getting services.

To compound this, let's look at where we will be tomorrow. Georgia will be the eighth largest state in 2010 with a population of 9.2 million people. At that time, there will be almost 644,000 individuals who may need services from a public mental health system. I would say that this is, potentially, a growing epidemic, and the question is what we do about it. Probably the most discouraging part of the whole Gap Analysis is not even these numbers. The most discouraging part of the Gap Analysis for us arose when we interviewed stakeholder groups around the whole state. We met with consumers, advocates, representatives from different divisions within the state Department of Human Resources, and providers.

Georgia will be the eighth largest state in 2010 with a population of 9.2 million people. At that time, there will be almost 644,000 individuals who may need services from a public mental health system.

The most discouraging piece of the Gap Analysis was that there was a lack of consensus on the who, what, where, when, and how of the needs of the system. People were all over the board in terms of what the state dollar, which is very small, should be funding. That was what was so discouraging – the lack of consistency, a common message, and a mission that you can put on a bumper sticker. Information is power, and now we have baseline information that we can measure year after year. We can look at the number of people being served and the amount of services they are getting.

What will it take to bend the trend? Interestingly enough, Georgia ranks 43rd in terms of per capita expenditures. My guess is that the state that is "number one" is having similar conversations. The President's New Freedom Commission on Mental Health Report indicated that the system is fragmented nationally. Georgia, thankfully, has created a front door. By having a single point of entry, a single call center in the state, we will be able to track over this next year what the need is and where those needs are getting met.

I want to leave you with a couple of quotes that are compelling to me. "Great things are not done by impulse, but by a series of small things brought together." This is one of those small things. When we have limited funds, how do those funds get spent effectively? How do we measure outcomes for services and know that, given limited funding, we are getting what we are paying for?

Finally, "A good battle plan that you can act on today can be better than a perfect one tomorrow." Action is what is key here. I have been to many conferences where there were compelling stories and testimonies. It is hard to keep a mission going without bringing people together, bringing advocacy groups and consumers and providers together to be able to set a course of action and to continue that course of action. We have numbers now to be able to identify where people are getting served and how many people will need services through our call center activity in the state. I believe that now is the time to be able to continue to ask what the score is. We need to continue to ask each other, "What is the score and are we winning?"

Wendy Tiegreen, M.S.W.
Program Director
Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases

We have the data, and we have to use it. One of the phrases I heard when I started in government employment in Georgia about 12 years ago was, "We work in a data-free environment. We make decisions in a data-free environment." Many of us have been busting a gut for many years to change that. We cannot make that claim anymore. We have the data we need to do things. We have to learn to use it in order to shape what we want. We have some tremendous tools in our toolbox, and we have got to figure out how to use them, because we know this data is compelling, and data is what our planners are going to respond to.

I am going to challenge everyone to think about access the way I think about it. You do not necessarily have to live with that. You do not necessarily have to hold that. But I think it is a good idea to conceptualize something in a way we all can share. We have heard several people today talk about screening for young children and screening in school systems and early identification. Anna [McLaughlin] referenced the personal story about her sister, so screening for adults is essential as well. That, to me, is one way of conceptualizing access. We are talking about access in terms of breadth. I think we would agree that mental health is so essential to wellness that it should be a part of every health care plan and that we as a health care system, as advocates, should encompass that concept in everything we do.

So we think about access as being broad. Now, however, I want you not to think just about breadth but about depth too. When we talk about things like aggressive screening and early identification, we do not want to fail to honor our commitment to provide services to those people who have a mental illness or a severe emotional disturbance. Worse than it not being identified is it being identified and not being able to get into a service, not being able to get your medication, not knowing where to go in terms of resources.

If you look at the bullets that are laid out in the Gap Analysis, every one is a little bit deeper. Beginning with the second or third item, the analysis about innovative services is not accessible right now. They are not being used. They are not available in all parts of the state. So you need to begin to think: If you get into this breadth level in terms of access, what else is there in terms of support? What else are we going to do in order to engage ourselves with families and adults and children? What are we going to do in order for people to reach all of the goals we are talking about in terms of resiliency and recovery? We have to think not just across the top, but we have to think deep and wide.

I also would like to reinforce that there are limited resources. All of us as planners are struggling with the best plan for the breadth and the depth and our roles. All of us are players in some form or fashion, and what is it that we all have to do to plan strategically? I am from the Division of Mental Health, Developmental Disabilities and Addictive Diseases, and I would like to comment on how we are beginning to look at these concepts and how we are changing the way we are doing things to address some of these concepts. It is important that with a

common vision, we can all move toward something, but we all have to manage what we each have in terms of our resources.

Historically, our division has had a fair amount of trouble with that top layer, the breadth, and we have struggled with there being crevices and peaks and valleys in that top layer. We have not had consistency across the state in terms of access. So one of the things we are pleased about is that we have created the momentum over the past year or so to pull together funds and look at a statewide access center. A "single point of entry," as Anna [McLaughlin] was reflecting, is more the term that we have all gotten used to using for an access center where we have a single phone number, a single entity that will help us begin to offer consistent and standard access to the people we serve, someone who is charged with holding all the information about all the resources – ours and others – in terms of offering some support. Again, that is that top layer, but we would like to see that top layer smoothed out so when people have a need, there is a place to turn to.

Recovery is not linear.

We are looking at equity across the state, and that has not been an easy process. We are looking at having funds equitably distributed based on population. We know, based on historical funding, we have had more money in certain counties than in other counties, more monies in certain parts of the state than other parts of the state. We need to be sure we are planning in a way where we can at least say that people who approach us can have access to a common benefit.

We need to make some really clear decisions on how we want to target our collective advocacy.

For us, it has been challenging to know that to create some services that are down in the depth portion of an issue, that sometimes means narrowing the breadth. It has been a tough path for us to travel to refine and narrow a core customer so we have time, energy, and resources to focus on the services you need once you come into the front door. If you get in the front door, if we know you have an issue, then what do we need to do to provide you real aggressive services that move you toward getting your life back or recovering your life or building your life? Those middle services – the community-oriented ones – how much of our resources are at the very bottom of that acuity level in terms of hospitals and crisis stabilization? What are the services we need to prevent those needs altogether? I have heard many of you say you do not think you are going to eliminate the need for state hospital acute stabilization, nor do I, personally, believe that. We have to have some services there for folks who do not necessarily need them, but in the absence of other community-based services, end up getting to a place where that is the only option.

We have to think about flexible services. Recovery is not linear. So we have to have services that accommodate all the ebbs and flows that happen in an individual's path to recovery or a child and family's process of gaining resiliency. We also have to address the other issues raised in the Gap Analysis. We have to have cultural diversity and personal diversity. I can meet the same demographic as 20 or 30 of you in this room, yet I do not need the same thing you may need even with a common diagnosis. So we have to think about services being ultra-flexible.

Some of our services are mandated to be provided in the community. We have new policy in effect this summer that will allow telecommunications to be billed with Medicaid. That was quite a win with the

Medicaid authority. We are looking at differential rates for physicians' services to children. We know that when you work with a child, you also are working with the family, so we have brokered with Medicaid and are setting our future rates on the fact that you have to spend a little extra time with a child's family as part of a diagnostic and treatment process for physicians. We are completely retooling children's services, and there will be a lot more to come on that. We are trying to set financial models that reinforce all those services that are right in the middle, those that are so essential to achieving and attaining recovery and resiliency.

We need to make some really clear decisions on how we want to target our collective advocacy. And then we have to figure out the strategies we want to use to achieve these goals. We know this is going to require vision, and not a fragmented vision. I want to commend all of you for your commitment, your perseverance, and your passion about this work. I am honored to be a member of this cohort.

Q: **Mark McClellan at the Centers for Medicare and Medicaid Services commented the other day that the Deficit Reduction Act and some aspects of it that just went into effect April 1 are giving states much more flexibility to do things they have been asking for and have previously had to get waivers for. Waivers, as you know, could take years, requiring a lot of bureaucracy on reporting. Last year, when the topic came up for the state of Georgia, the concern at the federal level was that if you are going to get this flexibility to provide new services and reimburse things that maybe are not traditionally reimbursed, the federal government said, "Wait a second, we want to put a cap on what we are going to pay you, because if you are wrong, your costs are going to go up rather than coming down." That was a big controversy here, and it was why much of what was happening last year on the idea of consumer-centric Medicaid got halted because of the fear of a cap and the fear proposals would not work. McClellan is now saying, under the Deficit Reduction Act, he will approve more than anybody thought possible, and many of the things proposed last year with a cap do not have a cap anymore and do not require a waiver. What do you think Georgia's possibilities are to implement broader programs, rewards incentives, extra services, more reimbursement, and more personalized needs in the environment that seems to be available now under the Deficit Reduction Act?**

A: Wendy Tiegreen: I am glad you self-identified some of the challenges. The very fact that it is called a Deficit Reduction Act gives planners pause in terms of hearing that it is expansive, flexible, and about reducing the federal deficit. Everybody is trying to get a sense of what that cap piece is going to be. For those of you not familiar with it, I think it is early, but we have had a phone call for mental health planners to have a dialogue with the federal government about this. Even the panelists presenting on this national conference call, unfortunately, talked a lot about turning patients in their beds and adaptations to physical equipment. Even though we were on the phone about mental health, it did not have a real sense of guidance from a mental health perspective. It was very much disability oriented, but it is clear that a lot of thought has not been given to how that will affect mental health. Many of us are involved in the national dialogue and are trying to push for those pieces of information so we can see how it will be applicable to our state in terms of advocacy and redesign. It is just too new yet for us to have a grip on that, and that is with me watching it closely. There is also the overarching financial concept that we have to learn more about before we move.

Q: **Using the data that we know is available now, that was not available in 2000 when Connecticut began its program, that there is a significant brain impairment in cognition and insight in approximately 35 percent of people with serious mental illness like schizophrenia and others in which they are unable to understand that they are ill, where in your model is how you address these people? Where in your plan are you going to get services to people who do not understand that they are ill, and because they do not understand they are ill, they are not going to go anywhere, even if it is the most wonderful care in the world? This segment utilizes the system most, costs the most with their revolving care and their recidivism, and they end up in our jails and are our chronic homeless.**

A: Larry Fricks: First, I firmly believe recovery is possible for everybody, and I think we are seeing a shift that happened in developmental disability. Twenty years ago, you did not see people with Down syndrome working, because the belief was they did not have the insight, they did not have the capacity. The advocacy movement in developmental disability said, "That is just not true; they have strengths." So they came up with this concept called supported employment, which did not start in mental health;

it started in developmental disability. The data we showed the folks in Baltimore blew them away when they saw what happened when we went under the Rehabilitation Option and saved money. The problem, not only in Georgia but in every state, is because Human Services is not politically strong. When you save those dollars, you often lose them, and somebody that is stronger like Corrections or Highways comes in and scoops those dollars back, so you have this weird, perverse funding situation where if you save dollars, you are liable to lose them. If we hold on to those dollars saved, they could be redirected and used for things like housing and jail diversion. But if you are going to lose those dollars, we lose the opportunity to redirect into community services.

A: Andrea Bradford: In psychiatry, we are focusing on treatment options for cognitive impairment, targeting cognitive impairment specifically. When you focus on somebody's impairment, you are not focusing on how to get them to recovery. If someone says, "I am not sick," then maybe you need to move to some place that they can understand, something like, "So you do not believe you are sick and I do. Let's look at what you want and what you can do with your life and how to get you where you want to go. You do not have to admit that you are sick to do the things that you need to do to get you where you want to go."

A: Larry Fricks: I want to add another concept that is hard for people to grasp. When I was psychotic, I thought God was communicating to me, and I got a one-way ticket to Bogotá, Colombia. I was going to bust the drug cartels. A one-way ticket. Thank the Lord my best friend told my family, and they got me in the hospital. What is hard for people to understand is that within that psychosis were islands of reality. I went and bought a plane ticket. I drove my car and stopped at red lights.

General Discussion – Work Group Presentations

Ron Koon, Ph.D.
Chief of Psychological Services
Georgia Department of Juvenile Justice

The Gap Analysis officially started in 2003, but began informally way before that with Cynthia Wainscott, Ellyn Jeager, and Sue Smith, all of whom had been pushing hard for years about getting good data. It finally came to a vote by the Mental Health Planning and Advisory Council in 2003 and was approved. We identified a source of funding for it, and it moved forward.

The work groups each had a charge of building consensus on the key issues in their particular area and identifying concrete actions to move the mental health system forward in their respective area in resolving problems. I asked each of the reporters for the three groups to consider three things: identify the topic, share the issues that got the most attention (and perhaps those about which there was no consensus), and comment on their action steps.

Group 1: State hospitals fill the void of community-based crisis services: Does privatization work?

Ellyn Jeager, *facilitator and reporter*

We talked about the roles of the hospital. Who should be in a state hospital? How do we identify those people? What is it that gives us the best outcome when a person is in the state hospital? How would the person transition out?

That in itself talks about the fact that the hospital is part of a continuum of care, and you cannot talk about who goes into the hospital unless you also talk about the alternatives to going into a hospital. What is in the community? How is the community supported? How is it funded? What does it do to the hospital when it is changed from a state hospital to a private one? You cannot fix one thing in isolation and say we have actually addressed the needs of the mental health community.

We also talked about different roles – roles of advocates, roles of the division, roles of the governor's office and his budget office, roles of the advocacy community – and how you take all of that and get a really good partnership so you understand the full complexity of what you are dealing with. After that discussion, we went back to the charge of what would happen if we did privatize a hospital.

I am pretty secure in saying that the bill we saw last year will not be duplicated word for word but that there will be another bill next session that looks at privatizing a hospital. How do we interact with that, and how do we become proactive instead of reactive? In fact, most of what we do in the mental health community is react to something we are not part of.

So how do we become proactive? To become proactive, the first thing is to have a seat at the table. You cannot write a bill without fully understanding what that bill has to look like, and you cannot write a bill until you have information. We talked about an RFI, a request for information, and how

important it is to get that information in hand. The Gap Analysis gave us some great information, but we could get even more specific information from the hospitals. For instance, what exactly is the role of the hospital in the community? What do they do besides house somebody for 24 hours a day and give them food, clothing, and medicine? Different hospitals do different things, and some of them, in fact, have a far greater outreach into the community than others.

Assuming then that we are moving forward, we need an RFP, a request for proposals. That has to go out broad-based across the United States. We should not assume that one company or just one state would be the only one who would reply. What do we need to have in this RFP to ensure that should a hospital be privatized, there would be some safeguards? Should DHR make the decision, or should legislators make the decision?

Different hospitals do different things, and some of them have a far greater outreach into the community than others.

How do we know if the hospital is privatized that, in fact, it is going to be cost-effective? We need to make sure that there is real evidence that if a hospital is privatized, it is going to work. We have to look at cost and quality. If a hospital is to be privatized, we want to make sure that the hospital has to play by the same rules. So it cannot just choose who would come into that hospital. It could not say only, "We are only taking people who have insurance, or this population, but, in fact, it would have to meet the same rules and regulations as the state hospitals do, which is to take anyone who shows up at the door. What services would a contractor agree to provide, and how do we define that role of that hospital? Would we require halfway houses, etc.?

If you saw the legislation that did not become law, you saw that there was an unreasonable time frame in that legislation. It was to happen overnight, basically. An RFP would have to include a realistic amount of time if the state were to move forward and we were going to privatize. There would have to be a reasonable expectation of how long that would take.

We would want to see a fiscal note saying what the plan would cost. The last legislative session had legislation that had no fiscal note, yet anytime we try to bring a bill like insurance parity forward, the first thing we are told is, "You have to have a fiscal note." And if they are talking about savings, what would it save? Another requirement would be that money saved in the mental health community be reinvested in the mental health community.

Would the employees of the state hospital have the first opportunity to be employed by a private hospital? Also, we would want to make sure that if the hospital were privatized that there was a voice for consumers, families, and advocates at that hospital, that there would be some kind of board or family session or advocate session – input from the community to make sure their voices were heard.

We will have to become more proactive, because we need to find out if the legislators who pushed this legislation last session are planning on doing it again. And if they are, how we can become involved in the process before it is already a bill.

Group 2: There is a fragmented vision for an improved mental health system.

Larry Fricks, *facilitator*
Anna McLaughlin, *reporter*

We thought that it would be nice to build a unified vision with a plan. We started by brainstorming what a good vision would include. Then we wanted to see if we could come up with something that could overarch all those statements. We want a vision statement such as: Create and continually improve a cost-effective, accountable recovery and resiliency environment for all Georgians. We felt this statement met all the things we talked about. Then we got to the "nuts and bolts" of the conversation, discussing the reality of what we do.

We were asked to write action steps, and we came up with three things we can all get behind for this year. First is 100 percent inclusion in services with equal coverage for all Georgians, especially around mental health benefits.

The second thing is to create a group that will define what we mean when we say "recovery" that is consistent. We now have a group of eight people who have agreed to meet in the next 90 days to come up with a definition around "capable, optimal, personal responsibility, recovery, resiliency" that we can all use consistently. So when we say it, we know what we mean, and when someone says, "What does that mean?," we can all use the same language to define it.

The third thing we can all get behind in the next year is reinvesting in our own system 100 percent of any savings we create.

Group 3: Public mental health services reach less than one-third of those estimated to have a serious mental illness or serious emotional disturbance.

Sue Smith, *facilitator and reporter*

We started with our charge: Public mental health services reach less than one-third of those estimated to have a serious mental illness or serious emotional disturbance. Given that, and hooked to an advocacy agenda around specific items and steps, we started with a general discussion. The general discussion gave us 11 barriers, four or five exemplary programs that exist in Georgia, and a number of strategies for engaging people. The interesting thing, if you look at the notes, is that everybody thought we should engage people at a different level in a different way.

We want mental illness to be looked at as any other treatable disease.

The exemplary programs that we talked about – crisis intervention team, advance directives, peer center, and mental health corps – were mentioned specifically numerous times. Our list included: (a) common message – to educate for advocacy across systems, (b) cost-benefit analysis, (c) understanding the messages of the gap for other populations – youth, aging, (d) recommendations of the Gap Analysis, (e) formal communication plan that could be tailored to community but would carry the message universally across the state, (f) developing a manual of all resources, and (g) having the chief medical officers here, which is going to be key to having them understand what we value and how we operate. We also talked

about what is good about the system. We have come a long way in our system, but what you hear is not the good things that are happening. You hear the things that are not good that are happening.

Our conversation ended with the need for moving dollars and putting them places where they would do more good. It was (somewhat) stated that some of that would be hospital money used differently or put in the community. We want mental illness to be looked at as any other treatable disease. It is a human relations issue. We need a strategic road map, we need a small group to get it done, and we need to get everybody on the same page.

If we could do all those things, we probably would not have two-thirds of the people not getting served. There also was a concern that if we actually reach the other two-thirds, we would not be able to serve them. It was the same concern that I had earlier when I heard about screening all children in school. There is no way we could meet the service needs. So it is not that we should not reach people, or try to reach people, or have every person correctly served. It is that we should think about having services for people when we engage with them.

Comment: Ellyn Jeager

Many folks who are diagnosed with mental illnesses may or may not be diagnosed with substance abuse/addictive diseases,

and we need to recognize that this co-occurring population is a large one. When we even talk about hospitals and community, we cannot keep isolating these groups. You cannot treat mental illness in the hospital and not treat substance abuse if, in fact, someone has both. One of the reasons the admission rate is so high is because we are not treating the whole person. We are treating whatever fits into that payment system.

Likewise, you cannot put somebody into the addictive disease system who has a mental illness and not treat that, because, of course, we are not going to have the results we should have. While I am very clear about my mission for mental health, I also clearly recognize that many do not have just a mental illness. People cannot be defined by their mental illness. We need to make sure that whether the hospital is a state or private hospital, it, in fact, addresses all the needs of the person.

General Discussion – Open Dialogue

Ron Koon: At the last Mental Health Planning and Advisory Council meeting, one of the division staff said something that really stuck in my mind: The Gap Analysis is a nice tool and it is a nice set of data, and we finally have a good snapshot of services in Georgia, a good snapshot of the need. But everyone knew we did not have enough. Our challenge has been to make sure that everybody had their fair share of "not enough." How do we move beyond managing "not enough?"

Ellyn Jeager: It is hard to move forward when there is no public will. There is no public will because there is no education and there is no education because there is no public will. The general population needs to be educated. It is not just our legislators or teachers or front-line mental health workers who need education. People need to have a better understanding of why mental health is so important and how you cannot separate mental health from overall health and wellness. If there was that knowledge, if people really understood what mental health meant, what the future is for mental health – that it is not a drain, that all of us have incredible potential given the opportunity – we could move forward.

Anna McLaughlin: So how do you do more with the same? There are economic studies that show that bureaucracies have so much "fat," but Georgia's mental health system has been cut so many times that there is no fat left and we are getting to lean meat now. There may be some redundancies, lacking an integrated system of care for children, for example, but that only addresses the children's issue. From a children's point of view, an integrated system of care might reduce some redundancies so you do not have a mental health case manager and a DFACS case manager and a probation officer case manager.

Sue Smith: Wendy [Tiegreen] pointed out that we have multiple systems. As we go forward, let's do it thoughtfully, in a timely manner – not too fast and not too slow – so we do not lose people. Let's manage wisely the resources we have been given before we ask for more. We should be sure we are doing the right thing right now first.

Boyd McLocklin: In our group, we talked a lot about recovery-based models as opposed to illness-based models, and that had ramifications for what we had to say. We attempted to apply that to advocacy to some extent. One of the things I have mused about is the fact that in 1993 we

sold the Legislature on the fact that the system was no good and we needed to fix it. Unfortunately, through the years since then, we have spent a lot of time analyzing how bad it is and what needs to be done. If we are to build an approach to advocacy for the future, I think it is time we begin to look at how organizations may be like individuals, that we may get further quicker if we use a wellness-based model as opposed to an illness-based model. It scares us all when we hear that more than 60 percent of the people who may need our services may not get them. But I believe as an advocacy community, we have to focus on what is right. As Larry Fricks said, "I think we have more going good for us than we know is going good for us." I hope that we can build a model for advocacy in Georgia that begins to look at the strengths of what we have and how we can use the CQI method of increasing those strengths, as opposed to a revolution method of "we have to fix it again next year with another program." I think that could also bring some stability to our service components, both private and public, in the community.

Ellyn Jeager: People advocate for their own programs, and, in the long run, that has been harmful, because legislators do not see us as one, large advocacy group. We do not have a coalition across lines that says to legislators, "We all are interested in this."

Closing Remarks

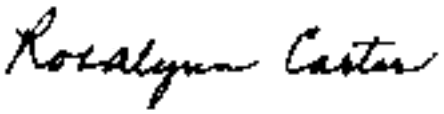
Rosalynn Carter
Chair, The Carter Center Mental Health Task Force

These meetings are so valuable because we gather the most respected state advocates together and no one is afraid to say what they think! It helps all of us to consider alternate positions. We cannot underestimate what we as advocates can do individually, but for some issues, we can succeed only when we are united. That does not mean giving up your cause or the things you are really interested in, but if we are going to get anything done, we sometimes must work together. I think that is really important.

Today we came together with the purpose of reaching consensus on some solutions to the poor state of mental health care in Georgia. I remember when Hillary Clinton started working on health care reform. I think the mental health community joined together then more than ever before because we knew that every interest, every group, was writing something to go into her health bill. And wisely, all of the different constituents realized that a piecemeal approach would never succeed. We had to work together ... and we did. Of course, in the end, no legislation was passed, but it taught us the value of partnership and that we could be far more effective and achieve more through collaboration.

We well know that there is a huge gap between what mental health services should be available in Georgia and what we have. But the actual extent of this gap had never been formally calculated. When we tried to get legislation passed or to get policy-makers to take action, we could not document the unmet need. We knew it was there, everybody knew it was there, but we did not have a way to show how big this gap is. Now we have the Mental Health Gap Analysis. This powerful tool can help us as we advocate for those whom we care about and want to help.

I think we can have an impact in Georgia, but it is going to take some time. And it is up to us to come together and speak with one voice. I am glad to know that the four statewide advocacy groups have committed to working together in the future, and I look forward to monitoring their progress. Hopefully, their combined effort will ensure that the solutions we recommend are implemented.



About the Speakers

Andrea Bradford, M.D., M.M.M., is the medical director for the Division of Mental Health, Developmental Disabilities and Addictive Diseases for the state of Georgia. She received her medical degree from the University of Alabama in Birmingham School of Medicine. Dr. Bradford was assigned to Martin Army Community Hospital at Fort Benning for 11 years and retired from the Army in 1997. She is an adjunct professor of psychiatry at the Uniformed Services University of the Health Sciences in Bethesda. Her major interests include issues surrounding implementation of evidence-based practice, quality/performance improvement in psychiatry, and integration of medical/surgical and psychiatric care to maximize disease management and prevention programs.

Linda Buckner has been an active consumer advocate with a strong working knowledge of the Georgia mental health system as well as consumer movements on the national level. She coordinated and established the S.H.A.R.E. Project, a consumer-run mutual support program, coordinated a statewide supportive employment consumer satisfaction survey, and has received numerous awards and honors, including Consumer Leader of the Year 2000 from the Mental Health Association of Georgia. Ms. Buckner is president of the Georgia Mental Health Consumer Network and is involved in the Georgia Mental Health Consumer Council, the Georgia Mental Health Planning and Advocacy Council, and numerous other organizations. Ms. Buckner is one of just a few consumers who are certified mental illness educators.

Michael Claeys, L.P.C., M.B.A., has been the APS Healthcare executive director since 2000. Under the leadership of Mr. Claeys, APS Healthcare provides training and quality assurance activities for all services funded by the Division of Mental Health, Developmental Disabilities and Addictive Diseases. Formerly, Mr. Claeys managed an intake and evaluation unit at a community mental health center in Georgia. He also has worked extensively in hospital settings and in private practice. Mr. Claeys holds a master's degree in business administration from Kennesaw State University and a master's of science from Georgia State University in community counseling. He received his undergraduate degree in psychology and education from Berry College, Rome, Ga.

Larry Fricks is director of the Appalachian Consulting Group and served nearly 13 years as director of the Office of Consumer Relations and Recovery for the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network, the Georgia Consumer Council, Georgia's Peer Specialist Training and Certification, and the Georgia Peer Support Institute. He serves on the board of directors of the Depression and Bipolar Support Alliance, among others, and on the advisory board for the Rosalynn Carter Fellowships for Mental Health Journalism. Larry has a journalism degree from the University of Georgia.

Patrice Harris, M.D., M.A., is a graduate of the West Virginia University School of Medicine and completed residency and fellowship training at the Emory University School of Medicine. Dr. Harris is the medical director for the Fulton County Department of Mental Health, Developmental Disabilities, and Addictive Diseases and is in private practice. She also is a clinical associate professor in the Emory University Department of Psychiatry and Behavioral Sciences. Dr. Harris is immediate past president of the Black Psychiatrists of America, serves on the American Medical Association's Council on Legislation, and is president-elect of the Legislative Committee of the Georgia Psychiatric Physician's Association.

Stanley S. Jones Jr., J.D., M.A., a partner of Nelson Mullins Riley & Scarborough LLP, serves on the executive committee of the Dean's Council for the Emory University School of Public Health. He was the founding president of Project Interconnections, an initiative that builds housing units in Atlanta for homeless people suffering from mental

illness. Mr. Jones has been involved in the mental health movement in Georgia since working on gubernatorial and presidential commissions for the Carter family. Mr. Jones earned a juris doctor, cum laude, from the University of Georgia School of Law and is a recipient of the Rhodes Scholarship.

Anna McLaughlin is a degreed criminologist and the co-chief executive officer for Georgia Parent Support Network, a nonprofit family organization serving children and adolescents with severe emotional disturbances and behavioral challenges. Since 1996, Ms. McLaughlin has been an essential partner in developing and monitoring Fulton County, Ga.'s, system of care serving youth with SED. Ms. McLaughlin represents GPSN programs in workshops around the country and has presented in London, and she is considered an expert in the subject of wraparound. Ms. McLaughlin's family includes of two young women with mental illness.

Wendy White Tiegreen is a program director for the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases' Medicaid Systems Design Section. Ms. Tiegreen coordinates the state's Medicaid Rehabilitation Option in partnership with the Department of Community Health's Division of Medical Assistance and manages the contract for the state's External Review Organization. Ms. Tiegreen was the primary mental health negotiator with the then Health Care Financing Authority (now CMS) in the establishment of peer supports as a unique Medicaid-financed service. She holds a master's degree in social work from the University of Georgia.

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