Building a Vision for Community Services

for Children, Adolescents, and Adults with Behavioral Health Disorders in Georgia

Georgia Mental Health and Addictive Diseases
Urgent Model Project

THE
CARTER CENTER

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The Carter Center Mental Health Program

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I. Executive Summary

This report envisions a Georgia where children, adolescents, and adults in every Georgia community with behavioral health challenges are able to recover, succeed, and thrive within their communities and their families. It seeks to give Georgia policy makers and stakeholders at the state and local level tools and ideas for building and maintaining a strong behavioral health infrastructure that supports optimal health for all its residents.

Georgia is in the process of transforming its behavioral health system from one that relies heavily upon institutional care to one that emphasizes community services that can prevent, identify, and treat disorders early and support ongoing recovery. Without community supports, too many people get swept up in our justice system or end up homeless on our streets.

The road to building a community infrastructure will not be easy. It will require insisting on quality and outcomes. It will require coordinated continued efforts by our communities, including families, stakeholders, the faith community, service providers, teachers, police, judges, universities, colleges, elected leaders, and those who have mental health and addictive disorders who can help us better understand the lived experience. We know it can be done because it is happening in communities all over our state. We know that eventually community services are less expensive than the alternatives of institutional and emergency care and the loss of human potential.

Behavioral health disorders are not rare. Over 2.4 million Georgians or approximately one in four adults and one in five children will be challenged each year with an identifiable behavioral health disorder, and over 5 percent will experience a serious disorder that significantly affects their ability to function in their family, workplace, schools, or in social relationships.

This vision document utilizes a public health perspective. It focuses on the whole person and targets the range of services needed by an individual and the entire population in a community to prevent, identify, treat, recover from, and maintain recovery from behavioral health conditions (mental health and addiction disorders) over the lifespan. It recognizes the inherent resiliency of communities and individuals as both seek to overcome stigma, learn about behavioral health disorders, heal, and maintain health. This approach was chosen because:

At any age a behavioral health disorder can develop, and all of us need to be empowered with information on how to recognize symptoms and access treatment without fear.

Recovery for individuals with behavioral health conditions is attainable.

Protective factors can be developed to give a person greater resiliency, lessen the effect of a disorder, and prevent the triggering of a behavioral health condition.

When identified and treated early, symptoms are likely to be less severe and have a shorter duration.

Mental disorders and addiction represent five of the most costly health conditions in the United States[1] and the least likely to be identified and treated early.

People with a serious behavioral health disorder are at increased risk for additional chronic medical conditions and were found to have a lifespan, on average, 25 years shorter than the average.

A person with a behavioral health disorder(s) or other chronic health disorder such as diabetes or cancer can experience relapses and crises. A quality community health system plans for these and assists individuals to have fewer relapses or crisis.

Background

In 2008, Georgia became involved in a U.S. Department of Justice suit for "*failure to serve adult patients in the most integrated setting appropriate to their needs*" and failure to protect individuals in state custody from harm. The Carter Center Mental Health Program was asked by a diverse group of stakeholders across the state to develop a vision for community behavioral health services. In 2010, the Carter Center Mental Health Program agreed to develop a vision report and to take it to three of the six Department of Behavioral Health and Developmental Disabilities (DBHDD) regions of the state for comment and input. In 2012, the draft vision report was presented at town hall meetings in the remaining three regions.

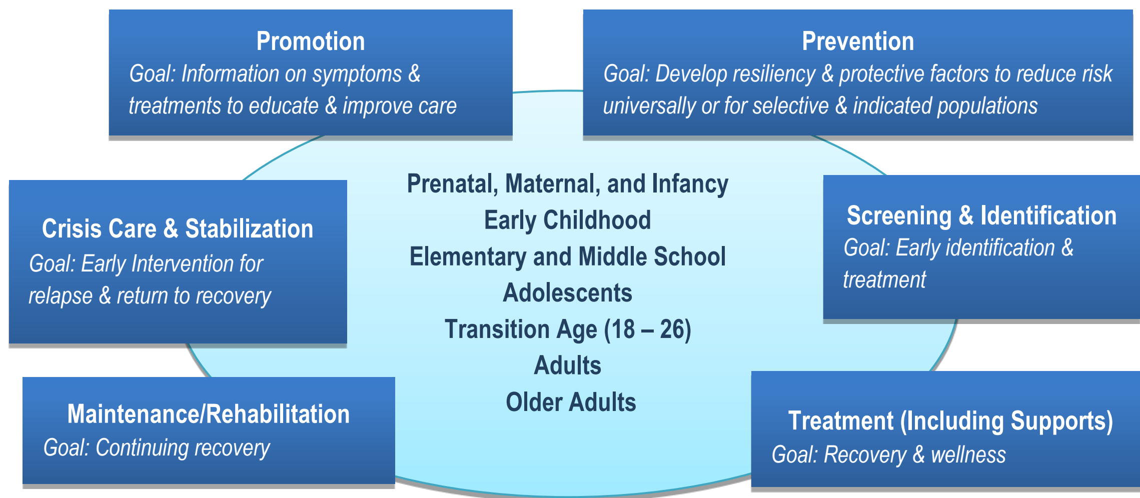
On Oct. 19, 2010, a settlement agreement was reached between the state and the U.S. Department of Justice that included specific services and timelines for community services for adults with "serious and persistent mental illness" to be fully implemented by July 2015. The settlement targets 9,000 adults who are frequently re-admitted to state psychiatric hospitals and emergency rooms as well as chronically homeless individuals or those released from jails and correctional institutions. Though the settlement adopted many stakeholder recommendations for adults at risk of institutional care, it did not address children; people with addictive disorders; adults with less serious conditions; or prevention, identification, and early intervention services that would lessen the demand for acute care.

An Overview of Key Linchpins in the Document

Challenges, best practices in treatment, promising strategies, and the input of citizens across Georgia guide the recommendations that are outlined here and appear in more detail in the report. A pragmatic approach was taken. Instead of checking off a laundry list of treatment services, "linchpins" were identified. Use of the word *linchpins* throughout the report indicates groups of services or events that, when implemented, can move the vision forward exponentially. Linchpins also take advantage of emerging opportunities where public support and willingness to improve services exist.

Linchpins for Community Planning, Infrastructure, and Services for All Ages

Figure ES-1 Community Planning for Key Infrastructure Supports Across the Life Span



Notes: Figure ES-1 is an adaptation of the Institute of Medicine Protractor that is widely used for continuum of care health and prevention planning. The age areas have been identified by the Interdepartmental Directors Team (IDT), a subgroup of the Georgia Behavioral Health Coordinating Council. [1]

Community-Level Consumer and Stakeholder Input and Engagement. A formal structure and process for consumers and stakeholders exists at the local level that engages them in planning and evaluating the quality and presence of an integrated, whole-health continuum of behavioral health services across the life span. This structure reports findings and recommendations to the Behavioral Health Coordinating Council and to specific agencies when state-level agency changes may be needed to improve the system of care in the community.

Public Information and Education. Information on the signs and symptoms of behavioral health disorders and where to access services is widely available, including how to access Georgia's Crisis and Access Line (GCAL) 1-800-715-4225. Suicide, addiction, depression, and trauma prevention information is strategically provided to at-risk groups and individuals. Services such as Mental Health First Aid and Family to Family Programs assist consumers, families, and friends to be supportive of the recovery process.

Integrated General Medical and Behavioral Health Care. Integrated care is accessed through a *patient-centered medical home* so that patient care can be coordinated with a continuum of wellness, prevention, treatment, rehabilitation, and crisis care services. Services and supports include:

- Standard behavioral health screening as part of a general medical screen by all health care providers. Screening for trauma, depression, addiction, and suicide risk is included.
- Early identification and treatment through a community behavioral health "hub"
- Care management
- A continuum of least restrictive, recovery-oriented core and specialty services. Stakeholders attending regional meetings across the state were particularly concerned about:
    - *Values and quality* assurance. Services are evaluated for client satisfaction. Providers are recovery-oriented and concerned with whole health and wellness as well as consumer choice.
    - Transportation. Reliable, trained Medicaid transportation providers understand the importance of regular treatment and potential consequences of missed appointments or waiting for long periods of time to be picked-up or brought home
    - Medication. A formulary for treating behavioral health conditions that do not restrict a physician's ability to find an effective medication and dosage level for the consumer. Child-serving agencies coordinate formularies and assure quality, recognizing the dangers of conflicting prescriptions
    - *Specialized infrastructure planning for often overlooked* populations. These include older adults in nursing homes, veterans, and individuals who experience trauma (e.g., abuse, rape, domestic violence, and gun violence)

Emergency Care. Individuals who experience or begin to feel that they may experience a relapse or behavioral health crisis have access in their community to mobile crisis services, recovery residences, hospital beds, pre-crisis planning support, respite care, and first responders who have received Crisis Intervention Team (CIT) training.

Workforce Development. A sufficient, competent, updated workforce is recruited to address the severe shortage of behavioral health professionals. *Certified peer support services* are expanded in every community for adults and children with mental health and substance use disorders. *Tele-behavioral health services* are available in areas with workforce shortages. Licensure boards for the healing professions require training in behavioral health best practices. State educational institutions develop *community-level internships* in behavioral health and *graduate more specialists* in psychiatry, psychology, counseling, and nursing. *Georgia's General Assembly provides incentives* for behavioral health professionals to practice in rural areas.

Finances. Funding mechanisms (a) incentivize a system of care by braiding agency services and funds, (b) support a coordinated service network of public and private providers, (c) involve consumers/stakeholders in assessing covered services and the quality of care, and (d) ensure that individuals with behavioral health conditions can access quality services regardless of payer source.

Medicaid. The Department of Behavioral Health and Developmental Disabilities plays a lead role with the Department of Community Affairs Medicaid Division (DCHMed) in developing the critical elements of a Medicaid managed care plan for behavioral health. Consumers and stakeholders serve as advisers to

state agencies in the development of the contract and in evaluating the chosen managed organization's performance. Medicaid managed care profits are capped, and savings are reinvested into evidence-based community services/supports. A community-level organization is charged with decision making and advising DBHDD and DCHMed on service gaps/needs for reinvested funds. An easily navigated appeals process ensures consumers' ability to access Medicaid services and the Medicaid agency's ability to identify systemic problems.

Safety Net. Safety net services assure availability of services in every community for children, adolescents, and adults with behavioral health conditions.

Data. Indicators are chosen to measure and evaluate the need for services as well as the quantity and quality of behavioral health services. *Data is collected at the state and community level* and made widely available to stakeholders and policy makers in the executive and legislative branches of government. *Cost-benefit analysis measures consumer satisfaction, the short- and long-term outcomes for individuals*.

Coordination and Consumer Informed/Directed Services. Children and adults with serious behavioral health disorders receiving services from multiple agencies or who are moved between agency services receive care and treatment informed and evaluated by the consumer and family (for children). The care received lacks conflicting pharmacology treatments, service gaps, and redundancy.

Alcohol and Drug Use Prevention and Treatment. Juveniles and adults with addictive disorders have access to evidence-based services, including recovery centers, crisis relapse care, and peer support services to assist them in their recovery. Evidence-based public information and promotion activities reach out to at-risk populations with signs of addiction and ways to access treatment services. Evidence-based community prevention laws and programs are enacted that deter behaviors that lead to addiction and incentivize community members to assist individuals from addictive forming behaviors. Examples of laws and programs are alcohol taxes, enforcement of underage drinking laws, alcohol prevention curriculums in schools, and wide use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model for alcohol use.

Community Linchpins for Maternal, Infant, Child, and Adolescent Services

Prevention and promotion programs target at-risk children and youth, helping them to develop resiliency and ensuring that protective factors are in place.

- *Home visiting, parenting education*, *respite* or other appropriate parental supports are available for at-risk pregnant women, teen parents, parents adopting neglected or abused children, parents with behavioral health disorders, and parents in stressful situations who may be at risk of child abuse, neglect, or domestic violence.
- *Quality preschools* serving 0- to 5-year-olds at risk for school failure, behavioral problems, or disabilities have access to mental health support.
- *Positive Behavioral Intervention and Supports (PBIS)* programs in district school systems address school climate and train all staff in learning positive techniques for disciplining and addressing the underlying special needs or situations of children with behavior problems.

- *Diversion* programs keep youth in school and out of juvenile courts and justice system.
- *Foster care and runaway youth transition programs* help youth without forever parents develop skills to successfully manage their independence.

All children in Georgia are screened for behavioral health disorders and are able to access quality behavioral health services in a timely manner in their community.

Obstetricians, pediatricians, and family practitioners are knowledgeable about behavioral risks and screen for maternal, child, and adolescent behavioral health risk conditions.

Preschools, public schools, colleges, and universities have onsite behavioral health clinics or support services.

Care Management Entity (CME) wraparound services are available for youth with serious behavioral health disorders at high risk for out-of-home placements or those in restrictive settings who could be moved from out-of-home placements, detention, and therapeutic institutions if CME services were available to them. Wraparound services are a cost-effective alternative to institutional care found to save, on average, $40,000 per year per child. In addition, outcomes for families and children improved significantly in many areas, including school attendance and grades, clinical and functional outcomes; stable living conditions; reduced suicide attempts; and decreased contacts with law enforcement. [2]

A common formulary, medication guidance, and quality control system are used across agencies that serve children with behavioral health disorders to ensure safety and reduce medicine-induced trauma/crisis or medical complications.

Quality transition services with cross-agency coordination and case management are provided to youth with behavioral health disorders (a) in state custody who are emancipated/aging out of foster care, (b) leaving juvenile detention, or (c) leaving special education programs with behavioral health disorders. They have the best chance of successfully living independently by finding employment, housing, and receiving the therapeutic and other health care they need to maintain their recovery.

A cross-agency plan for community services for children and adolescents with behavioral health challenges is developed that identifies core and specialty services, braids funds to implement the core services, defines outcomes expected, and delineates expected provider quality assurances. A cross-agency special package of Medicaid core and specialty services is established for children's behavioral health care.

Linchpins for Adolescents and Young Adults (18 to 26 years of age) Transitioning to Adulthood

The Georgia Department of Behavioral Health and Developmental Disabilities and partner agencies develop *a plan for youth and young adults with serious behavioral health conditions transitioning to adulthood* that identifies (1) responsibilities of *both adult and child serving agencies,* (2) specific agencies/programs who will coordinate, and (3) available federal grant funds that can assist. Each agency has dedicated/assigned staff to work on transition issues. Planning includes how support will be provided for *case management, education, employment, housing stability, financial security, health care, and treatment* in order to prevent costly, poor outcomes and provide tools to become independent, functioning adults.

Georgia *communities are assisted in implementing the transition plan for high-risk, transition-age youth/young adults*

with serious behavioral health challenges in the following scenarios: foster care and after emancipation; high schools (youth with seriously emotional disturbances, learning disabilities, behavior problem, suspended, and placed into alternative schools); technical schools and universities; incarcerated, paroled, or released from detention; pregnant/parenting; returning armed services; runaways or homeless; and poor families.

Community Linchpins for Adult Services

Intensive Care Management for Adults at Risk of Institutional Care. Effective intensive care management models such as Assertive Community Treatment (ACT) and Opening Doors to Recovery (ODR) support whole health recovery on a 24/7 basis. If needed, these model programs can assist individuals with one or more serious behavioral health disorders and guide them toward a meaningful life where they can reach their potential and live in their communities. The care management team helps the consumer with the development of a recovery care plan and access to a range of services to meet his/her recovery goals including but not limited to:

Supportive housing	Supportive employment	24/7 crisis care services
Peer support	Respite care	Medicaid management
Counseling	Exercise and nutrition	Transportation
Drug and alcohol residential and outpatient treatment		

Criminal Justice, Emergency Room, and Homeless Diversion. A number of successful community diversion programs are funded with adequate support and treatment services for individuals with behavioral health disorders who interact with the criminal justice system but do not pose a threat to public safety. Individuals who frequent hospital emergency rooms are assigned a case manager/peer navigator who assists them in accessing health clinics and/or behavioral health supports.

Older adults have community services that are designed for their unique behavioral health needs and living environment. These include exercise and nutrition programs and evidence-based treatments for caregiver stress, anxiety, and late-life depression that are delivered where the person is located if mobility is a factor. Geriatric behavioral health support services are located in nursing homes, day programs, hospitals, and other institutional settings that serve older adults at high risk for mental health disorders. Nontraditional volunteers such as Meals on Wheels or faith community volunteers are trained in identifying older adults in need of behavioral health support. The Department of Behavioral Health and Developmental Disabilities provides leadership on behavioral health services for older adults with designated staff. The department also partners with area agencies on aging to implement creative solutions in communities for older adults who are often invisible and may feel that seeking assistance will further stigmatize them.

Maintaining a Vision for Behavioral Health Community Services in Georgia

This vision is a living document for Georgia stakeholders that will remain on the website as the Carter Center Mental Health Program works with consumers, stakeholders, and community leaders to develop a system of community behavioral health services in Georgia, especially for children. Since the draft vision

report was developed in 2012, The Carter Center has held six regional meetings, a statewide forum, and met with key stakeholders to gather input to the Georgia vision recommendations, many of which already have been adopted.

We thank the J. B. Fuqua Foundation, the Tull Charitable Foundation, the Betty and Davis Fitzgerald Foundation, and the John and Polly Sparks Foundation, whose generous support made the Georgia Mental Health and Addictive Diseases Urgent Model Project and this vision document possible. We also thank the many agency staff, stakeholders, and consumers across Georgia who contributed their time and wisdom to the development of this document.

References

[1] Institute of Medicine and National Academy of Sciences "Preventing Mental and Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities." (2009, p. 67)

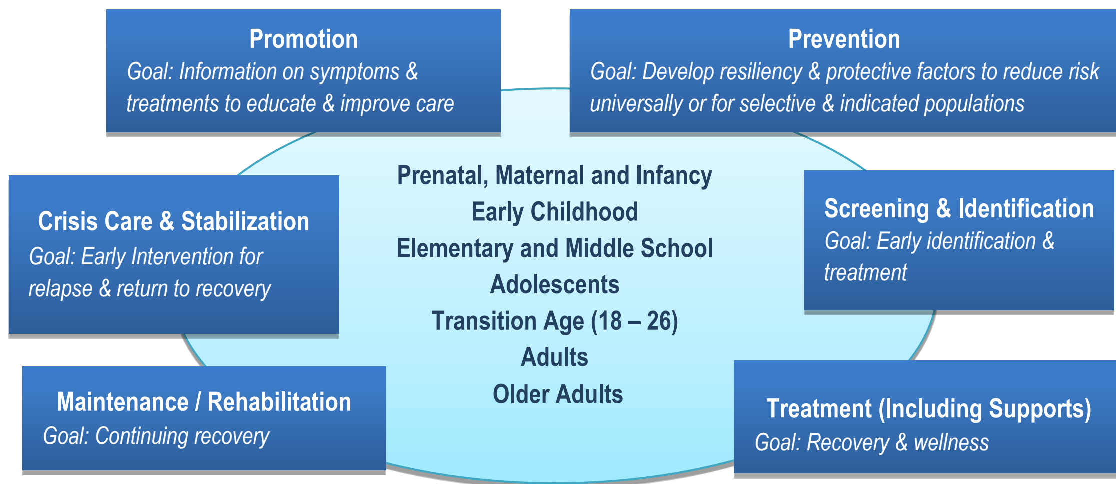
[2] Centers for Medicaid and CHIP Services and Substance Abuse and Mental Health Services Administration. Joint CMCS and SAMHSA Information Bulletin. May 7, 2013. Retrieved from: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

II. A Georgia Vision for Behavioral Health

Children, adolescents, and adults in every Georgia community with behavioral health challenges are able to recover, succeed, and thrive within their communities and their families.

The Vision was created at the request and input of many stakeholders across Georgia. It provides an agreed-upon overview of what is important to many of Georgia's behavioral health stakeholders, including policy makers, advocates, families, and consumers who will be most affected. It seeks to provide tools and ideas for building, maintaining, and tracking progress, recognizing that each community must be involved in marshalling its own unique resources. It is expected that the Vision will be modified over time as new information is available and progress is made.

Figure V-1 Community Planning for Key Infrastructure Supports Across the Life Span



Notes: This figure is an adaptation of the Institute of Medicine Protractor that is widely used for continuum of care health and prevention planning. The age areas were identified by the Interdepartmental Directors Team (IDT), a subgroup of the Georgia Behavioral Health Coordinating Council. [1] It is also included in the Executive Summary.

Vision Recommendations

The Vision recommendations emerged from a study of best practices in Georgia and the United States and the input of many stakeholders. It includes specific recommendations, with age-related targets, and some of the public/private sector "actors" whose leadership will be needed to implement a behavioral health infrastructure in communities. It is divided into the following overall sections:

1. Integrating General Medical and Behavioral Health Care
2. Infrastructure, Systems, and Coordination Across Agencies
3. Prevention, Early Intervention, and Resiliency
4. Screening and Identification of Behavioral Health Disorders
5. Behavioral Health Community Services and Supports

Children	Adolescent	Adults	Seniors	**II. A GEORGIA VISION FOR BEHAVIORAL HEALTH** √ =Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				Integrated General Medical and Behavioral Health Care	
x	x	x	x	√ ***All Georgia providers of primary care health care services have a strong working relationship*** with a provider of mental health and addiction services and vice versa and use a standard screening instrument for identifying behavioral health care needs.	DPH; DBHDD; DCHMed; DAS; CSBs; CHDs, FQHCs; G-AAP; GAPH; GAFP; GNA; GRHA
x	x	x	x	***Integrated care is accessed through a patient-centered medical home*** so patient care is coordinated with a continuum of wellness, prevention, treatment, rehabilitation, and crisis care services.	*Same as above*
x	x	x	x	☺ ***Georgia's Community Service Boards*** have strong integrated care partnerships with primary care providers in the communities in which they are responsible for establishing a behavioral health care safety net.	DBHDD; DPH; DCHMed; CSBs; FQHCs; Carter Center
x	x	x	x	***Children, adolescents, and adults with behavioral health disorders receive both primary care and behavioral health care services from providers that communicate with each other*** and know that individuals with a disorder are likely to also have one or more other special health care needs that affect their overall health.	DPH; DBHDD; DCHMed; DJJ; DOC; DOE; DFCS; CSBs
x	x	x	x	***Public information, training, and guidance*** on developing an integrated care practice are provided for primary care, pediatric providers, managed care primary care providers, public health clinics, federally qualified health centers, and school-based health services.	DBHDD; DPH; DOE; DCHMed; schools of medicine; FQHCs
				Infrastructure, Systems, and Coordination Across Agencies	
				Community Planning and Coordination	
x	x	x	x	√ **A formal structure and process for consumer input exists at the state and local level** for planning and evaluating the quality and presence of an integrated whole-health continuum of behavioral health services across the life span.	BHCC; DBHDD; DCHMed; CSBs; DHS-DAS-AAA; consumers; families; advocates
x	x			**A Strategic Plan for a Behavioral Health Community System of Care for All Children and Adolescents** in Georgia regardless of payer source or access to insurance is implemented. Since mental health is critical to the health of all children; the cross-agency plan includes a continuum of universal prevention services for all children; targeted services for at-risk children; and special, more intense services needed by those with behavioral health disorders. Since children's services are the responsibility of many agencies, DBHDD provides interagency leadership (with the BHCC and other agencies, as appropriate). **The Child and Adolescent Interagency Directors Team** of the BHCC develops the community plan that includes: *A formal community-level structure with strong consumer and stakeholder participation* *An index of services to prevent, screen, identify, treat, and respond to crisis* *A template for braiding and blending funds across agencies and funding safety net services*	DBHDD; BHCC; BHCC- IDT; DPH; DHS-DFCS; DCHMed; DECAL; DJJ; DOE; EOG; GGA; families, stakeholders, and advocates.

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				Quick access regardless of payer source for children in need of services *Addressing workforce challenges, especially in rural areas* *Quality assurance, including the safety and quality of out-of-home institutions and restricted settings*	
x	x			Each Major Child-Serving Agency: √ *Has interagency agreements (memoranda of understanding) to assist in coordinating/sharing data and services at the state and community level* √ *Has dedicated staff for behavioral health* √ *Screens for and identifies behavioral health disorders in its programs* √ *Provides training for staff on signs, symptoms, and best practices* *Agrees upon a common formulary, medication guidance, and quality assurance system to ensure safety and reduce medicine-induced trauma/crisis or medical complications in children with behavioral health disorders*	DBHDD; DPH; DHS-DFCS; DCHMed; DECAL; DJJ; DOE
	x	x		**DBHDD develops with partner agencies a separate plan for youth and young adults with serious behavioral health conditions transitioning to adulthood.** The plan identifies (1) responsibilities of both adult- and child-serving agencies, (2) specific agencies/programs who will coordinate, and (3) available federal grant funds that can assist. Each agency has dedicated/assigned staff to work on transition issues. (Note. A helpful list of federal grants to assist states and communities is available through the Bazelon Center for Mental Health Law. Promise for the Future: How Federal Programs Can Improve Career Outcomes for Youth and Young Adults with Serious Mental Health Conditions. Please see: http://www.bazelon.org/.	DBHDD; BHCC; DPH; DHS-DFCS; DCA; DCHMed; DJJ; DOC; DOE; USG; EOG;
	x	x		**Georgia communities are assisted in implementing the transition plan** for youth and young adults (17 to 25 years of age) with serious behavioral health challenges. Plans include case management and ways to support the individual's transition to adulthood in education, employment, housing stability, financial security, and health care treatment. Plans target transition-age individuals with serious behavioral health problems. *In foster care - prior to, during, and after emancipation* *In high schools: youth with SED, LD, behavior problems, suspended from high school, and/or placed into alternative school programs* *Incarcerated, paroled, or released from detention* *Runaways or homeless* *Pregnant/parenting, and/or at risk for perinatal mood disorders* *In technical schools and universities* *Returning armed services* *In poor families unable to support transition age with serious conditions*	DBHDD; BHCC; DPH; DHS-DFCS; DCA; DCHMed; DJJ; DOC; DOE; DOL; USG; EOG; private sector employers; advocates
				Infrastructure, Systems, and Coordination Across Agencies (continued)	
			x	√ The Department of Behavioral Health and Developmental Disabilities provides interagency leadership for older adults with behavioral health challenges through its Behavioral Health Coordinating Council in partnership with the Department of Human Services Divisions of Aging	DBHDD; DPH; DHS-DAS; GGA; DCHMed; Fuqua Center

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				Services, Community Health, Division of Medicaid, and Public Health (at the state and local level). These state agencies and the Fuqua Center for Late-Life Depression enter into a private-public partnership in order to build on the collaborative work done in Georgia to date aimed at the improvement of care for older adults in Georgia with mental and addictive illness.	
				Community Planning and Coordination (continued)	
			x	√ DBHDD, DHS-DAS, DCHMed, DPH and the Fuqua Center have: *Dedicated staff for older adults with behavioral health challenges* *A formal interagency planning team collaborating at the local and state level for older adults with behavioral health challenges. Interagency agreements exist to assist coordinating/sharing data and services at the community level. Findings, challenges, and accomplishments are reported to the BHCC.* *Community outcome indicators for older adult behavioral health* *Regional community plans to address older adults with behavioral health challenges* *Working relationships at the local level to assist Department of Corrections and county sheriffs to address older adults with behavioral health issues in their care*	DBHDD and regions; DHS-DAS and DHS-DAS-AAA; DPH & CHUs; FQHCs; DOC; CSDs; DCHMed; Fuqua Center/Emory University; and GGA
x	x	x	x	The Behavioral Health Coordinating Council (BHCC) membership is enlarged to include: *The Department of Early Care and Learning (DECAL)* ☺*The Georgia Departments of Education and* ☺*Public Health* ☺*A Child and Adolescent Task Force of the Council*	BHCC; DPH; DOE; BHCC-IDT; DECAL
	x	x		**Data is provided to policy makers on graduation rates and transition activities** for youth/young adults with behavioral health disorders by high schools, universities, and colleges to allow them to measure and improve graduation and employment outcomes for this very high-risk group.	DBHDD; DOE; BHCC-IDT; USG; Georgia judiciary; DOL; EOG; GGA
x	x	x		An independent cross-agency study is conducted to provide guidance on ways to reduce the disproportionate level of minority children, youth, and young adults with behavioral health challenges in restrictive placements.	DBHDD; DJJ; DFCS; DOE; Georgia judiciary; EOG; GGA
		x	x	√ The court system, private psychiatric hospitals, county sheriffs, and stakeholders develop and implement a plan for addressing the forensic population in state hospitals, including competency wait times, regional referral practices, numbers of individuals awaiting disposition for misdemeanors, and other problems the groups identify.	DBHDD; CSDs; EOG; GGA; Georgia Bar; Georgia judiciary
		x	x	√ DOC, DFCS, county sheriffs, and DBHDD develop an ongoing method for estimating the number of individuals **in need of supportive housing (by region)** served by their agencies with serious mental health and/or substance use problems leaving institutions.	DBHDD; CSDs; DFCS; DCA; EOG; GGA; Georgia Bar; Georgia judiciary
				Workforce - A sufficient, competent updated workforce is recruited to address the severe shortage of behavioral health professionals.	
x	x	x	x	**Health care professions receive training in behavioral health** through:	DBHDD; DCHMed; DPH; DOC; DJJ;

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				Initial professional training at universities and colleges *Improved current-provider skills, especially in areas identified as learning gaps (best practices, integrated care, co-occurring addictive and co-morbid health disorders, and disparities).* *Required continuing education units (CEUs) for licensure* *Provider contract requirements*	DFCS; DOE; G-AAP; GAFP; GAPH; GNA; GPA; GPPA; GRHA; MAG; TSCG; USG
x	x	x	x	√ **The pool of providers is expanded.** New providers are recruited, and partnerships are developed with universities.	DBHDD; DCHMed; TSCG; USG; GRHA
x	x	x	x	**State educational institutions develop community-level internships** in behavioral health, graduating more specialists in psychiatry, psychology, counseling, and nursing.	DBHDD; TSCG; USG
x	x	x	x	**Georgia's General Assembly** provides **incentives** for behavioral health professionals to practice in **rural** areas.	DBHDD; DCHMed; EOG; GGA; GRHA
x	x	x	x	√ **Tele-health and tele-behavioral health.** Georgia's rural community clinics, schools, nursing homes, and other appropriate sites have tele-health and tele-behavioral health contracts with professionals so children, adults, and seniors do not lose valuable time driving long distances, and local behavioral health services are expanded.	DBHDD; DCHMed; DHS-DAS-AAA; DOE; DPH; FQHCs; Georgia Partnership for Telehealth
			x	A **geriatric behavioral health workforce** is developed and provides integrated health care with general medical practices [2,3]	DBHDD; DPH; DCHMed; Fuqua Center/Emory University; TSCG; USG; GGA
	x	x	x	**Training in the use of SBIRT** with adolescents, adults, and older adults is available to all primary care providers.	DBHDD; DCHMed; GCSA; G-AAP; GAFP; GAPH; GNA
x	x			√ **Georgia Academy of Pediatrics (G-AAP) utilizes the American Academy of Pediatrics AAP Toolkit for Children's Mental Health** to implement and integrate mental health into community primary care practices and plays a leading role in strengthening community advocacy, funding, screening, identification, and supportive services for children's behavioral health.	G-AAP; DBHDD; DPH; DCHMed; CHDs; FQHCs
x	x	x		√ **Perinatal Mood and Anxiety Disorder (PMAD)** training for obstetric and pediatric providers is continued and expanded.	HMHB-Georgia MHA Georgia; G-AAP;
				Infrastructure, Systems, and Coordination Across Agencies (continued)	
				Workforce –(continued)	
x	x	x	x	√ **The number of peer support providers** is increased, and **Medicaid reimbursable peer support** services are expanded by the Georgia Department of Community Health for: ☺ *Establishing drug and alcohol abuse and addiction services* √ *A certified parent peer support professional* *Older adults/other populations with serious behavioral health conditions where*	DCHMed; DBHDD GMHCN; GPSN; GCSA

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				professional peer support services will improve outcomes	
x	x	x	x	√ ☺ **Crisis Intervention Training (CIT)** Training for first responders reaches at least 20 percent of all police, firefighters, and school police officers in a community.	DBHDD; CSDs; DOE; district schools; NAMI-GA
x	x	x	x	☺ **A Mental Health First Aid (MHFA) curriculum** for children and adolescents is available to preschools, school personnel, juvenile court judges, children's health care providers, and interested citizens. ***MHFA curriculum*** *is expanded to address the specific need in Georgia for youth and young adults transitioning to adulthood with serious behavioral health conditions and their families.* ***The MHFA USA*** *program for military members, veterans, and their families is available in the military in Georgia, especially for young adults and their families transitioning back into employment and the community.*	DBHDD; DECAL; DPH; DOL; GPSN; MHA-Georgia military bases; community advocates
				Transportation	
x	x	x	x	√ **A behavioral health crisis transportation plan is implemented that addresses the challenges** identified by county sheriffs and others responsible for transporting people having a behavioral health crisis to appropriate care.	DBHDD; CSDs; DCHMed; DOT; crisis care hospitals; EOG; GGA; GMHCN; consumers and advocates
x	x	x	x	√ **Transportation** services are available for: *Independent living (getting to work, church, and grocery-buying)* *Older adults with mobility challenges to maintain community involvement and treatment* *Siblings when parents are taking a child for treatment*	DBHDD; DOT; DCHMed; DHS-DAS; AAA; families, consumers, advocates, and stakeholders; EOG; GGA;
x	x	x	x	Medicaid transportation vendors: *Receive training on behavioral health and the effect of unreliable services* *Are incentivized to provide a good product through monitoring for reliability, timeliness, and consumer treatment* *Are accountable in contracts for performance* *Are rated by the consumers*	DCHMed; DBHDD; DFCS; DOT; families, consumers, advocates, and stakeholders
				Finances	
x	x	x	x	**Quick access to behavioral health** (mental health and addiction services) is available seamlessly in communities, regardless of payer source. A community mechanism exists to assist individuals learn about insurance or safety net services for which they may access and qualify.	CSBs; DBHDD; DCHMed; DPH; FQHCs; GRHA; GGA; family, stakeholders, and advocates
x	x	x		**Managed care contracts include requirements for outreach and promotion**, utilization of consumer input, best practices, levels of care, care coordination, and coordination with uncovered but critical ancillary	DBHDD; DCHMed; DOL; DCA

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				service providers (e.g., housing, supported employment)	
		x	x	**Housing placement assistant offices are provided staff and access to emergency and flexible funds**, including transition funds for ensuring the housing needs necessary for successful recovery and integration back into the community.	DBHDD; DCA; GGA; LHAs; DOC; CSDs; GMHCN; homeless organizations
x	x			√ A special package of Medicaid and PeachCare core and specialty services for children's behavioral health care is developed and implemented for eligible children with the input of stakeholders and families: *Includes the range of services known to be effective* *Requires providers funded by the Department of Community Health to meet outcome criteria and data tracking set by DBHDD* *Has a provider network inclusive of community safety net public health providers* *Reimburses providers fairly in a timely manner* *Has a consistent standard of quality, access, transparency, and accountability across the provider network* *Requires providers to base services on levels of function, need, and outcomes* A Medicaid "carve-out" may be one mechanism to explore. A financing plan with a mechanism for reinvesting a portion of savings as was adopted by other states (e.g. Arizona) should be considered. Note: Georgia DCH-Med has developed, with the input and promise of ongoing input from stakeholders and child-caring agencies, a package of services to meet the needs of vulnerable children in the DFCS system.	DCHMed with DFCS; DBHDD; DOE; DPH; DJJ; DECAL; family, stakeholders, and advocates; EOG; GGA
x	x			√ A plans of options for sharing funding and services to create behavioral health care clinics/services in or alongside public schools is developed for district schools. The Georgia DOE leads a study with child-serving agencies and other appropriate groups to develop cost-effective strategies for co-locating and co-funding health and behavioral health services in schools. Note. Emory School of Medicine, Urban Health Initiative is seeding school-based health centers in Georgia. Kaiser, Healthcare Georgia, and United Way also have provided support for these programs.	DOE; district schools; DJJ; DFCS; DPH; CSBs; FQHCs; CHDs; Emory Urban Health Initiative; DBHDD; DCHMed
x	x	x	x	Data is collected on services and outcomes to guide funding/service decisions: *Medicaid insurance contractor services* ☺ *Child and adolescent behavioral health services data is collected, shared, and reported across child-serving agencies. DBHDD takes the lead for compiling the numbers served with behavioral health disorders in all state agencies and the outcomes achieved. Data include (1) numbers of children, (2) the services they receive, (3) outcomes achieved, and (4) service costs and benefits.* Note. This is in process, but may need legislative funding to assure the service over time. The Andrew Young School of Policy Studies, Center for Excellence is providing cross-agency data analysis and support.	DBHDD; DCHMed; BHCC-IDT; with CSBs; DOC; DPH; DHS- DFCS; DECAL; DJJ; DOE; GS-CFE; and reported to EOG; GGA
				Infrastructure, Systems, and Coordination Across Agencies (continued)	
x	x			√ **Schools have adequate funding to support evidence-based:** √ alcohol / drug abuse prevention curricula, √ suicide prevention; √ bullying	district schools; DOE; EOG; GGA

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				prevention.	
				Promotion, Public Information, and Outreach	
x	x	x	x	√ Information on the signs and symptoms of behavioral health disorders, where to access services, and insurance coverage eligibility is widely available, including how to access Georgia's Crisis and Access Line (GCAL). *For children and youth: -churches, child care, schools, pediatric offices* *For older adults: nursing homes, day centers, Meals on Wheels, churches*	DBHDD; DOE; DCHMed; DHS-DAS-AAA; DPH; FQHCs; CSBs; GCSA; GPSN; GMHCN; faith, veterans, consumer, and advocate groups; Georgia press and media
	x	x	x	***Information on preventing and addressing suicide, addiction, depression, and trauma*** is available universally and to at-risk groups and individuals.	DBHDD; DPH; DOE; faith groups; veterans groups; consumers and advocates; Georgia press and media
x	x	x	x	High-risk groups receive strategic information on prevention, interventions, and services, (e.g., victims of domestic violence, individuals experiencing trauma and brain injury, veterans and their families)	DBHDD; DCHMed; DPH; FQHC; CSBs; DJJ; DOC; DOE; CSDs; DHS-DAS-AAA; National Guard; veterans groups
		x	x	☺ Stakeholder groups of consumers share their stories with the public.	GMHCN; MHA-G; NAMI-G; GPSN; consumer groups
x	x	x		☺ ***Family to Family programs*** continue to support the recovery process of their family member.	NAMI-G
x	x	x	x	√ **Georgia press and media educate the public on child, adolescent, adult, and older adult behavioral health issues** in order to reduce stigma that results in less individuals seeking care, and less identification early when prevention and recovery are easier. Note. At town hall meetings, there was concern that the public receives only information about violence, which has led to fear, harsher discipline, and less understanding of recovery, mental health prevention, and youth development.	press and media outlets; DBHDD press office; Carter Center Mental Health Program
				Promotion, Public Information, and Outreach - Child and Adolescents	
x	x			Information is made available through public media; in obstetric, pediatric, primary care offices; and other health care facilities; in child care; preschools; schools; and universities on: *"Normal" child social, emotional, and physical development* *Parenting/caregiving best practice skills for supporting child and adolescent mental health and resiliency in infancy, childhood, and adolescence* *Common behavioral health and general medical disorders, signs, and symptoms* *Perinatal mood depression and toxicities in the perinatal period* *Early signs of serious disorders in (e.g., depression and suicide, addiction, and the "prodromal" period in schizophrenia)*	DBHDD; DPH; DCHMed; DOE; CHDs; and FQHCs with support from public media; GCAL; preschools; public and private schools; universities; obstetric, pediatric, and primary care associations
x	x			√ **Ways individuals and community organizations such as faith groups, private sector companies, universities, and service groups can volunteer and support** children, youth, and young adults with behavioral health	DBHDD; DPH; DCHMed; DOE; DFCS; juvenile judges

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				challenges and their families *(e.g., peer mentors, CASA advocates in the courts, educators of the public, foster or adoptive parents)*	
				Promotion, Public Information and Outreach – Older Adults	
			x	**Prevention and early identification outreach services in communities help** older adults avoid and identify mental health and substance use disorders, and co-occurring illnesses early. Major community components may include: **Public information** *on (a) factors that can place older adults into at risk and vulnerable situations, (b) depression (that it is not a normal part of aging), (c) medication interactions and misuse, (d) ways to access community behavioral health resources for older adults, and (e) ways to advocate or report an older at-risk adult.* **Best practice prevention health and wellness services for older adults and their caregivers**, *including exercise, nutrition, and social interaction day programs to alleviate stressors/risks and help older adults develop protective factors.* **Screening** *for behavioral health (including suicide) as a routine part of general medical examinations/checkups.* **Identification and engagement of private sector and voluntary** *support services for outreach to older adults (e.g., faith community, Meals on Wheels).*	DBHDD and DBHDD-regions; DHS-DAS and DHS-DAS-AAA; Fuqua Center; DCHMed; DPH and DPH CHDs; FQHCs; private sector voluntary resources
				Prevention, Early Intervention, and Resiliency	
x	x	x		√ **Early identification, counseling, parenting education, respite,** and appropriate supports are available for parents suffering from depression, addiction, trauma, domestic violence, or other disorders that may interfere with parent-child bonding/attachment and their child's socio-emotional development. **Respite is available prior to a crisis** to avoid and prevent hospitalization, arrest, or child abuse.	DCHMed; DPH; DOE; DFCS; DBHDD regions
x	x	x		√ **Home visiting, parenting education is available for at-risk pregnant women and new mothers** (e.g., teen parents, low-income, single parents, other risk parents) so that they have the best chance of promoting resiliency and strong social emotional skills in their children.	DFCS; DECAL; Head Start; DPH; EOG; GGA
x				√ **Quality preschool and childcare** is available for all 0- to 5-year-olds who are at high risk for school failure, behavior problems, or disabilities.	DECAL; DPH; DOE; Head Start; EOG; GGA
x				√ Preschool program staff (e.g., Pre-K, Head Start, Early Head Start, and child care) have mental health training and supports to call when children are identified as potentially having behavioral health challenges.	DECAL; DFCS; DBHDD; DCHMed
x	x			√ ☺ **Parent education, support, and guidance** are offered to adoptive, foster, and grandparent caregivers of at-risk children and with behavioral health disorders to give each the best chance of successfully integrating into a family that can support them.	DFCS; EOG; GGA
				Older Children / Youth School Prevention and Early Intervention	

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x	x			√ **Schools have adequate funding to support evidence-based** alcohol/drug abuse prevention curricula, suicide prevention; and bullying prevention.	district schools; DOE; EOG; GGA
x	x			√ Schools keep children/youth in school with alternatives to "zero tolerance" disciplinary actions of suspension, judicial arrest, and expulsion of children/youth with behavior problem(s). (e.g., anger management, mediation, and other evidence-based programs for children who have difficulty controlling their anger) Note. Georgia Appleseed has developed a Web-based "Keeping Kids in Class Toolkit" to help schools and families assess and improve school practices and assist children. See http://www.gaappleseed.org/toolkit/.	district schools; DOE; DBHDD; juvenile court; Georgia Appleseed
x	x			The Positive Behavioral Interventions and Supports (PBIS) evidence-based program is adopted: √ In ***all publicly funded schools:*** *to improve school climate and the staff's behavior management skills, to reduce discipline referrals and school violence, and to support child graduation rates and mental health.* ***√ In Department of Juvenile Justice (DJJ) facilities***	district schools; DJJ schools; DOE; Georgia Appleseed; EOG; GGA
				Adult Prevention and Early Intervention	
		x	x	High-risk adults receive prevention, early identification, and intervention services/supports in their community to help them develop resiliency, protective factors, and immediate treatment if a behavioral health condition is identified. These include individuals who experience trauma, homelessness, domestic violence, a heart attack or other serious medical condition, perinatal mood disorder symptoms, job loss, armed services and National Guard returning from war and their families).	DBHDD; DCHMed; DHS-DAS-AAA; DOL; DPH; FQHCs; CSBs; private and nonprofit groups - businesses, faith, veteran, hospitals, insurers, and consumer advocates
				Screening and Identification of Behavioral Health Disorders	
x	x	x	x	***A simple routine universal screen*** is used for physical, mental, and substance abuse health problems in: *Physician practices as part of a health history or regular checkup* *Preschool, school, or universities* *Obstetric, pediatric, and primary care practices, which also screen for perinatal mood disorders before and after birth* ***Primary care providers use best practices suicide screening/****treatments for* at **risk groups** *(e.g., older adults and individuals with depression).*	DPH; DBHDD; DCHMed; DAS; CSBs; CHDs; FQHCs; medical / nursing associations (e.g.; G-AAP; GAPH; GAFP; GNA; GRHA; GA OBGYN Society; MAG)
	x	x	x	√ ***SBIRT*** *(Screening, Brief Intervention, and Referral to Treatment) evidence-based* services for alcohol, prescription, and illicit drug use/misuse are used in primary care practices. SBIRT screening services for particular populations are used in the settings these groups frequent such as: *SBIRT - Alcohol Screening and Brief Intervention for Youth* services are used by high school and university health clinics; *SBIRT for Older Adults* in aging services	DBHDD; DCHMed; DFCS; DJJ; GCSA
x	x			√ ☺ ***Screening for behavioral health disorders*** occurs prior to/at entry into *juvenile court, detention, foster care, and school suspension/expulsion for*	DFCS; DJJ; DOE; district schools; juvenile courts; EOG; GGA

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				behavior problems so that appropriate planning and care can be provided and a diversion program may be considered.	
Behavioral Health Community Services and Supports Services are recovery-oriented, strength-based, involve individuals receiving services in a meaningful way, are culturally sensitive/appropriate, and are coordinated by a single case manager**. (Children's services** include their parents/caregivers)					
x	x	x	x	**Basic outpatient core behavioral health community treatment, maintenance, and crisis services** are available so that individuals can recover, maintain their recovery, and extend the time between relapses.	DBHDD; DCHMed; CSBs; private and nonprofit health care providers
x	x	x	x	√ Children, youth and adults with a serious behavioral health disorder(s) **have a single case manager** who assists them in attaining mental, addictive, and/or general medical health treatment and other supports needed for recovery and maintaining their health over time.	DBHDD; DCHMed; CSBs; EOG; GGA
x	x	x	x	√ **Crisis stabilization and mobile crisis services** for children, adolescents, and adults are available in all communities.	DBHDD; DCHMed; EOG; GGA
x	x	x	x	√ **Behavioral health providers use evidence-based treatments** and promising practices that they monitor for fidelity and outcomes.	DBHDD; DCHMed; DJJ; DFCS; DOE; DOC
x	x	x	x	√ Children, youth, and adults with co-occurring substance and mental health disorders receive evidence-based treatments that address both.	DBHDD; DCHMed; DJJ; DFCS; DOE
Children and Adolescents with Behavioral Health Disorders					
x	x			☺ **A functional scale** for young children and youth with behavioral health challenges is used across child-serving agencies, providing continuity in measuring the type and intensity level of behavioral health services that may be needed and allowing measures of treatment outcomes.	BHCC-IDT; DJJ; DFCS; DBHDD
x	x			√ **Care Management Entity wraparound services** are available and funded in every community for youth and young adults with serious behavioral health disorders in restrictive or institutional settings and for those at high risk for out-of-home placements. Note: Georgia built an infrastructure in local communities to support evidence-based wraparound services as part of a Medicaid demonstration grant. This important option to institutional care requires ongoing funding and support. If not funded, Georgia will lose the infrastructure it built and the hope of recovery for the most vulnerable youth with behavioral health disorders.	DCHMed; DBHDD; EOG; GGA
Behavioral Health Community Services and Supports (continued)					
x	x			√ Public schools have on site a behavioral health clinic/services so that: *Children/youth do not have to leave school for treatment* *Children at risk and those who experienced behavioral health challenges can be addressed (e.g., trauma, suicide ideation, family homelessness/hunger, drug/alcohol misuse, bullying, or other mental health threat)*	DOE; district schools; DPH; EOG; GGA
	x			√ ***After-school programs such as Clubhouse*** are available for youth with substance abuse and mental health problems.	DOE; DCHMed; DBHDD; DJJ; DFCS;

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
				Note. Town hall meetings identified after-school programs as a big need.	
x	x			√ Children with serious behavioral health disorders develop with their families and case manager **a crisis plan** to assist them in receiving appropriate treatment in the event of a behavioral health crisis.	MHA-G; NAMI-G; DBHDD
x	x			√ A provider is funded in every community to assist families of children, youth, and young adults with behavioral health challenges to advocate and negotiate the service system. Note. The Georgia Parent Support Network serves as the Atlanta chapter and Georgia's statewide chapter for the National Federation of Families for Children's Mental Health.	GPSN; DOE; DBHDD; BHCC-IDT
				Late Adolescence and Young Adult (17- to 25-years-old) Transition to Adulthood Support	
	x	x		**Georgia makes full use of the Chaffee Foster Care Independence Program**, including the *Educational and Training Vouchers program* for youth and young adults through age 21 with serious behavioral health conditions and identifies additional funding sources to assist all Georgia's foster care children to successfully graduate and obtain employment.	DBHDD; DFCS; DCHMed; DOE; DOL; USG; EOG; GGA
x	x			√ **Quality transition services** with cross-agency coordination and case management are funded and provided to youth with serious behavioral health challenges who: *Are emancipated from foster care or leaving juvenile detention* *Have behavioral health disorders and are "aging out" of special education programs so that they have the best chance of successfully living independently, finding employment and housing, and receiving the therapeutic and health care they need to maintain their recovery.* Note: The Georgia General Assembly initiated in 2012 the study of best diversion and transition practices for youth within or leaving juvenile detention, with the intent of redirecting funds.	DFCS; DJJ; DOL; DOE; district schools; Georgia juvenile judges and courts; JUST Georgia Coalition EOG; GGA
				Adults with Behavioral Health Disorders	
		x	x	√ **Businesses establish policies that support people with behavioral health** disorders in the workplace and are publicly praised for their efforts.	DBHDD; business
		x	x	√ An appropriate level of intensive outpatient care services exists to assist adults with serious mental health and addictive disorders receive services in their community, including: ***Intensive case management*** *services such as Assertive Community Treatment* ***Supportive, safe housing and/or supportive employment*** *24/7* ***crisis care*** *services* ***Peer support and respite care*** ***Drug and alcohol residential and outpatient treatment services***	DBHDD; DCHMed; DCA; DOL; emergency care hospitals; GMHCN; GCSA; family stakeholders and advocates
		x	x	People with addictive diseases are able to access recovery and addiction services in their community that will promote long-term recovery and assist individuals who have relapses.	DBHDD; DCHMed; mental health and drug courts; GCSA; EOG; GGA

Children	Adolescent	Adults	Seniors	II. A GEORGIA VISION FOR BEHAVIORAL HEALTH √=Georgia Model/Initiative exists and can be built on: ☺=accomplished or in process	Entities Involved (Acronym legend)
			x	**Behavioral health services are made available where older adults are located** (a) home, (b) day centers, (c) nursing homes, (d) hospitals, (e) primary care facilities, and (f) churches.	DBHDD, DCA, DPH, DCHMed, CSBs; Fuqua Center; PSVR
				Diversion Services: Reducing the Criminalization of Behavioral Health	
	x	x	x	√ **Community diversion programs are funded** for people with serious behavioral health disorders who interact with the criminal justice system, emergency rooms, and other institutions but do not pose a threat to public safety. Diversion programs intercept individuals prior to and throughout their encounters with the justice system and may include: √ ☺ *Crisis Intervention Team (CIT) training for first responders* √ ☺ *Mental health/drug courts* √ *Judicial/sheriff education programs on mental health and addiction* √ *Alternatives to forensic status for nonviolent offenders* √☺ *Mobile crisis and crisis beds for individuals suffering a relapse or traumatic crisis* √ *Peer support* √ *Intensive case management* √ *Supportive housing and/or supportive employment*	DOC; DJJ; DBHDD; DFCS; DCHMed; CSDs; Georgia Bureau of Investigation; DOE; DCA; DOL; NAMI; GMHCN; GPSN; EOG; GGA
	x	x		√ ☺ **The Georgia Juvenile Code is rewritten** to reflect new knowledge on child and youth development, evidence-based practices, understanding of undetected and untreated behavioral health conditions, and the recent statewide study conducted by Georgia Appleseed.	EOG; GGA; JUST Georgia; Georgia Appleseed
	x	x	x	√ ☺ **The formerly successful Transition and After-care for Probationers and Parolees (TAPP) program or another transition program** is funded to reduce recidivism for youth and adults with behavioral health disorders on probation or released from correctional facilities.	DJJ; DOC; DBHDD; Georgia Bureau of Investigation; State Board of Pardons and Parole; EOG; GGA

Many individuals; agencies; and special committees contributed recommendations, including consumers, advocates, and staff from the Georgia Departments of Behavioral Health and Developmental Disabilities, Education; Juvenile Justice; Human Services Division of Family and Children's Services; Community Health; Corrections; Community Affairs; and Labor. Nearly 600 Georgians attended six town hall meetings to review the preliminary Vision.

Major reports providing information for the Vision included but were not limited to:

- Georgia's Mental Health Gap Analysis -– APS Healthcare Inc. (2006)
- *The Updated Analysis Of Behavioral Health Spending For Children and Adolescents in Georgia Across Child-Serving Systems* – Human Service Collaborative – Sheila Pires and Rachel Davis (2010)
- *The System of Care for Severely Emotionally Disturbed Youth Strategic Plan FY 2010–2014*
- The Georgia Settlement with the U.S. Department of Justice signed on Oct. 19; 2010
- *The Workforce as a Contributor to the Problems in Georgia's Behavioral Health Systems Report* –The University System of; Georgia Board of Regents – Center for Workforce Planning and Analysis; (2010)

- *A Call to Action by the Task force to Promote Criminal Justice/Mental Health Collaboration* – Chief Justice Leah Ward Sears of Georgia (2008)
- *Effective Student Discipline Keeping Kids In Class; An Assessment of Georgia's Public School Disciplinary Policies; Practices and Outcomes* – Georgia Appleseed Center for Law and Justice (2010)
- *Preventing Mental; Emotional; and Behavioral Disorders Among Young People – Progress and Possibilities* – The National Research Council and Institute of Medicine of the National Academies (2009)
- *Preventing Later Substance Use Disorders in At-Risk Children and Adolescentse* – The European Monitoring Centre for Drugs and Drug Addiction (2009)
- *The New Freedom Commission Report; Achieving the Promise – Transforming Mental Health Care in America Final Report* (2003)
- *Mental Health - A Report of the Surgeon General* – U.S. Department of Health and Human Services (1999)

References

[1] Institute of Medicine and National Academy of Sciences "Preventing Mental and Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities." (2009, p. 67)

[2] Center for Health Workforce Studies, School of Public Health, University at Albany. 2006. The impact of the aging population on the health workforce in the United States: Summary of Key Findings

[3] Committee on the Mental Health Workforce for Geriatric Populations; Board on Health Care Services; Institute of Medicine. 2012. The Mental health and substance use workforce for older adults: In whose hands? Institute of Medicine

[T]oo many people are still living on the streets, leading marginal existences. Millions more simply cannot find the services they need. If help is not readily available, lives are wasted or even lost. Mental illness is the leading cause of disability in the United States, Canada, and Western Europe, inflicting more damage than cancer, heart disease, or diabetes. It represents a major economic burden to individuals, families, and our society. (Former U.S. First Lady Rosalynn Carter, "Within our Reach," p. 16)

III. Introduction

Georgia is renowned around the world as the home state of Dr. Martin Luther King Jr., a leader who called upon our nation to uphold and protect the constitutional civil rights of all people. Georgia is once again at the epicenter of a civil rights effort for yet another population of Americans — people who have disabilities, including those with mental illnesses, who languish segregated in hospitals and institutions because of the unavailability of treatment and support services in their communities.

This report presents best-practice strategies for implementing community services for individuals with serious behavioral health disorders. It is written to assist in moving forward from a history where, hidden from our view in state institutions, over 115 men, women, and children with mental disorders died under suspicious circumstances between 2002 and 2006, and more than 190 others were physically or sexually abused while in our care. [1]

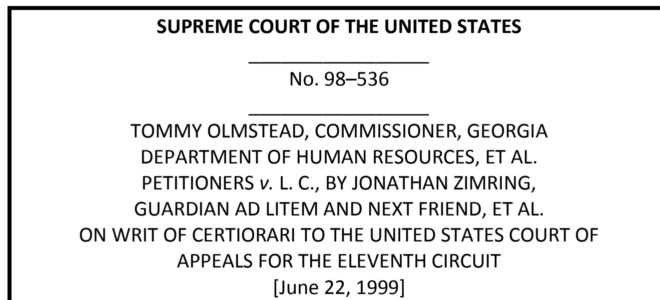
This history of patient abuse in psychiatric state hospitals has repeated itself over the years. After reforms are put into place, public interest wanes, and again our fellow citizens in institutions are forgotten until the exposé of a front page story gets our attention once again. Rosalynn Carter [2] (2010) wrote of the exposés of abuse in large psychiatric hospitals in Georgia prior to former U.S. President Jimmy Carter's first run for Georgia governor in 1966 and the "horror stories about the thousands of patients packed into the facility, often for a lifetime, with almost no services. [S]taff struggled to feed everyone and worked just to keep them alive; there was not time for services." (p. xvi).

After passage of the Community Mental Health Centers Act in 1963, all states began to move people with serious mental illnesses out of poorly funded, isolated, crowded, understaffed, and abusive state mental institutions. But instead of developing discharge plans to connect individuals to community mental health treatment and services, many were discharged to the streets and shelters. The result for many was homelessness or re-institutionalization in jails and eventually back to aging state psychiatric hospitals.

In 1995, Lois Curtis and Elaine Wilson requested assistance from the Atlanta Legal Aid Society to live a more normal life outside of their psychiatric hospital in Georgia. Sue Jamieson of Atlanta Legal Aid wrote of the lower court's decision which ruled in their favor.

"This case of first impression in the Eleventh Circuit sought community residential placements for L.C. and E.W. who had spent the majority of their lives in mental institutions. For several years, their treatment teams acknowledged that they no longer met the requirements for involuntary confinement but refused to release them to a community-based program with appropriate services."

The state appealed the decision and in 1999, the landmark Supreme Court decision Olmstead v. L.C. established that people with disabilities, *including people with mental illnesses*, have the right to live in the community rather than be segregated in institutions, "when with proper supports, they could live a more normal life."[3]


SUPREME COURT OF THE UNITED STATES

No. 98–536

TOMMY OLMSTEAD, COMMISSIONER, GEORGIA DEPARTMENT OF HUMAN RESOURCES, ET AL. PETITIONERS *v.* L. C., BY JONATHAN ZIMRING, GUARDIAN AD LITEM AND NEXT FRIEND, ET AL. ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT
[June 22, 1999]

In January 2007, a series of articles titled "A Hidden Shame" began in The Atlanta Journal-Constitution exposing the abuses and deaths in Georgia's psychiatric hospitals between 2002 and 2006. In April 2007, the U.S. Department of Justice initiated a Civil Rights of Institutionalized Persons Act (CRIPA) suit against the state.

On July 1, 2008, Georgia signed an Olmstead settlement with the Department of Health and Human Services Office of Civil Rights. Georgia committed to appointing an Olmstead coordinator to oversee the agreement; to establish an Olmstead plan; and to give 2,500 people in Georgia's seven public psychiatric hospitals the opportunity to live in their communities with appropriate supports.[4]

By August 2008, Georgia's mental health stakeholder groups began to organize through the coordination and support of The Carter Center. The group sought consultative help from the Judge David L. Bazelon Center, a respected mental health legal firm. The Center advised that Georgia stakeholders needed to know what type of infrastructure they wanted. Stakeholders formed workgroups to address the issue, and the resulting recommendations became the impetus for this report.

On Jan. 15, 2009, a conditional Civil Rights of Institutionalized Persons Act (CRIPA) settlement was signed by the U.S. Department of Justice and the State of Georgia, but it still needed the approval of the U.S. District Judge Charles Pannell, who was overseeing the suit. Stakeholders were concerned that the proposed settlement did not address an individual's right through the American With Disabilities Act (ADA) to live in the least restrictive environment in

their community. They also found that it lacked specific benchmarks and accountability requirements to assure adequate protection of individuals in state hospitals as required by CRIPA.

On Jan. 23, 2009, the stakeholders sent a letter to the court expressing their concerns, and on March 2, 2009, they formally requested that the court not approve the settlement. The court directed the parties to meet with the stakeholders to discuss their concerns by June 5, 2009. The stakeholder group was recognized by the court as *amicus curiae* (a friend of the court).

In July 2009, as a result of legislative and gubernatorial leadership, a new Department of Behavioral Health and Developmental Disabilities (DBHDD) was created. Between April 2009 and January 2010, as the new department began to actively address the many problems facing it, reports of abuse in the state psychiatric hospitals by the news media continued.

In September 2009, the Justice Department withdrew support for the settlement agreement. In January 2010, the Justice Department's Civil Rights Division filed for the appointment of a court monitor to protect patients in the seven psychiatric hospitals.[5]

> *...Georgia continues to fail to serve patients in the most integrated setting appropriate to their needs, and preventable deaths, suicides, and assaults continue to occur with alarming frequency in the hospitals. "States responsible for the care of individuals living in state-run facilities have a duty to protect them from harm. Individuals in Georgia's hospitals are being subjected to a widespread pattern of violence and are not being protected from preventable deaths," said Thomas E. Perez, Assistant Attorney General in charge of the Civil Rights Division. "We need quick action to protect these individuals."* (U.S. Department of Justice, Office of Public Affairs, Jan. 29, 2010)

On Oct. 19, 2010, Georgia's commitment to build a community system began in earnest with a second settlement agreement. The settlement agreement established specific annual deadlines for developing community services and for moving people with developmental disabilities and mental illnesses from institutions into the community by July 2015. While the settlement did not address children and those with less severe mental illnesses, it is an important first step to building a community infrastructure for mental health.

Georgia is on a brave course of change, and the nation is watching to learn from their efforts. Georgia has determined that losing the potential of our citizens to homelessness or institutional care is costly both in dollars and suffering — of individuals, families, and communities. It also is the law in the United States that people with mental illnesses cannot have their civil rights denied.

> *"[T]o the extent the state offers public services to qualified individuals with disabilities, such services shall be provided in the most integrated setting appropriate to meet the needs of such qualified individuals with disabilities."* (Title II of the Americans With Disabilities Act, 42 U.S.C. § 12101, and implementing regulations at 28 C.F.R. Part 35, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, and implementing regulations at 45 C.F.R. Part 84 (Section 504)

Research on behavioral health disorders demonstrates that most persons suffering the debilitating effects of even the most serious mental or addictive disorders can manage their symptoms and lead meaningful lives in their communities. Historically, we have — out of shame, fear, and ignorance — avoided seeking treatments for behavioral health as we would for "physical" health. We have not developed the infrastructure for a health system that links physical health services to behavioral health services and that provides a continuum of care addressing prevention, treatment, recovery, and crisis-care services. From a policy perspective, the shift from institutionalization and warehousing is the right thing to do, and it makes financial sense.

This report envisions a Georgia where children, adolescents, and adults in every Georgia community with behavioral health challenges are able to recover, succeed, and thrive within their communities and their families. It seeks to give Georgia policy makers and stakeholders at the state and local level tools and ideas for building and maintaining a strong behavioral health infrastructure.

Implementing this Vision will be difficult for communities losing large hospitals and for many who are invested in the current system of care. In addition, this change is happening as the nation is re-adjusting its health and mental health systems to accommodate mental health parity and the new Affordable Care Act. There will undoubtedly be difficulties, but it will be important to keep our promise and make this transition work for those who have the most to lose if we fail — children and adults with serious behavioral health disorders.

We must do this with our eyes and ears open to prevent the most vulnerable from falling through the cracks in the system and to ensure that our state continues to live up to its promise. Our agencies charged with this responsibility will need to be transparent, have clear plans, and implement quality assurance efforts. They will be required to stand ready to respond to hard questions that will inevitably occur. What we need now in every community is the will to discard our fears and roll up our sleeves. **All of us are needed**, including local and state officials and policy makers, health care providers, educators, faith communities, and especially those with behavioral health disorders and their families who have the lived experience and can guide our efforts. It is critical to get started now, not only because we have made legal commitments but because lives are being lost. We must realize that it will take time to get it right, and this is a long-term, ongoing effort.

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IV. Overview: Demographics and Basics

Demographic Challenges to Creating a Community System of Care

Georgia is a large diverse state with a growing population. It has the largest land mass east of the Mississippi, with an area of 59,425 square miles. The state ranks ninth in population, 19th in population density, and has168.4 people per mile. Although 109 of its 159 counties were labeled rural by the state in 2008, it has 14 of the nation's 388 metropolitan statistical areas (MSAs). The densely populated Atlanta metropolitan area has approximately 5.5 million residents and is the ninth most populated of the nation's MSAs. The large number of counties in the state presents a unique challenge for the state and policy makers at both the state and local level, who must work across county and municipal governing entities.

Georgia's population grew by more than 1.6 million people, or more than18 percent, since 2000 [1] and in 2010 had 9,687,653 residents. Seventy of its 159 counties had less than 20,000 residents and 30 had less than 10,000. Five cities had populations over 100,000 in 2012: Its largest cities include Atlanta (540,932), Augusta (195,639), Columbus (190,414), Savannah (134,703), and Athens (115,586). Georgia also has a large military population, with 13 military bases. The state's population numbers increased in all racial and ethnic groups. As a percent of the population, the largest increases have been in a small but rapidly growing Hispanic population, which grew from 5.3 to 8.8 percent or 96.1 percent from 2000 to 2010.[1*] [2]

Behavioral Health: Mental Health and Addictive Disorders

Terminology

Terms are used in this report as follows:

- **Behavioral health disorders include both mental health and addictive disorders.** Because the two often occur together, policy planning and treatment require recognizing this fact as well as the significant risk a person with a mental disorder has for developing an addictive disorder and vice-versa.
- **Co-occurring disorder** refers to the presence of a mental health and addictive disorder in the same person.
- **Co-morbidity** refers to the presence of mental and "physical" disorders in the same person.

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[*] Note. At the time of the writing of this report, only the overall 2010 population census data was available for Georgia; other more detailed census data in this report is from the 2009 U.S. Census annual survey(s) estimates.

How Many People Are Challenged by Behavioral Health Disorders in Georgia?

Behavioral health disorders are the leading cause of disability in the United States.[3] Like all chronic health conditions, behavioral health conditions vary in severity and duration of symptoms. Nearly 50 percent of us will, at some point in our lifetime, experience a diagnosable mental health disorder. Every year, more than one in four adults[4] experiences a diagnosable behavioral health problem. Over 40 percent will have two or more behavioral health disorders, and over half will have a co-morbid medical condition. Around 6 percent of adults will experience one or more serious mental health disorders, and approximately half of those will experience severe symptoms requiring substantial assistance for recovery.[5] Most mental disorders emerge in childhood or adolescence.

Less than 50 percent of people experiencing a behavioral health problem receive services.[6,7]

Table O-1 Twelve-Month Prevalence Estimates of Adults With Behavioral Disorders in Georgia

2010 Population*		12-months Incidence* [8]		Serious Mental Illness (SMI) [5]		Most Severe Symptoms	
18–64 years	6,164,066	26.2%	1,614,985	5.84%	359,981	2.6%	160,265

Source: U.S. Census Bureau, 2010 Census Summary File 2, Table PCT3

Table O-2 Twelve-Month Prevalence Estimates of Children With Serious Emotional Disorders in Georgia*

Georgia 2010 Census population estimates		12-month Incidence		With serious behavioral impairments[4]		With significant functional behavioral impairments[4]	
3 to 18 years[9]	2,491,552	20%	498,310	11%	274,071	5%	124,577

**Includes children and youth with mental health and addictive disorders*

Emotional disorders in childhood are indicated by "serious deviations from expected cognitive, social, and emotional development" that substantially limits the ability to function in family, school, or community activities[4]. The Surgeon General's 1999 report estimated that approximately one in five children have a serious emotional disturbance that meets the diagnostic criteria for a disorder. Eleven percent were estimated to have significant functional impairments, with 5 percent to have extreme functional impairments. The term "serious emotional disturbance" (SED) is used to describe children aged 0 to 18 years who have an impairment. While the 1999 report had to rely on surveys of children and youth 9 to 17 years of age, national data is now available on children as young as 3 years of age, but the data is limited to specific disorders.

What Is a Mental Disorder?

Mental health disorders are disorders causing disturbances in mood, emotions, cognition, and/or behaviors that range from mild to severe. People with disorders may have poor judgment, abnormal perceptions of reality, and an inability to relate to others or cope with life events. The disorder can be brief, episodic, or persistent and disabling. Diagnosis is by a mental health professional based on the "Diagnostic and

Statistical Manual of Mental Disorders," fifth edition (DSM-V).[10] People of all ages, races, and income levels are affected, yet some populations (e.g., veterans, foster children) are at greater risk due to environmental and social stressors that are part of their lives. Many serious disorders such as schizophrenia and depression will emerge in the adolescent years when the brain is undergoing rapid change. Around 50 percent of behavior disorders will begin before a child reaches his or her 14th birthday, and 75 percent will appear by age 24.[11]

Table O-3 An Example of Disorders and the Estimated 12-Month Adult Population Prevalence*	**12-Month Prevalence**
Anxiety - (panic, social phobia or specific phobia, post-traumatic stress, obsessive-compulsive, separation anxiety, generalized anxiety)	18.1%
Mood - (major depressive, bipolar, dysthymia)	9.5%
Impulse Control - (oppositional defiant, conduct, attention deficit/hyperactivity, intermittent explosive)	8.9%
Substance Disorders - alcohol or drug abuse or addiction	3.8%
Schizophrenia**	1.1%
Any Disorder	26.2%

* Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication (NCS-R). Arch Gen Psychiatry, 2005; 62: 617-627.
** Schizophrenia prevalence rates are from Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK. The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective one-year prevalence rates of disorders and services. *Archives of General Psychiatry.* February 1993; 50(2):85-94

What Are the Causes of Mental and Addictive Disorders?

Mental and addictive disorders are normally caused by a complex combination of factors, including: biochemical disturbances, biological conditions or events, environmental or social stressors, and/or the presence of a genetic susceptibility. Biochemical causes may include disturbances in the brain's chemistry. Biological factors may include traumatic brain injury, brain defects, or exposures in the womb to toxins. Social and environmental factors may include unrelenting stressful life experiences from abuse, bullying, unemployment, isolation, war, or loss of a significant person. Behavioral disorders often have a genetic interaction, but a person with a genetic susceptibility may never develop a disorder. An environmental, social, or biochemical event is needed to activate or trigger a disorder and its symptoms.

Resiliency and Protective Factors

Why are some people more resilient and able to weather trauma or other threats to their behavioral health? Individuals concerned with preventing and treating behavioral disorders say that resiliency occurs when a person possesses protective factors. Protective factors can prevent the triggering of a disorder even if a person has a genetic predisposition. Protective factors also can assist a person in recovery to prevent the re-emergence of a disorder or lessen its effect. Prevention and recovery programs that build protective factors are most often identified for children and their families. They also are important in assisting individuals with serious mental illnesses to recognize, handle, avoid, and reduce stress or situations that are known to trigger symptoms.

What Is Recovery and Wellness?

Recovery is a behavioral health term that recognizes that one can live a productive life with a serious behavioral health disorder by monitoring and maintaining a level of treatment that prevents the disorder from expressing debilitating symptoms and/or limiting one's ability to function in his/her daily life within the community. Wellness in recovery refers to the individual process of achieving and maintaining recovery and the dignity of living independently in the community.

A Special Word about Trauma

A person who has been raped, a child who has been abused or bullied, a family who has lost his/her home to floods, a soldier who has suffered constant traumas from war, and an elderly person facing dementia or the loss of a spouse — all are at increased risk for developing a mental illness or addictive disease. We no longer question that traumatic events can result in alterations to our brain and our ability to function, yet few people seek or are able to access help. Having prevention programs and treatments immediately available for predictable and unpredictable potential trauma can lessen the vast numbers of individuals who suffer from preventable behavioral health disorders.

Suicide

People with serious mental and co-occurring disorders are at a 12-fold greater risk of suicide than the general population. Statistics vary, but according to the National Institute of Mental Health, more than 90 percent of suicides in 2002 were among individuals who had mental or addictive disorders.[12] As Georgia moves people with serious mental illnesses into community settings from institutions, suicide prevention and awareness programs are a critical component to the process. Individuals leaving psychiatric hospitals and other institutions are at greater risk for suicide, and resources such as crisis beds in all Georgia communities are important. In 2009 and 2010, approximately 2,266 Georgia citizens over 10 years of age died by suicide, a rate of 13.7 per 100,000 population.[13] In the United States in 2009, suicide was the third leading cause of death for children and young adults 10 to 24 years of age, the second leading cause of death for 25 to 34 year olds, the fourth leading cause for 35 to 54 year olds, and the eighth leading cause for 55 to 64 year olds.[14] Adult white males over age 65 are over three times as likely to commit suicide as black males and over five times more than females. Standard screenings in primary care settings can help identify and prevent a person's suicide or behavioral health disorder risk.

Early Identification and Treatment

Emerging research on behavioral health disorders has given us solid evidence of the importance of early identification and treatment. Early identification can prevent an emerging disorder from causing further damage and prevent the development of co-occurring disorders and physical health co-morbidities. This Vision plan recommends educating the general public on symptoms and

treatments for behavioral health disorders, similar to education efforts used to help the public learn the symptoms of a heart attack or other chronic health condition.

Georgia is fortunate to have eminent researchers in the field of mental health to assist us. Dr. Elaine Walker, the Samuel Candler Dobbs Professor of Psychology and Neuroscience at Emory University, is part of an international effort to find answers to help people with schizophrenia. At a meeting of the Rosalynn Carter Fellowships for Mental Health Journalism, she spoke eloquently about the importance of early treatment.

> Prior to the onset of one of the most debilitating mental health disorders, schizophrenia, there is a "prodromal" period, occurring one to two years before onset. In the prodromal period, a person may experience auditory or visual hallucinations, but these hallucinations are transitory and the person knows that what they are hearing or seeing is not real. For instance, a young man may say, "I hear Mom talking, but it cannot be her because she is at work." With the full onset of schizophrenia, reality is changed. If we identify and start treatment early, the better the outcome. Shortening the duration of psychotic episodes increases the effectiveness of treatment in reducing hallucinations and further debilitation and may actually limit the course of damage to the brain.
> (Elaine Walker, Ph.D., personal communication, Sept. 13, 2010)

Stigma

Stigma is the result of fear and a lack of understanding that mental disorders are an illness and like other illnesses require treatment. The stigma surrounding behavioral health disorders results in feelings of shame, fear of losing one's job or friends, ignoring symptoms, and a reluctance to seek care. Public fear of violence from people with mental illnesses is a major issue. Media accounts of crime contribute to stigma by overwhelmingly portraying people with mental illnesses as perpetrators. What is not discussed is that individuals who have serious mental illnesses are eight times more at risk of being the victims of violence (3 percent for the general public versus 25 percent for people with disorders).[15] Shockingly, homeless women are the most likely to be violently victimized (44 percent).[16] Since we know that trauma is a contributor to mental disorders, it is important to do what we can to illuminate this problem and prevent those with behavioral illnesses from being victimized. The risk of being a victim of violence from someone with a serious mental illness is low (around 2 percent), and greater from other population groups (e.g., males 24 years and younger). Violent perpetration is higher for persons with serious behavior health disorders when co-occurring addictive disorders are present and treatment is not received.

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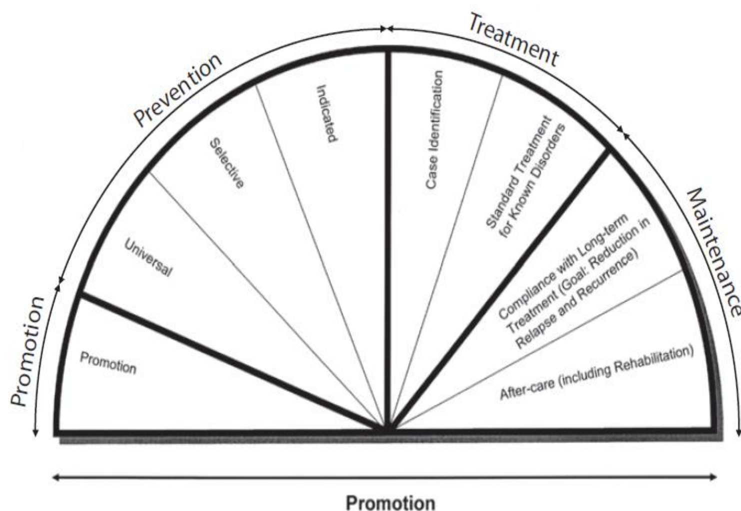
V. Integrated Whole Person Health Care

A Public Health Continuum in Communities [1]

The Institute of Medicine (IOM) protractor recognizes the dynamic continuous nature of wellness, illness, treatment, recovery, and maintenance. Designed to assist a community's prevention planning, it is an important tool for addressing all chronic health conditions, including mental health and addictive disorders. It recognizes that only by including the continuum can communities be sure to support continuous recovery, wellness, and appropriate levels of health care across the life span.

Figure IC-1 The IOM Public Health Continuum of Care Protractor



Source: Institute of Medicine and National Academy of Sciences "Preventing Mental and Emotional, and Behavioral Disorders among Young People: Progress and Possibilities." (2009, p. 67)

Definitions of Population Targets for Behavioral Health Interventions

Universal – (entire population) A universal intervention might publicize signs and symptoms of mental health disorders.

Selective – (individuals whose risk is higher than the general population) A selective intervention might be a best practice intervention that targets children who are in foster care or victims of domestic violence.

Indicated – (identified individuals who have minimal but detectable symptoms of a disorder) An indicated intervention might be an intervention with adolescents who are binge drinking or having prodromal (early) symptoms of visual or auditory hallucinations.

Case Identification – Individuals or populations at risk who become identified through outreach, screening, and assessment.

Treatment – Individuals identified with one or more illnesses/disorders and receive appropriate treatment.

Maintenance – Individuals in recovery continue levels of treatment and health behaviors that reduce relapse and recurrence. Communities support rehabilitation, wellness, and crisis care if relapse occurs.

Promotion and Prevention services strive to strengthen protective factors, increase resiliency, and reduce risks that might trigger chronic illnesses in individuals, groups, or the entire population. The treatment goal for an individual with a serious behavioral health condition is recovery and wellness, which includes (a) treatment for recovery; (b) maintenance of recovery; (c) promotion of greater learning about a disorder(s) and how to enhance recovery; (d) prevention of a new health condition, a co-occurring disorder or "triggers" that might cause a setback; and (e) early identification and treatment if there is a relapse or if another health condition/risk occurs.

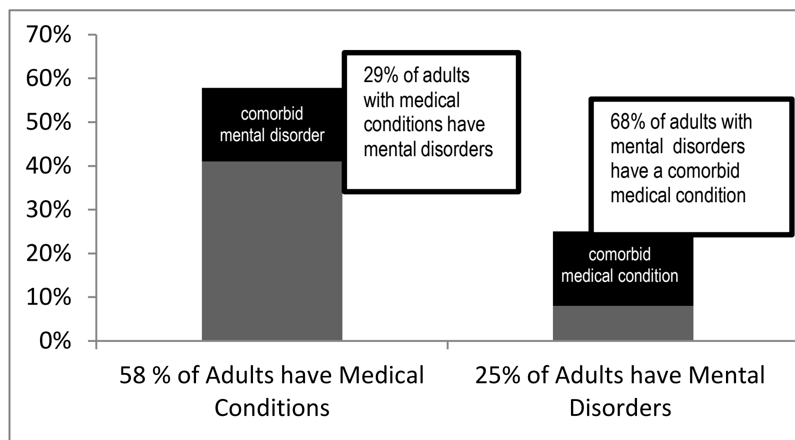
Whole Person Health Care

The brain is a complex physical organ involved in all of our physical movements and perceptions of the world. It is always adjusting to assist each of us in perceiving, organizing, and responding to the constantly changing landscape within and without our bodies, whether we have a chronic health condition or a brain disorder. Mental and physical health are not separate entities but are inexorably intertwined, and the brain always is involved. With 25 percent of the population likely to experience a diagnosable mental health condition, it is critical to recognize that our medical health care system is short-changed when mental health is not addressed or included in our training of all health professionals.

Co-Morbidity and Integrated Care

The co-morbidity of physical, addictive, and mental health disorders is not an accident but rather a consequence of increasing health vulnerability.

Figure IC--2 Co-morbidity of Mental and Physical Health Conditions in Adults



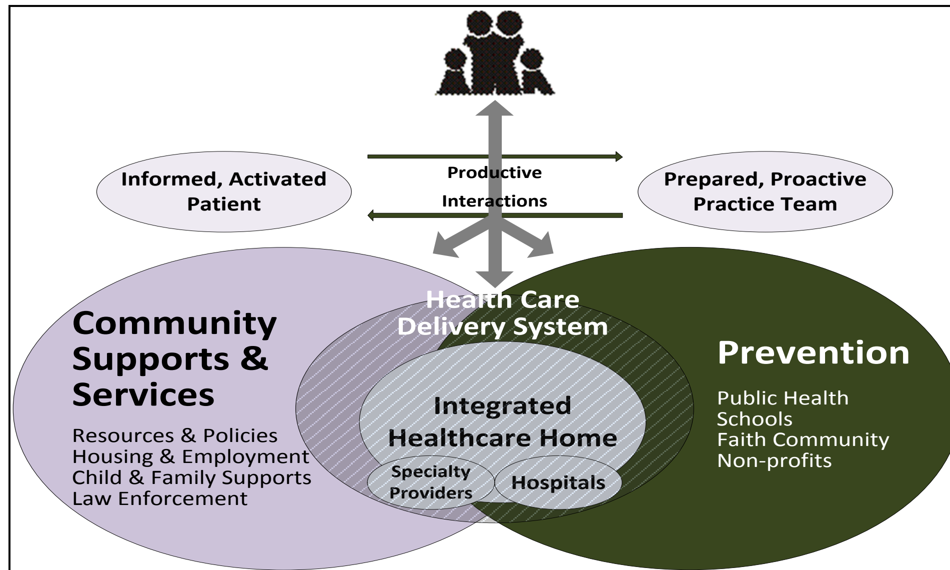
Source: National Comorbidity Survey Replication, 2001-2003[2] in Goodell S, Druss B, Walker, ER. Mental disorders and medical co-morbidity. Robert Wood Johnson Foundation, The Synthesis Project, 2011, Policy Brief No 21

A health care system that separates physical and behavioral health care has limited effectiveness in improving health and is not cost-effective.

- People with a serious mental illness (SMI) served in the public mental health system die on average 25 years earlier than the general population from largely treatable physical illnesses.[3]
- Sixty percent of additional morbidity and mortality for people with schizophrenia was found to be from physical illnesses such as cardiovascular disease, diabetes, respiratory, and infectious diseases, and 30 percent from suicide and injury.[4]

- Children aged 2 to 17 years of age with a behavioral disorder face a threefold increase in the risk for developing a chronic physical illness[5] Nearly 33 percent of children with an identified emotional, behavioral, or developmental condition (as compared to 11.7 percent without) were found to have at least one of seven of the most prevalent chronic health conditions.
- One in six people receiving care for a heart attack will have major depression after the heart attack.[6]

Figure IC-3 What Might an Integrated Setting Look Like in Communities



From: B. Mauer Vision for a System of Integrated Mental Health/Substance Use/Primary Care Treatment Services in Person-Centered Healthcare Homes. Discussion Draft 12-20-2010. Washington State Department of Social and Health Services Behavioral Health and Primary Care Integration Collaborative. Druss, B. 2011 Georgia Forum

Key Components of Integrated Care

The integrated health care model is a whole-person approach using a care manager and a collaborative care system that recognizes the dynamic nature of health and the importance of the individual in their care.

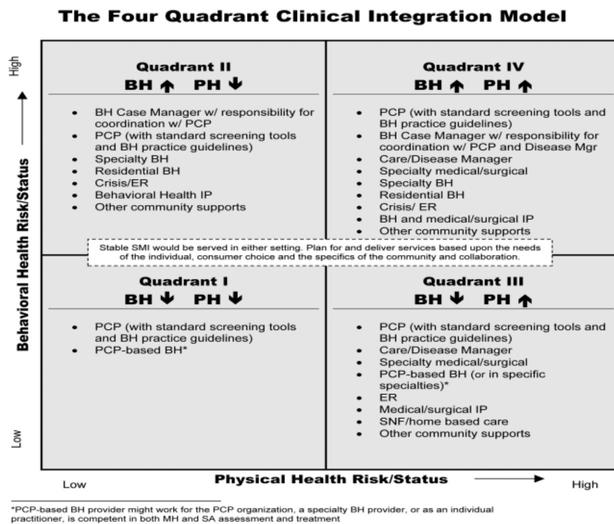
- Screening and patient registry
- Care manager
- Patient education and self-management
- Decision support for medication management
- Access to specialty providers
- Stepped care where outcomes are tracked and care is adjusted based on results
- Use of evidence-based guidelines and practices

These key components were described by Benjamin Druss, M.D., MPH, Rosalynn Carter Chair in Mental Health at the Rollins School of Public Health, Emory University, at a 2011 presentation

on integrated care. He has dedicated much of his work to moving our nation and Georgia forward in public health and behavioral health policy and is an expert on integrated care.[7]

Integrated Care Adjusts Treatment to a Patient's Health Care Status

Figure IC-4 The Four-Quadrant Clinical Integration Model



The four-quadrant integration model[8] was developed to assist in care planning to meet the specific health care acuity needs of an individual at a given time in a specific locale. The quadrant model and integrated care models can be effectively applied and adjusted to various populations, locations, and illnesses.[9,10]

Integrated health care models improve outcomes and are cost-effective.[11]

Integrated models effectively identify and treat chronic conditions and associated risks as well as empower patients to manage their care. While integrated care increases services for chronic health problems, it also reduces the use of costly emergency care services.

The greatest cost benefits occur as symptoms stabilize and the need for intensive care diminishes:

- A random study in five states of 1,801 seniors with depression found a doubling of effectiveness, greater satisfaction with care, and lower long-term costs (four years) of $3,363 per person.[12,13,14,15,16,17,18]
- Improved care management for diabetes and depression resulted in a cost savings of $300 per patient.[19,20]
- An integrated care clinic model for veterans randomly assigned clients with serious mental illnesses to regular care or integrated care. Findings included increased care visits, less emergency room use, improved outcomes, and cost neutrality after only one year.[21]

People with behavioral disorders may avoid seeking specialty care but are more likely to go to a physical health care provider. Two-thirds of primary care physicians reported they could not access mental health services for their patients.[22] Seventy percent of the elderly who commit suicide saw their health care provider within the preceding month.[23] **Integrated health care models can help overcome the effects of stigma, improve early identification and treatment, prevent suicide, and provide on-the-job professional learning.** In an integrated care model, the skills of physical health

care providers and behavioral health care providers are enhanced, and the sum becomes more than its parts.[24,25]

Key Challenges to Implementing Integrated Care

- There are severe shortages of health care professionals, especially in rural areas.
- Health care provider communities will need assistance in changing or adapting their business practices and cultures of patient care.
- Collaborative care requires developing strategies for sharing records and protecting confidentiality.
- Integrated care is better suited to a per-person-per-month (PPPM) fee structure due to its need for flexibility and its outcomes-based approach. The current fee-for-service environment creates numerous fiscal disincentives including:
    - Pressure for primary care doctors to spend less time with patients.
    - Few rewards for specialty care providers to collaborate.
    - Lack of reimbursement mechanisms for team-based care to treat patients with complex behavioral and chronic physical health conditions.
- State psychiatric hospitals focus on the treatment of mental health disorders and need a whole health approach to assist the overall wellness that is critical to recovery.

Promising Georgia Practices in Integrated Care

The West End Medical Centers, Inc. (a SAMHSA Primary Behavioral Health Care Integration Program) co-located a satellite clinic at the Cobb County Community Service Board Mental Health Clinic. In developing the integrated model, the two systems are providing valuable information on the benefits, challenges, and new tools they have developed to other Georgia communities. Additional funding from SAMHSA and other grants allowed them to expand to other sites and purchase a mobile clinic[26] It can take time and hard work to figure out how two different cultures can work together, share records, establish protocols, and develop strategies for different payment mechanisms. However, this model provides proof that it can be done and offers Georgia communities the mentoring they will need. The model was found to be personally rewarding to staff and effective in improving patient outcomes. In 2012, SAMHSA also awarded Primary Behavioral Integration grants to Highland Rivers and New Horizons Community Service boards.

The Atlanta PCARE (Primary Care Access, Referral, and Evaluation), set in an inner-city, randomly assigned people with serious mental illness to nurse care management or regular care. Improvements were found in preventive services, cardiovascular disease risks, mental health, and use of primary care.[27]

Georgia's 26 Community Service Boards (CSBs) and the Carter Center Mental Health Program's Integrated Care Project are working together with a goal of developing local

integrated care models across Georgia. CSBs were established in state law to organize, coordinate, and provide services in the community for persons with mental health disorders, addictive diseases, and/or developmental disabilities. Participating CSBs have identified a primary care partner(s), many of which are federally qualified health centers (FQHCs). Each participating CSB and FQHC are developing a model that will work within their communities. The task is not easy, but each community is on a continuum of learning and developing integrated services that range from (1) coordinating and communicating partnerships between separate behavioral health and primary care systems, (2) co-location of offices with sharing and collaborating between separate practices, and (3) a fully functioning, merged, integrated practice.

Georgia mental health and-certified peer specialists provide Medicaid-reimbursable whole health and wellness support. Wellness is a critical part of a skill set needed for everyone, but especially individuals with serious behavioral health disorders. This population was found to die 25 years earlier not from their mental illness, but from undiagnosed, untreated chronic health conditions such as diabetes, cancer, or heart disease. Wellness supports consumer self-direction and decision making to reduce and treat comorbid illnesses, decrease poor health behaviors (e.g. lack of exercise, smoking), improve quality of life, and increase longevity.

American Academy of Pediatrics Toolkit. Georgia Academy of Pediatrics is working with members to implement and use the toolkit for integrating mental health into community practices and playing a leading role to strengthen community advocacy, funding, screening, identification, and supportive services for children's mental health.[28]

Table IC-1 Vision Integrated Care Recommendations

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on)	Entities Involved (see legend for acronyms)*
√ ***All Georgia providers of primary care health care services have a strong working relationship*** with a provider of mental health and addiction services and vice versa and ***use a standard screening instrument for identifying behavioral health care needs***.	DPH; DBHDD; DCHMed; DAS; medical/nursing schools; associations (CSB; FQHC; GAAAP; GAPH;GAFP; GNA; GRHA; MAG)
√ ***Georgia's Community Service Boards*** have strong integrated care partnerships with primary care providers in the communities for which they have responsibility for establishing a behavioral health care safety net.	DBHDD; DPH; DCHMed; CSB; FQHC
Children, adolescents, and adults with behavioral health disorders receive both primary care and behavioral health care services from providers that communicate with each other and know that individuals with a disorder are likely to also have one or more other special health care needs that affect their overall health.	DPH; DBHDD; DCHMed
Public information, training, and guidance on developing an integrated care practice are provided for primary care physicians and nursing staff, pediatric providers, public health clinics, federally qualified health	DBHDD, DPH; DCHMed; schools of medicine

centers, and school-based health services.	
Primary care providers **are knowledgeable about best practices in screening and treatment for suicide risk,** especially among adolescents and older adults and individuals with depression.	DBHDD; DPH; DCHMed; DAS
A simple routine universal screening is used for physical, mental, and substance abuse health disorders/challenges (1) in physician practices as part of a health history or regular checkup; (2) in preschools, schools, and universities; and (3) by obstetric, pediatric and primary care practices that also check for perinatal mood disorders before and after birth.	DBHDD, DCH-Med, DPH, Georgia OBGYN Society, G-AAP, CHDs, FQHCs,
Health care professions serving children, adults, and older adults receive training in behavioral health through initial professional training, required continuing education units (CEUs) for licensure and provider contract requirements.	universities, colleges, DBHDD, DCH-Med, DJJ, DFCS
√ **Georgia Academy of Pediatrics (G-AAP) utilizes the American Academy of Pediatrics AAP Toolkit for Children's Mental Health** to implement and integrate mental health into community primary care practices and plays a leading role in strengthening community advocacy, funding, screening, identification, and supportive services for children's behavioral health.	G-AAP, DBHDD, DPH, DCH-Med, CHDs, FQHCs
√ **Healthy Mothers, Healthy Babies of Georgia (HMHB) and Mental Health America of Georgia (MHA-G-)** continue support for obstetric and pediatric practices (perinatal mood and anxiety disorders–PMADs) through health care provider training on screening and identification, an online evidence-based toolkit for providers, and a monthly newsletter.	HMHB-Georgia MHA Georgia

* CSB=Community Service Boards; DAS=Division of Aging Services; DBHDD=Department of Behavioral Health and Developmental Disabilities; DCA=Department of Community Affairs; DCHMed=Department of Community Health Medicaid Division; DPH= Department of Public Health; FQHC=Federally Qualified Health Centers; GAAAP=Georgia Chapter American Academy of Pediatrics; GAFP=Georgia Association of Family Physicians; GAPH=*Georgia Association*for *Primary* Health*Care*; GGA=Georgia General Assembly; GNA=Georgia Nursing Association; GPA=Georgia Psychological Association; GPPA=Georgia Psychiatric Physician's Association; GRHA=Georgia Rural Health Association; MAG=Medical Association of Georgia

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VI. Infrastructure

The infrastructure elements for supporting and maintaining accessible mental health and addiction services are addressed in this section. Key components explored include community planning, workforce, transportation, financing, promotion, public information, and outreach.

Communities Planning and Working Together

The key objective for the state of Georgia moving forward is to provide all citizens with a spectrum of behavioral health services. One of the greatest challenges to meeting this objective is the significant change each community must undergo to build the behavioral health supports agreed to in the settlement. Attitudes and fears about serious behavioral health disorders and the inevitable changes affecting a community's economic infrastructure are widespread and present significant challenges. Good public information, greater understanding of why we have chosen this path, and engagement of stakeholders as the settlement activities roll out are vital for success.

Many systems will need to work together to solve the various parts of this puzzle: hospitals, police departments, county jails, district schools, universities and colleges, and the regional offices of numerous agencies. The private and voluntary sector will continue to be the critical "glue," providing the valuable service of voicing concern when problems occur and coming up with solutions. Providers, veterans groups, businesses, faith groups, print and visual media, stakeholders — and **most of all, consumers** — will be important to guiding this effort. Inevitably, there will be problems and missteps as this new delivery system is built.

Community Planning – Best and Promising Practices

The following examples reflect the hard work that so many citizens of Georgia undertake to get behavioral health treatment in their communities, which often involves family members and friends. They are real heroes who have come out from the shadows to engage and teach an often fearful general public.

Perry Wellness Center, Americus, Georgia[1]

Georgia's first Peer Wellness Center is dedicated to recovery and wellness for adults with behavioral health conditions. It was founded by Stuart Perry, whose struggle with depression and his own father's suicide took him on a local and national journey to help the medical community and public understand that mental disorders and addiction are illnesses that can and should be

treated. Today, the peer- run program boasts a vibrant community produce market, recovery-oriented services, and professional staff, most of whom have experienced behavioral health challenges. People from Sumter and neighboring counties bring produce to be sold and bought from the market. Local sheriffs' departments are assisted by the center on ways to work with a person experiencing a mental health crisis. On any given day, individuals may be seen participating in wellness and recovery activities (exercising, working the gardens, cooking, selling produce), and involved in group or individual treatment sessions.

Opening Doors to Recovery (ODR)

ODR was a successful, innovative care coordination program piloted in 34 counties located in southeast Georgia and Region Five of the Department of Behavioral Health and Developmental Disabilities (DBHDD). A local National Alliance for Mental Illness of Georgia (NAMI-G) group worked with anyone in the community who would help develop recovery-oriented community services for people with serious mental health disorders who were in and out of state hospitals, local jails, emergency rooms, and/or homeless.

They collected data, studied best practices, and wrote a report.[2] Data allowed them to learn what was missing, give policy makers reliable facts, and apply for grants. NAMI-G set up and piloted intense case management service for 100 adults. Participants had three Community Navigation Specialists (CNS), a professional, peer, and family member available 24/7. Navigators helped participants experience a (1) meaningful day, (2) adequate treatment, (3) safe housing, and (4) technology to link with the CNS team. Findings demonstrated significantly improved measures of recovery, fewer hospitalizations, and shorter lengths of stay when a relapse occurred. Measures at four, eight, and 12 months showed steady improvements that increased as more time was spent in the program.[3,4] Participants testified that the Navigators were critical to helping them get their lives back, find employment, and experience fewer crises. Local and state law enforcement, hospitals, and caregivers testified to the cost savings for the community as alternatives to jails and hospitals became available for individuals with serious mental illnesses.[5,6,7]

The ODR partnership included DBHDD, Bristol-Myers Squibb Foundation, CSX Corporation, Georgia Regional Hospital in Savannah, local community service boards (Gateway Behavioral Health Services, Satilla, and Pineland), the Georgia Mental Health Consumer Network (GMHCN), and the Georgia Bureau of Investigation. Multiple community partners and individuals worked together, including local hospital emergency departments, county law enforcement, and NAMI members. The Georgia General Assembly will need to provide funds for the ODR pilot to become an ongoing service choice in Region Five.

Town Hall Public Meetings

In 2012 and 2013, the Carter Center Mental Health Program and DBHDD conducted public town hall meetings in each of the six DBHDD regions. Meetings included the DBHDD commissioner and

Dr. Thom Bornemann, director of the Carter Center's Mental Health Program, among others. At each meeting, local citizens learned about the plans for developing community services and about the Carter Center's preliminary report, "Building a Vision for Community Services for Children, Adolescents and Adults with Behavioral Health Disorders in Georgia." Local attendees discussed the Vision and contributed recommendations on children, adults, older adults, coordination and systems, housing, and corrections for their community. Over 80 individuals and as many as 120 attended each town hall meeting. The public meetings were well advertised in the public media and attended by consumers, interested citizens, and providers who wanted to assist in building their community mental health services.

Community Health Interfaith Partnership (C.H.I.P.)
CHIP is a coordinating body in the Atlanta region born out of a small group of faith organizations who formed to improve support for people with mental health challenges. Today, a group of public and private sector agencies work together with faith communities to speak with a unified voice for those who have mental health and addictive disorders.

Community Local Interagency Planning Teams (LIPT) and Regional Interagency Action Teams (RIAT)
Across Georgia, LIPT members meet to ensure agency coordination and planning for children with serious mental illness and/or addictive diseases. Created by Georgia law, LIPT members include mental health agencies providing services, district schools, the Division of Family and Children's Services, and the Departments of Juvenile Justice and Health. Parents are included if their child is under discussion. RIATs include the chairmen of every LIPT in a DBHDD region. They strive to address service gaps and local needs.

Behavioral Health Workforce

Challenges

Lack of an adequate behavioral health workforce is a problem facing all states. It is particularly challenging for Georgia, which is growing at a rapid pace and has large rural areas.

A Mental Health Gap Analysis study by APS Healthcare in 2005[8] and a 2010 study by the University System of the Georgia Board of Regents[9] provide data and recommendations. Both studies found significant problems, including high turnover and high vacancy rates of public agencies as well as growing populations to be served.

DBHDD had a 2009 vacancy rate of 27.3 percent, and the Department of Corrections had a turnover rate of 38 percent for psychiatrists. Georgia ranks low among states in practicing behavioral health professions: 41st for social workers, 40th for registered nurses, 42nd for psychologists, 30th for psychiatrists, and 28th for counselors.

Behavioral Health Workforce Best and Promising Practices

DBHDD Launched a Number of Workforce Initiatives Recommended by the GAP Analysis and the Board of Regents, including:

Partnerships with universities to staff hospitals and services
Incentivizing tele-health programs and training programs to retain and retool workers

Some recommendations will need legislative support, such as the development of service-cancelable loans for students.

Southeastern Tele-health Resource Center (SETRC), Operated by the Georgia Partnership for Tele-health (GPT), is one of 10 Tele-health Resource Centers in the United States[10]
Tele-health is a powerful workforce assistance for rural areas. Resources are located in clinics, schools, prisons, nursing homes, and other facilities across Georgia.

"As a small town nurse seeing the disadvantages that rural populations have in accessing healthcare, it was my passion and vision to see that healthcare can be equal in rural and urban communities. With technology it is possible. Tele-health is the key to reforming healthcare. Technology allows rural Georgians statewide to connect with the best healthcare providers in the state…even in the world. GPT has made a definite impact in advancing telehealth in Georgia. We are proud to say that we have become—if not the most, one of the most—comprehensive, robust, proven tele-health networks in the nation." (Paula Guy, CEO, Georgia Partnership for Tele-health)

GPT has grown exponentially – from eight tele-health encounters in January 2006 to over 75,000 in 2012, including "over 350 locations with over 200 specialists and providers participating."[11]

Providing tele-health services gets health professionals near where people live, reduces travel time and loss of work/school time, and can provide earlier access to care. It is helping Georgia solve some of the workforce problems we face in rural areas. Data provided in early 2011 indicate that GPT had sites in 108 rural counties and 51 urban counties in 2010. Some of Georgia's Community Service Boards and schools are using the service for local residents. Georgia Medicaid will reimburse providers for tele-health delivered in school-based health centers (SBHC), and SBHCs can bill Medicaid an originating fee for tele-health services received.[12]

The Fuqua Center for Late-Life Depression at Emory University

The center provides state-of-the-art care for older adults suffering from late-life depression and has dedicated itself to improving the knowledge base and workforce in Georgia and the nation through educational programs, workshops, and training. The center has extended its expertise to include providing tele-medicine support for long distance psychiatric evaluations and psychiatric care.[13]

Peer Support and the Georgia Mental Health Consumer Network (GMHCN) Are Helping to Bridge the Workforce Gap[14]

In 1999, Georgia became the first state to establish certified peer support professionals and recognize them as Medicaid-reimbursable mental health providers. Peer support professionals have "lived experience" and are, therefore, able to establish relationships with consumers that are valued and found to have positive outcomes for recovery.[15,16] Peer support training and Peer Support Wellness and Respite Centers of Georgia are projects of GMHCN, which have been the center of increasing wisdom and support for Georgia's consumer workforce effort.[17]

Transportation

Often overlooked, transportation is critical for independence, maintaining a job, health care, and improving the economic well-being of communities.[18,19] Accessible transportation allows individuals to get to health appointments, to buy medications, and to accomplish basic needs such as grocery shopping, finding affordable safe housing, attending church, or visiting family and friends. For people with behavioral health disorders, the ability to get to and from treatment in a timely manner can avert a behavioral health crisis. When experiencing a behavioral health crisis, transportation is necessary for access but can also be a source of trauma. A transporter's knowledge of behavioral health conditions is important.

Transportation Challenges

Medicaid Transportation

Consumers reported numerous problems with Medicaid transportation for treatment services, including poor management and an inability to count on specific times for being picked up or returned. They recommended quality control of transportation contractors with (1) improved

oversight, (2) required training for contractors on the challenges faced by their customers, and (3) allowing families to bring young children in their care who do not have an appointment. Foster families and other families with multiple children are only allowed to bring the child who has an appointment. Complicating the issue is the unreliability of the transportation, making it difficult to plan schedules for children left behind.

Individuals With Behavioral Health Conditions Using Accountability Courts, on Probation and/or Leaving Jail or Juvenile Facilities

Law enforcement personnel and judges attending town hall meetings in 2012 and 2013 reported that transportation challenges can contribute to a greater likelihood of recidivism. Individuals with behavioral health challenges on probation or those who have been released leave jail in recovery and need to continue treatments and the medications that will keep them well. They may be required to attend court or other meetings as a condition of their parole.

Crisis Transportation

In Georgia, when people experiencing a serious behavioral health crisis need immediate care to protect themselves and others from harm, transporting them to a hospital is the responsibility of county sheriffs. This becomes a great problem when there are no available hospital beds nearby and sheriff departments have to travel across the state. They may have to wait for long periods of time at a hospital for pending paperwork and/or waiting for an available bed.

Populations With the Greatest Need for Accessible Transportation Assistance Are Growing

Without access to transportation, low income elderly and disabled populations with mobility issues often get stuck in their homes where their condition can deteriorate.[20] Between 2010 and 2030, the elderly population is estimated to increase by 95 percent (from 9.6 percent to 15.9 percent) and faster than any other age group. In 2000, 13.5 percent of Georgians (5 to 65 years of age) had one or more disabilities. Georgia citizens living below poverty grew from 12.6 percent to 19.2 percent between 2000 and 2012.[21]

Rural Counties

Rural counties often lack the tax revenues to meet the public transportation needs of their citizens who lack access to transportation.

Transportation Promising Practices and Opportunities

The Southwest Georgia Regional Commissions Award-Winning Non-Emergency Transportation (NET) Program[22,23]

States are required to assure Medicaid patients without access to transportation a means of transport for medical appointments, but patients also may need public transportation for employment, shopping, or other destinations. The NET program allows all individuals to access public transportation for medical appointments and other services. The Southwest Georgia Regional Commission is the contracted broker for Medicaid within a 14-county, largely rural area.

Coordinating federal, state, local, and private sector funds, along with nominal rider fees, the commission has developed a uniquely efficient transportation model that received the National Association of Development Organizations' Excellence in Regional Transportation award. In 2012, 23 providers with 438 full-time drivers and 50 or so volunteer drivers are engaged in the effort that provided around 400,000 trips for health services and over 175,000 trips per year to work, shopping, and other activities. Medicaid-eligible patients receive the service free and other citizens can access the service through a nominal cost. The commission tapped the transportation management skills of a large private sector tourist transportation provider to assist in handling the numerous paperwork and program requirements of county governments as well as the state Departments of Transportation, Human Services, Behavioral Health and Development Disabilities, Human Services, and Labor.

> *Bollinger, the Regional Commission director, said, "They were looking for a way to combine their part of the program (the health-related element) with the public element, which local governments just weren't able to adequately fund through taxes."*

Georgia Department of Transportation Rural and Human Services Transportation Study – Phase 1 Needs Assessment

The needs assessment provides a list of identified state and federal funding sources and Georgia's community-level transportation strengths and challenges compared with model programs active in other states such as Florida, North Carolina, Iowa, and Wisconsin. The assessment identified strategies that could help Georgia improve community transportation for the disabled and other citizens lacking access.

Financing Community Behavioral Health Services

Behavioral health care financing is complicated and changing. It is not only concerned with health care but with services necessary for recovery and wellness, such as supportive housing. It requires behavioral health expertise and coordination of multiple payers and providers. Ideally, in every community, individuals with a mental or addictive disorder will be able to access the services they need to prevent and/or avoid a harmful escalation of their condition. Complicated or nonexistent funding options make it difficult to meet this goal.

Challenges

Behavioral health care has been a separate, unequal system. Georgia and other states have invested in deep-end crisis-driven expensive services (jails, state hospitals, and emergency rooms) and a safety net system (separate from general medical health services) that focuses on serious disorders and too often ignores wellness, prevention, recovery, and the whole-health concerns of behavioral health consumers. The safety net system has strived to serve a growing population of low-income

individuals and those with insurance products that did not cover behavioral health.

Changing insurance and financing for behavioral health and health care is an opportunity and an enormous challenge.

Georgia and national policy are addressing community behavioral health financing with a number of initiatives. These changes hold great promise but require attention as they are implemented.

The *Mental Health Parity and Addiction Equity Act* expands coverage by requiring equity in insurance benefit levels between behavioral and general medical health care.

The Affordable Care Act requires that behavioral health insurance products no longer deny coverage for a pre-existing condition; eliminate lifetime caps, and implement a number of quality cost-efficient requirements (e.g., coordination of behavioral health and primary care).

Georgia is designing a Medicaid-managed care coordination program for the aged, blind, and disabled (ABD). The stated goal is quality services that can reduce costly avoidable crisis care (e.g., emergency room visits and hospital readmissions).[24] The ABD population constitutes the largest proportion of expenditures (58 percent in 2012, yet comprised 29 percent of Medicaid enrollees.

The 2010 Georgia and U.S. Department of Justice Settlement commits the state to fund community services for adults with serious behavioral health conditions. Without such services, individuals continue to cycle in and out of institutional care, emergency rooms, and jail and are chronically homeless.

Corrections and juvenile justice reform legislation to implement best practices and accountability courts in Georgia has the potential of keeping nonviolent offenders with behavioral health conditions out of jail and on the road to recovery by assisting them with treatment and services.

Consumer, Stakeholder Policy Voice in Financing Decisions

Though they may feel uncomfortable including consumers and stakeholders, funding entities and insurance groups can gain expertise, efficiencies, and better tailor products with them at the table, especially since there is a lack of knowledge and experience implementing behavioral health.

Department of Behavioral Health and Developmental Disabilities (DBHDD) Input, Coordination, and Oversight Role in Medicaid and Other Behavioral Health Funding Policy

Providing expertise and coordination are critical functions to ensuring efficient quality resources for behavioral health of the many federal, state, local, and private agencies contributing funds for behavioral health care and services in Georgia's communities (See Table I-1). Because payers provide powerful incentives for determining what and who is covered, it is important to have state-agency-level behavioral health expertise at the "fiscal policy table," especially since DBHDD is responsible for guiding policy for this population.[25] Medicaid is the largest safety net payer for behavioral health services, but the agency with the expertise and responsibility for guiding

behavioral health policy in Georgia is the Department of Behavioral Health and Developmental Disabilities.

Medicaid Often Underappreciated As an Important Financing Mechanism

In 2010, Georgia spent $46.54 per person using Medicaid, which was 47th among states in mental health spending.[26] For every state Medicaid dollar in 2013, Georgia contributed approximately 34.5 cents and receives 65.5 cents from the U.S. Treasury. Because Medicaid cannot be used for behavioral health care in state hospitals and jails, it benefits the state to fund programs in the community that reduce institutional care and can be jointly funded with Medicaid. Georgia has large poverty populations and a growing elderly population. The costs to assist low-income populations with health care are sometimes seen as a drain on the budget rather than as a boost to the state's economy and help for meeting its obligations to assist citizens in maintaining health, independence, productivity, and living the end of their lives in healthcare settings.

Child and Adolescent Behavioral Health

In town meetings across Georgia and through a stakeholder survey, the Carter Center Mental Health Program learned of the statewide concern about the lack of children's behavioral health services. Children and youth with behavioral health risks are often unidentified. They are served by many agencies whose mission is not behavioral health (e.g., the Department of Juvenile Justice, district schools, and the Division of Family and Children's Services). Few children with behavioral health challenges are served by the regional Community Service Boards established by the Georgia General Assembly to coordinate services and be a safety net.

Other Challenges Identified by Georgia Consumers and Stakeholders

Georgia citizens were concerned about the lack of:

- A unified set of integrated behavioral health services accessible in a timely manner regardless of income or payer source
- Use of best practices and outcome-based reimbursement and funding
- Provider reimbursements in a timely manner and billing flexibility when specific consumer needs change
- Coordination/braiding of funds across agencies
- Full utilization of the Early Periodic Screening Diagnosis and Treatment (EPSDT) Medicaid program for children
- Funding for behavioral health supports in preschools, schools, and universities
- Lack of safety net services for children

Table I-1 Major Federal and State Behavioral Health Payers/Funders

Program and Eligibility	U.S. Agency	Georgia Agency
MEDICAID Health Insurance [27] *2013 Federal Poverty Level (FPL) and monthly income criteria* **Infants** *<185% FPL ($2,393 - family of 2).* **Children** *1-5 <133%FPL ($1,678 - family of 2);6-19 <100% FPL ($1,293 family of 2)* **Pregnant women** *<200% FPL ($2,586 - family of 2)* **Parents of dependent children** *<27% of FPL ($356 nonworking family of 2);<48% if working* **Aged, Blind & Disabled (ABD) with SSI** <$710 **Older Adults in Nursing Home** <$2,130 **Childless Adults** *not covered unless SSI-eligible*	**DHHS, CMS** - Dept. of Health and Human Services, the Centers for Medicaid and Medicare Service ***2013 Match*** - 65.56% *Note. U.S. match for Georgia changes annually based largely on percent of population in poverty in the state.*	**DCHMed** - Dept. of Community Health, Medicaid Division ***2013 Georgia Match*** - 34.44%
CHIP -Children's Health Insurance Program *0-19 years < 235% FPL*	**DHHS, CMS** Match around 76%	**DCHMed** Match around 24%
AFFORDABLE CARE ACT (ACA) MEDICAID EXPANSION *All adults <138% of poverty*	**DHHS, CMS** - *Match 100% 2014 – 2019; 90% after 2019*	**OPTED OUT** ACA Medicaid for 2014
MEDICARE* - Older Adults ≥ 65 – *Low-income older adults in nursing homes (may be dually eligible for Medicare & Medicaid)*	**DHHS, CMS** 100% federal	
FEDERAL BLOCK GRANT and DISCRETIONARY FUNDS [28] **State Mental Health (MH) and Substance Abuse (SA) Programs FY 2012/2013 funding $91,644,945** • Community MH Block Grant $14,426,622; • SA Prevention & Treatment Block Grant $50,140,789; • PATH - Projects for Assistance in Transition from Homelessness - $1,511,000; • PAIMI - Protection and Advocacy for Individuals with Mental Illness - $933,039 • Discretionary Funding for Various State and Local MH and SA programs $24,633,495	**DHHS, SAMHSA** Substance Abuse and Mental Health Services Administration	**DBHDD** – Dept. of Behavioral Health and Developmental Disabilities
STATE FUNDING FOR MENTAL HEALTH AND SUBSTANCE ABUSE		**DBHDD**
SPECIAL EDUCATION (IDEA *Individuals with Disabilities Education Act funds and Georgia Special Education Funds* IDEA Part B - 3 to 21 IDEA Part B Ages- 3 to 5 IDEA Part C Ages 0 to 2	**USDOE** - U.S. Department of Education	**GADOE** and Local School District. Ages 3-21 **GADPH** *-Department of Public Health, Ages 0-2*

Program and Eligibility	U.S. Agency	Georgia Agency
SUPPORTIVE HOUSING **state and federal funds** (see housing section)	**HUD** -U.S. Department of Housing and Urban Development, **DVA**-Department of Veterans Affairs	**DCA -Georgia Department of Community Affairs** **DBHDD-**
SUPPORTIVE EMPLOYMENT **state and federal funds**	**USDOL** -Department of Labor **DVA**	**Georgia Department of Labor** **DBHDD**

Best and Promising Practice and Opportunities

Colquitt County Mental Health Services Center Closure in 2009 Brings a Community Together.

When Georgia Pines Community Service board's budget was cut, the mental health center was closed. Lynn Wilson, whose son needed the services, knew that local services were critical especially for those who lacked access to transportation or could not sacrifice the time from school or work. She also knew that closing the center would be costly in dollars and outcomes for patients and the community. She approached Jim Matney, CEO of the Colquitt Regional Medical Center, and Frank Lang, Moultrie police chief, who were seeing an increase in individuals in crisis. Jim Matney, at the Carter Center's 2013 town meeting, testified that Lynn Wilson was the critical organizing force through speaking with groups and teaching the community the importance of community-based mental health treatment.

A mental health subcommittee was formed to deal with the crisis. Their goals included (1) education, (2) mental health supports within the judicial system, (3) reopening of the mental health clinic, and (4) funding. The clinic reopened in 2012 through a partnership between Georgia Pines, the Colquitt Regional Medical Center, and Turning Point Hospital, which provides inpatient and outpatient mental health and addiction services. Moultrie police began crisis intervention team training, and a drug court became a reality. The subcommittee is a part of the University of Georgia's (UGA) Archway Partnership with Colquitt County. Students from UGA's College of Public Health are gaining expertise in community health and assisting with grant writing for the project.

The Georgia Department of Community Health (DCH) (Georgia's Medicaid Agency) and Stakeholder Engagement

A group of stakeholders were concerned about DCH's plan to move the aged, blind and disabled (ABD) to a Medicaid-managed plan without considering their special needs and vulnerability. The concerns of consumers and stakeholders led DCH to delay its decision. Advocacy and consumer group experts were asked by DCH to develop recommendations. In addition, advocates began interviewing potential managed care organizations to learn about their strengths and weaknesses and to let them know the group intended on being involved after a contract has been awarded.

This has resulted in an ongoing relationship with DCH and an organized group of advocates who have learned the complexities of Medicaid and insurance.

Medicaid Expansion Opportunity for States

Under the Affordable Care Act, states may expand their safety net by offering Medicaid to populations below 133 percent of poverty with a 100 percent match in 2014 that will phase down to 90 percent in 2020. There are several ways states can decide to use Medicaid to implement community services, including the state's Medicaid plan, managed care, waivers, and the Early Periodic Screening, Diagnostic and Testing Program (EPSDT) for children. EPSDT is an important program used by states to fashion a quality insurance product. EPSDT requires children to be screened and receive all medically necessary services, including mental health.

Promotion, Public Information, and Outreach

The stigma associated with having a mental health condition has led to fear of behavioral health conditions and fewer people seeking treatment or recognizing common symptoms of disorders. This problem exists for many general medical providers and across institutions such as preschools, schools, universities, hospitals, jails, and emergency responders, making it difficult to identify behavioral conditions early and receive treatment in a timely manner. In order to have a working community public health behavioral health system, there is a great need for behavioral health public education and outreach. Individuals need to know (1) that behavioral health disorders are medical conditions that can be treated, (2) where to access services, (3) who to call when they or a loved one is experiencing a crisis, (4) the indicators or signs of behavioral health disorders, (5) and that they can trust that those who they ask to help will treat them with respect and understanding. Health care providers and institutions need appropriate support and training for themselves and their staff.

Table IC-1 Vision Infrastructure Recommendations

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
Community Planning and Coordination	
√ **A formal structure and process for consumer input exists** at the local and state levels for planning, and evaluating the quality and presence of an integrated, whole-health continuum of behavioral health services across the life span.	BHCC; DBHDD-Regions; DCHMed, CSBs;DHS-DAS-AAA; consumers, families, advocates
√ **The Department of Behavioral Health and Developmental Disabilities provides interagency leadership for older adults with behavioral health challenges through its Coordinating Council for Behavioral Health** in partnership with the Departments of Human Services Division of Aging Services, Community Health, Division of Medicaid, Public Health at the state and local levels. These state agencies and the Fuqua Center for Late-Life Depression enter into a private public partnership in order to build on the collaborative work done in Georgia to date aimed at the improvement of care for older adults in Georgia with mental and addictive illness.	DBHDD, DPH,DHS-DAS, GGA, DCHMed, Fuqua Center
√ The **DBHDD, DHS-DAS, DCHMed, DPH** and the **Fuqua Center have:** ***Dedicated staff*** for older adults with behavioral health challenges ***A formal interagency planning team*** collaborating at the local and state levels for older adults with behavioral health challenges. Interagency agreements exist to assist coordinating/sharing data and services at the community level. Findings, challenges, and accomplishments are reported to the Behavioral Health Coordinating Council. ***Community outcome indicators*** for older adult behavioral health ***Regional community plans*** to address older adults with behavioral health challenges Working relationships at the local level to assist Department of Corrections and county sheriffs to address older adults with behavioral health issues in their	DBHDD & DBHDD Regions, DHS-DAS and DHS-DAS-AAA, DPH & CHUs, FQHCs, DOC, CSD, GBPP, DCHMed, Fuqua Center/ Emory University, & GGA

* **BHCC**= Behavioral Health Coordinating Council, **BHCC-IDT**= BHCC Child & Adolescent Interagency Directors Team; **CHDs**=County Health Departments; **CSBs**=Community Service Boards; **CSDs**=County Sheriff's Departments; **DAS**=Division of Aging Services; **DBHDD**=Department of Behavioral Health and Developmental Disabilities; **DCA**=Department of Community Affairs; **DCHMed**=Department of Community Health Medicaid Division; **DECAL**=Department of Early Care & Learning; **DFCS**=Department of Human Services, Division of Family & Children Services; **DHS-DAS**=Department of Human Services, Division of Aging Services; **DHS-DAS-AAA** – Area Agencies on Aging; **DJJ**= Department of Juvenile Justice; **DOC** = Department of Corrections; **DOE**= Department of Education; **DPH**=Department of Public Health; **EOG**=Executive Office of the Governor; **FQHC**s= Federally Qualified Health Centers; **G-AAP**= Georgia – American Academy of Pediatrics; **GAFP**=Georgia Association of Family Physicians; **GAPH**=*Georgia Association* for *Primary* Health *Care; **GBI**= GA Bureau of Investigation;* **GCSA**=Georgia Council on Substance Abuse; **GGA**=Georgia General Assembly; **GMHCN**= Georgia Mental Health Consumer Network, **GNA**=Georgia Nursing Association; **GPA**=Georgia Psychological Association; **GPPA**=Georgia Psychiatric Physician's Association; **GPSN**= Georgia Parent Support Network; **GRHA**=Georgia Rural Health Association; **GS-CFE**=Georgia State University Center for Excellence; **HMHB-G**= Healthy Mothers Healthy Babies of Georgia; **LHAs** = Local Housing Authorities; **MAG**=Medical Association of Georgia; **MHA-G**= Mental Health America of Georgia; **NAMI-G**=-National Alliance on Mental Illness of Georgia; **PS** = Peer Support; **PSVR**=Private Sector Voluntary Resources; **USG-**University System of Georgia

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
care.	
A Strategic Plan for a Behavioral Health Community System of Care for All Children and Adolescents in Georgia regardless of payer source or access to insurance is implemented. Since mental health is critical to the health of all children, the cross-agency plan includes a continuum of universal prevention services for all children, targeted services for at-risk children, and those with behavioral health disorders. Because children's services are the responsibility of many agencies, the Department of Behavioral Health and Developmental Disabilities provides interagency leadership (with the Behavioral Health Coordinating Council and other agencies, as appropriate).	DBHDD, BHCC, DPH, DHS-DFCS, DCHMed, DECAL, DJJ, DOE; EOG; GGA; families stakeholders, and advocates
Each Major Child Serving Agency: √ Has interagency agreements (MOUs) to assist in coordinating/sharing data and services at the state and community levels √ Has dedicated staff for behavioral health √ Screens for and identifies behavioral health disorders in its programs √ Provides training for staff on signs, symptoms, and best practices Agrees on a common formulary, medication guidance, and quality assurance system to ensure safety and reduce medicine-induced trauma/crisis or medical complications in children with behavioral health disorders.	DBHDD, DPH, DHS-DFCS, DCH-Med, DECAL, DJJ, DOE
The Behavioral Health Coordinating Council (BHCC) of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) membership **is enlarged** to include: **Department of Early Care & Learning** (DECAL) ☺ Georgia Departments of Education and Public Health ☺ Child and Adolescent (C&A) Task Force of the Council √ **Regional Child and Adolescent Task Forces meet to develop regional strategies** for community service implementation.	BHCC, DPH, DOE, , BHCC-IDT, DECAL
An independent cross-agency study is conducted to provide guidance on ways to reduce the disproportionate level of minority children with behavioral health challenges in restrictive placements.	DBHDD, DJJ, DFCS, DOE, EOG, GGA
Workforce - A sufficient, competent updated workforce	
Health care professions receive training in behavioral health through: **Initial professional training** at universities and colleges **Improved current provider** skills especially in areas identified as learning gaps (best practices, integrated care, co-occurring addictive and co-morbid health disorders, and disparities)	DBHDD, DCH-Med, DPH, DOC, DJJ, DFCS, DOE, G-AAP, GAFP, GAPH, GNA,GPA,GPPA, GRHA, MAG, TSCG, USG

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
Required continuing education units (CEUs) for licensure **Provider contract requirements**	
√ **The pool of providers is expanded –** New providers are recruited, and workforce partnerships are developed with universities.	DBHDD, DCHMed,, TSCG, USG, GRHA
State educational institutions develop *community-level internships* in behavioral health and *graduate more specialists* in psychiatry, psychology, counseling, and nursing.	DBHDD, TSCG, USG
Georgia's General Assembly provides incentives for behavioral health professionals to practice in rural areas.	DBHDD, DCHMed EOG, GGA, GRHA
√ **Tele-health and Tele-behavioral health -** Georgia's rural community clinics, schools, nursing homes, and other appropriate sites have tele-health and tele-behavioral health contracts with professionals so children, adults, and seniors do not lose valuable time driving long distances and local behavioral health services are expanded.	DBHDD, DCHMed, DHS-DAS-AAA, DOE, district schools, DPH, county health clinics, FQHCs, Georgia Partnership for Tele-health
A **geriatric behavioral health workforce** is developed and provides integrated health care with general medical practices[29, 30]	DBHDD; DCHMed; DPH;;GGA; Fuqua Center/ Emory U,.TSCG, USG,
Training in the use of SBIRT with adolescents, adults, and older adults is available to all primary care providers.	DBHDD; DCHMed, GCSA, G-AAP, GAFP, GAPH, GNA
√ **Georgia Academy of Pediatrics (G-AAP) utilizes the American Academy of Pediatrics AAP Toolkit for Children's Mental Health** to implement and integrate mental health into community primary care practices and plays a leading role in strengthening community advocacy, funding, screening, identification, and supportive services for children's behavioral health.	G-AAP, DBHDD, DPH, DCH-Med, CHDs, FQHCs
√ **Perinatal Mood and Anxiety Disorder (PMAD) Training for Obstetric and Pediatric Providers** is continued and expanded. Note. The Healthy Mothers, Healthy Babies of Georgia (HMHB) and Mental Health America of Georgia (MHA-G) **PMAD Project** provides health care provider training on screening and identification and an online evidence based toolkit and monthly newsletter updates.	HMHB, MHA-G; DPH, G-AAP, GAFP, GNA, GOGA, GRHA,
√ **The number of peer support providers is increased and Medicaid reimbursable peer support services are expanded** by the Georgia Department of Community Health into every community for: ☺ **Drug and alcohol abuse and addiction** services √ Parents (A certified parent peer support professional) Older adults and other populations with serious behavioral health conditions where professional peer support services will improve outcomes	DBHDD , DCHMed, GMHCN, GPSN, GCSA

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
√ **Crisis Intervention Training (CIT)** Training for first responders reaches at least 20 percent of all police, fire fighters, and school police officers in a community.	CSDs, DBHDD, GBI, Georgia fire departments; district school systems, NAMI-GA
√ **Mental Health First Aid** training is widely available for workforce sites, nursing homes, voluntary organizations, and faith groups ☺ **Mental Health First Aid (MHFA) curriculum** for children and adolescents is available to preschools, school personnel, juvenile court judges, children's health care providers, and interested citizens.	DBHDD, DECAL, DPH, GPSN, MHA-GA
Transportation	
√A behavioral health crisis transportation **plan is implemented that addresses the challenges** identified by county sheriffs and others responsible for transporting persons having a behavioral health crisis to appropriate care.	CSDs, DBHDD, DCHMed, crisis care hospitals, GGA, GMHCN and advocates
√**Transportation** services are available Not only for medical appointments but for other support services such as getting to work, attending church, and shopping For older adults with mobility challenges to maintain community involvement and treatment For siblings when parents are taking a child for treatment	DBHDD, GGA, DCHMed; PSVR; DBHDD; DHS-DAS & DOT
Medicaid transportation vendors (1) receive training on behavioral health and the effect of unreliable services: (2) are incentivized to provide a good product through monitoring for reliability, timeliness, and consumer treatment; (3) are accountable in contracts for performance; (4) are rated by the consumers.	DCH-Med, DBHDD, DFCS, consumers and stakeholders
Finances	
Quick access to behavioral health (mental health and addiction services) is available seamlessly in communities, regardless of payer source. A community mechanism exists to assist individuals learn about insurance or safety net services for which they may access and qualify.	CSBs, DBHDD, DCHMed, DPH, FQHC, GRHA, GGA, veterans groups, consumers and advocates
Managed care contracts include requirements for promotion and outreach, utilization of consumer input, best practices, levels of care, care coordination, and coordination with uncovered but critical ancillary service providers (e.g., housing, supported employment)	DBHDD, DCHMed
Housing placement assistant offices are provided staff and access to emergency **and flexible funds,** including transition funds for ensuring the housing needs necessary for successful recovery and integration back into the	DBHDD; DCA, and GGA, AADA, LHAs, DOC, CSDs, GMHCN, homeless organizations

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
community.	
√ **A special package of Medicaid and PeachCare core and specialty services for children's behavioral health care** is developed and implemented for eligible children with the input of stakeholders, families, and youth. (1) includes the range of services known to be effective; (2) requires providers funded by the Department of Community Health to meet outcome criteria and data tracking set by the Department of Behavioral Health and Developmental Disabilities; (3) has a provider network inclusive of community safety net public health providers; (4) reimburses providers fairly in a timely manner; (5) has a consistent standard of quality, access, transparency, and accountability across the provider network; and (6) requires providers to base services on a child's level of function, need, and expected outcomes. A Medicaid carve-out may be one mechanism to explore for children with serious disorders. A financing plan with a mechanism for reinvesting a portion of savings as was adopted by other states should be considered. *Note: DCHMed has developed, with the input and promise of ongoing input from stakeholders, a package of services for vulnerable children in the DFCS system.*	DCH-Med with DFCS, DBHDD, DOE, DPH, DJJ, DECAL, FSA, EOG, GGA
√ **A plan of options for sharing funding and services to create behavioral health care clinics/services in or alongside public schools is developed for district schools.** The Georgia Department of Education leads a study with child serving agencies and other appropriate groups to develop, cost- effective strategies for co-locating and co-funding health and behavioral health services in schools. *Note. Emory School of Medicine, Urban Health Initiative is seeding school-based health centers. Kaiser, Healthcare Georgia, and United Way have also provided support. Medicaid can fund certain providers of telehealth services in school clinics.*	DOE, District Schools, DJJ, DFCS, DPH, CSBs, FQHC, CHDs, Emory Urban Health Initiative, DBHDD, DCHMed
Data is collected on outcomes to guide funding and service decisions: Medicaid insurance contractor services ☺ Child and adolescent behavioral health services data is collected, shared, and reported across child-serving agencies. DBHDD takes the lead for compiling the numbers served with behavioral health disorders in all state agencies and the outcomes achieved. Data include: (1) numbers of children, (2) the services they receive, (3). outcomes achieved, and (4) service costs and benefits. *Note. This is in process, but may need ongoing legislative funding to assure the service over time. The Andrew Young School of Policy Studies, Center for Excellence is providing cross-agency data analysis and support.*	DBHDD, ,DCHMed, BHCC-IDT, with CSBs, DOC, DPH, DHS-DFCS, DECAL, DJJ, DOE, GS-CFE, and reported to EOG, GGA,
Promotion and Outreach	

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
√ ***Information on the signs and symptoms of behavioral health disorders, places to access services, and insurance coverage eligibility*** are widely available, including how to access Georgia's Crisis and Access Line (GCAL). For children and youth -churches, child care, schools, pediatric offices For older adults -nursing homes, day centers, Meals on Wheels, churches	DBHDD, DCHMed, DOE, DPH, FQHC, CSBs, faith groups, veterans groups, consumers and advocates, Georgia press and media
Information on preventing and addressing suicide, addiction, depression, and trauma is available universally and to at-risk groups and individuals.	DBHDD, DPH, DOE, Faith groups, veterans groups, consumers and advocates, Georgia press and media
High-risk groups receive strategic information on prevention, interventions, services, and programs (e.g., victims of domestic violence, individuals experiencing trauma and brain injury, veterans, the National Guard, and armed services and their families)	DBHDD, DCHMed, DPH, FQHC, CSBs, DJJ, DOC, DOE, CSDs, DHS-DAS-AAA, National Guard, veterans groups
☺ **Stakeholder groups of consumers share their stories with the public.**	GMHCN, MHA-G, NAMI-G,
☺ **Family to Family programs** assist families in supporting the recovery process of their family member.	NAMI-G
√ **Georgia press and media educate the public on child, adolescent, adult, and older adult behavioral health issues** in order to reduce stigma that results in fewer individuals seeking care and in less identification early when prevention and recovery are easier. *Note. At town hall meetings, there was concern that the public receives only information about violence, which has led to fear, harsher discipline, less understanding of recovery, mental health prevention, and youth development.*	Press and media outlets, DBHDD press office, Carter Center Mental Health Program
Promotion, Public Information, and Outreach – Child and Adolescents	
Information is made available through public media and in obstetric, pediatric, and primary care offices and other health care facilities; and in child care, preschools, schools, and universities on: "Normal" child social, emotional, and physical development Parenting/caregiving best practice skills for supporting behavioral health and resiliency in infancy, childhood, and adolescence Common behavioral health disorders, signs, and symptoms Perinatal mood depression and toxicities in the perinatal period Early signs of serious disorders in youth e.g., depression and suicide, addiction, and the prodromal period in schizophrenia	DBHDD, DPH, DCH-Med, DOE, CHDs, & FQHCs with support from public media, GCAL, preschools, public and private schools, universities; obstetric, pediatric and primary care practices
√ **Ways individuals and community organizations such as faith groups, private sector companies, universities, and service groups can volunteer and support** children with behavioral health challenges and their families (e.g., peer mentors, CASAS advocates in the courts, educators of the public, foster or adoptive parents, school/university support groups)	DBHDD, DPH, DCH-Med, DOE, DFCS, Juvenile Judges
Promotion, Public Information, and Outreach – Older Adults	

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (☺=accomplished or in process)	Entities Involved (see legend for acronyms)*
Prevention and early identification outreach services in communities help older adults avoid and identify mental health and substance use disorders, and co-occurring illnesses early. Major community components may include: ***Public information*** on (a) factors that can place older adults into at risk and vulnerable situations, (b) depression (that it is not a normal part of aging), (c) medication interactions and misuse, (d) ways to access community behavioral health resources for older adults, and (e) ways to advocate or report an older adult at risk. ***Best practice prevention health and wellness services for older adults and their caregivers***, including exercise, nutrition, and social interaction day programs to alleviate stressors/risks and help older adults develop protective factors. ***Screen*ing** for behavioral health (including suicide) as a routine part of general medical examinations/check-ups. ***Identification and engagement of private sector and voluntary*** support services for outreach to older adults (e.g., faith community, Meals on Wheels).	DBHDD & DBHDD-Regions; DHS-DAS & DHS-DAS-AAA; Fuqua Center; DCHMed; DPH & DPH CHDs; FQHCs; private sector voluntary resources

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VII. Children and Adolescents with Behavioral Health Disorders

Twelve-year-old Stevie moved into a Cobb County middle school that is part of the Success for All Students school-based mental health program that serves 35 schools in Cobb County. Karen, her sister, is in a new elementary school, and her brother, John, is four years old. When Stevie arrived at her new school, she immediately began to have behavior problems and appeared to be experiencing profound anxiety. Her behavior resulted in discipline referrals. The school Response to Intervention (RTI) Student Support Team referred Stevie for services through the school-based mental health program. A licensed mental health therapist assessed Stevie. The assessment also revealed that John had significant developmental delays and that Karen appeared to be experiencing profound adjustment problems with mixed emotional features. The completion of the no-cost assessment led to the following recommendations:

- Individual therapy with a school-based licensed mental health therapist for Karen and Stevie
- A Registered Play Therapist to help Karen
- An Early Intervention Specialist to assist John
- A Family Support Specialist to work with mom to help her locate community resources and develop parenting strategies
- A Transition Specialist to help both girls adjust to their new schools and new living environments

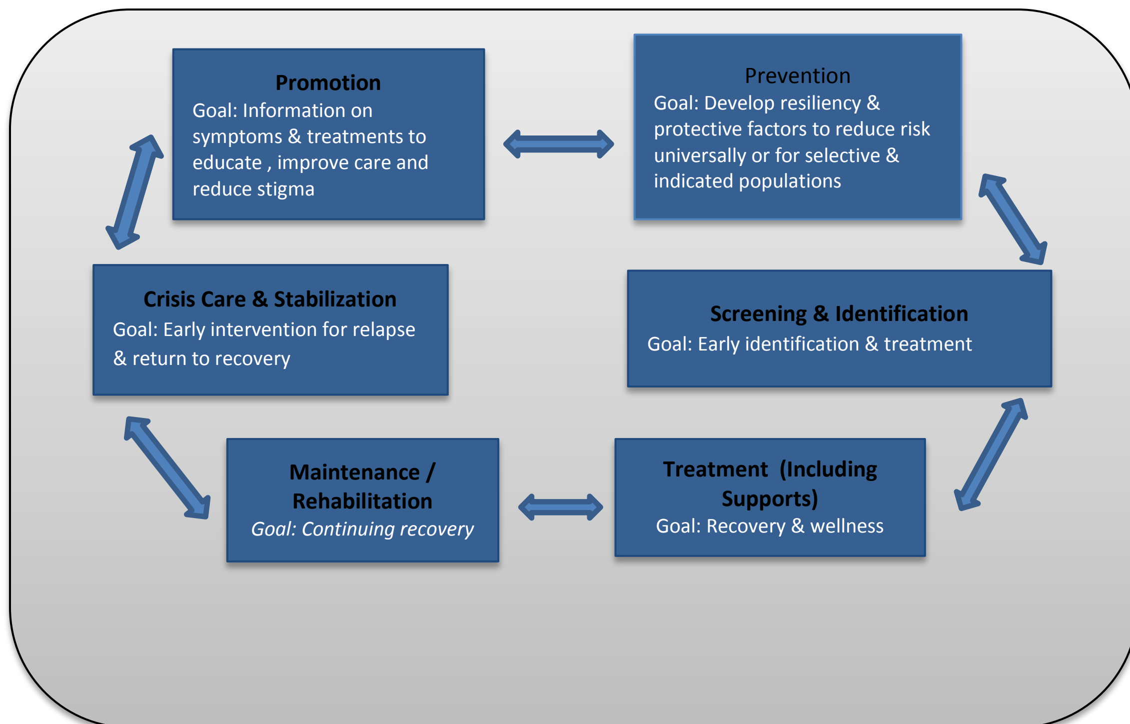
Without school-based services it is unlikely that the children's special needs for behavioral health services would have been identified or treated early. Stevie's mom, Louise, works part-time for a local grocery store and does not earn enough to purchase insurance for herself or her three children. Because she does not own a vehicle, Louise must rely on public transportation to get herself and her children to work or appointments.

We envision a Georgia where children and adolescents with serious behavioral health disorders can recover, thrive, and succeed within their communities, schools, and families. We envision a Georgia that harnesses the developmental opportunities of childhood so that each has protective factors and resiliency to prevent or lessen the disabling effects of a behavioral health disorder(s).

A Continuum of Quality Services in Communities for Children and Adolescents

Georgia's Vision for Behavioral Health for children and adolescents is concerned with the mental health of (1) adults prior to and during pregnancy; and children in (2) infancy, (3) early childhood, (4) elementary school, (5) middle school, and (6) high school. It seeks to define a continuum of best practice services in every community, utilizing the natural strengths of current services and stakeholders.

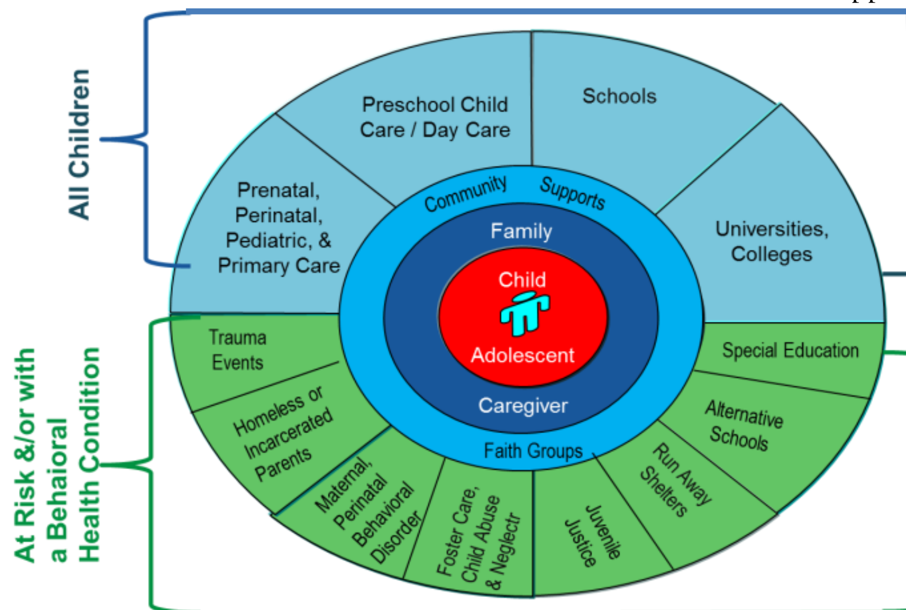
Figure C-1 A Continuum of Behavioral Health Services in every Community for Children and Adolescents



Where Children and Adolescents are Located in Communities

In Figure C-2, the circles represent primary supports for child and adolescent services. The outer edge top of the circle represents sites where universal interventions to identify, prevent, and provide treatment would reach most children and families in the least restrictive settings. The lower outer edge of the circle indicates locations or situations where children are at the highest risk of a behavioral health disorder. Communities should plan a prevention, case identification, and treatment interventions for children who are in these higher risk sites or situations.

Figure C-2 Children and Adolescents - Behavioral Health and Risk Reduction Opportunities



Major State Agencies Serving Children with Behavioral Health Disorders

The major agencies that serve and fund services for children and youth with behavioral health disorders in communities are the Georgia Departments of:

- Behavioral Health and Developmental Disabilities (DBHDD)
- Human Services, Division of Family and Children Services (DHS-DFCS)
- Education (DOE)
- Juvenile Justice (DJJ)
- Community Health (DCH)
- Public Health (DPH)
- Care and Early Learning (DECAL)

The Interagency Director's Team of the Behavioral Health Coordinating Council

In order to effectively and efficiently prevent, identify, and treat behavioral health disorders in children and adolescents, these agencies must collaborate. Many children and families receive

services from multiple agencies that may be unaware of services, medications, appointments, and treatments each may be providing to a single child or a sibling. A group of concerned staff within each agency formed a group to improve the coordination and effectiveness of services and make recommendations to their respective agencies. They have been joined by key stakeholders and families. This group is called the Interagency Directors Team, and it works to support the legislatively created Behavioral Health Coordinating Council chaired by the Department of Health and Human Services.

This overview describes behavioral health among children and adolescents and makes recommendations for fulfilling the vision of behavioral health services to support children in all of Georgia's communities. It was created with the input of stakeholders throughout Georgia and nationally.

Importance of Behavioral Health Prevention and Treatment in Childhood

Most symptoms of common behavioral health disorders appear and can be detected in childhood and adolescence. Around 50 percent of behavioral disorders will present before a child reaches his/her 14th birthday, and 75 percent will appear by age 24.[1] If identified early, when symptoms first appear, outcomes are less severe, the path to recovery is shorter, and some disorders may be prevented.

Childhood and adolescence provide a unique opportunity not to be wasted. The plasticity of a developing brain in the neonate, child, and adolescent provides opportunities to reduce risks and build protective factors that increase a child's resiliency from environmental and social stressors that may trigger the onset of a "physical" or behavioral disorder. Conversely, if left untreated, the effects of a serious developmental or behavioral disorder on a developing brain and body may be greater as neural pathways, physical capacities, and patterns of behavior become more established. This is why prevention, early detection and intervention in childhood and adolescence within schools, primary care offices, child care facilities, and other places where children are located are important. Prevention programs strive to either modify environments in order to avoid risks factors and/or promote strengths or protective factors associated with good integrated general medical and behavioral health care.

Childhood Behavioral Health Prevention, Identification, and Treatment Programs Can Save Dollars and Reduce Poor Outcomes for Children, Families, and Society

The annual cost of childhood behavioral health disorders is estimated to be $247 billion.[2]
Prevention Is Possible: A 2009 Institute of Medicine report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, has given us valuable public policy tools through a delineation of the growing evidence of effective prevention programs and the neuroscience underpinning the findings.

Prevalence

The Surgeon General's 1999 report estimated that approximately one in five children, nine to seventeen years old, have a serious emotional disturbance that meets the diagnostic criteria for a disorder as defined by the DSM-IV. The term Serious Emotional Disturbance (SED) is used to describe children aged 0 to 18 years of age who have an impairment that substantially limits their ability to function in family, school, or community activities.

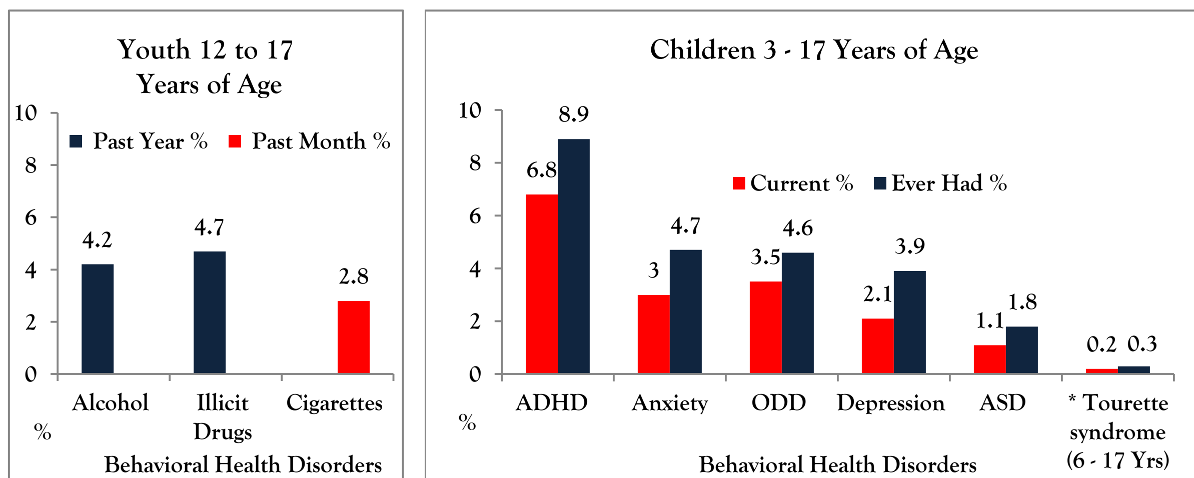
Table C-1 Twelve-Month Prevalence Estimates of Children With Serious Emotional Disturbance in Georgia*

Georgia 2010 Census population estimates		12 months incidence		With serious behavioral impairments		With significant functional behavioral impairments	
3 to 18 years[3]	2,491,552	20%	498,310	11%	274,071	5%	124,577

*Includes children and youth with mental health and addictive disorders

The Center for Disease Control and Prevention (CDC) released its first ever Morbidity and Mortality Weekly Report in May of 2013 on the Surveillance of Children's Mental Health. Prevalence in the report from the National Survey of Drug Use and Health (NSDUH) and the National Survey of Children's Health (NSCH-2007) are presented. The NSDUH surveyed parents of children 2 to 17 years of age for chronic illnesses, including behavioral conditions. Samples were from all 50 states. Parents were asked if they had ever been told by a doctor or other health care provider that their child had a developmental delay or one of six behavioral health conditions.

Figure C -3 Weighted Prevalence Estimates of Select Behavioral Health Disorders Among Children and Adolescents



Note ADHD =Attention Deficit Hyperactivity Disorder, ODD=Oppositional Defiant Disorder/Conduct Disorder, ASD=Autism Spectrum Disorder. Source. Centers for Disease Control and Prevention. Mental Health Surveillance Among Children – United States, 2005-2011. *MMWR* 2013; 62 (Suppl 2) p. 27-33. www.cdc.gov/mmwr/pdf/other/su6202.pdf2007. Also see: NSCH - 2007 - www.mchb.hrsa.gov/nsch/07emohealth/ and NSDUH 2010-2011 - www.samhsa.gov/data/NSDUH.aspx

Increases were found in Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) as well as hospital stays for mood disorders. In fact, services for hospital stays for mood disorders were found to be the most frequent of all hospital stays for children in 2010 and increased 80 percent between 1997 and 2010. These increases may also reflect improved surveillance and/or reduced stigma leading to greater levels of children diagnosed.

Behavioral Health Disorders Are the Most Prevalent of Chronic Health Conditions in Children

Table C-2 16 Most Prevalent Chronic Behavioral, Developmental, or Physical Health Conditions by Percent of Children Having One of the Conditions

Percent with CSHCN Condition	%
1. Allergies	53.0%
2. Asthma	38.8%
3. ADD/ADHD	29.8%
4. Depression, anxiety, or emotional problems	21.1%
5. Migraine/frequent headaches	15.1%
6. Mental Retardation	11.4%
7. Autism spectrum disorder	5.4%
8. Joint problems	4.3%
9. & 10. Seizure disorder/Heart problems	3.5%
11. Blood problems	2.3%
12. Cerebral palsy	1.9%
13. Diabetes	1.6%
14. Down syndrome	1.0%
15. & 16. Muscular dystrophy/Cystic fibrosis	0.3%

Source: The National Survey of Children with Special Health Care Needs Chartbook 2005-2006, p. 18

Among children less than 18 years of age with any special health care need, parents were asked if their child had one or more of 16 conditions. Ninety-one percent had one or more of the 16 conditions. Of children with one of the 16 conditions, 33.9 percent had one condition, 32.2 percent had two or more, and 25 percent had three or more.

Prevalence of Co-Morbidity and Co-Occurring Disorders among Georgia's Children[4]

- 43.9 percent with one behavioral health condition have at least one additional condition.
- 26.6 percent of infants and preschoolers, four months to five years of age, were at moderate or high risk of developmental or behavioral problems.
- Over 33 percent of those with a behavioral or developmental condition (as compared to 11.7 percent of those without) had a chronic "physical" health condition.

Lack of Screening, Identification, and Treatment Services

- Less than one-fourth (22.7 percent) of very young children aged 10 months to 5 years received a standardized screening for developmental or behavioral problems.
- Less than half (41.1 percent) of Georgia children (45.6 percent nationally) 2 to 17 years of age needing behavioral health treatment or counseling actually received it in the past year.
- Less than one-half (47.9 percent) of parents of children with behavioral health challenges in Georgia (40.2 percent nationally) reported their child received coordinated, ongoing, comprehensive care within a medical home.

Trauma in Childhood and Adolescence

Repeated exposure to stress and trauma in childhood is correlated with post-traumatic stress disorder, depression, anxiety, and other mental health, physical health, and co-occurring addictive disorders in childhood and later adulthood.[5] A 2005 representative study of U.S. children 2 to 17 years of age found that within one year.[6]

- 53 percent experienced a physical assault
- 27 percent a property offense
- 13.6 percent child maltreatment
- 8 percent sexual victimization
- 35.7 percent saw another person victimized
- 70 percent of child trauma victims had experienced more than one event; the average was three

The Adverse Childhood Experiences (ACE) study[7] found that adults who experienced four or more traumatic experiences as children were four to 12 times more likely to have behavioral health disorders of depression, alcoholism, and drug abuse. Higher levels of smoking, obesity, heart disease, cancer, chronic lung disease, and liver disease were also found.

Environmental disasters are a source of trauma for children. After two years, 51 percent of a large sample of displaced children from Hurricane Katrina were found to have at least one risk factor for poor outcomes, including numerous behavioral disorders such as depression and anxiety.[8]

Child abuse and neglect and the juvenile justice system are critical areas for trauma informed care. When Georgia's state agencies take custody of abused and neglected children, all Georgia citizens take on the parental role of protector, provider, educator, and guide for future success.

National studies have identified up to 80 percent of children and youth in state custody have behavioral health disorders or developmental delays needing mental health treatment.[9,10]

13,127 children were in the custody of Georgia's Division of Family and Child Services in 2011 because they suffered traumas of abuse and/or neglect. Forty-six percent or 5,910 were six years of age or younger. Sixty-two percent experienced the additional traumas of two or more placement moves while in custody.[11]

Widom and Maxfield, (2001) found that 59 percent of children who suffered child abuse and neglect were arrested in their youth. [12]

"Child traumatic stress is one of the most treatable mental health problems of childhood. (National Child Traumatic Stress Network, 2011)" [13] ***(http://www.nctsn.org/)***

Prior To and During Pregnancy [14,15,16,17,18]

Even before conception and during the prenatal years there are evidence-based practices that can assist us in preventing and reducing the disabling effects of physical and behavioral health disorders. Pre-birth conditions can affect the newborn's brain - the basic apparatus a baby uses to interpret, physically develop, and adapt to its new world. Among known prenatal behavioral health risks, for women and their newborns are exposure to chemicals, violence (e.g., domestic violence), incarceration, and other traumatic stressful events, poor nutrition, drugs, alcohol, smoking, adolescent pregnancy, chronic poverty, and/or the presence of a medical or behavioral health condition. For instance:

Maternal alcohol misuse has been linked to numerous health risks, including early birth, fetal alcohol syndrome, attachment disorders, attention deficit/hyperactivity disorder (ADHD), adult personality disorders, and later substance misuse.

Trauma and stress during pregnancy has been correlated to a greater risk of infant irritability and attachment disorders, ADHD, anxiety, conduct disorder, and later adult chronic health problems such as heart disease, diabetes, and depression.

Families suffering from chronic poverty are at greater risk because of the number of stressors they encounter.

Perinatal Mood Disorders

A perinatal mood disorder, prior to, during, or after birth, is an identifiable and treatable condition experienced by mothers and/or fathers. Because the bond between caregivers and infants and young children is critical for healthy growth, it is critical to identify perinatal mood disorders and treat them, not only for parents but for the developing child(ren). Perinatal mood disorders can be a result of dramatic hormonal changes that occur in pregnancy and post-pregnancy or may be a condition that already exists. If untreated, it can seriously affect parental health, parent-child bonding, and a child's development, behavioral health, and later school achievement.[19] While all races and income levels experience depression, individuals in poverty are at greater risk, with 25 percent experiencing depression annually compared to 5 percent to 12 percent of all women. Because mothers and fathers who are suffering mood disorders are likely to

accept guidance from their primary care physicians, obstetrician, and/or as part of parenting programs, it is important to implement screening and referral for services as part of general health care.

- *The incidence of depression and anxiety is approximately 5 percent in nonpregnant women, approximately 8-10 percent during pregnancy, and highest (13 percent) in the year following delivery.*
- *Suicide is one of the most common causes of maternal death in the year following delivery in developed countries.* (World Health Organization, 2013).[20]

Infancy and Early Childhood[21,22]

The human brain experiences the greatest development during pregnancy and the first three years of life. By age 6, a great deal of molding and shaping of neural and synaptic connections will be formed as a child interacts with his/her environment and caregivers.[23]

Infants and young children can experience Post Traumatic Stress Disorder (PTSD), anxiety, and depression as well as numerous other socio-emotional challenges.[24,25,26]

- About one-fifth (26.6 percent) of infants and preschoolers, 4 months to 5 years of age, were found to be at moderate or high risk of developmental or behavioral problems in Georgia.[27]
- Nine to 14 percent[28] of very young children are estimated to have serious social-emotional problems, and less than 1 percent are identified.[29]
- Young children are expelled from preschool programs at a greater rate than students in elementary, middle, or high school.[30] Their expulsion is most often because of a disruptive behavior problem.
- Indicators might include inconsolable crying; listlessness; unresponsiveness; slow growth; self-destructive behavior; aggressive behaviors such as hitting or biting; inability to use gestures for problem-solving with a caregiver; and/or difficulties with self-regulation as in eating, sleeping, or sensory integration.

School-Age Youth and Adolescents

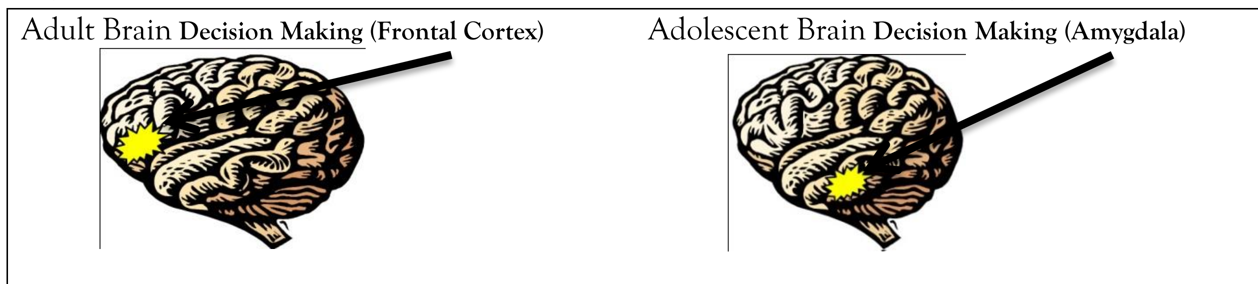
The first symptoms of depression, schizophrenia, and other disorders often emerge in adolescence

and early adulthood. The general population too often is unaware of the early symptoms and signs of a mental or addictive behavioral disorder. Identification is further complicated by the difficulty of distinguishing disorders from expected risk-taking and mood changes of young people. School staff, judges, pediatricians, and others who are charged with guiding the health and well-being of adolescents not only need help in identifying the signs and symptoms but they need community behavioral health resources and supports for troubled children. Recent knowledge of child development is assisting us to design prevention and early intervention programs to better protect the mental health of our youth.

Risky Behaviors and Youth

The brain's frontal cortex is not fully developed until age 26.[31] When reading emotions, adults rely on their brain's **frontal cortex** for self-control and decision making. Adolescents and young adults rely more on their brain's **amygdala** (associated with emotions) for decision making.

Figure C-4 Difference in Adult and Adolescent Brain Response When Reading Emotions



Adapted from the National Institute of Drug Abuse and Addiction: Addiction Science: From Molecules to Managed Care, Prevention/Development Training Slide 6 from Deborah Yurgelon-Todd 2000
http://www.nida.nih.gov/pubs/teaching/Teaching6/Teaching5.htm

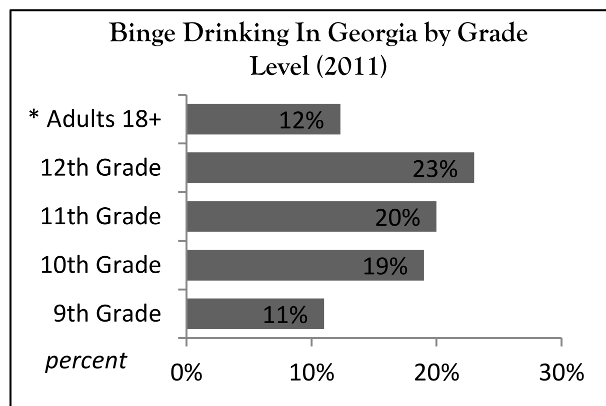
Adolescents and young adults not only lack experiences to guide their choices, but they are less likely to use the experiences they have encountered to guide their decisions. As any parent of an adolescent can attest, youth are more susceptible to instantaneous decision making based on the emotion "of the moment." This leads to greater experimentation, risk-taking, impulsive behaviors, and poor decisions, with less self-control especially when confronted with emotionally charged situations. Their brain is susceptible to alcohol and drugs misuse.[32,33] While many youth may appear fully developed, they are not little adults.

We now know that the adolescent and young brain is rapidly experiencing developmental changes. Physically they are experiencing hormonal changes. Socially they are individuating and separating from their parents as they march toward adulthood and are more susceptible to peer pressure and peer slights. Youth and adolescence are critical times for helping youth develop good mental health practices that will give them the resiliency they will need throughout life, including the skills for handling changing emotions, social relationships, stress, trauma, and behavioral health challenges.

Alcohol, Drugs, and Addiction

Addiction is a developmental disease that frequently starts in adolescence and childhood.[34] Because the youth brain has not matured, it is already susceptible to both risky decision making and misuse of addictive substances. In addiction, the brain changes; it becomes reliant on increasing levels of the addictive substance to activate pleasure and reward. Drug misuse results in increased dopamine transmission. Dopamine receptors are diminished; the use of the frontal lobe for decisions is further stunted; and the brain relies upon increasing levels of the addictive substance to activate pleasure and reward, rendering a person unable to exhibit self-control even in the face of losing everything of value. **Delaying the use of alcohol among youth is seen as an important strategy for preventing alcohol addiction and increased risky behaviors.**

Figure C-5 Youth Alcohol Misuse and Consequences in Georgia[35]



In 2011

- 34.6 percent of Georgia high school students had at least one drink of alcohol in last 30 days
- 17.5 percent of Georgia high school students reported binge drinking (five or more drinks at one time)

Between 2001 and 2005 in Georgia

- Over 150 youth under age 21 died each year from alcohol-related illness or injury
- 46 percent of youth alcohol-attributable deaths were due to motor vehicle crashes and 34 percent were due to homicide or suicide

*Adult data is 2010 (BRFSS) Source: Youth Risk Behavior Surveillance - 2013. http://www.cdc.gov/HealthyYouth/yrbs/index.htm

Table C-3 Cost Benefit of Prevention, Early Intervention, and Treatment of Substance Abuse in Youth [36]

"If effective prevention programs were implemented nationwide, substance abuse initiation would decline for 1.5 million youth and be delayed for two years on average. In 2003, an estimated:

- *8 percent fewer youth ages 13-15 would have engaged in binge drinking*
- *11.5 percent fewer youth would have used marijuana*
- *45.8 percent fewer youth would have used cocaine*
- *10.7 percent fewer youth would have smoked regularly*

The average effective school-based program costs $220 per pupil. It would save an estimated $18 per $1 invested if implemented nationwide. Nationwide school-based effective programming in 2002 would have had the following fiscal impact:

- *Saved state and local governments $1.3 billion, including $1.05 billion in educational costs during 2003 and 2004*
- *Reduced social costs of substance abuse-related medical care, other resources, and lost productivity over a lifetime by an estimated $33.5 billion*
- *Preserved the quality of life over a lifetime valued at $65 billion*

...

The out-of-pocket expenses would be repaid by savings to the education system alone in less than two years. *The program would offer additional savings to state and local governments by reducing spending on Medicaid, police, and other criminal justice services"*

Source: Miller, T. and Hendrie, D. *Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis,* DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008, p. 32

Using evidence-based interventions is important. While nearly 80 percent of adolescents in 2005 participated in school-based education programs on alcohol and drug use, only 20 percent participated in effective programs.[37] Effective prevention programs are multi-dimensional/whole-child oriented and range from home visiting with high-risk families and children to universal and targeted school-based interventions. The most effective programs strengthen the whole child and family and result not only in delay of initiation of substance use but in less violence and aggressiveness, greater management of mood and emotions, fewer school drop-outs, and improved school performance.

Suicide

Suicide is the third leading cause of death for 10- to 14-year-olds and 15- to 19-year-olds in Georgia and the United States in 2010.[38] One in four youth will experience serious diagnosable depression, and untreated depression can lead to death by suicide. One-third of Georgia youth reported feeling sad or hopeless in 2011. Over 15 percent reported they seriously considered suicide. Over 12 percent made a plan to complete suicide. Parents and teachers are often unaware of an adolescent's depression or suicidal plans and sadly, depression and feelings of worthlessness often go unrecognized. Youth, seeking independence, are vulnerable to slights and bullying from other children and are less likely to share their difficulties, feelings of depression, and suicidal thoughts or ask for help.

Table C- 4 Percent of Students Who Felt Sad or Hopeless(*), Seriously Considered, or Attempted Suicide, in Georgia, 2011

School Level	(*)Sad/Hopeless	Seriously Considered Suicide	Made a Plan to Commit Suicide	Attempted Suicide
High School	Total 30.6% Females 38.5% Males 22.6%	Total 15.5% Females 19.1% Males 11.7%	Total 12.8% Females 14.1% Males 11.5%	Total 10.8% Females 10.9% Males 10.0%
Middle School	N/A N/A N/A	Total 21.5% Females 26.4% Males 16.9%	Total 14.0% Females 16.5% Males 11.6%	Total 8.4% Females 9.9% Males 7.0%

Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance – United States, 2011. MMWR 2012; 61 (NO SS-4), p. 69-73
Centers for Disease Control and Prevention (CDC). 1991-2011 High School Youth Risk Behavior Survey Data. Available at http://apps.nccd.cdc.gov/youthonline. Accessed on 8/04/2013
(*) Felt during the last 12 months sad or hopeless almost every day for two weeks or more in a row, that they stopped doing some usual activities

School Discipline, Drop-out, Graduation, and Juvenile Justice Risks

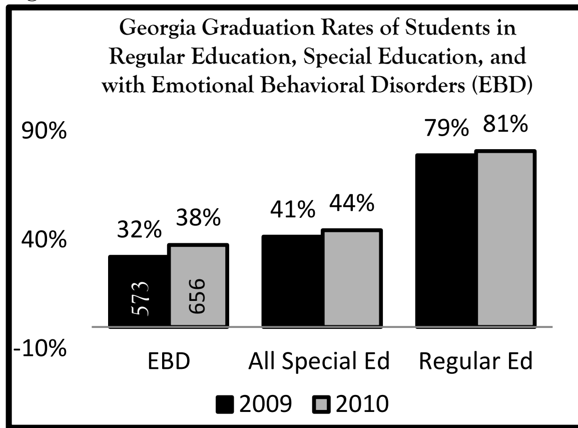
Children and adolescents with serious behavioral health disorders are at greater risk of poor school performance, greater disciplinary actions, lower graduation rates, and dropping out than other groups of children with disabilities. Keeping children in school and helping those with behavioral health disabilities succeed are national and state priorities that are critical to children and the community.

Table C-5 Georgia Children With Behavioral Disorders and Learning Disabilities Were the Most Likely to be Removed to Alternative Educational Setting by School Personnel (2009-2010)

Disability Category	Children Removed		Removals for Drugs		Removals for Weapons	
	#	%	#	%	#	%
Orthopedic Impairment, Visual Impairment, Traumatic Brain Injury, or Developmental Delay	0	0.0%	0	0.0%	0	0.0%
Autism	1	0.6%	0	0.0%	1	2.0%
Hearing Impairment, Speech or Language Impairment	1	0.6%	1	0.9%	0	0.0%
Mental Retardation	7	4.2%	4	3.4%	3	5.9%
Other Health Impairment	38	22.9%	29	24.8%	10	19.6%
Emotional Disturbance	48	28.9%	29	24.8%	19	37.3%
Specific Learning Disability	70	42.2%	53	45.3%	18	35.3%

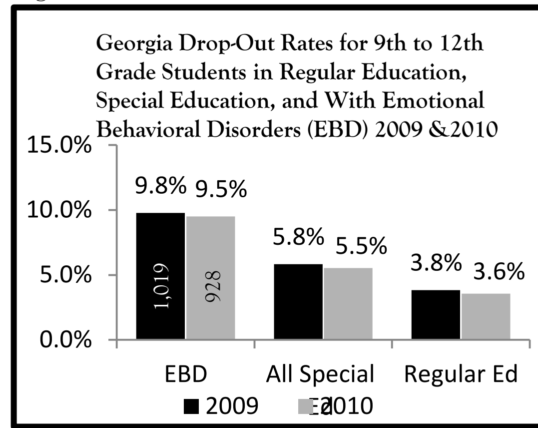
*Source: U.S. Department of Education, ED *Facts* (SFY 2009-2010) and Georgia Department of Education

Figure C-6



Source: State-Level Four-Year Graduation Rates, Georgia Department of Education, special data request, November 2010

Figure C-7



Source: Georgia Department of Education.
*Note: These numbers differ from the numbers for Special Education reported to the U.S.DOE Individuals Disabilities Education Act, which has different definitions.

School to Prison Pipeline. Too often, school staff lack mental health support services, and without them, troubled children who are suffering from serious trauma, depression, anxiety, conduct disorders, or attention deficit disorder in our schools are often not identified and assisted. Instead, they receive disciplinary measures rather than the guidance and treatment they need. Some are moved to segregated alternative schools, restricted environments, and the juvenile justice system. This phenomenon is called the school-to-prison pipeline. Zero tolerance school policies have been adopted as a way to allow "teachers to teach" and to increase school security. More and more troubled children in the United States end up in the juvenile justice system.

Over-represented in the juvenile justice system are youth who have been suspended or expelled from school, have behavioral disorders, are in foster care, and/or are minorities. The United States incarcerates juveniles younger than 18 at shockingly greater rates than other developed countries. The U.S. rate was 336 per 100,000 youth compared to 46.8 for England and Wales, 24.9 for Australia, 23.1 for Germany, 18.6 for France, 4.1 for Sweden and 3.6 for Finland. Between 60 percent and 70 percent of youth in U.S. juvenile justice systems were found to have a diagnosable behavioral disorder, and approximately 20 percent have a serious behavioral health disorder.[39,40,41]

Juvenile Justice Diversion and Georgia's Governor and General Assembly

> *"The time has come for us to rethink how our state is responding to children who have found themselves in trouble with the law."* Governor Nathan Deal, 2011

Georgia and other states experiencing budget challenges are revisiting zero-tolerance school policies, the use of juvenile detention for nonviolent offenses, and the charging of youth as adults. Georgia's Governor Deal, a former juvenile judge, has championed a reform of the Juvenile Code and the use of cost-effective, evidence-based diversionary community programs that address mental

health and substance abuse issues. A Council on Criminal Justice reform commissioned by the General Assembly reported in 2011 that current practices are not working and are expensive. [42]- Findings included:

- It costs Georgia over $91,000 per bed per year for children in the long-term Youth Development Campuses (YDCs) and over $88,000 for short-term Regional Youth Developmental Centers (RYDCs).
- Over 50 percent of children in the juvenile justice system were re-adjudicated as delinquent within three years.
- Diverting nonviolent offenders to community evidence-based programs could save more than $88 million.

Juvenile judges and participants at town meetings across Georgia in 2012 were supportive of the governor's call for reform. They expressed great concern that without community mental health support services for families and schools, juvenile justice facilities will continue to be Georgia's choice for dealing with emotionally troubled youth, lessening their chance for completing high school, finding employment, and successfully reintegrating into their family and society. Forum participants also felt education was needed on how brain development effects youth decision making and on best practices for assisting children with anger and impulsiveness.

Vision Recommendations for Child and Adolescent Behavioral Health

Table CA-6 Vision for Georgia's Children and Adolescents

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
INFRASTRUCTURE, SYSTEMS AND COORDINATION ACROSS AGENCIES	
A Strategic Plan for a Behavioral Health Community System of Care for All Children and Adolescents in Georgia, regardless of payer source or access to insurance, is implemented. Since mental health is critical to the health of all children, the cross-agency plan includes a continuum of	DBHDD, BHCC, DPH, DHS-DFCS, DCHMed, DECAL, DJJ, DOE; EOG; GGA; FSAs.

* **BHCC-IDT**= Behavioral Health Coordinating Council, Child & Adolescent Interagency Directors Team; **CHDs**=County Health Departments; **CSBs** Community Service Providers, **CSD**=County Sheriff's Departments; **F SAs**= families, stakeholders & advocates; **DBHDD**=Department of Behavioral Health and Developmental Disabilities**;** **DECAL**=Department of Early Care & Learning; **DCA**=Department of Community Affairs; **DCH-Med**=Department of Community Health Medicaid Division; **DFCS**=Department of Human Services, Division of Family & Children Services; **DJJ**= Department of Juvenile Justice; **DOE**= Department of Education; **DPH**= Department of Public Health; **EOG** –Executive Office of the Governor; **FQHCs**= Federally Qualified Health Centers; **G-AAP**-Georgia – American Academy of Pediatrics; **GCSA** = Georgia Council on Substance Abuse; **GGA**=Georgia General Assembly; **GMHCN** = Georgia Mental Health Consumer Network, **GPSN**= Georgia Parent Support Network; **GS-CFE** =Georgia State University Center for Excellence; **HMHB-G**= Healthy Mothers Healthy Babies of Georgia; **MHA-G=** Mental Health America of Georgia; **NAMI-G** =-National Alliance on Mental Illness of Georgia **PS** = Peer Support; **PSVR**=Private Sector Voluntary Resources; **USG**=University System of Georgia

<table>
<tr><th>A GEORGIA VISION FOR BEHAVIORAL HEALTH
(√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)</th><th>Entities Involved
(see legend for acronyms)*</th></tr>
<tr><td>universal prevention services for all children and targeted services for at-risk children and for those with behavioral health disorders. Because children's services are the responsibility of many agencies, the Department of Behavioral Health and Developmental Disabilities provides interagency leadership (with the Behavioral Health Coordinating Council and other agencies as appropriate).
• The Child and Adolescent Interagency Directors Team of the Behavioral Health Coordinating Council develops the interagency community plan that includes:
➢ A formal community level structure with strong consumer and stakeholder participation
➢ An index of services to prevent, screen, identify, treat, and respond to crisis
➢ A template for braiding and blending funds across agencies and funding safety net services
➢ Quick access regardless of payer source for children in need of services
➢ Addressing workforce challenges, especially in rural areas
➢ Quality assurance
➢ The safety and quality of out-of-home institutions and restricted settings</td><td></td></tr>
<tr><td>Each Major Child-Serving Agency:
√ Has interagency agreements (MOUs) to assist in coordinating/sharing data and services at the state and community level
√ Has dedicated staff for behavioral health
√ Screens for and identifies behavioral health disorders in its programs
√ Provides training for staff on signs, symptoms, and best practices
Agrees upon a common formulary, medication guidance, and quality assurance system to ensure safety and reduce medicine-induced trauma/crisis or medical complications in children with behavioral health disorders.</td><td>DBHDD, DPH, DHS-DFCS, DCH-Med, DECAL, DJJ, DOE</td></tr>
<tr><td>√ A special package of Medicaid and PeachCare core and specialty services for children's behavioral health care is developed and implemented for eligible children with the input of stakeholders and families: (1) includes the range of services known to be effective for this special population; (2) requires providers funded by the Department of Community Health to meet outcome criteria and data tracking set by the Department of Behavioral Health and Developmental Disabilities; (3) has a provider network inclusive of community safety net public health providers;</td><td>DCH-Med with DFCS, DBHDD, DOE, DPH, DJJ, DECAL and stakeholders, EOG, GGA</td></tr>
</table>

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
(4) reimburses providers fairly in a timely manner; (5) has a consistent standard of quality, access, transparency, and accountability across the provider network; and (6) requires providers to base services on levels of function, need, and expected outcomes. A Medicaid carve-out may be one mechanism to explore. A financing plan with a mechanism for reinvesting a portion of savings as was adopted by other states should be considered. *Note: This recommendation is in process. Georgia DCH-Med has developed with the input and promise of ongoing input from stakeholders and child caring agencies a special package of services to meet the needs of vulnerable children in the DFCS system. It has been working with stakeholders to develop packages for other Medicaid-eligible children with behavioral health disorders.*	
√ **A plan of options for sharing funding and services to create behavioral health care clinics/services in public schools is developed for district schools.** The Georgia Department of Education leads a study with child-serving agencies and other appropriate groups to develop cost- effective strategies for co-locating and co-funding health and behavioral health services in schools. *Note. Emory School of Medicine, Urban Health Initiative is seeding school based health centers in Georgia. Kaiser, Healthcare Georgia and United Way has also provided support for these programs.*	DBHDD, DCH-Med, DJJ, DFCS, DPH, CSBs, FQHC, CHDs, Emory Urban Health Initiative
An independent cross-agency study is conducted to provide guidance on how to reduce the **disproportionate level of minority children** with behavioral health challenges **in restrictive placements**.	DBHDD, DJJ, DFCS, DOE, EOG, GGA
◊ **The Behavioral Health Coordinating Council (BHCC)** of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) membership **is enlarged to include the Georgia Departments of Education and Public Health.** ☺ A Child and Adolescent (C&A) Task Force of the Council shares cross-agency best practices, service-gap concerns, and recommends issues for the Coordinating Council. √ **Regional C&A Task Forces meet to develop regional strategies** for community service implementation.	BHCC, DPH, DOE, BHCC-IDT
◊ **Data on child and adolescent behavioral health services and outcomes are collected, shared, and reported across child-serving agencies.** DBHDD takes the lead for compiling the numbers served with behavioral health disorders in all state agencies and the outcomes achieved. **Data includes (1)** numbers of children, (2) the services they receive, (3) outcomes achieved, (4) service costs and benefits. *Note. This is in process, but may need ongoing legislative funding to assure the service over time. The Andrew Young School of*	GS-CE, DBHDD, BHCC-IDT, DPH, DHS- DFCS, DCHMed, DECAL, DJJ, DOE, EOG, GGA

A GEORGIA VISION FOR BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
Policy Studies, Center for Excellence is providing cross agency data analysis and support.	
WORKFORCE	
√ **Georgia Academy of Pediatrics (G-AAP) utilizes the American Academy of Pediatrics AAP Toolkit for Children's Mental Health** to implement and integrate mental health into community primary care practices and plays a leading role in strengthening community advocacy, funding, screening, identification, and supportive services for children's behavioral health.	G-AAP, DBHDD, DPH, DCH-Med, CHDs, FQHCs
√ **Healthy Mothers, Healthy Babies of Georgia (HMHB) and Mental Health America of Georgia (MHA-G-) continue support for obstetric and pediatric practices through the Healthy Moms (Perinatal Mood and Anxiety Disorders PMADs) Project and** through health care provider training on screening and identification, an online evidence-based toolkit for providers, and a monthly newsletter.	HMHB-Georgia MHA Georgia
√ **Georgia's rural community clinics and schools have developed telehealth and tele-behavioral health** contracts with professionals so families do not have to drive long distances for care, children do not lose valuable school time, and the availability of local behavioral health services are expanded.	DBHDD, DOE, district schools, DPH, county health clinics, FQHCs
√ **Medicaid-reimbursable Certified Peer Support Professional services** are expanded into every community for adults, older adults, parents, and youth with mental health and substance use disorders. A ***Certified Parent Peer Support Professional for Behavioral Health Services*** is established and becomes a Medicaid-eligible and Medicaid-funded service.	DCH-Med, DBHDD
√ **School police officers receive Crisis Intervention Team Training (CIT)** to help their effectiveness with children experiencing a behavioral health crisis.	NAMI Georgia
Health care professions serving children and adolescents receive training in behavioral health through initial professional training, required continuing education units (CEUs) for licensure, and provider contract requirements.	universities, colleges, DBHDD, DCH-Med, DJJ, DFCS
◊ **A Mental Health First Aid (MHFA) curriculum** for children and adolescents is available to preschools, school personnel, juvenile court judges, children's health care providers, and interested citizens. *Note: MHA Georgia now offers MHFA for children.*	MHA-Georgia

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PROMOTION - UNIVERSAL PUBLIC INFORMATION AND EDUCATION is widely available	
in public media, obstetric, pediatric and primary care offices, and other health care facilities, in child care, preschools, schools, and universities on: • "Normal" child social, emotional, and physical development • Parenting/caregiving skills for supporting child and adolescent mental health and resiliency in infancy, childhood, and adolescence • Common behavioral health disorders, signs, and symptoms • Ways to seek care • Georgia's Crisis and Access Line (GCAL) 1-800-715-4225) • Perinatal mood depression and toxicities in the perinatal period are early signs of serious disorders in youth (e.g., depression and suicide, addiction, and the prodromal period in schizophrenia)	DBHDD, DPH, DCH-Med, DOE, CHDs, and FQHCs with support from public media, GCAL, preschools, public and private schools, universities, obstetric, pediatric and primary care practices
√ **Ways individuals as well as community organizations such as faith groups, private sector companies, universities, and service groups can volunteer and support** children with behavioral health challenges and their families (e.g., peer mentors, CASA advocates in the courts, educators of the public, foster or adoptive parents, school/university support groups)	DBHDD, DPH, DCH-Med, DOE, DFCS, juvenile judges
Georgia press and media educate the public on child, adolescent, adult, and older adult behavioral health issues in order to reduce stigma that results in fewer individuals seeking care and less identification early when prevention and recovery are easier. *Note. At town meetings, there was concern that the public receives only information about young people and violence, which has led to fear, harsher discipline of youth, and less understanding of the importance of supporting mental health prevention and treatment in schools and communities.*	Press and media outlets, DBHDD press office, Carter Center Mental Health Program
PREVENTION, EARLY INTERVENTION, AND RESILIENCY SERVICES	
√ **Home visiting, parenting education** is available for at-risk pregnant women and new mothers (e.g., teen parents, low-income, single parents, or other risk) so that they have the best chance of promoting resiliency and strong social emotional skills in their children.	DFCS, DECAL, Head Start, DPH, EOG, GGA
√ **Quality preschool and childcare** is available for all - to 5- year-olds who are at high risk for school failure, behavior problems, or disabilities.	DECAL, DPH, DOE, Head Start, EOG, GGA
√ **Early identification, counseling, parenting education, respite, and appropriate supports are available for parents suffering from depression,**	DCH-Med, DPH, DBHDD regions

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addiction, trauma, domestic violence, or other disorders that may interfere with parent-child bonding/attachment and their child's socio-emotional development. Respite is available prior to a crisis to avoid using as a punishment and to prevent child abuse, arrest, or hospitalization.	
√ **The Positive Behavioral Interventions and Supports (PBIS) evidence-based program is adopted in all publicly funded schools** to improve school climate, increase staff behavior management skills, reduce discipline referrals and school violence, and support the mental health of all children.	District schools, DJJ schools, DOE, EOG, GGA
√ **Public schools have on site a behavioral health clinic or support services so that** (a) children/adolescents do not have to leave school for behavioral health counseling/treatments; (b) programs can be designed to reduce the behavioral health challenges (e.g., bullying, suicide ideation, drug/alcohol misuse, aggressive behaviors, family homelessness, trauma) that result in an unhealthy school climate, dropping out of school, lost potential, and other poor outcomes.	DOE, district schools, DPH, EOG, GGA
√ **Schools have alternatives to disciplinary actions** of -suspension, judicial arrest, and expulsion of children with behavior problem(s) (e.g., anger management, mediation, and other evidence-based programs for children who have difficulty controlling their anger.	district schools, DOE, DBHDD, Juvenile Court
√ All schools receive adequate funding to support evidence-based • √ alcohol/drug abuse prevention curricula • √ suicide prevention • √ bullying prevention	district schools, DOE, EOG, GGA
Parent education, support, and guidance are available for adoptive parents, foster parents, and grandparent caregivers of at-risk children to give each the best chance of successfully integrating into a family that can support them.	DFCS, EOG, GGA
SCREENING AND IDENTIFICATION – INTEGRATED HEALTH CARE	
Health care providers provide integrated health care utilizing simple routine screens to identify physical, mental, and substance abuse health risks and co-occurring disorders as part of their general medical health history review: (1) In physician practices as part of a health history or regular check-up (2) In preschools, schools, and universities (3) By obstetric providers who also check for perinatal mood disorders	DBHDD, DCH-Med, DPH, Georgia OBGYN Society, G-AAP, CHDs, FQHCs,

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A youth screening assessment for behavioral health disorders occurs prior to/at entry into juvenile court, detention; foster care, and school suspension or expulsion for behavior problems so that appropriate planning and care can be provided and a diversion program may be considered.	DFCS, DJJ, DOE, district schools, Juvenile Courts, EOG, GGA
BEHAVIORAL HEALTH COMMUNITY SERVICES FOR CHILDREN AND ADOLESCENTS are recovery-oriented, strength-based, involve children and their parents/caregivers in a meaningful way, are culturally sensitive and appropriate, and are coordinated by a single case manager**.**	
√ **Behavioral health providers use evidence-based treatments and promising** practices that are monitored for fidelity and outcomes.	DBHDD, DCH-Med, DJJ, DFCS, DOE
√ **Children and adolescents with co-occurring substance and mental health** disorders are identified and receive evidence-based treatments that address both.	DBHDD, DCH-Med, DJJ, DFCS, DOE
√ **Care Management Entity wraparound services** are available and funded in every community for youth with serious behavioral health disorders in restrictive or institutional settings and for those at high risk for out-of-home placements. *Note: Georgia built an infrastructure in local communities to support evidence-based wraparound services as part of a Medicaid demonstration grant. This important option to institutional care requires ongoing funding and support. If not funded, Georgia will lose the infrastructure it built and the hope of recovery for the most vulnerable youth with behavioral health disorders.*	DCH-Med, DBHDD, EOG, GGA
√ **SBIRT – Alcohol Screening and Brief Intervention and Treatment for Youth,** an evidence-based program, is used in health care primary care practices and in high school health clinics/services.	DBHDD, DCH-Med, GCSA
√ **After-school programs such as Clubhouse** programs are available for youth with substance abuse and mental health problems	DOE, DCH-Med, DBHDD, DJJ, DFCS,
√ **Quality transition services with cross-agency coordination and case management are funded and provided to youth and young adults** who (a) are emancipated from foster care, (b) leave juvenile detention, or (c) have behavioral health disorders and are aging out of special education programs so that they have the best chance of successfully living independently by finding employment, housing, and receiving the therapeutic and health care they need to maintain their recovery	DBHDD, BHCC, DFCS, DJJ, DOE, district schools, EOG, GGA
√ **Crisis** stabilization and mobile crisis services for children are available in all communities.	DBHDD, DCH-Med
√ **Children and adolescents with serious behavioral health disorders have**	MHA-G, NAMI-G, DBHDD

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developed with their families and case manager a crisis plan to assist them in receiving appropriate treatment in the event of a behavioral health crisis.	
The formerly successful Transition and Aftercare for Probationers and Parolees (TAPP) program or other transition program is again funded to reduce recidivism for youth and adults with behavioral health disorders on probation or released from correctional facilities. *Note. This recommendation was made at town hall meetings.*	DJJ, EOG, GGA
√ ◊ A provider is funded to assist families of children and youth with behavioral health challenges to advocate and negotiate the service system.	GPSN, DOE, DBHDD, BHCC-IDT
◊ A functional scale for young children and youth with behavioral health challenges is used across child-serving agencies to provide continuity in measuring the type and intensity level of behavioral health services that may be needed and to allow measures of treatment outcomes.	BHCC-IDT, DJJ, DFCS, DBHDD

Examples of Evidence-Based and Promising Practices

Because the goal is the availability of quality community services for children and youth, a few evidence-based and promising practices that exist or might be easily replicated throughout Georgia are presented. Please see Appendix 3 for a more complete list.

Improving Integrated Care/Workforce

American Academy of Pediatrics AAP Toolkit for Children's Mental Health. Georgia Academy of Pediatrics is working with members to implement and use the AAP Toolkit for integrating mental health into community practices and playing a leading role to strengthen community advocacy, funding, screening, identification, and supportive services for children's mental health.[43]

Healthy Moms (Perinatal Mood and Anxiety Disorders PMADs) Project. Healthy Mothers, Healthy Babies of Georgia and Mental Health America of Georgia have collaborated to bring this PMAD Healthy Moms project to Georgia citizens experiencing PMAD and primary care providers. The project provides: (1) information to new mothers and the general public, (2) a peer support program for those experiencing PMADs, (3) health care provider training on screening and identification, (4) an online evidence-based tool kit for screening for providers to use, and (5) a monthly newsletter for updating Georgia health care providers.[44]

Promotion, Prevention, Screening, and Treatment Programs

Triple P (Positive Parenting Programs) Triple P is a five-level public health approach for children birth to age 12 largely utilizing media such as television and the Web to reach all families searching for help in child rearing challenges. Level 1 is a universal prevention parenting education program. Levels 2, 3, 4, and 5 provide more targeted educational support for specific behavioral health challenges. Australia found after initiating the program that 48 percent of children with diagnosed behavioral disorders fell below the

clinical score for a mental health disorder.[45] In the United States., three indicators of child maltreatment were reduced in nine treatment counties of an 18-county Centers for Disease Control and Prevention study of 0 to 9 year olds.[46] Bell and Jeste (2011) argue that mental health could benefit from a public health "immunization" effect with cost-effective programs like Triple P. Public health approaches can (a) be available in every community, thereby reaching more families; (b) improve the general population's knowledge about childhood mental health; (c) reduce the amount of children needing more intensive assistance; and (d) decrease the pressure on workforce shortages and a subsequent wait for care.

Prenatal and Infant Nurse Home Visiting is a public health best-practice approach for children at risk of behavioral disorders and other poor health outcomes. Results include less incidence of low birth weight, child abuse and neglect, and impairments from use of addictive substances. Savings ranged from $2.24 to $5.70 per child, and savings began to be realized before infants were 3 years of age.[47]

Community School-Based Health Clinics (SBHCs) With Integrated Behavioral Health. SBHCs have been found to be cost-effective and helpful to children through improved access to insurance and to medical and mental health screening, diagnosis, and treatment. Cobb County, Georgia, located services in 35 schools with high risk students. The Success for All Students (SFAS) program found decreases in student probation, in-school fights, use of alcohol and marijuana, and discipline events. In a study of the Atlanta-based Whiteford Elementary, SBHC found lower Medicaid expenses.[48] SBHC children used less -emergency care and more of the Early Periodic Screening Diagnosis and Treatment (EPSDT) preventive care services. Berrien Elementary school's SBHC in rural North Georgia has a telemedicine connection and a partnership with physicians miles away. Children receive behavioral health treatment and see a doctor or physician's assistant without missing school or without their parent missing work to drive long distances for an appointment. Emory University of Atlanta has a grant program to seed and support the implementation of SBHCs across Georgia.

SOS (Sources of Strength).[49] SOS is a best-practice suicide prevention model program. Adolescents often have a code of silence and do not share their problems with adults but with peers. SOS increases help-seeking behaviors in youth. It works by building sensitivity across youth to their peers and caring adults who learn the signs of depression, suicide risk, and helping skills. Youth build resilience and strengths to handle difficult problems they may face. Students are recruited to serve as peer leaders who work to identify and help kids going through a rough emotional time, connecting them to adults who can help. The Georgia Department of Behavioral Health and Developmental Disabilities is assisting county school systems in developing a Sources of Strength best-practice suicide prevention model program.

PBIS (Positive Behavioral Interventions and Supports) works within a school to provide evidence-based behavior support for all students. The multi-tiered process adjusts to the unique behavior needs of a child, including students who need more intensive supports, helping them in classroom and nonclassroom environments. All staff participate in ongoing training and development to be effective. Data is essential in assisting decision making and measuring impact. PBIS is effective in improving school climate and academic achievement and in reducing disciplinary problem behaviors and bullying.[50] Schools in Georgia adopting PBIS report decreased discipline referrals and more time in instruction as well as increased student satisfaction, achievement, and perceptions of school safety.[51,52] The Georgia Department of Juvenile Justice is implementing PBIS. A waiting list exists for schools wanting to implement PBIS. Staff development is essential, and the Georgia Department of Education has not been able to keep up with the demand.

SBIRT – Alcohol Screening and Brief Intervention and Treatment for Youth is an evidence-based program implemented by health care professionals in their community practices to identify, reduce, and prevent misuse, abuse, and dependence on alcohol and illicit drugs. A practitioner's guide and screening tool has been developed for alcohol misuse in youth 9 to 18 years of age.[53]

Programs for Children and their Families at High Risk of/or With Serious Behavioral Health Conditions

CME (Care Management Entities) – Evidence-Based Wraparound Care Programs High Fidelity. CMEs coordinate agency support of children with the most serious behavioral health disorders in their communities. Since significantly challenged youth are often seen by multiple agencies, CMEs blend/braid funds from numerous agencies with missions to implement programs of child welfare, behavioral health, juvenile justice, education, and financing (e.g., Medicaid and/or the Child Health Insurance Program). Intensive care management family/youth-guided teams with a never-give-up attitude deliver individualized care and planning that are strength-based and culturally competent and that build upon natural supports. Children and their families have better outcomes and avoid or lessen their need for costly, often ineffective institutional care. Georgia had a federal grant and Medicaid waiver which it used to build an infrastructure of community programs to effectively administer CMEs across the state. Though results were found to be good, Georgia has to decide how to keep funding this valuable infrastructure and continue developing the program for youth who are at greatest risk. Wraparound Milwaukee found that the program saved them over $150 million over 10 years. Youth functioning at home, school, and community improved significantly in just one year. For delinquent youth, results demonstrated that even youth with violent offenses are able to turn their lives around.

Clubhouse is a peer, education, and social support after-school program that helps youth cope with stigma, isolation, and the many challenges of dealing with substance abuse and mental health disorders. Youth in Clubhouse gain an "I can do" hopeful attitude through shared friendships with other youth with similar challenges and supportive staff. CETPA[54] operates a successful clubhouse program for Hispanic youth and provides statewide training for programs wishing to address the Hispanic community. CETPA is a state and national model bilingual program addressing the substance abuse and mental health service needs of the Latino community in four counties in the Atlanta area. It is the only Latino agency in Georgia to be licensed by the Georgia Department of Behavioral Health and Developmental Disabilities and to earn national accreditation by the Commission on Accreditation of Rehabilitation Facilities for bilingual substance abuse and mental health treatment prevention services.

Group Cognitive Behavioral (CB) prevention program[55] for adolescents of parents with depression. Only around one-quarter of youth with depression are identified and receive treatment. Prevention is important. Parental depression is a strong risk factor for development of adolescent depression and later adult persistent chronic depression. Depression is associated with numerous other health and behavioral health disorders as well as suicide. CB was found effective at preventing adolescent early onset. Treatment included eight weekly group sessions and six monthly continuation sessions with a trained clinician. Depression is an episodic disorder, and the CB program was found to be less effective for children of parents with active depression.

NAMI Basics is a free six-week peer education and support program for parents and other primary caregivers of children and adolescents with serious mental illnesses. Parents learn basics of mental illness identification and treatment options, advocacy and most importantly they are not alone.

Georgia Parent Support Network (GPSN). GPSN is a nationally recognized statewide program dedicated to providing support, education, and advocacy for children and youth with mental illness, emotional disturbances and behavioral differences and their families. GPSN assists families in negotiating multiple agencies and brings their expertise to service planning by helping them in learning and exercising their rights and advocating for their child.

Trauma-Focused Cognitive Behavior Therapy (TFCBT) is a short-term intervention designed to treat post-traumatic stress and related emotional and behavioral problems in children and adolescents. TFBCT is the most frequently used treatment and is a short-term intervention that encourages children and youth (3–18

years of age) to become more aware of how their thoughts about the traumatic event affect their reactions and behaviors [56]

Children and Their Families at High Risk of Abuse and Neglect Served by the Division of Child and Family Services (DFCS)

Pre- And Post-Training for Adoptive Families and Foster Parents has helped to reduce multiple placements and assisted foster and adoptive care for children who have learned to mistrust adults and often blame themselves for the maltreatment they have received.

Family Preservation and Support Programs, when possible, are preferable to the multiple traumas of separating a child from the only family they have known. Successful programs recognize and assess stressful family conditions that may contribute to a high risk for child neglect or abuse. They help high-risk families in crisis struggling with basic necessities or serious physical and/or mental health issues (e.g., unemployment, domestic violence, parental depression, poverty, homelessness). When a child with challenging behaviors leaves, a family has to again readjust. When the child returns, it can be painful and difficult. Evidence-based programs such as Functional Family Therapy (FFT), Intensive Family Therapy, and Wraparound Care Management Entity programs help the family enhance functioning of all members to support and protect the healthy development of youth with serious behavior problems within their family.

Therapeutic Foster Care offers long-term, out-of-home supportive and stable placement in the home of a trained Therapeutic Foster Care provider for children, removed from their homes, with emotional and behavioral challenges and for whom less intensive foster care does not meet the child's needs. Georgia's Parent Support Network (GPSN) has an award-winning program.

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VIII. Transition – Adolescents and Young Adults (17 to 25 Years Old) with Behavioral Health Challenges*

The Transition Youth Peer Center is important to me. It gives me hope and support from peers who are also living with mental health challenges. I know I can have a future, because I see that they are making it work - going to school and work. I just found an affordable place to live! [Conversation with a young adult on a visit to the Transition Youth Peer Center (TYPC) of the Georgia Parent Support Network.]

TYPC is a site where young adults with behavioral health challenges between the ages of 17 and 25 who are no longer eligible for foster, education, or other services can gain leadership skills and the ability to function effectively in school and the community and learn how to be part of a team that provides positive support.

****

Thank you for giving me this chance. I cannot not tell you the things that happened to me. After I was removed from my family, I had a lot of anger. Yet, inside I have a will to succeed. I stand here before you very grateful. I have worked so hard. I graduated from high school, have been accepted into college, and now am receiving this wonderful scholarship. I actually now have a girlfriend! I am fortunate that along the way, after many placements, there was a program where people believed in me, and that has been so important. Yes, I get anxious and depressed from time to time, but now I know it can be dealt with and I can have a future. I am determined to succeed and help others who have gone through this. [A short version of a young adult's story on the occasion of receiving a college scholarship from Families First in Atlanta. He participated in the Independent Living Program, a transition to adulthood support program for former foster youth.]

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I am an alcoholic in recovery and have not had a drink in three years. I am so thankful that people cared and there is a Drug Court that gave me a chance. Alcohol addiction took over my life; nothing else mattered. I dropped-out of school. I was arrested. I now have a job and am going to school. My mother had an alcohol addiction and drank when she was pregnant with me. It is easier for me to become addicted than others; I know that no matter how bad I feel I cannot ever drink or my addiction will return. It is important for everyone to know that these diversion and support programs change lives and give hope. [This is a shortened composite version of testimony from young adults at town hall meetings held in Georgia.]

Note. Names are changed. The pictures in this section are stock photos from Fotolia.

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* **We added this section on transitions for youth and young adults with behavioral health challenges in response to the feedback provided by many stakeholders in town hall meetings across the state who voiced concern for this population.**

We envision a Georgia where adolescents and young adults with behavioral health challenges can receive the education, employment and health supports in their community needed for them to be healthy, independent, resilient adults with a meaningful life.

Why Focus on the Behavioral Health of Late Adolescents and Young Adults in Transition?

"…Young adults…have a worse set of health outcomes than do adolescents – their rates of death from motor vehicles crashes, homicide, and suicide are significantly higher…and they are more likely to use tobacco, consume illicit drugs, binge drink, and contract HIV infection. …Young adults are at highest risk to be arrested … with… males of color at especially high risk. They also are at high risk of homelessness … are … least likely to be employed … [and] have the lowest levels of access to health care, especially among undocumented immigrants and other disadvantaged groups." (Trina Anglin, *2013, p. 6-7)*[1]

Fifty percent of behavioral health disorders will present before age 14, and 75 percent of all behavioral health disorders will appear by age 24; many will not be identified or treated for years.[2,3] Moreover, having a psychiatric disorder was found to have a disrupting influence on the ability to develop skills necessary for transitioning to adulthood.[4] Children's mental health dollars are ending, adult-oriented treatments are not geared for the specific tasks this age group faces, and to date only a few best practice transition programs have been identified.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is attempting to address this problem through specialized grants and transition programs in its Children's Mental Health Initiative (CMHI) Emerging Adult Initiative (EAI). Older adolescents and young adults with serious mental health conditions served by CMHI reported that within the last six months[5] *"27 percent had experienced … four or more … traumatic events…48 percent said they did not have an adult they could talk to about important things…9 percent…had experienced homelessness…16 percent were neither enrolled in school nor employed…10 percent reported having made a suicide attempt…28 percent had suicidal thoughts…25 percent had been arrested…12 percent were…having a serious substance use concern."* The good news is that programs geared to promote recovery, resilience, and skills for this age group can make a difference. Please see (http://www.samhsa.gov/children/SAMHSA_Short_Report_2013.pdf.)

Challenges and Risks

Young adults, with or without behavioral health disorders, are experiencing and experimenting with exciting new freedoms and negotiating dramatic and stressful life changes. At age 18, they become legally responsible for their actions, finances, housing, and education. Many may be able to rely on parents, but some will not have families that can support them. Public schools are no longer required to provide them an education. They must prepare themselves for a career and find employment. They are developing intimate relationships and possibly marrying and starting a family. Some will join the military, which can help them with their education and employment. Friends, peers, and other adults they encounter in school or work are now critical mentors and sources for affirmation.

Significant Brain and Physical Development Occurs in the Transition Years

Little is known or understood by the public at large about the tremendous amount of changes that occur in the brain during late adolescence. Developmental changes are affecting decision making, risk-taking, and mood.[6] Youth and young adults are risk takers and quick reactors not only because new found independence requires decisions for which they have little experience but because their brain is wired differently.

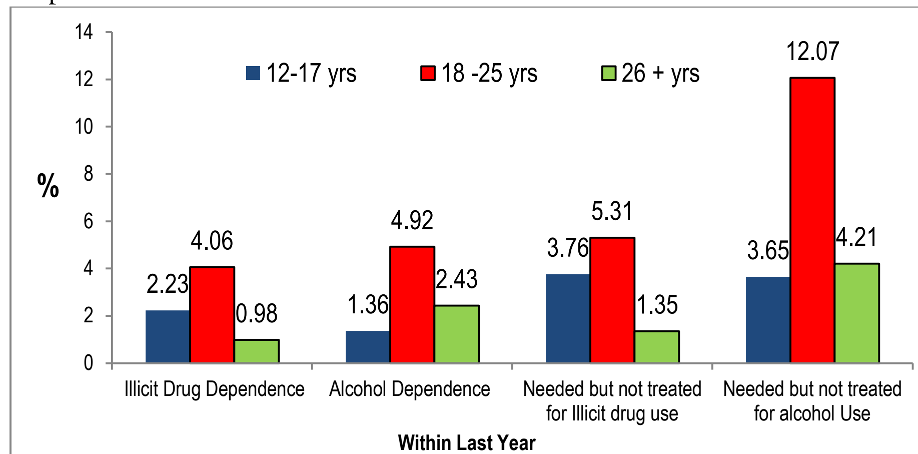
The brain's frontal cortex is the center for logic, planning, and keeping emotions in check, and it will not be fully developed until around age 26.[7] The amygdala, a part of the brain associated with emotions and impulse, has greater influence. Pruning, rewiring, and hormonal changes are occurring at a rapid pace. Hormonal imbalances and mood changes are common.

Researchers are searching for answers to how the rapid changes in connections and brain chemistry at this age may create a vulnerability to mental illness and addiction. They are also looking at opportunities to protect and improve behavioral health.

Drug and Alcohol Dependence

Risk-taking and experimentation with new freedoms may be illustrated in the strikingly elevated rate of 18 to 25 year olds who were found to be drug and/or alcohol dependent (see Figure T-1).

Figure T-1 National Survey of Drug Use and Health Estimates of Georgia Drug and Alcohol Dependence in 2010–2011

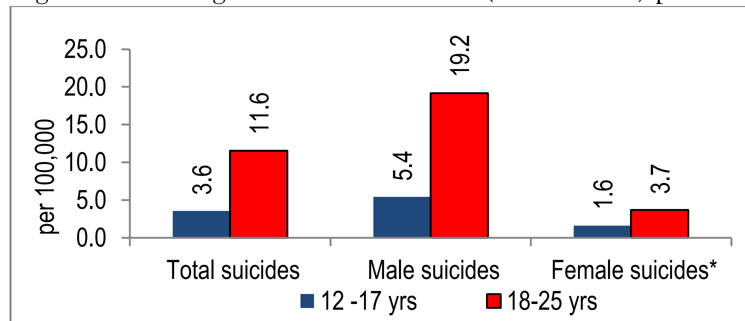


Source. Substance Abuse and Mental Health Services Administration. 2010-2011 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia) retrieved from: http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsae2011/ExcelTabs/NSDUHsaeTables2011.pdf

Suicide

Suicide and other intentional as well as unintentional death rates dramatically rise at this age.

Figure T-2 Georgia Suicide Estimates (2009–2010) per 100,000 [8]



*Georgia Female Suicides for 12 to 17 year olds (1.6 per 100,000) is less than 20 and an unstable rate.
Source. National Center for Injury Prevention and Control, CDC Vital Statistics System for Suicide Rates

The success of young adults is critical to Georgia and our nation. They will carry our country into the future and be the doctors, lawyers, teachers, police, fire fighters, scientists, and inventors that will keep our economy humming through good and bad times. As for each generation, the earnings of young people will support the economy and social security retirement income for senior citizens.

Successful programs for transition-age adolescents and young adults with serious behavioral health disorders address the skill sets needed to successfully navigate the transition years.

1. **Education** – Graduating from high school or equivalent
2. **Employment**
3. **Treatment –** Case management, access, and use of community behavioral health services

4. **Finances** – Financial security, handling finances, including access to affordable housing, transportation, and food
5. **Social and emotional skills** – Handling stress and developing positive supportive relationships
6. **Self-esteem, hope, and peer support**

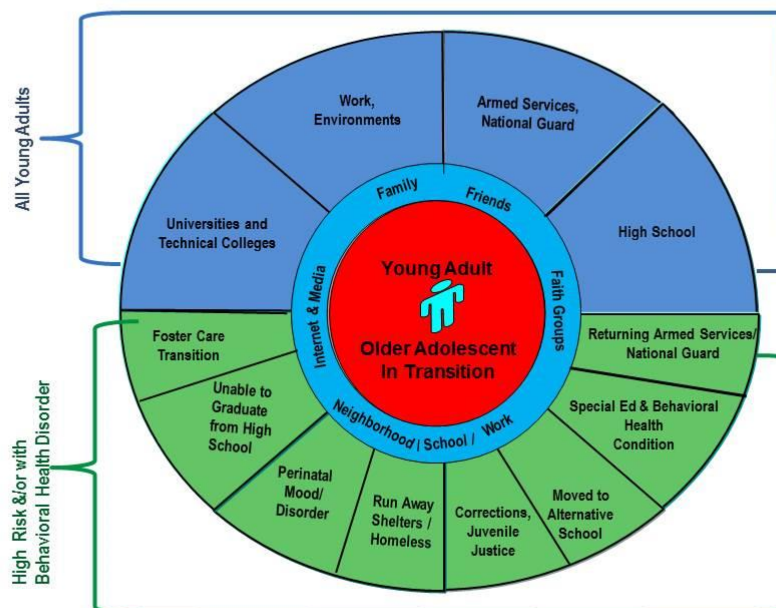
The Research and Training Center for Pathways to Positive Futures (Pathways RTC) in Oregon identified the following common individual goals that are best practices for this population target:[9] ***1. Positive identity, sense of purpose, efficacy, empowerment, self-determination; 2. Capacity, motivation, self-control, and confidence to make decisions and carry out plans; 3. Skills for adult roles and leveraging resources; 4. Supportive relationships and pro-social connectedness.***

States find that addressing the transition years requires learning new coordination skills across agencies and programs that serve adults and those that serve children.

Populations at Greater Risk and Places Support Might Focus

Figure T-3 illustrates where promotion and outreach to all older adolescents and young adults is important because it is where they are likely to be located. Specially designed interventions focus on groups at greatest risk.

Figure T-3 Young Adults and Older Adolescents with Behavioral Health Challenges – Systems Identification and Risk Reduction and Recovery Opportunities



A more in-depth look at three risk groups follows: (1) former foster care children, (2) incarcerated older adolescents and young adults, (3) youth with behavioral health challenges in the school-to-prison pipeline.

A serious behavioral health condition can occur to anyone regardless of age, income, or status in life, but when stress and trauma occur, the triggering of a disorder is more likely. When a young adult with a serious behavioral health disorder faces further stress and trauma, the task of maintaining health and meeting the expectations of this age can be overwhelming, especially if supportive adults are not available to mentor or serve as a safety valve when problems arise.

Former Foster Care Young Adults

Around 48 percent of youth in foster care programs were found to have serious emotional/behavioral problems.[10] Children who enter foster care become wards of the state when neglect or abuse has made it unsafe to remain with their families or when families request help because they cannot care for their child. It is our responsibility, to do all that can be done as a legal parent, to help them recover and have tools for success. They have endured great stress, trauma, multiple homes for some, and personal rejection. These traumatic conditions are a "recipe" for triggering mental health and substance use disorders.

The Chicago Chapin Hill study[11] tracked and studied the outcomes of foster care children from Illinois, Iowa, and Wisconsin after emancipation. In the fifth wave of interviews, 25- to 26-year-old former foster care children were interviewed regarding their behavioral health symptoms for depression, social phobia, and substance abuse (Table T-1). They struggled with behavioral health disorders and access to treatment.

Table T1 Former Foster Care Mental Health/Substance Dependence at Ages 25 and 26)

Mental Health or Substance Dependence Symptoms[11]		*females*	*males*
Mental Health Symptoms (past year)			
Social Phobia Symptom	34.7%		
Depression (sad, empty, or depressed for two weeks or more)	23.8%	27.7%	19%
Posttraumatic Stress (PTSD)	57.6%		
Alcohol / Substance Abuse Dependence (past year)			
Substance abuse symptoms	22.5%	10.3%	32.5%
Substance dependence (three or more symptoms)	19.9%	16.2%	22.9%
Alcohol abuse	15.6%	13.7%	17.7%
Alcohol dependence	13%	10.3%	15.9%
Received Treatment (past year)			
Psychological/emotional counseling, substance use treatment or medication for emotional problems	19.5%	22.9%	15.2%
Substance Use	4.2%		

Source. (Courtney et al., 2011) The Chapin Hill study fifth wave results

The Chapin Hill study compared 25- and 26-year-old former foster care youth with a nationally representative sample from a longitudinal study of youth and young adults — the Add Health Study, North Carolina, Chapel Hill.[12] While the Add Health study found many risks for 25 and 26 year old adults, the Chapin Hill study shows the steep climb required and poorer outcomes for emancipated foster youth (see Table T-2). Former foster care young adults are at greater risk for housing instability, education attainment, employment, and interactions with the justice system.

When foster care youth reach age 18, they are unlikely to have a family to help with finances, housing, and education. Foster care youth with behavioral health symptoms/disorders also have higher levels of victimization (abuse), which makes them at even greater risk of housing instability, mental health challenges, and substance use.[13,14]

T-2 Estimates of Outcomes for All 25- and 26-Year-Olds – and Former Foster Care Adults

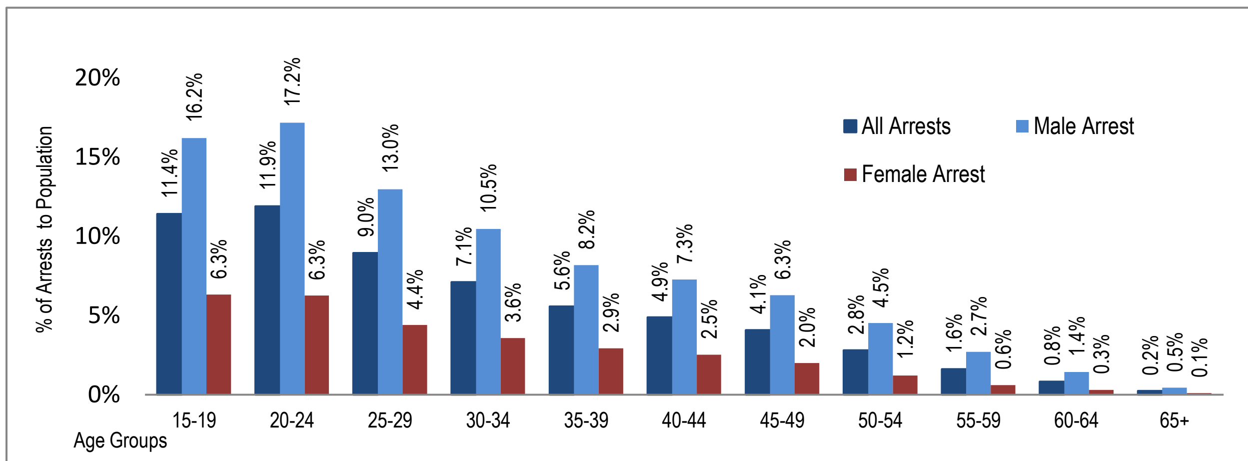
Outcome Area	Chapin Hill Study - Former Foster Care (25 - 26 yrs. old)	Add Health Study (all 25 - 26 yrs. old)
No high school diploma or GED	20%	6%;
Postsecondary degree/four-year degree	8% / 2.5%	46%/23.5%
Employed currently	46%	80%
Income -mean/median (in 2010 $s)	mean $13,989 median $8950	mean $32,313 median $27,310
Home owner	9.4%	30.4%
Can't pay rent	27.9%	5.9%
Gas or electricity shut off	31.4%	13.1%
Ever arrested	females 59% males **81.8%**	females 14.8% males 41%
Ever incarcerated	females 42.8% males **7.2%**	females 5.7% males 23.1%
Since age 18 arrested	females 41.6% males **68.2%** /	females 4.9 % males 22.1%
Since age 18 incarcerated	females 32.5% males **22.1%**	females 3% males 8.5%

Corrections and Behavioral Health – Concerns that We are Criminalizing Adolescents and Young Adults and Those with Behavioral Health Disorders

Thirty percent (16,182) of Georgia's Department of Corrections inmate population was admitted when they were 17 to 24 years of age in 2013.[15]

The U.S. Department of Justice estimates of arrests by age groups graphically illustrates the high rate of incarceration of adolescents and young adults as compared to other age groups. See Figures T-3 and T-4.

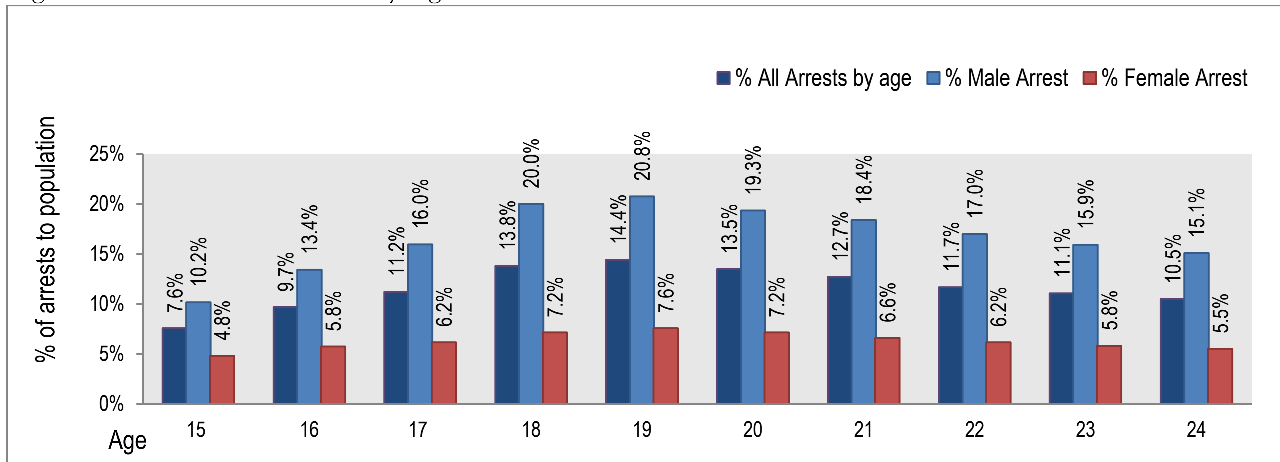
Figure T-3 Estimated U.S. Arrests in 2010 by Age Group[16]



Data Source. Snyder, H. Arrest in the United States, 1990-2010. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics October 2012, NCJ 239423. Note. Not every arrest results in a conviction.

Figure 4 shows that arrests increase from 7.8 percent at age 15 to a peak of around 14 percent between the ages of 18 and 21 and then go down to less than 11 percent at age 24. While not all arrests result in convictions, arrests have serious effects on young people in how they are viewed by friends, school, work, and the community.

Figure T4 U.S. 2010 Arrests by Age of 15- to 24-Year-Olds



Youth in secure detention before a trial: The practice of placing young people into secure detention to await a court hearing for minor nonviolent offenses has become a concern of those who want to reform the system. Secure detention introduces young people to other delinquent individuals, is traumatic, and takes even more time away from school, work, and family.[17]

When and why did the United States begin to arrest so many young people and those with behavioral health disorders?

In the 1980s and early 1990s, states reacted to increasing crime among youth by creating zero-

tolerance policies in schools and communities. Other forms of discipline were replaced by expulsion from schools, detention, and confinement in juvenile or adult correctional facilities. Forty-five states, including Georgia by 1992, made it easier to place juveniles in adult prisons, and more youth began to be committed to adult prisons. Over 50 percent were African-American, and over 70 percent were 17 years of age at admission. Many detained had a mental health problem with severe emotional disturbances. Educational services and mental health treatment were found to be seriously inadequate.[18]

At the same time, rehabilitation and education in prisons and juvenile facilities was de-emphasized. Schools added police officers and some began to eliminate "costly nonacademic programs" such as mental health counselors, physical education, art, and music in order to lower costs and concentrate on academics.[19]

By 2000, some states began to question the cost and results of policies that interrupt education, make it difficult to find employment, and introduce so many young people to hardened criminals.

Georgia and U.S. Corrections and Juvenile Justice Facilities and Mental Health Disorders
In 2011, the Georgia Department of Juvenile Justice (GDOJ) admitted 1,261 youth 17 years of age to regional youth detention centers and report that "*approximately 43 percent of those youth, screened upon admission, are found to have a mental illness, emotional disturbance, or substance abuse problem and are referred for a more thorough mental health assessment.*"

An important U.S. Department of Justice study estimated mental health problems of incarcerated individuals in federal and state prisons and local jails.[20] The likelihood of a mental health disorder was found to be significantly greater for young adults than for other age groups.[20] See select estimates for state prisons and jails in Table T-3.

Table T-3 Estimates of U.S. Inmates in State Prisons and Jails With Mental Health Problems

	State Prison	Local Jails
Inmates less than 24 years old	62.6%	70.3%
All Inmates	56.2%	64.2%
Male	55%	62.8%
Female	73.1%	75.4%
White	62.2%	71.2%
African-American	54.7%	63.4%
Hispanic	46.3%	50.7%

Source. James and Glaze. 2006. U.S. Department of Justice

Table T-4 Estimates of Risks Faced by Inmates With and Without Mental Health Problems Prior to Entry in State Prisons and Jails in 2005

Area	State Prison		Local Jails	
	With Mental Health Problem	No Mental Health Problem	With Mental Health Problem	No Mental Health Problem
With substance dependence	53.9%	34.5%	56.3%	25.4%
Females	*74.5%*	*53.6%*		
Homeless year prior	13.2%	6.3%	17.2%	8.8%
Females	*16.6%*	*9.5%*		
Employed month prior	70.1%	75.6%	68.7%	75.9%
Ever physically or/sexually abused	27%	10.5%	24.2%	7.6%
Former foster care	18.5%	9.5%	14.5%	6%

Few with behavioral health problems received treatment before admission and while in prison (Table T-4). In the year before their incarceration, 22 percent in state prisons and 22 percent in local jails prisons had received treatment. After being admitted to prison, 34 percent in state prisons and 17 percent in local jails received treatment. Like former foster children, adults in the corrections system with mental health problems reported a number of life stressors. Fewer females are arrested and in prisons, but their risk for mental health and substance dependence problems are greater.

School-to-Prison Pipeline: Georgia's Out-of-School Suspensions

Georgia Appleseed documents in its Effective Student Discipline: Keeping Kids in Class[21] report that Georgia has a very high rate of out-of-school suspensions for minor offenses (around 69 percent in the 2009/2010 school year). While across the state out-of-school suspensions occurred for 8.2 percent of youth, in some school districts the rate was over 50 percent of a school's population. In addition, out of school suspensions were disproportionately used for African-American, poor, and special education students. While producing this report The Carter Center found that children with serious emotional disturbances and learning disabilities were the most likely to be suspended and the least likely to graduate.

When children are suspended they lose valuable learning time, are often on their own while parents work, and do not receive guidance and help to handle the issue(s) that resulted in suspension.

Strict zero-based tolerance policies across the United States and Georgia in the 1980s and early 1990s led to foregoing alternative disciplinary practices that can keep youth in school; out of the court system; and with a greater likelihood of graduating, finding employment, and living the American dream. The Appleseed report calls for "alternative approaches for managing student

behavior that can supplant harsh and ineffective disciplinary actions." The report recognized the importance of ensuring the security of all students but also recognized the mission of schools to prepare youth for the future required the state to consider if the experiment with zero-tolerance policies actually were effective. It calls for best-practice disciplinary measures that recognize the risk-taking nature of youth and can help adolescents learn to manage anger, deal with peer pressure, and stay in school and graduate. The recommendations included - a rewrite of the over 40-year-old juvenile code, more discretion for school districts for managing students with behavior problems, and adoption of best-practice programs that can create healthy school climates such as the Positive Behavioral Intervention and Supports (PBIS). Their recommendations are incorporated into this section.

Other problems to be addressed identified by the Bazelon Center[22] for Mental Health Law and Georgia Stakeholders

- Lack of a specific entity and staff whose mission is to coordinate policy for the transition years. State and federal programs are divided into youth and adult programs, making it difficult to coordinate and provide accountability across the many entities and programs that could help.
- Little awareness by the public of best practices and poor outcomes faced by at-risk populations and young adults with serious behavioral health conditions during the transition year.
- State and local lack of knowledge of federal and state assistance programs that could help with education, job training, employment, housing, and social supports.

Is there a better, more cost-effective way to help young adults and older adolescents in transition?

The lost time to prepare for a career and the threat a record has on future employment impacts not only the individual but also taxpayers and the entire community. There are known best practices that can make a difference, and these usually include making sure young people have tools to heal their health conditions, get an education, become employed, have basic needs met for housing and food, and believe in their ability to have a meaningful life.

Georgia's governor and General Assembly have begun to address these issues.
Georgia and other states experiencing budget challenges are revisiting zero-tolerance school policies, the use of detention for nonviolent offenses, the charging of youth as adults, and adults who have committed minor offenses. In response to the Appleseed study and request of juvenile judges, Governor Deal, a former juvenile judge, supported a reform of Georgia's Juvenile Code. In addition, he has begun to implement a number of cost-effective, evidence-based community programs that address mental health and substance abuse issues and diversion. A Juvenile Code reform bill passed the Georgia General Assembly.

The Council on Criminal Justice Reform commissioned by the General Assembly reported in 2011 that current practices are not working and are expensive.[23] Findings included:

It costs Georgia over $91,000 per bed per year for children in youth development campuses (YDCs) and over $88,000 for short-term regional youth developmental centers (RYDCs).

Over 50 percent of children in the juvenile justice system were re-adjudicated as delinquent within three years.

By diverting nonviolent offenders to community evidence-based programs, more than $88 million could be saved.

Georgia Department of Behavioral Health and Developmental Disabilities and The Carter Center's 2012 Town Hall Meeting Vision Recommendations

Participants who attended Georgia's town hall meetings in 2012 expressed great concern that without community mental health support services for families and schools, juvenile justice facilities will continue to be Georgia's primary choice for dealing with emotionally troubled youth, lessening their chance for completing high school, finding employment, and successfully reintegrating into their family and society.

Town hall participants recommended **public education on greater understanding of youth risk taking – how brain development effects youth decision making** and **on best practices for assisting children with anger and impulsiveness**. They were **supportive of the governor's call for reform** and were concerned about assuring that **young adults in the transition years and returning armed services personnel with behavioral health disorders were assisted in getting an education, treatment, and employment in their community**. They were concerned about the **public attributing violent events to mental illness**.

Participants recommended that **school districts implement the Positive Behavioral Interventions and Supports program and mental health services in schools** to address adolescent behavior problems and give adolescents with behavioral health conditions a better chance of graduating.

Transition Vision Recommendations

Table T-5 Vision for Georgia's Adolescents and Young Adults 17 to 25 years old with Behavioral Health Challenges

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
INFRASTRUCTURE, SYSTEMS, AND COORDINATION ACROSS AGENCIES	
The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) develops with partner agencies a plan for youth and young adults with serious behavioral health conditions transitioning to adulthood. The plan identifies (1) responsibilities of both adult and child serving agencies, (2) specific agencies/programs who will coordinate, and (3) available federal grant funds that can assist. Each agency has dedicated/assigned staff to work on transition issues. Note. A helpful list of federal grants to assist states and communities is available through the Bazelon Center for Mental Health Law. Promise for the Future: How Federal Programs Can Improve Career Outcomes for Youth and Young Adults With Serious Mental Health Conditions. Please see http://www.bazelon.org/	DBHDD, BHCC, DPH, DHS-DFCS, DCA, DCH-Med, DJJ, DOC, DOE; USG, EOG;
Georgia communities are assisted in implementing the transition plan for high-risk transition-age youth and young adults with serious behavioral health challenges. • In foster care - prior to, during, and after emancipation • In high schools - youth with seriously emotional disturbances, learning disabilities, behavior problems, suspended and placed into alternative school programs • In technical schools and universities • Incarcerated, paroled, or released from detention • Pregnant/parenting and/or at risk for perinatal mood disorders • Returning armed services • Runaways or homeless • In poor families These plans include how support will be provided for case management, education, employment, housing stability, financial security, health care, and treatment.	DBHDD, BHCC, DPH, DHS-DFCS, DCA, DCH-Med, DJJ, DOC, DOE; USG, EOG;.private sector employers, advocates

* **BHCC-IDT**= Behavioral Health Coordinating Council, Child & Adolescent Interagency Directors Team; **CHD**s=County Health Departments; **CSBs**=Community Service Providers, **CSDs**=County Sheriff's Departments; **FSA**s= families, stakeholders & advocates; **DBHDD**=Department of Behavioral Health and Developmental Disabilities**;** **DCA**=Department of Community Affairs; **DCH-Med**=Department of Community Health Medicaid Division; **DFCS**=Department of Human Services, Division of Family & Children Services; **DJJ**= Department of Juvenile Justice; **DOE**= Department of Education; **DPH**= Department of Public Health; **EOG** –Executive Office of the Governor; **FQHCs**= Federally Qualified Health Centers; **G-AAP**-Georgia – American Academy of Pediatrics; **GCSA** = Georgia Council on Substance Abuse; **GGA**=Georgia General Assembly; **GMHCN**=Georgia Mental Health Consumer Network, **GPSN**= Georgia Parent Support Network; **GS-CFE**=Georgia State University Center for Excellence; **HMHB-G**=Healthy Mothers Healthy Babies of Georgia; **MHA-G**= Mental Health America of Georgia; **NAMI-G**=-National Alliance on Mental Illness of Georgia **PS** = Peer Support; **PSVR**=Private Sector Voluntary Resources; **USG**=University System of Georgia

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
An independent cross-agency study is conducted to provide guidance on how to reduce the **disproportionate level of minority children**, youth, and young adults with behavioral health challenges **in restrictive settings**.	DBHDD, DJJ, DFCS, DOE, EOG, GGA
WORKFORCE	
√ **Healthy Mothers, Healthy Babies of Georgia (HMHB) and Mental Health America of Georgia (MHA-G-) continue support for obstetric and pediatric practices through the Healthy Moms Perinatal Mood and Anxiety Disorders (PMAD) Project** through health care provider training on screening and identification, an online evidence-based toolkit for providers, and a monthly newsletter.	HMHB-Georgia MHA Georgia
√ **School police officers receive Crisis Intervention Team Training (CIT)** to help their effectiveness with youth experiencing a behavioral health crisis.	NAMI Georgia
The Mental Health First Aid (MHFA) curriculum is expanded to address the specific need in Georgia for youth and young adults transitioning to adulthood with serious behavioral health conditions and their families. **A Mental Health First Aid USA – Program for Military Members, veterans, and their families** is available in the military in Georgia, especially for young adults and their families transitioning back into employment and the community.	MHA-Georgia, DBHDD Georgia, military bases, advocates and voluntary support communities
PROMOTION - UNIVERSAL PUBLIC INFORMATION AND EDUCATION is widely available	
√ **on ways individuals, community organizations such as faith groups, private sector companies, universities, and service groups can volunteer and support** children, youth, and young adults with behavioral health challenges and their families (e.g., peer mentors, CASA advocates in the courts, educators of the public, foster or adoptive parents, school/university support groups)	DBHDD, DPH, DCH-Med, DOE, DFCS, juvenile judges
Georgia press and media educate the public on child, adolescent, adult, and older adult behavioral health issues in order to reduce stigma that results in less individuals seeking care, and less identification early when prevention and recovery are easier. *Note. At town meetings, there was concern that the public receives only information about young people and violence which has led to fear, harsher discipline of youth, and less understanding of the importance of supporting mental health prevention and treatment in schools and communities.*	Press and media outlets, DBHDD press office, Carter Center Mental Health Program

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
PREVENTION, EARLY INTERVENTION, AND RESILIENCY SERVICES	
√ The Positive Behavioral Interventions and Supports (PBIS) evidence-based program is adopted in all publicly funded schools to improve school climate, increase staff behavior management skills, reduce discipline referrals and school violence, and support the mental health of all children. **√ PBIS is also adopted by the Department of Juvenile Justice (DJJ)** to improve educational outcomes, and the climate in juvenile justice facilities.	district schools, DJJ schools, DOE, EOG, GGA
√ Public schools have on site a behavioral health clinic or support services so that: (a) children/adolescents do not have to leave school for behavioral health counseling/treatments; (b) programs can be designed to reduce the behavioral health challenges (e.g., bullying, suicide ideation, drug/alcohol misuse, aggressive behaviors, family homelessness, trauma) that result in an unhealthy school climate, dropping out of school, lost potential, and other poor outcomes.	DOE, district schools, DPH, EOG, GGA
√ Schools have alternatives to disciplinary actions of -suspension, judicial arrest, and expulsion of children with behavior problem(s) e.g., anger management, mediation, and other evidence-based programs for children who have difficulty controlling their anger.	district schools, DOE, DBHDD, Juvenile Court
Data is provided to policy makers on the graduation rate and transition activities for youth and young adults with behavioral health disorders by high schools, universities and technical colleges in order to allow them to measure and improve graduation and employment outcomes for this very high risk group whose successful transition has important consequences for the individuals, communities, and taxpayers.	DBHDD, DOE, USG, EOG, GGA
SCREENING and IDENTIFICATION - INTEGRATED HEALTH CARE	
A youth screening assessment for behavioral health disorders occurs prior to/at entry into juvenile court, detention; foster care, and school suspension, or expulsion for behavior problems so that appropriate planning and care can be provided and a diversion program may be considered.	DFCS, DJJ, DOE, district schools, Juvenile Courts, EOG, GGA
BEHAVIORAL HEALTH COMMUNITY SERVICES are recovery-oriented, strength-based, involve children and their parents/caregivers in a meaningful way, are culturally sensitive and appropriate, and are coordinated by a single case manager..	
√ Care Management Entity wraparound services are available and funded in every community for youth and young adults with serious behavioral	DCH-Med, DBHDD, EOG, GGA

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" (√=Georgia Model/Initiative exists and can be built on; ◊=Accomplished)	Entities Involved (see legend for acronyms)*
health disorders in restrictive or institutional settings and for those at high risk for out-of-home placements. *Note: Georgia built an infrastructure in local communities to support evidence-based wraparound services as part of a Medicaid demonstration grant. This important option to institutional care requires ongoing funding and support. If not funded, Georgia will lose the infrastructure it built and the hope of recovery for the most vulnerable youth with behavioral health disorders.*	
Georgia makes full use of the Chaffee Foster Care Independence Program, including the Educational and Training Vouchers program for eligible youth and young adults with serious behavioral health conditions through age 21 and identifies additional funding sources to assist all Georgia's foster care children successfully graduate and obtain employment.	DBHDD, DFCS, DCH-Med, DOE, USG, EOG, GGA
√ **SBIRT – Alcohol Screening and Brief Intervention and Treatment for Youth,** an evidence based program, is used in health care primary care practices and in high school and university health clinics/services.	DBHDD, DCH-Med, GCSA
√ **After-school programs such as Clubhouse** programs are available for youth with co-occurring substance abuse and mental health problems	DOE, DCH-Med, DBHDD, DJJ, DFCS,
√ **Quality transition services with cross-agency coordination and case management are funded and provided to youth and young adults** through age 24 who (a) are emancipated from foster care; (b) leaving juvenile detention; or (c) have behavioral health disorders and are aging out of special education programs so that they have the best chance of successfully living independently by finding employment, housing, and receiving the therapeutic and health care they need to maintain their recovery. *Note: The Georgia General Assembly initiated in 2012 the study of best diversion and transition practices for youth within or leaving juvenile detention with the intent of redirecting funds.*	DBHDD, BHCC, DFCS, DJJ, DOE, district schools, EOG, GGA
The former, successful Transition and Aftercare for Probationers and Parolees (TAPP) program or other transition program is again funded to reduce recidivism for youth and adults with behavioral health disorders on probation or released from correctional facilities. *Note. This recommendation was made at town hall meetings.*	DJJ, EOG, GGA
√ **A provider is funded to assist families of children, youth, and young adults in transition with behavioral health** challenges to advocate and negotiate the service system.	GPSN, DOE, DBHDD, BHCC-IDT

A Sampling of Best and Promising Practices for Youth and Young Adults in Transition

CME (Care Management Entities)

CMEs blend/braid funds from numerous agencies and coordinate agency support of children and youth with the most serious behavioral health disorders at risk of institutional care in juvenile facilities, child welfare, or psychiatric hospitals. Intensive care management teams have a never-give-up attitude. They deliver individualized care and planning that is strength-based, culturally competent, and built upon natural supports. Children and their families are essential members of the team. CMEs have better outcomes and avoid or lessen the need for costly, often ineffective institutional care. Wraparound Milwaukee found that the program saved them over $150 million over 10 years. Youth functioning at home, school, and community improved significantly in just one year. For delinquent youth, results demonstrated that even youth with violent offenses are able to turn their lives around. http://www.nwi.pdx.edu/NWI-book/Chapters/Meyers-5c.4-(workforce-devel).pdf

The Transition Living Program – Youth Villages

The Transition Living Program developed by Youth Villages targets children with mental health challenges who leave foster care, juvenile justice, or children's mental health systems. It has had good results. It focuses intensely on skill sets needed for living independently as an adult – a place to live, insurance, budgeting, education and career goals, etc. Transitional living counselors have small caseloads and meet minimally weekly but are available 24/7. Results for 5,091 youth and young adults included after two years having completed the Transition Living Program - 84 percent living independently or with their families, 83 percent in school, graduated, or employed, 77 percent with no involvement with the law. Their analysis found savings from the program to be $2.6 million.

Transitional Youth Peer Center – Georgia Parent Support Network

Youth and young adults 17 to 25 with behavioral health disorders are assisted and mentored by peer staff who have struggled and are succeeding with the issues of transition. Youth are assisted with leadership, education, employment and careers, independent living skills, and community living essentials such as problem-solving, relationships, leisure activities, and community social support. See .gpsn.org/transitional-youth-peer-center.html

Clubhouse and Clubhouse for Latino Youth – CETPA

Georgia has invested in Clubhouse programs for youth across the state. Clubhouse is a peer, education, and social support after-school program that helps youth succeed in school and cope with stigma, isolation, and the many challenges of dealing with substance abuse and mental health disorders. Youth in Clubhouse gain a hopeful attitude through shared friendship with other youth with similar challenges and supportive staff who assist with self-awareness, homework, self-esteem, and various activities that build social emotional and educational skills. CETPA in Norcross,

Georgia, is an award-winning Latino Youth Clubhouse program that assists Latino youth who have an even greater uphill battle in coping with substance abuse and co-occurring disorders. Services include tutoring, GED and SAT preparation, counseling for employment, exercise, social activities, peer support, and numerous after-care services. (See http://www.cetpa.org/CETPA_ENG_2Clubhouse.html

Transition to Independence Process (TIP)

TIP is "a community-based model for improving outcomes for youth and young adults with emotional/behavioral difficulties" (14 to 24 years of age) that is evidence-based. Research found TIP to be effective in improving educational attainment, employment, self-confidence, self-sufficiency, and behavioral health. The process can be a complement to other best practice-treatment models (e.g., Assertive Community Treatment). First an adult engages the youth/young adult in a relationship of caring, trust, and respect. TIP recognizes and respects the heightened quest for independence and self-determination for transition aged youth and young adults. Services are designed to be strength-based, accessible, coordinated and developmentally appropriate, with a focus on outcomes. Family, friends, providers, and the young adult are part of the process. Prevention planning and a safety net are created to reduce threats from high-risk behaviors. TIP actively advocates and improves the knowledge of all providers and support systems for the EBD youth and young adult. Please see http://tip.fmhi.usf.edu/ for information.

Active Minds

Active Minds combats stigma and builds hope on college campuses by creating a place for sharing, acceptance, advocacy, self-help, and supporting the recovery journey of young adults living with serious emotional disorders and their friends. There are over 400 chapters in the United States. Over 13 Georgia universities and colleges have Active Minds chapters, including Emory, Georgia Gwinnett, Georgia Tech, Georgia State, Georgia Perimeter, Georgia Southern, Kennesaw, Mercer, Paine, University of Georgia, and the University of West Georgia. For more information, see http://www.activeminds.org/

Early Assessment and Support Alliance (EASA)

EASA is an Oregon program that works with youth and young adults who have begun to experience their first psychotic symptoms. Its goal is to help maintain normality in the face of serious difficulties and challenges. Family and community supports are mobilized to assist the youth and/or young adult achieve their goals (e.g., finishing school, dealing with financial debts, improving or regaining skills that were diminished as a result of their illness). Supportive employment is utilized and occupational therapists are available to assist. EASA participants experienced significantly fewer hospitalizations.[24] Length of participation in EASA was related to a greater likelihood of being employed or in school.

Achieve My Plan! (AMP)

AMP can be utilized in any setting where youth and young adults engage in a team planning process such as an Individual Education Planning Process or Care Management Entity Process in which multiple agencies and the youth or young adult are part of the team. A personal coach

prepares the youth or young adult to be an effective advocate for herself/himself and assists other team members in creating a supportive positive team. AMP was found to result in improved participation of youth, adult support, and the team's ability to focus on issues important to the youth.[25]

Transition Living Programs for Foster Children

The University of Chicago Chapin Hill study found in their longitudinal study that just 8 percent of those who aged out of foster care (versus 46 percent of other youth) were likely to have a postsecondary degree; 20 percent had no high school diploma or GED versus 6.1 percent of teens not in foster care. Forty-six percent were employed (versus 80 percent), and those that were employed had median earnings of less than $18,000. They had more economic difficulties, including: a lack of money to pay rent (27.9 percent vs 5.9 percent) or utility bills (31.4 percent versus 13.1 percent), 55 percent were living in poverty, 25 percent were homeless, 45 percent had dropped out of school.[26] The risk for those with behavioral health challenges is even greater.

The Chafee Foster Care Independence Program (CFCIP) provides funds to states through Title IV-E of the Social Security Act to assist foster youth who are nearing the age of emancipation and young adults (16 to 21) transition to living on their own. The Education and Training Vouchers Program (ETV) was added to the CFCIP and provides vouchers up to $5,000 per year to help youth with postsecondary education and training and is a significant help to states seeking to assist youth transitioning to adulthood from foster care.

Transition living programs for youth (18 to 21) provide assistance families normally help their children with—housing education, employment, and basic skills for living independently and becoming financially independent. Youth Villages has been studying youth who participated and completed their intensive transitional living program for at least 60 days: 84 percent were found to be living independently, 83 percent were in school or employed, 77 percent had no involvement with the law.

Community support

Families First (Atlanta Metro) is an example of the many community nonprofit organizations whose support DFCS needs to achieve its mission and who can help communities overcome the stigma of mental illness. Families First engages local citizens, volunteers, the business community, and other nonprofit community organizations in addressing vulnerable families and children at high risk for a behavioral health disorder or who already have a disorder. The organization began over 140 years ago as an orphanage. It now has a wide array of programs and services specifically seeking to bring permanency and adult unconditional love to vulnerable children and youth. Some of these include adoption, foster care, a group housing cooperative model, and transitional housing and support for youth. Housing and support services are provided for chronically homeless families struggling with mental illness, substance abuse, and/or a medical illness. Counseling and parenting skills for new parents, teens, divorcing parents, and

parents and children in school environments strive to improve family strength and children's resiliency. It has built-in program evaluations and self-correction mechanisms to allow for continued improvement.

SOS (Sources of Strength)[27]

SOS is a best-practice suicide prevention model program. Adolescents often have a code of silence and do not share their problems with adults but with peers. SOS increases help-seeking behaviors in youth. It works by building sensitivity across youth to their peers and caring adults who learn signs and helping skills. Youth build resilience and strengths to handle difficult problems they may face. Students are recruited to serve as peer leaders who work to identify and help kids going through a rough emotional time, connecting them to adults who can help.

Mental Health First Aid for: Military Members, Veterans, and Their Families

Mental Health First Aid is an evidence-based program that assists individuals in identifying and assisting symptoms of mental illness. A toolkit for Mental Health First Aid is now available for veterans. With so many young adults returning from war and developing PTSD, committing suicide, and/or facing a transition to employment and community life outside of the military, this toolkit can be an important tool for communities. See http://www.thenationalcouncil.org/wp-content/uploads/2013/06/MHFA_State_Toolkit_2013.pdf

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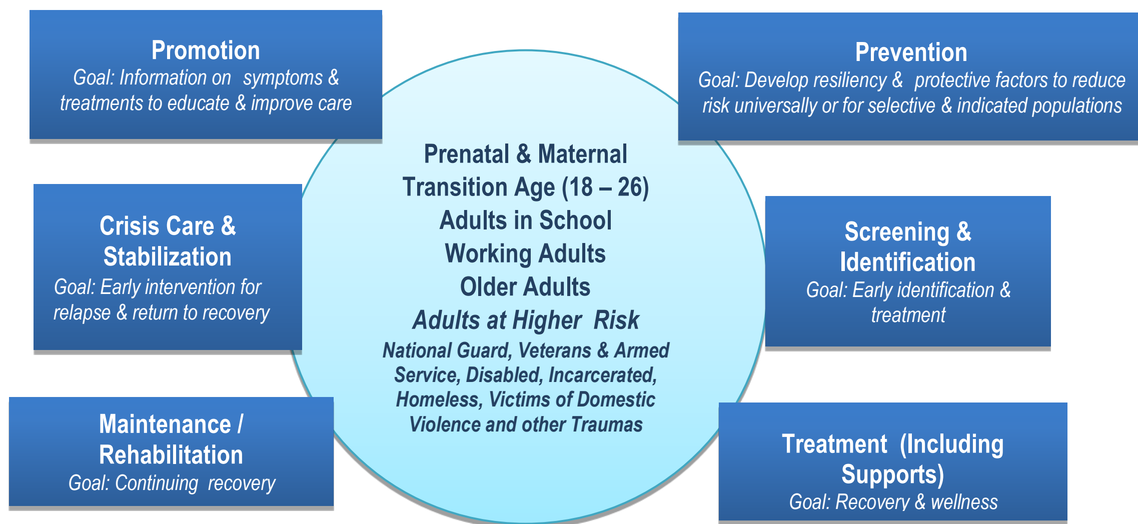
IX. Georgia Adults with Behavioral Health Disorders

Our Vision is that in every Georgia community behavioral health risks and disorders are identified and treated early, and adults with behavioral health disorders can access the essential services and supports they need to recover and thrive as independent, contributing, and valued members of their community, able to realize their full potential enjoying the support of families and friends.

Figure A-1 A Continuum of Community Behavioral Health Services for Adults



Behavioral Health Disorders are Not Rare

Over one in four adults, 18 to 64 years of age, are likely to experience a clinically diagnosable behavioral health disorder within one year and 50 percent will experience a behavioral health disorder in their lifetime.[1] A smaller percent (5.8 percent) are likely to experience a serious behavioral health disorder, severely affecting their ability to work and perform daily activities.

How Many Adults in Georgia May Need Behavioral Health Services?

Table A-1 Prevalence, Severity and Comorbidity of Behavioral Health Disorders in Adults 18 to 64 Years of Age as a Percent Georgia Adults in 2009

	Prevalence	Serious	Moderate	Mild
Any Disorder	26.2% 1,632,419	5.8% 364,029	9.8% 608,892	10.6% 659,497
1 Disorder	14.4% 897, 207	1.4% 86,132	4.5% 279,929	8.5% 531,147
2 Disorders	5.8% 361,375	1.5% 92,151	2.7% 167,678	1.6% 101,908
3 or more Disorders	6.0% 373,836	3.0% 186,544	2.6% 161,123	0.4% 26,169

Source of prevalence rates. Kessler RC, Chiu WT, Demler O, Walters, EE. 2009. Prevalence, Severity, and Co-morbidity of 12-Month *DSM IV* Disorders in the National Co morbidity Survey Replication. Arch Gen Psychiatry. 2005;62:617-627. Source of Georgia population of 18 - 64 years old (6,230, 605), Georgia Governor's Office of Planning and Budgeting

Researchers supported by the National Institute of Mental Health (NIMH) found that half of all lifetime cases of mental illness begin by age 14, and that despite effective treatments, there are long delays—sometimes decades—between first onset of symptoms and when people seek and receive treatment. The study also reveals that an untreated mental disorder can lead to a more severe, more difficult-to-treat illness and to the development of co-occurring mental illnesses (NIMH, 2005)[2]. Therefore, it is likely that many adults with a behavioral health disorder may have had an undiagnosed disorder in their adolescence for which they did not receive treatment, placing them at greater risk as adults of co-occurring mental or addictive illness and more acute disorders.

Personal and Taxpayer Costs

Table A-2 Costs to Individuals and the Nation for Unaddressed Serious Behavioral Health Illness

Personal Costs include a greater likelihood of:	**Some Costs to Society from Serious Behavioral Health Disorders**
Early death (25 years earlier, mainly from general physical/medical health diseases)[3] Lower earnings (-$26,435 less for men,- $9,302 less for women) [4] Lower educational attainment Suicide (12-fold risk)[5] Homelessness, loss of friends and family Other medical conditions (five times greater) [6], Cycling through institutional settings (hospitals, jails)	Overall - $317.6 billion dollars[7] Lower earnings costing the U.S. $193.2 billion dollars in 2002 [8] Health care expenditures over $100 billion dollars[9] Disability benefits of $24.3 billion Alcohol abuse/alcoholism in 1998 was estimated to cost the U.S. $184.6 billion[10]

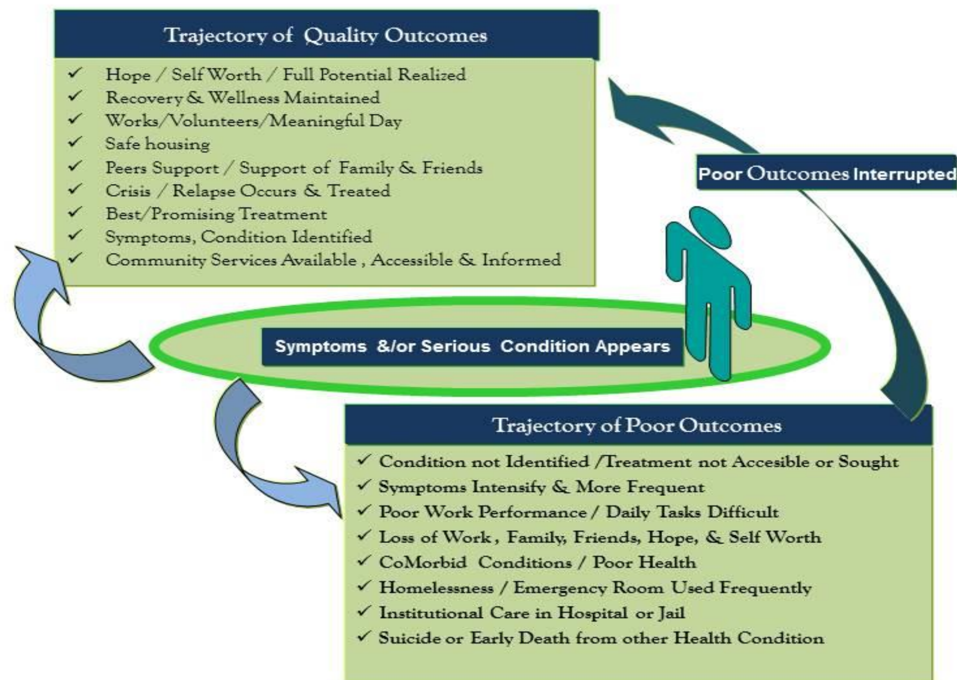
When services and supports are not available and more serious conditions arise, the ability of individuals with behavioral health disorders to recover quickly, find joy and meaning in their lives, and meet the demands of family and work are diminished. We have largely focused on serious behavioral health crisis and institutional care. This results in more individuals needing high-end

services for a longer time and not being able to easily maintain recovery or wellness. This is a costly scenario for individuals and taxpayers.

Accessible Services, Identification, and Treatment Make a Difference

Preventing more severe behavioral illnesses in adulthood requires attention to early identification and early treatment in childhood, adolescence, and adulthood. Good prevention practices along with best practice treatments help to reduce the impact, severity, and interval between a behavioral health event or crisis.

Figure A-2 Trajectory of Behavioral Health Outcomes and Community Services Accessibility



Challenges

Stigma

We are each at risk for a mental or addictive health disorder. Yet many of us do not even know how to identify symptoms early or where to find the health care we may need. This occurs even though the technology to treat behavioral health conditions exists.

In our midst are neighbors and fellow workers who fear to share their quiet suffering, do not get the treatment they need, and live through periods of hopelessness, anxiousness, and depression.

Living on our streets in urban centers are homeless individuals with serious behavioral health challenges who are unable to maintain employment and support themselves. Their life has "fallen apart." Some are veterans with post-traumatic stress disorder; some are women who have suffered domestic violence. Some are children or youth for whom the trauma of abuse and multiple foster care experiences triggered a disorder. The trauma of living in the streets without housing or treatment makes them more likely to be victims of violence, and poor health. Our state hospitals, jails, and emergency rooms become their "treatment facilities."

Stigma-driven health care delivery silos have led to separate care and payment for mental health, addiction, and general health chronic care conditions.

Fear that individuals with mental illness are violent and dangerous.[11,12]
A person with mental illness and individuals without mental illness are more likely to commit a violent act if they have an addictive disorder and/or experienced very stressful life changing events (divorce, unemployment, the victim of violence)[13,14] There is general agreement that more needs to be understood about precursors to violence for people with and without mental illness.

"…[P]*eople with severe mental illnesses – schizophrenia, bipolar disorder or psychosis – are 2 1/2 times more likely to be attacked, raped or mugged than the general population* (Hiday, Swartz, Swanson, et al., 1999).[15,16,17]

…The major determinants of violence continue to be socio-demographic and socio-economic factors such as being young, male, and of lower socio-economic status" (Stuart, 2003).[18]

Challenges of a Relapse or "Crisis"
Consider the panic one may feel with a heart attack, a stroke, a diabetic crisis, or asthma attack. Part of living with a serious mental or addictive health disorder can also be a relapse or a full-blown crisis where a severe form of symptoms occur without warning.

This can leave a person feeling helpless, unable to control the emotions, moods, panic, acute stress, and/or suicidal feelings they are experiencing. They may blame themselves, contemplate self-medication with alcohol or drugs, and/or try to harm themselves or another. Personal loss of control and having to relinquish decisions to others are difficult.

Crisis can be treated, often within a short time period, and recovery can return. The goal of treatment programs (for a behavioral health or other chronic illness such as diabetes) is recovery or to lessen intervals between symptoms and have fewer acute symptoms requiring a visit to the emergency room or other crisis center.

First responders such as police, firefighters, or 911 hotline responders are usually the first to encounter a person in crisis but often do not know how to use techniques that can de-escalate a

mental health crisis. Concerned with maintaining public safety, a first responder who does not understand mental health is more likely to arrest the person and incarcerate them. Consequently, critical hours are lost that could make a difference in outcomes.

Lack of Knowledge about Addiction[19]
Many believe that addiction is easily controlled with self- discipline. A person with drug-dependence has a chronic illness in which physical changes to the brain[20] result in unrelenting and powerful urges for the addictive substance. Recovery is possible, but the brain needs time and assistance to heal.

Even with the best intentions, most individuals with addictive illnesses experience multiple periods of recovery and relapse before achieving sustained recovery. After recovery, for many years a single encounter can bring the illness back.

Transportation Challenges
General transportation needs. Transportation to services and treatment was identified as critical by consumers and advocates attending town hall meetings across the state. Without a car, it is difficult for people with behavioral health disorders to apply for work, get groceries, or visit friends or family.

Transportation for medical appointments. There was considerable concern about contract transportation provider requirements and their lack of knowledge about behavioral health conditions, resulting in decisions that can lead to deterioration and possibly a crisis. Examples included leaving individuals waiting for long periods, forgetting appointments, and poor communications to people experiencing symptoms.

Transporting for behavioral health crisis care. County sheriffs in Georgia are frequently responsible for transporting individuals who need immediate care to protect themselves and others from harm. This becomes a great problem for them when there are no available hospital beds nearby and they have to travel across county lines. They may have to wait for long periods of time at a hospital for pending paperwork or an available bed.

Institutional Care in State Psychiatric Hospitals and Jails
Without community services, Georgia's large psychiatric hospitals and jails become the only choice for many experiencing a behavioral health crisis. When returning home, averting a subsequent crisis is difficult when community services for maintaining recovery are absent. Institutions are seldom near friends or family, which is important for recovery and assuring quality care.

In newspaper articles and legal briefs, Georgian's learned the names and faces of fellow citizen who suffered preventable deaths, suicides, and assaults in the state's psychiatric hospitals. They read stories of individuals released on the street without a treatment plan or a home. They learned about the painful, personally diminishing revolving cycle of homelessness, emergency room care, and re-entry into psychiatric hospitals and jails.

Incarceration of People with Mental Illness

Prisons and jails have become institutions for housing people with behavioral health challenges. Nationally, 56 percent of inmates in state prisons, 45 percent of inmates in federal prisons, and 64 percent of inmates in local jails were found to have a mental illness. Prevalence rates are even higher for female inmates. Many were not receiving treatment (49.3 percent in state prisons, 35.3 percent in federal prisons, and 42.7 percent in jails).[21]

With scarce community services available, individuals with serious mental illnesses but few resources can still get some mental health care and a bed in a correctional facility. This care often disappears when they are back "on the street." Without funds to purchase medicines, acquire treatment, or find stable housing, their disorder returns. Once a person has a "criminal" record, it is difficult to find work, housing, or credit. Some are picked up for nonviolent crimes such as panhandling, loitering, and disturbing the peace, and others may intentionally commit a small crime to get help. While a small number of individuals with behavioral health disorders are arrested for violent crimes and need to be in a correctional facility for the community's protection, the vast majority are not violent.

The cost of caring for people with mental illnesses in our correctional facilities and county jails is high. *"Georgia is spending six and a half million dollars in psychotropic drugs alone plus the cost of hiring and training of additional psychiatrists and therapists to work in the prison system. ...We're at full capacity during the summer, we have our hands full trying to manage the crisis." ... "A lot of facilities for the mentally ill are not air-conditioned. They can't cope with the heat and start decompensating by hurting themselves and hurting others and becoming really disorganized. So our CSU unit stays really busy during the summer. The CSU – Crisis Stabilization Unit – is where inmates in critical mental stress are taken in. Suicide attempts are not uncommon among some of the mentally ill inmates ... The alarming sounds and forceful treatment can make some more defensive and can even exacerbate some of their symptoms. Many of the inmates in Georgia's prisons are heavily medicated, and many are diagnosed with schizophrenia and bipolar disorders. Many come from poor communities where no mental health care is available.... A crime had to be committed in order for them to get treatment." Source: Dr. James Dermot interviewed by Helena Cavendash de Moura of Georgia Public Broadcasting as reported in 2011.*[22]

Many people with behavioral health disorders are not included in the 2010 U.S. Department of Justice settlement with Georgia. The settlement addresses an important population with serious mental health conditions most likely to use psychiatric hospitals, but it did not address other populations with behavioral health conditions who lack community services. It did not include children, youth, or adults with addiction disorders.

The future challenge for Georgia is to establish an integrated community behavioral health and

general health system that works for all citizens. This will be a formidable task. Screening, identification, and early intervention for behavioral health conditions do not routinely occur in health care. General medical and behavioral health practitioners are in short supply, especially in rural areas. Community Service Boards established throughout Georgia to serve as a behavioral health safety net are often unable to meet their challenge due to funding constraints.

Evidence-Based and Promising Practices for Adults with Behavioral Health Disorders

Throughout Georgia, we found many programs implementing evidence-based and promising practices to address the needs of adults with serious behavioral health disorders. In this section, we share some of these and a few other evidence-based services that can help communities implement programs that have proven effectiveness. Please see Appendix 3 for more guidance.

Substance Abuse and Mental Health Services Administration (SAMHSA) Evidence-Based Practices KITs

Below are toolkits developed by SAMHSA to help communities use evidence-based practices with fidelity in serving adults with serious behavioral health disorders and co-occurring disorders. Please see Appendix 3 of this document for an overview of evidence-based and promising practices and the SAMHSA store website to download these KITs (Knowledge Informing Transformation) - http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs

Assertive Community Treatment (ACT) – ACT is a team-based care management treatment designed to assist individuals with "serious, persistent mental illness" live in the community.

Permanent Supportive Housing (PSH) – PSH is "decent, safe affordable housing" linked to services such as ACT. Housing allows individuals with significant behavioral health conditions to stabilize and receive the treatment services they need for recovery.

Supported Employment – Supported employment builds hope and independence as the program assists individuals with significant behavioral health conditions "find and keep" meaningful work.

Medication Treatment, Evaluation, and Management (MedTEAM) – MedTEAM supports recovery by assisting medication prescribers to utilize the most current knowledge on medication treatments, the experience of consumers and careful evaluation of outcomes. Consumers are an active part of the team.

Family Psychoeducation – Family psycho-education has been found effective with people with serious mental illness and a co-occurring addiction disorder. Multifamily group meetings encourage peer support and mutual aid.

Integrated Treatment for Co-occurring Disorders – Through this effective model, mental health and substance abuse treatment are evaluated and addressed by the same team in the same location at the same time.

Illness Management and Recovery (IMR) – Practitioners help consumers define recovery for themselves and identify personally meaningful recovery goals. Consumers learn to identify early warning signs and plan steps that they can take to prevent relapses.

Consumer-Operated Services – Consumer-operated services consist of organizations owned and run by individuals in recovery with lived mental health experiences who support their peers. Though the types of services offered may differ, each focuses on self-help and recovery.

SBIRT (Screening Brief Intervention and Referral to Treatment)[23] is an important tool for addiction prevention and early intervention.

> *SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.* (http://www.samhsa.gov/prevention/sbirt/)

APIC Jail Re-entry GAINS Center model prepares inmates with behavioral health disorders to re-enter the community. The model includes four stages of planning. First, the clinical, social, and public safety needs of inmates are assessed (e.g. ability to pay for treatment and services); second, a treatment plan is developed to address basic re-entry challenges (e.g., family, housing, integrated treatment for co-occurring disorders, medical care, transportation); third, community and correctional programs for post-release services are identified; and fourth, a transition plan to ensure implementation and avoid gaps in care is developed.
(http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf)

Diversion and Transition from Incarceration – Georgia Efforts

Our nation incarcerates more of its citizens than other nations[24] One in every 35 adults in 2012 was in the criminal justice system, and Georgia has had one of the highest incarceration rates (around 19 percent higher than the national average in 2010). Faced with a budget shortfall and a costly prison system, Georgia's governor and General Assembly began work in 2010 to reform the judicial system, particularly focusing on diverting nonviolent offenders with mental illness or addictive disorders from jail. A bipartisan Special Council on Criminal Justice Reform appointed by the governor and General Assembly studied and developed recommendations.

"While we foresee this effort uncovering strategies that will save taxpayer dollars, we are first and foremost attacking the human costs of a society with too much crime, too many behind bars, too many children growing up without a much needed parent and too many wasted lives.... We must do a better job rehabilitating lives. ....Drug addiction is the root cause of much crime. Our entire society benefits if we can turn these tax burdens into taxpayers." Governor Nathan Deal in a written statement about the new legislation

Accountability Courts

Mental health courts and drug courts emerged as U.S. jails and prisons experienced large increases in their populations with serious mental illnesses (over 15 percent as compared to 5 .8 percent of the U.S. population). The results of reduced recidivism and reduced jail time have often been impressive. Georgia developed legislation incentivizing counties to develop accountability courts. Below are results reported in a presentation by Hall County Judge Kathlene Gosselin at a 2007 conference where she presented preliminary findings after 30 months of operations. Judge Gosselin wrote that housing, employment, a supportive law enforcement community, discretionary resources, and a continual focus on recovery were critical to the success of diversion programs.

Table A-3 Cost Benefit of Hall County Mental Health Court Results After 30 Months of Operation

Jail Days	Days	Average Days
• 18 months prior to entry	7,183	74
• While in program	1,333	14
• For 30 graduates (in 18 months)	9	
• For 30 graduates (prior 18 months)	1,759	59
Jail Costs	Cost	
• 18 months immediately prior to entry*	$359,150	
• 1333 days in jail for participants while active in program	$66,650	
• 30 Graduates - (9 days in jail after graduation)	$450	

Source. Gosselin, K. *Mental Health Court 101*, Slide 33. 2007 Georgia Drug and DUI Court Conference - Peachtree City, Ga.
* Only includes standard cost of $50 per day per jailed offender; does not include medical costs or transportation.

Crisis Intervention Team Training (CIT) is an innovative, police-based, first responder program of pre-arrest jail diversion for those experiencing a behavioral health crisis including individuals with mental illness, developmental disabilities, Alzheimer's disease and addictive disease. The goal is to train 20 percent of all law enforcement personnel in the state. CIT in Georgia is sponsored by NAMI-GA, the Georgia Department of Behavioral Health and Development Disabilities, the Georgia Bureau of Investigation, Georgia Association of Chiefs of Police, Georgia Sheriffs' Association Inc., and Georgia Public Safety Training Center.[25]

Metro Atlanta Jail Mental Health Task Force is an ongoing project of the sheriffs' departments of Clayton, Fulton, DeKalb, Gwinnett, Newton, and Rockdale counties and the National Alliance for Mental Illness of Georgia. The group meets on a quarterly basis with members of the judicial system, accountability courts, and other community advocates to share challenges and develop strategies to improve outcomes for people with mental health conditions in their care and in the community.

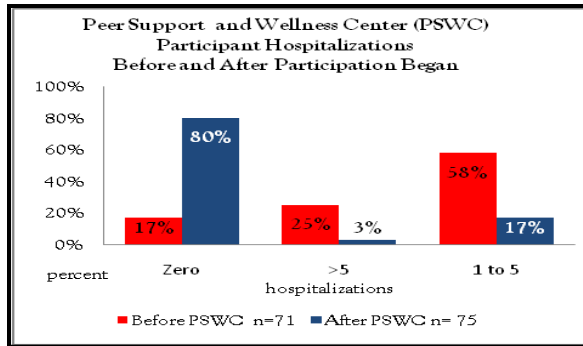
Promising Practices in Addressing Behavioral Health Crisis or Acute Psychiatric Episodes

The Georgia Mental Health Consumer Network (GMHCN)

GMHCN is an organization run and operated by consumers that has developed a number of the

programs to assist with recovery and the handling of a behavioral health crisis or acute psychiatric episode. The goals of these programs are to (1) avert a crisis, (2) reduce the length and/or time between crises, and (3) address the numerous complications that can occur when a behavioral health crisis occurs and sharing one's wishes with family and friends so they can be supportive.

Figure A-3 Peer Support and Wellness Centers (PSWC)



Source. Lingle J., Darnell,A. (2009) Peer Support, and Wellness Center Evaluation: Report compiled for the Georgia Mental Health Consumer Network

Peer Support and Wellness Centers are a Georgia-developed national best-practice model that includes community crisis prevention services. For example, the Wellness Center in Decatur, Georgia, is staffed by Certified Peer Specialists (CPS). It is a place where people who are recovering can share and learn from each other. As a model, Peer Wellness Centers also have a few private rooms for individuals who are experiencing a crisis that can be handled with peer supports. They can stay at the center for up to one week.

A Personal Diary and a Wellness Recovery Action Plan (WRAP) [26]

A personal diary, although time-consuming, can provide information on re-occurring events and warning signs prior to a crisis and give one assistance in developing a plan to avert triggers to a crisis. It can help a person figure out what they need to do every day to stay well.

A WRAP is an actual wellness recovery plan that can be a valuable outcome of using a diary. A WRAP may contain information such as: medications, allergies, phone numbers of places and people to contact, instructions on how to recognize a potential crisis, where you would like to be treated, and what has worked best in averting or minimizing the effects of a crisis.

(Please see www.gmhcn.org/ for more information.)

Psychiatric Advance Directives (PADs)

PADs provide guidance when a person becomes unable to make choices for themselves. Similar to a living will, it can provide information to friends, family, and medical or other emergency caregivers about who is authorized to make decisions on one's behalf, what treatments one is willing to have, and under what conditions one would refuse treatments. PADs allow people with a behavioral health disorder the comfort of knowing that they will receive care and treatment by individuals who know their health history and choices.

Mental Health First Aid
Sponsored by Mental Health America of Georgia (MHA-GA), Mental Health First Aid is an evidence-based curriculum available to the public and designed to address the lack of mental health literacy: recognizing the indicators of a behavioral health crisis, assessing the crisis, and providing initial assistance until professional help is available. Like CPR and First Aid, this knowledge can save lives.

Project Healthy Mom
Perinatal Mood and Anxiety Disorders (PMADs) **Warmline** and **Provider Education Programs** were initiated by Mental Health America of Georgia and Healthy Mothers and Healthy Babies to address the lack of public knowledge and programs for PMAD. Ten to 15 percent of women will experience PMAD.

- ***Warmline*** is a peer support program connecting women experiencing PMAD with another who has overcome it.
- ***PMAD Provider Education Programs*** provide training, an online toolkit, and a newsletter to assist providers with the latest information and best treatment practices for PMAD. (See ciclt.net/nmhag/ for more information)

The National Alliance on Mental Illness Georgia (NAMI-GA) with over 34 chapters provides adults with mental health challenges their families and advocates numerous programs.

- ***In Our Own Voice*** helps individuals gain presentation skills, overcome fear, and reduce public unawareness as they share their story of living with a mental illness.
- ***Family-to-Family*** has been found to help families and friends learn skills for promoting recovery and advocating for their family member or friend.
- ***Peer-to-Peer*** is a 10-week course in which peer mentors assist individuals with mental illness to gain strength to work toward recovery through greater knowledge of mental illness and sharing with others who understand. (Please see www.namiga.org for more information.)

Best Practices and the Oct. 19, 2010 Settlement Agreement Between the State of Georgia and the U.S. Department of Justice (Settlement) – an Infrastructure to Build Upon

While the settlement does not address the services needed by all of Georgia's citizens with behavioral health disorders, it does establish an infrastructure for community services. By July 2015, Georgia is to have funded and established services for 9,000 adults with a "serious and persistent mental illness" leaving one of Georgia's psychiatric hospitals or at high risk of cycling in and out of institutional care (e.g., homeless, leaving jail, and frequenting emergency rooms). Community services agreed to in the settlement included:

- Supportive housing
- Supportive employment

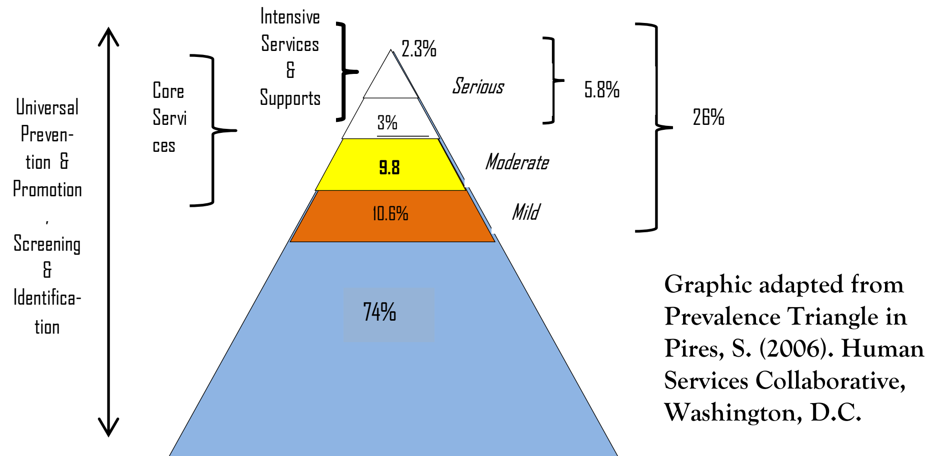
- Case management providers for urban and rural areas including (a) ACT (Assertive Community Treatment teams), (b) community support teams of three or more members, (c) intensive case management teams with caseloads of one-to-20 for rural areas and one-to-30 for urban areas, and (d) case management for step-down maintenance
- Professional Peer Support Services
- A 24/7 toll-free number/call center. Georgia Crisis and Access Line (GCAL), which is a nationally recognized best-practice established in 2006 for access to services and urgent crisis resources
- Bridge funding for individuals prior to their ability to pay. Many individuals with very serious behavioral health disorders and little to no income are eligible for federal supplemental disability income but have not obtained eligibility.
- Crisis services in the community, including (a) 24/7 walk-in services crisis service centers, (b) crisis stabilization programs of 16 beds each, (c) nonstate community hospital beds, (d) mobile crisis services available 24/7 in each county, and (e) crisis apartments staffed by peer specialists.
- Infrastructure and process safeguards, including (a) transition planning, (b) a quality management system, (c) contracts with community service boards and community providers, (d) a cost rate study to establish provider reimbursement rates, (e) provider training, and (f) a network analysis of available supports and services.

Figure A-4 State of Georgia and the U.S. Department of Justice Settlement Agreement Service Array

Recommendations for Adults

This Vision for Georgia's adults is rooted in the overall recommendation of a public health population-based integrated health care system that recognizes the critical importance of behavioral health: a system where all citizens in Georgia's communities have access to behavioral health promotion, prevention, screening, and identification services and where individuals with mental health and addiction disorders can receive the services and interventions needed for wellness and recovery.

Figure A-4 A Behavioral Health Public Health Population Based Focus: From Prevention to More Intensive Service Needs



Graphic adapted from Prevalence Triangle in Pires, S. (2006). Human Services Collaborative, Washington, D.C.

The Vision will require partnering with public and private sector providers for assistance in the settings where adults are located and reaching adults in situations that place them at greater risk.

Figure A-5 Reaching all adults with basic behavioral health services and those at higher risk with specialized information and/or interventions they may need

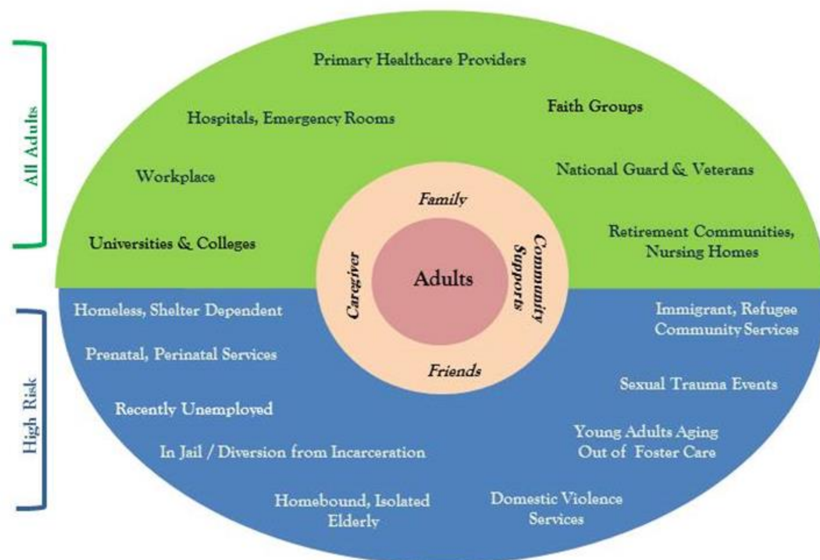


Table A-4 A GEORGIA VISION FOR ADULT BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (◊=accomplished or in process)	Entities Involved (See Legend for acronyms)*
Behavioral Health Community Services for Adults and Older Adults - are strength-based, involve adults in treatment and care decisions in a meaningful way, are culturally sensitive and appropriate, and are coordinated by a single case manager.	
√ **All individuals with serious behavioral health disorders, at high risk of institutional care, are able to access intensive outpatient care services in their community,** including intensive case management services; supported housing; supported employment; 24/7 crisis care that includes hospital beds, peer support, respite care, and drug and alcohol residential and outpatient treatment.	DBHDD, DCHMed, DCA, DOC, CSBs, GMHCN, GCSA,, LHAs
Basic outpatient core behavioral health community services are available for individuals with less severe conditions and those who are in recovery so they may maintain their recovery.	DBHDD, DPH, CSBs, DCHMed, EOG, GGA
People with addictive diseases are able to access recovery centers and addiction services in their community that will promote long-term recovery and assist individuals who have relapses in their struggle to overcome addiction.	DBHDD, DPH, CSBs, DCHMed, GCSA, EOG, GGA
Safe housing, supportive housing is available for adults including older adults and housing preserves choice, independence, and community living.	DCA, LHAs, DBHDD, DHS
Peer support, **respite, and caregiver support** are available core services in communities.	DBHDD, DCHMed, DHS-DAS, GMHCN in collaboration with the Fuqua Center
Promotion, Public Information, and Outreach	
√ **Information** is widely available on **(a) the signs/symptoms of behavioral health disorders**, (b) how/where to access **services, (c) insurance eligibility** and benefits for behavioral health conditions, (d) Georgia's Crisis and Access Line (GCAL), (e) ***preventing and addressing suicide, addiction, depression, and trauma***, and (f) **perinatal mood disorders** during and after pregnancy.	DBHDD, DCHMed, DHS-DAS-AAA, DOE, DPH, FQHC, CSBs, Faith groups, veterans groups, consumers and advocates, Georgia press and media

* **BHCC**= Behavioral Health Coordinating Council, **CHDs**=County Health Dept.; **CSBs** Community Service Boards; **CSDs**=County Sheriff's Dept.; **DBHDD**=Dept. of Behavioral Health & Developmental Disabilities; **DCA**=Dept. of Community Affairs; **DCHMed**=Dept. of Community Health Medicaid Division; **DHS-DAS**=Dept. of Human Services, Division of Aging Services; **DHS-DAS-AAA** – Area Agencies on Aging; **DOC** = Dept. of Corrections; **DOT**=Dept. of Transportation, **DPH**=Dept. of Public Health**; EOG**=Executive Office of the Governor; **FQHCs**= Federally Qualified Health Centers; **GAAP**= GA American Academy of Pediatrics; **GAFP**=GA Assoc. of Family Physicians; **GAPH**=GA *Assoc.* for *Primary* Health *Care*; **GCSA**=GA Council on Substance Abuse; **GGA**=GA General Assembly; **GMHCN**=GA Mental Health Consumer Network, **GNA**=GA Nursing Assoc.; **GPA**=GA Psychological Assoc.; **GPPA**=GA Psychiatric Physician's Assoc.; **GPSN**= GA Parent Support Network; **GRHA**=GA Rural Health Assoc.; **LHAs** = Local Housing Authorities; **MAG**=Medical Assoc. of GA; **MHA-G**= Mental Health America of GA; **NAMI-G**=-National Alliance on Mental Illness of GA

Table A-4 A GEORGIA VISION FOR ADULT BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (◊=accomplished or in process)	Entities Involved (See Legend for acronyms)*
High-risk groups receive appropriate information on risks, prevention, and services / programs (e.g., victims of domestic violence, individuals experiencing trauma, brain injury, post-traumatic stress)	DBHDD, DCHMed, DPH, FQHC, CSBs, DJJ, DOC, DOE, CSDs, DHS-DAS-AAA, National Guard, veterans groups
◊ **Consumers share their stories** with the public and assisting themselves to overcome fear and helping the community to understand that mental health and addictive disorders are illnesses.	GMHCN, MHA-G, NAMI-G, GPSN, other consumer groups
◊ **Family to Family Programs** assist families in supporting the recovery process of their family member.	NAMI-G
◊ **Mental Health First Aid** training is widely available for workforce sites, nursing homes, voluntary organizations, and faith groups	MHA-G
√ **Georgia press and media educate the public on child, adolescent, adult, and older adult behavioral health issues** in order to reduce stigma that results in fewer individuals seeking care and less identification early when prevention and recovery are easier. *Note. At town meetings, there was concern that the public receives only information about individuals and young people and violence which has led to fear, harsher discipline of youth, and less understanding of youth development and the importance of mental health prevention and treatment in schools and communities.*	Press and media outlets, DBHDD press office, Carter Center Mental Health Program
Screening and Identification	
A simple routine universal screening is used for physical, mental, and substance abuse health disorders/challenges (1) in physician practices as part of a health history or regular checkup; (2) in preschools, schools, and universities; and (3) by obstetric, pediatric and primary care practices that also check for perinatal mood and anxiety disorders before and after birth.	DBHDD, DCH-Med, DPH, Georgia OBGYN Society, G-AAP, CHDs, FQHCs,
Prevention, Resiliency, and Diversion:	
High-risk groups are targeted for prevention services/supports. (e.g., individuals who experience trauma, homelessness, domestic violence, a heart attack or other health trauma, job loss, returning veterans and National Guard and their families)	DBHDD, DPH,, BHCC
√ **Businesses establish policies that support people with behavioral health disorders** in the workplace and are publicly praised for their efforts.	DBHDD, advocates and advocacy groups
√ **Community diversion programs are funded** for people with behavioral health disorders who interact with the criminal justice system but do not pose a threat to public safety. Successful diversion programs intercept individuals prior to and throughout their encounters with the justice system and may include Crisis Intervention Team training for first responders, accountability courts, education of judges, alternatives to forensic status for nonviolent offenders, mobile crisis and crisis beds, peer support, case management, housing.	DBHDD, DCAMed, DCA, DOC, Georgia judiciary, EOG, GGA,

Table A-4 A GEORGIA VISION FOR ADULT BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (◊=accomplished or in process)	Entities Involved (See Legend for acronyms)*
The formerly successful Transition and After-care for Probationers and Parolees (TAPP) program or other transition program is again funded to reduce recidivism for youth and adults with behavioral health disorders on probation or released from correctional facilities. *This recommendation was made at town hall meetings.*	DJJ, EOG, GGA, DOC, CSBs, Georgia judiciary
Integrated General Medical and Behavioral Health Care	
√ All **providers of primary care health care have a strong working relationship with a provider of mental health and addiction services** and vice versa and use standard screening instruments for identifying behavioral health care needs.	DPH; DBHDD; DCHMed; CSB; FQHC; GAAAP; GAPH;GAFP; GNA; GRHA; MAG
Health care is accessed through **a patient-centered medical home** in order that patient care is coordinated with a continuum of wellness, prevention, treatment, rehabilitation, and crisis care services.	DPH; DBHDD; DCHMed; DAS; CSB; FQHC; GAAAP; MAG GAPH;GAFP; GNA; GRHA;)
◊ **Georgia's Community Service Boards** (CSBs) have strong integrated care partnerships with primary care providers in the communities that they are responsible for establishing a behavioral health care safety net.	DBHDD; DPH; DCHMed; CSB; FQHC
Individuals with behavioral health disorders receive both primary care and behavioral health care services from providers that communicate with each other and know that people with a disorder are likely to also have one or more other special health care needs that affect their overall health.	DPH; DBHDD; DCHMed
√ **Public information, training, and guidance on developing an integrated care practice** are provided for primary care providers, public health clinics, federally qualified health centers, and school-based health services.	DBHDD, DPH; DCHMed; Schools of Medicine, DOE, FQHC, GA-AAP,MAG
Primary care providers are informed of screening and treatment best practices for **suicide risk,** especially among seniors and individuals with depression	DBHDD; DPH; DCHMed; DAS, MHA-G, medical schools
√ Pediatric, obstetric, and family practitioners receive training and updates on the prevalence of **perinatal mood and anxiety disorders** and on best practice screening and treatments practices.	DBHDD; DPH; DCHMed; DAS, MHA-G, G-AAP and obstetric practices, medical schools
√ **Training in the use of SBIRT** with adolescents, adults, and older adults is available to all primary care providers.	DBHDD; DCHMed, DBHDD; DCHMed, GCSA, G-AAP, GAFP, GAPH,GNA
◊ **Crisis Intervention Team Training (CIT)** is provided to sheriffs' departments, school police officers, and other emergency responders to help their effectiveness when confronted with an individual experiencing a mental health crisis.	NAMI-GA, CSDs, DBHDD, GBI, Georgia firedepartments; district school systems,
Infrastructure, Systems, and Coordination across Agencies	
Community Planning and Coordination	
√ A **formal structure and process for consumer input** exists at the local and state level for planning and evaluating the quality and presence of an integrated, whole health continuum of behavioral health services across the life span. Findings and	BHCC; DBHDD-Regions; DCHMed, CSBs;DHS-DAS-AAA; consumers, families, advocates

Table A-4 A GEORGIA VISION FOR ADULT BEHAVIORAL HEALTH (√=Georgia Model/Initiative exists and can be built on) (◊=accomplished or in process)	Entities Involved (See Legend for acronyms)*
recommendations are reported to the Behavioral Health Coordinating Council (BHCC) and to specific agencies when state level agency changes may be needed.	
√ The **forensic population challenges are addressed** (competency wait times, regional referral practices, the numbers of individuals awaiting disposition for misdemeanors, and other problems identified).	DBHDD, Georgia judiciary, CSDs, private psychiatric hospitals
√ DBHDD works with the Department of Corrections (DOC), county sheriffs, and hospital emergency rooms to develop a method for estimating (by region) the number of adults with serious behavioral health disorders in need of supportive housing for recovery and to avoid institutional care.	DBHDD, DOC, CSDs, DCA, hospital emergency rooms, CSBs,
√ **The number of behavioral health peer support providers is increased** and Medicaid-reimbursable Peer Support Services are expanded for (a) ◊Drug and alcohol abuse and addiction services.(b) ◊Parent Peer Support, (c) Older adults, and (d) Other populations where peer support services will improve outcomes	DCHMed, DBHDD GMHCN, GPSN, GCSA
Transportation	
√A **behavioral health crisis transportation plan** is implemented to address challenges identified by county sheriffs for transporting people having a behavioral health crisis to appropriate care.	CSDs,, DBHDD, DCHMed, crisis care hospitals, GGA, GMHCN
Transportation services are available not only for medical appointments but for other support services (getting to work, looking for housing and employment).	DCHMed; DBHDD, PSVR; DHS-DAS & DOT
Medicaid transportation vendors (1) receive training on behavioral health and the effect of unreliable services; (2) are incentivized to provide a good product through monitoring for reliability, timeliness, and consumer treatment; (3) are accountable in their contracts for performance; (4) are rated by the consumers they transport.	DCH-Med, DBHDD, DFCS, consumers and stakeholders
Finances	
Quick access to behavioral health (mental health and addiction services) is available seamlessly in communities, regardless of payer source. A community mechanism exists to assist individuals learn about insurance or safety net services for which they may access and qualify.	CSBs, DBHDD, DCHMed, DPH, FQHC, GRHA, GGA, consumers
√ **Managed care contracts** include requirements for outreach and promotion, consumer input, best practices, levels of care, care coordination, and coordination with uncovered critical ancillary service providers (e.g., housing, employment)	DBHDD, DCHMed
Housing placement assistant offices have staff and flexible funds for emergencies and for transition into housing as necessary for successful recovery and integration into the community.	DBHDD; DCA, and GGA, AADA, LHAs, DOC, CSDs, GMHCN, homeless organizations

See Section X, Older Adults, for specific recommendations for seniors and Section VIII for Young Adults 18 to 24.

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X. Older Adults – Preventing and Treating Behavioral Health Disorders

Joanne felt hopeless, unable to will herself to do the most ordinary things in life. She could hardly move, did not want to get dressed, or leave her house. She did not want to go to church or see friends. Mary, her daughter, knew something was wrong and brought her to live with her so she could make sure she ate good food, bathed, and had contact with others. Mary brought Joanne to the Fuqua Center for Late-Life Depression. Through counseling and treatment, Joanne began to recover and now goes to volunteer. Joanne feels the center staff and peer group sessions are a lifeline. She volunteers to help others and to stay well herself. Mary felt it was very hard to see her mother so depressed.... She did not know how to help and missed a lot of work taking care of her mother. She said that it was important to get help for both of them. "It was a stressful situation, and I also felt helpless unable to assist my own mother. I knew we had to do something. I thought bringing her to my house would be enough, but she needed professional help. We are so grateful for the caring and respect my mom received; it saved her life and mine." (From a meeting of the Rosalynn Carter Fellowships for Mental Health Journalism, The Carter Center, Sept. 12, 2011)

The Importance of Behavioral Health Prevention, Early Intervention, and Outreach Uniquely Designed for Older Adults

Ninety-five percent of adults over the age of 60 report satisfaction with their life.[1] Older adults are a wonderful asset to communities and families. They bring the wisdom that having a long life can give to children, grandchildren, and communities. Yet, aging can also bring new risks and threats to mental health that, if addressed, can be alleviated or prevented from having a compounding effect. Older adults are more likely to experience a chronic illness, lose a life partner, have less independence and less mobility, have accidents such as falls, be isolated, and/or develop cognitive conditions such as dementia or Alzheimers.

For older adults with mental health and substance abuse disorders, healing from an illness, accident, or a chronic condition such as a heart attack takes longer than for their peers without a behavioral health disorder. **Most older adults do not receive services to treat their mental health disorder** [2] and are less likely to seek care. When they do seek health care, it is more likely from a primary care physician minimally trained in diagnosing or treating behavioral health disorders.[3] Ignoring these problems, results in significantly higher costs for chronic care for both older adults and taxpayers.[4] With a greater understanding of the costs associated with ignoring the older adult population's mental health needs and a growing population of baby boomers, the lack of mental health services has become even more urgent.

The Costs of Ignoring Mental Health for Older Adults

As the proportion of older adults within the population increases, the high cost of health and emergency room services has the attention of policy makers who are recognizing the importance of wellness and prevention both economically for taxpayers and for the future quality of life for themselves, their parents, and grandparents.

The 2012 news release of the Institute of Medicine (IOM) report, Baby Boomers Likely to Face Inadequate Care for Mental Health, Substance Abuse; IOM Report Recommends Ways to Boost Work Force, Fund Services, and Training, sums up the urgency of their study findings

> *"Inattention to older adults' mental health conditions and substance misuse is associated with higher costs and poorer outcomes" (National Academy of Sciences. July 10, 2012).*

For example, a study in five states of 1,801 seniors with depression and who received mental health care found a doubling of effectiveness, greater satisfaction with care, and lower long-term costs (four years) of $3363 per person[5,6,7,8,9,10,11] mainly through reduced chronic care episodes and emergency care.

Older Adults Are the Fastest Growing Age Group in Georgia, the United States, and Internationally.

The World Health organization declared that by 2017, the earth will have more adults over age 65 than children under the age of 5, and by 2050 older adults will outnumber children less than 14 years of age.[12] In the United States, the older adult populations grew faster than any other population group between 2000 and 2010.

Table OA-1 Growth in Population 65 Years and Older in the United States and Georgia

	2000	2010	2010	2000 to 2010	2010
	# ≥ 65	**# ≥ 65**	**% ≥ 65**	**% ≥ 65 Change**	**% ≥ 65 below Poverty**
U.S.	34,991,753	40,437,581	13.1%	15.3%	9.0%
GA	785,275	1,037,287	10.7%	31.4%	10.7%

Source: U.S. Census Bureau, Census 2000 Summary File 1. In The Older Population 2010 Census Briefs November 2011

In Georgia, adults over age 65 are a lower proportion of the population than the United States, but that is changing. **Older adults grew at a faster rate in Georgia than all but four states** (Arizona, Colorado, Idaho, and Nevada). Ninety-one of Georgia's 159 counties exceeded the national average of older adults.[13] The Atlanta region, comprising 10 counties and approximately 42 percent of Georgia's population, has projected a doubling of the over-age-60 population by 2015, and one in five residents to be over age 60 in 2030.[14]

Prevalence

Table OA-2 Prevalence of Older Adults With a Mental Health Disorder That Is Not Part of the Aging Process (e.g. mood, , and substance abuse disorders) ****

≥ 60 years Prevalence	Any Behavioral Health Disorders	Two or more Disorders	Three or more Disorders	Substance Disorders
*Lifetime Prevalence (%) Number***	26.1% 398,818*	11.6% 177,252*	5.3% 80,986*	6.3% 96,266*
12 month Prevalence Number*	15.5% 230,734*	N/A	N/A	5.9% 90,154*

*Source: Kessler, et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. 2005. Arch Gen Psychiatry. 62 Table 2
** Kessler, et al., National Comorbidity Survey NCS -A Lifetime and 12 M prevalence estimates. 2007. Updated data as of July 19, 2007 (Retrieved 3/19/2013 at http://www.hcp.med.harvard.edu/ncs/index.php)
*** Note 1. Florida's 2010 population numbers were applied to give policy makers and the reader an estimate of impact for planning. It is expected that Florida's rate would be higher than the national average.
**** Note 2. Estimates vary from 15 percent to 20 percent. Measuring older adult disorders is difficult and considered under-reported.

From 15 percent to 20 percent of the U.S. population 60 years or older have experienced a mental health disorder within the last 12 months that is not part of the normal aging process (Table OA-2)**.** Over 26 percent are estimated to have been diagnosed with one or more disorders over their lifetime (11 percent with two or more and 5.3 percent with three or more).

The Behavioral Risk Factor Surveillance System (BRFSS) 2006 survey estimated that 7.3 percent of Georgians and 6.5 percent of U.S. residents over age 65 experienced frequent mental distress (FMD) of 14 days or more within the last 30 days. This BFRSS estimate gives us a proxy indicator of how many older adults suffer from serious mental illness (Table OA-3). The BRFSS also estimates the prevalence of depression and anxiety, two of the most prevalent disorders for older adults.

Table OA-3 Georgia and U.S. Estimates of Older Adults who have suffered Frequent Mental Distress, Current Depression, Lifetime Depression and Lifetime Anxiety

	Frequent Mental Distress		Current Depression		Lifetime Depression		Lifetime Anxiety	
AGE	**U .S.**	**GA**	**U .S.**	**GA**	**U .S.**	**GA**	**U .S.**	**GA**
≥50	**9.2%** (8.9 - 9.5)	**10.3%** (9.2-11.5)	**7.7%** (7.3-8.0)	8.5% (7.4-9.6)	**15.7%** (15.3-16.1)	16.0% (14.6-17.4)	**10.6%** (10.3-11.0)	12.2% (10.9-13.5)
50-64	11.1% (11.1-11.6)	12.0% (10.5-13.6)	9.4% (8.9-9.9)	9.9% (8.5-11.6)	19.3% (18.7-19.9)	18.7% (16.8-20.7)	12.7% (12.2-13.3)	14.1% (12.4-16.0)
≥ 65	**6.5%** (6.5-6.9)	**7.3%** (5.9-9.1)	**5.0%** (4.6-5.4)	5.9% (4.5-7.6)	**10.5%** (10.1 - 11.0)	11.5% (9.8-3.5)	**7.6%** (7.2 -8.0)	9.1% (7.5-11.0)

Source. Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, **(2006)**
❖ CI = Confidence Interval; ** number is based on Georgians 65 years or older estimated in the 2010 census

Social support is an important protective factor associated with less risk for mental illness, especially depression. 13.4 percent of older adults in Georgia and 10.9 percent in the United States felt they did not have the social and emotional support they needed.[15]

Substance Abuse Among Older Adults.

Seventeen percent of older adults were found to abuse alcohol, medications, or other substances,[16] and the number with a substance abuse disorder is expected to double by 2020[17]. The Nov. 15, 2011, TEDS Report (Treatment Episode Data Set) of hospital admissions described the problem.[18]

- *Treatment admissions aged 50 or older increased from 6.6 percent of all admissions in 1992 to 12.7 percent in 2009*
- *The proportion of older adult alcohol admissions who reported alcohol as their only substance of abuse decreased from 87.6 percent in 1992 to 58.0 in 2009, while the proportion who reported alcohol in combination with drugs increased from 12.4 to 42.0 percent*
- *The proportion of older adult alcohol admissions who reported a co-occurring psychiatric problem tripled between 1992 and 2009 (from 10.5 to 31.4 percent)*

Suicide among Older Adults (Table OA-4).

Sadly, the rate of suicide, an indicator of untreated mental illness, is highest among adults over age 75 and white males. Georgia's suicide rates were higher than the national average for older adults. Communities can monitor the rate of suicide change among older adults over years as a way to measure the effectiveness of behavioral health services to older adults. One study found that 70 percent of the elderly who commit suicide saw their health care provider within the preceding month.[19]

Table OA-4 Suicide Among Older Adults in Georgia and in the United States 2002-2004 and 2005-2007 (per 100,000)

	60-74 Late Adulthood		75+ Older Adulthood	
	2002-04	2005-07	2002-04	2005-07
United States #	11,700	12,803	8,917	8,952
rate	12.8	13.1	16.9	16.3
Georgia#	368	382	245	233
rate	15.6	14.2	22.1	19.3
Georgia White Males #	282	283	205	198
rate	32.8	29.1	65.5	56.9

Source of Georgia data - 2003-2010 Version 2.8.4 CV: 1.9 Georgia Department of Community Health, Division of Public Health, Office of Health Information and Policy, Oasis Mortality/Morbidity Query, http:oasis.state.ga.us/oasis/qryMorbMort.aspx 8/24/2010.
U.S. Data Source: NCHS Vital Statistics System for numbers of deaths, Bureau of Census for population and estimates. http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html)

Challenges in Creating a Community System of Care for Older Adults with Behavioral Health Disorders

We learned through numerous regional meetings and from advocates and caregivers that they struggle to access help with a lack of services, information, and/or a trained supportive workforce. A well-trained workforce can help to address the unique myths and risks and provide services for older adults facing mental health and substance abuse challenges. Some of the myths associated with aging and mental health include:

- **Behavioral health disorders are a consequence of the aging process**.
- Mental illness such as late-life depression and addictive disorders cannot be successfully treated in older adults with dementia.

Critical life-changing events, stressors, or traumas such as the loss of a life-time partner, a medical condition (e.g., heart attack, cancer), diminished mobility, and/or the stress of being the only caregiver to a spouse can trigger late-life depression and **are not targeted for risk prevention or early intervention activities** such as public information, provider training, or preventive mental health interventions. **Isolation and a lack of social supports exists for many older adults**, who do not live close to family, have less mobility, and are confined in their home or nursing home.

A lack of trained professionals or volunteers who work with the elderly results in little early detection, outreach, and best practice treatments for behavioral health disorders. The problem is more acute in rural areas.

- General medical care professionals, nursing home staff and residential care staff, and community-based aging services providers are not likely to have training in mental health. Likewise, mental health providers are not likely to have training in the care of older adults with behavioral health disorders.
- Having a cognitive condition can make the diagnosis and treatment of a mental health condition more complex for untrained personnel[20] *as well as more difficult to access public mental health services.*

The fears of being stigmatized and losing independence are greater among individuals whose knowledge of mental illness is burdened by an earlier history when having a mental illness was more stigmatizing and little knowledge of treatments was widely known. **Older adults with a substance misuse/abuse are more severely affected physically as they are more likely to have a chronic condition** (e.g., heart condition, diabetes); use prescription drugs that interact adversely with alcohol or other substances; and have a reduced tolerance due to slower metabolization of substances. The result is poor management of chronic medical conditions, injuries from accidents, immune system weakness, and earlier onset of cognitive impairment.[21]

The lack of a lead agency and collaboration agreements across agencies at the state and local levels to address mental health and addiction in older adults results in less monitoring, less public information, less efficient use of resources currently available to the state and local agencies, and less grant making to address the unique needs of the elderly with behavioral health challenges and risks. Although many state agencies must collaborate in the community on behalf of older citizens, four key state agencies have the ability to ensure coordination at the community level and

could benefit from interagency agreements and a vision of how they can work together on behalf of older citizens with behavioral health challenges and risks. They are:

- ***The Department of Behavioral Health and Developmental Disabilities***, with six regional offices, has a legislative mandate to lead on behavioral health (mental health and addiction).
- ***The Department of Human Services and its Division of Aging and area agencies on aging*** have a state and federal mandate to work in communities on behalf of aging adults.
- ***The Department of Public Health (DPH)***, with 18 health districts and a health department in every county. The DPH is responsible for the health of Georgia communities and the vital records system that tracks health care outcomes.
- ***The Department of Community Health*** **is Georgia's Medicaid authority and is responsible for the state's Medicaid plan and Medicaid waivers that care for the most vulnerable and at risk older adults.**

Best and Promising Practices in Communities for Prevention, Early Intervention, Treatment, Rehabilitation, and Maintenance of Recovery[22, 23, 24]

Please see the appendices for more information on these and other best and promising practices.

The Fuqua Center for Late-Life Depression at Emory University is an example of how universities can make an important contribution to staff development, training the workforce in evidence-based models of care, and direct patient services. The Fuqua Center currently plays a lead role in planning, facilitating collaboration between state authorities, and policy related to the provision of care for older adults with mental illness. The Fuqua Center provides state-of-the-art care for older adults suffering from mental illness and has dedicated itself to improving the knowledge base and workforce challenges in the Atlanta region, Georgia, and the nation through implementation of evidence-based models of care (i.e., IMPACT, PEARLS, Healthy IDEAS, PROSPECT, Gatekeeper models) and trainings. In efforts aimed at improving access to geriatric psychiatry services, the center has extended its expertise, providing telemedicine support for long-distance psychiatric evaluations and psychiatric care and in providing on-site services in numerous low-income residential facilities in metro Atlanta[25]. (See http://fuquacenter.org/index.php)

Evidence-Based Models of Care That Improve the Mental Health Care of Older Adults:

IMPACT (Improving Mood-Promoting Access to Collaborative Treatment) is a treatment for older adults with major depression or dysthymic disorder within primary care settings but also in home health care and chronic disease management. (See www.nrepp.samhsa.gov/ViewIntervention.aspx?id=105)

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is a community depression program to detect and reduce the severity of depressive symptoms in older adults

with chronic health conditions and functional limitations through existing community-based case management services. (www.cdc.gov/aging/pdf/mental_health_brief_2.pdf)

Gatekeeper models such as HEROS (Helping Elders through Referral and Outreach Services) engage nontraditional partners in the community that have daily contact with older adults to recognize and refer at-risk older adults (e.g., delivery personnel, first responders, clergy, Meals on Wheels staff, etc.)

PEARLS (Program to Encourage Active Rewarding Lives for Seniors) is a best-practice intervention for older adults who have minor depression or dysthymia and are receiving home-based social services from community services agencies. The program is designed to reduce symptoms of depression and improve health related quality of life. (www.pearlsprogram.org/)

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trail) has proven to be a best practice to prevent suicide among older adult primary care patients with depression. (www.nrepp.samhsa.gov/ViewIntervention.aspx?id=128)

SBIRT (Screening Brief Intervention and Referral to Treatment)[26] is a best practice and comprehensive, integrated, public health approach used to deliver early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. A universal screen is used to identify and assess substance use severity, identify the appropriate level of treatment, and assist with appropriate referral for services if indicated. Georgia's Fuqua Center for Late-Life Depression has become a state leader in SBIRT with older adults and will be a great help as Georgia begins the important task of training primary care providers.

Table OA-5 Vision for Georgia's Older Adults With Behavioral Health Challenges

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" **(√=Georgia Model/Initiative exists and can be built on)**	**Entities Involved** (see legend for acronyms)*
The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides interagency leadership for older adults with behavioral health challenges through its Coordinating Council for Behavioral Health and collaborates with the Departments of Human Services Division of Aging Services (DHS-DAS), the Department of Community Health, Division of Medicaid (DCHMed), Public Health (DPH) at the state and local levels.	DBHDD, DPH,DHS-DAS, GGA,DCHMed, Fuqua Center

* **CSD**=County Sheriff's Departments; **CHDs**=County Health Departments; **DBHDD**=Department of Behavioral Health and Developmental Disabilities; **DCHMed**=Department of Community Health Medicaid Division; **DCA**=Department of Community Affairs;**DHS-DAS**=Department of Human Services, Division of Aging Services; **DHS-DAS-AAA** – Area Agencies on Aging; **DOC** = Department of Corrections; **DPH**= Department of Public Health; **FQHCs**= Federally Qualified Health Centers; **Fuqua Center** = Fuqua Center for Late-Life Depression, Emory University; **GGA**=Georgia General Assembly; **GBPP**=State Board of Pardons and Paroles; **GMHCN** = Georgia Mental Health Consumer Network; **LHAs** = Local Housing Authorities; **PS** = Peer Support; **PSVR**=Private Sector Voluntary Resources; **USG**; University System of Georgia

DBHDD, DHS-DAS, DPH, and the Fuqua Center for Late-Life Depression enter into a private–public partnership in order to build on the collaborative work done in Georgia to date aimed at the improvement of care for older adults in Georgia with mental illness.	
√ **The DBHDD, DHS-DAS, DCHMed, DPH, and the Fuqua Center have**: • ***Dedicated staff*** for older adults with behavioral health challenges • ***A formal interagency planning team*** collaborates at the local and state level for older adults with behavioral health challenges. Interagency agreements exist to assist coordinating/sharing data and services at the community level. Findings, challenges, and accomplishments are reported to the Behavioral Health Coordinating Council. • ***Community Outcome Indicators*** for older adult behavioral health • ***Regional community plans*** to address older adults with behavioral health challenges • ***Working relationships at the local level to assist Department of Corrections and county sheriffs*** to address older adults with behavioral health issues in their care.	**DBHDD & DBHDD regions, DHS-DAS and DHS-DAS-AAA, DPH & CHUs, FQHCs, DOC, CSD, GBPP, DCHMed,** Fuqua Center/Emory University **, and GGA**
Prevention and early identification outreach services in communities help older adults avoid and identify mental health and substance use disorders and co-occurring illnesses early. Major community components may include: • ***Public information*** on (a) factors that can place older adults into at risk and vulnerable situations, (b) depression (that it is not a normal part of aging), (c) medication interactions and misuse, (d) ways to access community behavioral health resources for older adults, and (e) ways to advocate or report an older adult at risk. • ***Best practice prevention health and wellness services for older adults and their caregivers***, including exercise, nutrition, and social interaction day programs to alleviate stressors/risks and help older adults develop protective factors. • ***Screening*** for behavioral health (including suicide) as a routine part of general medical examinations/check-ups. • ***Identification and engagement of private sector and voluntary*** support services for outreach to older adults (e.g., faith community, Meals on Wheels).	**DBHDD and DBHDD-regions; DHS-DAS and DHS-DAS-AAA; Fuqua Center; DCHMed; DPH and DPH CHDs; FQHCs; private sector voluntary resources**
Behavioral health services are made available where older adults are located (a) home, (b) day centers, (c) nursing homes, (d) hospitals, (e) primary care facilities, and (f) churches.	**DBHDD, DCA, DPH,DCHMed, CSBs; Fuqua Center; PSVR**
Safe housing and supportive housing is available for older adults and housing preserves choice, independence, and community living.	**DCA, LHAs, DBHDD, DHS-**
Transportation is available for older adults with mobility challenges to maintain community involvement and treatment.	**DCHMed; PSVR; DBHDD; DHS-DAS**

Peer support, **respite, and support for caregivers** are core services that are available in communities.	**DBHDD, DCHMed, DHS-DAS, GMHCN in collaboration with the Fuqua Center**
A geriatric behavioral health workforce is developed and provides integrated health care with general medical practices [27, 28] • ***Universities and colleges*** develop competencies for medical and social work students on aging and behavioral health, and these include involving consumers and caregivers in planning and choosing the services they receive. • ***Continuing education*** on behavioral health best practices in serving older adults is required for state licensing/certification of medical and social work staff. • ***A peer support Medicaid-reimbursable professional workforce*** for older adults with behavioral health challenges exists in each community. • ***ACT (Assertive Community Treatment), CST (Community Support Teams), and case management teams*** include older adult specialists when the needs of an older adult with serious behavioral health challenges are addressed. • ***Nursing home*** staff receive on-the-job training in behavioral health. • ***Crisis personnel*** **are trained in best practices** for serving older adults. • **Training** to be actively sensitive to risks and where to refer **is provided for volunteers, caregivers, GCAL (Georgia Crisis Access Line), medical professionals, and pharmacists** who are often in contact with older adults. o Training in the use of SBIRT with older adults is available to all primary care providers.	**DBHDD; DCH-Med; DPH; University System of Georgia; Georgia Board of Regents; GGA; Fuqua Center/ Emory University**

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XI. Supportive Housing and Employment for Adults With Serious Behavioral Health Disorders

Robert has a serious mental disorder and is now living in recovery. For many years, he lived under a bridge and ate out of trash cans. He purposely panhandled to get arrested more than eight times so he could have a bed, food, warmth, and treatment for his mental illness; although, he says, in prison they medicated him but did not provide the counseling supports he now understands he needs to control his disorder. Finally, he received help from Grady Hospital, which provided him Assertive Community Treatment, an evidenced-based program that provides therapy, medicine management, and a wide variety of services that allow a person to function as independently as possible.

As a child, he grew up in Buckhead, Atlanta; today he lives in a one-bedroom supportive housing apartment. He is happy to have running water, electricity, clean clothes, and a bed that he does not have to share with rodents and bugs. He loves to tend the garden near his apartment and would like to have a job using his skills in gardening.

Today he sees a caseworker two to three times a week who helps him manage his medication, provides guidance for problems that crop up, and connects him to programs in the community. He is glad to no longer need such intensive services so others can have the chance he had. When he repeated second grade, he was diagnosed with a learning disorder, but now he knows he has a mental health disorder. He feels that if he had been diagnosed correctly in second grade, he could have had a different outcome. He says that so often in life as a child, he just needed someone to listen, understand, and talk to him. As he re-enters life, finding friends and employment are important, but few want to employ someone with a criminal record who also did not graduate from high school.

Note. Story is real, but to protect the individual, the name has been changed. Pictures are stock photos and not of person in story.

Supportive Housing and Employment Works

Stable housing and employment allow us to have dignity and take care of ourselves. For individuals with serious behavioral health disorder(s), it is a lifeline and critical for recovery. Georgia recognized in its settlement with the U.S. Department of Justice that in order for individuals to leave psychiatric hospitals and live a meaningful life in recovery, supportive housing in communities would be needed. This is a difficult, complex task for Georgia and its communities. It requires an upfront investment in cash and training that will reap human and cost benefits over time. It requires the engagement of many, including legislative representatives, local advocates, housing authorities, judges, correction staff, sheriffs, builders, employers, churches, and many more. Even more importantly, we will have a new tool for helping vulnerable populations regain their dignity and health.

Permanent Supportive Housing Is a Best Practice

Permanent supportive housing is *"Decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet tenants' needs and preferences."*[1] (Substance Abuse and Mental Health Services Administration Permanent Supportive Housing Toolkit)

Permanent supportive housing is evidence-based, consumer-driven, recovery-oriented, and effective for those individuals who are leaving psychiatric hospitals, frequenting emergency rooms, are chronically homeless, or being released from jails or correctional institutions. For these consumers, cycling in and out of expensive institutional settings can be an all too frequent occurrence. This puts them at greater risk for exacerbation of their condition, self-harm, suicide, addictive disorders, poor physical health, and victimization by others.

Models for permanent supportive housing may differ. However, each recognizes that people with a serious, persistent mental illness, who have been in institutions or been homeless, face many complex problems and require both stable housing and support services. Not all people will want permanent supportive housing, but studies show that the vast majority will. Quality, permanent supportive housing first programs normally have an 80 percent or greater success rate (98 percent for Veterans after 1 year).[2,3]

For service delivery a collaborative team best-practice model – Assertive Community Treatment (ACT) or Intensive Case Management Support teams are usually chosen. However, care management models may vary depending on location (rural/urban) and the complexity of the consumer's physical, mental, and/or addictive health care problems. The team is concerned with the whole person. Support services may include counseling, peer support, detox, medication management, assistance with cooking and nutrition, self-care, transportation, social skills, finding a faith home, education, supportive employment, financial management, and medical care. A team member is available 24 hours a day, 7 days a week for emergencies. After achieving recovery and gaining independent living skills, the need for intense services diminishes, but affordable housing

and some ongoing planning and supports may be needed to maintain recovery and assist when and if a relapse or crisis occurs.

Components of Permanent Supportive Housing

Best Practices in Permanent Supportive Housing Are Likely to Occur When An Individual:
Is able to enter housing as soon as possible after being identified
Has a choice of safe, decent, and affordable housing as well as living arrangements (e.g., sharing housing with a roommate)
Signs a standard lease with all of the legal rights, protections, and responsibilities, including complying with rules of behavior that are required within the lease
Has housing where its management is separate from the service delivery
Is located in an apartment building or house where a majority of the rentals are not reserved for people with disabilities and there are opportunities to be involved in the community
Has a flexible case management team providing support services, peer services, and access to specialized supports that may be needed
Pays part (usually 30 percent) of their income for rent and utilities and receives rental assistance for the remainder
Has support services that are provided as long as needed. There may be periods of relapse and displacement from housing, but the team continues to work with the consumer as long as the consumer chooses to continue working toward recovery

The Human and Dollar Cost Benefits of Supportive Housing

Chronically homeless people and those with serious mental illnesses who cycle in and out of psychiatric institutions, hospitals, prisons, and jails represent a costly outcome of a failed community mental health system - a result that does not have to occur. The road to recovery is steeper and costs are higher when interventions are not delivered early and sustained.

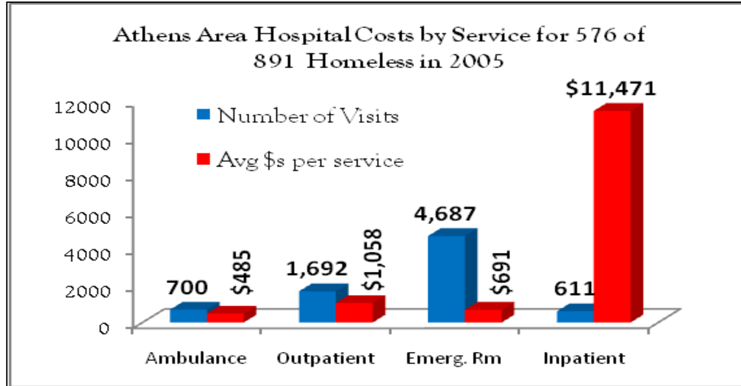
Two Georgia communities that studied some of the costs are illustrated below. One looked at hospital costs for all of the homeless population as measured in a 2005 homeless census in their county. The other analyzed individuals with severe and persistent mental illnesses who were homeless or were cycling in and out of psychiatric hospitals, emergency rooms, or jails. It measured pre- and post-supportive housing program outcomes. While each measured only a fraction of the potential savings and benefits, they both provide important information for Georgia communities seeking to understand the costs associated with mental illnesses, addiction, and homelessness to their community.

Athens-Clark County Homeless Hospital Medical Costs

Athens Regional Medical Center and St. Mary's Hospital found that homeless individuals in their community were in poorer health and were using health services inappropriately. Homeless patients often arrived in the evening when outpatient health services were unavailable (e.g., 6 p.m. to 6 a.m.). Of the 891 homeless people found in the 2005 (point-in-time) census, 576 visited the medical center and hospital 7,000 times, incurring costs of $12,377,800. While nationally 20 percent to 25 percent of homeless people are estimated to have serious behavioral health

challenges, 49 percent of the Athens-Clark homeless cohort were diagnosed with a mental health disorder, an addictive disorder, or both.

Figure H-1 Athens Area Hospitals Homeless Health Care
Average cost per service and the number of services utilized. [4]



Athens Area Total Cost of Services	
Service	Total $s
Inpatient Visits	$7,008,170
Outpatient Visits	$1,776,600
Emergency Room Visits	$3,234,030
Ambulance Rides	$339,000
Total Cost	**$12,357,800**

Atlanta Forensic Assertive Community Treatment (FACT)[5]

FACT provided Assertive Community Treatment Services (ACT) for 60 individuals with severe and persistent mental illness and/or addictive disorders. Supportive housing was provided for the 45 who were homeless. Some were identified because they cycled in and out of state psychiatric hospitals, hospital emergency rooms, and shelter care. Others were having numerous encounters with the criminal justice system for minor nuisance offenses such as trespassing, panhandling, or disturbing the peace. Most (49 percent) were referred to the program from the criminal justice system. Others were referred from a psychiatric hospital, other hospitals (Grady Hospital, Atlanta) or were transferred to the FACT program from another ACT team. Consumers were assisted with housing and intensive supportive services. Support services included a blend of ACT and psychiatric rehabilitation. Consumers' use of the criminal justice system, psychiatric hospital stays, and shelter systems were analyzed 12 months prior and post the program.

Significant changes in the quality of life for consumers and public cost offsets consistent with national studies were found. Of the 45 consumers who were homeless at enrollment, 62 percent were placed in housing, 25 percent had family housing, and 13 percent declined housing. Not analyzed were numerous other services ~ outpatient hospital health care, acute, inpatient, and emergency department use, crisis calls, shelter cost, or law enforcement costs.

Figure H-2 Atlanta FACT 2004-05 - Improved Quality of Life for 60 Homeless People With Mental Illness

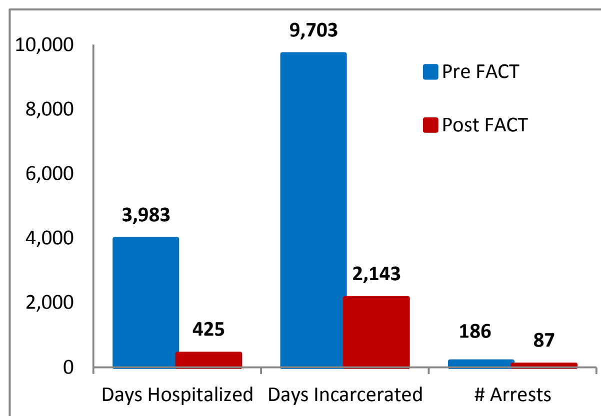
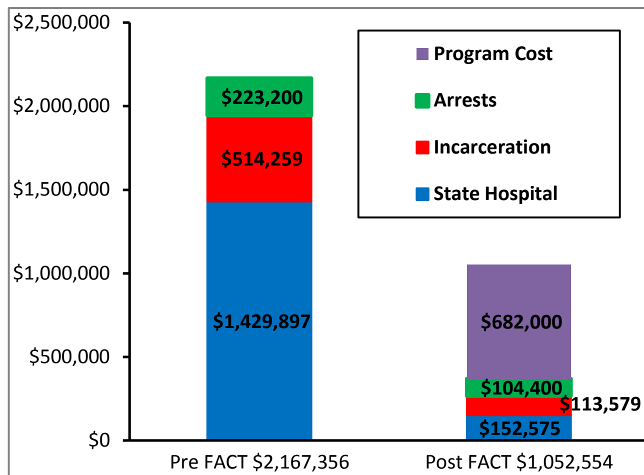


Figure H-3 Atlanta FACT Cost Benefit



Other State Permanent Supportive Housing Cost Studies

Dennis Culhane and Thomas Byrne (2010)[6] reviewed a number of programs in other states that evaluated the human and dollar cost savings from permanent supportive housing. These included supportive housing programs in Seattle, New York, Connecticut, San Francisco, San Diego, New Orleans, Cleveland, Chicago, Denver, and Maine. None of these programs measured all of the potential savings, but each had impressive improvements in health for their citizens, cost offsets, and benefits for their states. Georgia's savings or offsets would be a reduction in Medicaid. Below are a few of the reported findings from these studies that illustrate state savings.

Seattle realized a $4 million dollar savings ($2,499 per person) in the first year of its intervention. Ninety-five chronically homeless people with severe alcohol addiction were followed. Savings included a 41 percent reduction in Medicaid charges; 42 percent fewer jail days; 19 percent fewer EMS encounters; and decreases in shelter, detoxification, and other services.[7]

A New York City study found a $4.5 million decrease in Medicaid billing and a 95 percent housing cost offset within two years. Health care utilization prior to and after placement in supportive housing was gathered on 5,000 homeless people with severe and persistent mental illnesses. Consumers reduced their use of acute health services - 89 percent fewer inpatient hospitalizations and 40 percent fewer Medicaid reimbursements for inpatient care.[8]

A San Diego study of chronically homeless people with mental illness found a 41 percent reduction in per person use of mental health services for inpatient and emergency care as well as a reduction in encounters with the criminal justice system. The costs of intensive outpatient mental health and case management services were replaced within two years after entering housing.

Who May Need Supportive Housing?

Individuals stabilized and discharged from Georgia's state psychiatric hospitals. In 2010, nearly 11 percent of the 9,650 individuals with serious mental illness stayed for an average of 112 days and were re-admitted within 30 days.

Inmates in county jails and state prisons with serious mental illness. Nationally, 56 percent of inmates in state prisons, 45 percent in federal prisons, and 64 percent in local jails were found to have a mental illness. Prevalence rates were higher for females.[9]

Homeless with serious mental illness. 21,095 individuals in Georgia were estimated to be homeless on a single night in January 2009, and 90,000 at some point in the year.[10] People with mental illness are more likely to comprise the chronic, long-term population of homeless. Nationally, between 20 percent and 40 percent of homeless people have one or more severe and persistent mental health and/or addictive disorders. [11,12] Thirty-five percent reported that they had used hospital emergency room services in the previous six months, with approximately 50 percent of these using the ER more than once. In Georgia, 11,616 homeless adults and children were authorized for community behavioral health services in 2008, and 15,700 Georgia school children were reported as homeless by the Georgia Department of Education in the 2007-08 school year.

Homeless veterans. 2,530 Georgia veterans were reported to be homeless; 12 percent of the Georgia 2009 homeless census.

Homeless with traumatic brain injury. Forty to 60 percent of homeless individuals versus 8-9 percent of the general population have traumatic brain injury (TBI).[13] TBI can be both a contributor and result of homelessness.

Homeless women with serious mental illness. Many homeless women have been victims of domestic violence (33 percent to 88 percent) [14,15] and have experienced high levels of sexual abuse when homeless contributing to Post-Traumatic Stress Disorder (PTSD) and severe depression (17 percent to 72 percent).

Elderly with behavioral health disorders. Elderly people in nursing homes are forecasted to represent a greater strain upon Medicaid budgets. Permanent supportive housing may be a higher quality, less costly service option than nursing homes for some elderly citizens.[16]

Supportive Housing Challenges

Permanent supportive housing apartment units are lacking.

Local housing authorities have long-standing priorities on their use of federal and state housing grants that will need to shift.

Building apartments with state or federal funds can take many years. The private-public partnership of developer grants has been popular. But Georgia will need to divert more funds into quick housing access solutions.

Long waiting lists exist for Section 8 vouchers, a popular tool for rapid placement of individuals into housing. In many cases, waiting lists are actually closed and people in need cannot apply.

Support services are lacking **but** essential to the effectiveness of supportive housing.

Stigma and fear of people with mental illness creates difficulties when seeking employment and housing in the community.

Data on the need for housing is lacking on whether institutionalized, hospitalized, or incarcerated individuals with behavioral health disorders will have secure housing when released. Yet Georgia's accountability courts and diversion programs need housing alternatives.

Georgia does not have cost benefit data specific to Georgia, which makes it more difficult to develop and continue ongoing public policies that require an investment of taxpayer dollars.

Permanent supportive housing funds are managed by multiple federal, state, and local agencies, each with complicated requirements and specific population targets.

Workforce challenges exist in mental health, especially in rural areas, making it difficult to provide services with housing.

Affordable housing is expensive for low-income individuals who must rely on social security income and low-wage jobs. For 77,000 individuals with a serious mental illness who received Social Security Income (SSI) in 2008 in Georgia, their SSI payment consumed, on average, 97 percent of their rent.[17]

Applying for SSI/SSDI benefits is a challenging, complicated, lengthy process but important to the success of Georgia's program for supportive housing. Only about 37 percent of individuals who apply for these benefits are approved on initial application. Appeals take an average of two years to complete. Accessing these benefits is often a critical first step in recovery.

Transitional housing support and funding is a practical issue that is difficult to fund but critical for individuals needing rental and utility down payments prior to becoming eligible for SSI and Medicaid or for builders to hold apartments.

Private hospital emergency rooms report long stays as hospital administrators seek placement for patients. County jails, accountability courts, and juvenile judges all need supportive housing alternatives so individuals can transition successfully. Without a way to help people immediately with housing, short-term crisis alternatives, and support services, this situation becomes expensive for institutions and individuals.

Best Practices/Promising Programs and Examples from Communities

> *"Some people think when you give housing away that you're actually enabling people as opposed to helping them get better. Our experience has been that the offer of housing first, and then treatment, actually has more effective results in reducing addiction and mental health symptoms, than trying to do it the other way. The other way works for some people, but it hasn't worked for the people who are chronically homeless."* (Sam Tsemberis, Founder and CEO of Pathways to Housing) [18]

A Department of Justice settlement with the state has committed Georgia's governor, General Assembly, and state agencies responsible to fund housing for 900 individuals with serious mental illness leaving institutions in order to assist in their recovery and reduce the need for institutional care. State and local leaders are learning about the importance of housing as they implement the agreement.

Toolkits for the evidence-based best practices of Permanent Supportive Housing, Supported Employment, and Assertive Community Treatment were developed by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA). These can assist communities in Georgia that are implementing quality permanent supportive housing.

Pathways Housing First, identified as a best-practice model by SAMHSA**,** provides housing before treatment and other supports. Begun in New York in 1992, over 40 U.S. cities and numerous foreign countries have adopted the program model, which has demonstrated 85 percent stability in housing and high marks from the consumers it has helped. The project started as an effort to get housing for individuals who were rejected by other housing programs due to the severity of their condition and often the presence of a co-occurring addictive disorder.

Social Security Disability Insurance (SSDI) is a disability income benefit designed for individuals less than 65 years of age who have a disability preventing them from "substantial gainful activity" for at least 12 months. For homeless people with mental health or disability problems, these programs can be critical for housing, survival, and recovery.

SOAR (SSI/SSDI Outreach, Access, and Recovery)[19] is a national program built to help states access mainstream benefits for people who are homeless or at risk of homelessness.

SOAR is in 34 states, including Georgia, and has resulted in success rates on initial application of 71 percent compared to the usual 10-15 percent. In Georgia, the SOAR initiative works closely with the Department of Labor and the Disability Adjudication staff to improve the social security application process.

Georgia Housing Search.org The Georgia Department of Community Affairs website that helps individuals, their families, or care managers locate affordable rental housing across the state at a price they can afford with the unique characteristics they may need. The system can assist authorized caseworkers with locating housing for traditionally hard-to-place clients, including those with behavioral health disorders, disabilities, or a detention record. A toll-free number, 1-877-428-8844, is available for those without Internet access.

Since 2009, Georgia has had a Homeless Management Information System (HMIS) to track services and housing for homeless throughout the state, increasing the ability to match resources with needs and assist local communities in their affordable housing planning.

Hope House, Inc. of Augusta: The Highland's West is a permanent supportive housing project providing long-term housing and a best-practice therapeutic recovery program for women and their children. It assists women with co-occurring disorders of chemical addiction and mental illnesses.

Macon - Grove Park Village, developed in 2005, provides permanent supportive housing for individuals with mental illnesses and a co-occurring substance use disorder. Residents pay a rent of no more than 30 percent of their monthly income. Georgia's Department of Community Affairs Permanent Supportive Housing Program provided the development loan of $3.2 million utilizing funding from the Federal HOME program and Georgia's Housing Trust Fund for the Homeless. Project developers have figured the cost savings to be substantial – a per unit cost of $2,700 a year over the life of the project versus a yearly cost of hospitalizing patients for mental health and substance abuse of $84,600.

Georgia Rehabilitation Outreach (GRO) in East Point, Georgia, is a nonprofit specialty provider of evidence-based behavioral health services - Assertive Community Treatment (ACT) and Integrated Dual Disorders Treatment (IDDT). GRO also leases apartments to people enrolled in the ACT or IDDT programs. Evaluations of consumers show an overall satisfaction of 87 percent with ACT team services; 93 percent with residential services; 100 percent stability in housing by the third and fourth quarters; decreased criminal justice involvement (100 percent reduction in the first, second, and third quarters and 94 percent for the fourth quarter); and few readmissions to a state hospital.

Financing Permanent Supportive Housing

There are a number of funding sources at the federal level for permanent supported housing that states use with some form of state or community level match. Most are financed through the Housing and Urban Development (HUD) McKinney-Vento Homeless Assistance Supportive Housing Program and/or the Shelter Plus Care Program. In addition, Health and Human Services block grant and entitlement states match programs such as Medicaid, and veterans' homeless service programs are also available to stretch state dollars further. Financing housing requires: capital funds, rent subsidies, and services

Table H-1 Major Supportive Housing Financing Sources for Georgia

Financing Service Type	Capitol Funds	Rent Subsidies	Services	Source
Shelter Plus Care		X	X*	U.S. HUD; GA DCA
Section 8 Housing		X		U.S. HUD; GA DCA
HUD VASH		X Veterans	Case Man. 1 per 25	U.S. HUD; GA DCA
Tax Credits for New Low Cost Housing	X			U.S. Treasury; GA DCA
Community Development Block Grants	X			U.S. HUD; GA DCA Local Jurisdictions meets guidelines
HOME Investments Partnerships	X	X		U.S. HUD; GA DCA Local Jurisdictions meets guidelines
Medicaid			Health Services	U.S. DHHS, CMS; GA DCH
Parolee - Transition Funds to establish Community Stability, rent subsidy		90 days		GA DOC
GBHI - Grants for the Benefit of Homeless Individuals Housing Support for Low income with Disabilities and Behavioral Health disorders		X		U.S. DHHS, SAMHSA; GA DBHDD
Georgia Housing Trust Fund				GA DCA

Note. Services are not funded by Shelter Plus Care, but are a condition for obtaining these funds.

The new Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act modifies the McKinney-Vento Homeless Assistance Act, creating one continuum of care program out of three programs. Providers can now use one financing source to provide permanent supportive housing. It provides new funding for homelessness prevention and Rapid Re-Housing, includes people at risk who have unstable housing situations in the definition of homelessness, and focuses on performance in reducing episodes of homelessness.

The Housing and Urban Development Veterans Affairs Supported Housing Program - (HUD-VASH) targets homeless veterans. When compared with case management only and standard Veterans Administration care, the HUD-VASH program with Section 8 vouchers and intensive case management for veterans with mental illnesses and/or addictive disorders resulted in significantly improved housing stability and a larger social network after three years. No significant outcome differences in substance abuse or psychiatric status were found.[20]

Transitional housing, supports, and funding are part of the plan by Georgia's Department of Behavioral Health and Developmental Disabilities to assist individuals accessing permanent supportive housing prior to becoming eligible for SSI and Medicaid.

Georgia's Housing Trust Fund provides rental assistance funding for individuals and families with disabilities.

Georgia's Department of Community Affairs Permanent Supportive Housing Program provides funding for the development of new supportive housing units.

Rent vouchers through the Section 8 housing program allow individuals to be placed into housing quickly by using housing that is already available in a community.

Supportive Employment (SE) is an evidence-based, cost-effective program for people with serious mental illnesses and/or co-occurring disorders.

> *"Supported employment helped me turn my life around. They were with me every step of the way, all of the way through to finding and keeping a job. Who would believe I could do all of this?"* (Supported Employment Participant) Source: Fact sheet provided by GA-APSE (The Georgia Network on Employment) Walker-Lass, D. President

Employment gives people hope, structure, routine, income, self-esteem, and a sense of personal value as a contributor to the community. Supported employment is an effective program for a culturally diverse population with serious mental illness, addictive disorders, and/or co-occurring disorders who want to work as well as find and maintain competitive employment in an integrated setting[21]. Though a part of supportive housing case management team services, it can be a service utilized for the individual who does not need supportive housing.

> *"Approximately [60 percent to] 65 percent of people with SMI [severe mental illness] in the U.S. public health mental health system endorse employment as a goal" ... [yet] only about 15 percent are employed (Bond and Drake, 2012, p. 1)."*[22]

Individual Placement Services (IPS) SE Model – People with serious mental health diagnosis (including those with dual disorders, substance use disorders, Post-Traumatic Stress Disorder (PTSD), schizophrenia, major depression, and bipolar disorders) find recovery faster with IPS-supported employment than those with treatment alone and those with treatment and other vocational rehabilitation programs such as sheltered workshops and day training programs [23,24]. The supported-employment IPS does not require training before seeking and placing a person in competitive employment and is associated with faster recovery, higher salaries, longer work times, (20 and 40 hours a week), greater social inclusion, greater self-esteem, lower costs ($5,500 in 2012 dollars) and a decrease in public health care costs (Medicaid, other state and federal funds)[25].

An employment specialist, as part of the case management or Assertive Community Treatment (ACT) team, assists the consumer with finding and applying for a meaningful job based on their choices, preferences, strengths, and experiences. When a job is found, the employment specialist and team are there to support skills that will help with employment success.

Bond and Drake (2012) reviewing the literature on Individual Placement and Support (IPS) compiled data on why it is an important policy and practice; yet is fraught with numerous implementation problems and roadblocks.

Components of Supportive Employment (SE)[26]

Best Practices in Permanent Supportive Employment include:

Rapid access, search for jobs, and no eligibility requirements – Consumer is able to access a SE specialist quickly after requesting the service regardless of prior work history or disability.

Paid Employment

Integrated Work Sites – Individuals are employed in the community and hired by local businesses where the general public can apply for employment.

Individualized and ongoing - SE support is individualized and continues as long as consumers want the service.

Consumer preferences and choice – Consumers preferences, strengths, experiences and choice drive the direction of SE specialist search for employers and employment.

Employment specialist is part of the mental health treatment team.

Employment specialists provide job options that are -in a variety of settings in the community, are competitive, and have permanent status. There may be periods of problems with the employment setting, but the employment specialist continues to work with the consumer as long as the consumer chooses.

Employment specialist provides ongoing follow along support - for employers and the consumer taking into account the individualized needs of each including training, transportation, social support, etc.

Table H-2 Vision Housing and Supportive Employment Recommendations

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" (√=Georgia Model/Initiative exists and can be built on)	Entities Involved/Responsible (see legend for acronyms)*
√ **Communities have a continuum of quality, safe, supportive housing and housing crisis choices** for people with behavioral health disorders including permanent supportive housing, transitional housing placements, peer support and other forms of respite care; crisis housing, shelter plus care, and day programs that allow care givers to work and individuals to stay in their home.	DBHDD; DCA; DCHMed
√ **An appropriate level of intensive outpatient care services exists to assist individuals with serious behavioral health disorders to live and receive services in their community and home including**: intensive case management services such as Assertive Community Treatment (ACT), supportive employment, 24/7 crisis care services, peer support, respite care, medication assistance; transportation; wellness and nutrition guidance; and peer support and drug and alcohol residential and outpatient treatment services.	DBHDD; DCHMed; DCA; DOL
√ **Quality assurance of supportive housing and services goes beyond paperwork and the physical plant and prioritizes consumer satisfaction,**	DBHDD, DCA; DCHMed

* ACs=Accountabiity Courts, CSD=County Sheriff's Departments; DAS=Division of Aging Services; DBHDD=Department of Behavioral Health and Developmental Disabilities; DCHMed=Department of Community Health Medicaid Division; DCA=Department of Community Affairs; DFCS=Division of Family and Child Services; DJJ=Department of Juvenile Justice; DOC = Department of Corrections; DPH= Department of Public Health; DOL=Department of Labor; ED=Hospital Emergency Departments; CSU=Crisis Stabilization Units; LHAs = Local Housing Authorities; GGA=Georgia General Assembly; GBPP=State Board of Pardons and Paroles

"A GEORGIA VISION FOR BEHAVIORAL HEALTH" **(√=Georgia Model/Initiative exists and can be built on)**	**Entities Involved/Responsible** (see legend for acronyms)*
consumer choice, staff appropriately trained in recovery orientation and best practices, health, and safety.	
Supportive housing data is collected by region/county on individuals with serious mental health and/or addiction disorders whose behavioral health recovery and successful reintegration would be compromised without stable, safe housing and supports. This would allow the state as well as communities and local health authorities to understand the scope of the problem in their communities and be able to work together on a health environment for their citizens with behavioral health challenges. Data would be collected on the number of individuals who are homeless, in state care or the armed services. This would include those with behavioral health disorders who are (a) emancipated from foster care; (b) in juvenile justice custody; (c) homeless (d) returning veterans; (e) in parole and/or probation status, (f) domestic violence victims; (g) adult children of aging parents who can no longer care for their child; (h) older adults with behavioral health disorders who do not need nursing care; (i) released from county jails, correctional facilities, hospital emergency departments, and state psychiatric hospitals.	DBHDD/DCA lead with CSUs; DFCS; DOC; DJJ; ACS; and EDs
Housing Placement Assistance county or regional offices are in place for individuals with serious behavioral health disorders to assist in supportive housing placement needs for successful diversion, release from institutions, hospitals, foster care emancipation, homeless veterans with serious behavioral health needs; and older adults for whom nursing home care is an inappropriate choice.	DBHDD; DCA, and GGA, AAOA, and LHAs
Housing placement assistant offices are provided staff and access to emergency and flexible funds including transition funds for ensuring the housing needs necessary for successful recovery and integration back into the community.	"
√ **Quality Best Practice Supportive Employment Services** are in place and seen as a critical service in communities for people with serious behavioral health problems who must overcome stigma to have the dignity and self-respect so important to recovery.	DOL; DBHDD
√ **Successful community diversion programs and services have access to supportive housing and employment services in every community** for people with behavioral health disorders who interact with the criminal justice system but do not pose a threat to public safety.	DOC, DJJ, ACs, CSD, DBHDD, LHAs; GBPP

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Appendix 1

Evidence-Based and Promising Practices in Community Mental Health Care

The following list of evidence-based and promising practices is by no means exhaustive; rather, it is a resource for mental health care professionals. *Evidence based practices* are those for which systematic, empirical research has provided consistent evidence of statistically significant effectiveness of a particular treatment. *Promising practices* are acceptable treatments based on initial research findings, consumer values and expectations, general professional acceptance, and clinical anecdotal literature.

Evidence based practices in this section include the major *Toolkits* developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assist professionals and communities implement evidence based practices with fidelity. SAMHSA Toolkits are available online at the SAMHSA Publications Store. Please see: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/about.asp. We are especially grateful to the National Association of State Mental Health Program Directors (NASMHPD) Research Institute for the format we used to display information and the evidence based programs prepared by Jacqueline Yannacci, M.P.P. and Jeanne C. Rivard, Ph.D. in their excellent 2006 "*Matrix of Children's Evidence Based Interventions*" which was developed to assist state Mental Health Programs implement high quality evidence based programs for children and youth. *Please see:* http://www.nri-inc.org/reports_pubs/2006/EBPChildrensMatrix2006.pdf.

Readers may also find the following lists of evidence based and promising practices helpful:

SAMHSA has developed a-National Registry of Evidence Based Programs and Practices. NREPP - Please see: http://nrepp.samhsa.gov/.

NASMHPD has a list of state and international best and promising practices in *Brag and Steal Resource Guide: Mental Health Programs from Around the World* - http://www.nasmhpd.org/docs/publications/docs/2008/Brag%20and%20Steal%202008.pdf.

In *Psychiatric Services*, November 2002 Vol. 55, No 11, we found the helpful article Evidence-Based Practices in Geriatric Mental Health Care by Stephen J. Bartels, M.D., Aricca R. Dums, B.A., Thomas E. Oxman, M.D., Lon S. Schneider, M.D., Patricia A. Areán, Ph.D., George S. Alexopoulos, M.D. and Dilip V. Jeste, M.D. http://www.cmhda.org/committees/documents/oasoc_ebp_(10-18-06)_bartels_(psych_services_2002).pdf

The American Academy of Pediatrics has developed a guidance to assist pediatricians in taking leadership on children's mental health in communities. Within the AAP guidance is a useful table of treatment practices by condition and level of evidence supporting the treatment. http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/CRPsychosocialInterventions.pdf

The Council of State Governments, Justice Center provides helpful links and information on promising practices for youth and adults with mental health and substance use problems in the corrections system. Youth programs - http://csgjusticecenter.org/mental-health/publications/better-solutions-for-youth-with-mental-health-needs-in-the-juvenile-justice-system/ and Adult programs - http://csgjusticecenter.org/mental-health/webinars/webinar-archive-a-new-collaborative-framework-for-reducing-recidivism-and-promoting-behavioral-health/

The Rand Corporation provides an excellent website called the *Promising Practices Network on children families and communities* with issue briefs on evidence based and promising practices. Outcomes include improved mental health and decreased substance use. Please see http://www.promisingpractices.net/default.asp.

The National Traumatic Stress Network provides an ongoing listing of best practices and training opportunities. Please see: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices#q4

How to read the appendix: The appendix is divided into two main categories: SAMSHA Toolkits and another section of evidence-based and best and promising practices. The SAMHSA Toolkits are a series of evidence-based practices that SAMHSA has explicitly endorsed. The best and promising practices section is broken down into four sections: Children, Transition Years, Adults, and Older Adults. Within each category are a series of evidence-based practices as well as promising practices for use within that population. The appendix reads left to right.

SAMHSA Toolkits[1]: Vetted and suggested evidence based practices

Retrieved from: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/about.asp

Disorder	Treatment Name	Description
Serious mental illness (SMI) & high risk for institutional care (Adults and Older Adolescents)	**Assertive Community Treatment** (ACT)	"ACT is one of the most ... effective models of integrated community care for people with serious and persistent mental illness..." Goals are to help people stay out of hospitals/institutions, and develop skills for living in the community. Services are delivered by a team and available 7/24 hours a day.
"	**Medication Treatment, Evaluation, and Management** (MedTEAM)	MedTEAM assists medication "prescribers" increase expertise, integrating the most current scientific knowledge on medications, the experience of consumers, and careful evaluation of outcomes. Consumers are an active part of the team. Results include improved consumer use of prescribed medication, greater confidence in: managing their medication.
"	**Permanent Supportive Housing** (PSH)	PSH is decent, safe, and affordable housing, linked to services which are flexible, voluntary, and recovery-focused. Tenants have a lease in their name and full rights of tenancy under law. Results include greater stability, community integration, ability to manage treatment, reduced use of inpatient services, increased use of outpatient services, reduced interaction with judicial system, and improved physical health and quality of life.
"	**Supported Employment**	Supported Employment assists individuals with behavioral health conditions "find and keep" meaningful work. Supported employment brings dignity, supports recovery, independence, hope, integration into the community, and quality of life. Individuals often gain the ability to have more choices in what they can purchase and where they live.
"	**Consumer-Operated Services** (COS)	COSs are owned and run by individuals in recovery with lived mental health experiences who support their peers. The types of services offered may differ, but each assists consumers with self-help and recovery. The mentorship of shared experience builds strength and hope and has improved outcomes in reaching personal goals of wellness and recovery.
"	**Family Psychoeducation**	Multifamily group meetings encourage peer support and mutual aid. Consumers experience fewer relapses and less time in the hospital, increased participation in vocational rehabilitation; and higher rates of employment, when combined with supported employment.
"	**Illness Management and Recovery**	IMR practitioners help consumers define recovery for themselves and identify personally meaningful recovery goals. Consumers learn to identify early warning signs and plan steps that they can take to prevent relapses. Trained IMR practitioners meet weekly with consumers either individually or as a group for 3 to 10 months.
SMI and Co-Occurring Substance Use Disorder (Adults / Adolescents)	**Integrated Treatment for Co-Occurring Disorders**	Mental health and substance abuse treatment are evaluated and addressed by the same team in the same location at the same time.
Depression (Older Adults)	**Treatment of Depression in Older Adults**	The toolkit assists in appropriately evaluating, selecting, and implementing among known evidence based practices in the treatment of depression among older adults, an often overlooked treatable condition.
Conduct Disorder or Oppositional Defiant Disorder (Children)	**Interventions for Disruptive Behavior Disorders**	The toolkit provides information on disruptive behavior disorders and known evidence based practices in the treatment of children of all ages. It provides information on appropriately evaluating, selecting, and implementing.
Serious behavioral health disorders, dual diagnosis, and/or developmental disabilities (Adults & Older Adolescents)	**Supported Education**	Supported Education provides supports for persons with serious mental illness interested in vocational training and post-secondary education. Significant improvements have been found in educational enrollment and completion, future competitive employment, self-esteem and hospitalizations in this promising practice that addresses a serious concern of young adults and adults seeking to improve their future outcomes.[2,3,4]
Suicide – (High School Youth)	**Preventing Suicide SAMHSA Toolkit**	For high schools and school districts includes programs and strategies to prevent suicide and promote behavioral health.

Evidence Based Practices (EBP) –Sampling of Best Practices and Promising Practice

Note. Please see National Association of State Mental Health Program Directors (NASMHPD) Research Institute's (NRI) Center for Mental Health Quality and Accountability's review of EBPs (http://www.nri-inc.org/projects/CMHQA/matrix.cfm);The Rand Corporation website - *Promising Practices Network on children families and communities* (http://www.promisingpractices.net/default.asp.); American Academy of Pediatrics http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/CRPsychosocialInterventions.pdf; and the National Traumatic Stress Network http://www.nctsn.org/resources/topics/treatments-that-work/promising-practice#q4

CHILDREN & Youth		
Children and Youth with Severe Emotional and Behavioral Health Conditions[5]		
Serious behavioral problems and mental health symptoms including bipolar, depression, anxiety, impulsivity, and self-harm behaviors. Juveniles at risk of out-of-home Placement and/or juvenile offenders. (ages 9 – 18) (family- and community-based)	Multisystemic Therapy (MST) (various models adapted for youth's environment) http://mstservices.com/ (MST With Psychiatric Supports) – (MST for Juvenile Offenders) http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=Multisystemic	MST is an evidence based treatment focusing on the entire network of interconnected systems (family, school, peers). MST therapy works to facilitate positive surrounding systems changes in order to support individual change. MST clinicians are on call 24/7. They work intensively with parents / caregivers. Caregivers are supported to keep the adolescent focused on school and job skills. Youth are introduced to activities such as sports and recreational activities as positive alternatives. Outcomes have included reduction in out-of-home placements up to 50 percent and re-arrest rates up to 70 percent, improvements in family relations and functioning, decreases in psychiatric symptoms, and drug and alcohol use.
Co-occurring substance use and mental disorders, high risk for continued substance abuse, conduct disorders, and delinquency (ages 6 to 17)	Multidimensional Family Treatment (MDFT) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=16 MDFT Fostercare (several models) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=48	MDFT is an evidence based practice that views the multi systems affecting youth with serious behavioral health symptoms as critical to affecting their health. MDFT targets youth- interactions and communications with family, peers, school, welfare, foster care, juvenile justice, mental health systems that may be affecting behavior. MDFT also assists parent/family functioning. MDFT can be a family-based outpatient program or partial hospitalization (day treatment) program. It is an intensive program usually consisting of 12 to 16 weekly (or 2X a week) 60 to 90 minute sessions. Outcomes have included: reduced substance use, abstinence, improved school performance; and decreased delinquency.
Delinquent or at high risk of delinquency (11-18 years) (multiple settings)	Functional Family Therapy (FFT) http://www.fftinc.com/about_model.html http://www.blueprintsprograms.com/factSheet.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028	An evidence based practice that includes short-term treatment intervention of approximately 8-12 sessions for mild cases and up to 30 hours over three-months for severe cases. FFT seeks to identify and maximize family strengths and protective factors while mediating risk factors. Outcomes include: decreased out-of-home placement, drug use, violence, delinquency, and recidivism; as well as a closer relationship with parents.
Depression, Anxiety, PTSD, Conduct Disorder, AD/HD, drug and alcohol abuse, eating disorders, obsessive compulsive disorder. (ages 6 – older adults)	Cognitive Behavioral Therapy (CBT) (numerous models adapted to specific disorders) [6,7] http://apt.rcpsych.org/content/7/3/224.full	CBT is an Evidence Based Practice that is a short term (4 to 7 months) therapeutic approach that works by helping an individual to identify and redirect/change thoughts, images, beliefs and attitudes (cognitive processes) that affect/drive the expression of and magnitude of problem behaviors and mental health disorders.
Severe emotional disturbance and involved with 2 or more service systems and at risk of institutional care or in residential care (ages 12 to 17 and a separate 17 to 24 years transition program)	**Wraparound Milwaukee** - one of numerous Care Management Entity (CME) Wraparound Models http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086808/ For CMEs and wraparound see http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086808/	Wraparound Milwaukee is a cost effective evidence based CME for youth and young adults at great risk of institutional care and their families. Multiple public service agencies braid funding streams and staff to provide a comprehensive, integrated package of treatment and ancillary support services in the home and community. An individualized system of care is built with the child and family that builds on and expands the strengths of family and youth to create a road for success at home, school, and community. Some of the many measured results include significantly reduced delinquency, hospitalizations, and crisis care; and improved behavioral health, school attendance, and family satisfaction. CMEs are organizations that are accountable of improving the quality of services and outcome. Numerous CMEs are showing great progress for children.

Conduct Disorder, Oppositional Defiance Disorder		
Trauma, Conduct, Behavior Disorder physical abuse recurrence, (0 to 12 years of age) (Clinical Setting)	Parent - Child Interaction Therapy (PCIT) [8] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=23	PCIT uses structural play and specific communication skills to improve/change parent and child interaction patterns. Parents learn constructive discipline and limit setting.
Aggressive / Disruptive Behavior in schools or other institution-prevention, early intervention and access to treatment. (school age)	PBS/PBIS Positive Behavioral Intervention & Supports System Approach www.nasponline.org/resources/factsheets/pbs_fs.aspx	PBIS is a best practice school-wide approach to building positive supports in and out of the classroom, changing the school climate, eliminating challenging behaviors and replacing them with prosocial skills. PBS/PBIS is based on ***behavioral theory*** (problem behavior continues because the child is either rewarded by getting something positive or escaping something negative).
Oppositional Defiance Disorder / Conduct Disorder (6-12 years)	Videotaped Modeling Parent Training [9]	Parents and children improve skills in interacting and responding to problem behaviors. Outcomes include: fewer problem behaviors, better attitude toward children, and greater confidence as a parent.
SED with Aggressive Behavior (applied/tested in 5th grade)	Student-Mediated Conflict Resolution Program [10]	Students learn to become peer mediators in conflict resolution and use these skills during recess assisting fellow students resolve conflicts. Outcomes include less playground aggressive behavior and conflicts after 1 year.
Behavior problems (1st–3rd grade)	Project Achieve	Program works on school and staff effectiveness as well as student academic achievement and social skills. Outcomes after 3 years included: decreased special education placement, disciplinary referrals, and suspensions.
Conduct and severe conduct problems (high risk children) (1st- to 10th grade) (school based)	The Fast Track Project www.fasttrackproject.org/	Fast Track is designed to prevent serious and chronic antisocial behavior in children selected as high-risk at school entry because of their conduct problems in kindergarten and home.
Conduct Disorder, juvenile delinquency (3-8 years)	Helping the Noncompliant Child http://www.strengtheningfamilies.org/html/programs_1999/02_HNCC.html	Helping the Noncompliant Child is a family training program that occurs in weekly 60 to 90 minute sessions for around 10 weeks.
Conduct Disorder Delinquency Prevention and Early Intervention with high risk ,aggressive boys (7 to 9 years of age)	Montreal Longitudinal Experiment Study [11] http://publications.gc.ca/Collection-R/LoPBdP/MR/mr132-e.htm	The Montreal Longitudinal Experiment Study is a 2 year program for aggressive boys (identified by kindergarten teachers). The program teaches social skills and self-control and helps parents to reinforce skills at home. Outcomes after 3 years included: less behavior problems, fewer school performance problems, and less delinquency.
Conduct problems / disruptive behavior, substance abuse (6 to 12 year old children and 26 to 55 year old adults)	Early Risers "Skills for Success" Risk Prevention http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=304	Targets elementary school students at risk for developing conduct disorders and substance use problems and their families. Includes social-emotional skills training, school skills with behavioral management protocols for building and supporting social, emotional, problem solving and peer friendship skills. Outcomes included: improved social competence, behavioral self-regulation, school adjustment, parental investment in child, and violence reduction.
Maternal anxiety/depression, child conduct disorder (expectant couples and children through 6 months)	Family Foundations http://www.promisingpractices.net/program.asp?programid=294	Home visiting program consisting of 8 pre and post birth classes to develop "co-parenting" skills. Results included: less maternal depression and anxiety, children with less violent behavior or conduct problems, greater support between parents of each other, improved infant self-regulation, and less negative parenting practices.
Depression, Suicide, and Anxiety		
Depression (children in3rd-to 6th grade)	Primary and Secondary Control Enhancement Training for Youth Depression- PASCET http://www.promisingpractices.net/program.asp?programid=157	PASCET is a promising practice model with the primary goal of learning how to control situations that are modifiable and to adjust one's thinking to events that are not modifiable. Outcomes have included: improved (lower) scores on the Child Depression Interview (CDI) and/or more individuals with a normal CDI range, nine months after intervention.

Depression, Suicide, and Anxiety continued		
Complex and Serious Behavioral Health Disorders (Youth at risk of out-of-home placement and their families)	**High Fidelity Wrap** www.choicesteam.org/choicesmodelhifiwrap.html and/or http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3086808/	High Fidelity Wrap is an intensive community-based care coordination program that utilizes a team with a can do positive attitude who support and build on family and youth strengths by providing a coordinated system of care for youth who are involved with multiple agencies and at high risk for out-of home institutional placements.
Depression Symptoms, "demoralization" and depression risk (middle/high school or community setting)	Coping with Stress Course (CWS) http://www.promisingpractices.net/program.asp?programid=151	CWS assists students at risk of depression develop protective coping skills. CWS uses cognitive-restructuring techniques to help youth identify negative or irrational thoughts and learn to challenge them.
Depression (youth) *Clinical setting intervention*	Self Control ("Taking Action" Program for Depressed Youth)	Self Control ("Taking Action" Program for Depressed Youth) employs a self-observation to chart one's behavior to understand environmental triggers and enact strategies to effectively respond to those triggers.
Depression (13 to 17 year olds) (numerous outpatient setting – schools, detention centers,)	Adolescent Coping with Depression Course (CWD-A) http://www.promisingpractices.net/program.asp?programid=152 http://nrepp.samhsa.gov/ViewIntervention.aspx?id=11	CWD-A is a short term group intervention for adolescents with depression, consisting of 16 small group sessions over 8 weeks with 6 monthly follow up sessions to teach skills to relieve depression including: relaxation, assertiveness, cognitive restructuring , mood monitoring and others. Parents are also part of the program and play an important role in supporting what their child is learning.
Depression, suicide risk (13 to 17 years of age) (school based)	SOS Signs of Suicide http://nrepp.samhsa.gov/ViewIntervention.aspx?id=53	High school suicide prevention program through education and supporting help-seeking behaviors from adults.
Stress , Anxiety (school & clinic) (child & adolescent 6 to 18 years of age & adaptation for preschool and autism)	Cool Kids Child and Adolescent Anxiety Management Program, various adaptions http://nrepp.samhsa.gov/ViewIntervention.aspx?id=327	The program teaches anxiety management skills - identifying anxious thoughts feelings and behaviors, employing cognitive restructuring, and assisting youth to employ coping skills. Parents are also involved in supporting their child. Outcomes include: fewer treatment group children meeting the DSM-IV criteria for anxiety than control group children.
Anxiety - Anxious and Avoidant (6 to 17 years of age) (school and outpatient settings)	Coping Cat http://nrepp.samhsa.gov/ViewIntervention.aspx?id=91	Coping Cat is a 16 session, clinically based intervention using Cognitive Behavioral Therapy –CBT to help youth identify their anxiety; events that may trigger their anxiety; coping skills they might employ; planning to address anxiety symptoms when they occur; and how to evaluate, congratulate, and support themselves positively.
Anxiety, Depression (4 years of age to adulthood) (school or clinic based settings)	Friends Program http://nrepp.samhsa.gov/ViewIntervention.aspx?id=334	The Friends Program uses Positive Psychology and Cognitive Behavioral Therapy with adaptations for children by age grouping. Children learn the psychological cues for their anxiety and how to change behavior responses to those cues. Outcomes include reduced anxiety and depression, improved coping, and greater social-emotional strength.
Prevention of depression, drug abuse and drop-out in high risk youth (13 to 18 years of age)	School Transitional Environmental Program (STEP)[12] http://www.promisingpractices.net/program.asp?programid=243	STEP focuses on reducing the stress of transitioning (e.g. from middle school to high school). Homeroom teachers are trained to support successful transition, parents are supported to help their child, and students are assisted to be successful in school and relationships. Outcomes include improved attendance; higher grades; less drop-out; and less self-reported depression, substance abuse, and delinquent acts.

PTSD / Trauma / Bullying *Please see the National Traumatic Stress Network for Evidence Based Practices and Training Resources: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices#q4*		
Post Traumatic Stress Disorder (multiple traumas (6 to 19 years of age) (children of immigrants, refugees)	Trauma Systems Therapy (TST) nctsn.org/sites/default/files/assets/pdfs/tst_general.pdf	TST works to assist children and families not only with the multiple traumas/stressors they have experienced but with the stressors of living in a new culture with limited resources (e.g., language, transportation, clothing, knowledge of cultural norms).
Post Traumatic Stress Disorder (PTSD) *(3 to 18 years of age)*	Trauma Focused Cognitive Behavioral Therapy (TF-CBD) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=135	(TF-BCT) is " *the most frequently used treatment, is a short-term intervention that encourages children and youth" … "to become more aware of how their thoughts about the traumatic event affect their reactions and behaviors."* (SAMHSA, 2011 Fact Sheet *Helping Children and Youth Who Have Experienced Traumatic Events* - May 3, 2011 Retrieved from: http://systemofcarealumni.org/wp-content/uploads/2011/SAMHSA_Short_Report_2011.pdf)
PTSD, PTSD risk, and comorbidity impairments (12 to 21 years of age)	Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) http://www.nctsn.org/sites/default/files/assets/pdfs/sparcs_general.pdf	SPARCS is an evidence based, short term intervention that can be used in numerous settings. It uses a Cognitive Behavioral Therapy and Dialectical Behavioral Therapy Model.
PTSD, depression, general anxiety from Trauma exposure	Cognitive Behavioral Intervention for Trauma in Schools (CBITS) http://www.promisingpractices.net/program.asp?programid=145	CBITS works with children on processing, through drawing and communication, their traumatic memories and grief. They learn relaxation skills, how to challenge upsetting thoughts and improve problem-solving when these occur. Outcomes included significant differences in clinical depression, PTSD symptoms, and school work.
PTSD (children ages 0 to 18)	Assessment Based Treatment for Traumatized Children: Trauma Assessment Pathway (TAP) http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices#q	TAP can be adapted for Hispanic and other cultures and has been found to be effective with a wide range and number of trauma experiences.
Bullying Prevention 4th to 7th Grades	Bullying Prevention Program[13]	Bullying Prevention Program is an intervention program works within the school, classroom, and with an individual. Outcomes reported includes: significant reduction in: bullying, vandalism, fighting, thefts, and truancy. Improvements in social relationships and attitudes about schools were reported.
	Parent Child Interaction Therapy (PCIT)	Please see above (page A1-page 5 under Conduct Disorders in Children and Youth
AD/HD		
AD/HD ((ages 8 to 14 years)	HeartMath: Coherence Training in Children with ADHD http://nrepp.samhsa.gov/ViewIntervention.aspx?id=307	HeartMath uses 6 to 12 brief sessions or more as needed to learn "coherence building" skills to sustain attention emotional self-regulation. Children learn to monitor their pulse rates as they learn to use rhythmic breathing and positive feelings while viewing results on a computer and engaging in various games.
AD/HD and related disruptive behaviors (Grades 1 6) and teen version (Grades 7-10)	Children's Summer Treatment Program (STP) http://nrepp.samhsa.gov/ViewIntervention.aspx?id=8	STP assists with peer relationships, classroom, and parenting skills. Includes an intensive summer treatment program and school follow-up.
(Also see page-3 - SAMHSA Toolkit Interventions for Disruptive Behavior Disorder and The Incredible Years and Triple P – Positive Parenting above in section on Prevention, Resiliency, Protective Factors and Early Intervention (page 8)		

Autism Spectrum Disorders (ASD)[14] *Please see http://autismpdc.fpg.unc.edu/sites/autismpdc.fpg.unc.edu/files/2014_EBP_Report.pdf*		
Autism (Early Childhood and Elementary School)	Functional Communication Training (FCT)	FCT assists children with ASD with communication and negative behaviors.
Autism and Communication Disorders (Pre-school age and their families)	(TEACCH) Treatment and Education of Autism and Related Communication Disorders http://www.autismweb.com/teacch.htm	TEACCH is a University of North Carolina developed community based service that uses a structured teaching framework for intervention. It began as a preschool program for both families and children embracing the characteristics of autism and strengths of each child.
Autism (0 to 14 years of age)	Pivotal Response Training http://autismlab.ucsd.edu/about/pivotal-response-training.shtml	Parents training program to help them help their child respond appropriately in various social and other situations.
Prevention, Resiliency, Protective Factors and Early Intervention – Young Children – http://www.promisingpractices.net/programs.asp		
Prevention - Alcohol/drug abuse, behavior risk, resiliency (Pregnant women and their child through age 2)	Nurse Family Partnership http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=Nurse%20home%20visiting	Nurse home visiting program that addresses risky behaviors in pregnancy and dysfunctional caregiving. Outcomes include numerous economic and quality of life improvements for participant's children ~ less alcohol and drug abuse, fewer behavior problems, less abuse and neglect, less interactions with juvenile justice, fewer teen pregnancies, less violent behavior, more employed, …..
Prevention - Behavior problems, corrections system risk, resiliency protective factors- (3 to 4 year old children from low income households)	High / Scope Perry Preschool http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=18	The High/Scope Perry Preschool tracked children into adulthood and found that quality preschool with trained teachers, using best practices for early development and intellectual stimulation resulted in numerous positive and cost beneficial outcomes in adulthood. Some of these included improved employment, income, self-esteem, educational achievement; and less interaction with law enforcement, or special education placements..
Prevention - Behavior problem, substance dependence risk, (2 - 5 years of age) African American and Hispanic families and children	Dare to Be You http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=65	Targets parenting skills of high-risk families to improve resiliency .Parent training and education program combines didactic lessons with therapist guided practice sessions. Outcomes addressed include behavior problems and substance use and dependence.
Prevention, Mental Health Disorder, Resiliency (birth to12 years)	Triple P Positive Parenting Program [15] http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=1	Triple P is a5-level public health approach of parent education. Level 1 is a universal prevention parenting program utilizing media. Levels 2, 3, 4, and 5 provide targeted care services. Universal applications of Triple P in Australia found 48% of children with behavioral disorders fell below the clinical score for a Mental Health disorder. Parents used tools brought to them from a TV program and the web.
Prevention - Conduct problems, juvenile delinquency (prenatal, infants, toddlers and families continued to elementary school)	Syracuse Family Development / Research Program http://www.promisingpractices.net/program.asp?programid=133	Population target included Single low income African-American in last trimester of pregnancy. Intervention included weekly family visits, quality child care/ preschool setting with infants and toddlers from high risk low-income families to provide parent training and day care. Longitudinal studies reveal less juvenile delinquency, improved mental health, less aggressiveness and negative behaviors, more self-assurance, higher IQ, …
Behavior Disorders, Resiliency (0 to 8 years) parent, teacher, child training	The Incredible Years http://www.promisingpractices.net/program.asp?programid=134	Multi-component program that educates parents on social learning and child development and non-violent discipline techniques as well as helps parents cope with personal and interpersonal problems. Teacher training component helps the teacher learn how to manage misbehavior and develop a plan with parents for behavior management. Child training component promotes competencies and reduced aggression through increased emotional awareness and self-esteem.
Prevention - mental health, physical or emotional abuse trauma, anxiety, mood disorders, resilience, physical health (Parents of Infants)	Family Thriving Program (FTP) http://www.promisingpractices.net/program.asp?programid=271	Home visitation parenting education model where parents are assisted through cognitive reframing of problematic child-parent relationships or biases. Parents develop positive problem solving strategies. Outcomes include significantly improved physical health and less child abuse, neglect and use of corporal punishment.
Prevention of severe and chronic conduct problems (5 to 15 years of age) (settings include elementary /middle school / home)	FAST Track http://www.promisingpractices.net/program.asp?programid=189	FAST Track is a long term intervention program to prevent conduct problems in children identified at high risk in kindergarten. Includes parent training, home visits, and support for child's school work and social skills. Intensive interventions occur during school transitions (e.g., school/grade changes).

Perinatal Disorders		
Perinatal Disorders (Pregnant women and mothers of infants and young children zero to 1 years of age)	Beyond Baby Blues http://thinkgp.com.au/education/beyond-babyblues-detecting-and-managing-perinatal-mental-health-disorders-primary-care	Program to assist primary care professionals in screening for, identifying and helping parents to find services for managing and overcoming perinatal mental health disorders. .
Substance Abuse / Addiction		
Substance abuse & co-occurring mental health / behavioral disorders (Grades 8-12)	Phoenix House Academy http://nrepp.samhsa.gov/ViewIntervention.aspx?id=2	Therapeutic residential community model with co-located school. Program built on belief successful recovery occurs by a holistic approach that also addresses the underlying problems leading to addiction and substance abuse.
Drug Addiction - Use relapse prevention parents and prevention among children of drug addicted parents (children 0 to 12 years)	Focus on Families http://www.promisingpractices.net/program.asp?programid=191	Designed for former heroin addicts currently receiving methadone treatment and their family. The program for children is to build protective factors and reduce risks for substance abuse for them. With therapist guidance children and families learn and implement skills, parents learn how to set family goals, to communicate with and manage the family effectively, to speak with the children about drugs and alcohol, to help children succeed in school and other child rearing skills.
Drug/ Alcohol/ tobacco prevention (14-19 yrs.) School based	Project Towards No Drug Abuse[16]	Students learn consequence of drug/alcohol/tobacco use and how to resist when encounter peer pressure. Students develop communication, stress management, coping, and self-control skills. Results include significant decreases in cigarette, marijuana and hard drug use as well as weapon carrying of males.
Substance Abuse and Disruptive Behaviors Prevention and Early Intervention Hispanic community (6-12 years)	Family Effectiveness Training (FET)[17]	Family-based program for Hispanic/Latino children reduces risk factors and increases protective factors for adolescent substance abuse as well as disruptive behaviors. Assists with family functioning, parent-child conflicts, and parent-child cultural conflicts.
Prevention program (middle school age – school based)	Life Skills Training http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=109	3 year curriculum. Outcomes include reduced tobacco, alcohol, marijuana polypharmacy, inhalants, narcotics, and hallucinogens use.
School, home and community based (6th and 7th grade) (8th-12th grade)	Midwestern Prevention Project / Project STAR http://www.promisingpractices.net/program.asp?programid=72	Evidence based program that includes parent education and youth development. Program develops skills to avoid drug use. Outcomes include significant reductions in smoking, marijuana, alcohol and hard drug use through 12th grade and beyond.
Also see AP 3 page 3 SAMHSA SMI and Co-occurring Substance Use Disorder Toolkit		

Children and Youth removed from their family		
Removed from home, chronic delinquency, substance use, and / or involvement in juvenile justice (ages 12 to 17)	Multidimensional Treatment Fostercare (MTFC) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=48	MTFC is an evidence based practice based on social learning theory, used as an alternative to institutional care for adolescents removed from their home. MTFC helps them live in the community and prepares their family (other support family) to provide a positive home environment that helps youth succeed and recover. Children normally spend 6 to 9 months with foster parents. Outcomes include: reduced days in a locked institutional setting,, decreased substance use, less delinquent acts, improved school attendance and decreased pregnancies among MTFC youth.
Children and Youth removed from their family (continued)		
Children in Foster Care with Emotional & Behavioral Problems (ages 7 to 15) in home	Wrap Around Foster Care http://www.nri-inc.org/reports_pubs/2006/EBPChildrensMatrix2006.pdf http://www.ffta.org/research_outcomes/Practice_Approaches/Wraparound.pdf	Social, mental health, and health services are "wrapped around" the child and foster family and natural family supports are reinforced. Results include: improved permanency and less inattention, withdrawal,, runaway, and length of time in juvenile detention.
Behavioral health crisis (newborn to 21)	Home Based Crisis Intervention (HBCI) http://www.nri-inc.org/reports_pubs/2006/EBPChildrensMatrix2006.pdf http://www.childcenterny.org/homevisitingintro.html	24/7 short term in-home, intensive emergency service for families and youth experiencing a behavioral health crisis and prevent psychiatric hospitalization. Outcomes include: stabilization and less need to remove the child from the home, providing families skills for handling future crisis and service referrals
Behavioral health crisis, mobile crisis intervention/stabilization for (children and youth all ages)	Youth Emergency Services http://www.nri-inc.org/reports_pubs/2006/EBPChildrensMatrix2006.pdf	A mobile crisis clinical team intervenes with crisis stabilization services where child is located. Results include: prevention of hospital emergency department visits and institutional crisis care placements.
Juvenile Justice , Juvenile Offenders		
Youth with severe behavioral, or emotional disorders in Juvenile Detention (males 13 to 17 years of age)	The Mendota Juvenile Treatment Center (MJTC) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=38	MJTC is a 45 to 83 week program providing intensive mental health treatment for the most violent male youth who are in secure correctional institutions as well as social training and school services. MJTC uses a cognitive-behavioral treatment approach combined with a variant of the "Decompression" treatment model and Aggression Replacement Training. MJTC focuses on youth responsibility for their behavior, social skills, treatment for their behavioral health issues, and skills for building positive relationships with their families and others. Outcomes included significantly less recidivism (50% less), 6 times less likely to commit felony offenses, and less aggressive behaviors.
Serious Behavior Problems in Juvenile Offenders (10-17 years) with long arrest histories.	Multi-systemic Therapy (MST) for Juvenile Offenders http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=254	Family and community-based treatment program focusing on the environment of chronic and violent juvenile offenders – their homes, families, schools, teachers, neighborhoods, and friends. Outcomes have included reduction in out-of-home placements up to 50 percent and re-arrest rates up to 70 percent; improvements in family relations and functioning; decreases in adolescent psychiatric symptoms; and adolescent drug and alcohol use.

Adolescents and Young Adults – Transition to Independence

Serious Behavioral Health Disorders (14 – 24 years)	Transition to Independence Process (TIP) http://tip.fmhi.usf.edu/	TIP is "a community-based model for improving outcomes for youth and young adults with emotional/behavioral difficulties" that is evidence based. Research found TIP to be effective in improving educational attainment, employment, self-confidence, self-sufficiency, and behavioral health.
Mental Health Disorders & Advocates (University Age)	Active Minds http://www.activeminds.org/	Active Minds combats stigma on college campuses by creating a place for sharing, acceptance, advocacy, self-help, and supporting the recovery journey. In the process, tragedies are prevented, staff / students learn about mental health

Adolescents and Young Adults – Transition to Independence – Transition to Independence continued

Foster Children with and without Mental Health Conditions (14-21 years of age)	The Independent Living Program https://www.childwelfare.gov/outofhome/independent/	Extended foster care program to assist youth aging out of the foster care system d transition to independence safely, continue education and/or find employment and avoid homelessness.. This is a vulnerable time for youth and young adults who do not have "forever families" and especially those with behavioral health conditions. States can apply for grants to assist youth develop skills necessary to living on one's own, including housing, finances, employment, health, and further education.

Adults and Juveniles

Mental Health, Substance Abuse, a Corrections, and Reentry Support

Co-occurring disorders, Mental Health, Substance Abuse (13 to 55 years of age) Corrections population	Moral Recognition Therapy (MRT) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=34	Cognitive-behavioral treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Outcomes include reduced recidivism, and improved principled reasoning and perceptions of meaning/purpose in life.
Addiction (26 to 55 years of Age) Settings include outpatient and correctional	Living in Balance (LIB) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=72	LIB consists of 12 core and 21 supplemental (1.5 to 2 hour sessions) and is a comprehensive addiction treatment program that focuses on relapse prevention. Outcomes include: significant likelihood of continuation in treatment program, less relapse, less drug related illegal activities
Addiction, Probation/Parolees (18 to 55 years) Corrections & Community settings	Friends Care www.nrepp.samhsa.gov/ViewIntervention.aspx?id=143	Program extends and maintains drug treatment gains after a probationer or parolee leaves a court ordered program for 6 months. Friends care helps clients develop and strengthen supports for drug-free living in the community. Includes individual counselling and case management to strengthen family/peer support/job skills/education/crisis intervention, and other skills that may be needed to succeed drug and crime free.
Drug and alcohol abuse also treats accompanying mental health disorders (women) (26 to 55 years), Corrections/aftercare/community parolee	Forever Free www.nrepp.samhsa.gov/ViewIntervention.aspx?id=118	Four to 6 month, days a week program for incarcerated women and women on parole with drug abuse and behavior problems. Individual Substance abuse counseling, 12 step program/ special workshops/parole planning/self- esteem /anger management/PTSD/ other behavioral health disorders. After discharge from corrections and graduating from program, participants may enter residential or other treatment services in the community. California program found significantly fewer participants using drugs, less returning to prison, and more were employed.
Co-occurring substance use and mental health disorders (residential community treatment and corrections population(25 to 55 years of age)	Modified Therapeutic Community for Persons with Co-Occurring disorders (MTC) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=144	MTC is a 12- to 18-month is an intensive, long-term residential treatment program that modified the traditional treatment model to meet the special needs/issues of co-occurring disorders. Results include: less frequent alcohol intoxication and use of illegal drugs, decrease in criminal behaviors, increased employment, less use of emergency and other health care) and decreased psychological problems.

Co-occurring Mental Health and Substance Use Disorders (Jail Re-entry) (18 to 55 years)	APIC Jail Re-entry - GAINS Center model http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf	Prepares persons with behavioral health disorders to reenter the community. Consists of 4 stages of transition planning to assist and ensure the best possible outcome by addressing clinical, medical, housing, income, transportation, employment, social, and other essential issues that will need to be in place in order that the individual who is released from prison is able to maintain health and wellness and succeed in the community.
Co-occurring Disorders, Diversion	SAMHSA GAINS Center http://gainscenter.samhsa.gov/	SAMHSA's Gains Center site provides information on best practices for diversion and treatment at each step of the corrections system – prior to incarceration to after care and release.
ADULTS - GENERAL		
Severe Mental Illness, Homelessness prevention, Institutional Care transition (18 to 55+ years of age)	Critical Time Intervention (CTI) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=125	Evidence based nine month program which works to strengthen ties to family, services and friend and give support during the transition to community living. CTI aims to prevent homelessness, emergency health care, and the cycle of poor outcomes that can occur when individuals lack treatment and support in the community to handle their disorder(s). NREPP, SAMHSA Evidence –based Program)
Substance Abuse Relapse Co-occurring disorders (18 to 55+ years of age) Outpatient setting	Relapse Prevention Therapy (RPT) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=97	Cognitive and behavioral treatment techniques designed to develop and train in use of coping skills and behavioral self-control to reduce and prevent relapse of substance disorders.
Depression (rural primary care integration) (Ages 26 to 55+)	Telemedicine-Based Collaborative Care www.nrepp.samhsa.gov/ViewIntervention.aspx?id=127	Eight to 10 month telemedicine care model for depression treatment using an on-site primary care team and off--site psychiatric services in rural areas without community access to psychiatric services.
Depression and health care (primary health care integration) (Ages 26 to 55+)	Partners in Care (PIC) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=126	Model for integrated mental, addiction and medical health care within a managed primary care setting.
PTSD & accompanying Depression, Anxiety and Anger) (Ages 18 to 55+)	Prolonged Exposure Therapy for Posttraumatic Stress Disorders (PE) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=89	Eight to 15 session twice weekly for 90 minutes to assist individuals with PTSD from a single or multiple events. PE is an adapted cognitive-behavioral treatment program and treatment duration is adjustable to individual needs.
Older Adults		
Schizophrenia and other serious mental illnesses (ages 26-55+)	Cognitive Behavioral Social Skills Training (CBSST) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=149	CBSST is an evidence based program delivered by trained mental health professionals skilled in working with the older adult population. It utilizes CBT cognitive and behavioral coping techniques and SST Social Skills Training to assist individuals with serious emotional disorders achieve improved functioning in the community. The program
Schizophrenia / Schizoaffective disorder (ages 40 +) (in board-and-care facilities)	**Functional Adaptation Skills Training (FAST)** www.nrepp.samhsa.gov/ViewIntervention.aspx?id=92	FAST utilizes a social cognitive theory model and an independent living program to improve independence and quality of life. Group meetings are led by a professional and occur once per week for 24 weeks. Medication management, social skills, communication, organization, planning, transportation, and financial management are included in the sessions.
Depression and Illness Management (older adults with chronic health conditions) (ages 55+) Outpatient community program at multiple sites	**EnhanceWellness** www.nrepp.samhsa.gov/ViewIntervention.aspx?id=188	Prevention and illness management program model for older adults with chronic health conditions including mental health conditions. Assists individuals to self-manage their illnesses and minimize the over use of prescription psychoactive medications, lack of physical inactivity, depression symptoms, and lack of interactions with others. Program offers a peer support mentor.

Depression, Dysthymic disorder, comorbid panic, PTSD and/or chronic medical disorder (older adults ages 55+) Also used for younger adult populations	**IMPACT** (Improving Mood-Promoting Access to Collaborative Treatment) www.nrepp.samhsa.gov/ViewIntervention.aspx?id=105	The intervention is normally up to a 1-year with various collaborative care approaches. A nurse, social worker, or psychologist works with the patient's regular primary care provider to develop and implement a course of treatment and support.
Minor Depression, Dysthymic disorder (older adults)	**PEARLS** (Program to Encourage Active Rewarding Lives for Seniors) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=29	In home program to reduce depression symptoms and older adults quality of life. PEARLS is a depression care management model, utilizing a systematic and team-based approach to depression treatment in older adults.
Older Adults continued		
Depression, Dysthymic disorder (older adults with chronic health conditions) (older adults 60+ years of age)	**Healthy IDEAS** (Identifying Depression, Empowering Activities for Seniors) www.cdc.gov/aging/pdf/mental_health_brief_2.pdf	Healthy Ideas is program implemented in community and in-home settings which assists in the identification and treatment of depression in older adults, especially individuals with mobility limitations and other chronic conditions. The program also seeks to improve linkages with and between community aging service providers.
Depression and Suicide Prevention (55+ years)	**PROSPECT** (Prevention of Suicide in Primary Care Elderly: Collaborative Trail) http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=257	Works to prevent suicide among older adults through education primary care physicians on identifying and providing best practice treatments, referrals and management of depression.
SCREENING TOOLS		
Depression, Suicide, Suicide Ideation Primary Care, Obstetrical Care settings	The Patient Health Questionnaire (PHQ-9) http://www.cqaimh.org/pdf/tool_phq9.pdf and/or http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/	PHQ9 is a self-administered 9 question instrument designed to be used in primary care settings for screening diagnosing, monitoring and determining the severity of depression.
Suicide Children, Adolescents, Adults	SAFE-T Suicide Assessment Five Step Evaluation and Triage http://www.integration.samhsa.gov/images/res/SAFE_T.pdf and/ or http://www.sprc.org/sites/sprc.org/files/library/jcsafetygoals.pdf	For youths and adults and conducted by a Mental Health Professional. Five steps include (1) Identify risk factors, identify protective factors, conduct suicide inquiry, (4) Identify risk level/intervention, (5) Documenting
Alcohol and Substance Abuse	SBIRT – Screening, Brief Intervention, and Referral to Treatment http://www.samhsa.gov/prevention/sbirt/	SBIRT is an evidence based community- approach that can be used in multiple health care and community settings (clinics, hospitals, doctor's offices). It has 3 major interrelated components that start with screening by a health care professional in a health care setting using standardized screening tools followed by a brief intervention for patients with risky substance misuse behaviors and referral to treatment for patients who are in need of therapy and additional services. Project Assert (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=222) and the Brief Negotiation Interview for Harmful and Hazardous Drinkers, (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=343) adaptations of SBIRT for specific settings, have also been found to be effective. See

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Appendix 2

Indicators

1. **Education -** Proportion of children with behavioral health disorders who receive an education that prepares them for independence in adulthood.
   1.1. High school graduation rate of youth with behavioral health disorders, exceptional education students and students without disabilities
   1.2. Drop-out rate of youth with behavioral health disorders, exceptional education students and students without disabilities
   1.3. District Schools with school based mental health services
   1.4. District Schools with active Positive Behavioral Interventions and Supports (PBIS)[1]

2. **Suicide -** (Rate per 100,000)

3. **Peer Support Services -**
   3.1. GA Counties with Peer Support and Wellness Centers
   3.2. GA Counties with Peer Support Addiction Services
   3.3. GA Counties with Peer Support Children's Services

4. **Substance Abuse**
   4.1. Binge drinking of alcohol substances
   4.2. Past month use of illicit substances

5. **Positive Mental Health -** Proportion of the population experiencing positive mental health.
   5.1. Depressive episodes among adolescents
   5.2. Major depressive episode experienced by adults (18+)

6. **Housing - Access to appropriate safe, affordable housing that meets the recovery needs for persons with behavioral health disorders**
   6.1. Permanent Supportive Housing Beds
   6.2. Homeless

7. **Employment** - Percent of persons with serious mental illness who are employed

8. **Whole Health Care - Integrated Primary and Behavioral Health Care**
   8.1. Proportion of Community Service Boards (CSBs) who have formalized and implemented integration of Primary Care and Mental Health Care with Primary Care providers

9. **Access to Behavioral Health Care Services**
   9.1. Children (aged 2 to 17) needing mental health care in the past 12 months, who received treatment from a mental health professional
   9.2. Adults aged 18 years and older with serious mental illness (SMI) receiving mental health care in the past 12 months
   9.3. Needing but not receiving treatment for alcohol use in the past year

Indicator Measures

1. **Education -** Proportion of children with behavioral health disorders who receive an education that prepares them for independence in adulthood. Children with behavioral health disorders are less likely to graduate and more likely to drop-out of school than all children with disabilities and children without disabilities.

1.1 School graduation rate of youth with behavioral health disorders

High School Graduation	Georgia
2009	32%
2010	38%

Data Source: Georgia Department of Education

1.2 Drop-out rate of youth with Behavioral Health Disorders

School Drop-out rate	Georgia
2009	9.8%
2010	9.5%

Data Source: Georgia Department of Education.

1.3 District Schools with school based mental health services

Data Source: Georgia Department of Education.

1.4 District Schools with Positive Behavioral Interventions and Supports (PBIS)

Data Source: Georgia Department of Education.

2. **Suicide**

Over 90% of people who die by suicide suffer from one or more behavioral health disorders; 70% tell someone about their plan and few are receiving treatment for their disorder. The risk for committing suicide increases with comorbid disorders especially when a person suffers from both depressive disorders and substance use.[2] For every person who commits suicide, 11 more attempt to kill themselves.

Suicide (per 100,000)				
	Baseline 2007		2008	
	GA	US	GA	U.S.
	Rate (#)	Rate	Rate (#)	Rate (#)
All Ages	10.46 (#=997)	11.47	10 0 (# 967)	
13 to 19 year olds	3.21 (#=31)	5.38	4.6 (# 44)	
75+ year olds	18.38 (#=77)	16.11	18.5 (# 79)	

Data Source. National Vital Statistics System (NVSS), CDC, NCHS. The 2007 data was gathered from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. WISQUARS, http://webappa.cdc.gov/cgi-bin/broker.exe. Georgia 2008 data was gathered from the Online Analytical Statistical Information System (OASIS) Georgia Department of Public Health, Division of Public Health, Office of Health Information and Policy. July 30, 2011. http://oasis.state.ga.us/
Note. Suicide is a Mental Health Indicator measure for Healthy People 2020.

3. **Peer Support Services -** Proportion of GA counties with peer support services

Peer Support Services	GA Counties with Peer Support and Wellness Centers	GA Counties with Peer Support Addiction Services	GA Counties with Peer Support Children's Services
2011 baseline			

4. **Substance Abuse -** Proportion of population engaged in substance abuse

4.1Binge Drinking -

"Excessive alcohol use* accounted for an estimated average of 80,000 deaths and 2.3 million years of potential life lost (YPLL)† in the United States each year during 2001–2005, and an estimated $223.5 billion in economic costs in 2006 [3](1). Binge drinking accounted for more than half of those deaths, two thirds of the YPLL [4](2), and three quarters of the economic costs (1). Binge drinking also is a risk factor for many health and social problems, including motor-vehicle crashes, violence, suicide, hypertension, acute myocardial infarction, sexually transmitted diseases, unintended pregnancy, fetal alcohol syndrome, and sudden infant death syndrome [5] (3)" (MMWR Weekly, January 13, 2012 / 61(01);14 (http://www.cdc.gov/mmwr))

High School Students - Percentage of high school students who had five or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 days.

Binge Drinking High School Students	Georgia	U.S.
2007	19.0%	26.0%
2009	18.8%	24.2%
2011	17.5%	

Data Source: Youth Risk Behavior Surveillance System (YRBSS).[6,7]

Binge Drinking - Adults - Binge drinking for adult males was defined as having five or more drinks and for adult females as having four or more drinks on at least one occasion during the last 30 days.

Binge Drinking	Adults GA	Adults U.S.	≥ age 65 GA	≥ age 65, U.S.
2007	12.6%	15.7%		
2010	15.4%	17.1%		3.8%

Data Source: Behavioral Risk Factor Surveillance System (BFRSS).[8]

Note. Healthy People 2020 indicator Healthy People 2020 data source is the National Survey on Drug Use and Health (NSDUH), SAMHSA.

4.2 Illicit Substance Use[9]

Past Month Use of Illicit Drug Use	2004-2005 Georgia	2005-2006 Georgia	2005-2006 U.S.
12 to 17 s	8.81	8.71%	9.84%
18 to 25	17.39	18.04%	19.97%
26 +	5.52	5.83%	5.91%

Data Source: National Surveys on Drug Use and Health
Note. Healthy People 2020 indicator

5. **Positive Mental Health -** Proportion of the population experiencing positive mental health. Major depression[10] is a mental health disorder that is treatable and affects a large proportion of the population. Depression often begins in adolescence and early adulthood (18 to 24 years of age). Persons with chronic conditions such as cardiovascular disease, cancer, asthma, and obesity are at higher risk for major depressive disorder. Prevalence is also greater among women, young adults, middle aged adults, those with a lower educational attainment, and individuals who have never been married.

5.1 Major Depressive episodes among adolescents
Percentage of High School students who felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing some usual activities during the last 12 months.

Major Depressive episodes among adolescents	Georgia	U.S.
2007	29.8%	28.5%
2009	28.8%	26.1%

Data Source: Youth Risk Behavior Surveillance System (YRBSS).
Note. Healthy People 2020 uses the National Survey on Drug Use and Health as its data source. Georgia Voices data source is the YBRSS.

5.2 Major Depressive Episodes (MDE) among Adults (18+ years)[11]
Percentage having at least one MDE in past year. MDE is defined as a period of at least 2 weeks within a year that a person experiences depression as detailed in the ***Diagnostic and Statistical Manual of Mental Disorders*** (DSM-IV).with a majority of the nine symptoms for depression.

Major Depressive - Adults	Georgia 18 and Older	Georgia 18 - 25	Georgia 26 or Older
2004 &2005	7.96%	8.37	7.88%
2005 &2006	7.15%	8.48%	6.91%
	U.S. 18 and Older	U.S. 18 - 25	U.S. 26 or Older
2004 &2005	7.65%	9.93%	7.25%
2005 &2006	7.25%	9.36%	6.88%

Data Source. National Survey on Drug Use and Health (NSDUH), SAMHSA. This is a mental health indicator measure for Healthy People 2020.

6. **Housing -** Access to appropriate safe, affordable housing that meets the recovery needs for persons with behavioral health disorders.

6.1 Permanent Supportive Housing Beds

Year	Permanent Supportive Housing Beds
2008-2009	2,608[12]

Data Source. [13] Georgia Department of Community Affairs Statewide Bed Inventory, Georgia Homeless Management Information System.

6.2 Homeless - Twenty to 25% of homeless are estimated to have a serious mental illness.[14]

Year	Homeless
2008-2009	21,095 [15]

Data Source. [16] Georgia Department of Community Affairs Statewide Bed Inventory, Georgia Homeless Management Information System.

7. **Employment -** Percent of persons with serious mental illness (SMI) who are employed. Persons who experience serious behavioral health disorders have difficulty finding and maintaining employment.[17]

Year	GA Percent with SMI employed	U.S. Percent with SMI employed
2008-2009 Baseline		58.5% [18]

Data Source. National Survey on Drug Use and Health (NSDUH). Data will be available for states.
Note. This is a Healthy People 2020 indicator for Mental Health

8. **Integrated Care-**
   8.1. **Number of Georgia Community Service Boards (CSBs)** that have formalized and implemented integration efforts with primary care partners.

   Data Source. Carter Center Mental Health Program Integrated Care project with Georgia Community Service Boards.

9. **Access to Behavioral Health Care Services**

9.1 Children (aged 2 to 17) needing mental health care in the past 12 months, who received mental health treatment or counseling.

Children 2 to 17 years who received mental health treatment/counseling.	2007
Georgia	41.1%
U.S.	45.6%

Data Source. The National Survey of Children's Health

9.2. Adults with serious mental illness (SMI) receiving mental health care in the past 12 months.

	Georgia	U.S.
2008		58.7%

Data Source. National Survey on Drug Use and Health (NSDUH), SAMHSA.
Note. This is a Healthy People 2020 indicator measure for Mental Health.

9.3 Needing but not receiving treatment for alcohol use in the past year

Needing but not receiving treatment for alcohol use	Georgia 12 to 17	Georgia 18 - 25	Georgia 26 or Older
2004 &2005	4.07%	11.79%	4.82%
2005 &2006	4.29%	13.64%	5.62%
	U.S. 12 to 17	U.S. 18 - 25	U.S. 26 or Older
2004 &2005	5.51%	16.92%	5.93%
2005 &2006	5.22%	17.03%	5.88%

Data Source. National Survey on Drug Use and Health (NSDUH), SAMHSA.
Note. This is a Healthy People 2020 indicator measure for Substance Abuse.

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Appendix 3

County Data Tables

Table Ap3-1 Georgia 2010 Population Estimates and Estimated Prevalence of Behavioral Health Disorders by Age

Table Ap3-2 Georgia Homeless and At-Risk of Homelessness Estimates

Table Ap3-3 Georgia Students with an Emotional and Behavioral Disorder by District School System FY 2010

Table Ap3-4 Children served by the Georgia Department of Human Resources, Division of Family and Children Services at Risk of a Behavioral Health Disorder(s).

Table Ap3-5 Suicide Rate and Change between 2002-2004 and 2005-2007 by age group (per 100,000)

Table Ap3-6 Georgia Department of Corrections Inmates in January 2011 with a Serious Mental Illness and Estimates Released in 2010 Who Needed Housing

Table Ap3-7 Georgia's Counties with Access to Mental Health, Drug, and Veterans Courts (July 2011)

This data is provided to assist communities in planning services and supports for individuals with behavioral health disorders and those at risk.

It is hoped that planning data can be updated and made available on a regular basis so that communities can monitor progress and needs for achieving the vision that persons with behavioral disorders can recover and live meaningful lives with friends and family in their communities.

County data that might be helpful to communities not included in this appendix are: (1) juveniles with mental health disorders served by the Georgia Department of Juvenile Justice, (2) graduation and drop-out rates of students with emotional and behavioral disorders by school district, (3) numbers of children with mental health disorders identified and served by the Division of Family and Children's Services, (4) the availability of supportive housing units, and (5) availability of mental health providers, (6) first responders who received Crisis Intervention Training and (7) number of schools per school district who have received Mental Health First Aid Training or similar training. More county and district data may be made available in the final document.

Table Ap3-1 2010 Georgia Population Estimates and Estimated Prevalence of Behavioral Health Disorders, by Age

	Population	Under Age 5	Age 5 to 9		Age 9 to 17		Age 18 to 64					Age 65 plus	
			Prevalence		Prevalence		Prevalence			Prevalence			Prevalence
	Total	< 5 yrs	With SED (1)	5 -9	With SED (1)	9- 17	With SED (2)	Extreme Impairment (2)	18-64	Serious Disorder(3)	Any Disorder (3)	65Plus	Any Disorder(4)
			7.4%		7.4%		11%	5%		5.8%	26.2%		20%
Georgia	9,687,653	686,785	50,822	695,161	51,442	1,254,716	138,019	62,736	6,157,989	357,163	1,613,393	1,032,035	206,407
Appling	18,236	1,306	97	1,286	95	2,341	257	117	11,105	644	2,909	2,456	491
Atkinson	8,375	708	52	648	48	1,202	132	60	5,056	293	1,325	890	178
Bacon	11,096	825	61	796	59	1,347	148	67	6,807	395	1,784	1,480	296
Baker	3,451	220	16	222	16	401	44	20	2,123	123	556	530	106
Baldwin	45,720	2,775	205	2,647	196	5,437	598	272	29,883	1,733	7,829	5,508	1,102
Banks	18,395	1,132	84	1,315	97	2,443	269	122	11,468	665	3,005	2,300	460
Barrow	69,367	5,832	432	5,634	417	9,108	1,002	455	43,448	2,520	11,383	6,472	1,294
Bartow	100,157	6,980	517	7,572	560	13,542	1,490	677	62,967	3,652	16,497	10,611	2,122
Ben Hill	17,634	1,398	103	1,279	95	2,217	244	111	10,528	611	2,758	2,468	494
Berrien	19,286	1,325	98	1,410	104	2,454	270	123	11,715	679	3,069	2,664	533
Bibb	155,547	11,465	848	10,931	809	20,085	2,209	1,004	95,563	5,543	25,037	19,689	3,938
Bleckley	13,063	754	56	766	57	1,976	217	99	7,749	449	2,030	1,971	394
Brantley	18,411	1,326	98	1,284	95	2,467	271	123	11,331	657	2,969	2,260	452
Brooks	16,243	1,095	81	1,041	77	1,901	209	95	9,854	572	2,582	2,560	512
Bryan	30,233	2,203	163	2,499	185	4,477	492	224	18,839	1,093	4,936	2,715	543
Bulloch	70,217	4,197	311	4,044	299	9,714	1,069	486	46,670	2,707	12,227	6,401	1,280
Burke	23,316	1,774	131	1,893	140	3,243	357	162	14,018	813	3,673	2,767	553
Butts	23,655	1,425	105	1,486	110	2,724	300	136	15,332	889	4,017	2,985	597
Calhoun	6,694	368	27	398	29	649	71	32	4,562	265	1,195	797	159
Camden	50,513	3,983	295	3,680	272	6,769	745	338	32,261	1,871	8,452	4,556	911

Candler	10,998	788	58	805	60	1,379	152	69	6,603	383	1,730	1,584	317
Carroll	110,527	7,803	577	7,878	583	14,918	1,641	746	69,395	4,025	18,182	12,108	2,422
Catoosa	63,942	4,084	302	4,426	328	8,196	902	410	39,465	2,289	10,340	8,656	1,731
Charlton	12,171	728	54	691	51	1,360	150	68	7,987	463	2,093	1,543	309
Chatham	265,128	18,526	1,371	16,475	1,219	30,046	3,305	1,502	170,512	9,890	44,674	32,864	6,573
Chattahoochee	11,267	1,071	79	892	66	1,576	173	79	7,486	434	1,961	420	84
Chattooga	26,015	1,578	117	1,610	119	2,987	329	149	16,361	949	4,287	3,801	760
Cherokee	214,346	15,801	1,169	17,353	1,284	28,593	3,145	1,430	136,372	7,910	35,729	19,698	3,940
Clarke	116,714	6,960	515	5,679	420	13,194	1,451	660	82,065	4,760	21,501	9,952	1,990
Clay	3,183	205	15	199	15	355	39	18	1,841	107	482	623	125
Clayton	259,424	21,939	1,623	20,779	1,538	36,322	3,995	1,816	167,304	9,704	43,834	17,236	3,447
Clinch	6,798	526	39	529	39	863	95	43	4,118	239	1,079	868	174
Cobb	688,078	48,318	3,576	49,463	3,660	87,323	9,606	4,366	452,895	26,268	118,658	59,972	11,994
Coffee	42,356	3,113	230	3,035	225	5,646	621	282	26,478	1,536	6,937	4,691	938
Colquitt	45,498	3,788	280	3,456	256	5,976	657	299	27,107	1,572	7,102	5,863	1,173
Columbia	124,053	8,305	615	9,424	697	17,538	1,929	877	77,971	4,522	20,428	12,700	2,540
Cook	17,212	1,305	97	1,288	95	2,306	254	115	10,250	595	2,686	2,320	464
Coweta	127,317	9,283	687	9,748	721	17,204	1,892	860	79,791	4,628	20,905	13,240	2,648
Crawford	12,630	728	54	771	57	1,507	166	75	8,116	471	2,126	1,662	332
Crisp	23,439	1,696	126	1,679	124	3,037	334	152	14,090	817	3,691	3,273	655
Dade	16,633	912	67	949	70	2,086	229	104	10,479	608	2,746	2,397	479
Dawson	22,330	1,275	94	1,445	107	2,599	286	130	14,168	822	3,712	3,132	626
Decatur	27,842	1,867	138	1,931	143	3,692	406	185	16,859	978	4,417	3,879	776
DeKalb	691,893	50,407	3,730	45,290	3,351	78,641	8,650	3,932	464,385	26,934	121,669	62,228	12,446
Dodge	21,796	1,355	100	1,308	97	2,718	299	136	13,662	792	3,579	3,015	603
Dooly	14,918	857	63	882	65	1,599	176	80	9,702	563	2,542	2,055	411
Dougherty	94,565	7,150	529	6,711	497	12,633	1,390	632	57,956	3,361	15,184	11,457	2,291
Douglas	132,403	9,732	720	10,357	766	19,085	2,099	954	84,056	4,875	22,023	11,244	2,249
Early	11,008	717	53	809	60	1,508	166	75	6,344	368	1,662	1,791	358

Echols	4,034	358	26	332	25	539	59	27	2,473	143	648	398	80
Effingham	52,250	3,668	271	4,153	307	7,754	853	388	32,743	1,899	8,579	4,763	953
Elbert	20,166	1,311	97	1,226	91	2,419	266	121	12,065	700	3,161	3,390	678
Emanuel	22,598	1,656	123	1,570	116	2,824	311	141	13,700	795	3,590	3,162	632
Evans	11,000	847	63	857	63	1,309	144	65	6,653	386	1,743	1,505	301
Fannin	23,682	1,131	84	1,272	94	2,335	257	117	14,001	812	3,668	5,197	1,039
Fayette	106,567	4,913	364	7,455	552	16,280	1,791	814	65,865	3,820	17,257	13,545	2,709
Floyd	96,317	6,521	483	6,559	485	12,180	1,340	609	58,666	3,403	15,371	13,702	2,740
Forsyth	175,511	13,593	1,006	16,640	1,231	25,383	2,792	1,269	107,585	6,240	28,187	15,638	3,128
Franklin	22,084	1,291	96	1,379	102	2,631	289	132	13,330	773	3,492	3,729	746
Fulton	920,581	62,581	4,631	61,510	4,552	110,084	12,109	5,504	615,284	35,686	161,204	83,424	16,685
Gilmer	28,292	1,670	124	1,680	124	3,163	348	158	17,100	992	4,480	5,015	1,003
Glascock	3,082	199	15	220	16	420	46	21	1,822	106	477	465	93
Glynn	79,626	5,352	396	5,348	396	9,491	1,044	475	48,528	2,815	12,714	11,976	2,395
Gordon	55,186	4,110	304	4,142	307	7,346	808	367	33,993	1,972	8,906	6,423	1,285
Grady	25,011	1,890	140	1,785	132	3,056	336	153	15,101	876	3,956	3,536	707
Greene	15,994	898	66	959	71	1,602	176	80	9,369	543	2,455	3,358	672
Gwinnett	805,321	62,242	4,606	66,698	4,936	115,643	12,721	5,782	518,972	30,100	135,971	55,105	11,021
Habersham	43,041	2,885	213	2,953	219	5,100	561	255	26,094	1,513	6,837	6,599	1,320
Hall	179,684	14,123	1,045	14,573	1,078	24,200	2,662	1,210	109,692	6,362	28,739	20,010	4,002
Hancock	9,429	433	32	415	31	938	103	47	6,258	363	1,640	1,468	294
Haralson	28,780	1,848	137	2,085	154	3,705	408	185	17,523	1,016	4,591	4,036	807
Harris	32,024	1,762	130	2,104	156	4,071	448	204	20,270	1,176	5,311	4,238	848
Hart	25,213	1,542	114	1,522	113	2,854	314	143	15,073	874	3,949	4,527	905
Heard	11,834	746	55	822	61	1,609	177	80	7,257	421	1,901	1,565	313
Henry	203,922	13,835	1,024	16,514	1,222	31,668	3,484	1,583	128,159	7,433	33,578	17,048	3,410
Houston	139,900	10,211	756	10,345	766	18,686	2,055	934	88,156	5,113	23,097	14,571	2,914
Irwin	9,538	602	45	658	49	1,183	130	59	5,742	333	1,504	1,485	297
Jackson	60,485	4,313	319	4,675	346	7,862	865	393	37,373	2,168	9,792	7,197	1,439

Jasper	13,900	946	70	976	72	1,725	190	86	8,684	504	2,275	1,764	353
Jeff Davis	15,068	1,183	88	1,190	88	2,009	221	100	9,050	525	2,371	1,874	375
Jefferson	16,930	1,171	87	1,221	90	2,089	230	104	10,195	591	2,671	2,498	500
Jenkins	8,340	613	45	607	45	1,145	126	57	4,840	281	1,268	1,256	251
Johnson	9,980	550	41	585	43	1,055	116	53	6,518	378	1,708	1,389	278
Jones	28,669	1,890	140	2,027	150	3,864	425	193	17,707	1,027	4,639	3,586	717
Lamar	18,317	1,087	80	1,056	78	2,412	265	121	11,486	666	3,009	2,487	497
Lanier	10,078	896	66	729	54	1,264	139	63	6,231	361	1,632	1,104	221
Laurens	48,434	3,462	256	3,489	258	6,134	675	307	29,163	1,691	7,641	6,884	1,377
Lee	28,298	1,865	138	2,261	167	4,163	458	208	18,107	1,050	4,744	2,354	471
Liberty	63,453	6,552	485	5,244	388	8,587	945	429	40,148	2,329	10,519	3,971	794
Lincoln	7,996	420	31	415	31	888	98	44	4,960	288	1,299	1,396	279
Long	14,464	1,355	100	1,198	89	2,086	229	104	9,010	523	2,361	1,055	211
Lowndes	109,233	8,264	612	7,329	542	14,540	1,599	727	69,873	4,053	18,307	10,693	2,139
Lumpkin	29,966	1,765	131	1,688	125	3,678	405	184	19,379	1,124	5,077	3,794	759
McDuffie	21,875	1,559	115	1,576	117	2,842	313	142	13,241	768	3,469	2,972	594
McIntosh	14,333	785	58	799	59	1,628	179	81	8,803	511	2,306	2,478	496
Macon	14,740	857	63	838	62	1,726	190	86	9,660	560	2,531	1,827	365
Madison	28,120	1,727	128	1,888	140	3,605	397	180	17,523	1,016	4,591	3,754	751
Marion	8,742	569	42	568	42	1,084	119	54	5,420	314	1,420	1,215	243
Meriwether	21,992	1,429	106	1,422	105	2,652	292	133	13,307	772	3,486	3,467	693
Miller	6,125	423	31	406	30	686	75	34	3,568	207	935	1,123	225
Mitchell	23,498	1,732	128	1,561	116	2,883	317	144	14,548	844	3,811	3,087	617
Monroe	26,424	1,461	108	1,645	122	3,144	346	157	16,834	976	4,411	3,669	734
Montgomery	9,123	552	41	560	41	1,174	129	59	5,776	335	1,513	1,173	235
Morgan	17,868	1,026	76	1,218	90	2,371	261	119	10,723	622	2,809	2,774	555
Murray	39,628	2,822	209	3,019	223	5,378	592	269	24,727	1,434	6,479	4,286	857
Muscogee	189,885	14,135	1,046	13,226	979	24,317	2,675	1,216	118,770	6,889	31,118	22,082	4,416
Newton	99,958	7,563	560	8,105	600	14,683	1,615	734	61,398	3,561	16,086	9,830	1,966

Oconee	32,808	1,924	142	2,693	199	5,006	551	250	20,145	1,168	5,278	3,578	716
Oglethorpe	14,899	877	65	987	73	1,868	205	93	9,251	537	2,424	2,114	423
Paulding	142,324	11,186	828	12,510	926	21,280	2,341	1,064	89,630	5,199	23,483	10,220	2,044
Peach	27,695	1,831	135	1,695	125	3,880	427	194	17,464	1,013	4,576	3,164	633
Pickens	29,431	1,742	129	1,935	143	3,306	364	165	18,030	1,046	4,724	4,805	961
Pierce	18,758	1,309	97	1,400	104	2,426	267	121	11,272	654	2,953	2,631	526
Pike	17,869	1,011	75	1,400	104	2,645	291	132	10,897	632	2,855	2,196	439
Polk	41,475	3,307	245	3,142	233	5,223	575	261	24,896	1,444	6,523	5,535	1,107
Pulaski	12,010	707	52	734	54	1,287	142	64	7,547	438	1,977	1,882	376
Putnam	21,218	1,346	100	1,276	94	2,195	241	110	12,811	743	3,357	3,845	769
Quitman	2,513	133	10	147	11	272	30	14	1,437	83	376	554	111
Rabun	16,276	817	60	868	64	1,850	204	93	9,456	548	2,477	3,459	692
Randolph	7,719	499	37	437	32	912	100	46	4,582	266	1,201	1,376	275
Richmond	200,549	14,851	1,099	13,400	992	24,727	2,720	1,236	127,539	7,397	33,415	22,712	4,542
Rockdale	85,215	5,763	426	6,049	448	12,071	1,328	604	53,476	3,102	14,011	9,066	1,813
Schley	5,010	318	24	452	33	800	88	40	2,874	167	753	657	131
Screven	14,593	993	73	898	66	1,913	210	96	8,795	510	2,304	2,174	435
Seminole	8,729	501	37	537	40	1,067	117	53	5,074	294	1,329	1,657	331
Spalding	64,073	4,625	342	4,555	337	7,949	874	397	39,316	2,280	10,301	8,539	1,708
Stephens	26,175	1,620	120	1,587	117	3,113	342	156	15,825	918	4,146	4,348	870
Stewart	6,058	273	20	201	15	519	57	26	4,247	246	1,113	858	172
Sumter	32,819	2,367	175	2,159	160	4,443	489	222	20,139	1,168	5,276	4,143	829
Talbot	6,865	362	27	367	27	799	88	40	4,292	249	1,124	1,119	224
Taliaferro	1,717	96	7	69	5	179	20	9	1,035	60	271	352	70
Tattnall	25,520	1,496	111	1,459	108	2,740	301	137	17,145	994	4,492	2,971	594
Taylor	8,906	543	40	565	42	1,164	128	58	5,417	314	1,419	1,330	266
Telfair	16,500	946	70	928	69	1,614	178	81	10,947	635	2,868	2,251	450
Terrell	9,315	669	50	603	45	1,145	126	57	5,631	327	1,475	1,388	278
Thomas	44,720	3,035	225	3,009	223	5,613	617	281	26,925	1,562	7,054	6,740	1,348

Tift	40,118	2,960	219	2,903	215	5,449	599	272	24,264	1,407	6,357	5,123	1,025
Toombs	27,223	2,219	164	2,082	154	3,644	401	182	15,952	925	4,179	3,742	748
Towns	10,471	383	28	452	33	1,096	121	55	5,569	323	1,459	3,061	612
Treutlen	6,885	496	37	488	36	851	94	43	4,208	244	1,102	940	188
Troup	67,044	4,749	351	4,864	360	9,121	1,003	456	40,980	2,377	10,737	8,303	1,661
Turner	8,930	597	44	598	44	1,124	124	56	5,329	309	1,396	1,401	280
Twiggs	9,023	522	39	471	35	962	106	48	5,704	331	1,494	1,459	292
Union	21,356	927	69	1,028	76	2,045	225	102	11,887	689	3,114	5,675	1,135
Upson	27,153	1,691	125	1,685	125	3,350	368	167	16,512	958	4,326	4,252	850
Walker	68,756	4,202	311	4,413	327	8,399	924	420	42,322	2,455	11,088	10,302	2,060
Walton	83,768	5,804	429	6,351	470	11,351	1,249	568	51,440	2,984	13,477	10,092	2,018
Ware	36,312	2,500	185	2,298	170	4,227	465	211	22,215	1,288	5,820	5,531	1,106
Warren	5,834	403	30	385	28	651	72	33	3,425	199	897	1,047	209
Washington	21,187	1,407	104	1,297	96	2,553	281	128	13,309	772	3,487	2,881	576
Wayne	30,099	2,182	161	2,074	153	3,585	394	179	18,811	1,091	4,928	3,862	772
Webster	2,799	164	12	209	15	368	40	18	1,680	97	440	420	84
Wheeler	7,421	409	30	425	31	681	75	34	5,109	296	1,339	882	176
White	27,144	1,589	118	1,685	125	3,263	359	163	16,190	939	4,242	4,754	951
Whitfield	102,599	8,131	602	8,290	613	14,429	1,587	721	61,962	3,594	16,234	11,445	2,289
Wilcox	9,255	481	36	471	35	912	100	46	6,164	358	1,615	1,321	264
Wilkes	10,593	632	47	597	44	1,215	134	61	6,297	365	1,650	1,971	394
Wilkinson	9,563	658	49	636	47	1,131	124	57	5,761	334	1,509	1,504	301
Worth	21,679	1,434	106	1,407	104	2,772	305	139	13,214	766	3,462	3,134	627

Source(s) and notes. 2010 Census Population by age data is from the Governor's Office of Planning and Budgeting

Retrieved from: http://opb.georgia.gov/00/channel_title/0,2094,161890977_169375908,00.html

1. Prevalence rate for (0-8) applies Dr. Holzer's statewide rate found in APS Health Care. (2005). Georgia mental health gap analysis. P 30.

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Prevalence - refers to a clinically diagnosable behavioral disorder within the last 12 months.

SED - refers to a Serious Emotional/Behavioral Disturbance

Table Ap3-2 -Georgia Homeless and At-Risk of Homelessness Estimates (2009)

GA Counties /School Districts	Homeless Single Night (Jan. 2009 (1)	Estimate with Serious Mental Illness(2)	Estimate of Homeless Veterans (3)	Eman-cipated from Foster Care (4)	Emergency & Transi-tional Beds (1)	Emergency/ Transition Beds for Domestic Violence (1)	Homeless Children By School District (2009-10) (5)		
	#	20%	12%	#	#	#		School Districts	
Georgia [2]	21095	4219	2531	754	10139	1308	*23796*		*3580*
All School Districts								27338	
Appling	51	10	6	3	0	0	80	Atlanta Public Schools	982
Atkinson	23	5	3	0	0	0	1	Bremen City	28
Bacon	27	5	3	2	0	0	36	Buford City	9
Baker	13	3	2	1	0	0	0	Calhoun City	263
Baldwin	120	24	14	1	8	0	0	Carrollton City	266
Banks	27	5	3	3	0	0	10	Cartersville City	192
Barrow	117	23	14	7	69	27	416	Chickamauga City	9
Bartow	126	25	15	3	38	12	342	Commerce City	2
Ben Hill	40	8	5	0	0	0	85	Dalton City	544
Berrien	45	9	5	0	0	0	147	Decatur City	46
Bibb	576	115	69	26	368	12	294	Dublin City	371
Bleckley	16	3	2	0	0	0	15	Gainesville City	28
Brantley	38	8	5	0	0	0	0	Jefferson City	47
Brooks	41	8	5	2	0	0	16	Marietta City	314
Bryan	38	8	5	2	0	0	5	Pelham City	8
Bulloch	126	25	15	3	45	45	74	Rome City	276
Burke	49	10	6	1	0	0	0	Social Circle City	0
Butts	41	8	5	0	0	0	8	State Schools	2
Calhoun	18	4	2	0	0	0	0	Thomasville City	5
Camden	78	16	9	1	16	16	27	Trion City	62
Candler	31	6	4	2	0	0	18	Valdosta City	126
Carroll	239	48	29	19	87	32	424		
Catoosa	84	17	10	6	0	0	186		
Charlton	33	7	4	0	0	0	15		
Chatham	996	199	120	19	874	48	314		
Chattahoochee	2	0	0	0	0	0	0		
Chattooga	87	17	10	2	12	0	311		
Cherokee	28	6	3	19	13	13	80		
Clarke	434	87	52	15	213	16	225		
Clay	14	3	2	0	0	0	0		
Clayton	391	78	47	15	210	42	1943		
Clinch	24	5	3	0	0	0	5		
Cobb	494	99	59	29	445	44	1539		
Coffee	94	19	11	1	0	0	3		
Colquitt	157	31	19	5	62	62	137		

Columbia	20	4	2	0	5	0	315
Cook	56	11	7	1	28	0	22
Coweta	47	9	6	12	37	37	143
Crawford	32	6	4	2	0	0	0
Crisp	53	11	6	1	0	0	22
Dade	30	6	4	1	0	0	144
Dawson	31	6	4	0	0	0	152
Decatur	59	12	7	3	0	0	0
DeKalb	597	119	72	62	507	57	984
Dodge	47	9	6	0	0	0	0
Dooly	29	6	3	2	0	0	0
Dougherty	412	82	49	2	260	22	0
Douglas	183	37	22	17	144	38	279
Early	23	5	3	2	0	0	0
Echols	16	3	2	0	0	0	0
Effingham	53	11	6	1	0	0	123
Elbert	61	12	7	2	18	18	63
Emanuel	71	14	9	1	0	0	29
Evans	32	6	4	1	0	0	17
Fannin	88	18	11	3	27	13	181
Fayette	47	9	6	6	33	33	24
Floyd	155	31	19	28	58	32	512
Forsyth	152	30	18	9	32	32	674
Franklin	51	10	6	1	0	0	31
Fulton	6434	1287	772	95	4204	45	2066
Gilmer	101	20	12	0	4	0	0
Glascock	21	4	3	0	0	0	0
Glynn	180	36	22	4	40	18	56
Gordon	77	15	9	6	0	0	338
Grady	59	12	7	2	0	0	319
Greene	48	10	6	2	15	12	0
Gwinnett	150	30	18	38	150	70	1655
Habersham	106	21	13	1	53	33	160
Hall	241	48	29	6	23	16	53
Hancock	39	8	5	1	0	0	40
Haralson	68	14	8	1	0	0	553
Harris	52	10	6	1	0	0	0
Hart	67	13	8	6	0	0	14
Heard	23	5	3	0	0	0	56
Henry	48	10	6	20	15	15	703
Houston	194	39	23	5	128	18	521
Irwin	22	4	3	1	0	0	12
Jackson	249	50	30	5	180	0	69
Jasper	30	6	4	0	0	0	4
Jeff Davis	35	7	4	3	0	0	13
Jefferson	44	9	5	1	0	0	47
Jenkins	444	89	53	1	0	0	0
Johnson	27	5	3	0	0	0	49
Jones	28	6	3	2	0	0	0
Lamar	32	6	4	0	0	0	13
Lanier	26	5	3	2	0	0	34
Laurens	114	23	14	5	15	15	166
Lee	2	0	0	0	0	0	323
Liberty	142	28	17	9	59	15	20

Lincoln	31	6	4	0	0	0	0
Long	25	5	3	1	0	0	51
Lowndes	251	50	30	9	113	20	3
Lumpkin	41	8	5	2	7	7	63
McDuffie	56	11	7	1	30	30	11
McIntosh	17	3	2	3	0	0	0
Macon	40	8	5	1	0	0	13
Madison	59	12	7	0	4	0	143
Marion	32	6	4	1	0	0	0
Meriwether	49	10	6	6	0	0	0
Miller	50	10	6	0	0	0	24
Mitchell	47	9	6	5	0	0	47
Monroe	32	6	4	2	0	0	42
Montgomery	47	9	6	0	24	24	0
Morgan	22	4	3	1	0	0	14
Murray	92	18	11	4	0	0	125
Muscogee	441	88	53	8	280	39	1263
Newton	99	20	12	10	0	0	16
Oconee	15	3	2	3	5	0	33
Oglethorpe	21	4	3	0	0	0	0
Paulding	103	21	12	6	17	17	560
Peach	41	8	5	2	0	0	0
Pickens	89	18	11	3	2	0	39
Pierce	43	9	5	0	0	0	37
Pike	14	3	2	0	0	0	1
Polk	109	22	13	5	12	12	1102
Pulaski	13	3	2	1	0	0	0
Putnam	67	13	8	1	0	0	19
Quitman	17	3	2	0	0	0	0
Rabun	65	13	8	0	0	0	39
Randolph	34	7	4	0	0	0	364
Richmond	666	133	80	15	518	0	29
Rockdale	41	8	5	11	20	20	96
Schley	9	2	1	0	0	0	0
Screven	50	10	6	0	0	0	16
Seminole	29	6	3	0	0	0	0
Spalding	147	29	18	12	79	50	28
Stephens	65	13	8	3	0	0	0
Stewart	10	2	1	1	0	0	0
Sumter	73	15	9	6	0	0	0
Talbot	17	3	2	0	0	0	0
Taliaferro	7	1	1	0	0	0	0
Tattnall	59	12	7	3	0	0	1
Taylor	71	14	9	0	46	0	0
Telfair	42	8	5	1	0	0	0
Terrell	20	4	2	0	0	0	0
Thomas	149	30	18	2	146	56	329
Tift	122	24	15	4	108	12	87
Toombs	75	15	9	3	40	0	10
Towns	47	9	6	0	0	0	3
Treutlen	23	5	3	0	0	0	0
Troup	119	24	14	11	53	16	232
Turner	18	4	2	1	0	0	0
Twiggs	25	5	3	1	0	0	0

Union	84	17	10	1	14	14	16
Upson	51	10	6	7	0	0	
Walker	151	30	18	2	20	20	66
Walton	81	16	10	4	0	0	195
Ware	93	19	11	4	24	14	474
Warren	17	3	2	0	0	0	0
Washington	30	6	4	1	0	0	0
Wayne	79	16	9	1	24	24	42
Webster	8	2	1	0	0	0	0
Wheeler	17	3	2	0	0	0	0
White	52	10	6	2	0	0	67
Whitfield	205	41	25	18	55	25	258
Wilcox	19	4	2	0	0	0	2
Wilkes	29	6	3	0	3	0	0
Wilkinson	28	6	3	2	0	0	0
Worth	39	8	5	2	0	0	81

1. Source: Georgia Department of Community Affairs. 2009 *Report on Homelessness, Georgia's 21,000. Georgia DCA September 2009.* Numbers are based on Georgia's 2008-2009 Continuum of Care Housing Inventories & 2009 Homeless Count & Predictive Model.
(http://www.dca.state.ga.us/housing/specialneeds/programs/documents/HomelessCountReport09web_000.pdf
2. The 20% estimate of homeless with serious mental illness is the "lower" of the 20% to 25% estimate of homeless with Severe and Persistent Mental Illness as reported in *Outcasts on Main Street*: A Report of the Federal Task Force on Homelessness and Severe Mental Illness, 1992.

http://www.nationalhomeless.org/publications/facts/Mental_Illness.pdf
3. The 12 % estimate was applied to each homeless county estimate The Department of Community Affairs found that 12% of the homeless in Georgia's 2009 homeless count were Veterans.
4. The Division of Family and Child Services (DFCS), Georgia Department of Human Services. *Child Welfare in Georgia 2009: House Bill 1406*.
5.The Georgia Department of Education, Homeless Program. *Homeless Education 2009-2010 Student Count.* September 24, 2010. The U.S. Department of Education definition of homeless includes families who are doubled-up with family or friends and move frequently among temporary living arrangements. It is broader than the Georgia or federal definition.
Georgia's Definition of Homelessness includes someone that lives in an emergency shelter or in transitional housing for homeless persons, or lives in a car, park, abandoned building,
encampment, dilapidated building, on the sidewalk, or similar location; or is facing imminent loss of their housing (within the week).

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
Appling Co.		2	19	20	22	63	1.71%
Atkinson Co.		0	0	0	2	2	0.10%
Atlanta Pub. Schs.	5	58	156	220	88	527	0.87%
Bacon Co.		0	8	9	4	21	1.06%
Baker Co.		2	2	1	0	5	1.18%
Baldwin Co.	3	15	24	51	29	122	1.88%
Banks Co.		3	16	14	16	49	1.69%
Barrow Co.		18	44	57	37	156	1.28%
Bartow Co.		11	41	57	44	153	0.95%
Ben Hill Co.	2	5	10	13	15	45	1.24%
Berrien Co.		2	9	12	3	26	0.77%
Bibb Co.	7	62	149	218	83	519	1.79%
Bleckley Co.		1	22	29	20	72	2.82%
Brantley Co.	1	3	11	10	11	36	0.93%
Bremen City		0	2	8	4	14	0.77%
Brooks Co.		0	1	10	5	16	0.60%
Bryan Co.		6	21	15	16	58	0.86%
Buford City		3	7	16	3	29	1.05%
Bulloch Co.	3	11	35	60	24	133	1.38%
Burke Co.		7	17	20	14	58	1.14%
Butts Co.	1	3	12	15	12	43	1.10%
Calhoun City	1	3	10	12	6	32	0.95%
Calhoun Co.		4	0	2	1	7	0.92%
Camden Co.	1	7	24	42	32	106	0.97%
Candler Co.		0	11	12	5	28	1.32%
Carroll Co.		21	44	104	73	242	1.43%
Carrollton City		3	5	8	4	20	0.48%
Cartersville City		4	13	17	2	36	0.83%
Catoosa Co.		8	34	44	37	123	1.06%
CCAT		0	0	0	1	1	0.53%
Charlton Co.		1	2	5	4	12	0.57%
Chatham Co.		28	80	104	67	279	0.72%
Chattahoochee Co.		1	2	1	4	8	1.00%
Chattooga Co.		5	13	19	15	52	1.53%
Cherokee Co.		15	48	90	56	209	0.57%
Chickamauga City		1	1	0	2	4	0.29%
Clarke Co.		15	67	117	64	263	1.98%

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
Clay Co.		0	0	1	0	1	0.26%
Clayton Co.		40	152	274	142	608	0.99%
Clinch Co.		0	1	0	0	1	0.07%
Cobb Co.	2	95	233	370	159	859	0.73%
Coffee Co.		8	8	15	10	41	0.45%
Colquitt Co.		10	41	33	24	108	1.15%
Columbia Co.		9	30	40	36	115	0.49%
Commerce City		3	8	10	2	23	1.41%
Cook Co.		4	5	9	6	24	0.68%
Coweta Co.	1	6	45	74	39	165	0.73%
Crawford Co.		6	18	15	12	51	2.30%
Crisp Co.		1	7	29	20	57	1.19%
Dade Co.		3	0	1	5	9	0.33%
Dalton City		1	2	4	1	8	0.11%
Dawson Co.	2	12	11	12	8	45	1.25%
Decatur City		0	4	13	5	22	0.85%
Decatur Co.	1	7	12	21	19	60	0.94%
DeKalb Co.	4	60	207	346	256	873	0.73%
Dodge Co.		11	20	30	17	78	2.04%
Dooly Co.		1	2	5	4	12	0.73%
Dougherty Co.	2	14	27	38	22	103	0.53%
Douglas Co.	7	19	47	111	81	265	1.02%
Dublin City		6	9	9	7	31	0.95%
Early Co.		8	17	12	12	49	1.83%
Echols Co.		0	2	1	1	4	0.50%
Effingham Co.	1	15	32	51	26	125	1.10%
Elbert Co.		4	8	8	3	23	0.59%
Emanuel Co.		7	15	39	27	88	1.79%
Evans Co.		2	2	4	11	19	0.91%
Fannin Co.		4	10	7	17	38	1.10%
Fayette Co.	1	14	22	41	32	110	0.46%
Floyd Co.		14	32	75	44	165	1.41%
Forsyth Co.		21	47	66	54	188	0.68%
Franklin Co.		4	10	9	6	29	0.70%
Fulton Co.	3	92	182	231	171	679	0.75%
Gainesville City	1	1	9	18	9	38	0.63%
Gilmer Co.		2	7	28	18	55	1.20%

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
Glascock Co.		1	3	7	3	14	2.11%
Glynn Co.	1	17	31	81	50	180	1.30%
Gordon Co.	1	3	13	38	28	83	1.10%
Grady Co.		2	8	13	6	29	0.59%
Greene Co.		6	10	9	1	26	1.12%
Gwinnett Co.	10	172	394	555	405	1536	0.94%
Habersham Co.		8	21	41	18	88	1.25%
Hall Co.	2	17	50	74	43	186	0.69%
Hancock Co.	1	5	6	16	10	38	2.49%
Haralson Co.	3	14	15	21	28	81	1.90%
Harris Co.		3	12	15	8	38	0.74%
Hart Co.		4	9	6	7	26	0.65%
Heard Co.		15	7	6	3	31	1.25%
Henry Co.	6	53	100	136	142	437	1.08%
Houston Co.	1	20	84	128	96	329	1.16%
Irwin Co.		7	13	18	10	48	2.55%
Jackson Co.		8	22	34	29	93	1.30%
Jasper Co.		6	9	17	13	45	1.92%
Jeff Davis Co.		5	11	22	12	50	1.70%
Jefferson City		1	3	3	5	12	0.51%
Jefferson Co.		1	4	9	17	31	0.90%
Jenkins Co.		3	7	16	9	35	1.88%
Johnson Co.	4	1	7	17	6	35	2.63%
Jones Co.		6	18	32	20	76	1.36%
KidsPeace		0	0	0	0		0.00%
Lamar Co.	1	6	14	14	5	40	1.47%
Lanier Co.		2	2	6	3	13	0.71%
Laurens Co.	2	7	14	47	73	143	2.07%
Lee Co.		3	14	19	7	43	0.67%
Liberty Co.	2	7	20	52	38	119	0.90%
Lincoln Co.		1	1	3	5	10	0.68%
Long Co.		3	4	8	8	23	0.91%
Lowndes Co.	1	8	21	39	28	97	0.93%
Lumpkin Co.	4	10	20	27	14	75	1.80%
Macon Co.		2	14	8	8	32	1.42%
Madison Co.		7	21	31	25	84	1.64%
Marietta City		3	21	30	18	72	0.75%

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
Marion Co.		2	4	4	3	13	0.72%
McDuffie Co.		7	24	24	14	69	1.49%
McIntosh Co.		1	5	12	10	28	1.32%
Meriwether Co.	1	10	14	24	18	67	1.58%
Miller Co.		1	0	3	3	7	0.62%
Mitchell Co.		2	3	10	2	17	0.53%
Monroe Co.		4	15	27	17	63	1.49%
Montgomery Co.		0	3	1	7	11	0.76%
Morgan Co.		3	16	19	25	63	1.81%
Mountain Ed Cntr		0	0	5	34	39	#DIV/0!
Murray Co.		1	5	13	11	30	0.34%
Muscogee Co.	1	20	57	93	72	243	0.68%
Newton Co.	2	16	58	109	77	262	1.31%
Oconee Co.		0	10	19	12	41	0.64%
Odyssey		2	11	16	0	29	17.26%
Oglethorpe Co.		1	3	13	4	21	0.82%
Paulding Co.		23	59	106	73	261	0.99%
Peach Co.	1	5	13	14	10	43	0.94%
Pelham City		0	4	17	10	31	1.83%
Pickens Co.	1	4	10	20	11	46	0.98%
Pierce Co.		4	2	15	9	30	0.80%
Pike Co.		2	7	4	9	22	0.66%
Polk Co.		8	25	51	30	114	1.44%
Pulaski Co.		6	11	14	18	49	2.77%
Putnam Co.		7	16	12	13	48	1.64%
Quitman Co.		0	1	4	0	5	1.53%
Rabun Co.		3	5	2	7	17	0.70%
Randolph Co.		0	1	8	0	9	0.54%
Richmond Co.		14	97	158	106	375	0.95%
Rockdale Co.		12	23	40	43	118	0.68%
Rome City	1	7	18	11	15	52	0.86%
Schley Co.		6	2	3	3	14	1.03%
Scholars Acad.		0	0	0	0		#DIV/0!
Screven Co.	1	4	10	11	6	32	1.00%
Seminole Co.		1	3	12	5	21	1.14%
Social Circle City		1	3	6	3	13	0.71%
Spalding Co.	1	18	30	38	26	113	0.90%

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
State Sch.		0	0	0	0		0.00%
Stephens Co.		3	11	25	17	56	1.20%
Stewart Co.		0	1	2	1	4	0.52%
Sumter Co.	1	10	10	18	11	50	0.82%
Talbot Co.		1	3	2	3	9	1.19%
Taliaferro Co.		1	0	1	2	4	1.30%
Tattnall Co.		4	7	11	15	37	0.97%
Taylor Co.		2	3	15	22	42	2.47%
Telfair Co.		1	3	10	8	22	1.15%
Terrell Co.		1	4	2	1	8	0.46%
Thomas Co.		8	12	18	12	50	0.81%
Thomaston-Upson Co.		3	9	34	17	63	1.18%
Thomasville City		8	17	29	10	64	1.98%
Tift Co.		9	38	42	24	113	1.31%
Toombs Co.		2	9	10	11	32	1.04%
Towns Co.		1	7	7	5	20	0.84%
Treutlen Co.		1	3	8	5	17	1.28%
Trion City		0	1	1	1	3	0.22%
Troup Co.	1	5	16	34	38	94	0.70%
Turner Co.		2	3	4	5	14	0.74%
Twiggs Co.		4	3	10	7	24	1.70%
Union Co.		2	15	28	11	56	2.01%
Valdosta City	1	5	14	24	7	51	0.63%
Vidalia City		1	3	6	12	22	0.78%
Walker Co.	1	9	44	53	50	157	1.53%
Walton Co.	1	10	28	40	25	104	0.80%
Ware Co.	1	7	19	26	18	71	0.99%
Warren Co.		0	3	3	1	7	0.74%
Washington Co.		2	10	12	9	33	0.86%
Wayne Co.		2	11	20	20	53	0.89%
Webster Co.		1	3	3	0	7	1.72%
Wheeler Co.		2	9	9	9	29	2.47%
White Co.		0	16	17	12	45	1.05%
Whitfield Co.		4	9	17	23	53	0.36%
Wilcox Co.		0	4	9	9	22	1.44%
Wilkes Co.		3	4	6	2	15	0.80%

Table Ap3-3 Georgia Students with an Emotional & Behavioral Disorder By District School System - 2010

Grade	PreK/KK	1st to 3rd	4th to 6th	7th to 9th	10th to 12th	Total	% of all Students
School District							
Wilkinson Co.		2	5	10	3	20	1.11%
Worth Co.		2	10	8	4	24	0.54%
All Districts	103	1582	4202	6592	4468	16947	0.94%

Source: Georgia Department of Education

Table Ap3-4 Children Served by the Georgia Division of Family and Children's Services in 2009 at-High Risk of a Behavioral Health Disorder(s)[1]

					Placement		
Counties	Total Served DFCS 2009	Substantiated Abuse / Neglect	Emanci-pated	Transferred to another Agency /RYDC	Nonrelative Foster Home / Emergency Shelter	Group Home	Institution
Georgia	16384	15422	754	40	7162	807	1,883
Appling	40	38	3	0	0	0	10
Atkinson	3	50	0	0	0	0	1
Bacon	18	30	2	0	0	0	1
Baker	1	1	1	0	1	1	0
Baldwin	42	91	1	0	0	0	3
Banks	20	27	3	0	0	0	3
Barrow	138	118	7	1	0	0	25
Bartow	341	251	3	0	0	0	32
Ben Hill	28	38	0	0	0	0	1
Berrien	57	89	0	0	1	1	3
Bibb	285	469	26	0	1	1	46
Bleckley	2	32	0	0	0	0	0
Brantley	47	58	0	1	0	0	6
Brooks	32	41	2	1	0	0	5
Bryan	25	39	2	0	0	0	2
Bulloch	52	79	3	0	0	0	7
Burke	28	26	1	0	0	0	2
Butts	108	65	0	0	0	0	15
Calhoun	1	7	0	0	0	0	0
Camden	77	79	1	0	1	1	5
Candler	21	25	2	0	0	0	1
Carroll	146	113	19	0	1	1	28
Catoosa	119	157	6	1	0	0	15
Charlton	22	42	0	0	1	1	0
Chatham	560	291	19	1	2	2	74
Chattahoochee	8	33	0	0	0	0	1
Chattooga	61	98	2	1	0	0	4
Cherokee	367	294	19	2	3	3	38
Clarke	146	136	15	0	0	0	16
Clay	3	8	0	0	2	2	0
Clayton	476	441	15	3	0	0	48
Clinch	9	21	0	0	0	0	0
Cobb	894	724	29	2	0	0	105
Coffee	63	134	1	0	0	0	0
Colquitt	137	158	5	0	1	1	11
Columbia	59	162	0	0	0	0	4
Cook	48	74	1	0	0	0	3
Coweta	232	116	12	1	0	0	38
Crawford	56	71	2	0	0	0	10
Crisp	52	42	1	0	0	0	9
Dade	28	47	1	0	0	0	3
Dawson	14	35	0	0	0	0	2
Decatur	65	80	3	0	0	0	3
DeKalb	1229	727	62	0	0	0	160
Dodge	24	58	0	0	0	0	0
Dooly	13	16	2	0	0	0	4
Dougherty	90	251	2	0	0	0	8
Douglas	261	241	17	0	0	0	49
Early	23	11	2	0	3	3	1
Echols	13	9	0	0	0	0	0
Effingham	72	64	1	0	0	0	8
Elbert	29	33	2	3	0	0	2
Emanuel	22	66	1	0	1	1	3

Evans	22	31	1	0	1	1	3
Fannin	80	56	3	0	1	1	8
Fayette	74	44	6	1	0	0	12
Floyd	433	213	28	1	9	9	54
Forsyth	103	135	9	1	0	0	15
Franklin	47	56	1	0	0	0	2
Fulton	1753	1,331	95	9	0	0	196
Gilmer	47	110	0	0	0	0	3
Glascock	3	6	0	0	0	0	0
Glynn	166	101	4	0	0	0	19
Gordon	197	122	6	0	7	7	8
Grady	52	42	2	0	0	0	3
Greene	33	24	2	0	0	0	3
Gwinnett	645	416	38	7	0	0	99
Habersham	39	96	1	0	0	0	6
Hall	179	193	6	0	0	0	27
Hancock	3	6	1	0	0	0	0
Haralson	95	62	1	0	0	0	7
Harris	19	28	1	0	0	0	3
Hart	101	72	6	0	0	0	5
Heard	28	32	0	0	0	0	1
Henry	222	257	20	0	0	0	46
Houston	207	202	5	0	0	0	13
Irwin	12	29	1	0	0	0	2
Jackson	132	102	5	0	0	0	18
Jasper	8	21	0	0	0	0	2
Jeff Davis	32	16	3	0	0	0	12
Jefferson	34	26	1	0	0	0	0
Jenkins	27	24	1	0	0	0	1
Johnson	14	30	0	0	0	0	1
Jones	67	110	2	0	1	1	4
Lamar	51	63	0	0	0	0	3
Lanier	33	70	2	0	0	0	2
Laurens	118	124	5	1	0	0	14
Lee	47	64	0	0	0	0	7
Liberty	110	161	9	0	0	0	12
Lincoln	4	14	0	0	0	0	0
Long	23	35	1	0	0	0	2
Lowndes	235	194	9	0	0	0	8
Lumpkin	84	71	2	0	0	0	8
Macon	30	29	1	0	0	0	2
Madison	34	34	0	0	0	0	1
Marion	9	14	1	0	0	0	0
McDuffie	24	83	1	0	0	0	2
McIntosh	30	33	3	0	0	0	4
Meriwether	89	33	6	0	0	0	9
Miller	16	15	0	0	0	0	0
Mitchell	45	39	5	0	0	0	3
Monroe	80	74	2	0	1	1	7
Montgomery	9	16	0	0	1	1	1
Morgan	21	35	1	0	0	0	3
Murray	128	104	4	1	0	0	13
Muscogee	289	388	8	1	0	0	47
Newton	87	124	10	0	0	0	19
Oconee	28	36	3	0	0	0	4
Oglethorpe	17	14	0	0	0	0	1
Paulding	144	229	6	0	0	0	15
Peach	72	58	2	0	0	0	7
Pickens	80	56	3	0	0	0	10
Pierce	16	27	0	0	0	0	0
Pike	21	25	0	0	0	0	4
Polk	281	198	5	0	0	0	27
Pulaski	10	50	1	0	0	0	0
Putnam	30	44	1	0	0	0	6
Quitman	2	3	0	0	0	0	0
Rabun	36	54	0	0	0	0	3

Randolph	19	15	0	0	0	0	0
Richmond	397	295	15	0	1	1	13
Rockdale	101	96	11	0	0	0	22
Schley	1	13	0	0	0	0	0
Screven	16	37	0	1	0	0	1
Seminole	28	12	0	0	0	0	2
Spalding	202	200	12	0	0	0	26
Stephens	89	100	3	0	0	0	3
Stewart	8	12	1	0	0	0	0
Sumter	45	43	6	0	0	0	10
Talbot	6	6	0	0	0	0	0
Taliaferro	2	3	0	0	0	0	0
Tattnall	15	32	3	0	0	0	3
Taylor	7	15	0	0	0	0	0
Telfair	19	27	1	0	0	0	1
Terrell	22	27	0	0	0	0	1
Thomas	48	67	2	0	0	0	11
Tift	162	154	4	0	0	0	13
Toombs	54	54	3	0	0	0	6
Towns	22	21	0	0	0	0	0
Treutlen	10	19	0	0	0	0	0
Troup	167	142	11	0	0	0	14
Turner	12	22	1	0	0	0	3
Twiggs	22	17	1	0	0	0	3
Union	21	23	1	0	0	0	4
Upson	119	84	7	0	0	0	26
Walker	135	149	2	0	0	0	11
Walton	119	111	4	0	0	0	15
Ware	78	87	4	0	0	0	9
Warren	1	24	0	0	0	0	0
Washington	30	43	1	0	0	0	1
Wayne	28	39	1	0	0	0	3
Webster	2	2	0	0	0	0	0
Wheeler	3	13	0	0	0	0	0
White	49	89	2	0	0	0	6
Whitfield	319	218	18	0	0	0	38
Wilcox	12	13	0	0	0	0	1
Wilkes	0	11	0	0	0	0	0
Wilkinson	35	24	2	0	0	0	1
Worth	45	53	2	0	0	0	4

Source: Georgia Division of Child and Family Services. Welfare in Georgia 2009: House Bill 1406.

1. Studies have found that between 50% and 80% of children in foster care have mental health disorders. See Haflon, N., Zepeda, A., Inkelas, M. (2002). Mental Health Services for Children in Foster Care. UCLA Center for Healthier Children, Families and Communities. Retrieved from:
http://www.healthychild.ucla.edu/Publications/ChildrenFosterCare/Documents/Mental%20health%20brief%20final%20for%20

	02-04		05-07	
All Ages GA	10.9	2854	10.2	2844
All Ages US	11		11.2	

Table Ap3-5 Georgia Suicide Rate and Change between 2002-2004 and 2005-2007 by Age Group (per 100,000)

	13-19 Adolescence				20-29 Early Adulthood				30-44 Young Adulthood				45-59 Middle Adulthood				60-74 Late Adulthood					75+ Older Adulthood			
	05-07 #	02-04 rate	05-07 rate	change rate	05-07 #	02-04 rate	05-07 rate	change rate	05-07 #	02-04 rate	05-07 rate	change rate	05-07 #	02-04 rate	05-07 rate	change rate	05-07 #	change #	02-04 rate	05-07 rate	change rate	05-07 #	02-04 rate	05-07 rate	change rate
U. S.	5134	6.07	5.77	-0.3	15502	12.4	12.5	0.11	27506	14.5	14.5	0.08	30426	15.7	16.6	0.95	12803		12.8	13	0.28	8952	17	16	-0.64
Georgia	106	5.9	3.8	-2.1	415	11.5	10.2	-1.3	781	13.2	12.2	-1	826	16.1	15	-1.1	382		15.6	14	-1.4	233	22	19	-2.8
GA Rural	23	6.7	4.6	-2.1	82	11.9	11	-0.9	166	15.4	15.8	0.4	204	18.8	20.3	1.5	101		20.3	16	-3.9	59	23	20	-3.3
GA Non Rural	83	5.7	3.7	-2	333	11.4	10	-1.4	615	12.8	11.5	-1.3	622	15.5	13.9	-1.6	281		14.1	14	-0.6	174	22	19	-2.6
White Males	59	12	6.8	-5.2	254	21.1	19	-2.1	505	24.9	23.4	-1.5	552	30.8	29.2	-1.6	283		32.8	29	-3.7	198	66	57	-8.6
White Females	16	2.4	2.8	0.4	50	4.8	4.2	-0.6	137	7.6	6.8	-0.8	181	9.5	9.5	0	73		6.7	6.8	0.1	22	4.6	3.7	-0.9
Black Males	27	6.2	5.4	-0.8	88	5.5	13.4	7.9	114	12.2	12.7	0.5	75	11.8	11.1	-0.7	19		9.5	8	-1.5	10	11	14	2.8
Black Females	3	*	*		17	1.5	2.5	1	19	2.1	1.8	-0.3	9	1.9	1.1	-0.8	5		0	1.5	1.5	1	*	*	
Appling	0	0	0	0	2	0	*	*	0	*	0		3	0	*		1		*	*		0	0	0	0
Atkinson	0	*	0		0	0	0	0	0	*	0		0	0	0	0	0		*	0		0	0	0	0
Bacon	0	0	0	0	0	0	0	0	1	0	*		0	*	0		1		0	*		0	*	0	
Baker	0	0	0	0	1	*	*	*	0	0	0	0	0	0	0	0	1		0	*		0	0	0	0
Baldwin	0	*	0		2	*	*	*	3	*	*		5	*	19		0		*	0		3	*	*	
Banks	0	*	0		2	0	*	*	2	55.9	*		3	*	*		1		*	*		1	0	*	
Barrow	2	0	*		3	*	*	*	4	21	*		13	23	40.9	17.9	3		*	*		2	*	*	
Bartow	3	*	*		5	*	12.9		15	11	23.2	12.2	10	30.9	19.6	-11.3	6		*	23		0	*	0	
Ben Hill	0	0	0	0	0	*	0	*	0	*	0		2	*	*		0		0	0	0	0	*	0	
Berrien	0	0	0	0	1	*	*		1	*	*		2	*	*		1		*	*		0	*	0	
Bibb	0	*	0		7	*	11.5		19	13.3	20.9	7.6	6	18.2	6.4	-11.8	6		14.7	12	-2.8	7	34	24	-10.5
Bleckley	0	*	0		1	0	*		1	*	*		3	0	*		0		*	0		2	0	*	
Brantley	0	0	0	0	0	0	0	0	1	0	*		0	*	0		0		*	0		0	*	0	
Brooks	0	*	0		0	*	0		0	0	0	0	2	*	*		1		*	*		0	*	0	
Bryan	0	*	0		3	*	*		3	*	*		3	*	*		0		*	0		1	0	*	
Bulloch	1	*	*		1	*	*		4	*	*		3	27.2	*		3		*	*		3	*	*	
Burke	0	0	0	0	1	*	*		2	*	*		3	*	*		2		0	*		1	*	*	
Butts	0	0	0	0	1	*	*		1	*	*		3	*	*		2		*	*		0	*	0	
Calhoun	0	0	0	0	0	0	0	0	0	0	0	0	0	*	0		0		0	0	0	0	*	0	
Camden	1	*	*		4	32.4	*		6	*	18.6		6	*	25.4		1		*	*		1	*	*	
Candler	0	0	0	0	0	0	0	0	1	0	*		0	*	0		1		*	*		1	0	*	
Carroll	2	*	*		7	13.5	12.3	-1.2	7	16.4	9.7	-6.7	18	27.9	31.8	3.9	4		*	*		3	41	*	
Catoosa	0	0	0	0	2	*	*		6	12.2	14.4	2.2	4	18	*		9		40.5	42	1.4	2	*	*	
Charlton	0	0	0	0	0	*	0		0	*	0		0	*	0		1		0	*		1	0	*	
Chatham	1	*	*		10	11.1	9	-2.1	17	12	11.8	-0.2	20	9.9	14.2	4.3	18		10.7	23	12.1	9	21	20	-0.7
Chattahoochee	1	*	*		1	*	*		2	*	*		0	0	0	0	0		0	0	0	0	0	0	0

Chattooga	0	*	0		4	0	*		3	*	*		5	*	32.5		0	*	0		1	0	*	
Cherokee	3	*	*		5	11.7	5.9	-5.8	20	16.3	14	-2.3	15	17.8	12.9	-4.9	11	13.6	23	9.6	2	*	*	
Clarke	1	*	*		9	7.6	8.7	1.1	10	8.5	16.8	8.3	8	17.3	19	1.7	3	*	*		4	47	*	
Clay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	*		0	*	0	
Clayton	2	*	*		11	13.4	9.6	-3.8	19	13.4	9.4	-4	15	20.3	10.2	-10.1	7	13.2	12	-1.6	3	*	*	
Clinch	0	0	0	0	0	*	0		1	*	*		0	*	0		0	0	0	0	0	0	0	0
Cobb	12	6	6.2	0.2	25	10.5	9.6	-0.9	43	10.6	8.6	-2	50	12.8	11.4	-1.4	20	14.5	11	-3.4	16	20	23	3.3
Coffee	0	*	0		2	*	*		4	*	*		1	*	*		4	0	*		1	*	*	
Colquitt	1	*	*		2	*	*		1	22.1	*		1	*	*		1	*	*		4	*	*	
Columbia	0	*	0		7	*	16.3		11	8.8	16.5	7.7	12	15.8	16.5	0.7	7	18.9	23	3.8	3	*	*	
Cook	2	0	*		1	*	*		0	*	0		4	*	*		1	*	*		0	*	0	
Coweta	1	*	*		3	*	*		18	8.9	21.4	12.5	18	16.1	27.6	11.5	3	19.1	*		4	*	*	
Crawford	0	0	0	0	1	*	*		2	*	*		0	0	0	0	1	*	*		0	*	0	
Crisp	0	0	0	0	0	*	0		0	0	0	0	2	*	*		0	69.7	0	-69.7	1	*	*	
Dade	0	0	0	0	2	0	*		4	0	*		3	*	*		1	0	*		1	*	*	
Dawson	0	0	0	0	0	0	0	0	4	*	*		1	*	*		1	*	*		0	0	0	0
Decatur	0	0	0	0	2	*	*		3	*	*		1	*	*		2	*	*		1	0	*	
DeKalb	3	7.9	*		27	12.1	9.1	-3	42	11	7.6	-3.4	53	12.7	12	-0.7	18	9.5	9.8	0.3	15	27	19	-7.6
Dodge	0	*	0		3	0	*		0	*	0		5	*	44.4		1	*	*		2	*	*	
Dooly	0	0	0	0	1	0	*		2	0	*		2	*	*		0	0	0	0	1	0	*	
Dougherty	0	0	0	0	3	*	*		7	12.5	13.3	0.8	4	22.9	*		5	*	16		1	*	*	
Douglas	2	*	*		5	*	9.2		15	16.8	17.6	0.8	6	20.3	8.7	-11.6	3	20.1	*		2	*	*	
Early	0	0	0	0	1	0	*		1	*	*		1	*	*		0	0	0	0	0	0	0	0
Echols	0	0	0	0	1	*	*		0	0	0	0	1	0	*		0	0	0	0	0	0	0	0
Effingham	0	0	0	0	1	*	*		8	19	23.8	4.8	4	33.6	*		2	*	*		0	*	0	
Elbert	1	0	*		0	0	0	0	5	*	41.4		3	*	*		2	0	*		2	*	*	
Emanuel	0	0	0	0	1	*	*		1	*	*		3	0	*		2	*	*		0	*	0	
Evans	0	0	0	0	0	*	0		1	*	*		2	*	*		1	*	*		0	*	0	
Fannin	0	0	0	0	2	0	*		4	*	*		5	*	36.7		1	*	*		5	*	84	
Fayette	2	*	*		6	15.6	14.7	-0.9	6	9.9	10.5	0.6	10	14.7	12.1	-2.6	3	*	*		4	*	*	
Floyd	4	*	*		5	12.2	12.3	0.1	11	20.2	19.1	-1.1	17	9.8	31.2	21.4	6	27.8	18	-10.2	3	*	*	
Forsyth	2	*	*		8	*	12.7		12	14	10.1	-3.9	8	16.4	9.6	-6.8	9	24.3	24	-0.6	1	*	*	
Franklin	0	0	0	0	1	*	*		5	37.6	37.7	0.1	1	59.9	*		3	*	*		1	0	*	
Fulton	12	4	4.5	0.5	37	11.6	9.8	-1.8	59	12.8	8	-4.8	65	15.1	10.8	-4.3	18	8.4	7.2	-1.2	15	17	15	-2.3
Gilmer	0	0	0	0	2	*	*		4	*	*		4	53.9	*		4	*	*		1	*	*	
Glascock	0	0	0	0	0	0	0	0	0	*	0		0	0	0	0	0	0	0	0	0	0	0	0
Glynn	0	*	0		4	*	*		6	*	14.3		10	16.3	21.8	5.5	6	*	21		1	*	*	
Gordon	0	0	0	0	2	*	*		4	35.6	*		2	*	*		2	0	*		0	*	0	
Grady	1	0	*		1	*	*		0	0	0	0	0	0	0	0	0	*	0		0	*	0	
Greene	1	0	*		0	0	0	0	0	*	0		2	*	*		0	*	0		1	0	*	
Gwinnett	4	8.6	*		36	13.5	11.8	-1.7	56	9.4	9.5	0.1	71	11.6	15.6	4	20	12.5	12	-0.2	10	18	19	1.6
Habersham	1	0	*		0	0	0	0	2	*	*		4	28.3	*		0	*	0		1	0	*	
Hall	3	*	*		8	15.6	10	-5.6	12	19.7	9.9	-9.8	14	10.1	15.6	5.5	6	11.9	12	0.2	8	*	38	
Hancock	0	0	0	0	0	0	0	0	1	*	*		0	0	0	0	1	0	*		1	0	*	

Haralson	1	0	*		2	*	*		4	43.2	*		5	60.1	31	-29.1	2	*	*		3	*	*	
Harris	1	0	*		1	*	*		1	*	*		4	*	*		1	*	*		1	*	*	
Hart	0	0	0	0	2	*	*		2	*	*		3	0	*		0	*	0		1	*	*	
Heard	0	*	0		0	0	0	0	1	*	*		3	*	*		1	*	*		0	0	0	0
Henry	3	0	*		7	*	8.5		13	18.3	9.6	-8.7	20	18.1	21.2	3.1	10	23.6	25	1.2	4	0	*	
Houston	2	*	*		6	16.1	11	-5.1	19	8.2	22.8	14.6	9	19.2	11.7	-7.5	4	14.5	*		3	*	*	
Irwin	0	0	0	0	0	0	0	0	1	0	*		1	*	*		0	0	0	0	0	*	0	
Jackson	0	0	0	0	5	*	18.8		6	20.3	15.3	-5	6	*	20.2		1	*	*		1	*	*	
Jasper	0	*	0		1	0	*		3	*	*		2	0	*		0	121	0	-121	0	0	0	0
Jeff Davis	1	0	*		2	*	*		1	*	*		2	0	*		1	0	*		1	0	*	
Jefferson	0	0	0	0	1	*	*		1	0	*		3	*	*		0	*	0		0	*	0	
Jenkins	0	0	0	0	0	*	0		1	0	*		0	*	0		1	*	*		0	0	0	0
Johnson	0	0	0	0	0	0	0	0	1	0	*		0	0	0	0	3	0	*		0	0	0	0
Jones	0	0	0	0	1	0	*		5	*	28.8		7	*	40.5		2	0	*		1	0	*	
Lamar	0	0	0	0	2	0	*		4	*	*		1	*	*		0	*	0		0	0	0	0
Lanier	0	0	0	0	2	*	*		0	0	0	0	0	*	0		1	0	*		0	0	0	0
Laurens	0	0	0	0	0	*	0		3	20.8	*		5	18.9	17.6	-1.3	0	*	0		1	*	*	
Lee	2	0	*		2	*	*		4	*	*		4	*	*		1	*	*		0	0	0	0
Liberty	1	*	*		5	*	15.1		3	16.7	*		6	*	24.8		1	*	*		1	*	*	
Lincoln	1	0	*		1	0	*		1	0	*		1	*	*		0	0	0	0	1	0	*	
Long	0	0	0	0	1	*	*		1	*	*		1	0	*		3	*	*		0	0	0	0
Lowndes	0	*	0		5	10.8	8.8	-2	10	*	16.2		8	21.7	15.8	-5.9	4	20.8	*		2	*	*	
Lumpkin	0	*	0		0	*	0		3	*	*		2	*	*		1	*	*		0	*	0	
McDuffie	0	*	0		1	*	*		1	*	*		5	*	37.8		1	72.6	*		1	0	*	
McIntosh	0	0	0	0	1	0	*		1	*	*		0	*	0		0	*	0		0	*	0	
Macon	0	*	0		0	0	0	0	4	0	*		1	0	*		0	0	0	0	0	*	0	
Madison	0	0	0	0	1	*	*		3	*	*		3	*	*		2	*	*		1	*	*	
Marion	0	0	0	0	0	0	0	0	0	0	0	0	1	*	*		2	*	*		1	0	*	
Meriwether	0	0	0	0	2	*	*		6	*	45.2		1	*	*		3	*	*		0	*	0	
Miller	0	0	0	0	0	0	0	0	0	*	0		1	*	*		0	*	0		0	*	0	
Mitchell	0	0	0	0	1	*	*		2	*	*		1	*	*		1	*	*		0	*	0	
Monroe	1	*	*		0	0	0	0	4	*	*		3	34	*		2	0	*		1	*	*	
Montgomery	1	0	*		0	*	0		2	*	*		0	*	0		2	*	*		1	*	*	
Morgan	1	0	*		0	0	0	0	2	*	*		2	*	*		1	0	*		1	0	*	
Murray	1	0	*		3	*	*		5	*	16.9		3	*	*		3	*	*		1	0	*	
Muscogee	0	*	0		13	13.9	16.2	2.3	14	19.8	12.7	-7.1	6	15.7	5.5	-10.2	11	*	20		8	26	25	-1.5
Newton	1	*	*		1	14.1	*		5	12.2	7.5	-4.7	12	26.5	26.9	0.4	4	*	*		0	*	0	
Oconee	0	*	0		1	0	*		3	*	*		5	*	23.3		1	*	*		1	0	*	
Oglethorpe	0	0	0	0	3	*	*		0	*	0		2	*	*		0	0	0	0	0	0	0	0
Paulding	0	0	0	0	7	*	12.7		10	15.9	10	-5.9	14	13.2	23.8	10.6	4	*	*		3	*	*	
Peach	1	*	*		2	*	*		3	*	*		7	*	49.5		2	*	*		1	0	*	
Pickens	4	*	*		0	*	0		4	*	*		2	*	*		0	*	0		2	0	*	
Pierce	1	0	*		1	*	*		1	*	*		2	0	*		2	*	*		0	0	0	0
Pike	0	*	0		0	0	0	0	2	*	*		1	*	*		2	0	*		1	0	*	

Polk	0	0	0	0	2	*	*		3	23.5	*		7	*	31.1		0	*	0		1	*	*	
Pulaski	0	*	0		0	*	0		2	*	*		0	*	0		0	*	0		0	0	0	0
Putnam	0	0	0	0	1	0	*		2	*	*		1	*	*		0	*	0		2	*	*	
Quitman	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	*		0	0	0	0
Rabun	0	0	0	0	0	*	0		2	0	*		4	*	*		3	0	*		1	0	*	
Randolph	0	0	0	0	0	0	0	0	0	0	0	0	0	*	0		0	0	0	0	1	0	*	
Richmond	3	*	*		8	14.3	9.3	-5	21	10.5	18.3	7.8	12	17.5	10.4	-7.1	12	17.2	20	2.5	3	27	*	
Rockdale	0	0	0	0	5	*	15		2	13.7	*		6	23.5	11.5	-12	2	*	*		3	*	*	
Schley	0	0	0	0	0	0	0	0	2	0	*		0	0	0	0	0	0	0	0	0	0	0	0
Screven	0	0	0	0	0	*	0		0	*	0		1	*	*		2	0	*		0	0	0	0
Seminole	0	0	0	0	0	0	0	0	1	*	*		0	0	0	0	0	0	0	0	0	0	0	0
Spalding	0	0	0	0	3	*	*		8	22.9	20.5	-2.4	4	*	*		6	41.8	29	-13	3	*	*	
Stephens	0	*	0		3	*	*		2	*	*		3	34.2	*		1	*	*		2	*	*	
Stewart	0	0	0	0	0	0	0	0	0	*	0		1	0	*		0	0	0	0	0	0	0	0
Sumter	0	0	0	0	0	0	0	0	1	*	*		5	*	28.1		1	*	*		0	0	0	0
Talbot	0	0	0	0	0	0	0	0	0	0	0	0	2	0	*		0	0	0	0	0	0	0	0
Taliaferro	0	0	0	0	0	0	0	0	0	*	0		0	*	0		0	0	0	0	0	0	0	0
Tattnall	1	*	*		1	*	*		1	*	*		5	*	42		0	0	0	0	1	*	*	
Taylor	0	0	0	0	0	0	0	0	0	*	0		1	*	*		1	0	*		1	0	*	
Telfair	0	0	0	0	1	0	*		1	0	*		0	*	0		3	*	*		0	0	0	0
Terrell	0	*	0		0	0	0	0	0	*	0		2	0	*		2	*	*		0	0	0	0
Thomas	0	*	0		2	*	*		5	22	19.3	-2.7	3	19.7	*		4	*	*		0	0	0	0
Tift	0	*	0		1	*	*		4	*	*		6	*	26.2		2	0	*		1	*	*	
Toombs	0	0	0	0	2	*	*		3	0	*		1	*	*		2	*	*		1	*	*	
Towns	0	0	0	0	0	*	0		1	*	*		2	110	*		2	*	*		1	0	*	
Treutlen	0	0	0	0	0	0	0	0	1	*	*		1	0	*		0	0	0	0	0	0	0	0
Troup	2	*	*		2	20.3	*		6	18.4	15.7	-2.7	3	*	*		0	*	0		1	*	*	
Turner	0	0	0	0	1	0	*		0	0	0	0	0	*	0		0	0	0	0	0	0	0	0
Twiggs	0	0	0	0	1	*	*		0	0	0	0	3	*	*		1	*	*		0	*	0	
Union	0	0	0	0	0	0	0	0	2	*	*		6	0	53.4	53.4	1	45.5	*		1	*	*	
Upson	0	*	0		0	*	0		2	*	*		2	37.7	*		2	47.6	*		0	0	0	0
Walker	1	*	*		4	*	*		6	*	15		4	13.4	*		1	*	*		6	0	48	48.3
Walton	2	*	*		2	17.6	*		9	13.6	16.1	2.5	7	16.2	16.2	0	4	*	*		1	*	*	
Ware	1	*	*		0	*	0		5	*	24.4		1	*	*		1	*	*		1	*	*	
Warren	0	0	0	0	0	0	0	0	0	*	0		1	0	*		0	0	0	0	1	*	*	
Washington	0	0	0	0	0	*	0		0	0	0	0	2	*	*		0	0	0	0	1	0	*	
Wayne	0	0	0	0	0	*	0		5	*	25.9		8	*	46.8		2	*	*		0	0	0	0
Webster	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	1	0	*		1	*	*		0	*	0	
White	0	0	0	0	2	*	*		6	*	39		4	47.3	*		1	*	*		0	0	0	0
Whitfield	3	*	*		5	13.7	13.7	0	11	16.9	18.8	1.9	7	16.8	13.5	-3.3	3	*	*		2	*	*	
Wilcox	1	0	*		0	0	0	0	0	0	0	0	2	0	*		1	*	*		0	0	0	0

Wilkes	0	0	0	0	1	*	*	0	*	0	0	*	0	0	*	0	1	*	*
Wilkinson	0	0	0	0	0	*	0	2	*	*	1	*	*	1	*	*	0	*	0
Worth	0	0	0	0	2	0	*	2	0	*	0	*	0	1	*	*	1	*	*

"." = not enough data to reliably produce a rate.

Source: Georgia data - 2003-2010 Version 2.8.4 CV: 1.9 Georgia Department of Community Health, Division of Public Health, Office of Health Information and Policy,

Oasis Mortality/Morbidity Query, http:oasis.state.ga.us/oasis/qryMorbMort.aspx 8/24/2010

US Data Source: NCHS Vital Statistics System for numbers of deaths, Bureau of Census for population and estimates.(http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html).

Produced by : Office of Statistics and Programming, National Center for Injury Control and Prevention, CDCNCIPC, WISQUARS

Table Ap3-6 (updated 1/20/2012) **Georgia Department of Corrections Inmates in January 2011 with a Serious Mental Illness (SMI) and Estimate Released in FY 2010 who Needed Housing**

	Georgia Department of Corrections Active Inmates Identified with a Serious Mental Illness (SMI) in January 2011[1]						Released in FY2010[3] - Estimate with SMI[4] in need of Housing Support (32%)[5]				
Home County[2]	Total w/SMI	% w/SMI	Males w/SMI	Males % w/SMI	Females w/SMI	Females % w/SMI	All	w/SMI	20% Homeless	12% Unstable Housing	32% Need
Georgia	12,134	23%	9,981	20%	2,153	58%	20,540	4,714	943	566	1,509
Appling	29	24%	23	21%	6	67%	43	10	2	1	3
Atkinson	7	16%	7	18%	0	0%	9	1	0	0	0
Bacon	16	31%	14	29%	2	67%	24	8	2	1	2
Baker		0%	0	0%	0	0%	4	0	0	0	0
Baldwin	71	27%	61	26%	10	50%	139	38	8	5	12
Banks	21	34%	17	33%	4	44%	20	7	1	1	2
Barrow	63	21%	53	19%	10	56%	125	27	5	3	8
Bartow	114	20%	82	16%	32	53%	272	56	11	7	18
Ben Hill	57	25%	49	23%	8	47%	60	15	3	2	5
Berrien	29	35%	24	31%	5	83%	35	12	2	1	4
Bibb	313	27%	270	25%	43	64%	430	116	23	14	37
Bleckley	17	23%	16	23%	1	25%	36	8	2	1	3
Brantley	20	37%	16	33%	4	67%	14	5	1	1	2
Brooks	22	22%	18	19%	4	100%	24	5	1	1	2
Bryan	35	32%	30	29%	5	100%	44	14	3	2	5
Bulloch	83	23%	62	19%	21	68%	111	25	5	3	8
Burke	53	26%	48	25%	5	83%	74	20	4	2	6
Butts	27	20%	21	17%	6	55%	60	12	2	1	4
Calhoun	6	12%	5	10%	1	100%	18	2	0	0	1
Camden	28	21%	23	19%	5	56%	26	6	1	1	2
Candler	30	28%	22	23%	8	73%	32	9	2	1	3

Carroll	166	26%	118	21%	48	68%		**220**	**57**	**11**	**7**	**18**
Catoosa	67	27%	51	23%	16	59%		**83**	**22**	**4**	**3**	**7**
Charlton	12	21%	11	20%	1	33%		**12**	**3**	**1**	**0**	**1**
Chatham	476	21%	428	19%	48	60%		**943**	**196**	**39**	**24**	**63**
Chattahoochee	7	26%	6	24%	1	50%		**20**	**5**	**1**	**1**	**2**
Chattooga	56	22%	45	20%	11	58%		**77**	**17**	**3**	**2**	**6**
Cherokee	120	27%	82	21%	38	70%		**228**	**61**	**12**	**7**	**19**
Clarke	126	24%	98	21%	28	70%		**163**	**40**	**8**	**5**	**13**
Clay	9	21%	8	21%	1	25%		**12**	**3**	**1**	**0**	**1**
Clayton	275	18%	219	16%	56	53%		**715**	**130**	**26**	**16**	**42**
Clinch	14	22%	13	21%	1	50%		**22**	**5**	**1**	**1**	**2**
Cobb	528	23%	412	20%	116	59%		**1,198**	**281**	**56**	**34**	**90**
Coffee	64	25%	56	24%	8	42%		**88**	**22**	**4**	**3**	**7**
Colquitt	46	17%	40	16%	6	60%		**92**	**16**	**3**	**2**	**5**
Columbia	47	22%	33	17%	14	82%		**79**	**17**	**3**	**2**	**6**
Cook	25	19%	21	17%	4	67%		**47**	**9**	**2**	**1**	**3**
Coweta	106	23%	78	19%	28	61%		**223**	**51**	**10**	**6**	**16**
Crawford	6	21%	2	8%	4	100%		**10**	**2**	**0**	**0**	**1**
Crisp	68	26%	55	23%	3	14%		**72**	**18**	**4**	**2**	**6**
Dade	16	21%	16	22%	0	0%		**40**	**8**	**2**	**1**	**3**
Dawson	23	23%	16	18%	7	70%		**39**	**9**	**2**	**1**	**3**
Decatur	67	22%	50	18%	17	68%		**105**	**23**	**5**	**3**	**7**
DeKalb	569	19%	472	17%	97	52%		**1,211**	**229**	**46**	**27**	**73**
Dodge	45	29%	34	24%	11	85%		**92**	**27**	**5**	**3**	**9**
Dooly	17	20%	13	17%	4	57%		**29**	**6**	**1**	**1**	**2**
Dougherty	241	25%	206	22%	35	60%		**367**	**90**	**18**	**11**	**29**
Douglas	161	23%	129	21%	32	47%		**245**	**57**	**11**	**7**	**18**
Early	16	20%	12	16%	4	80%		**20**	**4**	**1**	**0**	**1**
Echols	4	40%	4	40%	0	0%		**4**	**2**	**0**	**0**	**1**
Effingham	46	27%	37	24%	9	50%		**67**	**18**	**4**	**2**	**6**
Elbert	35	24%	29	21%	6	67%		**62**	**15**	**3**	**2**	**5**
Emanuel	40	24%	32	21%	8	73%		**48**	**12**	**2**	**1**	**4**
Evans	19	22%	16	20%	3	60%		**33**	**7**	**1**	**1**	**2**

Fannin	23	23%	18	20%	5	50%		**39**	**9**	**2**	**1**	**3**
Fayette	35	21%	28	18%	7	47%		**69**	**14**	**3**	**2**	**5**
Floyd	188	25%	141	21%	47	63%		**336**	**83**	**17**	**10**	**27**
Forsyth	55	25%	37	19%	18	75%		**85**	**22**	**4**	**3**	**7**
Franklin	32	27%	28	26%	4	44%		**55**	**15**	**3**	**2**	**5**
Fulton	1,333	24%	1,165	22%	168	59%		**2,307**	**550**	**110**	**66**	**176**
Gilmer	38	27%	33	25%	5	56%		**42**	**11**	**2**	**1**	**4**
Glascock	3	38%	3	43%	0	0%		**4**	**2**	**0**	**0**	**0**
Glynn	103	28%	89	25%	14	78%		**100**	**28**	**6**	**3**	**9**
Gordon	77	25%	55	20%	22	56%		**136**	**33**	**7**	**4**	**11**
Grady	32	18%	28	17%	4	80%		**85**	**16**	**3**	**2**	**5**
Greene	30	28%	26	26%	4	57%		**40**	**11**	**2**	**1**	**4**
Gwinnett	282	16%	211	13%	71	51%		**810**	**131**	**26**	**16**	**42**
Habersham	30	25%	23	20%	7	88%		**64**	**16**	**3**	**2**	**5**
Hall	157	23%	118	19%	39	60%		**373**	**86**	**17**	**10**	**27**
Hancock	16	28%	15	27%	1	100%		**19**	**5**	**1**	**1**	**2**
Haralson	28	24%	25	22%	3	50%		**61**	**14**	**3**	**2**	**5**
Harris	28	27%	23	24%	5	71%		**50**	**13**	**3**	**2**	**4**
Hart	17	18%	14	16%	3	60%		**62**	**11**	**2**	**1**	**4**
Heard	22	32%	20	32%	2	40%		**32**	**10**	**2**	**1**	**3**
Henry	123	24%	87	19%	36	63%		**271**	**65**	**13**	**8**	**21**
Houston	142	26%	119	24%	23	58%		**197**	**52**	**10**	**6**	**16**
Irwin	16	20%	14	18%	2	67%		**24**	**5**	**1**	**1**	**2**
Jackson	59	30%	50	27%	9	90%		**85**	**25**	**5**	**3**	**8**
Jasper	22	26%	22	28%	0	0%		**29**	**8**	**2**	**1**	**2**
Jeff Davis	24	28%	16	21%	8	73%		**25**	**7**	**1**	**1**	**2**
Jefferson	23	16%	20	15%	3	43%		**48**	**8**	**2**	**1**	**3**
Jenkins	17	26%	14	23%	3	75%		**21**	**5**	**1**	**1**	**2**
Johnson	18	32%	12	25%	6	75%		**18**	**6**	**1**	**1**	**2**
Jones	35	29%	29	26%	6	75%		**43**	**13**	**3**	**2**	**4**
Lamar	21	29%	17	26%	4	57%		**33**	**10**	**2**	**1**	**3**
Lanier	9	20%	8	19%	1	33%		**21**	**4**	**1**	**0**	**1**
Laurens	78	25%	66	22%	12	55%		**156**	**38**	**8**	**5**	**12**

Lee	17	21%	16	21%	1	33%		**34**	**7**	**1**	**1**	**2**
Liberty	45	17%	37	15%	8	47%		**125**	**21**	**4**	**3**	**7**
Lincoln	9	30%	9	31%	0	0%		**10**	**3**	**1**	**0**	**1**
Long	12	24%	7	16%	5	71%		**24**	**6**	**1**	**1**	**2**
Lowndes	92	19%	80	18%	12	40%		**205**	**39**	**8**	**5**	**12**
Lumpkin	23	26%	18	23%	5	63%		**55**	**15**	**3**	**2**	**5**
McDuffie	27	30%	24	28%	3	100%		**41**	**12**	**2**	**1**	**4**
McIntosh	27	23%	18	17%	9	64%		**43**	**10**	**2**	**1**	**3**
Macon	5	10%	2	4%	3	60%		**24**	**2**	**0**	**0**	**1**
Madison	40	22%	37	22%	3	33%		**50**	**11**	**2**	**1**	**4**
Marion	17	26%	15	23%	2	100%		**15**	**4**	**1**	**0**	**1**
Meriwether	47	23%	39	20%	8	62%		**80**	**18**	**4**	**2**	**6**
Miller	9	27%	7	23%	2	100%		**11**	**3**	**1**	**0**	**1**
Mitchell	42	20%	36	18%	6	46%		**61**	**12**	**2**	**1**	**4**
Monroe	37	25%	33	24%	4	50%		**31**	**8**	**2**	**1**	**3**
Montgomery	17	28%	11	20%	6	100%		**20**	**6**	**1**	**1**	**2**
Morgan	22	20%	20	19%	2	22%		**38**	**7**	**1**	**1**	**2**
Murray	59	32%	44	27%	15	65%		**94**	**30**	**6**	**4**	**10**
Muscogee	317	22%	273	20%	44	54%		**663**	**143**	**29**	**17**	**46**
Newton	131	22%	106	19%	25	46%		**296**	**64**	**13**	**8**	**20**
Oconee	11	24%	9	22%	2	40%		**20**	**5**	**1**	**1**	**2**
Oglethorpe	14	24%	9	17%	5	100%		**28**	**7**	**1**	**1**	**2**
Paulding	77	25%	56	21%	21	62%		**172**	**44**	**9**	**5**	**14**
Peach	32	29%	27	26%	5	71%		**57**	**17**	**3**	**2**	**5**
Pickens	31	23%	21	18%	10	59%		**76**	**18**	**4**	**2**	**6**
Pierce	26	39%	24	39%	2	33%		**21**	**8**	**2**	**1**	**3**
Pike	15	25%	13	23%	2	50%		**27**	**7**	**1**	**1**	**2**
Polk	77	33%	60	30%	17	55%		**92**	**30**	**6**	**4**	**10**
Pulaski	23	29%	22	29%	1	33%		**43**	**13**	**3**	**2**	**4**
Putnam	35	24%	31	22%	4	67%		**51**	**12**	**2**	**1**	**4**
Quitman	1	7%	1	8%	0	0%		**2**	**0**	**0**	**0**	**0**
Rabun	18	35%	12	29%	6	55%		**32**	**11**	**2**	**1**	**4**
Randolph	19	29%	17	27%	2	100%		**19**	**6**	**1**	**1**	**2**

Richmond	442	27%	373	24%	69	75%		**584**	**156**	**31**	**19**	**50**
Rockdale	69	18%	47	14%	22	58%		**180**	**32**	**6**	**4**	**10**
Schley	7	30%	6	29%	1	50%		**11**	**3**	**1**	**0**	**1**
Screven	24	19%	18	16%	6	60%		**35**	**7**	**1**	**1**	**2**
Seminole	24	37%	17	31%	7	64%		**18**	**7**	**1**	**1**	**2**
Spalding	152	26%	122	23%	30	59%		**223**	**57**	**11**	**7**	**18**
Stephens	46	26%	36	22%	10	63%		**67**	**17**	**3**	**2**	**6**
Stewart	10	29%	8	25%	2	100%		**16**	**5**	**1**	**1**	**2**
Sumter	34	16%	30	14%	4	40%		**84**	**13**	**3**	**2**	**4**
Talbot	19	27%	17	25%	2	67%		**15**	**4**	**1**	**0**	**1**
Taliaferro	1	10%	1	10%	0	0%		**4**	**0**	**0**	**0**	**0**
Tattnall	43	26%	35	23%	8	47%		**57**	**15**	**3**	**2**	**5**
Taylor	14	16%	12	15%	2	33%		**39**	**6**	**1**	**1**	**2**
Telfair	34	29%	25	24%	9	75%		**46**	**13**	**3**	**2**	**4**
Terrell	10	15%	7	11%	3	75%		**23**	**3**	**1**	**0**	**1**
Thomas	64	25%	55	22%	9	64%		**115**	**28**	**6**	**3**	**9**
Tift	77	28%	72	27%	5	42%		**72**	**20**	**4**	**2**	**6**
Toombs	60	20%	47	16%	13	65%		**77**	**15**	**3**	**2**	**5**
Towns	11	26%	9	25%	2	33%		**13**	**3**	**1**	**0**	**1**
Treutlen	16	25%	14	23%	2	50%		**31**	**8**	**2**	**1**	**2**
Troup	121	22%	97	19%	24	50%		**300**	**66**	**13**	**8**	**21**
Turner	12	16%	11	15%	1	25%		**14**	**2**	**0**	**0**	**1**
Twiggs	21	31%	18	28%	3	100%		**21**	**7**	**1**	**1**	**2**
Union	30	39%	21	32%	9	82%		**35**	**14**	**3**	**2**	**4**
Upson	61	35%	45	29%	16	89%		**101**	**35**	**7**	**4**	**11**
Walker	98	25%	75	21%	23	64%		**124**	**30**	**6**	**4**	**10**
Walton	78	20%	65	18%	13	36%		**198**	**39**	**8**	**5**	**13**
Ware	73	28%	62	25%	11	61%		**102**	**28**	**6**	**3**	**9**
Warren	10	26%	8	22%	2	100%		**21**	**6**	**1**	**1**	**2**
Washington	50	30%	36	24%	14	82%		**41**	**12**	**2**	**1**	**4**
Wayne	34	18%	26	15%	8	50%		**70**	**13**	**3**	**2**	**4**
Webster	2	29%	1	17%	1	100%		**6**	**2**	**0**	**0**	**1**
Wheeler	7	19%	5	17%	2	33%		**12**	**2**	**0**	**0**	**1**

White	27	28%	18	21%	9	75%		**51**	**14**	**3**	**2**	**4**
Whitfield	156	29%	120	25%	36	55%		**261**	**75**	**15**	**9**	**24**
Wilcox	19	29%	13	22%	6	86%		**20**	**6**	**1**	**1**	**2**
Wilkes	14	22%	12	20%	2	50%		**28**	**6**	**1**	**1**	**2**
Wilkinson	16	28%	12	24%	4	67%		**30**	**8**	**2**	**1**	**3**
Worth	25	23%	21	20%	4	67%		**45**	**10**	**2**	**1**	**3**
Unknown	281	22%	225	19%	56	62%		**451**	**98**	**20**	**12**	**31**
Not Reported	794	20%	728	19%	66	39%		**333**	**67**	**13**	**8**	**21**

1. Georgia Department of Corrections: Inmate Statistical Profile - Active Inmates with Mental Health Level 2 and Above, January 2011.

2. Home County: self-reported at entry to prison

3. Georgia Department of Corrections. Inmate Statistical Profile 14-SEP-10: Inmates Released During Fy 2010.

4. Inmate population prevalence of level 2 mental health and above for January 2011 was used to estimate SMI for Inmates released.

5. An ad hoc study conducted for a NAMI workgroup in DBHDD Region 3 found that approximately 20% of inmates in county jails treated for Serious Mental Illness reported being homeless at entry and 12% reported they would have unstable housing plans upon release.

Notes.

(a) All Georgia counties also house prisoners in county jails; some of whom will transfer to Georgia Department of Corrections. The information on this table, therefore partially estimates the numbers of incarcerated individuals with serious mental illness.

(b) Mental Health and Drug Courts and other diversion programs that help individuals recover and stay out of jail report that affordable and supportive housing is a critical tool for them.

(c) National studies have consistently found undiagnosed Mental Illness (MI) and significantly higher levels of MI in women inmates.

Table Ap3-7 Georgia's Counties with Access to Mental Health, Drug, and Veterans Courts (FY 2014) [1, 2]

	Mental Health (MH) Courts			Drug Courts			Veterans Courts
Counties (Co)	Adult	Juvenile (Juv)	Felony Drug Mental Health Ct	Adult / Felony / Misdemeanor	Juvenile (Juv)	Juv Family (Fam) Drug/Dependency	
Georgia (2)	45	4	16	82	17	19	13
Appling							
Atkinson				x			
Bacon							
Baker							
Baldwin	x		x	x	x	x	
Banks	x			x			
Barrow	x			x			
Bartow				x		x	
Ben Hill							
Berrien				x			
Bibb	x	x		x	x		
Bleckley							
Brantley	x			x			
Brooks							
Bryan				x			
Bulloch	x			x			
Burke	x		x	x		***	x
Butts	x		x	x			x
Calhoun							
Camden				x			
Candler							
Carroll				x	x		
Catoosa							
Charlton							
Chatham	x	x		x	x	x	x
Chattahoochee	x						x
Chattooga							
Cherokee	x			x			
Clarke	x			x		x	
Clay							
Clayton				x			
Clinch				x			
Cobb	x			x	x	x	
Coffee				x			
Colquitt	x		x	x			
Columbia	x		x	x			x
Cook				x			
Coweta				x			
Crawford				x			
Crisp							
Dade							
Dawson	x			x			
Decatur							
DeKalb	x	x		x	x		
Dodge							
Dooly							
Dougherty	x		x				

Douglas						x	
Early							
Echols							
Effingham				x			
Elbert				x			
Emanuel							
Evans				x			
Fannin	x			x	x	x	x
Fayette				x			
Floyd							
Forsyth	x			x	x		
Franklin							
Fulton	2		x	x	x	x	
Gilmer	x			x	x	x	x
Glascock							
Glynn							
Gordon							
Grady							
Greene	x		x				
Gwinnett	x			x	x		
Habersham				x			
Hall	x			x		x	
Hancock							
Haralson				x			
Harris	x						x
Hart							
Heard				x			
Henry	x	x		x			
Houston							
Irwin							
Jackson	x			x			
Jasper	x		x				
Jeff Davis							
Jefferson							
Jenkins							
Johnson				x			
Jones	x		x			x	
Lamar	x		x	x			x
Lanier				x			
Laurens				x	x		
Lee							
Liberty				x			
Lincoln							
Long				x			
Lowndes							
Lumpkin	x			x		x	
McDuffie							
McIntosh				x			
Macon							
Madison							
Marion							
Meriwether				x			
Miller							
Mitchell	x			x			
Monroe	x		x	x			x
Montgomery							
Morgan	x		x				
Murray				x			
Muscogee	x			x	x		x

Newton	x		x	x		
Oconee			x			
Oglethorpe						
Paulding						
Peach			x			
Pickens	x		x	x	x	x
Pierce	x		x			
Pike			x			
Polk			x			
Pulaski						
Putnam	x	x			x	
Quitman			x			
Rabun			x			
Randolph			x			
Richmond	x	x	x			x
Rockdale			x	x		
Schley						
Screven						
Seminole						
Spalding			x			
Stephens			x			
Stewart						
Sumter						
Talbot						
Taliaferro						
Tattnall			x			
Taylor						
Telfair						
Terrell			x			
Thomas						
Tift						
Toombs						
Towns			x		x	
Treutlen			x			
Troup	x		x			
Turner						
Twiggs			x			
Union			x		x	
Upson			x			
Walker						
Walton	x			x		
Ware	x		x			
Warren						
Washington						
Wayne			x			
Webster						
Wheeler						
White			x		x	
Whitfield			x			
Wilcox						
Wilkes						
Wilkinson	x	x			x	
Worth						

Note. See the site below to update information. New legislation has provided incentives for increased Mental Health Courts in GA.
1. Georgia Accountability Courts (http://www.gaaccountabilitycourts.org/)
2. The Georgia counts represents the number of counties with the particular type of court.