



GEORGIA MENTAL HEALTH GAP ANALYSIS

TABLE OF CONTENTS

<u>CHAPTER TITLE and SECTIONS</u>	<u>Page Number</u>
Executive Summary	i
Chapter I: Introduction and Methodology	1
A. An Introduction to Georgia and Georgia’s Mental Health Gap Analysis	1
B. An Introduction to Georgia’s Mental Health Gap Analysis Research Team	4
C. Data Collection Methods Data Analysis of Populations Served and Service Utilization from Multiple Sources	4
D. Limitations of Data	8
Chapter II: Promising Practices, Emerging Trends, and Strengths within Georgia	10
A. National Trends and Research	10
B. Georgia’s Implementation of Evidence-Based Practices	13
C. Spotlight on Georgia’s Peer Support Program	17
D. New Leadership and Current Initiatives at the system and regional levels	19
Chapter III: Population in Need of Services	25
A. Definitions of Serious Mental Illness and Serious Emotional Disorder	25
B. Review of Prevalence and Differing Methods for Estimates Methodologies	27
C. The Number of Georgians Estimated to Mental Illness	29
D. The Uninsured in Georgia	32
Chapter IV: Stakeholder Involvement	39
A. Regional and Specialized Focus Groups	39
B. Online Survey Summary	42
C. Personal Interview with State Policymakers	48
D. Building on Current Strengths: A Review of Priorities Set by Leaders within Georgia’s Service System	48

Chapter V: Availability of Community Services	58
A. Characteristics of an Ideal System of Support	58
B. Georgia's Community Based Mental Health System	67
C. Availability of Current Community Services	68
Chapter VI: Who is Currently Receiving Community Services in Georgia?	80
A. The Population Currently Enrolled in Community Based Services	80
B. Services Provided by Different State Agencies	107
C. In-Depth Analysis of Utilization and Intensive Services	117
Chapter VII: Community Services for Special Populations	128
A. Children, Adolescents, and Transitional Youth	129
B. Adult and Youth Probation and Parole	131
C. Older Adults and the Elderly	135
D. Individuals that are Homeless	137
E. Individuals with Co-Occurring Mental Health and Substance Abuse	139
F. Individuals who are Deaf or Hearing Impaired	144
G. People with Limited English Proficiency Limited English Proficiency	146
Chapter VIII: Current Hospital System and Services	151
A. Availability of Current Hospital Services	151
B. Current Hospital System Capacity	159
C. Population Currently Enrolled in Hospital Services	165
Chapter IX: Assessment of Available Public Mental Health Workforce	190
A. State of Nation and State of Georgia	190
B. Who is working in Georgia's Public Mental Health System?	199
C. Salary Comparisons	211
D. Community vs. Hospital Workforce	217
E. Opportunities to Strengthen Georgia's Workforce	227
Chapter X: Current Community System Capacity	241
A. Introduction to Capacity of Georgia's Community System	241
B. Workforce Issues: Recruitment and Retention of Qualified Staff	243
C. Provider Productivity	244
D. Quality of Services	246
E. Analysis of Provider Pool and Array of Services Offered	247
F. Issues of Access	249
Chapter XI: Public Financing and Information Systems	258
A. Cost Analysis of Current System	258

B. Information Systems	263
Chapter XII: State to State Comparison	275
A. Community Comparisons	276
B. Hospital Comparisons	297
Chapter XIII: Recommendations for Steps to Address Mental Health Service Gaps	315
A. Recommendations for Ongoing Gap Analysis	315
B. Establishing the Foundation to Address Mental Health Service Gaps	319

LIST OF APPENDICES

Executive Summary:

APPENDIX i-1 DEMOGRAPHIC CHARACTERISTICS

Chapter II:

APPENDIX II-1: Core Customer Eligibility Form

Chapter III:

Appendix III-1: Prevalence Estimation Methodology

Appendix III-2A and III-2B: Division of MHDDAD Prevalence Tables

APPENDIX III-3 Poverty estimates by age gender and race

APPENDIX III-4 Prevalence by Age and County

APPENDIX III-5 Prevalence Detail by County

APPENDIX III-6 Prevalence for Poverty Households

Chapter IV:

APPENDIX IV-1: Gap Analysis Focus Group Summary

Chapter V:

APPENDIX V-1: Services Available by Provider

Chapter VI:

APPENDIX VI-1: Allocation of Resources Map

APPENDIX VI-2 FY04 EARF Consumer Counts by Service & Provider

APPENDIX VI-3 FY 04 EARF CSB Area Consumer Counts by Service Category

APPENDIX VI-4 FY 04 EARF Regional Age Analysis by CSB Area & County

APPENDIX VI-5 FY 04 EARF Regional Consumer Counts by Service Category

APPENDIX VI-6 FY 04 EARF Regional Gender Analysis by CSB Area & County

APPENDIX VI-7 FY 04 EARF Regional Gender Analysis by Service Category

APPENDIX VI-8 FY 04 EARF Regional Gender Analysis

APPENDIX VI-9 FY 04 EARD Regional Race Ethnicity Analysis by CSB Area and County

APPENDIX VI-10 FY 04 EARF Statewide Age Analysis by Service

APPENDIX VI-11 FY 04 EARF Consumer Counts by CSB

APPENDIX VI-12 EARF Statewide Age Analysis by Service

Chapter VII:

APPENDIX VII-1: MHDDAD Best Practices Suggestions for Co-Occurring Disorders

APPENDIX VII-2: Latino Mental Health and Substance Abuse Services in Georgia

Chapter VIII:

APPENDIX VIII-1: FY04 Hospital Utilization by Hospital

APPENDIX VIII-2: Average Client Load by Hospital Cost Center

APPENDIX VIII-3: Hospital Count by Age and County

APPENDIX VIII-4: Hospital Count by Age and Hospital

APPENDIX VIII-5: Hospital Count by Race and Gender by Hospital

APPENDIX VIII-6: Hospital Count by Unit and Age

APPENDIX VIII-7: FY04 Inpatient Admissions Statewide to DMHDDAD Hospitals

APPENDIX VIII-8: Average Length of Stay for Discharged Consumers by Hospital

APPENDIX VIII-9: Mean and Median Length of Stay for Discharged Consumers

APPENDIX VIII-10: 2003 CMHS Uniform Reporting System Output Table

Chapter IX:

APPENDIX IX-1: Roster of Practitioners by Type

APPENDIX IX-2: Average Salary Data

APPENDIX IX-3: Workforce Focus Group Conference Call Notes

Chapter X:

APPENDIX X-1: Analysis of Time Between Service Dates

Chapter XIII:

APPENDIX XIII-1: Matrix for Ongoing Gap Analysis



Georgia Mental Health Gap Analysis Executive Summary May 2005

Established by a Federal mandate, Georgia's Mental Health Planning and Advisory Council has the oversight responsibility for providing ongoing guidance to the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Disease (DMHDDAD) on services and system design throughout the state. The Mental Health Planning and Advisory Council requested a Gap Analysis of the mental health delivery system that serves Georgia. This Mental Health Gap Analysis provides a comprehensive assessment of the state's publicly funded mental health system, the system of care paid for by federal, state, and local tax dollars to support adults with Serious Mental Illness (SMI) and children and adolescents with Serious Emotional Disorders (SED).

In September 2004, the State of Georgia, through a competitive bidding process, awarded a contract to APS Healthcare to conduct the Mental Health Gap Analysis. APS Healthcare, one of the most prominent and diverse specialty and mental health companies in the field of health care, partnered with the National Council on Community Behavioral Health (NCCBH) represented by Lee Ann Slayton, Senior Consultant and Dougherty Management Associates, Inc., of Lexington, Massachusetts.

The goal of this project is to identify information that can be used to shape the public delivery system to best meet the needs of those Georgians that rely upon state supported Mental Health services to live in the community. This Gap Analysis provides a planning tool for local planning boards to determine the types of services needed, an advocacy tool to be used with legislators to justify funding requests, and a resource allocation tool with state policy.

The Mental Health Gap Analysis was conducted in the following manner:

- ❖ Baseline focus groups were conducted with local planning councils, regional advisory councils and statewide mental health groups
- ❖ The current service delivery system was thoroughly examined, determining the availability of persons in need and also determining adequacy, or lack of adequacy, of services for persons in need
- ❖ The public mental health workforce, including community based services and state funded hospitals, was reviewed to identify issues related to capacity, recruitment and retention of staff
- ❖ The numbers of persons who use public mental health services, along with the types of services, were summarized
- ❖ Utilizing social indicators and prevalence data on the general population related to mental health risk factors, system capacity was analyzed and the need for additional services was estimated

- ❖ An analysis was conducted on the differences in profiles between those receiving services and those not receiving services
- ❖ A data collection system and process was developed for the Department to utilize to compare the services currently available with services needed
- ❖ Recommendations were made for the Department of Human Resources to strategically enhance services to achieve the greatest impact on the mental health service system.
- ❖ The Public Mental Health System in Georgia was compared to that of Virginia, North Carolina, Tennessee and Maryland

With over 8 million residents, the state of Georgia is the 21st largest state in the nation. As Georgia's population grows, so does the number of individuals in need of Mental Health services. However, funding over the past decade has not grown in conjunction with the increased demand for community services. In fiscal year 2004, Georgia's Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases contracted for services that were provided to less than 180,000 people in the community. Additionally, the state's seven regional hospitals served over 16,000 people. Currently, the state of Georgia ranks 43rd nationally in per capita expenditures for mental health services. In fiscal year 2004, the Public Mental Health System in Georgia served only 22%-40% of those who have Serious Mental Illness (SMI) or Serious Emotional Disorders (SED).

In addition to the funding challenges that contribute to major service gaps within the Public Mental Health system, the state experiences several barriers related to its infrastructure that hinder optimal implementation of a unified strategy. Despite these challenges, the state has been extremely successful in several key areas. For instance, in 1999, it obtained approval from the Centers of Medicaid and Medicare (CMS) to offer several innovative community-based services. In fact, Peer Supports was pioneered in Georgia as a Medicaid billable service that is nationally recognized. Additionally, the state has trained over 280 Certified Peer Specialists who promote recovery within provider agencies across Georgia. At a local level, there are a number of positive examples of innovative programming, collaboration across agencies and technologically advanced solutions that result in quality care and high consumer satisfaction. In the midst of a national health care crisis, state budget reductions, and competition for local resources, the staff that form the public mental health system in Georgia remain dedicated and steadfast in their mission to serve citizens within their community who are affected by mental illness.

The following findings summarize many of the primary gaps within the public mental health system in Georgia. Despite many obstacles, these limitations could potentially be much larger if it were not for Georgia's most valuable asset: its administrative and clinical workforce.

Overall in 2004, Georgia's public mental health services supplied through the MHDDAD system, reached less than a third of those estimated to have a serious mental illness or a serious emotional disturbance



- It is estimated that Georgia has 348,040 Adults with SMI and 158,302 Children and Adolescents with SED. In FY 04 the Public Mental Health System served less than 180,000 Adults and Children combined.
- In FY 04, each region within the Public Mental Health System served only 22%-40% of those who have Serious Mental Illness (SMI or Serious Emotional Disorders SED).

Regions	Youth In Need Receiving Services	Adults In Need receiving services	Percentage In Need receiving services
Central	32.0%	42.7%	39.3%
East Central	26.8%	33.1%	31.1%
Metro	13.3%	27.2%	22.8%
North	24.6%	35.8%	32.3%
Southeast	32.7%	44.0%	40.4%
Southwest	30.6%	47.1%	42.0%
West Central	26.1%	34.9%	32.0%
Statewide Total	23.8%	35.5%	31.8%

Data Source: Number in need generated from Holzer estimates compared to MHMRIS Enrollment Data for FY 04

- Georgia's overall expenditures on MHDDAD community services are lower than in other states. In fact, Georgia is ranked 43rd nationally in mental health expenditures per capita.
- There are estimated to be **110,293** Georgians who are uninsured and that are in need of mental health treatment and many more who are underinsured (*Uninsured as defined by Kaiser Health Facts*).
- Georgia's overall prevalence rate of individuals with mental illness within the total population is 6.7%. Youth 17 and under have a somewhat higher rate at 7.4%, and adults a somewhat lower rate at 6.43%.
- When compared to similar states Georgia is getting mental health services to fewer of its Medicaid enrollees and it is providing a lower intensity of services to those that do get services.

The Public Mental Health System Struggles to Serve Special Populations and Minorities in Georgia



- **T**ransitional Youth (ages 17-24), Individuals with Limited English Proficiency, Deaf and Hearing Impaired, and people with Co-Occurring disorders face significant barriers to accessing appropriate community services.
- **C**ertain Minority Groups are underserved as a percentage of all recipients of public services.
 - 2.1% of service population is Hispanic compared to national 4.9% average served
 - 0.5% of service population is Asian compared to national 1.1% average served
 - 0.1% of service population is Native American/Native Alaskan compared to national 1.0% average served
- **G**eorgia's high prevalence subpopulations are: Adolescents, Adult Females, Non-White Children, and Individuals Below 200% of Poverty. These groups need to be further evaluated for how well each group is provided access to services and whether the services they get are meeting their needs.
- **F**or children and adolescents needing mental health services at any point in time there are approximately 1300 LOC children in DFCS custody in placement, and an additional 300 under the custody of DJJ.
- **I**n Georgia's correctional population, 10.5% males and 26.8% females are classified as needing mental health services.
- **F**ifteen to 25 percent of older adults in the United States suffer from significant symptoms of mental illness, yet the Division of MHDDAD provided services to only 5,254 individuals over the age of 65, comprising less than 3% of the total population served, and less than 1% of the total population of adults over the age of 65.
- **I**t is estimated that nearly 10,000 homeless individuals are in need of mental health services across the state.
- **A**cross the state there are 55,080 individuals with co-occurring Mental Health and Addictive Diseases enrolled in services in FY04.
- **U**sing the statewide percentage for prevalence of SMI or SED there are estimated to be between 2,900 – 4,600 individuals who are deaf and experience a mental illness.
- **L**atino's represent nearly 6% of Georgia's population, however only 2% of the public mental health system consumers enrolled in services were identified as Latino.

Even with the high numbers of Georgians in need of Mental Health services, many do not receive an intensity of care needed by people with serious Mental Illness.



- **Only 7% of people in need of services are receiving Individual Community Support, which should be the primary service delivered to individuals with SMI.**

SERVICE	# Served	% In Need Served	% Of 200% Poverty In Need Served
Community Support Individual - Adult	24,919	7%	17%
Community Support Individual – Child and Adolescent	13,011	8%	18%

Data Source: Holzer prevalence estimates compared to MHMRIS Enrollment Data for FY04

- **Despite the fact that Georgia purchases Innovative Community Services (Assertive Community Treatment, Intensive Family Intervention, Community Support Teams), they are not consistently available across the state:**
 - The majority of services provided in Georgia remain clinic-based outpatient services with most consumers enrolled in Diagnostic/Functional Assessment, along with pharmacy services and physician and nursing assessment provided to the majority of consumers.
 - While Community Service Boards (CSBs) serve as much as 90% of the public MH population, only 4 of 25 CSBs offer Assertive Community Treatment teams. Numbers served range from as many as 100 at one CSB, to and as few as 2 another CSB.
 - Most CSBs offer Community Support Teams but to a very limited number of recipients – on average about 150 consumers per agency.
- **During FY2004, less than 15% of total adults served, and fewer than 10% of children and adolescents served, were enrolled in intense community services.**
- **Only 45% of consumers (statewide average) were enrolled in Innovative Community Services (such as Community Support or Intensive Family Intervention) with great variation among providers, from a low of 15% at Cobb CSB to a high of 92% at Georgia Pines CSB.**
- **Older Adults were served at a much lower rate than the general population, with less than 2,000 individuals over the age of 64 enrolled in intensive services. This represents less than 1% of the consumers served statewide.**

Based on current productivity and inequitable distribution of resources across the state, community provider staffing ratios are insufficient to meet the minimum need for services. When prevalence of needs is considered, the gap is even greater.



- As a percentage of Georgia's healthcare workforce (health care professionals only), MHDDAD hospital and community-based mental health clinicians and paraprofessionals represent only 3.6% (and only 2.5% of the Georgia's entire healthcare workforce).

MHDDAD Community and Hospital Professional Licensure* by Region per 100 Square Miles							
	Population enrolled in Services	Square Miles Per Region	Clinical Social Workers per 100 Square Miles	Master Social Workers per 100 Square Miles	Professional Counselors per 100 Square Miles	LPNs per 100 Square Miles	RNs per 100 Square Miles
Central	17,743	8,573	0.34	0.18	0.57	0.88	1.27
East Central	17,152	8,331	0.34	0.28	0.34	0.08	0.78
Metro	34,328	1,808	8.32	2.63	4.56	3.68	10.95
North	42,166	9,520	0.33	0.16	0.67	0.51	0.89
Southeast	23,531	11,768	0.18	0.12	0.22	0.35	0.76
Southwest	18,506	9,452	0.22	0.22	0.44	0.61	0.77
West Central	21,552	9,178	0.31	0.14	0.56	0.73	0.91
Total	174,298	58,630	0.53	0.25	0.58	0.62	1.20

**Licensure data is not exclusive to direct care workforce*

- The supply of Certified Peer Specialists is not being used to its potential.
 - Sample survey results estimate that 65% of trained Certified Peer Specialists are not employed by the MHDDAD system.
- Based on current productivity, staffing ratios by community providers are insufficient to meet minimum need for services based on population prevalence for those in poverty with mental illness.
 - An extrapolation of current staffing patterns indicates a needed increase in statewide staff of 799 licensed professionals (278 social workers, 217 nurses, 81 medical doctors/psychiatrists, and 19 psychologists) and 1,008 non-licensed professionals.

Based on current productivity, community provider staffing ratios are insufficient to meet the minimum need for services. When prevalence of population need is considered, the gap is even greater. (Continued)



- Salaries of the public mental health service system staff are predominantly non-competitive in the marketplace. The availability of higher salaries through employment by private sector and other public agencies that provide mental health services presents a disincentive for the public mental health workforce recruitment and retention efforts.
 - MHDDAD's entry level salary for registered nurses is 38% lower than the entry level salary for registered nurses with the Department of Corrections (\$31,474 compared to \$43,680 respectively).
 - Starting salary for an inpatient Licensed Practical Nurse is \$21,401 for East Central Hospital compared to \$25,410 for Roosevelt Warm Springs Rehabilitation Center (Department of Labor).
 - Georgia salaries for primary clinical professionals are one of the two lowest in a comparison to North Carolina, Tennessee and Virginia.
 - \$38,500 is the Department of Corrections' midpoint salary for non-licensed social service providers where the average salary of MHDDAD's non-licensed hospital social service providers tops out at \$38,315.

The fragmented infrastructure of the State's many offices involved in financing, accounting and information management does not support Division goals for measuring utilization, trending and planning for system needs.



- **C**urrent State Data Management and Accounting Systems do not support the Division's goals to enhance continuous quality improvement or strengthen the link between community and hospital treatment services for continuity of care.
 - Continuous quality improvement is not possible without the ability to accurately trend utilization. MHMRIS utilization data is not complete because it does not have the ability to track encounter data by provider, quantity, intensity and funding streams or audit records for more current individualized personal demographic information.
 - Consumers who receive both hospital and community treatment are tracked in two independent data information systems rather than a system that supports consumer transition between both treatment environments through a single, centralized electronic record. This does not support continuity of care across systems.
 - Data maintenance and management absorbs unnecessary human resource time from both the user input perspective and centralized system management perspective due to inefficient system design infrastructure and architecture.
- **T**here is no centralized accounting system for tracking all dollars from multiple funding streams within the Community Mental Health System.
 - Expenditure totals for FY2004 were reported differently from three different sources

State Hospitals appear to fill the void of community-based crisis services, putting strain on an overcrowded hospital system.



Measure	National Average	Georgia Average
Occupancy Rate	83.4%*	96.6%
Median Length of Stay	30.4 days	5 days
Readmission Rate (30 day)	8.5%	13.2%
*National Average = Average of 3 comparison states		

- **H**ospital facilities are overburdened and hospital treatment is often provided as a first option rather than last resort.
 - Georgia's hospitals have an average 96% occupancy rate compared to an optimal 85%. (Average occupancy rates of comparison states do not exceed 93.45%)
 - For every 1,000 Georgians, 2.09 will receive hospital treatment compared to the national average of 0.62.
- **C**ontinuity of care supports are insufficient to ensure system effectiveness
 - 28% of hospital Adult Mental Health discharges in FY04 were not enrolled in community services either prior to admission or following discharge in FY04; 41% were not enrolled in any service following their last discharge. During FY04, 30% of discharges were not enrolled in any service other than diagnostic assessment services and 44% were not enrolled after their last discharge in any service other than diagnostic assessment services.
 - 45% of Adult Mental Health unit discharges were for consumers with a primary or secondary diagnosis of substance abuse
 - 23-Hour observation beds are reportedly overly utilized for assisting consumers to become sober or assessing need for detoxification treatment.
 - Georgia's hospital 30-day readmission rates are 55% greater than the national average
 - Georgia's statewide hospital median length of stay is 5 days compared to an average length of stay of 30.4 days. This suggests that hospital services may not be optimally utilized.
 - The staffing ratio proposed for Adult Mental Health per MHDDAD workgroup guidelines distributed in February 2003 was 1.8 staff per consumer. All hospitals fall short of this ratio and three hospitals fall below 0.60 staff per consumer.

Focus Groups and Surveys reflect a fragmented vision for an improved Mental Health System.



- **Surveys** report that there is a misinterpretation of the role that the Division of MHDDAD should hold within the state
 - There is a lack of understanding regarding the Core Customer to be served using public mental health dollars
 - 54% say People with private insurance should be receiving services from the public mental health system, yet only a few CSBs billed private insurance companies
 - 78% say People with moderate incomes and 41% believe that people with high incomes should be receiving services from the public mental health system
 - Infrastructure barriers to community living such as transportation and housing were seen to be the responsibility of the public mental health system

- **Barriers** to services were all across the board, with no clear priorities rising to be the focus for the advocacy community
 - Georgia is need of a prioritized agenda for change, with accompanying campaigns to educate legislators and the general public about public mental health services

CHAPTER I: MENTAL HEALTH GAP ANALYSIS INTRODUCTION AND METHODOLOGY

In this chapter you will find:

- ❖ *An Introduction to Georgia and to Georgia's Mental Health Gap Analysis*
- ❖ *An Introduction to Georgia's Mental Health Gap Analysis Research Team*
- ❖ *Data Collection Methodology*
- ❖ *Limitations of Data*

In fiscal year 2004, Georgia's Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases contracted for mental health services that were provided to nearly 200,000 people in the community. Additionally, the state's seven regional hospitals served over 16,000 people with mental illness. As Georgia's population grows, so does the number of individuals in need of mental health services. However, funding over the past decade has not grown in conjunction with increased demand for community services. The purpose of this study is to measure the gap between those in need of services and Georgia's capacity to serve its most vulnerable citizens.

A. An Introduction to Georgia and Georgia's Mental Health Gap Analysis

The People of Georgia

The State of Georgia is the largest state east of the Mississippi River and the 24th largest state in the country. In 2000, there were 8.2 million people living in Georgia, an increase of 26.4% from 1990. This makes Georgia the 10th most populous state in the country, and state officials project a population of 9.2 million people by 2010. There are 159 counties in Georgia. Of these, 151 (95%) experienced population growth during the period 1990-2000.

County population density ranges dramatically from almost one million people living in urban Fulton County, site of Atlanta, to 2,077 in rural Taliaferro County. There are 32 counties with populations under 10,000 and eight counties that have fewer than 5,000 residents. Slightly more than 47% of Georgia's cities have populations under 1,000.

According to the 2000 census:

- Twenty-nine percent (29.5%) of Georgians were age 19 or younger, which is above the national average of 28.6%
- Nine percent (9.6%) of the state's population was 65 or older compared with 12.4% nationally

- The 2000 census also indicated that 65.1% of Georgians were white, 28.7% were Black or African-American, and 2.1% were Asian. Hispanics, who may be listed as Black or White in the census data, accounted for 5.3% of Georgia's population
- African-Americans represent greater than 50% of the population in 17 of Georgia's counties
- In 2004, there were 767,595 foreign born Georgians, with the majority coming from Mexico, Germany, Korea, India and Jamaica. (U.S. Census Bureau: Current Population Survey – Supplement, March 2004)

DHR's Mission

In an effort to meet the needs of Georgia's diverse and growing population, the Department of Human Resources (DHR) is responsible for "ensuring the appropriate use of state, federal and other funds to provide quality services" for seriously mentally ill (SMI) adults and seriously emotionally disturbed (SED) children and adolescents who are served by the public system. Additionally, it is charged to "protect consumers of these services from abuse and maltreatment." The Division of Mental Health, Developmental Disabilities and Addictive Diseases has an "obligation and responsibility to develop and implement planning and service delivery systems" that meet the criteria of functional disability and are financially unable to pay for all or part of the services. To this end, the Division has adopted a core set of consumer-oriented community-based values and principles incorporated into the planning and delivery of services.

DEPARTMENT OF HUMAN RESOURCES PRINCIPLES AND VALUES

- ❖ Consumers and families should have choices about services and their providers and should have input into the planning and delivery of all services;
- ❖ A single point of accountability should exist for fiscal, service and administrative issues to ensure coordination of services among all programs and providers;
- ❖ The system should be comprehensive and adaptive to allow consumers and their families access to the services they desire and need;
- ❖ Public programs are the foundation of the system and should be valued and nurtured, while private sector involvement is increased for expanded consumer choice;
- ❖ Planning should reside at the local level;
- ❖ The functions of service planning, coordination, contracting, resource allocation and consumer assessment should be separated from the actual provision of services; and
- ❖ Consumer and families should have a single, community based point of entry into the system.

Georgia's Mental Health Planning and Advisory Council

Established by a Federal mandate, The Mental Health Planning and Advisory Council has the oversight responsibility for providing ongoing guidance to the Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases (hereafter referred to as DMHDDAD) on services and system design throughout the state. The Mental Health Planning and Advisory Council remained invested in securing an analysis of the mental health delivery system and the Monitoring and Evaluation subcommittee was formed to work with DMHDDAD to conduct a gap analysis to identify existing service utilization and the service needs. The goal of this project is to identify information that can be used to shape the public delivery system to best meet the needs of those Georgians that rely upon state supported services to live in the community. The Gap Analysis will be a planning tool for local planning boards to determine the types of needed services, an advocacy tool to be used with legislators to justify funding requests, and a resource allocation tool with state planners and policy makers to guide the allocation and distribution of resources.

The Gap Analysis provides a comprehensive assessment of the state's publicly funded mental health system -- that is the system of care paid for by federal, state, and local tax dollars to support adults with Serious Mental Illness (SMI) and children and adolescents with Serious Emotional Disorders (SED.) It is extremely important to take into account the limitations of this report in that it is focused primarily on the publicly funded system. There are many private and community resources that provide treatment to individuals with mental illness. However, most people served by these entities have resources to cover costs and may not need the intensive services offered by the public system.

The activities and products of Georgia's Mental Health Gap Analysis follow:

- ❖ Conduct baseline focus groups with local planning councils, regional advisory councils and statewide mental health groups.
- ❖ Examine the current service delivery system, determining the availability of persons in need and also determining adequacy or limitations of services for persons in need.
- ❖ Review the current status of the available public mental health workforce, including community based and hospital inpatient services.
- ❖ Analyze the number of persons who use the public mental health services and the types of services they use.
- ❖ Utilizing social indicators and prevalence data on the general population related to mental health risk factors, estimate the need for services.
- ❖ Analyze the differences in profiles between those receiving services and those not receiving services.
- ❖ Develop an on-going data collection system/process that the Department and Division will utilize to update the services currently available and compare with services needed (Gap Analysis.)

- ❖ Recommend and prioritize steps for the Department of Human Resources to strategically enhance services to achieve the greatest impact on mental health service system development on an ongoing basis.

B. An Introduction to Georgia's Mental Health Gap Analysis Research Team

In August 2004, the State of Georgia, through a competitive bidding process, awarded a contract to APS Healthcare to conduct the Mental Health Gap Analysis. APS Healthcare, one of the most prominent and diverse specialty and mental health companies in the field of health care, has partnered with the National Council on Community Behavioral Health (NCCBH) and Dougherty Management Associates, Inc., of Lexington, Massachusetts. The National Council for Community Behavioral Healthcare (NCCBH) Consulting Services has also been actively involved with the Georgia MHDDAD system. Lee Ann Slayton, Senior NCCBH Consultant played a key role conducting focus groups for this Gap Analysis. The National Council for Community Behavioral Healthcare is the oldest and largest trade association representing the nation's providers of mental health, substance abuse and developmental disability services. Members include community mental health centers, hospitals, state associations of providers and local behavioral health authorities. Individual practitioners, consultants, and senior behavioral health administrators are members of the National Council's individual membership section. Dougherty Management Associates (DMA) provides health and human service organizations in the public and private sectors with superior management consulting services to improve healthcare delivery systems and manage complex organizational change. DMA works nationally with health and human service initiatives on quality and change management, design, implementation, financing of public services, research and policy analysis and management and procurement consultation. The combined expertise of all partner agencies has provided a thorough and diverse team to develop Georgia's Mental Health Gap Analysis.

C. Gap Analysis Data Collection Methodology

Georgia's Mental Health Gap Analysis was a collaborative effort among APS Healthcare, its partner agencies, NCCBH and DMA, the Division of MHDDAD's state office, regional and hospital staff and the State Mental Health Planning Council. Multiple methods of data collection and information gathering were employed to develop the final product. This section provides an overview of the processes with greater detail of the methodology incorporated into each chapter, as appropriate. However, throughout the body of this report, methodology and data analysis techniques are cited in order to help the reader understand the information as it is presented.

The following provides a brief overview of the methods that were utilized to complete Georgia's Mental Health Gap Analysis:

- 1. Stakeholder Focus Groups across the State of Georgia:** APS Healthcare, in conjunction with National Council for Community Behavioral Healthcare (NCCBH) Consultant Lee Ann Slayton, facilitated a total of 21 stakeholder focus groups throughout the State of Georgia. Two meetings were held in each of the seven Department of Human Resources MHDDAD Regions. The first meeting in each region was targeted to MHDDAD Regional Planning Boards, and the second meeting included all community stakeholders--including providers, consumers and family members, as well as representatives from other social service and state agencies. In addition to the Regional stakeholder focus groups, several meetings in multiple areas of the state were facilitated with providers and advocacy groups: Mental Health Planning and Advisory Council, mental health providers, state agency staff, Georgia Mental Health Consumer Network, Georgia Parent Support Network, CETPA (Focus Groups with Latino population) and the National Mental Health Association of Georgia.
- 2. Mental Health Gap Analysis Online Survey:** APS Healthcare developed an online survey which was completed by more than 1,000 participants across the state. The survey was used as a gauge to examine the current climate of services within the state. Information was collected on demographics, populations that should be served by the Public Mental Health System, perceptions on the availability and adequacy of services throughout the state, barriers to receiving and providing services, services or processes that are strengths within the system, resources that improve service delivery and prioritized list of gaps in services. The survey results were then analyzed by regional responses and differences in demographics (providers vs. consumer responses, etc.).
- 3. Key Stakeholder Interviews:** Throughout Georgia's Mental Health Gap Analysis, key stakeholder interviews proved to be an invaluable source of information. Interviews were conducted either on the phone or in person with key personnel from all state agencies providing supports to individuals with mental illness: Department of Human Resources, Division of Family and Children's Services (DFCS), DMHDDAD, Department of Corrections, Department of Pardons and Parole, Department of Community Health, Department of Community Affairs and the Department of Juvenile Justice.
- 4. National and State Document and Reports Review:** APS Healthcare realizes the wealth of knowledge and information that has been produced over the past decade, supporting best practices and quality improvement in mental health services both in Georgia and nationally. Research is cited throughout the Gap Analysis. In particular, the Surgeon General's Report on Mental Health released in 1999 and the President's Commission on Mental Health (2002) both provide excellent recommendations to mental health systems across the state and are cited heavily throughout the report. Documents and reports generated by the state were also reviewed and incorporated into the Gap Analysis: Regional MIERS reports, Regional Plans from Fiscal Year 2006, current grants with the federal government, and previous research studies were all used to inform the Gap Analysis.

- 5. Data Analysis of Populations Served by the Public Mental Health System:** Several data sets were collected in order to complete this analysis:
- a. Georgia's Division of Mental Health, Developmental Disabilities and Addictive Diseases provided a data extract to APS Healthcare from its Mental Health Mental Retardation Information System (MHMRIS).
 - b. Data was collected from the state's Medicaid claims vendor to analyze Medicaid Rehabilitation Option utilization rates and costs for services.
 - c. Data was obtained from the Department of Community Health on types and amounts of general Medicaid State Plan services provided to consumers with mental health diagnoses.
 - d. Data extracts were received from the Department of Corrections, and Department of Juvenile Justice, with information on the numbers of consumers with mental illness served in each county.
 - e. Information was collected from the Division of Family and Children's Services website on the number of children and adolescents involved in the Level of Care program in recent years.

Data from the DHR, Division of MHDDAD information system proved to be the most beneficial in assessing the population served by the public mental health system. The Division of MHDDAD provided two sets of data from Fiscal Year 2004 (FY 04) from their Mental Health Mental Retardation Information System (MHMRIS): Data from the Basic Intake Form (BIF) and the community Enrollment Addition and Release Form, herein after referred to as the EARF. Both of these data sets contain demographic and service utilization information on consumers served within the community. APS Healthcare primarily utilized EARF data for the Gap Analysis because the level of detail regarding specific service enrollment was greater than the BIF, however analyzed data did rely on demographic information from BIF records. Comparison data was obtained from Maryland, North Carolina, Tennessee and Virginia for benchmarking purposes.

Additionally, APS obtained a data extract from all seven of the state hospitals. Data from each individual hospital proved to be more detailed than information pulled at the statewide level. While each hospital categorized its admissions slightly differently, APS identified the primary categories of hospital based psychiatric care as 1) Adult Mental Health, 2) Child and Adolescent Long Term Care, 3) Child and Adolescent Short Term Care, and 4) Forensic Services (which included subsets for Forensic units with different levels of security). These categories were then separated into four age categories: Birth – 17, 18 – 24, 25 – 64, and Over 64. Additionally, an analysis was completed to stratify for Age, Race, Gender, Marital Status, Service Category and County for each hospital. Comparison data was obtained from North Carolina, Tennessee and Virginia hospital systems for benchmarking purposes, to compare hospital utilization, client loads and staffing patterns.

- 6. Analysis on the Services Provided Throughout the State:** Again, EARF data from the MHMRIS system proved to be the most beneficial in assessing the population served by

the public mental health system. Initially APS imported the raw EARF data file into a local Structured Query Language (SQL) database. Using data definitions provided by the Division of MHDDAD, APS categorized each EARF's Service into one of eight categories based on the Subunit Code number, as listed below:

- Screening, Crisis and Outreach Services
- Day and Employment Services
- Outpatient Services
- Personal Living and Residential Services
- Service Entry and Linkage
- Other Services
- Ready for Work and Other TANF Programs
- Substance Abuse Services

Next, EARF records were categorized by diagnosis into one of three disability categories: Mental Health, Substance Abuse or Developmental Disabilities. Only EARF records with at least one Mental Health classification were included in reporting all the reporting throughout the Gap Analysis. **Thus, consumers with co-occurring mental health diagnoses and addictive diseases, AND co-occurring mental health diagnoses and mental retardation are included in ALL reports and analysis.** Finally, each EARF record was assigned an age category based on the consumer's Date of Birth in relation to services. All records were assigned an Age Category as follows: Birth – 17, 18 – 24, 25 – 64, Over 64. Additional age categories were created as needed to perform more in depth analysis on specific populations (i.e. transitional youth). Using Crystal Reports, SQL data was analyzed in a number of ways and stratified for Age, Gender, Service Category, County of Residence, Primary Disability and Race. Additionally, the counties of residence codes were used to link consumers to the MHDDAD Region, and CSB Catchment Area.

7. **Data Analysis of Prevalence Figures:** Prevalence figures were gathered from two different sources: the Center for Mental Health Services (CMHS) and from the University of Texas Medical Branch and Dr. Charles Holzer. Dr. Charles Holzer and the University of Texas Medical Branch (UTMB) developed a synthetic estimation model that estimates prevalence of SMI and SED at the county level, looking at multiple variables and adjusting prevalence rates for differences. Chapter 3 provides an in-depth review and details the methodology in developing prevalence figures utilized within the Gap Analysis.
8. **Analysis on Public Financing and Funding Streams:** Data was collected from the following sources to determine funding streams and expenditures: DMHDDAD Regional Offices, the Governor's Office of Planning and Budget, the DHR Office of Planning and Budget Services, the Division of MHDDAD, and Medicaid claims paid for FY04. Ultimately, information provided by the Uniform Accounting System (UAS) and the Medicaid claims was the most reliable source of information that captured expenditures for Fiscal Year 2004. Budget figures were also obtained from two other state agencies

(Department of Juvenile Justice and Department of Corrections) that provide mental health services as well in order to gauge the amount of funding they spend to support mental health services.

- 9. Provider Focus Group and Data Analysis on the Mental Health Workforce:** Data was collected from multiple sources to measure the current mental health workforce, and determine the availability of providers across the state. APS Healthcare staff collected the number of licensed and credentialed staff employed by each community provider agency and obtained an extract of hospital personnel employed by DHR/MHDDAD for Fiscal Year 2004. Additionally, data was purchased from the state licensure boards to identify the current number of licensed practicing nurses, registered nurses, licensed master social workers, licensed clinical social workers, and licensed professional counselors within the state. APS Healthcare also hosted a focus group held by teleconference call with providers to discuss the challenges of recruitment and retention of qualified staff. National benchmarking sources include the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, publication: State Health Workforce Profiles, National Association of State Mental Health Program Directors Research Institute, and the United States Department of Labor, Bureau of Labor Statistics.
- 10. Research on Other States' Community and Inpatient Services:** APS obtained data from Maryland, North Carolina, Tennessee, and Virginia that provided a state-to-state comparison with Georgia. This data included: the number of people served by Medicaid and state funding, expenditures for mental health services, eligibility criteria and other important similarities and differences related to both community-based and hospital services.

D. Limitations of Data Sources

Throughout the gap analysis the writers will cite instances where there may be limitations of data within each analysis. However, it is important to understand the limitations of the major data sources that were used. This will help the reader with interpretations throughout the report.

- ❖ EARF Reports – utilization by service category sorted by county, CSB level and Region
 - The most consequential limitation in the data analyzed revolves around the fact that each EARF merely represents an enrollment in service and does not indicate a service delivery encounter. However, Medicaid claims, representing roughly 40% of the population, did contain encounter data useful for analyzing service utilization.
 - Anonymity of records in data extracts provided by the state did not allow for cross-referencing to either hospital or Medicaid records that could have revealed more detail regarding unique consumer counts.

- EARF data collects only “County of Residence” of the individual receiving services, not the location where the services were delivered. Additionally, there is no way to verify if that the county of residence is current.
- The EARF data was based on one discreet fiscal year of service enrollment (FY 04), therefore longitudinal analysis was not possible.
- The EARF data from the MHMRIS did not track marital status, thus comparisons of percentages of consumers based on marital status between the hospital and community was not conducted.
- ❖ Hospital Reports – similar limitations to those cited above regarding county of residence, unique identifiers of consumers in records, and fiscal year time span limiting ability to conduct longitudinal analyses, apply to hospital extract data as well. Additionally, lack of consistent data entry protocol among hospitals into the Behavioral Health Information System can prohibit an accurate analysis (e.g., the data entered into one field to indicate the unit in which a patient was served by one hospital is not consistent with the terminology used by another hospital to indicate the same type of unit).
- ❖ Medicaid Rehab Option Services – locations of where services were provided should be easily identified by the provider code. However, the reliability of this data is minimal since providers have had to use one or two primary sites in order to get paid by the Medicaid Claims vendor.

Moving Forward

APS and its partners were able to work with many state agencies, regional offices, and individual hospitals to gather information to complete the comprehensive Gap Analysis. In order to be truly comprehensive with the approach, to follow APS provides an objective analysis and recommendations for all components of Georgia’s public mental health system: Strategy, Organizational Structure, Systems, Staff, Skills, and Rewards. By examining the entire system, at various levels of services, the Gap Analysis presents Georgia’s first complete research study of the community and hospital based mental health systems.

CHAPTER II: PROMISING PRACTICES, EMERGING TRENDS, AND STRENGTHS IN GEORGIA

In this chapter you will find:

- ❖ *National Trends and Research*
- ❖ *Implementation of Evidence Based Practices within Georgia*
- ❖ *Spotlight on Georgia's Peer Support Program*
- ❖ *New Leadership and Current Initiatives within Georgia*



Highlights of significant findings in this chapter include:

- ❖ *Georgia has made great progress in the implementation of evidence-based practices by including many in the array of available services*
- ❖ *Initial data shows that, Peer Support services in Georgia, improve the consumer outcomes at a 50% cost reduction of traditional mental health services.*
- ❖ *New leadership, additional grant funding, and planned system changes all hold hope for Georgia's Mental Health system.*

Throughout this analysis, APS documents National best practices and how each relates to Georgia's public mental health system. This chapter reviews National Studies that support Evidence-Based Practices, excellence in mental health delivery systems, and current initiatives, at the state and regional levels, that are working to strengthen Georgia's public mental health system.

A. National Trends and Research

In the last decade an enormous amount of research and work has been done on America's public mental health systems. With innovations in medications and treatments, mental health services have come into the public eye like never before, such that two high profile initiatives by the Surgeon General (1999) and the President of the United States (2002) have focused their attention on improving access to mental health services across the country. This section will highlight major findings within these two comprehensive reports as they, utilize a multitude of data sources and research to provide guidance for improvement at the state and systems level.

In 2002 President Bush introduced his New Freedom Initiatives and authorized a Commission on Mental Health to complete a comprehensive review of the nation's mental health system. The President's New Freedom Commission on Mental Health was given the

task of completing comprehensive research in order to determine the current state of affairs of the mental health service delivery system. The commission found three major obstacles that prevent excellent mental health care. The stigma of seeking mental health care, the unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and the fragmented mental health delivery system all deter those in need of receiving quality mental health care. Barriers to receiving needed services include the fragmentation and gap in care for children, adults with serious mental illness, and older adults, the high unemployment and disability for those with serious mental illness, and the lack of national priority for mental health and suicide prevention.

The commission found that the current system is not oriented to the hope of recovery. Currently, state-of-the-art treatment is not transferred from research to community settings in a reasonable period of time. Many of those in need do not have access, or have very limited access to services. The commission believes that the answer is a completely transformed mental health care delivery system. This transformed system should focus on recovery and should include an individualized plan of care where chosen mental health professionals share in the decision making process with the consumer and their family. In order for this transformation to be successful, services and treatment must be consumer and family centered, offering real and meaningful choices. Also, care must focus on increasing consumer's coping skills, facilitating recovery, and building resilience.

The commission developed six goals, each with several recommendations¹:

Goal 1: Americans will understand that mental health is essential to overall health.

Recommendations:

- Advance and implement a national campaign to reduce stigma of seeking care and a national strategy for suicide prevention.
- Address mental health with the same urgency as physical health.

Goal 2: Mental Health care will be consumer and family driven.

Recommendations:

- Develop individualized plan of treatment for serious mental health and severe emotional disturbance.
- Involve consumers and families fully in orienting the system toward recovery.
- Align relevant federal programs to improve access and accountabilities for mental health services.
- Create a comprehensive state mental health plan.
- Protect and enhance the rights of people with mental illness.

Goal 3: Disparities in mental health services will be eliminated.

Recommendations:

- Improve access to quality care that is culturally competent.

¹ <http://www.mentalhealthcommission.gov/reports/reports.htm>

- Improve access to quality care in rural and geographically remote areas.

Goal 4: Early mental health screening, assessment, and referral to services will be common practice.

Recommendations:

- Promote the mental health of young children.
- Improve and expand school mental health programs.
- Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- Screen for mental disorders in primary healthcare, across the lifespan, and connect to treatment and supports.

Goal 5: Excellent mental health care will be delivered and research is accelerated.

Recommendations:

- Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illness.
- Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- Improve and expand the workforce providing evidence-based mental health service and supports.
- Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6: Technology will be used to access mental health care and information.

Recommendations:

- Use health technology and tele-health to improve access and coordination of mental health care, especially for Americans in remote areas and/or underserved populations.
- Develop and implement integrated electronic health record and personal health information systems.

Mental Health: A Report of the Surgeon General

The Surgeon General's report contains general information on mental health, mental illness, treatment issues, stigma, and how these affect different age groups and documents the disabling affects of mental illness. The disability-adjusted life scale is used to rank how disabling diseases are in comparison to each other based on lost years of healthy life regardless of whether it is due to premature death or disability. This report cites that mental illness is the second most disabling category in established market economies, which includes the United States. When considering individual disorders, major depression ranks as the second most disabling condition.

The next two themes discussed address mental health versus mental illness and the mind/body connection. Mental health and mental illness are not polar opposites, but rather

two points on a continuum. Neither is easily defined since they both rely on subjective measures such as culture, values, and ‘quality of life’ issues. The issue of the mind/body connection is also not easily defined. The separation of mind and body, even though disputed by scientific research, is evident in the language that is used and the separation of treatment systems. This separation leads to the final theme discussed, which is stigma. Stigma remains the most influential factor affecting the decision to seek services. Nearly two-thirds of those in need do not seek mental health services. Polls show that the public perception of mental illness has changed very little since the 1950’s. Even though the public is more knowledgeable about symptoms and treatment of mental illness, those diagnosed are still perceived to be dangerous.

The Surgeon General’s report contains several statistics about the prevalence of mental illness, the percentage of those who seek treatment, and the overall costs²:

- 1 in 5 adults experience a mental disorder in the course of a year.
- 15% of those experience a co-occurring substance use disorder.
- 15% of adults use mental health services in the course of a year.
- 8% use services for a mental disorder and 7% use services for mental health problems.
- 1 in 5 children and adolescents experience symptoms of a mental disorder in the course of a year.
- 5% of those experience extreme functional impairment.
- 21% of children and adolescents receive mental health services in the course of a year.
- In 1996, \$99 billion was spent on treatment for mental illness, substance use disorders, and Alzheimer’s disease.
- Mental disorders alone cost \$69 billion, in 1996.

B. Georgia’s Implementation of Evidence-Based Practices

Evidence-based practices are those that are supported by experimental research with random design or a matched control group, where the research shows a statistically significant effect on symptom frequency/intensity, number of hospitalizations, and quality of life. The research can be replicated, and the effect is sustained for one year following treatment. The Iowa Consortium for Mental Health published a document listing 9 evidence-based models of mental healthcare for adults, children, and adolescents:

- Programs for Assertive Community Treatment (ACT)
- Supported Employment
- School-based Clinical Mental Health Services
- Family Psychoeducation
- Mental Health Courts

² <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

- Medication Treatment Algorithms
- Early Childhood Interventions
- Integrated Mental Health/Substance Abuse Services
- Elder Outreach Programs

The Surgeon General's report discusses several evidence-based practices that overlap with the list above and recognizes additional supports that are proven to be effective:

- Illness Management and Recovery
- Family Psychoeducation
- Supported Employment Services
- Integrated Treatment of Co-occurring Disorders
- Assertive Community Treatment
- Medication Management Through Algorithms
- Specialized Therapies

The Illness Management and Recovery program focuses on building illness self-management skills using psychoeducation, social skills training, coping skills training, and cognitive therapy. Family Psychoeducation consists of learning about mental illness, decreasing stress and tension in the family, and providing support within the family. Supported Employment Services helps the individual to move beyond the patient role to a productive role in the community by providing continuous support. Integrated Treatment of Co-occurring Disorders treats both the mental illness and the substance abuse at the same time in the same setting. Assertive Community Treatment is a comprehensive program which helps the individual stay out of the hospital and continue to be a contributing part of the community. Medication Management Through Algorithms is a step-by-step decision making process to determine appropriate medications and dosages. Specialized Therapies include such therapeutic techniques as cognitive behavioral therapy, dialectic behavior therapy, and interpersonal therapy.

The Surgeon General's report also discusses several promising or emerging evidence-based practices:

- Self-help (Wellness Recovery Action Plan)
- Peer Supports
- Consumer-operated Services
- Cognitive Enhancement Therapy

Self-help focuses on the development of a Wellness Recovery Action Plan (WRAP) by an individual. Peer Supports is a consumer-lead group or service that discusses symptoms of mental illness with a focus on empowerment and recovery. Consumer-operated Services include drop-in centers, employment/housing programs, outreach, crisis services, and case

management. Cognitive Enhancement Therapy consists of strategies to address maladaptive thinking and train individuals to respond appropriately to normal situations.

Currently, the state of Georgia is implementing many proven and emerging evidence-based practices. Georgia is to be commended for these efforts. However, the extent to which specific best practices are implemented varies greatly within the same region. DHR is working to identify this disparity and create a uniform system of support across the state, however funding restrictions and other limitations have prevented this from actualizing. Below is a summary and discussion of the degree to which certain evidence-based practices are implemented throughout the state:

- **Psychosocial Rehabilitation** uses the fundamentals from Illness Management and Recovery. Psychosocial Rehabilitation is defined by the state as being a therapeutic, skill building, and recovery promoting services for individuals to gain the skills necessary to allow them to remain in or return to community settings and activities. Services include assistance with problem solving skills, social and coping skill development, illness and medication self-management, and other skills that improve self-esteem and recovery. In FY 2004, **5,142 adults** with mental illness benefited from Psychosocial Rehabilitation. Psychosocial Rehabilitation service was offered to consumers in 150 of Georgia's 159 counties, reflecting a moderate to high degree of availability.
- **Family Psychoeducation** is included in Georgia's defined services of Family Training/Counseling and in Intensive Family Interventions. Intensive Family Intervention (IFI) is a service provided to preserve the family by stabilizing the child's MH issues that effect the living arrangement, promoting reunification or preventing out-of-home placement for children to a more intense therapeutic setting. Services diffuse the crisis situation, and ensure linkage to appropriate community-based services. **Nearly 30 providers provided Intensive Family Intervention to 1,283 individuals** across the state. Family Training/Counseling services are therapeutic interventions focused on specific goals to enhance or maintain illness and medication self-management knowledge and skills (including behavior management), problem-solving and cognitive skills, family roles and relationships, daily living skills, and resource access and management. **Family Training and Counseling reaches over 9,000 individuals across** Georgia, and is provided by 32 agencies within the state.
- **Supported employment services** are offered in Georgia, however more individuals could benefit from such supports. Supported employment services offer help with job development, job placement, and on the job training with coaches. The Mental Health Information System reports that **4,360 consumers benefited from supported employment statewide**, this includes individuals with co-occurring disorders such as mental illness and developmental disabilities. There are nearly 70 providers of

supported employment services, however many of these are traditional developmental disability service providers thus widening the provider pool.

- **Assertive Community Treatment (ACT)** is a recovery focused high-intensity community based service for individuals that may be hard to engage in treatment, or who have been hospitalized for long durations. A multi-disciplinary team is used to provide intensive individualized interventions focused on facilitating recovery. ACT teams are offered by just a few providers, due to the staffing ratios that need to be maintained for program integrity. During FY04 Georgia had **735 people enrolled** in its ACT programs, with only four agencies across the state providing Assertive Community Treatment.
- **Integrated Treatment of Co-occurring Disorders** can be seen in adult and child/adolescent substance abuse day services, and on a smaller scale for co-occurring mental health and developmental disabilities, throughout the state in several programs. Many of these programs are specialized and targeted to a specific population, thus they are not found in every community. Specific programs integrating treatment for individuals with co-occurring disorders are highlighted in future chapters
- **Medication Management Through Algorithms** should be used in tandem with these other services throughout the state of Georgia. Medications are a part of recovery for most people diagnosed with severe mental illnesses, and with the increase in the types of antipsychotic medications in the recent decade research has proven shows that by using certain algorithms and/or guidelines in the use of Medication Management, physicians can help facilitate recovery. The algorithms, or guidelines specify and define “good” medication management practices, they can be helpful in identifying “bad” practices for closer scrutiny and, when necessary, corrective actions.³ While individual physicians may utilize these guidelines, there is currently no systemic evidence that the state or regions utilize algorithms for medication management of psychiatric disorders.
- Georgia has long been recognized as a leader in the development of and implementation of **Peer Support services**. Since inception in the late 90’s, Peer Supports have become more prevalent and utilization of the Wellness and Recovery Action Plan is becoming standard practice in most mental health centers. Peer Support services promote socialization, recovery, self-advocacy, development of natural supports, and assist with community living skills. Activities must support self-directed recovery and help consumers attain personal recovery goals. **During fiscal year 2004 3,316 adults with mental illness received peer supports in Georgia.**

³ <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/medication/workbook/chapter11.asp>

Evidence-based practices and “Best Practices” will be discussed throughout the Gap Analysis as the gold standard for mental health services. As additional research is completed, and practice and theory evolve to better meet the needs of individuals with mental illness, it is essential that Georgia stay ahead of the curve in adopting and implementing the most creative, efficient, and effective service technologies that are available. Attainment of replicable outcomes through the use of best practices is just as vital as offering sufficient capacity within the state.

C. Spotlight on Georgia’s Nationally Recognized Peer Support Program

Self-help and Peer Support are becoming more recognized in the mental health system as an integral part of a long lasting recovery process. Self-help and Peer Support provide consumers with an opportunity to share and learn coping skills that help them to progress and grow in their recovery. It is an alliance of individuals who have a commonality of living with a mental illness. Peer Support has been defined as a form of social network therapy in which stigmatized persons interact with each other, and gain feelings of self-acceptance and strive to be valued members of a community Schubert & Borkman, 1991.

The National Mental Health Association (NMHA) believes that Peer Support is a unique and essential element of recovery-oriented mental health systems. Peer Support programs provide an opportunity for consumers to direct their own recovery and advocacy process, and to teach one another the skills that are necessary to lead meaningful lives in the community. NMHA urges Mental Health Associations, mental health service provider organizations, and other advocates to make Peer Support an integral part of mental health service delivery. These urgencies are also to insure that consumers are involved at multiple levels of planning and implementation of Peer Support services, including senior management positions in service programs.

Peer Support services have demonstrated effective outcomes, such as reduced isolation and increased empathic responses to consumers. The final report of the President’s New Freedom Commission on Mental Health stated that Peer Support serves as an important resource in the recovery of individuals with mental health problems. The report also encourages the promotion of consumer-run organizations and consumers who work as providers; studies show that consumer-run services and consumer providers can broaden access to Peer Support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis.” The report goes on to describe how persons with psychiatric disabilities, because of their experiences, bring different attitudes, motivations and insights to mental health services. The provision of mental health support services by persons who have experienced mental illnesses is the epitome of empathy, empowerment, and ultimately, recovery

There are three different approaches in which Peer Support is used for those with severe mental illness: (1) Mutual Support Groups – voluntary, informal, often drop-in, groups led by peers, for a specific condition or life transition, (2) Consumer-run Services - peers as paid employees of a program that cultivate a consistent and regular interaction with peers, (3)

Employment of Consumers as mental health providers within clinical and rehabilitative settings (Davidson, et al, 1999).

"The increasing proliferation of peer support services and the evolution of the recovery movement may represent the brightest stars in the future of mental health treatment systems. The lived experience of people with mental illnesses is having a major impact on the shape of contemporary mental health services."

- Emerging New Practices in Organized Peer Support, National Association of State Mental Health Program Directors (NASMHPD), 2003

A natural outgrowth of the 1999 Surgeon General's Report on Mental Health has been the realization of the value of Peer-to-Peer support in the acquisition of real recovery. With the Surgeon General's Report backing the effectiveness of Peer Support, Georgia was able to demonstrate to the Center for Medicaid and Medicare Services, and the state Medicaid authority, that Peer Support was a vital component to the recovery process of the mental health system for all consumers. This resulted in the state of Georgia being the first in the nation to receive approval to bill Medicaid for Peer Support services. For the first time in history, consumers provided recovery-based services to their peers while billing Medicaid.

Peer Support services are now viewed as part of the array of services necessary for a culturally competent, recovery-based, mental health system. Peer Support services are equal partners to quality clinical care. Consumer leaders, partnered with the state of Georgia, to design the program guidelines for this new innovative service. Two major components that guided the program were that the consumers receiving this service should be in charge of the design of their own program, and persons who have lived the experience of having a mental illness must provide the service.

Consumers providing Peer Support needed training. Therefore, the Georgia Mental Health Consumer Network (GMHCN) applied for a federal grant and partnered with the Department of Human Resources Office of Consumer Relations and Recovery (OCR) to provide a statewide training and certification. In December of 2001 approximately 35 current and former mental health consumers completed their training and examination to become Georgia's first class of Certified Peer Specialists (CPSs). Today approximately 250 Certified Peer Specialists (CPS') have served approximately 3,300 consumers across Georgia. CPS' provide hope, and role model the possibility of recovery to every consumer they serve. As paid employees of public and private providers, CPS' neatly transition ownership of Peer Supports, into the hands of the consumers, seeking services in Peer Support programs. Initial data shows that, Peer Support services in Georgia, improve the consumer outcomes at a 50% cost reduction of traditional mental health services.

As a result of Georgia's success in Peer Support, the Center for Mental Health Services (CMHS) is currently developing a Peer Support Services Resource Guide, also called a Tool Kit. It will include a manual for other states, with detailed instructions needed to design, plan, implement, and manage, Medicaid-funded Peer Support services. It will also examine approaches for the training and certification of a peer workforce for service delivery. Additionally, the tool kit includes a fact sheet on the important aspects of a Peer Support program, and a Peer Support Services Guide, for consumers and advocates. The resource guide highlights the experience of Georgia, which initiated a Peer Support program in 1999 that is financed by state, federal, and private revenues. Georgia has also been recognized internationally for its innovative Peer Support Program. Representatives from New Zealand, United Kingdom, and Canada have sent representatives to view the program. Additionally, the Medical College of Georgia is looking at hiring a CPS to work with, and train interns, on recovery and Peer Supports. It is becoming recognized that CPS' are needed at all levels of the mental health system, and the importance of providing hope to all consumers, at the onset of their illness. While Georgia has made great strides in the implementation of this program within the community, use of Consumer Peer Specialists vary in the state hospital settings. In other states, Peer Specialists are utilized to orient consumers with the community mental health system and integration into the community. However in Georgia, they are used primarily for transportation and to review complaints and could possibly be utilized in a greater capacity.

D. New Leadership and Current Initiatives within Georgia

With new leadership within the Department of Human Resources, brings new vision and a renewed push for excellence in services for individuals with mental illness. The Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD) had experienced many changes in its leadership over the previous 5 years until Commissioner B.J. Walker was appointed in the spring of 2004, and the appointment of Gwen Skinner, previously with the Department of Juvenile Justice, in summer 2004. Both individuals bring years of experience and diverse backgrounds to the Department of Human Resources. New leaders bring new ideas and sense of renewed optimism to a Department that was in need of clear vision and strong, consistent leadership. With new Leadership come new plans, policies, and strategies. Discussed in this section is an overview of current initiatives creating systems change throughout the state, at all levels of the service delivery system.

System Changes

Most recently the Department of Human Resources has announced that it will realign the Regional MHDDAD offices and the Division of Family and Children's Services to be congruent with the Regions of the Department of Juvenile Justice. The announcement was made in January 2005, with changes being implemented by July 2005, the beginning of State Fiscal Year 2006.

With the new tie to the Department of Juvenile Justice, the Division of MHDDAD is working very closely at the state level to identify children who are served by both service systems, and provide continuity of care across the agency boundaries. The Division of MHDDAD has engaged in data sharing agreements with the Department of Juvenile Justice (DJJ), and the Department of Corrections (DOC) to link data sources and begin to track consumers across agency lines. In addition to these outside agencies, MHDDAD will work to better collaborate within the Department of Human Resources with the Division of Family and Children's Services, and the Division of Public Health.

Similar cross agency collaboration and information sharing agreements are working at the regional level. The Southeast regional office has entered into agreements with regional offices of the DJJ and DOC to share information and to better coordinate consumers care and costs when individual move between systems. The North Region office staff coordinate a Children and Adolescents Interagency Council where staff from different parts of the system come together to share information and network with one another, keeping the lines of communication open at all times. Coordination supports the continuum of care provided across the spectrum of services.

Service Enhancements and Budget Requests

In the midst of state budget shortfalls resulting in cuts to the Department of Human resources budget, the Division of MHDDAD suffered major cuts in State Fiscal Years 2003 – 2005. With an upturn in the economy, and revenues from tax collections that exceeded expectations during fiscal year 2005, the Division was able to submit several service enhancement requests to the Governor's Office of Planning and Budget for consideration. The Division requested additional funds to support the development of new Children and Adolescent Services offered in the community, enough to support an addition 625 children and adolescents. Requests were also made to support additional community services for adults who are currently hospitalized. Governor Sonny Purdue included these expanded service requests in the State FY06 Budget recommendations to the legislature in January 2005. The Division also requested, and was granted, funds to upgrade its mental health and mental retardation management information system, referred to as MHMRIS throughout this report.

Core Customer

As stated earlier, the Division of MHDDAD has sustained budgets cuts over the last several years, forcing leaders to make tough decisions on priorities for limited resources. In order to prioritize who should be receiving publicly funded mental health services, the Division is working to promote and fully implement its Core Customer Eligibility Criteria across the state for adults, and child and adolescent services. All new and current consumers of mental health and or addictive disease services must meet the Core Customer Eligibility Determination in order to receive mental health of addictive disease services paid for with public services. The DHR Adult Core Customer Eligibility Determination Form is included in the report as **APPENDIX II-1: Core Customer Eligibility Form**. For adults the Core

Customer definition was implemented July 1, 2004 with a phase in period of several months in order to transition consumers who may not meet eligibility criteria to more appropriate community services.

Adults, who are seeking services for mental illness, or addictive diseases, must have a behavioral health diagnosis on Axis I in accordance with the most recent version of the Diagnostic and Statistical Manual of Mental Disorders IV (commonly referred to as the DSM IV) and the individuals' functioning must be significantly affected by mental illness or substance abuse disorder. Examples of Axis I diagnosis that meet criteria are Schizophrenia and other Psychotic disorders, Mood Disorders such as Bipolar disorder, Anxiety disorders, and Adjustment Disorders.

For Children and Adolescents in need of public mental health services, the Core Customer definition is still being drafted and will be implemented in Fiscal Year 2006. Components of eligibility state the following: individuals must be under the age of 18, or ages 18-21 and transitioning to adult services; individual must have an Axis I diagnosable emotional disturbance or substance abuse related disorder; individual's level of functioning must be significantly affected by the disorder, and the child or adolescent, or his legal guardian must be financially unable to pay for all or part of the services.

Core and Specialty Services

In an effort to build service provider capacity and ensure that services are provided consistently across the state, Georgia plans to expand the number of providers that can provide Core Services, those services that have been determined critical components to the behavioral health service system:

- Diagnostic and Assessment
- Crisis Services
- Medical Services
- Community Support
- Outpatient Treatment
- Peer Support

Currently only Community Service Boards are contracted to be Core Service Providers through the Division of MHDDAD. With the implementation of the Division's new policy effective Fiscal Year 2006, MHDDAD Regional Offices will have the authority to contract with additional service providers to offer Core Services. In theory this will broaden the provider pool and increase the capacity of service providers. The inability to provide Core Services (such as diagnostic assessment and outpatient services) has been a complaint of specialty service providers for a number of years. However, this new policy will allow them to be reimbursed for these services.

Short Term Grants

The Division has been successful in recent years in securing supplemental planning and improvement grants intended to support infrastructure development and systems change. With the award of the Real Choice Systems Change Grant, the Child and Adolescent State Infrastructure Grant, and the Data Infrastructure Grant the Division of MHDDAD has worked to improve the infrastructure of the service delivery system. A brief synopsis of the goals and objectives of each grant is below:

Real Choice Systems Change Grant – Georgia has received several Real Choice Systems Change Grants from the federal Center for Medicare and Medicaid (CMS) in recent years. The first of which had several projects related to mental health services. This grant was \$1.3 Million over 3 years, with the following goals and outcomes:

- Develop a medication administration certification program for adoption by the Division of Mental Health, Developmental Disabilities and Addictive Diseases: Draft policy, regulations and curriculum were submitted to the MHDDAD Division Director in December 2003. The draft policies and regulations are currently in the Attorney General's office for review.
- Develop strategies that will enhance the ability to recruit, retain and improve the direct care workforce that supports elderly people and people with disabilities in community-integrated settings: Partnership with the Department of Technical and Adult Education to implement direct support professional certification program.
- Evaluate the effectiveness of supported housing for adults with serious mental illness: The Department is working with the state housing agency to use subsidized housing to support individuals with mental illness or other disabilities in the community
- Develop training programs for peer supporters to enhance transition of individuals from institutions to community-integrated settings: Peer support programs for people with mental illness are well established within the state, and peer support programs for people with physical and developmental disabilities are being piloted in Georgia.
- Develop and implement actions for improved communication with elderly people, people with disabilities and family members and advocates and to improve communication and coordination among state agencies: the Department hopes to extend this grant to continue working on this project

Child and Adolescent State Infrastructure Grant - The overall purpose of the Child and Adolescent State Infrastructure Grant Project in Georgia is to provide the ability to strengthen the capacity, from a state level, to develop, expand and sustain mental health, substance abuse and co-occurring services and supports at the community-based level for youth who have serious emotional disturbances, substance abuse and co-occurring disorders and their families. Georgia will focus on building comprehensive systems of care to meet the needs of youth with serious emotional disturbance, substance abuse and co-occurring

disorders and their families. Strategies addressed include: development of a trained workforce, funding strategies, policies and practice guidelines and web resource development and improved data infrastructure development.

Data Infrastructure Grant - The Substance Abuse and Mental Health Services Administration (SAMHSA) Infrastructure Grants provide funds to increase the capacity of mental health and/or substance abuse systems to develop or enhance their data infrastructure to improve management of mental health service delivery. Specific program goals include: adoption of common data and information technology standards at the local level and improvement in program management/decision support, planning, and service quality improvement through better information at both State and local levels. Since its inception, the Center for Mental Health Services has supported the development of statistical data standards and related data infrastructure to assist State mental health agencies, local public providers, and private sector entities in better management and program planning, as well as service quality improvement. Without adequate data systems to record information in a comparable way, there can be no reporting of useful information. Hence, evidence-based management, planning with quantitative information, and good measures of program effectiveness, are only possible if comparable data standards are used to record data. The primary focus of the grant is to create sound State and local data infrastructure so that State mental health agencies can report performance measures that lead to service quality improvement, better system management, and quantitative planning.

Resources and Strengths within the Community

In addition to all of the initiatives, grants, and projects that were discussed in this section, it is important to incorporate the voice of the community into Georgia's Strengths. Below is a bulleted list of strengths taken directly from community stakeholders around the state:

- ❖ Staff who care and go the extra mile
- ❖ Intensive Family Intervention Program
- ❖ Task forces that try to coordinate care across multiple provider agencies
- ❖ Peer Advocacy, Peer Specialists
- ❖ Mental Health Corporation of America
- ❖ Georgia Health Policy Center
- ❖ CASA – Court Appointed Special Advocate
- ❖ Family Connection
- ❖ Parent participation, collaborating councils
 - Collaboration should be filtered down to all levels – not just happening at regional level
 - Internal QI, Special needs for cases that need additional support
- ❖ Non-profit agencies within the state
- ❖ Employment Services
- ❖ Single Point of Entry where you have it and where it works
- ❖ Ambulatory Detoxification Program

- ❖ Community Support for Individuals and Community Support Teams
- ❖ Local Match Committee
- ❖ Community based Prevention services
- ❖ Local partnerships are victories
- ❖ Court Diversion programs
- ❖ Home based services
- ❖ Residential services for adolescents with substance abuse issues

The examples above are representative of the things to come in Georgia's public mental health system. All of the system design changes and grants are just a few ways in which the staff at the Division of MHDDAD is moving forward with creating a more ideal, more cost effective, and more efficient service delivery system for people with mental illness.

Moving Forward

New leadership, additional grant funding, and planned system changes all hold hope for Georgia's public mental health system, a system desperately in need of hope, direction, and stability. The Gap Analysis provides the information for Georgia's leaders to make sound judgments about planning and service delivery. As stated throughout the report, the Gap Analysis should be the first step, and not the last step, towards effecting positive changes within Georgia's public mental health system.

CHAPTER III: THE POPULATION IN NEED OF MENTAL HEALTH SERVICES IN GEORGIA

In this chapter you will find:

- ❖ *Definitions of Serious Mental Illness (SMI) and Serious Emotional Disorder (SED)*
- ❖ *Review of Prevalence of Mental Illness and Estimation Methodologies*
- ❖ *The Number of Georgian's Estimated to Have SMI and SED*
- ❖ *The Uninsured in Georgia*



Highlights of significant findings in this chapter include:

- ❖ *There are 348,040 adults estimated to have a serious mental illness and 158,302 children estimated to have a serious emotional disorder in Georgia.*
- ❖ *There are an estimated 110,293 of these Uninsured Georgians who need mental health services.*
- ❖ *Private insurers do not adequately cover mental health services, especially for those with intense needs.*

A. Definitions of Serious Mental Illness and Serious Emotional Disorder

In order to measure mental illness within a population, one must begin with a definition of mental illness. This definition encompasses numerous diagnoses found in the Diagnostic and Statistical Manual. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) contains criteria for the most common mental disorders including: description, diagnosis, treatment, and research findings. The Diagnostic and Statistical Manual is in its fourth edition and is published by the American Psychiatric Association. It is the main diagnostic reference of Mental Health professionals in the United States of America. The DSM-IV is used to operationalize or develop some criteria for the definition of Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED). With this research, one can determine who falls into the category of adults with serious mental illness and children or adolescents with severe emotional disturbance.

Discussed fully in **Appendix III-1: Prevalence Estimation Methodology**, the abbreviated definitions for different levels of mental illness are nationally recognized standards. These standards allow people to make judgments about the need for services based on the severity and duration of mental illnesses – for example, Severe and Persistent Mental Illness is more severe than Serious Mental Illness. The term Severe and Persistent Mental Illness (SPMI), as defined by the National Comorbidity Study (NCS), is when a person experiences the following: “(a) 12 month prevalence of non-affective psychosis or mania; (b) lifetime prevalence of non-affective psychosis of mania if accompanied by evidence that the

respondent would have been symptomatic if it were not for treatment (defined by either use of medication or any professional treatment in the past 12 months); or (c) 12 month prevalence of either major depression or panic disorder with evidence of severity indicated either by hospitalization or use of major psychotropic medications."

Further, Kessler operationalizes the term Serious Mental Illness (SMI) as applied to National Survey respondents in four parts:

- (1) all respondents meeting the SPMI definition given above.
- (2) respondents who "had a 12-month DSM-III-R mental disorder and either planned or attempted suicide at some time during the past 12 months."
- (3) respondents "with a 12-month DSM-III-R mental disorder that substantially interferes with their vocational capacity." Two such groups are described, although it is unclear whether those are exclusive definitions: (a) those who are unemployed or working part-time for reasons not explained by being physically disabled, a student, or being a primary caregiver of pre-school children; or (b) those with a DSM-III-R disorder who missed at least a day a month for reasons that they perceived (reported) related to the mental illness. The duration of this interference is not defined in the text.
- (4) respondents with a DSM-III-R disorder " who had serious interpersonal difficulty" demonstrated by: (a) the lack of: marriage, a intimate relationship, confiding relationships, or affiliative interactions more frequent than once a month; or (b) reported lack of intimacy, ability to confide, and sense of being cared for or supported in all social relationships.

For children and adolescents, the term Serious Emotional Disturbance is used to describe disorders experienced by youth under the age of 18 that have meet diagnostic criteria in the DSM-IV. The CMHS (Center for Mental Health Services) definition is that "children with serious emotional disturbance" are persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM- IV that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. In addition to the diagnostic criteria for SED, there are functional criteria to be met as well: "Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skill. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional

impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.”

B. Review of Prevalence of Mental Illness and Estimation Methodologies

Identifying the number of individuals with mental illness in a geographic area requires an understanding of several principles. If time and resources were unlimited, a survey could be conducted to produce the most accurate representation of need. However, due to natural limitations, we must rely on research that makes inferences about need based on strong correlations. Researchers devote substantial portions of their careers to this process in order to define, as accurately as possible, the prevalence of mental illness nationally or within a specific geographic area.

When estimating prevalence for SMI, SPMI, and SED, there is not one single method for determining the number of individuals “in need.” Even with the operationalized definitions discussed previously, which are widely accepted and utilized, there are multiple methodologies for determining exactly how many people are affected by mental illness. This section will discuss two different strategies for estimating prevalence of SMI and SED in Georgia’s population.

The first method has been utilized by the state of Georgia for planning purposes for several years. Publications in the Federal register provide general percentage prevalence estimates for states, and then the states use applied statistics to overlay these estimates on the general population throughout each state. These include:

- Estimation Methodology for Adults with Serious Mental Illness (SMI), Federal Register: March 28, 1997 (Volume 62, Number 60) (fr28mr97), and
- Estimation Methodology for Adults with Serious Mental Illness (SMI), Federal Register: June 24, 1999 (Volume 64, Number 121) (fr24jn99-67).

Overall, these publications estimate that 2.6% of the U.S. population has Severe and Persistent Mental Illness (SPMI), and that 5.4% have Serious Mental Illness (SMI), and 8% of children and adolescents have a Serious Emotional Disturbance (SED). The Georgia Department of Human Resources, Division of Mental Health Developmental Disabilities, and Addictive Diseases uses these national rates and applies them directly to the population of each county to derive a prevalence estimate. In **Appendix III-2A and III-2B: Division of MHDDAD Prevalence Tables**, tables developed by the Division of MHDDAD represent the prevalence of adults with SMI and children with SED (ages 9-17) using the applied percentages published in the federal register, detailed by county and by the current MHDDAD Region. The table below illustrates the totals for the state:

Table III-1: MHDDAD Prevalence of SMI/SED by Age

	Total Population in Georgia	Estimated Percentage SMI/SED from the CMHS Reports	Estimated Number of SMI/SED in the Population
Adults	6,389,675	5.4%	345,042
Children and Adolescents Ages 9-17	1,141,361	8.0%	91,307

One must recognize that the CMHS Report figures utilized by Georgia for predicting the prevalence are widely used and accepted by many states within the nation. The state is to be commended on their efforts to estimate the need for services using National standards. The figures represent a generalization of people that experience the conditions defined as SMI and SED; the figures however do not identify the actual people in need of public sector services. In addition, the Division of MHDDAD recommends that regional MHDDAD offices further estimate prevalence based on individuals at or below 200% of the Federal Poverty Level. This component will be addressed later in this chapter.

The primary limitation as seen by the writers of this report is that the National estimates utilized by the state do not take into account specific factors that affect Georgia's citizens. Georgia is a very diverse and complex state; cultural, geographic, socioeconomic, and racial diversity are part of the richness of Georgia. However, these indicators also have a direct correlation to health and wellness conditions. For example, in a rural, southern Georgia county such as Clinch, the state's method of application prediction of those in need is 5.4%. Taking into account the high level of poverty, racial and ethnic diversity, and other demographic indicators and using other methodologies one could predict that 7.36% of Clinch county residents experience Serious Mental Illness – a difference of nearly 2% of the population.

In order to obtain a measurement of prevalence by county, rather than applying one figure to the entire state, APS Healthcare and NCCBH partnered with Dr. Charles Holzer and the University of Texas Medical Branch (UTMB) to gather a more precise methodology with estimates based on varying demographic factors within the state, regions, and counties. Dr. Charles Holzer, as a function of his role at UTMB, developed a synthetic estimation model that estimates prevalence of SMI and SED at the county level, looking at multiple variables and adjusting prevalence rates for differences. California, Washington, and Colorado have used this method, as well as some other Western states for the kinds of gap analysis performed in Georgia. The table below illustrates Holzer's percentages applied to the same population figures, showing a slight increase in Adult prevalence, and a slight decrease in Child and Adolescent needs.

Table III-2: Holzer Prevalence by Age

	Total Population in Georgia	Estimated Percentage SMI/SED using Holzer Methodology	Estimated Number of SMI/SED in the Population
Adults	6,389,675	6%	383,380
Children and Adolescents Ages 9-17	1,141,361	7.34%	83,775

C. The Number of Georgian's Estimated to Have Mental Illness

This section provides an overview of the prevalence rates applied to 2000 Census data (the most recent census) for Georgia in order to generate county prevalence estimates. These estimates were generated by Dr. Charles Holzer of the Department of Psychiatry and Behavioral Sciences, The University of Texas Medical Branch. His estimates are based on the National Comorbidity Survey and a set of SED studies commissioned by the Centers for Medicare and Medicaid Services (CMS) and published in the Federal Register. These studies have found prevalence to be related to such factors as gender, poverty, race, marital status, educational status, age, and type of residence (household vs. group or institutional living). The estimation methodology divides county Census data into 8100 cells representing the different combinations of the above listed characteristics. Then the appropriate prevalence rate for people with those characteristics is applied. The prevalence for all the cells is then rolled up to provide an estimated prevalence for the county and then state totals.⁴ The data is classified in a way that also allows stratification estimates by such characteristics as race, age, education, etc.

The following table shows Georgia's prevalence rates for different subpopulations using this method of estimation. **Detailed accounts of Prevalence can be found in APPNEDICES III-3 – III-6.** Georgia's overall rate using this method is 6.7%, with youth 17 and under having a somewhat higher rate and adults a somewhat lower rate. Youth rates varied little by age group, while adults experienced a rate exceeding 10% between ages 18 and 20, largely falling through the rest of adulthood and reaching a low of 5% at about age 50 and rising slightly thereafter. Genders differed little between boys and girls, but women had a considerably higher rate, almost 8%, than men, at only 5%.

Table III-3

Georgia Rates of Prevalence for Serious Emotional Disturbance and Serious Mental Illness Using Holzer Estimation Methods	
Total Population - All ages	6.69%

⁴ See <http://psy.utmb.edu/estimation/estimation.htm> for additional description of the methodology and sources used in these estimates.

Table III-3

Georgia Rates of Prevalence for Serious Emotional Disturbance and Serious Mental Illness Using Holzer Estimation Methods			
Youth		Adults	
Age	Percent	Age	Percent
Youth total	7.4%	Adult total	6.43%
0-5	7.44%	18-20	10.32%
6 -11	7.35%	21-24	7.85%
12-17	7.43%	25-34	5.86%
		35-44	7.39%
		45-54	4.99%
		55-64	5.28%
		65+	5.97%
Gender	Youth age 0-17	Adults age 18 and older	
Male	7.43%	5.07%	
Female	7.38%	7.71%	
Ethnicity	Youth age 0-17	Adults age 18 and older	
1.White-NH	6.95%	6.27%	
2.African Am-NH	8.05%	6.77%	
3.Asian-NH	7.10%	5.74%	
4.Pacific I-NH	10.29%	9.79%	
5.Native-NH	7.71%	4.48%	
6.Other-NH	8.03%	8.86%	
7.Multi-NH	7.53%	7.60%	
8.Hispanic	7.94%	6.79%	
Poverty level	Youth age 0-17	Adults age 18 and older	
1.Below 100%	10%	11.4%	
2.100%-199%	8%	7.42%	
3.200%-299%	7%	5.74%	
4.300%+ pov	6%	4.57%	
5.Undefined	12.7%	19.44%	
Residence	Youth age 0-17	Adults age 18 and older	
Household	7.34%	6%	
Institution	21.16%	25.8%	
Group	9.7%	8.31%	
Marital status	Youth age 0-17	Adults age 18 and older	
Married		4.55%	
Sep/Wid/Div		10.83%	
Single		7.29%	
Education	Youth age 0-17	Adults age 18 and older	
Grades 00-11		9.76%	
HS graduate		6.45%	
College grad		2.96%	

Table III-3

<p>Georgia Rates of Prevalence for Serious Emotional Disturbance and Serious Mental Illness Using Holzer Estimation Methods</p>

<p><u>Source: Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</u> <u>http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm</u></p>

Among children, Georgia's major ethnic groups showed some differences, with African Americans, Hispanics, Pacific Islanders, and Native Americans all showing elevated rates, of at least a half percentage above the state average. In contrast, white children experienced rates somewhat lower than the state average. Georgia's major ethnic groups did not show great variation among adults. African-Americans and Hispanics were very close to the overall state average while Caucasians were somewhat less. Pacific Islanders, a small group in Georgia, showed highly elevated rates.

Prevalence rates increased with rates of poverty, with individuals lower than 200% of the federal poverty level having higher than average rates, and those with incomes higher than 200% of FPL, having lower than average rates.

People living in institutions, which includes nursing homes, prisons and hospitals -including psychiatric hospitals - had highly elevated prevalence rates. People living in group quarters, primarily college dormitories and military quarters, had somewhat elevated rates while the bulk of the population which lives in households had rates somewhat below average.

Married adults experienced a much lower than average rate of serious mental illness compared to those who are single and whose rates are somewhat above average, while those who are separated, divorced, and widowed had rates that were considerably elevated.

Finally, the higher the level of education of an individual, the lower the incidence of SMI. Adults who graduated from college have the lowest incidence of any subgroup measured in this table. High school graduates have average incidence, and those with less than a high school education have an elevated incidence.

Implications

The subpopulations in Georgia with particularly high prevalence are:

- Young adults
- Adult females
- Pacific Islanders
- Non-white children

- Individuals of all ages below 200% of poverty
- People living in institutions and group quarters
- Adults who are separated, divorced or widowed
- Adults with less than a high school education.

With this data, the state is in position to evaluate how well it is reaching these high need groups and whether the services they get are meeting their needs.

D. The Uninsured in Georgia

America's healthcare system is becoming ever more complex by the day. Healthcare costs in general are rising at an unprecedented rate causing even more complexity regarding who pays for what – employers are shifting costs to the employees, states are limiting the eligibility for who benefits from public insurance, and it is reported that there are nearly 44 million Americans without any health insurance coverage today. This section provides statistics and a discussion on who is insured in Georgia, and how they are insured. Additionally, an overview is presented identifying the different types of coverage and how many individuals are estimated to be in need of mental health services by insurance type.

A recent survey of Southern federally funded community health centers found that 46% of patients are uninsured, and 66% are below the federal poverty level. Table III-1 outlines the different types of health insurance that Georgians utilize: 63% of Georgia's citizens are protected by employer or individual sponsored coverage while those covered by public programs and who are uninsured represent the remaining portion of the distribution (37%). The portion of uninsured in Georgia is even larger in rural areas where large employers are sparse, thus decreasing the number of individuals who have company sponsored benefits.

Table III-4: Types of Insurance for Georgia's Population

	Children under 18	Adults Ages 19-64	Adults 65+	GA #	GA %
Employer	1,365,430	3,571,510	47390	4,984,330	59
Individual	69,520	261,220	12020	332,760	4
Medicaid	618,460	294,840	66740	980,040 ⁵	12
Medicare	9,230	110,070	672620	791,930 ²	9
Uninsured	312,170	1,063,760	5460	1,381,390	16
Total	2,374,820	5,301,390	744,820	8,470,460	100

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2003 and 2004 Current Population Surveys.

The Uninsured

⁵ This represents an unduplicated count for the state. Actual enrollment may differ from estimates due to dual eligibility in Medicaid and Medicare.

The number of uninsured within the United States is staggering: 16% of Americans or more than 44 Million individuals are without basic healthcare coverage. 1.3 Million Georgians are Uninsured,⁶ keeping pace with the national statistic of 16% of Georgia's total population, with 13% of children under age 18 having no private insurance. Even with the implementation of PeachCare (Georgia's SCHIP program), there are over 300,000⁷ children without health insurance within the state. Forty-one percent (41%) of the uninsured in Georgia are Hispanic/Latino and 24% are multi-racial. The tables and figures below illustrate the uninsured, privately insured, and publicly insured within the State of Georgia.

Based on information compiled by the Kaiser Commission on Medicaid and the Uninsured for 2003, the poverty breakout for individuals without insurance coverage is represented in Table III-2 below where:

- 62% of the uninsured fall below 200% of the Federal Poverty Level.
- Over 1/3 of the Uninsured fall in the category above 200% of the Federal Poverty Level, which amounts to \$31,340 for a family of three.

Table III-5: Income Levels of Uninsured

Income Levels of Uninsured	GA #	GA %
Under 100%	508,450	37
100-199%	342,960	25
Low Income Subtotal	851,410	62
200% or more	524,520	38
Total	1,375,930	100

The majority of the uninsured fall into the category of the working poor. Many of the uninsured work at low paying jobs that do not offer employer sponsored health insurance. The cost of health insurance is enormous, making it a lesser priority than rent, food, and transportation. This also leads to additional questions about why individuals under the poverty limit are not enrolled in Medicaid and results in the following conclusions:

- Individuals may be transient, homeless, or do not have legal documentation of United States residence.
- They may move in and out of enrollment based on employment status.
- Stigma associated with receiving public services may inhibit enrollment.
- The eligibility process may be overwhelming.

⁶ Data Source: Kaiser Family Foundation, State Health Facts <http://statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=United+States&category=Health+Coverage+%26+Uninsured&subcategory=Insurance+Status&topic=Distribution+by+Insurance+Status>

⁷ <http://www2.gsu.edu/~wwwghp/publications/children/Uninsured2.18.pdf>

Prevalence of SMI or SED in individuals that are uninsured within Georgia based on poverty limits:

Table III-6: Estimate of Uninsured in Need of Services

Poverty Level	GA #	% In need of services	Estimation of total uninsured in need
Low Income Uninsured	851,410	9.03%	76,882
200% or more	524,520	6.37%	33,411
TOTAL			110,293

**GAP:
110,293
Uninsured
Georgians
need
mental
health
services**

It was not possible to compare the number of Georgians without insurance who are in need of services to those that actually received services due to limitations in the data collection at the service delivery site. Information on consumer incomes is not kept consistently across provider agencies. However, this information can be a valuable tool in planning for public sector services since the uninsured may be considered a priority population for the Division of MHDDAD.

Publicly Funded Health Insurance

The government's two largest health programs for the poor, disabled, and elderly, Medicaid and Medicare, support a large number of individuals with mental illness throughout the country. According to the Department of Community Health more than 1.7 Million Georgians were enrolled in Medicaid during Fiscal Year 2004. Just as with the number of Uninsured, this too is in line with the National average of 25% of Americans receiving Medicare or Medicaid. Below, an overview of the population in need of publicly funded services is provided.

Medicaid

Based on policy statements made by the Division of MHDDAD, public services should go to the most in need. A loose guideline of serving individuals below 200% of the poverty level has been utilized by some to make planning and funding decisions.

Table III illustrates the income levels of individuals currently receiving Medicaid in Georgia. The majority fall below the 200% federal poverty limit (FPL). Those over the FPL limit may include children and pregnant women who are eligible with incomes to 185% and for the blind and disabled populations that may have higher incomes, yet are still eligible for services.

Table III-7: Non-Elderly Medicaid Enrollees Income Levels		
Non-Elderly Medicaid Enrollees Income Levels	GA #	GA %
Under 100%	435,950	35
100-199%	303,940	23
--Low Income Rate	739,890	29
200% or more	259,880	5

If the mental health prevalence statistics are applied to the uninsured and to individuals receiving Medicaid who are both above and below 200% of the poverty level we can estimate how many individuals may be in need of services that are uninsured and that receive public health insurance.

Table III-8: Prevalence of Mental Illness in Medicaid Population⁸

Poverty Level	# of Medicaid	% in need of services	Estimation of Georgia's total
Low Income – Under 200% Poverty	739,890	9.03%	66,812
200% or above FPL	259,880	6.37%	16,554
TOTAL			83,366

The table below shows the number of total Medicaid and PeachCare enrollees in FY04. As a total percentage of the population within Georgia, 24% received some form of Medicaid within FY04.

Table III-9: Medicaid Population

	Georgia Total Population	Population Enrolled in PeachCare	Population Enrolled in Medicaid	Medicaid+Peachcare Population
TOTAL	8,186,453 ⁹	276,184	1,717,979	1,994,163

Medicare

As a percentage of the population, older Americans over the age of 65 represent a lower percentage of the uninsured than do other groups due to high enrollment in the government sponsored Medicare program. Individuals under the age of 65 are eligible if they have a disability and receive Social Security Disability benefits. Table III-10 below displays an age breakdown for Medicare recipients in Georgia.

⁸ Using Holzer estimates for SMI and SED prevalence

⁹ This figure is based on updated Census population estimates for 2003.

Table III-10: Medicare Beneficiary Breakdown

MEDICARE BENEFICIARY BREAKDOWN	GA #	GA %	US #	US %
Children 18 and Under	9,230	1	220,930	1
Adults 19-64	110,070	14	3,683,380	11
Elderly 65+	672,620	85	30,286,400	89
Total	791,930	100	34,190,710	100

It is estimated that almost \$10 billion is spent annually by Medicare to cover mental health costs for 30 million enrollees, averaging to just \$320 per person per year.¹⁰ Using that figure, Medicare mental health spending for Georgia alone would total \$256,371,200 for FY04.

Additionally, data obtained from the state's mental health information system indicates that 20% of individuals enrolled in public mental health services have Medicare. This figure is most likely over representative of individuals under age 55 with disabilities who may have worked some and became eligible for Medicare when they became disabled.

Private Insurance

“Millions of Americans with mental disorders do not have equal access to health insurance. Many health plans discriminate against these people by limiting mental health and substance abuse healthcare by imposing lower day and visit limits, higher co-payments and deductibles, and lower annual and lifetime spending caps”
(NMHA, 2003).

Private insurance coverage of behavioral healthcare has become a hot topic in recent years. As more health insurers move to managed care models, as opposed to fee for service health insurance, this topic has become even more of an issue when insurers put capitation and limitations on services provided for mental health services.

“Mental Health Parity” in health insurance policies is a major advocacy effort across the United States. In 1997 national legislation was passed ensuring that policies cannot discriminate. However, reports indicate that advocacy and the new law have not had a significant impact on the comparability of mental health services to other health services. The General Accounting Office reported in 2000, that for the most part health insurance plans complied with the law, but “87 percent of those plans restricted their mental health coverage in other ways, substituting new barriers for those ruled out under the law” (NMHA, 2003). Many private insurance plans assign higher cost-sharing to mental health services.

¹⁰ This statistic was cited in the Surgeon General's report on Mental Health, 1999.

“More than half of all outpatient specialty mental health services provided to children with private insurance are out-of-plan.”

http://datatrends.fmhi.usf.edu/summary_42.pdf

Limits on the benefits provided for mental health services under private insurers can become an enormous responsibility on individuals and families who have significant needs. Table III-11 exemplifies the difference an average family would spend in “out-of-pocket” expenses for mental health treatment compared to those of medical/surgical treatment.

Table III-11: Mental Health Treatment Costs¹¹

	Treatment Costs	Average Out of Pocket Expenses
Mental Health Services	\$35,000	\$12,000
Mental Health Services	\$60,000	\$27,000
Medical/Surgical Treatment	\$35,000	\$1,500
Medical/Surgical Treatment	\$60,000	\$1,800

With the privatization of service delivery becoming increasingly popular with the public sector, all of these issues need to be taken into account when making decisions.

What services should be covered by Private Insurance?

The Surgeon General’s Report on Mental Health provides suggestions for services that should be included in private insurance coverage that are effective and evidence based:

- Hospital and other 24-hour services (e.g., crisis residential services)
- Intensive community services (e.g., partial hospitalization)
- Ambulatory or outpatient services (e.g., focused forms of psychotherapy)
- Medical management (e.g., monitoring psychotropic medications)
- Case management
- Intensive psychosocial rehabilitation services
- Other intensive outreach approaches to the care of individuals with severe disorders

“No coverage. Private insurance has only one mental health facility available in Cobb County, over 1 hour from our home. Will not reimburse for any other facility or provider of mental health. Had to wait over 2 years for assistance for son, although we informed them he was very depressed and withdrawn. They state this is the school system's problem, school system states this is a medical problem. Our child remains caught in the middle.”
- Survey Respondent

¹¹ <http://www.surgeongeneral.gov/library/mentalhealth/home.html>

Insured and Uninsured Individuals in Need of Public Mental Health Services

Using the information that is available, it is difficult to accurately estimate the number of people who need public services based on what type of insurance they have – either because they have no insurance or their private insurance is inadequate for the coverage that they need. Without access to income levels and insurance type of every consumer served by the public mental health system, the state cannot accurately account for who is being served. However, by reviewing the information presented in this section one can make more generalized statements about the need for services within the state of Georgia:

- *There are 1.3 Million Georgians who are uninsured.*
- *There are an estimated 110,293 of these Uninsured Georgians who need mental health services.*
- *Private insurers do not adequately cover mental health services, especially for those with intense needs.*
- *The public system has to have the capacity to absorb individuals whose insurance is inadequate and who meet the states core consumer criteria.*

Moving Forward

Based on prevalence estimates, research indicates that there are several hundred thousands of Georgians in need of mental health services. The Gap Analysis presents these figures at the beginning of the report so the reader has an understanding of the magnitude of the issue at hand. In future chapters of the Gap Analysis, statistics will be presented on how many people are served in the community, how many are hospitalized each year, and their demographic makeup. It is imperative that the Gap Analysis reader remember that over half a million people are estimated to have mental illness in Georgia, and an even greater number are touched by it every year.

CHAPTER IV: STAKEHOLDER INVOLVEMENT

In this chapter you will find:

- ❖ *Regional and Specialized Focus Groups*
- ❖ *An Online Survey using an automated survey instrument*
- ❖ *Additional Input developed by stakeholders*
- ❖ *Personal Interviews with key policymakers and leaders within multiple public systems*



Highlights of significant findings in this chapter include:

- ❖ *Community Crisis Beds were the #1 Priority of survey respondents.*
- ❖ *Survey respondents reported that 54% of individuals with private insurance should be served by the public system, and 41% felt that people with high incomes (\$35,000) should be served by the public system.*
- ❖ *Despite the efforts to broaden the provider pool within Georgia, 67.1% of the respondents reported that there is Insufficient Choice in Provider agencies within their region.*

The cornerstone of Georgia's Mental Health Gap Analysis was the extensive Stakeholder Involvement throughout the process. APS is committed to all stakeholders being a part of the product development, especially individuals with mental illness, people who utilize services and their family members, providers, and policymakers at the state and regional levels. To capitalize on stakeholder involvement at varying levels, APS utilized four separate methods to collect information from different perspectives:

A. Mental Health Gap Analysis Stakeholder Input: Regional and Stakeholder Focus Groups

In October and November 2004, APS conducted 21 focus groups with Regional Planning Boards, stakeholders in each region, and statewide advocacy groups. More than 400 people participated across the state. Questions addressed at each group included:

- Who should the public mental health system in Georgia serve? Who are the most underserved populations? Who are the most vulnerable/at risk populations?
- What is working to meet the needs of these populations being served by the public mental health system?
- What else is needed to meet the needs of these populations?
- What barriers get in the way of meeting the needs of these populations?

- What one thing, if it could be done, would have the biggest impact on improving the system and service to these populations?

Responses from the focus groups fell into two major categories. The first described issues within the system that either create gaps or prevent programs and services from being effective. The second category focused more on specific programs or services that are either not present, or not sufficiently present. In all cases, participants were clear that they believed that adding services without addressing system issues would be ineffective. Major priorities from each category are summarized here. An extended report on themes is attached to this report as **APPENDIX IV-1: Gap Analysis Focus Group Summary**.

System Priorities and Issues:

- **Significant regional differences** exist across the state in such areas as:
 - Availability of qualified staff
 - Access to private mental health resources
 - Cooperation and collaboration among different agencies (DFCS, DJJ, DOC, etc.)
 - Homeless population
 - Non-English speaking population
 - Migrant and transient population

Respondents believed that attempting to have one statewide model of service delivery and funding interfered with the ability to address the regional differences. Regional planning boards, which have the responsibility of “localizing priorities,” appear to base plans on emotional appeal rather than utilizing data or empirical evidence.

- **Funding and payer mix.** Participants were unanimous in their view that Georgia’s public mental health system was significantly under funded (sources ranged from 43rd to 46th in *per capita* spending on mental health), reducing the effectiveness of all programs and services. Limited funding was exacerbated by dependence on two primary payer sources: state Grant-In-Aid and Medicaid, with limited third party, community or philanthropic resources. Lack of clarity about the structure of the predominant public provider – the CSBs – contributes to the lack of community development of broader sources of funding and support.
- **System Instability.** Participants from all levels of the system –statewide advocates, central MHDDAD staff, regional staff, CSB staff, planning board members, local advocates, consumers, family members, and representatives of other systems – cited system instability as a major factor detracting from Georgia’s ability to serve public mental health populations.
- **Poverty.** Poverty and the resulting lack of social supports, safe and affordable housing, transportation, access to primary medical and dental care, and limited social, educational, and other resources have a major impact on access to and the effectiveness of the available public mental health programs.
- **Collaboration, Cooperation, and Communication.** Whenever there was significant communication, collaboration and cooperation among agencies – whether at a local or

regional level – there was increased access to and effectiveness of services within the public mental health system. However, such collaboration was limited. Participants consistently placed a high priority on “breaking down silos” beginning at the state-agency level. Reducing the “bureaucracy” and paperwork caused by the lack of collaboration and coordination was a powerful secondary issue.

Service Gaps and Priorities

- Crisis stabilization units (CSUs) and services, where present, are seen as highly effective in treatment and in reducing hospitalizations. More CSUs, crisis services, and hospital diversion programs are needed for adults. No CSUs exist for children and adolescents, and other crisis and hospital diversion options, such as respite beds, are limited.
- Access to medication is a major gap for consumers without Medicaid. Indigent programs through drug companies are supplying millions of dollars in medications to Georgians. However, the indigent programs do not address the needs of all consumers without Medicaid and the programs are not long-term solutions.
- Services specific for those with co-occurring mental illness and developmental disabilities are needed.
- Where present, jail diversion programs, including mental health and drug courts, were seen as effective by the majority of participants. Increased services for mentally ill persons of all ages who come into contact with law enforcement were cited as a priority.
- Clinical staff that is bilingual, especially in Spanish, are sparse. Interpreters may be available but may only be used in emergency situations.
- More peer support programs, and increasing wages for Certified Peer Specialists are highly valued.
- The focus for all services needs to shift to a Recovery model. The dominant philosophy in Georgia still appears to be one of a Medical model, which focuses on compliance with treatment protocols rather than instilling hope and fostering independence.
- More residential treatment options at all levels of intensity and for all ages are needed.
- More vocational services, from vocational rehabilitation to supportive employment, are needed.
- Enhanced parallel services such as transportation, affordable housing, primary medical care, and dental care will contribute to personal recovery for individuals with mental illness.
- More services and programs for transitional youth, especially those who have been in intensive residential treatment or foster care, are needed.
- More services and programs for the aging population are needed. There are few specialized programs for people with mental illness as they get older.

- The array of rehabilitation services, especially the community-based services and the Psychosocial Rehabilitation programs, are seen as essential to maintain and expand.
- Intensive capability to respond to people in early stages of their disease, to prevent or ameliorate their deterioration, and impending chronicity is necessary. A proactive approach to education, assessment, and intervention would have a major impact both financially and at the individual recovery level.
- Funded systems of care for children and youth that incorporate public and private resources need to be explored.
- More services for the homeless, including outreach and engagement, are necessary.
- Education, prevention, and early intervention at all levels would allow the state to decrease the high prevalence of some people with mental illnesses who are currently not served.
- Services for persons who might not fit within the current Medicaid-driven rehabilitation service definitions are necessary. The service array and definitions of services need to be congruent for those with Medicaid benefits and those who are served with state grant-in-aid funding.
- More intensive levels of care for children and youth are necessary to prevent hospitalization.
- Cultural Barriers – There is stigma within different cultures where mental health treatment is a taboo and people do not seek services. Providers need to bridge this gap by employing staff with a cultural background reflective of the community.

B. Mental Health Gap Analysis Stakeholder Input: Online Survey Summary

One of the innovative components APS Healthcare was able to deploy was an online survey targeted to all stakeholders of the Public Mental Health System. APS Healthcare developed the survey with input from numerous individuals familiar with the Public Mental Health System in Georgia. The web-based program called *Survey Monkey* was chosen for its cost-effectiveness and its easy to use format.

The survey was originally intended to provide insight to the facilitators of the focus groups about the current climate of the service delivery system. However, once the survey was drafted it became a powerful tool due to the easy access it offered all stakeholders and immediate results it provided APS. The survey was designed to gather information that would be similar to the focus group discussions, but by collecting data online the information could be quantified. Additionally, the survey allowed APS to collect information from individuals confidentially, so people were more candid than they might have been in focus groups surrounded by providers, peers, or supervisors.

The survey was launched on October 1, 2004 and targeted to individuals who would be participating in the focus groups and people who would not be able to attend a focus group

across the state. APS Healthcare also made hard copies of the survey available at all of the focus groups so that individuals without Internet access could complete the survey and mail it to our office for data entry. APS Healthcare received nearly 200 surveys in hard copy format completed primarily by consumers. In total **1,025 individuals completed the survey** between October and December 2004.

The survey collected information on the following topics:

- Demographic information such as profession/affiliation, MHDDAD Region, and number of years supporting people with mental illness
- Populations that should be served by the Public Mental Health System
- Perceptions on the availability and adequacy of services throughout the state
- Barriers to receiving and providing services
- Services or Processes that are Strengths within the system
- Resources that Improve Service Delivery
- Prioritized list of Gaps in Services

Demographic Information on Respondents

The table below lists the percentage of respondents from each region. Participants in the Southeast, North, Southwest and Metro regions responded two to three times more than individuals in the remaining regions. This trend also mirrored participation from those areas in the focus groups.

Table IV-1

<i>Regional Breakdown of Respondents</i>	
Southeast Region	23%
North Region	20%
Southwest Region	18%
Metro Region	17%
East Central Region	9%
West Central Region	7%
Central Region	6%

The survey was targeted to providers of services, consumers and family members, and policymakers. Survey links were sent out over email, so that individuals could simply click on the hyperlink and be automatically connected to the survey.

The majority of the respondents (28%) were employed by a Community Service Board or a Private Mental Health Provider. The majority of “Other” respondents consisted of Department of Juvenile Justice judges, school social workers, probation officers, and other social services workers. This figure, in addition to the “Other State Agency” figure, represents the mix of stakeholders who completed the survey. The table below details the respondents’ affiliations:

Professional or Volunteer Affiliation

Regional MHDDAD Staff	4%
Regional Planning Board Member	5%
CSB Staff Member	21%
Private Mental Health Provider	7%
Hospital Staff	6%
Advocate	11%
MHDDAD Central Office Staff	2%
Other State Agency Staff (DJJ	19%
Other (please specify)	26%

Within the affiliations, the survey asked for individual's roles. Responders were: 21% Consumers or Family members, 34% Administrators/managers, 16% Clinicians, 4% Volunteers, 3% Peer Specialists, and 1% policymakers. Information was gathered on the public mental health workforce by assessing the average number of years individuals had been working within the system. Respondents indicated that 29% have been working in mental health MORE than 20 years, and when individuals employed by CSB's are filtered, that number climbs to 33%. Over 50% of the staff have been working in the field more than 11 years. This is a good indicator for the level of expertise and experience individuals may have, but an eye-catching number when looking at workforce trends and attracting new employees to the public mental health system.

Populations that should be receiving services

Another indicator that the survey measured was "who the respondents thought the public mental health system should be serving." Overall, respondents thought that the majority of people should be served: People of all ages, people with low and moderate income levels, and people with all types of illnesses. Of the ***respondents, 54% thought that individuals with private insurance should be served, and 41% felt that people with high incomes (\$35,000) should be served by the public system.***

Respondents identified underserved populations within the public mental health system. The following are all subgroups that were perceived to be an "Underserved" population:

- Children and Adolescents, especially Transitional Youth ages 18-24
- Older Adults/Seniors
- Individuals with Co-Occurring Disorders: People with Mental Illness and Mental Retardation, Mental Illness and Addictive Disease, and Mental Illness and Physical Disability

All ethnic and racial minority populations were seen as Underserved populations. Latino, Asian, Native American, and Pacific Islander were all listed as underserved within the public mental health system.

The Availability and Quality of Services

Due to a lack of information on the capacity of the current system, individuals' perceptions and experiences were measured regarding the availability and quality of services within their regions. The term "Available" was defined as –"you can get it when you need it," and "Quality" was defined as "services are good – supporting recovery and independence."

The following table summarizes the extent to which respondents viewed services as Available or Somewhat available and Good:

Table IV-2: % of Services Viewed as Good or Somewhat Good					
	Day Services	Community Based	Supportive Housing	Jail Diversion	Outpatient
Adult	67%	61%	44%	37%	67%
Senior	48%	47%	33%	22%	56%
Child	48%	52%	25%	23%	58%
Adolescent	53%	51%	24%	28%	57%
TransYouth	39%	42%	24%	27%	52%

Despite the efforts to broaden the provider pool within Georgia, ***67.1% of the respondents reported that there is Insufficient Choice in Provider agencies within their region.***

Strengths and Barriers

The survey captured both the strengths and the barriers to receiving services within Georgia. Respondents stated that there were some strong points and glimmers of hope within the service delivery system. Community-based and recovery-oriented services ranked at the top of the list.

The top five strengths with the percentage of respondents that believed they were strengths are listed below:

Community Based Services	55%
Peer Support	50%
Certified Peer Specialists	47%
Psychosocial Rehabilitation	46%
Single Point of Entry	42%

In addition to strengths survey respondents were asked to identify resources within the community that improve and enhance service delivery. Advocacy groups such as National Alliance for the Mentally Ill and National Mental Health Association of Georgia were seen as the primary resources for improving service delivery. The Community Service Board Association, Regional MHDDAD Offices, and External Support Organizations (such as

JCAHO) were all the next highest with near 50% selecting them as resources to improving services.

Respondents were forthcoming with their thoughts on barriers to receiving services. In addition to the checklist of options, more than 200 respondents recorded detailed and lengthy narrative responses to barriers that prohibit service delivery. In hopes that participants would remain solution focused and provide greater insight into the specific barriers, the topic of “funding” was not offered as an option in the barriers menu of the survey. However, the number one response for barriers ultimately came down to issues of funding:

The following table outlines the barriers rated by priority:

Table IV-3: Barriers

Barriers	% that thought this was a BARRIER
Staff are Underpaid	91%
Bureaucracy or Regulatory Policies	88%
Provider costs exceed reimbursement for services	87%
Lack of Transportation	84%
Language Barriers	74%
No Coordination across agencies	73%
Lack of Choice in Provider	73%
Distance to service site	73%
Agencies choose not to provide desired services	71%
Limited Technology - such as no TTY phones	67%
Lack of Cultural Competency	66%
Limited Office Hours of Providers	63%
Lack of staff expertise	61%
No Access to Telephone	48%

In addition, respondents were asked “what barrier if removed or overcome would most enhance the quality of life for individuals using the public mental health system.” The top three responses were:

1. Bureaucracy and Regulatory Policies
2. Lack of Transportation
3. Provider costs exceed reimbursement for services

Service Enhancement

Survey respondents were asked to choose their Top Five services that would enhance the quality of life for individuals accessing public mental health services. The list included 25 different services that are available, including those outside of the public mental health system. By adding all the respondents' priorities together, one list of services by order of significance was obtained:

1. Community Crisis Beds
2. State Hospital Beds
3. Day Services - Adult/Senior
4. Day Services - Child/Adolescent
5. Permanent Supportive Housing - Adult/Senior
6. Transportation
7. Outpatient Services - Adult/Senior
8. Mobile Community Services - Adult/Senior
9. Outpatient Services - Child/Adolescent
10. Transitional Housing - Adult/Senior
11. Mobile Community Services - Child/Adolescent
12. Supported Employment
13. Transitional Housing - Child/Adolescent
14. Community Education/Prevention Supports
15. Parenting Skills and Supports

The information collected from this survey is very revealing and indicative of the current climate of the public mental health system: Individuals are invested in services and want them to get better. Public Services should benefit all of Georgia citizens in need. Services are not available to all that need them and there are few choices in providers. Georgia faces significant barriers to providing services. There are pockets of excellence where positive strides have been made in the areas of Community Support, Psychosocial, Rehabilitation and Peer Support services. Unfortunately, from a statewide perspective, services are not being provided at the level that they need to be due to an abundance of issues. Complicating the ability to agree on a unified strategic plan is the fact that each stakeholder has a different perception of what priorities are at the top of the list based on their individual experiences. This quote summarizes the above section well:

“When we are speaking literally about people's lives, there is no #1, #2, #3, #4..... By unanimously agreeing on a single priority, you omit others that are equally critical.”
- Consumer/Family Member

C. Personal Interviews with Key Policymakers and Leaders within Multiple Public Systems

In order to gather accurate and up-to-date information for Georgia's Mental Health Gap Analysis, it was necessary to conduct interviews with staff from each agency supporting people with mental illness. Commentary and data from these key informant discussions is woven throughout the Analysis, as it became a key component to involving stakeholders at all levels of research and development.

Staff members from the Department of Human Resources Division of Mental Health, Developmental Disabilities, and Addictive Diseases were of great assistance in providing information, support, and clarification of data when this was appropriate. Individuals from the Office of Mental Health, the Systems Design Unit, Forensic Services, Regional Hospitals, and the Evaluation Unit were very helpful in providing ongoing information and support to the research team. Additionally, a personal interview was held with Division Director Gwen Skinner to discuss the initial findings of the Mental Health Gap Analysis and to incorporate the Division's new leadership goals and outcomes into the analysis.

In addition to the Division of MHDDAD within DHR, representatives from the Division of Family and Children's Services were interviewed as well. These interviews proved to be very helpful in the analysis of child and adolescent mental health services. Interviews were also held with representatives from the Department of Community Health, Department of Juvenile Justice, and the Department of Corrections.

D. Building on Current Efforts: Additional Input Developed by Stakeholders

Across Georgia there are many different organizations and groups committed to improving the mental health service delivery system. Hundreds of dedicated people work very hard to develop and implement enhancements in mental health services, thus APS Healthcare would like to recognize their work and include their priorities in the Gap Analysis. Many of the priorities and challenges outlined by these different stakeholders mirror the findings of the Gap Analysis.

Priorities of the Georgia Mental Health Consumer Network

The Georgia Mental Health Consumer Network (GMHCN) is made up of 3,000 members statewide. Each year during the annual meeting of the GMHCN, consumers gather together and develop a list of priorities for advocacy within the state. At the 2004 meeting, the GMHCN identified Georgia's top advocacy priorities as follows:

- Peer supports
- Jobs
- Transportation

- Education and higher education, job training, and certified peer specialist training, plus education about illnesses
- Increased wages for peer workers
- Services for homeless persons
- Access to newer and lower-cost medications
- Better quality housing
- Better access to quality physician care
- Mutual support groups
- Addressing State Medicaid cuts and proposed Medicaid managed care

Other Georgia consumers identified such problems as a scarcity of family housing in rural areas, insufficient community support services, forced medication, seclusion and restraint, discharge from institutions without proper supports, medical neglect and stigma in some hospitals, and lack of focus on the needs of persons with co-occurring mental health problems and mental retardation. They asserted that vocational rehabilitation should provide educational opportunities for consumers, and advocacy that focuses on homes instead of housing, professions rather than jobs, and communities instead of systems and institutions will enhance consumers' interests.

FY 2006 Division of Mental Health, Developmental Disabilities, and Addictive Diseases Regional Plans Summary

Each of the seven MHDDAD Regional Planning Boards is charged with developing its own set of priorities and goals each fiscal year. As noted in the focus groups section, these priorities are as different as each of the regional demographics and geography. Each of the regional offices works with the planning board to collect information by conducting community focus groups, analyzing utilization rates, and looking at prevalence statistics in each region.

While the regions' priorities differ based on geography and demographics, there were issues that regions agreed are important to an enhanced service delivery system. Themes that reflect the similarities across the regions are listed below:

- **Collaboration** - Nearly all of the regions cited collaboration among various state agencies and providers as a goal. Realizing that limited public funds can go only so far, most regions are beginning to work on collaborating across agencies to ensure a continuum of care for consumers.
- **Crisis Intervention and Crisis Stabilization Units** were listed as a priority in most of the regions. These resources have been shown to be an effective method of decreasing expensive hospitalization stays.
- **Community Residential options** – It is widely recognized that a full continuum of residential supports is lacking in all regions of the state, whether it due to inadequate housing supply, lack of housing subsidies, or limited funding to support staff in the community.
- **Prevention** efforts were listed as a priority in each region.

- **Transitioning from hospital to community** and integrating hospital and community services were a priority in many of the regions.

REGION	<u>REGIONAL PRIORITIES</u> Taken from the FY06 Regional Annual Plans developed by each Regional Planning Board and Staff
West Central	<ul style="list-style-type: none"> • <i>Our major providers will work to increase the public’s awareness and understanding of the services that are available in their area.</i> • <i>We will promote increased transitions from institutions to community (Olmstead).</i> • <i>We will continue to insist on consumer safety by focusing on the consistent identification and reporting of serious incidents.</i> • <i>Residential services including stable housing options for consumers across all disabilities will be expanded.</i> • <i>Supported employment services for all disabilities will be expanded.</i> • <i>Agencies providing respite services will develop and execute plans to educate eligible consumers and families and increase the accessibility of respite services. Standards will be established and training provided for all people who deliver respite providers.</i> • <i>The MHDDAD service system will actively support planning for consumer transitions to adulthood.</i> • <i>Regional office staff will update and distribute the resource directory on an annual basis.</i> • <i>The “Safe and Drug Free Schools and Communities (SDFSC) Principles of Effectiveness” will be used in funding all requests for information for Substance Abuse Prevention service programs serving individuals in the region.</i> • <i>Prevention programs targeting the general populations will use one or more of the six CenterCenters for Substance Abuse Prevention approved Prevention Strategies.</i> • <i>Outreach and delivery of services to consumers over 60 years old will be expanded across all disabilities.</i> • <i>Services will be modified to accommodate all ages and disabilities that are dual-diagnosed.</i> • <i>Services will be provided in an integrated setting to include all disability-related needs.</i> <p><u>Long Range Goals - The Board has the following long-range goals:</u></p> <ul style="list-style-type: none"> • We will support the continued integration of community and hospital services by placing an emphasis on collaborative staff training and the establishment of a program that awards a certificate of completion of training in the core competencies of best practices to staff members employed by our providers. • We will continue to support a community-based resource as a step down program for forensic consumer placement.

	<ul style="list-style-type: none"> • The Regional Planning Board and regional office staff will work to promote, support, and expand additional Mental Health Courts within the region. • The Regional Planning Board and regional office staff will work to promote and support the development of additional Drug Courts within the region. • Major issues making transportation a barrier to service delivery in the West Central Region will continue to be identified and strategies to address each one will be developed and implemented. • Contingent on additional child and adolescent/addictive diseases finding, the West Central Region will establish another addictive disease residential facility for children and adolescents. • Establish a regional quality improvement process that actively engages all West Central Regional providers.
East Central	<ol style="list-style-type: none"> 1) Community crisis services 2) Increase consumer vocational opportunities 3) Increase residential capacity 4) Day services 5) Improve systems of care 6) Family and natural supports 7) Specialized services for co-occurring disorders 8) Increase use of mental health care recovery principles. 9) Increase and expand prevention 10) Improve transportation services <p>The East Central Region MHDDAD Board is aware of the tremendous needs that exist and is appreciative of the scope of the tasks ahead. Efforts will continue to improve collaboration with community stakeholders; including consumers, families, other DHR agencies, criminal justice system, Vocational Rehabilitation, local housing authorities, Office of Aging, public and private providers and community leaders.</p>
Metro	<p><u>Access to Services</u></p> <ul style="list-style-type: none"> • A Single Point of Entry with assignment to appropriate levels of care (MH/DD/AD and GRH/A) • Transportation (MM/DO/AD) • Increase opportunities for Respite care between 3:00 p.m. and 7:00 p.m. Monday-Friday (MR/DD) • Increase treatment opportunities for underserved and high-risk populations (MH/DD/AD) • Eliminate the Planning List by 2007 (MR1DD) <p><u>Service Expansion</u></p> <ul style="list-style-type: none"> • Expand services to treat Autism (MR/DD) • Provide a full continuum of substance abuse and addiction services for adolescents and adults (AD)

	<ul style="list-style-type: none"> • Increase crisis residential services within the Metro region (MM/AD and GRM/A) <p><u>Consumer Protection</u></p> <ul style="list-style-type: none"> • Ensure the health, safety and well being of consumers (MH/DD/AD) <p><u>Integration and Coordination</u></p> <ul style="list-style-type: none"> • Improve coordination of community programs with the adult and juvenile criminal justice systems (MRDDAD) • Participate in creative, collaborative, coalitions for planning services (MH/DD/AD) • Integrate Georgia Regional Hospital services with community systems of care (MH/DD/AD and GRH/A) • Promote workable service models for treating consumers with co-morbid conditions (MH/DD/AD) • Create a comprehensive, integrated information system (MH/DD/AD and GRH/A) • Create flexibility in use of dollars (MH/DD/AD) <p><u>Quality, Efficiency, Effectiveness</u></p> <ul style="list-style-type: none"> • Make services more efficient, accessible, and consumer-focused, by promoting state-of-the-science, evidence-based practices and models for recovery (MM/DO/AD and GRH/A) • Promote the expectation that consumers “give back” to their communities (AD) <p><u>Prevention</u></p> <ul style="list-style-type: none"> • Increase comprehensive community organization and development efforts, especially in underserved areas with high-risk populations, to prevent those conditions that are preventable (MH/DD/AD)
North	<ul style="list-style-type: none"> • Improve Access to services for all disabilities • Improve transportation services through out the region • Insure that MHDDAD services are publicized in order to better inform the public about available programs and supports in the community. • Planning Board members will increase collaboration, communication and networking with local legislative officials and other elected local officials. • Add prevention emphasis for all disabilities • Increase Adolescent Mental Health Programs that provide Day Treatment. • Develop community-based programs to address sexual predator issues. • Expand and/or initiate Intensive Family Intervention (IFI) services. • Close the service gap for young adults (18+) by increasing Independent Living Programs for those transitioning out of Intensive Residential Placements (MATCH) who have custodial parents but are ‘unable’ to return home. • Collaborate with DJJ and DFCS to develop innovative Crisis Respite and Emergency Services (ORES) to serve ALL CM consumers (to include suicide and sexual predator consumers). Incorporate a “No reject and

	<p>No Eject” policy.</p> <ul style="list-style-type: none"> • Increase Adolescent Substance Abuse Programs that provide day treatment. • Develop additional ambulatory detoxification services as part of a continuum of care plan with step down outpatient treatment services. Additional resources would include establishing partnerships for residential Living Supports for consumers in need of temporary living assistance as part of a rehabilitative plan to serve consumers residing in the North Region. • Develop transitional housing and support services to persons with mental illness or co-occurring disorders to serve consumers residing in the North Region. • Establish Peer Centers in the North Region for adults with Mental Health, Addictive Diseases and Co-occurring Disorders. • Assign and train liaison staff within each community mental health agency to assist local law enforcement to divert individuals from the hospitals or jails. Liaisons would have screening capabilities in order to assist in providing information to judges, law enforcement: sheriffs, jails and local detention centers as to the treatment alternatives available in lieu of and/or in addition to incarceration or hospitalization. • Develop transitional housing in the North region for consumers found Not Guilty by Reason of Insanity (NGRI). This resource will facilitate conditional release of consumers from the hospital to move toward permanent community integration.
Southeast	<ul style="list-style-type: none"> • Build natural supports to include circle of support for C&A SED. • Increase availability of clinical and psychiatric services, crisis planning for crisis support for C&A SED. • Reduce staff to consumer ratio for C&A SET). • Collaborate with law enforcement on transportation of consumers committed on 1013 order (Adults, C&A). • Reduce hospital utilization for adults with serious mental illness. • Expand peer and day support services to new locations and increase capacity (Adults, C&A). • Improve Service Entry and Linkage for MHDDAD (Adults, C&A). • Develop integration of hospital and community services to provide comprehensive <i>continuum</i> of care so consumers may step up/down the MHDDAD (Adults, C&A) treatment levels. • Expand housing and employment options for persons with DD. • Eliminate duplication of services for persons with DD. • Identify additional/alternative-funding sources for services for persons <i>with DD</i> and persons diagnosed with autism, include services in early intervention, support groups, outreach, medical services, therapy,

	<p>transportation, crisis intervention and local respite services.</p> <ul style="list-style-type: none"> • Improve the number and quality of treatment facilities and expand Treatment Court Program for adults with addictive diseases] including recovery residences, crisis stabilization, long term, and halfway houses. • Increase intervention efforts and enhance services and activities for adolescents with addictive diseases. • Increase funding for comprehensive prevention approach for individuals, family, peers and community. • Build a coalition of agencies to strategize and brainstorm as a whole, to develop best practices for persons with multiple <i>service</i> needs. • Provide comprehensive provider staff training to address provider staff development needs. • Reduce Adult Mental Health Units at Georgia Regional Hospital. • The Southeast Region will continue to address major transportation issues that impacts services to Consumers. • Develop transitional services the children and adolescents discharged <i>from</i> Georgia Regional Hospital at Savannah to Community Based Services. • Increase Family Support Services. • Increase Substance Abuse Detox Services. • Improve Prevention capacity.
Southwest	<ol style="list-style-type: none"> 1. <u>Adults with Mental Illness:</u> <ul style="list-style-type: none"> • Improve access to high intensity services for consumers in “crisis” in lieu of hospitalization. • Improve timely access to physician services <i>in</i> the community. • Expand access to residential supports (intensive, in-home supports and respite care). 2. <u>Children and Adolescents with Serious Emotional Disturbance:</u> <ul style="list-style-type: none"> • Develop additional community residential supports in order to respond to the transition from MATCH to Level of Care. • Develop additional community inpatient and other community-based alternatives for children ages nine (9) years and under. • Increase utilization of consumer and family education in child and adolescent programs. 3. <u>Persons with Developmental Disabilities:</u> <ul style="list-style-type: none"> • Adequate funding to address residential, day services, respite care/family support, and transportation needs of consumers on the “<i>ever growing</i>” <i>planning</i> list <i>for</i> services. • Increase identification and utilization of community resources including natural supports as avenues for socialization and community integration. 4. <u>Adults with Addictive Diseases:</u>

	<ul style="list-style-type: none"> • Expand utilization of research and evidence-based treatment practices by providing special regional training opportunities. • Utilization of real-life community integration activities as a component of the treatment model(s). <p>5. <u>Adolescents with Addictive Diseases:</u></p> <ul style="list-style-type: none"> • Enhance existing continuity of care plan to involve families and other stakeholders. • Develop additional “long-term” residential treatment programs to serve the whole region. <p>6. <u>Individuals with Multiple Service Needs:</u></p> <ul style="list-style-type: none"> • Improve service access to dual diagnosis consumers (i.e., no wait time for enrollment, adequate 1-to-1 time with physician). • Expand availability of step-down supportive living for dually diagnosed consumers. <p>7. <u>Substance Abuse Prevention:</u></p> <ul style="list-style-type: none"> • Expand prevention services for Pre-K through Middle School age youth. • Increase funding allocations for existing providers who show results. <p>8. <u>Southwestern State Hospital:</u></p> <ul style="list-style-type: none"> • Seek approval to develop 23-hour hold beds. • Develop crisis response capacity for MHDD populations.
Central	<ul style="list-style-type: none"> • Development of Full array of Community Residential Services for DD, MH, AD, & C&A • Regional Planning Board shall remain as the primary tool for assuring local input • Maintain commitment for newer generation medications in community and hospitals • Support the stability of current CSBs and other Providers • Clarification regarding who serves as the “Safety Net” for each disability group and how this is funded • Expansion of Work and Skill building Services • Develop process to blend community and hospital medication services • Increase prevention services and expand suicide education program • Facilitate the expansion of Regional Capacity as part of autism training/Family Support

It is clear that Georgia's stakeholders are passionate about mental health services. Consumers, their family members, service providers, and staff members at all levels of the system have strong emotions about the need for services. Employees within the system show dedication and commitment to providing supports for individuals with mental illness. Stakeholder comments and statements of commitment are woven throughout the Gap Analysis as evidence of the foundation that all stakeholders are valuable, and should positively contribute to a better mental health system. In the next several chapters community and hospital services are analyzed with facts, and figures, but while reading the Gap Analysis report remember that all of these numbers represent people and their lives, everyday.²

CHAPTER V: AN IDEAL COMMUNITY SYSTEM AND THE AVAILABILITY OF GEORGIA'S COMMUNITY SERVICES

In this chapter you will find:

- ❖ *Characteristics of an Ideal System of Support*
- ❖ *Georgia's Community Based Mental Health System*
- ❖ *Availability of Community Services*



Highlights of significant findings in this chapter include:

- ❖ *The majority of services provided in Georgia remain clinic based outpatient services with Diagnostic/Functional Assessment enrolling the most consumers, along with pharmacy services, and physician and nursing assessment provided to the majority of consumers.*
- ❖ *Innovative Community Services are not available consistently across the state, and are not provided to all of those that would benefit from such services. Statewide, on average 45% of the consumers received Innovative Community Services, with the range for providers varying greatly.*
- ❖ *Often, services are not available locally.*
- ❖ *The public is not informed of what services exist and how to access them.*

A. Characteristics of an Ideal System of Support

Before examining Georgia's current system for community based mental health care, it is important to examine the characteristics of an effective system of support. What are the desirable characteristics of a good system of support? The following section identifies characteristics of an effective service delivery system for a population with Severe Emotional Disturbance or Severe Mental Illness.

Components of an Ideal System of Support

The National Alliance for the Mentally Ill (NAMI Georgia) has adopted the following Standards of Care as their ideal system of support: Access to Appropriate Medication, Inpatient Care, ACT Programs, General Medical Care, Integrated Services for Dual Diagnosis, Family Psychoeducation and Support, Peer Provided Services and Supports, Supported Employment Services, Affordable Housing and Supports, Jail Diversion Programs, and Non-Stigmatizing and Non-Discriminating Environment.¹²

¹² <http://home.bellsouth.net/p/s/community.dll?ep=87&subpageid=77422&ck=>

A *Behavioral Health Needs and Gaps in New Mexico* report identifies elements that are common to those systems providing good behavioral health care. These elements are listed below:

- Consistent leadership
- Single, clear vision
- Informed and supportive public
- Stakeholder engagement
- Accountable sub-state system managers
- Data for decision-making
- Incentives and Rewards
- Quality improvement culture ¹³

In addition to the above common elements of a good behavioral healthcare system, there are some guiding principles that should be common to all service systems. These elements provide the foundation for the service delivery system:

- Customer orientation
- Commitment to recovery/resiliency
- Clarity of system design
- Clinical and service excellence
- Sufficiency of resources
- Attention to human resources
- Equity of access and continuity
- Integration of care
- Community-based solutions
- Stewardship of public funds ¹⁴

Characteristics of Good Behavioral Health System for Children/Adolescents

At the federal level, the Child and Adolescent Service System Program (CASSP) philosophy has long been recognized as defining best practice and preferred systems of care for children and their families, especially those with severe emotional disorders (SED).¹⁵ The CASSP principles clearly state that services for children and families should be child-centered, family-focused, community-based, multi-system, culturally competent, and least restrictive. There is currently not a sufficient research base at this time as to determine what works best clinically with children and adolescents; however, this is starting to be addressed by both the Federal and various State governments. While there have been mixed results in prior research about how systems of care make a difference for

¹³ *Behavioral Health Needs and Gaps in New Mexico* (2002), Chapter IV, Pg. 143

¹⁴ *Behavioral Health Needs and Gaps in New Mexico* (2002), Chapter IV, Pg. 144-5.

¹⁵ The federal definition of children with severe emotional disturbance (SED) includes children from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV-R). That DSM diagnosis must have resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

children/adolescents clinically, there is evidence that such approaches increase access, satisfaction, and involvement of families.¹⁶ The most recent data from SAMHSA's systems of care demonstrations show great promise in reducing behavioral problems and out-of-school days and increasing school performance for children/adolescents.¹⁷ The Surgeon General recently released a report entitled *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*.¹⁸ This report describes the needs in children's mental health services and research and calls on states and local systems to implement more effective services for children and youth based on the principles outlined above.

A number of specialized programs have been developed during the last decade to target high-risk children and families. These include the Family Preservation Program, based on the Homebuilder Model pioneered in Tacoma, Washington, which addresses children at imminent risk of out-of-home placement. Intensive Case Management, tried in several states (New York, Ohio, Oklahoma, Texas), has been used to work with children and families who have not responded to traditional approaches of service delivery. In recent years, the advent of the evidence-based practice called multi-systemic therapy (MST) developed and evaluated by practitioners and researchers in South Carolina, has gained national recognition as the most effective intervention for children/adolescents with conduct disorders and other behavioral aspects to their diagnoses.¹⁹ In some places, a similar but not as well researched intensive team-based approach for children/adolescents and their families is called intensive family interventions (IFI). **Several** problems with the implementation of any of these "models" or therapies is the lack of **qualified credentialed staff** credentialing, required training, and demonstration of proficiency in the use of the model prior to providing and billing the service.

A Word of Caution

The Georgia system can introduce new service codes and approaches to increase the provider pool. However, new providers often do not possess the necessary training to implement a new service in line with the best practice model. For instance, in Georgia, Medicaid funds pay for residential placements for children/adolescents without a requirement that programs such as IFI or Community Support serve them once back in the home. Emerging research has demonstrated that residential treatment (that is, treatment in a group residential setting outside the home) and group homes for children/adolescents have consistently been shown to be ineffective in creating long-term gains for

¹⁶ Arizona has published evidence-based clinical guidelines for these and other SED conditions.

¹⁷ Substance Abuse & Mental Health Services Administration Press Release. (March 21, 2002). Available from the World Wide Web: <http://www.mentalhealth.org/newsroom>; and SAMHSA's publications at <http://www.mentalhealth.org/publications>.

¹⁸ Satcher, D., (2000). Report of the Surgeon General's conference on children's mental health: A national action agenda. U.S. Department of Health and Human Services, U.S. Public Health Service. Washington, DC: U.S. Government Printing Office.

¹⁹ Henggeler, S. W., Rowland, M. D., Randall, J. et al. (1999). Home-based multi-systemic therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 1331-1339.

children/adolescents with behavioral health needs.²⁰ In fact, in some cases, this type of residential setting has been shown to be detrimental to outcomes for high-risk problem behavior males.²¹

Elements of a good system for children/adolescents include:

- System-wide commitment to tearing down system barriers to allow state and local child-serving agencies to openly and fully coordinate access to and delivery of their discrete services;
- Methods and supports for empowering children and their families and front-line staff to provide them. Children and their families do best when they participate fully in treatment planning and service choice. In many best practice models, families choose service models, select providers, and train and supervise them to work in their own homes and schools.
- Systematic and coordinated approaches to access, comprehensive assessment, service planning, and outcome measurement for services. Children and their families should have one and only one integrated assessment and treatment plan, and should be able to access all needed and chosen services from wherever they present in the system. This unified access and treatment planning approach should also assure continuity of treatment and supports as well as facilitate access to a variety of services across agency lines;
- CASSP principles should be implemented consistently on a statewide basis. These include:
 - Provision of needed services in the child's home community and in the child's home;
 - Least restrictive, most normalized environment;
 - Comprehensive array of services that address physical, emotional, social, and educational needs;
 - Child and family-centered approach to strengths-based service delivery;
 - Culturally appropriate services;
 - Interagency collaboration and cooperation;
 - Early identification and intervention (including but not limited to EPSDT);
 - Specific child/family outcomes in the accountability system; and
 - Allocation of significant resources to prevention and early intervention services that have been proven effective.

Communities that have been successful in implementing comprehensive service systems for children and youth have the following themes in common:

- A planned and thoughtful willingness on the part of all parties to cede control and share resources in meaningful ways;
- Single-site management of all resources, with the authority to access all applicable service modalities and to commit funds for these services;
- Integration of and adherence to CASSP principles throughout the system of care;
- A unified comprehensive, strengths-based assessment and treatment plan governing all aspects of service access and delivery;
- Leadership committed to managing and delivering services in new, creative, and flexible ways;

²⁰ Hoagwood, et al., 2001.

²¹ Marsenich, L. (2002). Evidence-Based Practices in Mental Health Services for Foster Youth. California Institute for Mental Health: Sacramento, CA. Available from the World Wide Web: <http://www.cimh.org>.

- A commitment to include families and their children in all levels of service planning, implementation, management, and evaluation as well as in treatment planning and provider choice; and
- A promise not to let children and their families go – the system will be there for them whenever and wherever they want, with whatever they need and choose.

Children/Adolescents with Substance Abuse or Dependence

Services for adolescents should be directed toward the following goals:

- Availability of and access to an array of services without having to place the adolescent in state custody to attain them.
- Services individualized to the needs of the adolescent including attention to developmental processes and co-occurring mental health issues.
- Active and informed participation by the youth and family in treatment planning.
- Availability of supports for families/caregivers to bolster family relationships and to maintain the adolescent in the community.
- Availability of a single comprehensive assessment that is used to inform service planning and delivery, across systems.
- A long-term view that guides service delivery and works toward goals of successful community functioning both in adolescence and adulthood.
- Continuity of care and, when necessary, successful transitions to other service providers and other levels of care.
- Service planning and coordination that take place among all providers and agencies delivering services and have responsibility for the care of the adolescent.²²

Research shows that few people initiate drug use/abuse after the age of 25. Thus, it is imperative that early intervention and moreover, prevention interventions be provided. Research has shown that prevention programs that are based on the following principles are the most successful:

- Early Intervention - the earlier prevention is started in a person's life, the more likely it will succeed;
- Evidence-based - prevention programs should be knowledge-based, incorporating state-of-the-art findings and practices drawn from scientific research and expertise;
- Comprehensive - prevention programs should be comprehensive, e.g., include components of education, health care, social service, religion, and law enforcement, as well as family involvement and should focus on at least one of the six prevention domains [individual, family, peer, school, community, and society] identified by the Center for Substance Abuse Prevention (CSAP);
- Evaluated for both process and outcomes - programs should include process as well as outcome evaluations to ensure that knowledge derived from prevention programs is validated and disseminated to communities;

²² Heflinger, C. A., & Flowers, A. (2002). Teen substance abuse: Treatment lessons learned from TennCare. Behavioral Health Management, 22:3, 10-13; and Heflinger, C.A. (2001). Unpublished paper. Principles of a system of care for adolescents with substance abuse problems. Vanderbilt University. Nashville, TN.

- Reduce risk factors and increase resiliency - prevention strategies must be structured to reduce individual and environmental risk factors and to increase resiliency factors in high-risk populations;
- Mixed in with general health care systems - prevention programs should be intertwined with the general health care and social services delivery systems and must provide for a full continuum of services;
- Promote life skills - prevention programs should build social competencies and life skills, such as decision-making, problem-solving, communication and resistance skills, critical analysis (for example, of media messages), stress management and systematic and judgmental abilities;
- Information dissemination – programs should provide accurate information on the nature and extent of alcohol, tobacco, and other drug use, abuse, and addiction and their effects on individuals, families, and communities, as well as information to increase perceptions of risk. Additionally, they should provide knowledge and awareness of prevention policies, programs, and services;
- Targeted approach - prevention programs that are tailored to differing population groups are most effective;
- Alternative activities – programs should provide constructive, fun and healthy activities to offset the attraction to, or otherwise meet the needs usually filled by, alcohol, tobacco, and other drug use;
- Problem identification and referral - screening for already existing tendencies toward substance abuse and referrals for preventive treatment for curbing such tendencies;
- Community initiated - successful programs are initiated and conducted by communities themselves;
- Environmental approach - changes to written and unwritten community standards, codes, and attitudes; for example, laws to restrict availability and access, price increases for alcohol and tobacco and community-wide actions.

Adults with Mental Health Needs

Services and technology within behavioral health services for adults has significantly improved over the past 3 decades. More research has been done and more is known about what works for adults with serious mental illness than for many other populations. For general mental health issues (i.e., depression, anxiety, post-traumatic stress, etc.) some combination of new medications and brief cognitive-supportive therapies or supportive therapeutic groups have proven to be almost universally effective if delivered appropriately and with sensitivity to culture and individual needs.²³ Adults with serious mental illness (i.e., schizophrenia, bipolar disorder, major depression) are likely to constitute the vast majority of the publicly funded service delivery system's clients. Newer technologies include: atypical anti-psychotics, anti-depressants, and anti-anxiety medications, and community treatment approaches such as assertive community treatment (ACT); family psycho-educational services; illness self-management or peer supports; recovery-oriented psychosocial rehabilitation services, including supported employment, education and housing; and integrated

²³ U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. (1999). Mental health: A report of the Surgeon General. (ISBN 0-16-050300-0). Washington, DC: U.S. Government Printing Office.

treatment for adults with co-occurring disorders. These six services are considered evidence-based²⁴ and therefore, any good system of care should have all these services available at a minimum.²⁵ Additionally, the use of specific types of therapy tailored for specific disorders is important (e.g., short term cognitive therapy for individuals with depression; dialectical behavioral therapy for individuals with anxiety disorders).

In recent decades, the federal community support program (CSP)²⁶ has been the widely accepted, preferred model of community-based services for adults with serious and persistent mental illness. States that have fully implemented the CSP model tend to be the furthest along in terms of truly integrating recovery and empowerment values and principles into the local public behavioral health delivery systems. A good public mental health system is comprised of a number of interlocking and interdependent elements. These start with basic treatment philosophy and values, and extend to specific face-to-face clinical and community support services. The integration and continuity of these components are important to consumers and families as is the presence of each discrete element. The following are the key characteristics of a good mental health system for adults:

- Recovery values and principles
- Consumer self-determination and choice
- Continuity of connection with the system
- Psychosocial rehabilitation approaches – “Recovery is what people with disabilities do....rehabilitation [is] what helpers do to facilitate recovery....”²⁷ Psychosocial rehabilitation, also known as psychiatric rehabilitation, includes a set of services and supports designed to assist individuals regain maximum independent functioning in living environments and communities of their choice.²⁸
- Peer supports/consumer-operated services – Consumer-operated peer support and self-help activities can take a number of forms. Many consumers form clubhouses or drop-in centers and/or operate warm lines, peer outreach, and related services. Consumers as peer supports have also been successfully integrated into crisis outreach teams and assertive community treatment teams. Consumers have become engaged in training, satisfaction and quality reviews, ombudsmen services, and a variety of related self-advocacy activities.
- Prevention/early intervention and diversion services – Early intervention is better for consumers and their families because it reduces the long-term negative effects of the illness and initiates the recovery process at a time when the disabling effects of the illness are minimal and personal and family resources are not yet exhausted.²⁹

²⁴ Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Flynn, L., Rush, A. J., Clark, R. E., Klatzker, D. (2001). Implementing evidence-based practices for persons with severe mental illnesses. *Psychiatric Services*, 52:1, 45-50.

²⁵ Lehman, A. F., Steinwachs, D. M. (1998). Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. *Schizophrenia Bulletin*, 24, 11-20.

²⁶ For example, see Sproul, B. A., *Models of Community Support Services: Approaches to Helping Persons with Long Term Mental Illness* NIMH August, 1986

²⁷ Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 90s. *Psychosocial Rehabilitation Journal*, 16:4.

²⁸ Hughes, R., & Weinstein, D. (Eds.). (2000). Best practices in psychosocial rehabilitation. International Association of Psychosocial Rehabilitation Services. Columbia, MD.

²⁹ For example, Fenton, W. S. (2002). Residential program for mentally ill a cost-effective alternative to hospitalization. *Archives of General Psychiatry*, 59, 357-364.

- Crisis services – Crisis delivery systems are best developed and operated to address the immediate assessment, intervention, and service authorization processes for both mental health and substance abuse, for both children/adolescents and adults.
- Mobile outreach/ACT/ACM teams – Assertive Community Treatment (ACT) is the model most commonly used to provide intensive mobile services to consumers who are: (a) at very high risk of hospitalization or otherwise losing community housing and supports; and (b) who are unwilling or unable to participate in or benefit from traditional clinic or facility-based services. ACT is “a self contained clinical team” that provides multiple methods of support to individuals including housing, employment, and physician care.
- Medical and clinical treatment/medication management – There are a number of fundamental principles or standards for high quality and effective clinical treatment services in the public behavioral health arena.
- Services for families – It is now well established that families of adults with severe mental illness have needs for education and support in order to assist their family member and in order to manage the effects of the family member’s illness on the rest of the family. It is also established by research that psycho-educational classes for families produce better outcomes for families and the individual with mental illness.³⁰
- Use of clinical pathways or guidelines – Another important development in the clinical treatment arena is the development of evidence-based and widely accepted treatment guidelines and clinical pathways for most major mental illnesses. Preferred clinical interventions, which include combinations of medication, clinical treatment, and on-going community support, are no longer a mystery for most mental illness. Services for persons with co-occurring mental illness and substance abuse disorders. Co-occurring disorders are major contributing factors in loss of housing, treatment non-compliance, emergency room use, and re-hospitalization. When mental illness and substance abuse diagnoses co-occur, they both must be treated concurrently with the primary diagnosis, not as one or the other. The systems of assessment, care, and competencies must be fully embedded in the entire system of care for individuals with serious mental illness.³¹ The technology and competencies necessary to serve individuals with co-occurring disorders have been proven for a considerable period of time over many empirical studies.
- Geriatric services – There should be integration and coordination among resources important to elders, particularly primary health care, mental health and substance abuse treatment, and elder services such as homemakers, meals-on-wheels, and visiting nurse services.
- Housing – People with serious mental illnesses have difficulty locating and maintaining safe, affordable housing for a number of reasons. In addition to the debilitating symptoms of the illness itself, they often lack adequate income and social supports, and many have co-occurring disorders, including alcohol or other drug problems and acute or chronic physical health problems. They often face the stigma associated with their illnesses and the fears of potential landlords or neighbors. Progressive systems of care should attempt to provide independent living alternatives. This requires a set of core service capacities that sharply contrast with traditional mental health services and service delivery. Thus, a movement to develop supportive housing often involves a significant reorganization of existing services. Some key components of the service array should include home-based services, natural community supports, housing-

³⁰ Amenson, C. S., Liberman, R. P. (2001). Psychiatric Services 52:5, 589-592.

³¹ Minkoff, Kenneth. Presentation to the National Community Behavioral Health Directors, St. Louis, July, 1999

related activities (e.g., owner outreach and housing search), and developing a flexible and readily available safety net, such as respite and mobile crisis services, assistance with access to financial subsidies for housing costs, daily living expenses and health care.

- Employment – The technology of successful supported employment programs is well documented. It includes:³²
 - Assuring consideration of individual's interests, abilities, and goals in selecting jobs;
 - Early intervention efforts designed to assist people to return to work as soon as possible after the onset of a psychiatric disability;
 - Strategies that focus on getting people into the workplace and then training on the job, rather than spending time in pre-employment training;
 - Strategies that match individuals' education and skill levels with employment opportunities. People with mental illness do not have to work only in minimum wage, service sector jobs;
 - Provision of a range of on-going services and supports to assist people to work and interact effectively in the workplace;
 - Flexibility in work expectations during periods of acute exacerbation of the mental illness;
 - Provision of a range of work experiences including short term job tryouts, on the job training, and part time jobs;
 - Provision of a range of other satisfying and productive activities, including education and volunteer activities;
 - Assuring that all components of the public behavioral health system provide sufficient employment opportunities³³ for current and former consumers; and
 - Establishment of multi-disciplinary teams to blend vocational supports with other clinical and community supports.

These attributes of successful supported employment programs do not have to be contained in separate and discrete employment service program components. A variety of approaches have been used, including the ACT team model, expanded clubhouse programs, and consumer operated models. In fact, recent experience has shown that all program elements should be focused on supporting individuals in moving towards their choice of productive activity, and then providing sufficient supports to maintain the productive activity.

A System of Care, Not Just a Collection of Services

The system must be planned and designed coherently, managed and led effectively, and owned and guided by those who benefit from and contribute to the system's existence and success. This system

³² The following were extracted from a National Technical Assistance Center for Mental Health Planning publication on supported employment published in 1999. See also, Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., Bell, M. D., Blyler, C. R. (2001). Implementing supported employment as an evidence-based practice. *Psychiatric Services*, 52:3, 313-322.

³³ Some public behavioral health systems have made the mistake of employing consumers only as "consumer advocates" or representatives. While these roles are necessary and productive, consumers should also be employed as case managers, administrative staff, and any other functions that meet their skills, education level, and choices.

of care can be created by design and organization (e.g., a single state agency or local entity in charge of behavioral health issues regardless of population and funding source) or by good processes in place to coordinate design and services across multiple agencies. In either case, the result should be enhancement of services for better outcomes while making the most of the limited dollars available.

Next, Georgia's current System of Care will be discussed and analyzed. While Georgia offers many of the services as suggested above in the Ideal System of Support, it is important to note that the system and its providers have been slow to implement best practices and have been even slower to change business models in order to adapt services to be more efficient and effective.

B. Georgia's Community Based Mental Health System

Georgia's Department of Human Resources, Division of Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD) is the primary administrative entity responsible for Mental Health Services both in the community through its contracted provider network and in hospital settings through its seven regional state funded and operated hospitals. While Chapter VIII is dedicated solely to Georgia's hospital system, the remainder of this chapter and the next 2 chapters focus on Current Community Based Services.

Community based mental health services have been provided in Georgia for decades, continually evolving and expanding to meet increased demand for services. House Bill 100 (HB 100) passed in the 1993 General Assembly, has become infamous within Georgia due to the drastic changes that were brought about in the structure and in the delivery of community based services. HB 100 mandated that the Division of MHDDAD be divided into regional geographic areas encompassing many counties, and governed by local citizens. Originally the state was divided into 19 regions with regional board members consisting of community members, family members and advocates, appointed by county commissioners governing the planning and implementation of mental health services within the community. The regions were reduced to 13 in the late 1990s, and to seven regions in 2000 with the implementation of House Bill 498. Each of the seven regions was centralized around the regional hospital, in order to better coordinate care from hospital to community. In addition to changing the number of regions, HB 498 altered the governing and administrative capacities of the regional boards, shifting governance authority from the board members to the MHDDAD Central Office staff. This in effect removed the authority from community members, but kept them marginally intact by titling them "Planning Boards," responsible only for the planning of services within each region.

***"Through every administration and every 'new trend' the CSBs have been the only constant source of help to consumers over the past decade."
- Community Service Board Executive Director***

Another change brought about by House Bill 100 in 1993, was the creation of the Community Service Board system. The Community Service Boards (CSBs) existed as publicly funded state programs that legally became Community Service Boards with the new legislation, and became the primary provider of public community mental health and substance abuse services. There are currently 25 CSBs, each with an assigned service catchment area. These are much like Community

Mental Health Centers in other areas of the country. Provided services include outpatient services, residential services, supported employment, day programs for treatment or training, crisis intervention, and case management. Additionally, there are a small number of state-operated mental health and addictive disease community programs managed through the hospital(s). Currently, seven regional offices contract with the 25 CSBs within the state (along with other providers) to serve more than 150,000 children, adolescents, and adults with mental illness³⁴. Many of the Community Service Boards have multiple sites where clinicians are employed helping to support the geographic challenges faced in a state as large as Georgia. Despite this network of sites within a CSB, accessibility remains a problem for many in need of services, especially in rural areas.

In 2001 the state expanded its Clinic Option Medicaid services and adopted the Rehabilitation Option, which allowed for more services to be delivered outside of the “clinic” and within the community. Six new Medicaid services were created: Assertive Community Treatment, Community Support Team, Community Support Individual, Intensive Family Intervention, Residential Rehabilitation, and Psychosocial Rehabilitation. Since 2001, with the implementation of the Rehabilitation Option through Medicaid, nearly 40 specialty providers have emerged to provide services to individuals served through the public mental health system. However, these specialty providers are only allowed to provide the new Rehab services above (with the exception of CSI) and Peer Support.

Georgia has greatly expanded its array of services to individuals with mental illness in the past four years with the implementation of Medicaid Rehabilitation Option Services. The changes offered by the Medicaid Rehab option promote recovery and resiliency in adults, children, adolescents, and their families in community based settings and the service delivery approach is a holistic, strength-based model. However, despite the availability of numerous in-clinic and out-of-clinic services, providers have struggled with offering the full array of services. If a service is offered, assuring that it is accessible to all individuals within the catchment area is also challenging. In examining the availability of services to persons in need, one must also examine the adequacy of services to individuals. For instance, in many cases the service provided does not meet the minimum standards for contact, staff to consumer ratio, nor do they generally provide activities that are therapeutic in nature.

C. Availability of Current Community Services

Array of Services

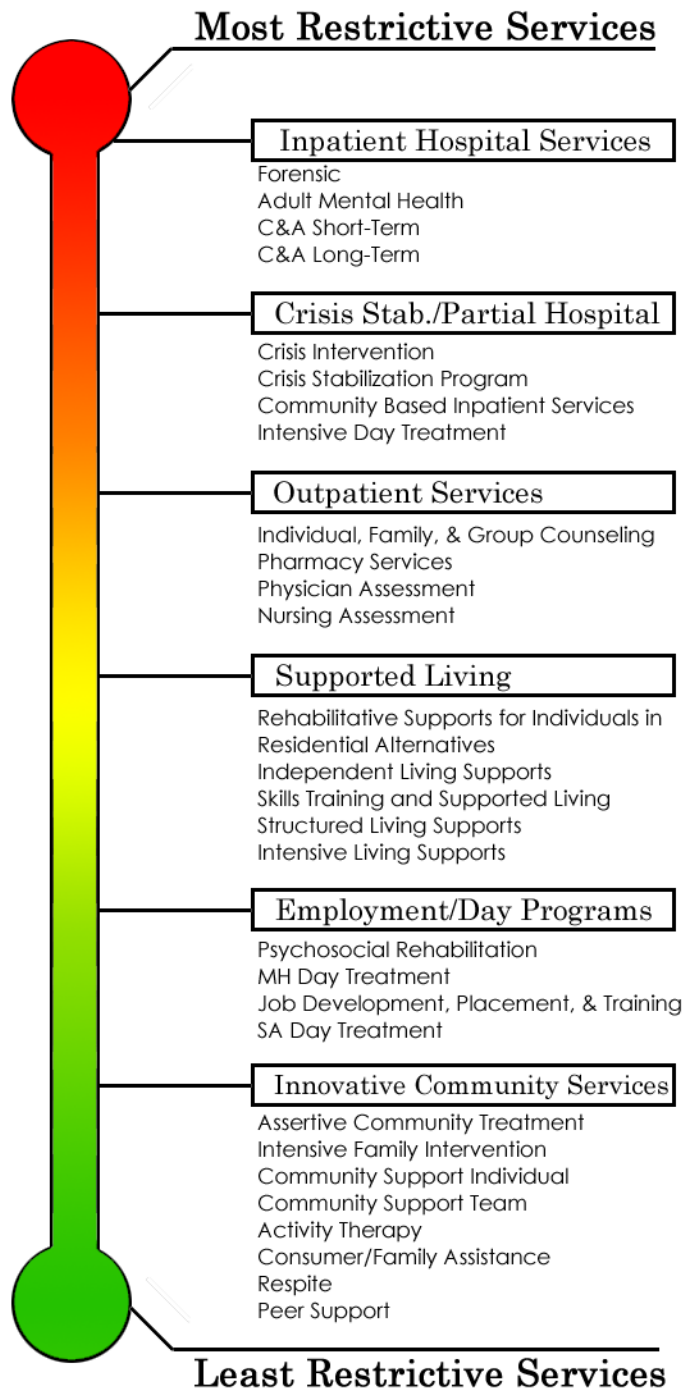
There is a need to differentiate between service availability (offered by providers) and services for which the state recognizes and provides compensation for the treatment of mental illness (funded by state or Medicaid dollars). Likewise, it is important to acknowledge that the infrastructure to provide innovative and effective community supports is in place, yet due to myriad reasons, community providers do not offer the entire spectrum of services that could be delivered to individuals. The state has built its continuum of services that can be offered in the community, but due to staffing

³⁴ Data source used is the FY04 EARF Reporting System operated by the Division of MHDDAD

issues, or low economies of scale, services that could be furnished by community providers are not being offered.

The diagram on the next page illustrates the spectrum of services that are supported by the Public Mental Health System in Georgia. For the purpose of this analysis larger subcategories are used to view services from most intensive, to least intensive. To aid in the categorization of services, state Medicaid service definitions were used to determine which services were high, medium, and low intensity. It is important to recognize that high intensity services can still be based in the community, such as Assertive Community Treatment and Community Support Team.

Figure V-1 Spectrum of Available Services



“The closest state hospital is 90 miles away and they no longer take children and adolescents. So that group has to be taken to Milledgeville, which is a 3-hour drive. We have a mental health office in our area but it takes several weeks to get an appointment. There are no services available other than individual counseling and sporadic visits by a psychiatrist.”

- Family Advocate

Availability of Services

The American Heritage Dictionary defines the word *available* as: Present and ready for use; capable of being gotten, obtainable. In order to determine the availability of mental health services within Georgia this definition of ready for use and currently obtainable is used. While a variety of services are furnished through Georgia’s public mental health system, whether or not these services are obtainable to her citizens is a complex question to answer. Additionally, the extent to which individuals with mental illness access services is directly related to whether or not appropriate and desirable services are available to them in their local community.

Survey Accessing Availability

This report utilizes both data and the perceptions and experiences of others to measure the availability of services. Detailed tables and reports summarizing actual service delivery are included in Chapter VI. The measurement of perceptions and experiences occurred through the online survey that APS Healthcare administered, where data was collected from individuals that have direct and indirect connections to the public mental health system, such as consumers, family members, staff, advocates, and policymakers. The tables and information presented below illustrate the extent to which survey respondents stated services were available, and the adequacy of the services within their communities. The questions were asked for different age groups so that differences in populations could be highlighted. From the survey, respondents stated the underlying issue affecting the availability of services most was a lack of funding. Shortage of funds means individuals do not have a choice of services, and services that are available cannot handle the number of people in need leading to long waiting lists. Many people travel long distances for services because money is not available to provide services locally, even when an agency provides a full array of services. Transportation then becomes a barrier, especially in rural areas. Lack of funding can lead to low salaries and high staff turnover, or staff that is overworked, underpaid, or under qualified. Finally, the services that are available may be rendered ineffectively or inadequately. Other major issues identified in the survey include a lack of services for children and adolescents, housing programs and appropriate housing placements, supported employment programs, information for the public about what services are available and how to access them, and help for those trying to qualify for services.

GAPS in AVAILABILITY OF SERVICES as cited by
respondents:

- ❖ Services not available locally
- ❖ Services cannot accommodate the number of people in need
- ❖ Public is not informed of what services exist and how to access them
- ❖ Takes too long and is too difficult to qualify for services
- ❖ Services available are ineffective or inadequate
- ❖ People do not have a choice of providers
- ❖ Medicaid limits services available/makes services hard to access

The table below illustrates the extent to which respondents stated specific services were available or somewhat available and good³⁵:

Table V-1

	Day Services	Community Based	Supportive Housing	Jail Diversion	Outpatient
Adult	67%	61%	44%	37%	67%
Senior	48%	47%	33%	22%	56%
Child	48%	52%	25%	23%	58%
Adolescent	53%	51%	24%	28%	57%
Transitional Youth	39%	42%	24%	27%	52%

Looking at the information above, respondents stated that overall services were more available for Adults than any other population. Outpatient services were perceived to be available to the majority of the population in need. Housing and Jail Diversion services ranked very low overall as not being available in local communities. Outpatient, day, and community services for seniors, children, and transitional youth (defined as ages 17-24) were perceived to be available to about half of those in need.

The table below exhibits the extent that respondents stated additional services were available or somewhat available and good, sorted by what services were most available to respondents:

³⁵ A “Good” service was defined as one promoting independence and recovery

Table V-2

Services	% who stated services were good and available
Educational Support (i.e. GED classes)	70%
Peer Supports	62%
Community Education/Prevention Supports	60%
Vocational Rehabilitation	60%
Parenting Skills and Supports	56%
DFCS - Child Protective Services	55%
Adult Protective Services	53%
Wellness Programs	52%
Supported Employment	52%
Community Crisis Stabilization Beds	48%
State Hospital Beds	47%
Single Point of Entry to Services	47%
Transportation	41%
Telepsychiatry	15%

Educational supports were cited as the most available service within the community, with other community services following behind. Only 47% stated that the Single Point of Entry to the mental health service system was available and good, which may be an indicator of the inconsistencies in the Single Point of Entry System across the state. Fifteen percent of respondents indicated that Telepsychiatry was available to them, leaving a large gap in a service that could be very effective in delivering services to rural areas, or areas with psychiatrist shortages.

The table below represents survey respondents perceptions of the extent to which culturally competent services are available to specific populations groups:

Table V-3

Population	% who felt services were good and available
Caucasian	67%
African American	62%
Latino	39%
Native American	32%
Asian	31%
Pacific Islander	27%

The majority of respondents felt that culturally competent services were available to Caucasians and the African American community, however the rates drop considerably when looking at Latino, Native American, Asian, and Pacific Islander populations. Only 39% felt that culturally competent services were available to the Latino population and 31% for the Asian community. Both of these minority populations are growing within Georgia, so perhaps additional emphasis should be focused on this area.

Additional highlights from the survey regarding availability of services include:

- ❖ 30% stated that community supports were not available to them.
- ❖ 26% of survey respondents indicated that Peer Specialists were not available to them.
- ❖ Nearly 60% of all respondents stated that Jail Diversion programs were not available for all ages of people, and when they were available 15% rated them as Poor.
- ❖ 30% indicated that the outpatient or clinic based services were Poor in their areas.
- ❖ More than half of respondents indicated that they when community based services were available or somewhat available they were Good.
- ❖ 30% stated that no crisis stabilization units were available to them.

The information collected on the availability of services is invaluable. If the perception exists that services are not available, or if services are offered and people cannot access them to due to transportation or geographic barriers, then the services are essentially not available.

Availability of Services by Provider

In order to balance the subjective method of the survey with objective data, APS analyzed services delivered by providers across the state. Reviewing services provided in Fiscal Year 2004, APS organized services by the categories presented in the Array of Services section earlier in this chapter: Innovative Community Services, Employment and Day Programs, Supported Living, Outpatient (or Clinic Based Services), and Crisis Stabilization or Partial Hospitalization. By looking at each provider and what services they offer one can gauge the availability of services within service catchment areas. **For the purpose of this written report, only providers serving more than 250 consumers and rehab option specialty providers were included.** This excluded many smaller agencies that provide services to individuals with mental retardation who may have a co-occurring mental illness, however a detailed report for all services for all providers is included as **APPENDIX V-1: Services Available by Provider.**

Observations of Service availability by Provider:

- ❖ The majority of services provided in Georgia remain clinic based outpatient services with Diagnostic/Functional Assessment enrolling the most consumers, along with pharmacy services, and physician and nursing assessment provided to the majority of consumers. On average, 90% of consumers seen at the provider agencies received outpatient services: Diagnostic/Functional Assessment, Physician and Nursing Assessment, and Pharmacy are the top 4 services within this category.
- ❖ Only eight of 25 Community Service Boards enrolled consumers in Assertive Community Treatment teams, serving as many as 100 at one CSB, and as few as 2 in two other CSBs.
- ❖ Most CSBs offer Community Support Teams but to very limited number of recipients – on average about 150 consumers per agency.
- ❖ Both Ogeechee CSB and Oconee CSB do not have any consumers enrolled in Community Support Teams nor do they offer Assertive Community Treatment teams (ACT). However external audits report that there is a need for these services.
- ❖ DeKalb County CSB has only 66 individuals enrolled in Community Support Team, and they do not offer ACT teams.

- ❖ Many community providers, including 14 Community Service Boards, provide crisis stabilization.
- ❖ Innovative Community Services are not available consistently across the state and are not provided to all of those that would benefit from such services. Statewide, on average 45% of the consumers received Innovative Community Services, with the range for providers varying greatly: from a low of 15% at Cobb CSB to a high of 92% at Georgia Pines CSB. Since innovative community services may be the only services provided by most Specialty providers, virtually all of their consumers receive this service.

While providers traditionally serve a majority of consumers in the clinic setting, the growth of innovative community services has been somewhat slow. Potential barriers may include:

- Lack of skilled workforce to provide services
- No incentive to provide more intensive supports
- Focus on recovery has not been embraced by some provider agencies
- Economy of scale issues as a barrier to providing more intensive services: that is current reimbursement rates do not allow a cost effective service to be provided. As an example, many providers stated that they cannot staff ACT teams because the staff requirements are too great, and that they cannot see enough consumers to pay for the teams themselves.

GAP:
***Innovative Community Services are not consistently available
across the state***

Table V-4 on the next 2 pages provides information on the number of individuals enrolled in specific services for each provider. For more information on the specific service categories see **Figure V-1**.

TABLE V-4: Services Offered by Provider Based on Service Categories
(Figures represent # ENROLLED in Services)

Provider Agency	Innovative Community Services	Employment/Day Programs	Supported Living	Outpatient Services	Crisis Stabilization/ Partial Hospital	Total
ADVANTAGE BEHAVIORAL HEALTH SYSTEMS	2,857	539	450	7,527	1,340	7,931
ALBANY AREA COMMUNITY SERVICE BOARD	2,949	463	419	3,936	758	4,047
AMERICAN WORK INC	95	253	131	0	0	403
B & B CARE SERVICES, INC	352	2	3	0	0	357
BARTOW BD OF HEALTH/WOODRIGHT INDUSTRIES	586	51	0	36	0	625
BEHAVIOR SOLUTIONS INC	77	0	0	0	0	77
BRIGGS AND ASSOCIATES INC	0	431	0	0	0	431
CHRIS KIDS INC	1	80	4	0	1	86
CLAYTON CO. BOARD OF EDUCATION DBA WORKTEC	0	152	0	0	0	152
CLAYTON COMMUNITY MH/SA SER BRD	794	489	81	2,910	82	3,128
CLINICAL ALTERNATIVE RESOURCE ASSOCIATES, LLC	27	0	0	0	0	27
COBB COUNTY COMMUNITY SERVICES BOARD	1,445	1,702	251	8,555	775	9,393
COLQUITT COUNTY BOARD OF HEALTH/GREEN OAKS CTR	116	42	0	1	0	119
COLUMBUS MEDICAL SERVICES, LLC	6	0	0	430	0	436
COMMUNITY FRIENDSHIP INC	248	254	336	0	0	623
COMMUNITY SERVICE BOARD OF MIDDLE GEORGIA	1,891	603	728	4,721	375	4,901
CONCERTED SERVICES INC	0	0	29	0	0	29
CREATIVE COMMUNITY SERVICES INC.	274	0	15	0	0	284
CSB OF EAST CENTRAL GEORGIA	2,950	689	477	5,506	55	5,613
DEKALB COMMUNITY SERVICE BOARD	3,079	1,091	226	10,035	1,428	10,140
DOUGLAS COUNTY COMMUNITY SERVICES BOARD	455	330	49	2,906	56	2,993
FULTON COLLABORATIVE SERVICE SYSTEM	0	0	0	6	279	283
FULTON COUNTY DMHDDAD	245	338	0	3,697	28	3,763
FULTON COUNTY JUVENILE JUSTICE FUND	18	0	0	0	0	18
FULTON DEKALB HOSPITAL AUTHORITY	383	136	0	3,595	84	3,685
GATEWAY COMMUNITY SERVICE BOARD	4,792	1,610	554	11,620	679	11,884
GEORGIA COMMUNITY SUPPORT AND SOLUTIONS INC	492	0	0	0	0	492
GEORGIA MOUNTAINS COMMUNITY SERVICE BOARD	4,267	476	111	7,645	927	8,585
GEORGIA PARENT SUPPORT NETWORK INC	293	2	0	9	0	301
GEORGIA PINES COMMUNITY SERVICE BOARD	4,086	844	192	5,677	58	5,801
GEORGIA PSYCHOLOGICAL SERVICES, L.L.C.	84	82	0	0	0	166

TABLE V-4: Services Offered by Provider Based on Service Categories
(Figures represent # ENROLLED in Services)

Provider Agency	Innovative Community Services	Employment/Day Programs	Supported Living	Outpatient Services	Crisis Stabilization/ Partial Hospital	Total
GRN COMMUNITY SERVICE BOARD	2,849	669	495	9,205	1,943	9,914
HARALSON BOARD OF HEALTH	320	62	16	841	14	842
HARALSON COUNTY BOARD OF HEALTH	1	1	1	2	0	5
HERITAGE FOUNDATION INC	8	27	21	30	0	31
HIGHLAND RIVERS COMMUNITY SERVICE BOARD	4,920	1,111	1,196	14,849	2,552	15,408
INTEGRATED HEALTHCARE RESOURCES	23	1	0	581	29	634
INTEGRATED LIFE CENTER INC	0	0	36	106	0	139
LOOKOUT MOUNTAIN COMMUNITY SERVICES	1,673	350	345	4,355	575	4,685
MAY SOUTH INC	266	0	0	0	0	266
MCG HEALTH INC	0	0	0	0	352	352
MCINTOSH TRAIL CSB	4,976	772	418	4,892	858	5,388
MIDDLE FLINT BEHAVIORAL HEALTHCARE CSB	1,385	682	234	3,130	570	3,404
NATIONAL MENTOR HEALTHCARE, INC.	0	0	270	0	0	270
NEW HORIZONS COMMUNITY SERVICE BOARD	2,836	1,691	339	6,388	1,232	7,254
NEW SOLUTIONS A SUBS OF OPPORT & SOLUTIONS INC	0	4	0	0	0	4
NEWPORT DETOX CENTER INC	259	0	265	356	348	364
NORTHSIDE HOSPITAL INC	219	242	26	1,189	2	1,280
OCONEE COMMUNITY SERVICE BOARD	1,143	479	125	2,509	708	2,720
OGEECHEE BEHAVIORAL HEALTH SERVICES	1,042	330	134	2,057	56	2,173
OPEN ARMS INC	0	0	18	0	0	18
PATHWAYS CENTER FOR BEHAV HEALTH	1,110	674	399	4,974	670	5,073
PHOENIX CENTER COMMUNITY SERVICE BOARD	1,604	453	244	2,911	648	3,228
PINELAND COMMUNITY SERVICE BOARD	2,510	765	248	4,571	1,137	5,280
RIVEREDGE BEHAVIORAL HEALTH CENTER	4,956	1,395	591	6,648	683	6,882
S & T ASSESSMENT AND COUNSELING SERVICES	5	0	0	0	0	5
SAINT JOSEPH'S MERCY MOBILE	582	0	58	0	0	623
SATILLA COMMUNITY SVC. BOARD FOR MHM RSA	3,839	537	323	4,628	228	5,056
SAVANNAH AREA BEHAVIORAL HEALTH	40	14	1	1,543	0	1,543
SOUTH GEORGIA COMMUNITY SERVICE BOARD	5,734	472	182	5,425	449	7,013
SOUTHSIDE HEALTHCARE INC	0	0	0	10	0	10
SW STATE HOSPITAL COMMUNITY SERVICES	243	0	30	0	0	268

TABLE V-4: Services Offered by Provider Based on Service Categories
(Figures represent # ENROLLED in Services)

Provider Agency	Innovative Community Services	Employment/Day Programs	Supported Living	Outpatient Services	Crisis Stabilization/ Partial Hospital	Total
THE FAMILY INTERVENTION SPECIALISTS	147	0	0	0	0	147
THE METHODIST OF HOME OF SOUTH GA CONFERENCE	121	0	0	0	0	121
THOMAS COUNTY BOARD OF HEALTH	6	2	0	9	0	10
TWIN CEDARS YOUTH SERVICES INC	112	0	24	0	0	136
VOLUNTEERS OF AMERICA OF GEORGIA INC	0	0	56	12	0	68

Limitation of this Data

While the table above reports numbers enrolled in services, there is no central source to gather the number of people attempting access to the system with which to compare enrollment. Another limitation in the data above is the fact that while it identifies that a service is provided in a catchment area, it does not clearly identify the geographical accessibility. That is, how far does a consumer have to travel for a specific service within the multiple county catchment area often represented by CSBs? Finally, even if a service is geographically accessible, frequently the ability to accept new consumers is limited by insufficient numbers of trained staff. One cannot clearly discern the true availability of services without knowing if a service is actually present and ready for use without a centralized source for this information such as Single Point of Entry. For instance, an independent Single Point of Entry service within geographic regions can track waiting lists for services and also assess provider capacity.

Moving Forward

This discussion on availability of services provides an overview of what services are offered by provider agencies; however it is difficult to see where the services are being provided, and where the gaps in services are throughout the state. The following chapters contain more detail about the penetration of service utilization: who is receiving services, what services are they getting, and where they are receiving them.

CHAPTER VI: WHO IS CURRENTLY RECEIVING COMMUNITY BASED SERVICES IN GEORGIA?

In this chapter you will find:

- ❖ *The Population Currently Enrolled in Community Based Services: analysis of individuals receiving services from the public system by age, race, location, and gender*
- ❖ *Services Provided by Different State Agencies*
- ❖ *Analysis of What Services Individuals are Receiving*



Highlights of significant findings in this chapter include:

- ❖ *An estimated 178,885 Georgians with a Mental Health diagnosis required public assistance in either a state hospital and/or a community setting in Fiscal Year 2004.*
- ❖ *There is inequitable utilization of services across regions within Georgia.*
- ❖ *Data systems across multiple state agencies do not track client service utilization, preventing true continuity of care and services.*
- ❖ *Georgia's Medicaid program spent more than \$278 Million dollars on psychotropic medications during Fiscal Year 2004.*
- ❖ *During FY2004, less than 15% of adults, and less than 10% of children and adolescents were enrolled in intense community services.*
- ❖ *After controlling for Utilization, the number of people in need of services who are receiving them ranges from 18% - 35%.*

A. Population Currently Enrolled in Services

An estimated 178,885 Georgians with a Mental Health diagnosis received public assistance in either a state hospital and/or a community setting in FY 04

Data Sources Utilized to Identify Population

Several data sources informed the analysis of the population currently enrolled in services. The bulk of the analysis relies heavily on the data extract of all service enrollments for FY04 provided by the Division of MHDDAD. Service enrollment records were included for all consumers who had either a primary or secondary diagnosis of mental illness. Service enrollments originate from the creation of an Enrollment Addition and Release Form by a provider that is submitted to the state's Mental Health Mental Retardation Information System. Data extracts included a record for each service enrollment (i.e., a consumer receiving multiple

services would have an enrollment record for each service) that occurred between July 1, 2003 and June 30, 2004. Each service enrollment record has information about the service and subunits that help further identify the specific service for which the individual is enrolled and about the provider serving them. Personal information about the individual recipient of that service including age, gender, and race was also captured from the correlating basic intake records in the information system. For estimates of penetration related to Medicaid recipients, data was obtained from the Georgia Department of Community of Health which provided FY04 counts of all Medicaid eligible members by county and by membership in Medicaid or PeachCare (Georgia's SCHIP program). Additional data sources included Rehabilitation Option utilization and claims records and service provision data published or shared by the DHR/Division of Family and Children Services, Department of Juvenile Justice, and Department of Corrections.

Broad comparison data for the purposes of the analyses were available for FY 2002 state statistics from the NASMHPD National Research Institute and from the FY 2003 CMHS (Center for Mental Health Services of SAMHSA's National Mental Health Information Center (which is within the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services) Uniform Reporting System Output Tables.

For the purpose of this gap analysis, services were organized by the categories as defined by the Mental Health Mental Retardation Information System (MHMRIS) and specifically in the Enrollment Addition and Release Form (EARF). **Detailed EARF Reports are available as APPENDICES VI-2 – VI-12.** The EARF data allows us to extrapolate information so that we can see how many consumers are enrolled in specific services. The categories and examples of services included under each are as follows:

- Screening, Crisis and Outreach:** Outreach, Diagnostic Assessment, Crisis Intervention, Crisis Stabilization, Community based inpatient, consumer and family education
- Outpatient Services:** Physician assessment and care, nursing assessment and health services, medication administration, Assertive Community Treatment (ACT), Individual Counseling, Group counseling, individual community support, community support team, intensive family intervention
- Day and Employment Services:** Day treatment, activity therapy, psychosocial rehabilitation, peer support, intensive day treatment, supported employment
- Personal Living and Residential Services:** Independent living supports, structured living supports, therapeutic foster care, and therapeutic group homes
- Service Entry and Linkage:** Service entry and linkage

The majority of the information is organized by these broad categories, however, APS found it very beneficial to perform analyses on specific services such as crisis stabilization, individual community support, and intensive family intervention. Since specific services are designed for targeted populations (SED or SMI), by examining which services were provided and how many people were served, we are able to make better judgments about the gaps in mental health services. This additional analysis is provided later in this chapter.

Stakeholder Perspectives on Target Population

The table below provides stakeholder perspective on the target population for services as gathered through the APS online survey instrument. The percentages listed represent the total number of respondents who answered positively that they believed the segment of the population cited should be receiving mental health services.

Table VI-1: Mental Health Target Populations According to Survey

POPULATION	% That Should Be Receiving Services According To Survey
People with Severe and Persistent Mental Illness	94%
Children with Severe Emotional Disturbance	91%
People experiencing Short- Term Life Adjustments	64%
Co-Occurring Mental Illness and Addictive Disease	89%
Co-Occurring Mental Illness and MR/DD	89%
Co-Occurring Mental Illness and Physical Disability	87%
Children	92%
Adolescents	91%
Adults	94%
Seniors	88%
Transitional Youth (ages 17-24)	84%
People who have Medicare	82%
People who have Medicaid	87%
People who have Private Insurance	54%
People who have No Public Benefits	85%
People with Low/No Income (Less than \$17223 annually)	91%
Moderate Income (\$17 224 - \$35000)	78%
High Income (\$35001+ annually)	41%

Total Population Enrolled in Services in FY 04 with a Mental Health Diagnosis

The total number of consumers with a Mental Health diagnosis served in either hospital and/or community settings is estimated at 178,885 (174,298 in community, plus 27.59% of 16,627 hospital recipients). Since an estimated 72.41% of all hospital services recipients are also treated

in the community, only the estimated unduplicated number was included. This information is based on an analysis of unduplicated hospital episodes of care and consumer community service enrollment represented by an EARF (Enrollment Addition& Release Form). However, it must be noted that enrollment in a service does not necessarily translate to actual provision or receipt of services. There exists no comprehensive or single set of data that would serve as a representation of services actually provided. This is discussed in greater depth in Chapter XI, which reviews the Mental Health Mental Retardation Information System and documents the lack of encounter data. Regardless of the ability to correlate the total number of enrollees to the total number of actual service recipients, or lack of ability thereof, in this section consumers are discussed as being “served,” as well as enrolled in services.

Overview of Community Service Utilization

An episode of service is defined as enrollment into one of the following categories of services: Service Entry and Linkage, Screening, Crisis, and Outreach, Outpatient, Day and Employment, Personal Living and Residential. There were a total of 382,014 episodes of community mental health services provided in FY04, to a total of 174,298 consumers. Thus, each consumer received approximately two categories of service in FY04.

The North Region has the greatest number of consumers enrolled in services at 42,922, 23% more consumers than the next largest region--34,974 in the Metro Region. The other regions, in descending order of number of consumers served are Southeast with 23,862 consumers; West Central with 22,044 consumers; Southwest with 18,610 consumers; Central with 17,979 consumers; and East Central with the fewest number of consumers at 16,997. (These numbers indicate the region by which the consumer was served in FY04, but is not necessarily indicative of the consumers’ county of residence). For a broad overview of how the 382,014 enrollments are distributed, the table below reflects the count of consumers served by region compared with the rate of penetration at which all individuals with mental illness are served and the number of services each consumer receives on average. The difference between the regions in the range of average number of services per consumer is not statistically significant.

Table VI-2: Broad Overview of Service Utilization and Penetration

	Count of FY04 Consumers Served	Penetration Rate of Population Estimated to Have Mental Illness	Average # of Services per Consumer
Central	17,979	40.15%	2.57
East Central	16,997	30.96%	2.19
Metro	34,974	23.33%	2.01
North	42,922	33.07%	1.97
Southeast	23,862	41.24%	2.17
Southwest	18,610	42.53%	2.30
West Central	22,044	32.97%	2.22

Analysis of community service data was conducted concentrating on six primary service categories:

- ❖ Service Entry and Linkage
- ❖ Screening, Crisis, and Outreach
- ❖ Outpatient
- ❖ Day and Employment
- ❖ Personal Living and Residential
- ❖ Other Services including TANF/Ready for Work and Substance Abuse Services

Screening, Crisis and Outreach Services and Outpatient Services are the most frequently provided services. For example, almost 92% of all consumers served in the Southeast Region received Screening, Crisis and Outreach services. The region that provides the lowest "coverage" of Screening, Crisis and Outreach services is the North with just over 70%. For Outpatient Services, the percentage of consumers receiving this service ranges from 73.87-82.91% (Southwest and East Central respectively). The breakdown of community mental health services provided statewide is:

- ❖ Screening, Crisis and Outreach 37.72%
- ❖ Outpatient 37.03%
- ❖ Other 9.27%
- ❖ Day & Employment 6.45%
- ❖ Service Entry and Linkage 3.07%
- ❖ Personal Living and Residential 2.21%

Since the "Other" category encompasses a variety of services and is the third most often provided category of service it would be worth looking at actual types of services provided under "Other" to determine if there is sufficient data to establish an additional service category.

The table below displays the counts of service enrollments for each of the targeted community services by region. Counts are duplicated since many consumers receive more than one service.

Table VI-3: Service Enrollment Counts by Region and Service

Service Enrollment Counts	Screening, Crisis and Outreach Services	Service Entry and Linkage	Outpatient Services	Day and Employment Services	Personal Living and Residential Services	Other Services
Central	16,258	4,177	14,926	3,164	1,118	5,046
East Central	15,638	229	14,162	2,100	925	3,029
Metro	28,506	345	28,129	4,496	2,102	6,162
North	30,922	1,855	36,300	4,851	1,346	7,527
Southeast	23,297	50	19,824	3,465	1,173	4,651
Southwest	15,558	5,051	14,304	2,754	1,004	3,634
West Central	18,884	100	17,483	4,274	951	6,350

- ❖ **Service Entry and Linkage:** 11,738 consumers are enrolled in Service Entry and Linkage, which represents 3.07% of all mental health service enrollments statewide. There are significant differentials between regions in the numbers of consumers who receive Service Entry and Linkage as evidenced in the table above. While East Central, Metro, Southeast and West Central individually only have a count as much as 345 and as few as 50, North has ten times the count of the average of the former regions (181); Central's count is 23 times the average and Southwest's almost 30 times. It is to be determined whether this reflects inequitable access to service across the state, whether some regions are more equipped to provide Service Entry and Linkage (perhaps by virtue of the type and breadth of providers they have), or whether utilization of the service is being abused in favor of other services that are more difficult to provide.
- ❖ **Day and Employment:** Day and Employment (D&E) service enrollments account for only 6.45% of the total amount of regional mental health services. Both North and Metro share the same Day and Employment service utilization percentage of 10.5%. Of all D&E services provided statewide, the North Region provides the greatest amount -- 19.22%. Metro and West Central come in 2nd and 3rd with 17.5% and 17.17% respectively. Notably, even though North is responsible for providing the greatest percentage of D&E services for the state, fewer North region consumers, as a percentage, receive D&E services:

Table VI-4: Day & Employment Service Statistics by Region

Day & Employment Statistics by Region	Count of Day and Employment Services Enrollees	% of Region's Consumers Receiving D&E	D&E is X% of Total MH Regional Services	Region Provides X% Of Total Statewide D&E Services
Central	3,149	17.5%	6.82%	12.79%
East Central	2,089	12.3%	5.62%	8.48%
Metro	4,310	12.3%	6.14%	17.50%
North	4,734	11.0%	5.59%	19.22%
Southeast	3,426	14.4%	6.60%	13.91%
Southwest	2,693	14.5%	6.29%	10.93%
West Central	4,229	19.2%	8.62%	17.17%

- ❖ **Personal Living and Residential Services:** While Personal Living and Residential Services make up only 2.21% of the state's total mental health services rendered, it is an important service that supports the DMHDDAD's philosophy of recovery, rehabilitation, independence and community integration. Metro provides the greatest amount of this service and because of the type of service, it is reasonable to assume that this count is actually indicative of services provided rather than simply service enrollments. The Metro Region alone provides almost 25% of the state's Personal Living and Residential Services. This is directly correlated to the fact that there are 38 providers in the Metro Region that provide this service,

whereas the region that has the closest to that amount has less than half that number of providers -- 18 in the North Region. (The North's Personal Living and Residential Services account for over 15% of the state's total). Across all regions, Personal Living and Residential Services make up less than 3% of all services provided in that region, with a regional range from 1.53% (North) to 2.91% (Metro).

- ❖ Outpatient Services represent over 37% of all statewide mental health services provided with 139,713 enrollments in FY04. More consumers in East Central receive Outpatient Services than in any other region though not by a large margin. Even so, the East Central Region accounts for one of the lowest percentages of Outpatient Services statewide. The North Region provides the most outpatient services both in terms of having the highest number of consumers receiving the services (35,100) and by the percent makeup of outpatient services in the region (41.44%).

Table VI-5: Outpatient Service Statistics by Region

Outpatient Statistics by Region	Count of Outpatient Services Enrollees Services	% of Region's Consumers Receiving Outpatient Services	Outpatient Is X% Of Total MH Regional Services	Region Provides X% Of Total Statewide Outpatient Services
Central	14,703	81.78%	31.86%	10.39%
East Central	14,092	82.91%	37.90%	9.96%
Metro	27,122	77.55%	38.63%	19.17%
North	35,100	81.78%	41.44%	24.81%
Southeast	19,344	81.07%	37.27%	13.67%
Southwest	13,747	73.87%	32.09%	9.72%
West Central	17362	78.76%	35.40%	12.27%

- ❖ Screening, Crisis and Outreach Services: This service category represents 37.72% of all statewide services with 142,151 consumers having been enrolled in FY04. This set of services can include a telephone or face-to-face intervention with the consumer and family to address an immediate crisis and provide a link to services. Thus, in and of itself, Screening, Crisis and Outreach is not a treatment service, although it is certainly a valuable part of the service spectrum. Screening, Crisis and Outreach represents no less than 31% of each region's annual services and no less than 77% of the consumers in any one region utilized the service. The high volume and proportion of utilization is perhaps indicative of a lack of well-promoted and/or well-known community resources for crisis situations or simply a lack of such existing resources.

Table VI-6: Screening, Crisis and Outreach Statistics by Region

Screening, Crisis, & Outreach Statistics by Region	Count of Screening, Crisis, & Outreach Services	% of Region's Consumers Receiving Screening, Crisis, & Outreach Services	Screening, Crisis, & Outreach Is X% Of Total MH Regional Services	Region Provides X% Of Total Statewide Screening, Crisis, & Outreach
Central	15,843	88.12%	34.33%	11.00%
East Central	15,313	90.09%	41.18%	10.63%
Metro	27,293	78.04%	38.87%	18.94%
North	30,238	70.45%	35.70%	20.99%
Southeast	21,859	91.61%	42.12%	15.17%
Southwest	14,942	80.29%	34.88%	10.37%
West Central	18,599	84.37%	37.93%	12.91%

GAP:
There is inequitable utilization of services across regions within Georgia

Recipients of Multiple Services: While an efficient system of services provides a treatment plan that is individualized based on the consumer's needs with no more or no less than the amount and type of services needed, there is a tendency to believe that a multiple array of services is more comprehensive and holistic. The majority of community mental health services recipients get between one and five services. The following is the count of consumers by the number of services in which they were enrolled during FY04.

- ❖ Enrolled in 1 Service: 42,673
- ❖ Enrolled in 2 Services: 79,478
- ❖ Enrolled in 3 Services: 37,168
- ❖ Enrolled in 4 Services: 10,821
- ❖ Enrolled in 5 Services: 3,500

Slightly less than half of the service population is enrolled in two services. Twenty-five percent receive only one service and just over 21% have three services. Six percent receive 4 services while only 2% receive five. This data in of itself is not necessarily very meaningful, but does offer a different perspective on utilization.

Service Recipients by Gender: More females than males are recipients of community services by a margin of 9.5%. Statewide there are 91,100 female recipients and 83,198 male recipients and the difference among regions varies between 50-54% female to 45-49% male. In each region, more females than males are served by an average of 8.76%. The only region to fall out

of this norm is the North with over 18% more females served. This runs contrary to the gender split among hospital services recipients, where the rate leans significantly toward males with a 57-64% per region range for males as opposed to a range of 36-43% for females. Such treatment offsets crisis that would require more intensive services, such as in a hospital. Without seeking community treatment, males are more likely to reach crisis and need inpatient services. Also, the higher prevalence for males to occupy hospital forensic units contributes to the difference.

Table VI-7: Service Recipients by Gender by Region

Region	Female	Male	Total
Central	9,450	8,529	17,979
East Central	8,595	8,402	16,997
Metro	17,805	17,169	34,974
North	23,245	19,677	42,922
Southeast	12,520	11,342	23,862
Southwest	9,686	8,924	18,610
West Central	11,426	10,618	22,044
Total	91,100	83,198	174,298

Service Recipients by Age: Adults aged 25-64 represent 62% of all age groups of those served (Birth-17 = 24%; 18-24 = 11.7%; 65 and Over = 3%). A total of 476 community service recipients could not be linked with a county of origin, but all ages could be identified. The fewest consumers in the Birth to age 17 group come from the Southwest Region and the most are from the North Region with 241% more than the Southwest. It is interesting to note that most consumers originate from the North Region in every age group even though we know that the greatest numbers of consumers statewide are from the North Region. Residents from Cobb County largely drive these percentages.

Table VI-8: Service Counts and Percentages by Age Groups by Region

Region	Birth - 17		18-24		25-64		65+		Total
	Count	% of Total in Age Group	Count	% of Total in Age Group	Count	% of Total in Age Group	Count	% of Total in Age Group	Count
Central	4,315	10.3%	2,030	9.9%	10,797	10.0%	601	11.4%	17,743
East Central	4,609	11.0%	1,974	9.7%	10,059	9.3%	510	9.7%	17,152
Metro	6,845	16.4%	3,733	18.3%	22,694	21.0%	1,056	20.1%	34,328
North	10,151	24.3%	5,240	25.7%	25,686	23.8%	1,089	20.7%	42,166
Southeast	5,964	14.3%	2,770	13.6%	14,127	13.1%	670	12.8%	23,531
Southwest	4,209	10.1%	2,169	10.6%	11,471	10.6%	657	12.5%	18,506
West Central	5,627	13.5%	2,417	11.8%	12,849	11.9%	659	12.5%	21,552
Other	29	0.1%	75	0.4%	360	0.3%	12	0.2%	476
Total	41,749		20,408		108,043		5,254		174,298

Variations in the extent to which regions served different age groups were considered. Using the three-sigma test (for three standard deviations from the mean), no variation was found to be statistically significant. Therefore, the proportions of age groups served per region are relatively equitable across the state. The greatest percentage of any age group for any region is 66.1% from the Metro Region for the 25-64 age group. The lowest percentage is 2.6% of those older than 64 from the North Region.

Table VI-9: Service Counts by Age Groups with Regional Percentages

Region	Birth - 17		18-24		25-64		65+		Total
	Count	% of Total in Region	Count	% of Total in Region	Count	% of Total in Region	Count	% of Total in Region	Count
Central	4,315	24.3%	2,030	11.4%	10,797	60.9%	601	3.4%	17,743
East Central	4,609	26.9%	1,974	11.5%	10,059	58.6%	510	3.0%	17,152
Metro	6,845	19.9%	3,733	10.9%	22,694	66.1%	1,056	3.1%	34,328
North	10,151	24.1%	5,240	12.4%	25,686	60.9%	1,089	2.6%	42,166
Southeast	5,964	25.3%	2,770	11.8%	14,127	60.0%	670	2.8%	23,531
Southwest	4,209	22.7%	2,169	11.7%	11,471	62.0%	657	3.6%	18,506
West Central	5,627	26.1%	2,417	11.2%	12,849	59.6%	659	3.1%	21,552
Other	29	6.1%	75	15.8%	360	75.6%	12	2.5%	476
Total	41,749		20,408		108,043		5,254		174,298

In comparison to the percentage breakdown of hospital service recipients, the primary difference is between the Birth to 17 and 18-24 age groups. Where fewer than 12% of hospital consumers are younger than 18, that same age group makes up 24% of the community population. Likewise, where just over 15% of hospital consumers fall between the ages of 18 and 24, this age group constitutes just under 12% of the community population. Seventy percent of hospital consumers are aged 25-64 compared to the community's 62%. The statewide average percent of elderly consumers served who are aged 65 and over are virtually the same with a hospital make-up of 3.15% compared to 3.01% in the community.

The same trend for those between the ages of 25 and 64 to be the predominant users of community services is reflected in the types of services rendered. For example, 79% of those persons receiving Personal Living services are in this age group. In other services, the range of service utilization by this age group is 61-77%. Among older persons, while most identified services have a participation rate of 2-3%, the Other Services category has a service rate of 6% for those 65 and over. Persons 18-24 receive Service Entry and Linkage services more than any other (15%) and there is fairly well balanced distribution among the other services (8-11%). For ages 0-17, Screening, Crisis and Outreach, Outpatient, Day and Employment, and Service Entry and Linkage are used about the same (21-23%), while 9% of this age group receives Personal Living services and/or Other services.

Service Recipients by Race: The table below provides the counts per racial/ethnic group by region. In the following table, the same data is presented depicted as the percentage of each regions' breakdown between groups and for the state.

Table VI-10: Service Counts by Race by Region

Region	White	Black	Hispanic	Asian	Native American	Other	Un-known	Total
Central	9,552	8,106	137	62	24	55	43	17,979
East C.	9,290	7,285	204	64	28	82	44	16,997
Metro	13,060	19,750	1,260	406	37	254	207	34,974
North	35,175	5,925	1,313	139	71	221	78	42,922
S. East	14,836	8,449	359	51	23	106	38	23,862
S. West	9,447	8,844	208	26	17	51	17	18,610
W. Central	12,402	9,209	206	58	23	122	24	22,044
Total	101,695	66,635	3,636	798	216	874	444	174,298

The North Region far outweighs other regions in terms of the percentage of the service population that is White at 82%. This is consistent with state's higher prevalence for Whites to have mental illness and the region's population prevalence for Whites, which is 219% greater than the statewide average, and as a percentage of the population served, Whites served in the North region represent 215% greater than the average.

Table VI-11: Service Percentages by Race by Region

Region	White	Black	Hispanic	Asian	Native American	Other	Un-known	Total
Central	53.1%	45.1%	0.8%	0.3%	0.1%	0.3%	0.2%	100.0%
East C.	54.7%	42.9%	1.2%	0.4%	0.2%	0.5%	0.3%	100.0%
Metro	37.3%	56.5%	3.6%	1.2%	0.1%	0.7%	0.6%	100.0%
North	82.0%	13.8%	3.1%	0.3%	0.2%	0.5%	0.2%	100.0%
S. East	62.2%	35.4%	1.5%	0.2%	0.1%	0.4%	0.2%	100.0%
S. West	50.8%	47.5%	1.1%	0.1%	0.1%	0.3%	0.1%	100.0%
W. Central	56.3%	41.8%	0.9%	0.3%	0.1%	0.6%	0.1%	100.0%
Total	58.3%	38.2%	2.1%	0.5%	0.1%	0.5%	0.3%	100.0%

The percentage of regional prevalence of mental illness for each racial/ethnic group is compared to the percentage breakdown of the consumers being served to determine consistency. In all regions, the expectation would be for there to be a higher representation by those of Hispanic and Asian origin. Almost forty-three percent (42.9%) of East Central's consumers are black, but the prevalence would suggest a lower percentage of 32%. Southeast's prevalence percentage matches its percentage of population served for Whites exactly at 62%. The prevalence percentage for Blacks in the North region is 10%, however almost 14% of the consumer population is Black. In a later section of this chapter related to penetration rates, we will discuss this in further depth as well as consider other variables such as poverty, which have an impact on more defined prevalence figures.

Service Recipients by Race: Community vs. Hospital

While the following comparisons are interesting to note, the statements cannot be construed as statistically significant. The percentages of each region's service utilization make-up by race is influenced primarily by those who are either Black or White, and analyses on such a small proportion of minority racial/ethnic groups service enrollees that make up the balance would not render statistically significant conclusions.

The proportions of persons served based on race between hospital and community is fairly well balanced in the statewide aggregate. In a regional breakout, we see that both North and West Central are equal or more well balanced. While the differences in the other regions do not on first review appear to be significant, the outlier is the Southeast, where there are 22% more Blacks served in the hospital and 14% more Whites served in the community. The only other difference of note is in East Central where there are 6% more Whites served in the community; however, East Central, Metro, and North are the only regions where both blacks and Whites are served at a higher percentage in the community (although the difference in the North is not significant with less than a 1% difference in each case). This may indicate that these regions are succeeding more fully in comparison to other regions in their efforts to provide services in the least restrictive setting. (See Table VI-12.) Other items of interest include:

- ❖ East Central and Central Regions' hospitals provide services to the fewest number of Hispanics statewide, while Northwestern and Atlanta Regional serve the most. Given the prevalence of Hispanics in the Central Region this makes sense, but the same is not entirely true for East Central, which has a prevalence twice as high as the Central Region.
- ❖ East Central is the only region that served a racial group at exactly the same percentage in both the hospital and community, Native Americans/Alaskans at .16%. However, because the total percentages of persons served from minority groups are so small to begin with, it is difficult to argue that the percentage differences between hospital and community serve a valuable analytical purpose.

Thus far, we have reviewed data related to the current enrollment in community based mental health services by consumers with mental illness. At this point we can compare these findings

GAP:
Minority groups are underserved as a percentage of all recipients of public services.

against the survey data that reflected the public perception of who the recipients of services should be. We have found that 92% of survey respondents believed Children should be receiving services, but less than 24% of all persons served were Children. Eighty-four percent of respondents believed that Transitional Youth should also be a target population, but fewer than

12% of recipients are estimated to be in this age group. While the figures from the survey should not be used as percentage benchmarks of the demographic groups to be served (because they do not reflect the extent to which respondents believed services should be provided), they do provide a loose indicator that would lead us to expect a more equitable balance between the percentages, relative to the percentage breakdown of the total population. Next we will look next at penetration rates which will offer additional insight into the depth with which certain populations are receiving services.

Table VI-12: Comparison of Hospital vs. Community Racial/Ethnic Group Utilization

Statewide

	American Indian/ Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.14%	0.56%	40.53%	1.87%	56.63%	0.33%
Community	0.12%	0.46%	38.23%	2.09%	58.35%	0.76%

By Region

North	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.13%	0.38%	13.96%	2.69%	82.66%	0.28%
Community	0.17%	0.32%	13.80%	3.06%	81.95%	0.70%

Metro	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.21%	1.47%	52.97%	4.08%	40.74%	0.61%
Community	0.11%	1.16%	56.47%	3.60%	37.34%	1.32%

Central	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.07%	0.25%	49.24%	0.79%	49.21%	0.49%
Community	0.13%	0.34%	45.09%	0.76%	53.13%	0.55%

East Central	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.16%	0.47%	37.72%	0.69%	60.93%	0.09%
Community	0.16%	0.38%	42.91%	1.20%	54.72%	0.62%

Southeast	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.20%	0.25%	43.29%	1.58%	54.41%	0.25%
Community	0.10%	0.21%	35.41%	1.50%	62.17%	0.60%

Southwest	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.18%	0.55%	43.56%	1.65%	54.06%	0.00%
Community	0.09%	0.14%	47.52%	1.12%	50.76%	0.37%

West Central	American Indian/Alaskan Native	Asian or Pacific Islander	Black/African American	Hispanic	White	Other
Hospital	0.05%	0.31%	42.15%	1.09%	56.19%	0.26%
Community	0.10%	0.26%	41.78%	0.93%	56.26%	0.66%

Penetration of Public Mental Health Services

The prevalence estimates of children with SED and adults with SMI can be compared to the population served by MHDDAD, to calculate the percentage of individuals who meet clinical standards for services are actually receiving those services. **We refer to this measure as a penetration rate³⁶.** The selection of clinical standards is based on the existing and newly drafted “Core Customer” definitions promoted by the MHDDAD. For comparison to estimated prevalence rates for those whose income falls below federal poverty levels, penetration rates are also based on a loose understanding found in practice, if not in regulations, that the public system should only be serving people who earn at or below 200% of the federal poverty limit.

Study Limitations: Population Change

Our analysis of MHDDAD penetration compares 2004 data on the number of people served in Georgia’s public mental health system with prevalence estimates based on 2000 Census data. Because these estimates are based on 2000 data, they may not hold true for any counties or regions that have experienced greater than average growth or population loss during the period between 2001 and 2004. The following table shows Census Bureau estimates of population change in Georgia regions between 2000 and 2003. These estimates show that the North region grew at 9% over the 3-year period, considerably more than the average growth rate of 6%. The West Central region grew 7% slightly greater than the state average. This means that our SED/SMI estimates using 2000 data will tend to underestimate the numbers of such individuals in the North and West Central regions, while they will overestimate those in the remaining counties. This overestimation will be most pronounced for the Southwest region, which grew only 2% and the Southeast and Central regions, which grew at 3%. The East Central region and Metro regions also grew at less than average rates, 4% and 5% respectively.

Table VI-13: Estimated Change in Total Population by Region and Area

Regions	2000 to 2001	2001 to 2002	2002 to 2003	Annual Average 2000 to 2003	Percent change 2000 to 2003
Central	1%	1%	1%	1%	3%
East Central	1%	1%	1%	1%	4%
Metro	2%	1%	1%	2%	5%

³⁶ For a discussion of this measure of penetration, see: <http://www.mhsip.org/ChuckMcGee02.pdf>

North	3%	3%	3%	3%	9%
Southeast	1%	1%	1%	1%	3%
Southwest	0%	0%	1%	1%	2%
West Central	2%	2%	2%	2%	7%
Georgia Total	2%	2%	2%	2%	6%
<i>Source: Table 1: Annual Estimates of the Population for Counties of Georgia: April 1, 2000 to July 1, 2003 (CO-EST2003-01-13), Population Division, U.S. Census Bureau, Release Date: April 9, 2004</i>					

Implications

Since Georgia's prevalence estimates are understated because they do not reflect population growth between 2000 and 2004, and prevalence serves as the denominator of the penetration calculation, Georgia's penetration rates will be somewhat overstated. In addition, since the North and West Central regions grew faster than the rest of the state, their penetration rates will be further overstated in comparison to the other regions. An additional issue that may balance these estimates is the fact that when we calculate penetration, (number in need divided by those served) not all of those served are SED or SMI. Thus, in many areas the gap may be understated.

Penetration by Broad Age Group

Table VI-13 shows that, overall, in 2004, Georgia's public mental health services supplied through the MHDDAD system reached not quite a third of those estimated to have a serious mental illness or a serious emotional disturbance during a 12 month period. The rate was somewhat higher for adults, exceeding the one-third mark, and quite a bit lower for children, where not quite a quarter with SED received services.

Regional Variation in Penetration

Penetration varied between Georgia counties and between MHMRDD service regions. Overall penetration ranged from 22% to 42%, with Metro and the North having lower rates and the Southeast and West having higher rates. However, because the northern regions have considerably more population than those in the south, the lower penetration rates dominate the overall state averages. The pattern was similar for children, but the low was only about 13%, which was experienced in the Metro area, and the high was slightly above 25%. For adults the rates ranged from 27% in the Metro area to 47% in the Southeast.

Table VI-14: Penetration of Public Mental Health Services by Broad Age Group and Region

	Ages birth to 17					Ages 18 and over					Total				
Regions	# Receiving Public Mental Health Services	Percent of state total	Estimated Number with SED	Percent of state total	Percentage with SED receiving services	# Receiving Public Mental Health Services	Percent of state total	Estimated Number with SED	Percent of state total	Percentage with SED receiving services	# Receiving Public Mental Health Services	Percent of state total	Estimated Number with SED	Percent of state total	Percentage with SED receiving services
Central	4315	10%	12502	8%	34.51%	13428	10%	32279	8%	41.60%	17743	10%	44784	8%	39.62%
East Central	4609	11%	15883	10%	29.02%	12543	9%	39020	10%	32.15%	17152	10%	54904	10%	31.24%
Metro	6845	16%	46170	29%	14.83%	27483	21%	103759	27%	26.49%	34328	20%	149929	27%	22.90%
North	10151	24%	37214	23%	27.28%	32015	24%	92595	24%	34.58%	42166	24%	129808	24%	32.48%
Southeast	5964	14%	16792	10%	35.52%	17567	13%	41060	11%	42.78%	23531	13%	57855	11%	40.67%
Southwest	4209	10%	12764	8%	32.98%	14297	11%	30999	8%	46.12%	18506	11%	43762	8%	42.29%
West Central	5627	13%	19882	12%	28.30%	15925	12%	46980	12%	33.90%	21552	12%	66863	12%	32.23%
Statewide Total	41720		160630		25.97%	133258		386843		34.45%	174978		547473		31.96%
Average					26.6%					32.7%					34.3%
Standard Deviation					6.6%					12.7%					6.8%
Source: EARF Regional Age Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm															

Penetration of Those in Poverty

Georgia's public mental health resources are targeted primarily, but not exclusively, toward those people with SED and SMI who are poor and uninsured. However, people with SED or SMI who do have health insurance may benefit from services not covered by insurance plans or may have needs that exceed insurance plan limits. Georgia's public mental health system is also available to meet such needs, and providers will typically charge a sliding fee for individuals whose income exceeds established limits, for example starting at 185% of the federal poverty level. As noted above, the prevalence of SED and SMI is greater among people in poverty than for those at higher income levels.

For these reasons, it may be more accurate to look at how Georgia is providing services to poor people with SED or SMI. Georgia data on public mental health services does not identify the income levels of the people it serves. Therefore, we cannot be certain that all services are provided to people below 185% of poverty. However, if we assume that most people receiving services are at or below 185% of poverty, we can look at what percentage of their need is being met. Dr. Charles Holzer out of the UTMB has estimated the rate of SED and SMI in households with incomes at or below 200% of poverty, not far from the 185% limit Georgia has set for Medicaid eligibility and a typical beginning point for providers' sliding fee scale. Additional information on Dr. Holzer's methodology can be found in Chapter III.

Table VI-15: Statewide Penetration by More Defined Age Groups

	Utilization	Penetration of Total Population Prevalence	Penetration of Household Population Prevalence	Penetration of <200% Poverty Prevalence
Birth-17	41,749	25.99%	26.37%	56.92%
18-24	20,408	27.24%	31.67%	60.24%
25-64	108,043	40.77%	43.32%	117.22%
Over 64	5,254	11.20%	15.36%	29.59%

Both Tables VI-15 and VI-16 show the penetration rate for people in households under 200% of poverty, assuming that they receive the vast majority of public mental health services. Table VI-15 allows us to consider rates of penetration for the state by less broad age groups. In other tables that reflect the adult age group for all those aged eighteen and over, here we see that total number of adults who fall between the ages of 25 to 64 exceeds the total number of adults we have estimated to have mental illness and whose income is less than 200% of the federal poverty limit. In other tables, the combination of all adults by age 18 and over disguised this. This statistically supports and emphasizes the need for transitional supports at that vulnerable young adult period once consumers are no longer eligible for

school-based services. Correlating the numbers of those utilizing services to those estimated to have a mental illness, without considering the application of poverty, we see that the state is only reaching 32% of those between the ages of 18-24 and 43% of those between the ages of 25-64. Moreover, without lumping in those older than 64, we see that this older population is the least served age group.

Looking specifically at Table VI-16, **if** all public mental health services were provided to children in households below 200% of poverty, they would reach just over half of the population estimated to have SED, this is double the penetration of public mental health services for children of all income groups with SED. However, the Metro region would remain significantly below average, reaching only a third of poor children estimated to have SED. Interestingly, the North region would do considerably better at reaching poor children with SED, reaching almost 70% of poor children estimated to have SED, compared to one quarter of all children with SED. If all of Georgia's adult services were provided to those in households under 200% of poverty, they would reach most such adults, 96%. In some regions, like the Central and North region, they would reach beyond this group. Interestingly, the East Central region, which was close to average in penetration of all adults with SMI becomes the least well served region when poverty is considered. It would reach only 75% of its poor adults with SMI. While the Metro region remains low at 83%, compared to other regions, in this instance it exceeds the East Central region. Overall, Georgia's public mental health resources could reach most, 81% of individuals with SED and SMI who are in poor households. The Metro and East Central regions stand out as reaching fewer of this population, about two-thirds, while the Central and Northern regions would be able to reach most of them, over 90%.

Implications

Both methods of analysis indicate that children are less well served than adults across all regions, and that the Metro area is relatively underserved compared to the other areas. However, the North area appears to serve children poorly, unless poverty is considered, while East Central appears to serve adults well, unless poverty is considered. To resolve these discrepancies, it will be important for Georgia to better understand the degree to which its services are targeted to people in poverty.

Table VI-16: Penetration of Public Mental Health Services for Households in Poverty by Broad Age Group and Region

Regions	Ages birth to 17			Ages 18 and over			Total		
	Number Receiving Public Mental Health Services	Estimated Number less than 200% of poverty with SED	Percentage with SED receiving services	Number Receiving Public Mental Health Services	Estimated Number less than 200% of poverty with SED	Percentage with SMI receiving services	Number Receiving Public Mental Health Services	Estimated Number less than 200% of poverty with SED	Percentage with SED receiving services
Central	4315	6653	65%	13428	12500	107%	17743	19155	93%
East Central	4609	7982	58%	12543	17175	73%	17152	25155	68%
Metro	6845	18579	37%	27483	34084	81%	34328	52664	65%
North	10151	13294	76%	32015	30426	105%	42166	43716	96%
Southeast	5964	8974	66%	17567	18010	98%	23531	26981	87%
Southwest	4209	7609	55%	14297	14241	100%	18506	21850	85%
West Central	5627	9452	60%	15925	17353	92%	21552	26802	80%
Georgia Total	41720	73347	57%	133258	143808	93%	174978	217155	81%
Source: EARF Regional Age Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi0) for 2000 Index for Population all ages http://psy.utmb.edu/p5profile_html/Georgia/p5wsmi01_caindex1.htm									

Penetration by Gender

The following table shows that males of all ages have a somewhat higher penetration rate than females, even though the number of men and boys using public mental health services are less than the number of girls and women. This reflects the higher incidence of SMI among women. The same pattern is seen in each region, and in some regions, like East Central and the Southwest, the gap between male and female penetration is 10% and exceeds the state differential of 7%. A similar pattern of high and low penetration as described above is seen in this table.

Table VI-17: Penetration of Public Mental Health Services by Gender and Region

Regions	Female			Male		
	Utilization	Prevalence	Penetration	Utilization	Prevalence	Penetration
Central	9,450	25,565	37%	8,529	19,219	44%
East Central	8,595	32,230	27%	8,402	22,675	37%
Metro	17,805	86,718	21%	17,169	63,211	27%
North	23,245	75,171	31%	19,677	54,633	36%
Southeast	12,520	33,026	38%	11,342	24,830	46%
Southwest	9,686	25,565	38%	8,924	18,197	49%
West Central	11,426	39,020	29%	10,618	27,836	38%
Georgia Total	91,100	317,072	29%	83,198	230,401	36%
<i>Source: EARF Regional Gender Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</i> http://psy.utmb.edu/p5profile_html/Georgia/p5wsmi01_caindex1.htm						

While overall penetration figures show a small differential between males and females, looking at how well existing services would reach people in poor households shows a much greater differential between males and females, with services able to reach about two-thirds of females with SED or SMI in poverty, but able to reach all males with SED or SMI in poverty. The nature of the regional variations would also change somewhat. The Metro region has the lowest overall female penetration, and is also at the low end for females in poverty. However, the East Central region, which was close to average in overall female penetration, falls to the lowest in ability to reach females in poverty. The North region had the highest female penetration on both measures.

Table VI-18: Penetration of Public Mental Health Services to those in Poverty by Gender

Regions	Female			Male		
	Utilization	Prevalence in Households under 200% of Poverty	Penetration	Utilization	Prevalence in Households under 200% of Poverty	Penetration
Central	9,450	12,058	78%	8,529	7,097	120%
East Central	8,595	15,648	55%	8,402	9,507	88%
Metro	17,805	31,983	56%	17,169	20,680	83%
North	23,245	26,628	87%	19,677	17,089	115%
Southeast	12,520	16,824	74%	11,342	10,162	112%
Southwest	9,686	13,643	71%	8,924	8,206	109%
West Central	11,426	16,952	67%	10,618	9,859	108%
Georgia Total	91,100	134,193	68%	83,198	82,962	100%

Source: *EARF Regional Gender Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages*
http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm

For males, penetration reached much higher levels, exceeding 100% in some regions. This may in part reflect the fact that males in poverty may not be found in the household sector as much as females. They may be included in counts of the institutional population, such as prisons. In this analysis, the Metro region changes places with the East Central region to have the lowest penetration rate for poor males, while East Central comes in second lowest. The North and Central regions stand out as having the capacity to serve significantly more males than those who are in poor households.

Implications

Though more females received MHDDAD services, the services did not meet elevated rates of mental illness prevalence among females as well as the needs of males were met. Considering poverty greatly magnifies differences in male and female penetration rates, and the ways that it does so, including how well household poverty accounts for males with SED and SMI, needs to be better understood. In addition, since both gender and age show differences in penetration rates, it will be important to see how they interact to affect penetration, and to better allow Georgia to target its resources appropriately.

The Metro area showed low female penetration for both total SED/SMI population and for the female SED/SMI population in poverty. The East Central area showed low penetration only when considering services in comparison to females in poverty.

Penetration by Race

Table VI-18 below shows that penetration varies considerably between the different racial groups in Georgia. Whites are close to average, blacks are considerably higher, at

40%, and Hispanics are very low at only 12%. Georgia's small population of Asians has even lower penetration, at 7%, and its Native American population with an estimated 1000 individuals with SED or SMI has a penetration rate of 23%. There is similar variation in each region between racial groups. The regional patterns of high and low penetration with Metro and North being low and the Southeast and Southwest being high are also seen within each racial group. However, the relative differences vary.

Table VI-19: Penetration of Public Mental Health Services by Race and Region

Regions	White Penetration	Black Penetration	Hispanic Penetration	Asian Penetration	Native American Penetration
Central	40%	51%	23%	32%	38%
East Central	37%	44%	17%	17%	28%
Metro	26%	43%	12%	8%	30%
North	19%	31%	9%	6%	20%
Southeast	33%	45%	13%	8%	26%
Southwest	41%	45%	16%	8%	22%
West Central	39%	49%	13%	11%	19%
Georgia Total	29%	42%	11%	9%	16%
<i>Source: EARF Regional Race Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</i> http://psy.utmb.edu/p5profile_htm/Georgia/p5wsmi01_caindex1.htm					

Considering poverty makes a considerable difference in analyzing how well racial groups are served. While blacks have the highest overall penetration, if we assume that public mental health services serve primarily people in poverty, then Whites with SED or SMI in poor households become the group whose needs are best met. The relative position of regions also changes. While the North region had lowest overall White penetration and the Metro region was only somewhat higher, both exceed the average in providing services able to reach its poor White population with SED or SMI. East Central, which exceeded the average in overall penetration, fell considerably below all other regions in being able to reach its poor White population.

Overall, public mental health services could reach three-quarters of black individuals with SED and SMI living in poor households. Interestingly, the North region, which was lowest in overall black penetration, is highest in its capacity to serve its black population with SED and SMI who live in poor households. It is the only region able to reach all of them. In contrast, the Metro region, which was above average in overall black penetration, falls to the lowest, able to reach only two-thirds of its poor black population with SED or SMI.

When poverty levels are considered, Native Americans penetration rates rise more than three fold and Asian and Hispanic rates come close to doubling. However, all remain underserved compared to Whites and blacks.

Table VI-20: Penetration of Public Mental Health Services for Households in Poverty by Race and Region

Regions	White	Black	Hispanic	Asian	Native American
Central	114%	79%	31%	46%	72%
East Central	69%	71%	22%	24%	75%
Metro	102%	66%	16%	20%	50%
North	111%	108%	21%	36%	67%
Southeast	104%	75%	26%	16%	51%
Southwest	104%	76%	20%	26%	44%
West Central	95%	72%	18%	26%	44%
Georgia Total	101%	74%	19%	22%	49%
<i>Source: EARF Regional Gender Analysis by County and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</i> http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm					

Implications

Dramatic differences that appear when poverty is considered in conjunction with race make it imperative for Georgia to understand how to best quantify the needs it is trying to meet. It is clear that Hispanics, Asians and Native Americans are underserved, but it is not clear whether Whites or blacks are being underserved because of the way the picture changes when income levels are considered. Regional differences are dramatic. While the North area appears to have low penetration when looking at all individuals with SED or SMI, it shows very high penetration for both Whites and blacks when poverty is considered. East Central stands out as having very low penetration for poor Whites with SED and being the only area in which White penetration is less than black penetration for poor households.

Our analysis shows that MHDDAD services reach relatively more adults with SMI than children with SED, and relatively more males with SED or SMI than females. They reach more African-Americans and Whites than Hispanics and other racial groups. Regionally, the Metro Region is distinguished as having relatively low penetration in comparison to other regions, both for the general population and for the low income population.

Other patterns of penetration change when poverty is considered. For example, African-Americans with SED/SMI at all income levels appear to receive the most services, and Whites are slightly lower than the statewide average, but when poverty is considered, the relative positions of these two races are reversed. In addition, the North region serves relatively few children of the entire SED population compared to other regions, but serves its poor children with SED relatively well compared to other regions. The East Central region appears to be about average when poverty is not considered, but does not serve poor adults, poor females, or poor Whites as well as other regions. It is important

for the state to better understand the income levels of the population it serves or wishes to serve in order to accurately assess the care it provides to different racial groups and regions.

Penetration of Rehab Option Services for People with SED/SMI

Rehab Option services are a subset of the MHDDAD services analyzed above. They are available specifically to individuals who have serious mental illnesses or emotional disturbances, and also are enrolled in Medicaid. We do not know what proportion of people who are estimated to have SED or SMI are enrolled in Medicaid. However, comparing Rehab Option utilization to SED/SMI estimates does let us know what percentage of the population eligible clinically is being reached. We will also look at the percentage of all Medicaid recipients who get Rehab Option services.

Rehab Option by Age Category Penetration

As would be expected, Rehab Option services do not reach as many individuals with SED and SMI as all public mental health services. An average of 12% of people statewide estimated to have SED or SMI receive these services. Penetration of youth is greater than that for adults, with 18% of youth receiving Rehab Option services across the state. Among adults, those falling between 25 and 65 receive Rehab Option services at almost the same rate as the state average, while only 8% of young adults and a very low 3% of elderly adults with SMI use Rehab Option services.

Table VI-21: Rehab Option Penetration by Age Category and Region

Regions	Ages 0-17	Ages 18-24	Ages 25-64	Over 65	Total
Central	24%	11%	16%	4%	16%
East Central	21%	7%	13%	4%	13%
Metro	12%	6%	8%	3%	8%
North	17%	8%	8%	2%	10%
Southeast	23%	8%	13%	3%	14%
Southwest	23%	11%	18%	5%	17%
West Central	19%	8%	12%	3%	13%
Georgia Total	18%	8%	11%	3%	12%
<i>Source: FY04 Rehab Option Summary by Race and Age and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</i> http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm					

The regional distribution of Rehab Option services differs a little from that of public mental health services. The Metro and North regions continue to be at the low end of the range. While the Central region joins the southern regions at the high end of penetration.

Rehab Option by Race Penetration

There appear to be significant differences in the rates that different racial groups use services. Blacks had the highest penetration rates in all regions, considerably exceeding the overall average penetration rate. Native Americans had the next highest rate on a statewide basis, but their average fell slightly below the overall state average, and their penetration rates varied considerably by region. In the southern regions, which often have relatively high penetration in relation to the state average, Native American penetration fell significantly below the state average. In contrast, the East Central, which is not usually far from the mean, had a very high penetration rate. Caucasians had the next highest rate, falling a little below the state average and dropping below the regional average in most regions. Hispanics and Asians both have very low state penetration rates, only 2% of their SED/SMI populations were receiving services. However, in the West Central region, the rate of Asian penetration was highest among all regions, almost double the next highest regional rate, and the rate of Hispanic penetration was even lower than in other regions.

Table VI-22: Rehab Option SED/SMI Penetration by Race

Regions	White	Black	Hispanic	Asian	Native American	Other (divided by other plus unknown)	Total
Central	12%	22%	4%	3%	12%	14%	16%
East Central	10%	22%	3%	3%	22%	15%	13%
Metro	6%	13%	2%	2%	11%	12%	8%
North	10%	17%	2%	2%	9%	24%	10%
Southeast	12%	19%	5%	2%	11%	16%	14%
Southwest	12%	24%	4%	4%	6%	19%	17%
West Central	9%	20%	1%	8%	7%	26%	13%
Georgia Total	10%	18%	2%	2%	11%	17%	12%

Source: FY04 Rehab Option Summary by Race and Age and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages
http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm

Rehab Option by Gender Penetration

In general, as shown by the table below, female penetration is less than that of males. Only in the Central region were penetration rates equivalent. Though females represented almost 55% of service users, because their relative need is greater than for males, it is not met quite as well.

Table VI-23: Rehab Option SED/SMI Penetration by Gender

Regions	Female Penetration	Male Penetration	Total Penetration
Central	16%	16%	16%
East Central	12%	15%	13%
Metro	7%	9%	8%
North	10%	11%	10%
Southeast	13%	15%	14%
Southwest	16%	18%	17%
West Central	12%	14%	13%
Georgia Total	11%	13%	12%
<i>Source: FY04 Rehab Option Summary by Race and Age and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages</i> http://psy.utmb.edu/p5profile.htm/Georgia/p5wsmi01_caindex1.htm			

Rehab Option Medicaid Penetration

The following presents information about Medicaid enrollment and the percentage of Medicaid enrollees using Rehab Option services. On average, 20% of Georgia's population is enrolled in Medicaid. (This excludes PeachCare.) The most urbanized regions, Metro and North are both below average in Medicaid enrollment, at 18% and 16% respectively. West Central is right at the average. Central, East Central and Southeast are clustered between 22% and 24%, while the Southwest region has particularly high enrollment at 29%.

Service areas vary somewhat more. Several service areas have Medicaid enrollment as high as 31% and Cobb has the lowest enrollment at 11%, followed by GRN at 14% and McIntosh Trail at 15%. All the other service areas fall within the regional range of 16% to 29%.

Table VI-24: Rehab Option Medicaid Penetration by Region and Service Area

Regions	Service Areas	Percent of Population Enrolled in Medicaid	Utilization	Medicaid Enrollment	Penetration
Central	River Edge	25%	2,524	52,734	5%
	Phoenix Ctr.	18%	1,345	28,617	5%
	Oconee	24%	1,313	27,754	5%
	Middle GA	27%	2,037	38,017	5%
Subtotal: Central		23%	7,219	147,122	5%
East Central	Advantage Beh.	18%	3,230	72,662	4%
	CSB of EC GA	23%	2854	78915	4%

Table VI-24: Rehab Option Medicaid Penetration by Region and Service Area

Regions	Service Areas	Percent of Population Enrolled in Medicaid	Utilization	Medicaid Enrollment	Penetration
	Ogeechee	33%	1,240	29,310	4%
Subtotal: East Central		22%	7,324	180,887	4%
Metro	Fulton Cty	21%	3,878	170,687	2%
	DeKalb CSB	18%	3,547	123,518	3%
	GRN CSB	14%	3,379	113,188	3%
	Clayton CSB	24%	1,468	62,524	2%
Subtotal: Metro		18%	12,272	469,917	3%
North	Lookout Mtn.	19%	1,557	31,528	5%
	GA Mountains	16%	2,984	82,078	4%
	Cobb CSB	11%	2,133	74,834	3%
	Douglas CSB	17%	757	17,014	4%
	Highland Rivers	18%	5,675	137,065	4%
Subtotal: North		16%	13,106	342,519	4%
Southeast	Pineland CSB	27%	1,827	50,552	4%
	Satilla CSB	31%	2,205	44,020	5%
	Gateway CSB	20%	4,002	102,442	4%
Subtotal: Southeast		24%	8,034	197,014	4%
Southwest	Albany CSB	29%	1,883	5,3784	4%
	GA Pines	31%	2,701	5,3611	5%
	BHS of S. GA	27%	2,747	6,3436	4%
Subtotal: Southwest		29%	7,331	170,831	4%
West Central	Pathways	21%	2,465	61,212	4%
	McIntosh Trail	15%	1,977	57,551	3%
	New Horizons	23%	2,749	58,782	5%
	Middle Flint	31%	1,388	32,144	4%
Subtotal: West Central		20%	8,579	20,9689	4%
Georgia Total		20%	63,865	1717979	4%
<i>Source: FY04 Rehab Option Summary by Race and Age and Medicaid and PeachCare Members by County FY2004</i>					

In contrast to enrollment rates, Rehab Option penetration rates fall very close to 4%. The statewide average percentage of Medicaid enrollees utilizing Rehab Option services in 2004 was 4%, as were the East Central, North, Southwest and West Central. Only the Central region was elevated to 5% and Metro was slightly lower at 3%. The range for service areas was somewhat wider, with two service areas in the Metro region having only 2% penetration, while all other service areas fell between 3% and 5%. This suggests that once enrolled in Medicaid, there is relatively equivalent access to Rehab Option

services. The variation we see in access of people with SED/SMI to Rehab Option services may therefore be related, at least in part, to their relative enrollment in Medicaid.

This analysis has demonstrated the significance of defining the target population and taking important demographic characteristics into account in determining how well the target population is being reached. (How well service expenditures are distributed will be addressed in Chapter XI, Public Financing and Information Systems.) Georgia has reason to be concerned that children, females and races other than African-American and White are being underserved in comparison to other groups. Young adults and older adults are also being relatively underserved by Rehab Option services. However, Georgia has important questions to answer in understanding how well it is serving Whites and African Americans and in appropriately interpreting penetration in the North and the East Central regions. In these cases, considering poverty levels fundamentally changes the conclusions to be drawn, thus making it imperative for Georgia to better understand to what degree it is serving people in poverty and to what degree it is serving a broader group. The implications of these differences need to be better understood in order to determine whether they result from desirable responsiveness to different needs or whether they stem from or cause undesirable disparities between groups.

B. Mental Health Services Provided by Different State Agencies

Though they are the primary agency responsible for providing mental health services, the Division of MHDDAD is just one of many state agencies providing mental health supports. The Department of Corrections, the state's prison system, the Department of Juvenile Justice, and the Division of Family and Children's Services all provide mental health services to their current populations.

"The lack of planning to meet the needs of the community is evident between agencies. Each agency plans for itself but there is no cross communication that would meet the real needs in the community. The Dept of Corrections, Juvenile Justice, School system, etc. should all be coordinating with MHDDAD to meet the needs of the mentally ill in the community and they don't. Planning meetings should not be separate and there should be less concentration on how to get money for your group and more on how to get money to meet needs."

- Survey Respondent

The Department of Juvenile Justice

The mission of the Department of Juvenile Justice is "to protect and serve the citizens of Georgia by holding youthful offenders accountable for their actions through the delivery of effective services, in appropriate settings, establishing youth in the communities as law abiding citizens." The Department of Juvenile Justice (DJJ) provides supervision, detention and a wide range of treatment and educational services for youths referred to the Department by the Juvenile Courts, and provides assistance or delinquency

prevention services for at-risk youths through collaborative efforts with other public, private and community entities. DJJ has a staff of over 3,500 dedicated employees managing programs, services and facilities throughout the state. Over 59,000 youths are served annually, including youths who are placed on probation, sentenced to short-term incarceration, or committed to the Department's custody by Juvenile Courts.

During Fiscal Year 2004, DJJ served 23,780 youth in its programs. Of these 23,000+, 68% received a mental health screening to determine if additional services would be needed. Of those screened, 3,474 youth received a mental health diagnosis, which totals 15% of the total DJJ population. It is estimated this number would be higher if all consumers received a mental health screening, as of those screened 22% received a diagnosis.

Table VI-25 below illustrates the number of youth screened and diagnosed with mental health issues within the Department of Juvenile Justice system.

Table VI-25: DJJ Screenings for Mental Illness

Not Screened	Screened			Total Served
	No MH Diagnosis	MH Diagnosis	Total	
4,278	4,935	14,40	6,375	10,653
3,083	7,125	18,97	9,022	12,105
275	610	137	747	1,022
7,636	12,670	3,474	16,144	23,780

Department of Juvenile Justice also serves more African American and minority youths than white youths on the whole. **Table VI-26** shows the racial breakdown of youth involved with the Department of Juvenile Justice.

Table VI-26: DJJ Screenings for Mental Illness by Race

	Not Screened	Screened			Total Served
		No MH Diagnosis	MH Diagnosis	Total	
White	4,278	4,935	1,440	6,375	10,653
African American	3,083	7,125	1,897	9,022	12,105
Other	275	610	137	747	1,022
TOTAL	7,636	12,670	3,474	16,144	23,780

African American youth are being screened for mental illness more often than Whites. Of those receiving a mental health diagnosis, 59% are minorities, and the remaining 41% are white. However, minorities make up 55% of the total population involved. The majority of youth served are males, making up nearly $\frac{3}{4}$ of the total DJJ population.

Looking at Table VI-27, DJJ Screenings for Mental Illness by Age, one can also see that younger individuals are more likely to be diagnosed with a mental illness. The percentages drop off considerable once individuals are 16 years of age or more.

Table VI-27: DJJ Screenings for Mental Illness by Age

Age	Not Screened	Screened			Total Served
		No MH Diagnosis	MH Diagnosis	% with MH Diagnosis	
10 & Under	167	46	28	12%	241
11	228	180	63	13%	471
12	526	541	235	18%	1,302
13	898	1337	545	19%	2,780
14	1,443	2,406	868	18%	4,717
15	1,717	3,582	940	15%	6,239
16 & Older	2,657	4,578	795	10%	8,030
TOTAL	7,636	12,670	3,474	16,144	23,780

Children are relatively less well served than adults by the MHDDAD system, whether or not poverty is considered. However, children may receive services in other systems, including Medicaid, Division of Family and Children's Services (DFCS), and Department of Juvenile Justice. When looking at the broader scope of services being provided by public funding sources, one must take into account ALL public funding sources. **The Department of Juvenile Justice estimates spending \$20 Million dollars per year on residential mental health services alone.** One major gap is that the Division of MHDDAD and the Department of Juvenile Justice currently cannot track system utilization by client across data systems. So the 3,474 youth receiving mental health services within the DJJ, may also be receiving services from community providers but one cannot calculate an unduplicated count. This is currently being addressed with new data sharing agreements between the Division of MHDDAD and the DJJ.

Children Receiving Services through Division of Family and Children Services (DFCS)

APS utilized data from the DFCS website to analyze some important mental health services that were provided to children. DFCS provides specific mental health services to a relatively small number of children. Less than 1% of children with SED are in the Level of Care or LOC program, formerly referred to as the MATCH program. The LOC program created 6 different levels of support based on each child's intensity of needs. Level 1 is the least intensive, and level 6 is the most intensive. This program is intended to meet the children's multiple and intensive needs through residential services, ranging from therapeutic foster care to inpatient hospitalization. Levels 5 and 6 are still referred to as 'MATCH' placements and are included here as such. As the table below shows, there appears to be little variation across regions in access to MATCH services, with only the Southeast region far from the state average. Almost 1% of children with SED receive Level of Care services. There is somewhat more variation between regions, with the Southeast and the Southwest receiving less than average, and the West Central region receiving more than average. While these services are undoubtedly significant for high need children, they do not appreciably expand access for children with SED.

**Table VI-28: FY2003 Penetration of
DFCS Match Program and Level of Care Services**

Regions	Children Receiving MATCH Services	Children Receiving Level of Care Services	Estimated Children with SED	Percentage with SED receiving MATCH services	Percentage with SED receiving Level of Care services
Central	78	122	12,502	0.6%	1.0%
East Central	101	138	15,883	0.6%	0.9%
Metro	271	441	46,170	0.6%	1.0%
North	247	381	37,214	0.7%	1.0%
Southeast	70	119	16,792	0.4%	0.7%
Southwest	77	77	12,764	0.6%	0.6%
West Central	132	229	19,882	0.7%	1.2%
Georgia Total	976	1,507	160,630	0.6%	0.9%
<i>Source: Division of Family and Children Services Data: Children in MATCH Program, Level of Care Children. http://www.dfcsdata.state.ga.us/ and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages http://psy.utmb.edu/p5profile_html/Georgia/p5wsmi01_caindex1.htm</i>					

Using the population of children with SED in poverty shows that MATCH services would reach over 1%, while level of care services would reach 2% of children in this group. There is somewhat more variation between regions in penetration of LOC services, but little change in relative position. Level of care penetration also showed little change in relative position.

**Table VI-29: FY2003 Penetration of DFCS Match Program
and Level of Care Services among Poor Children**

Regions	Children Receiving MATCH Services	Children Receiving Level of Care Services	Estimated Children with SED in poor households	Percentage receiving MATCH services	Percentage receiving Level of Care services
Central	78	122	6,653	1.2%	1.8%
East Central	101	138	7,982	1.3%	1.7%
Metro	271	441	18,579	1.5%	2.4%
North	247	381	13,294	1.9%	2.9%
Southeast	70	119	8,974	0.8%	1.3%
Southwest	77	77	7,609	1.0%	1.0%
West Central	132	229	9,452	1.4%	2.4%
Georgia Total	976	1,507	73,347	1.3%	2.1%
<i>Source: Division of Family and Children Services Data: Children in MATCH Program, Level of Care Children. http://www.dfcsdata.state.ga.us/ and Series P5 Estimates of Need for Mental Health Services For Georgia for Serious Mental Illness (wsmi01) for 2000 Index for Population all ages http://psy.utmb.edu/p5profile_html/Georgia/p5wsmi01_caindex1.htm</i>					

Department of Corrections

The mission of the Georgia Department of Corrections is to protect and serve the public as a professional organization by effectively managing offenders while helping to provide a safe and secure environment for the citizens of Georgia. Georgia has the eighth largest state prison population in the nation, and ranks fifth nationally in incarceration rates at 550 prisoners per 100,000 adults. Georgia also leads all other states with 6.8% of all adults, or one in fifteen, under some form of correctional supervision. Over 15,000 inmates are released each year from Georgia prisons.

In FY03 the Department of Corrections spent \$143,680,480 on inmate health care, including both physical and mental health. This translated into a cost/inmate/day of \$9.13, a 5% reduction from expenditures in FY02. This decrease was even more remarkable given the continued growth in the number of mental health and other chronically ill inmates.

With regard to mental health caseload growth, at the end of FY 03 there were 6,714 mentally ill inmates within the correctional system, compared to 6,349 the previous Fiscal Year. Again, at the end of FY 03 approximately 14.5% of the total inmate population was on a mental health caseload, a number that has continued to increase at the rate of 1% per year. \$6.6 million was spent on psychiatric medications during FY 2004: that's nearly a third of the prison system's \$23.2 million pharmaceutical bill. The total bill comes to more than \$125 million a year to house, guard and treat 6,000 mentally ill prison inmates – or 13 percent of total inmate population.

Within the Department of Corrections there are 6 different levels for categorizing inmates with mental illness, ranging from Level 1 as the lowest level of need, where individuals may just get medications and remain in the typical inmate unit, up to Level 6 where inmates are most likely to be housed at the Binion Building, the forensic state hospital on the grounds of Central State Hospital, or other inpatient forensic units across the state.

Table VI-30 details the Inmate population the number of inmates that had a mental health diagnosis during December of 2004.

Table VI-30: Inmate Mental Health Status

Current / last mental health treatment level						No MH Diagnosis	Total	TOTAL MH
1	2	3	4	5	6			
5,491	5,301	1,377	281	14	23	31,654	44,141	12,487

The status of inmates can change from day to day, so this method of calculations does not represent everyone that needed Level 6 services throughout the year, this is a point in time snapshot of the services being provided to inmates with mental illness by the Department of Corrections. The total number of inmates with a MH diagnosis equals 12,847 or 28% of the total corrections population. Of those, 5,491 are level 1, which means that they most likely received psychotropic medications and remained with the general inmate population. Inmates categorized as Level 2 receive some supportive

services but generally stay with the population. Inmates categorized as Level 3, 4, and 5 live in designated facilities in order to protect them from victimization within the larger population. At times, Level 3 inmates can perform work duty, or participate in other group activities with the general population.

As stated earlier, when looking at the broader scope of mental health services being provided by public funding sources, one must take into account ALL public funding sources: Department of Human Resources, Department of Juvenile Justice, and Department of Correction. There is currently no centralized information system that can track common, or shared consumers across multiple agencies, thus creating multiple barriers. Continuity of care, maximizing cost efficiencies, and the quality of service delivery are all jeopardized by a system that is not conducive to collaboration.

GAP:
Data systems across multiple state agencies do not track client service utilization, preventing true continuity of care and services.

Medicaid Provided Services

In addition to the Medicaid Rehabilitation option services provided through the public mental health system, Georgia's Medicaid program covers services for those individuals who have mental illness and are eligible under different categories of Medicaid. For example, a child may be eligible for PeachCare but have Attention Deficit Hyperactivity Disorder and receive services from his community health center. A more detailed analysis of all the Medicaid funded services is completed in the State Comparison chapter, but in order to get an idea of the services provided for non-rehab option Medicaid enrollees Table VI-31 illustrates the most expensive services provided, the dollars spent on each service, and the age of clients receiving those services. (Psytx stands for Psychiatric Treatment in the service column.)

**TABLE VI-31: Expenditures for Generic Medicaid Covered Services for
FY 2004, by Age and service**

SERVICE	Birth-17	18-24	25-64	Over 64	Total
INDIVIDUAL/FAMILY PSYCHOTHERAPY	\$ 15,522,396	\$ 627,470	\$ 2,204	\$ 712	\$ 16,152,783
Department of Human Resources - DFCS	\$ 12,967,718	\$ 1,256,730	\$ 0	\$ 0	\$ 14,224,449
Psytx, Office, 20-30 Min	\$ 3,766,057	\$ 467,976	\$ 2,422,052	\$ 54,867	\$ 6,710,953
PSYCHOLOGICAL EVALUATION	\$ 4,644,848	\$ 99,751	\$ 41	\$ 27	\$ 4,744,667
Psych Diagnostic Interview	\$ 725,054	\$ 109,442	\$ 343,164	\$ 11,054	\$ 1,188,714
Family Psytx W/Patient	\$ 615,233	\$ 43,098	\$ 70,813	\$ 1,374	\$ 730,518
Psytx, Hosp, 20-30 Min	\$ 56,765	\$ 31,567	\$ 178,659	\$ 6,525	\$ 273,516
Psychological Testing	\$ 79,768	\$ 4,703	\$ 11,112	\$ 281	\$ 95,864
COUNSELING EVALUATION	\$ 58,253	\$ 1,679	\$ 0	\$ 0	\$ 59,932
Total Served	48,929	4,155	13,362	1,384	67,102
TOTAL EXPENDITURES	\$ 38,436,093	\$ 2,642,415	\$ 3,028,045	\$ 74,841	\$ 44,181,394

As seen above, the majority of the services are provided to children ages birth to 17, who are most likely eligible for Medicaid because of their families' income level. Again, this is just a sample of the generic Medicaid services that are provided within the state.

Chapter XII: State-to-State Comparison delves into more detail with Medicaid generic services and the number of recipients and expenditures.

Medicaid and Prescription Drugs

Georgia's Medicaid program spent more than \$278 Million dollars on psychotropic medications during Fiscal Year 2004.

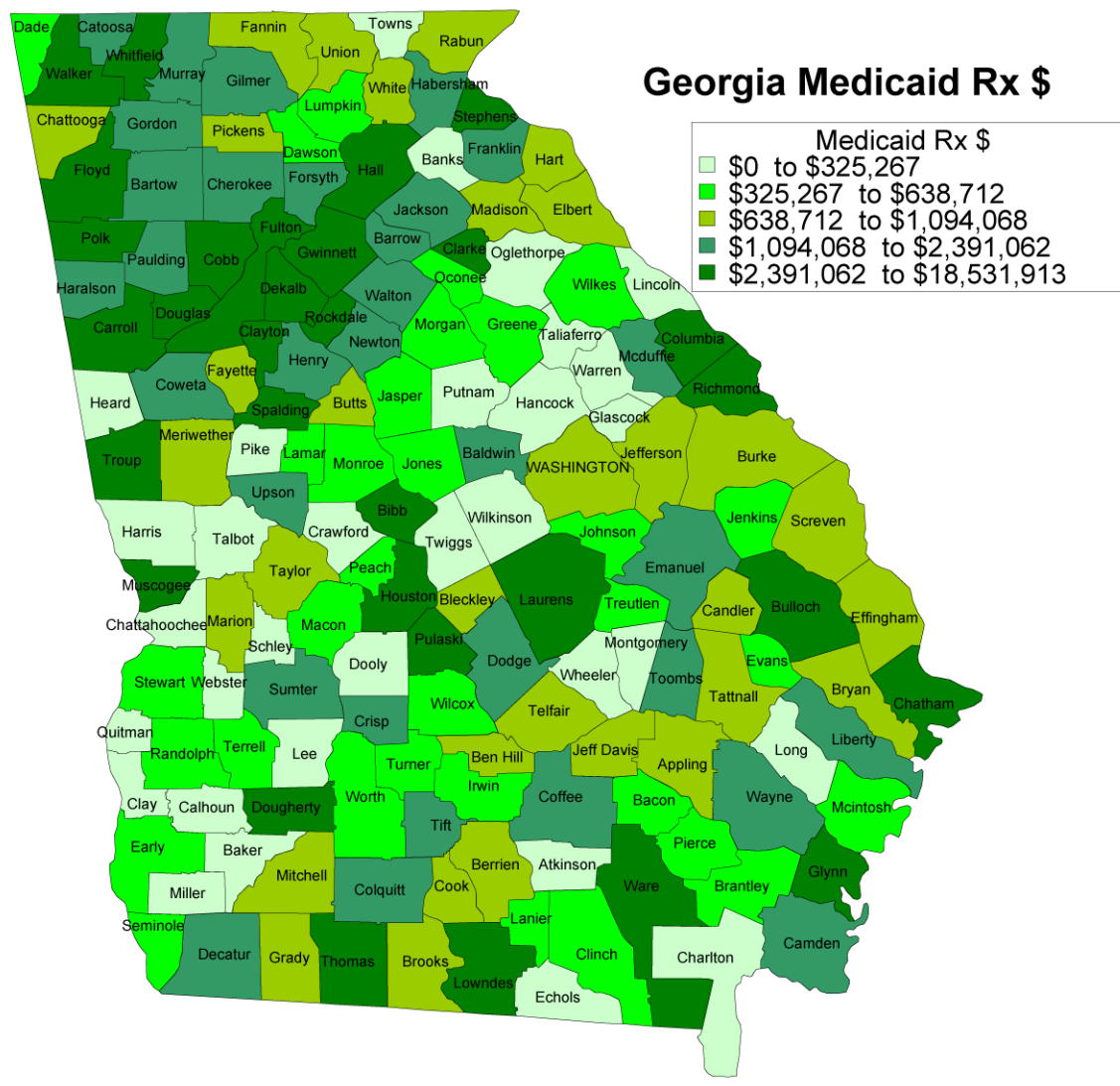
As stated throughout this report, the use of psychotropic medications as a component in a comprehensive treatment plan is a nationally supported evidence based practice. New generation medications to treat Schizophrenia, Depression, and Attention Deficit Hyperactivity Disorder (ADHD) are helping millions achieve recovery, without the side effects that older drugs caused. However, success comes at a cost: new generation psychotropic medications are expensive, and unaffordable to many people who need them. Thousands of people with mental illness have Medicaid to pay for their prescription drugs, but for individuals without Medicaid there is a dire situation. Even for those with Medicaid, looming budget cuts and drug formulary changes threaten to decrease benefits and change the medications that Medicaid will cover. It is for all of these reasons that one must look at the extent to which medications are used and available within Georgia's public mental health system.

Unlike the rest of healthcare, medications comprise only 3% of costs for treating mental illnesses nationally. Some experts contend that they may be responsible for more than 50% of positive treatment outcomes (*M. Graham, "Restrictive Formularies," National Mental Health Association, Department of Healthcare Reform*). Because Medicaid is the primary payer source for nearly 60,000 individuals with mental illness receiving services through the rehabilitation option within the state, as well as others in different categories of Medicaid eligibility, the analysis will focus on Medicaid payments for psychotropic medications. APS Healthcare received a data extract from the state Medicaid department detailing the prescription drug claims for fiscal year 2004 for individuals who have mental health diagnoses. APS Healthcare then analyzed the claims filtering all drugs used for medical purposes. A total of all Medicaid paid claims equals nearly \$280 Million for the entire year: a number slightly higher than the total budget for mental health services as allocated within the Division of MHDDAD. Table V- below illustrates the 20 highest costs medications and what they cost the state in paid pharmacy claims during fiscal year 2004.

**Table VI-32 Medicaid Prescription Drug Expenditures
FY 2004**

DRUG	DOLLARS EXPENDED ON CLAIMS	# Of Consumers with Scripts	Per Capita Expenditure for each Drug
ZYPREXA	\$36,831,305	21,375	\$1,723.10
RISPERDAL	\$30,966,980	29,096	\$1,064.30
SEROQUEL	\$19,063,853	17,999	\$1,059.16
NEURONTIN	\$16,266,319	26,165	\$621.68
ZOLOFT	\$16,152,489	39,643	\$407.45
ABILIFY	\$11,874,583	8,923	\$1,330.78
ADDERALL XR	\$10,178,125	24,803	\$410.36
CONCERTA	\$10,132,671	24,541	\$412.89
TOPAMAX	\$9,294,150	9,086	\$1,022.91
EFFEXOR-XR	\$8,664,659	15,293	\$566.58
STRATTERA	\$8,392,722	20,688	\$405.68
DEPAKOTE	\$8,312,883	12,377	\$671.64
LEXAPRO	\$5,907,898	24,615	\$240.01
LAMICTAL	\$4,533,973	3,350	\$1,353.42
GEODON	\$4,361,529	4,008	\$1,088.21
AMBIEN	\$4,314,828	26,325	\$163.91
DEPAKOTE ER	\$4,278,445	7,987	\$535.68
TRILEPTAL	\$4,247,979	6,545	\$649.04
PAXIL CR	\$4,014,664	13,109	\$306.25

From reviewing **Table VI-32** it is apparent that the 3 highest costs medication are all anti-psychotic drugs used to treat Schizophrenia, and total \$86,862,143 for the year for 68,470 consumers. However, the number is put in perspective when examining costs per consumer: for the 21,375 consumers benefiting from the drug Zyprexa the costs averaged \$1,723 per person for the entire year. The Figure on the following page provides an illustration of the dollars spent on psychotropic medications in each county in Georgia.



By looking at Figure **VI-1**, one can determine the Medicaid dollars spent on psychotropic drugs by residents in each county. There is a greater concentration of high cost areas surrounding the metropolitan Atlanta region, and to the northwest of Atlanta.

In addition to Medicaid coverage for prescription drugs, the Community Service Boards use state grant in aid funding, as well as donations to supply free or discounted

medications to indigent clients who do not have Medicaid or private insurance. Most large drug companies offer Patient Assistance Programs (PAP) to individuals who cannot afford to pay for their prescription drugs. Many of the CSBs throughout the state use these programs and enroll their consumers in order to get the needed medications. The difficulty with the PAP is that the enrollment process is cumbersome and needs to occur often in order to maintain continuity on the program. During the focus groups held across the state it was determined that almost 10 CSBs use the PAP at a system level: several even employing clerks who process only PAP enrollment forms in order to keep people enrolled in the programs. It is estimated that the nearly \$20 Million dollars was leveraged by community organizations in free and discounted drugs during FY04. Of the 8 CSBs reporting data, the range for the funds was between \$800,000 per year for a smaller provider, up to \$4.5 Million for larger provider in the central region. DeKalb CSB alone provided 17,035 scripts using the Patient Assistance Programs. The drug company Patient Assistance Programs are filling a major void within the public mental health system for people who are uninsured, who for those that are underinsured and their insurance either won't cover the drugs or the co-pays are too high for low income families.

Research has demonstrated that the appropriate management of symptoms by a prescribing professional can reduce hospitalizations and support recovery. It is recommended that Georgia's Medicaid program carefully consider the impact of changes in drug formularies.

Other State's Experiences

- For every dollar saved, reducing the budget on medication for patients in Medicaid with Schizophrenia, \$17 was spent on emergency services to those patients as a consequence. (*New Hampshire*)
- Forcing people with mental illnesses to switch to cheaper medications cost the state \$6,000 to \$8,000 additional dollars per patient due to increased hospitalizations. (*California*)
- Restricting access to medications through drug formularies increased Louisiana's Medicaid cost by 4.1 percent. (*Louisiana*)
- A year's worth of medications averages \$3,800, just over \$10 per day versus an average of \$950 *a day* for hospitalizations. (*Florida*)³⁷

³⁷<http://www.nami.org/Template.cfm?Section=Kentucky&template=/ContentManagement/ContentDisplay.cfm&ContentID=14301>

C. In-Depth Analysis of Utilization and Intensive Services

Measuring Penetration as a Percentage of those in Intensive Services

Below, an analysis of intensive services is provided. People served in these services primarily consist of those with SMI and SED. Thus, analyses of these services are valuable.

From the review of an ideal service delivery system, one knows that for individuals with serious mental illness or serious emotional disorders intensive community based services are the most cost effective and desirable modes of treatment available today. The previous section provided a thorough review of penetration, the number of people in need who actually received services, for all services based on broad service categories. The analysis below reviews penetration of intensive services for Georgia's citizens in need.

Intensive services are categorized by the level of support that they provide. High and medium intensity services are listed below for adults and children and adolescents:

CHILD AND ADOLESCENT	ADULT
Activity Treatment	Intensive Day Treatment
C&A Day Treatment	Ambulatory Detox
Adolescent Substance Abuse Day treatment	Community Based Inpatient Detox
C&A Day Supports	Psychosocial Rehabilitation
Intensive Family Intervention	Residential Supports
Community Supports Team	Crisis Intervention
Community Supports Individual	Crisis Stabilization
Crisis Intervention	Independent Living Supports
Therapeutic Group Home	Skills Training
Structured Living Supports	Assertive Community Treatment
Therapeutic Foster Care	Community Support Individual
	Community Support Team
	SA Day
	Community Based Inpatient
	Residential Detox

These services are categorized by Georgia's Medicaid guidelines or the state as designed to serve individuals with intensive needs. By definition, the number of people in need of services, as calculated by Holzer's methodology, would most likely benefit from one or several of the intensive services listed above. APS calculated the number of unique consumers that received these intensive services for Fiscal Year 2004, and then calculated the penetration rates for each region's population as illustrated in the table below:

VI-33: Intense Services Penetration Rates for Adult and C&A

REGION	ADULTS RECEIVING INTENSE SERVICES	CHILD & ADOLESCENT RECEIVING INTENSE SERVICES	ADULT PENETRATION RATES	C&A PENETRATION RATES
CENTRAL	5,519	1,075	17%	9%
EAST CENTRAL	4,292	1,278	11%	8%
NORTH	9,573	1,458	9%	3%
METRO	8,282	1,584	9%	4%

SOUTHEAST	9,573	1,402	23%	8%
SOUTHWEST	7,070	745	23%	6%
WEST CENTRAL	6,751	1,999	14%	10%
TOTAL	51,060	9,541	13%	6%

The gaps in providing intense services to individuals in need are clearly seen above. There is also great disparity in the penetration rates among the regions. The Southeast and Southwest are meeting the needs of more adults in need of services, whereas the Central and West Central regions are meeting the needs of more children and adolescents than other regions.

GAP:
During FY 2004, Less than 15% of adults, and less than 10% of children and adolescents were enrolled in intense community services.

Measuring Penetration as a function of Length of Stay

Access to services is a critical factor in the success of public mental health systems of care. In order to further understand access to services among mental health consumers, APS developed a system of categorization regarding service utilization for the Medicaid rehabilitation option population.

This system serves as the foundation for more in-depth analysis, e.g., access by income, race, primary language, ethnicity, etc. Using the analytic approach outlined below, it is possible to determine critical factors such as length of stay and type of service provided.

As the stated Medicaid External Review Vendor, APS consistently reviews consumer access to services and utilization patterns specific to Georgia's Medicaid Rehabilitation Option providers. This population comprises 35 – 40% of the entire population receiving services from MHDDAD. With this large of a sample size, we can apply utilization rates and the analysis to the greater population to get a better understanding of what services are truly being provided. Rehab Option providers serve approximately 63,000 people a year. Based on a 12-month analysis of Medicaid claims, the study conducted by APS categorized consumers served into four quadrants. Each quadrant represents two variables - length of stay in services and frequency/amount of contact - as follows:

- ❖ *Quadrant One:* people who have had less than three contacts with the agency.
- ❖ *Quadrant Two:* people who received services for less than 3 months and have received between 50 and 500 units of services.
- ❖ *Quadrant Three:* people who received services for greater than 9 months and have received more than 500 units of services.
- ❖ *Quadrant Four:* All other people

Using these statistically derived quadrants, analysis of data at both statewide and local levels identified the following patterns of access.

- Agencies with a significant number (greater than the state average) of people in *Quadrant One* (less than 3 agency contacts) may have one or more of the following:
 - ❖ Barriers that may prevent timely access to services
 - ❖ Unattractive programming
 - ❖ Limited MD (or other staff) availability
 - ❖ Poor consumer screening techniques
 - ❖ Poor consumer orientation techniques
- Agencies with a significant number (greater than the state average) of people in *Quadrant Two* (short length of stay and high utilization of services) may have one or more of the following:
 - ❖ Effective programming that met the consumer's needs during an acute episode.
 - ❖ A mandated (or court ordered population) that remained in services until their obligations were met.
 - ❖ A chronic, but non-compliant population that were initially engaged in services but left services prematurely.
- Agencies with a significant number (greater than the state average) of people in *Quadrant Three* (long length of stay and high utilization of services) may have one or more of the following:
 - ❖ Attractive programming;
 - ❖ Motivated, compliant consumer population;
 - ❖ Utilization stagnation where consumers attend day programs long term with no real impact in learning to live independently;
 - ❖ A consumer being served in a residential site that requires structured programming during the day; and/or
 - ❖ Gridlock (or a waiting list) where no new consumers can enter a day program because no one is being discharged and the program is full.
- Agencies with a significant number (greater than the state average) of people in *Quadrant Four* may have one or more of the following:
 - ❖ A large population of consumers who are stable and receiving maintenance doses of medication or therapy, and/or
 - ❖ People who show up briefly several times a year for medication or supportive psychotherapy.

By offering a more thorough understanding of the consumer population to providers and state officials, APS is able to assist the system of care to improve capacity, provide timely access to care, modify the intensity of clinical programming, develop treatment alternatives, and improve outcomes for all consumers.

The graphic below provides an overview of the findings for Rehab Option Consumers for Fiscal Year 04 and their access to services in Georgia. APS titles this the **Allocation of Resources Map (ARM)** because it provides a snapshot of utilization. The term “Visitors” applies to those people seen less than 3 contacts. “Absentees” refers to those in services less than three months but receiving more than 50 units of service. “Family”

refers to those in services longer than 9 months and receiving more than 500 units of service and “Members” referrers to the remaining people. This group consists of people seen occasionally throughout the year.



Allocation of Resources Map (ARM)

July 2003 - June 2004

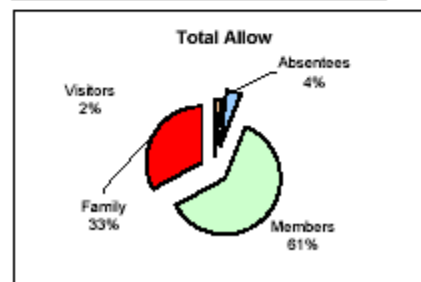
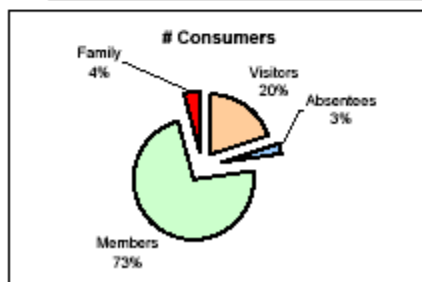
Agency:	Statewide	# Consumers:	68,706
Disability:	Total	Total Allow:	\$99,050,812
Average Allow Per Consumer:		\$1,442	

Absentees	
Units >50; LOS < 3 Months	
Consumers	
1,874	3%
Allow Total (Amount Paid)	
\$4,096,870	4%
Average Allow Per Consumer	
\$2,186	

Family	
Units >500; LOS > 9 Months	
Consumers	
2,823	4%
Allow Total (Amount Paid)	
\$32,631,220	33%
Average Allow Per Consumer	
\$11,559	

Visitors	
Fewer Than 3 Claims	
Consumers	
13,710	20%
Allow Total (Amount Paid)	
\$1,934,391	2%
Average Allow Per Consumer	
\$141	

Members	
Remaining Consumers	
Consumers	
50,299	73%
Allow Total (Amount Paid)	
\$60,388,331	61%
Average Allow Per Consumer	
\$1,201	



Data Source: ACS Paid/Denied Claims for Service Dates.

For the purposes of penetration, APS will focus on the Visitors to services, that is individuals who received less than 3 contacts within the year. Individuals may have shown up for a few initial appointments but were not engaged in ongoing services, thus not utilizing a great deal of agency resources, unlike the FAMILY who received more than 500 units of service in the same time frame. The statewide average for Visitors to all agencies is 20%. So, 1/5 of all consumers enrolled in services, received less than 3

contacts by the provider agency. Table VI-34 below is a regional distribution of Visitors and new penetration rates for services when you remove the Visitors from the client enrollment.

Table VI- 34: Visitors By Region and Adjusted Penetration

Region	# of People Enrolled	% Of Visitors per Region	# Of Visitors	Adjusted # Truly Served (Minus Visitors)	New Penetration Rates based on Adjusted Total Served
Central	17,743	16%	2,838	14,905	33%
East Central	17,152	20%	3,430	13,722	25%
Metro	34,328	21%	7,208	27,120	18%
North	42,166	21%	8,854	33,312	26%
Southeast	23,531	24%	4,000	19,531	34%
Southwest	18,506	17%	3,146	15,360	35%
West Central	21,552	18%	3,879	17,673	26%

By applying the percentage of Visitors by region to the total EARF enrollment figures, it allows one to see regional differences in access to services. The Southeast region has the highest percentage of visitors in the state, whereas the Southwest region has one of the lowest rates yet they represent similar geographic areas – vast, rural communities. As stated before, regions with higher visitor percentages might have specific barriers that affect access to services: geographic barriers, unattractive programming, limited workforce (creating long waiting lists), poor consumer screening techniques, or poor orientation to services. A complete Allocation of Resources Map Table is provided as **APPENDIX VI-1: Allocation of Resources Map**.

Table VI-34 below illustrates the differences in penetration rates by region after adjusting to remove the visitors from the total number of individuals removed. Penetration rates drop from 4% – 7 % overall.

Table VI-35: Adjusted Penetration vs. Original Penetration

Region	Adjusted Penetration Rates	Original Penetration Rates
Central	33%	39%
East Central	25%	31%
Metro	18%	22%
North	26%	32%
Southeast	34%	40%
Southwest	35%	42%
West Central	26%	32%

Studying the adjusted rates for penetration paints a more accurate picture of service utilization and of who is truly receiving the services that they need.

GAP:
After controlling for Utilization, the number of people in need of services who are receiving them ranges from 18% - 35%.

Penetration as a Percentage of Services Recognized as “Best Practice”

Earlier in the Gap Analysis there was a discussion and information on Evidence Based Practices and best practices. To get a better idea of how available these specific services are, APS studied enrollment rates and utilization for the following services:

- ❖ Intensive Family Intervention
- ❖ Psychosocial Rehabilitation
- ❖ Community Support Individual
- ❖ Community Support Team
- ❖ Assertive Community Treatment Team
- ❖ Peer Support
- ❖ Supported Employment
- ❖ Family/Consumer Education
- ❖ Integrated Mental Health and Substance Abuse Treatment
- ❖ Medication Algorithms

Table VI-36 below illustrates the extent to which most of Georgia’s evidence based practices are received throughout Georgia:

Table VI-36: Penetration by Utilization of Evidenced Based Practices			
Service	# of Individuals Served	Penetration Rates for those in need	Penetration for 200% Poverty Level in need
Assertive Community Treatment	735	< 1%	> 1%
Community Support Team	3,678	1%	3%
Community Support Individual – Adult	24,919	7%	17%
Community Support Individual – Child and Adolescent	13,011	8%	18%
Supported Employment	3,086	< 1%	2%
Psychosocial Rehabilitation	5,137	1%	4%
Peer Support	3,315	1%	2%
Intensive Family Intervention	1,283	1%	2%
Family/Consumer Education (All ages)	9,140	2%	4%

The rates at which Assertive Community Treatment and Community Support Teams are provided to individuals in need is extremely low across the state. Less than 1% in need

receive these services, and then when controlling for individuals under the 200% poverty level, the number increases to 3% for Community Support Team, but remains below 1% for Assertive Community Treatment. Providers have called their Community Support Teams “ACT Lite” because they can provide similar services in the community, without the requirement of having a dedicated psychiatrist on the team. Supported Employment, Psychosocial Rehabilitation, and Peer Support are all day services that are provided to less than equal to 1% of the population in need. Intensive Family Intervention is provided to 1% of the total population in need, and 2% of the population under 200% of the federal poverty limit.

The highest penetration comes from Community Support Individual, which is shown for adults and for children and adolescents. **Table VI-37** further illustrates the extent to which Community Support Individual is provided, based on Community Service Board catchment areas. In several areas additional providers have been contracted to provide this service, but the numbers are extremely small so the focus remains on the CSB catchment area.

Table VI-37: Community Support Individual by Adult and Child & Adolescent

CSB CATCHMENT AREA	% C&A In Need who Received CSI	200% Pov C&A In Need who received CSI	# Primary MH C&A Served FYO4 EARF CSI	% Adults In Need who Received CSI	200% Pov In Need who received CSI	# Primary MH Adults Served FYO4 EARF CSI
ADVANTAGE	7%	15%	498	7%	16%	1,312
ALBANY	20%	32%	628	15%	33%	1,330
CLAYTON	2%	6%	132	2%	6%	229
FULTON	3%	8%	34	3%	8%	1,141
COBB	1%	5%	365	1%	5%	306
EAST CENTRAL	4%	7%	588	3%	7%	491
MIDDLE GEORGIA	18%	34%	613	13%	32%	1,234
DEKALB	3%	8%	464	3%	8%	789
DOUGLAS	2%	6%	150	2%	6%	82
GATEWAY	12%	24%	1,037	10%	24%	1,686
GEORGIA MOUNTAINS	10%	26%	601	3%	8%	626
GEORGIA PINES	26%	42%	928	32%	68%	2,951
GRN	13%	36%	855	4%	14%	698
HIGHLAND RIVERS	10%	24%	1,182	8%	21%	2,218
LOOKOUT MOUNTAIN	7%	17%	201	15%	40%	1,259
MCINTOSH TRAIL	5%	12%	264	13%	40%	1,929
MIDDLE FLINT	17%	30%	494	4%	9%	297
NEW HORIZONS	19%	31%	658	10%	20%	796
OCONEE	12%	22%	304	3%	9%	238
OGEECHEE	7%	12%	138	8%	15%	362
PATHWAYS	11%	22%	477	4%	9%	380
PHOENIX	8%	16%	114	5%	13%	417
PINELAND	8%	12%	294	6%	13%	635
RIVEREDGE	9%	18%	593	6%	16%	686
SATILLA	28%	47%	973	22%	45%	1,753
SOUTH GEORGIA	9%	16%	374	11%	24%	1,160
STATEWIDE TOTAL³⁸	8%	17%	13,011	7%	17%	24,919

With penetration rates for children and adolescents ranging from 1% to 28% for the total population, and 5% to 47% for children and adolescents below 200% of the federal poverty level, there is much variance across the state. The same variance holds true for adults: 2% to 32% penetration for all adults, and 6% to 68% for adults below 200% of the federal poverty level. In the more urban areas the penetration rates tends to be lower than in more rural areas where Community Service Boards are most likely the only providers of mental health services in a multi-county area. Statewide penetration rates for Children and Adolescents are 8% for the whole population, and 17% for those below 200%

³⁸ Statewide totals may differ from total county or CSB catchment areas combined because of missing data – if a consumer has no county of residence they are included in an ‘Other’ category and not reflected in the county breakdown, but ARE included in the statewide total.

poverty level, and for adults the penetration rate is 7% for the total, and 17% for those under 200% poverty level. Overall, for all age groups, there are 7% of people who need services enrolled in Community Support Individual. Poverty penetration should only be used as a guide and estimate because it is impossible to determine whether the individuals receiving services are actually within those income guidelines.

GAP:
Only 7% of people in need of services are receiving Individual Community Support.

Dual Diagnosis

The remaining Evidence Based Practices are difficult to quantify in terms of access, availability, and utilization. There are several programs across the state featuring integrated treatment for addictive disease and mental illness, however they are not categorized as such in the information system. The Gateway program in South Georgia is one such program that is featured in Section V-D Specialized services for specialized populations. APS ran an analysis on **individuals with mental health diagnoses** that were enrolled in detox services during FY04 and found:

- ❖ 243 Individuals were enrolled in community based detox services
- ❖ 4,283 individuals were enrolled in residential detox programs
- ❖ 701 Children or adolescents were enrolled in Substance Abuse Day Treatment

Medication Administration

During FY 04, 38 agencies provided Medication administration to 17,376 individuals with mental illness. Additionally, Medication Algorithm as a best practice is interwoven with other support services. Georgia's psychiatrists and other prescribing professionals are working on medication algorithms to achieve optimal recovery for individuals followed by other professionals who are working with the consumers on medication management. These support services are built into other services, such as Psychosocial Rehabilitation and Peer Support services, so it is difficult to ascertain exactly how many people received such services. However, Georgia does provide a service titled Medication Administration where professionals oversee and monitor the administration of various psychotropic medications.

Supported Employment

The Georgia Mental Health Consumer Network surveys consumers across the state of Georgia every year for what they consider to be the top priorities for services to enhance their recovery; consistently they have chosen jobs as a top 5 priority. Research has shown that 70% of adults with mental illness desire to work and 60% can be successful at working when using supported employment. Employment is an important outcome of

services because productive activity is an essential component of adult role functioning that enhances self-esteem and improves the economic prosperity of individuals. The United States Department of Health and Human Services Administration, Center for Mental Health Services recognizes six practices as Evidence Based Practices (EBP) that promote recovery, Supported Employment is one of those practices. Research has suggested that even people who are assumed unlikely to succeed in employment can improve their employment outcomes with the help of supported employment. When an agency develops a culture of work and encourages people to consider employment options, the number of people who go to work increases. Giving people the choice to decide whether or not to participate in supported employment is consistent with the recovery philosophy. Many consumers in agencies with supported employment programs identify themselves as wanting to work in competitive jobs.

Supported Employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Employment specialists have frequent meetings with treatment providers to integrate supported employment with mental health services. The core principles of this program include:

- Eligibility based on consumer choices and preferences
- Supported employment as an integrated treatment
- Continuous follow-along supports
- Help with moving beyond the patient role and developing new employment-related roles as part of the recovery process

Currently, some of the elements of supported employment have more supporting evidence than others. The following components are predictive of better employment outcomes:

- Focus on competitive employment
- Rapid job searches
- Jobs tailored to individuals
- Time-unlimited follow-along supports
- Integration of supported employment and mental health services
- Zero exclusion criteria (that is, no one is screened out because they are not ready)

In the FY 2004 Georgia Performance Measurement and Evaluation System (PERMES) report, only 20% of the individuals surveyed reported that they were working. This figure is below the national average of 23%. Of those unemployed, 51% indicated that they would like to work with only 22% reporting that someone was helping them find a job. Of those unemployed only 28% were working 40 hours or more per week. Of the individuals who indicated that they did not want to work, 59% said they were unable to work due to physical problems, 18% feared losing some or all of their benefits, 11% indicated that others didn't feel they are ready and 9% said they did not realize they could work.

Various reasons are given for why individuals are not offered supported employment services with lack of transportation noted as a major obstacle for individuals being employed.

GAP:
Georgia does not deploy sufficient emphasis and resources into Supported Employment services for individuals with mental illness.

Moving Forward

By completing a thorough assessment of individuals who are currently receiving services within the current system, and what is it they are receiving, APS provides the state with new and powerful information. After reading Chapter VI it becomes evident that there are great Gaps within Georgia's community system. While at first glance, penetration rates (the rate at which people in need of services are getting served) may seem acceptable by some standards, especially for those below 200% of the Federal Poverty Level, when examining for true utilization and specific services, the rates become more dismal. The Gap Analysis provides a baseline of information for the state to move forward with measuring their success in reaching their intended target population, and the information presents an opportunity for growth and expansion of services. In Chapter VII, the community analysis is expanded and focused on specific populations in need of specialized services.

CHAPTER VII: COMMUNITY SERVICES FOR SPECIAL POPULATIONS

In this chapter you will find an analysis of community based services for the following sub-populations:

- ❖ *Children, Adolescents, and Transitional Youth*
- ❖ *Adult and Youth probation and parole*
- ❖ *Older Adults and the Elderly*
- ❖ *Individuals That are Homeless*
- ❖ *Individuals with Co-Occurring Mental Health and Substance Abuse*
- ❖ *Individuals who are Deaf/Hearing Impaired*
- ❖ *People with Limited English Proficiency (LEP)*



Highlights of significant findings in this chapter include:

- ❖ *Transitional Youth (ages 17-24), Individuals with Limited English Proficiency, Deaf and Hearing Impaired, and people with Co-Occurring disorders face significant barriers to accessing appropriate community services.*
- ❖ *For children and adolescents needing mental health services at any point in time there are approximately 1300 LOC children in DFCS custody in placement, and an additional 300 under the custody of DJJ.*
- ❖ *In Georgia's correctional population, 10.5% males and 26.8% females are classified as needing mental health services.*
- ❖ *Fifteen to 25 percent of older adults in the United States suffer from significant symptoms of mental illness, yet the Division of MHDDAD provided services to 5,254 individuals over the age of 65, comprising less than 1% of the total population served.*
- ❖ *It is estimated that nearly 10,000 homeless individuals are in need of mental health services across the state.*
- ❖ *Across the state there are 55,080 individuals with co-occurring disorders enrolled in services in FY04.*
- ❖ *Using the statewide percentage for prevalence of SMI or SED there are estimated to be between 2,900 – 4,600 individuals who are deaf and experience a mental illness.*
- ❖ *Latino's represent nearly 6% of Georgia's population, however only 2% of the public mental health system consumers enrolled in services were identified as Latino.*

One requirement for completion of the mental health gap analysis was to identify mental health services for populations that have unique or special needs including:

- Children, Adolescents, and Transitional Youth

- Adult and Youth probation and parole
- Older Adults and the Elderly
- Individuals That are Homeless
- Individuals with Co-Occurring Mental Health and Substance Abuse
- Individuals who are Deaf/Hearing Impaired
- People with Limited English Proficiency (LEP)

Across the state there are pockets of excellence in supporting the unique needs of individuals within each of these subcategories. APS Healthcare has identified unique needs and barriers for each population, and highlighted programs, or pockets of excellence in each of the populations that could serve as a model program or as a source of information for people across the state looking to provide similar services.

A. Children, Adolescents, and Transitional Youth

Children and Adolescents is getting some additional focus within the Division of MHDDAD because of the implementation of the Child and Adolescent Infrastructure grant, and the introduction of new services within the last several years which have encouraged growth in the system. Children and Adolescent services are a focus throughout the gap analysis, however in this section one program deserves recognition as a good model that can be replicated across the state.

The Metro MHDDAD Regional Office contracts to provide a comprehensive system of care titled: **ChAMPS: Child and Adolescent Multidisciplinary Program System of Care** – A system of care for children, adolescents, and their families who have unique emotional and behavioral needs. ChAMPS services are provided through contracts with 9 different service agencies – each with an expertise in one or many components that make up a comprehensive, integrated, community based system of care. The Georgia Parent Support Network provides oversight, monitoring and services for this collaborative, comprehensive child and adolescent system of care in Fulton County. ChAMPS services are detailed below:

- Assessment: Diagnostic Psychiatric Assessment provided at multiple locations
- Behavioral Aides: One-to-one supervision to address skill building and help to involve youth in community activities
- Day Support: Education, life skills, leisure and socialization training provided in supportive environments
- Day Treatment: Intensive therapeutic services
- Family Support Specialists: Family members provide ongoing support through education and support groups
- Flexible Funding: Special funding can be accessed for ‘whatever it takes’
- Fulton Family Resource Center: Identify community resources or appropriate placement for children and adolescents in state custody
- Inpatient Crisis Stabilization: Short term inpatient psychiatric stabilization
- Respite Care: Temporary therapeutic care for children and adolescents to provide support to primary caregiver

- Service Coordination/Team Workers: Coordinates array of services that are identified in the Individualized Service Plan
- Substance Abuse Treatment and Recovery: Intensive outpatient treatment and intervention program for adolescents ages 13 – 17
- Therapeutic Group Homes: Intensive supervision and therapeutic intervention for small groups of youth
- Therapeutic Foster Care: Community homes that provide stable, supportive environments for children and adolescents while keeping birth family involved as a support system

In addition to providing the services and supports as mentioned above ChAMPS partners with other community agencies to increase the continuity of care across all service delivery systems: Public Schools, Juvenile Justice, Family and Children’s Services, Juvenile Court, and Georgia Regional Hospital. As detailed in an earlier chapter in the ideal system of support for children and adolescents, ChAMPS represents an ideal blend of services offered to children and families within the Metro Atlanta region.

Transitional Youth

“We need more mental health services for youth, transitional youth and their families. Everything is either already full, or full to capacity and due to overcrowding the services are poor. We need a better substance abuse program in the area for youth who have moderate to severe dependencies, we need better services for adult youth (17-24).”
- Survey Respondent

One specific population that often falls between cracks is adolescents who are “aging out” of child and adolescent services, specifically residential facilities. At any point in time there are approximately 1300 LOC children in DFCS custody in placement, and an additional 300 under the custody of DJJ. These youth have been living with supports for most of their lives, and the minute they turn 18, their world changes. Adolescents do not yet have the skills needed to live independently, yet are no longer eligible for services as children. Adolescents ages 17-24 fit into a category of Transitional Youth – individuals who are transitioning from one set of services to another. These youth have increased risk of becoming homeless, because many times they have been isolated from their families and other supports.

For children who are aging out of the Level of Care (LOC) System (formerly MATCH) where they have most likely been in a residential facility or therapeutic foster home, a process is in place in which there are transition planning services provided. For many years community providers received calls the day before an adolescent turned 18 requesting services as soon as possible, and the adolescent often had no place to live once their birthdays came. The state created a state level work group made up of LOC providers /community providers, DJJ, DFCS, MHDDAD, and Rehabilitation Services staff to work on the issue. Meeting over several months the team developed a protocol to

help the transition of adolescents who would be ‘aging out’ so that they are identified when they turn 17. A regional staff liaison with DMHDDAD is notified and would coordinate all communication. In most regions this process is working, however staff liaisons often claim to be overworked with no time to focus on this issue.

Table VII-1 illustrates the extent to which Transitional Youth ages 17 – 24 were enrolled in services within the public mental health system served by MHDDAD.³⁹

TABLE VII-1: Transition Youth Ages 17 – 24 Service Utilization by Category

Day and Employment Services	Outpatient Services	Personal Living and Residential Services	Screening, Crisis and Outreach	Service Entry and Linkage	Substance Abuse Services	Total Unduplicated Consumers Ages 17 - 24
2,579	17,759	927	19,467	1,976	2,511	24,297

Additionally, Youth ages 17 – 24 received the following services:

- ❖ Nearly 4,000 were enrolled in Individual Community Support
- ❖ 1,269 enrolled in Consumer and Family Education
- ❖ 17,089 received Diagnostic and Functional Assessment Services
- ❖ 6,364 were enrolled in individual counseling services
- ❖ Over 10,000 received Nursing Assessments
- ❖ 13,800 were enrolled in Physician Assessment

As stated above, one of the primary issues affecting Transitional Youth are their lack of independent living skills. Looking at the # of youth ages 17-24 enrolled in Personal Living and Residential Services the number is extremely low: just 927 were enrolled in services in 2004. When looking at specific services within this category, even less are served: 100 enrolled in Skills Training and Supported Living, 114 enrolled in structured living group homes, 200 enrolled in structured living residential services, and 85 individuals enrolled in Independent Living Supports.

B. Adult Probation and Parole

“In Georgia’s correctional population, 10.5% males and 26.8% females are classified as mental health cases”
– State Board of Pardons and Paroles

The Adult Probation and Parole population is one that is very unique. Individuals who are on probation, or are being released on parole experience much greater difficulty in obtaining community services than those without any criminal history. However, through advocacy and dedication of many people throughout Georgia services targeted to probationers and parolees are improving.

³⁹ Data gathered from the Mental Health Information System Enrollment and Release Form for fiscal year 2004.

Mental Health Courts

Through an extensive advocacy effort, ***Treatment Not Jail!*** has become a reality for individuals with mental illness in several counties. For people with mental illness that commit low-level offenses, special programs within the court system have been established to divert offenders to treatment, and not incarceration. There are currently Mental Health Treatment Courts in several urban communities across the state: Muscogee County (Columbus), Macon, DeKalb County, Albany, and City of Atlanta. The Atlanta Community Court (ACC) is a division of the Atlanta Municipal Court that responds to “quality of life crimes”: prostitution, disorderly conduct, panhandling, and low-level drug offenses. The Atlanta Community Court, one of the most comprehensive community courts in the country, includes the following components: restorative justice, drug court, mental health court, homeless court, re-entry court initiatives, community re-development, family reunification, benefits procurement, and family court. Atlanta Community Court handles more than twice as many cases when compared to other Drug Courts, Mental Health and Alternative Sentencing Courts nationally. The ACC is committed to the dual principles of restorative justice and rehabilitation: restorative justice promotes the idea that with low-level offenses, the criminal justice system can better serve the community by using alternative sentencing options, such as community service to allow individuals “to give something back” to their community. Additionally, as an alternative to incarceration, community service allows the Court to move low-level offenders out of the criminal justice system, freeing up costly jail space for more serious criminals. At the first court appearance, defendants who have been identified as treatment candidates are referred to the Court's Psychological Specialists for assessment and treatment recommendations. When mental illness and/or substance abuse are identified as driving factors in an individual's antisocial or criminal behavior, the Court's case managers review community-based and in-custody treatment options, diverting individuals to resources that offer the best chance of success. The ACC takes a supervisory roll in the offenders' treatment plans through frequent review hearings, assertive case coordination with the Probation Division and the Restorative Boards, and when necessary, tough sanctions for non-compliance. The ACC maintains valued partnerships with multiple government agencies, and over fifty private and non-profit agencies, many of them Regional Board and United Way affiliates provide treatment services to the Courts' defendants. Since its inception, the Court has been able to divert 58% of treatment cases from incarceration to community treatment with the support and dedication of the network of providers.⁴⁰ After individuals are placed on probation, the Probation Division plays an important role by serving as a liaison to community providers in order to insure client accountability and support offenders in treatment programs.

Treatment and Aftercare For Probationers and Parolees

The Treatment and Aftercare for Probationers and Parolees (TAPP) Program is targeted to Adult Probationers and Parolees. The TAPP program is administered by the

⁴⁰ http://www.georgiacourts.org/courts/atlanta_community/programs.html#mental

Department of Human Resources, Division of MHDDAD. The DMHDDAD Regional Offices currently contract with a service provider within each region to provide TAPP services to more than 1,500 individuals across the state. A TAPP mental health professional in each of the regions acts as case manager to mental health offenders returning to that area. The special-need parolee then has a professional team of parole officer plus a mental health professional monitoring behavior and arranging ongoing community support⁴¹. The case managers' duties include the following:

- Arrange post-discharge treatment appointments
- Coordinate communication with parole and probation officers
- Provide linkage to the most appropriate community-based mental health treatment, vocational, residential, and support resources

There are several providers across the state that offer the TAPP program, one of which is also a Community Service Board. The program is funded both by the Division of MHDDAD and the Department of Corrections. The MHDDAD contributes more the \$1 million, where Corrections contributes \$250,000 annually to support the 7 contracts. The Division of MHDDAD provides oversight and training to the contracted providers, and works collectively with the Department of Corrections to review common customers and track who is moving between programs. The DMHDDAD works collaboratively with the DOC to project how many individuals will be released from prison each year and who will be in need of TAPP services. However, it is difficult to track the number served on any given day because there is a large amount of transition in and out of the program. During FY2004, TAPP served a total of 1,580 total consumers, with an average of 704 on any given day. This amount is extremely low for the larger group of probation and parolees, and even lower for the probationers alone. It is common for participation in the TAPP program to be a condition for parole, so that individuals may continue their treatment in the community. One group that is being underserved is those that have 'maxed out.' Maxed out refers to those individuals who completed their sentences, thus having no mandate to participate in the TAPP program.

Data extracted from the Statewide Mental Health Information System captures the number of individuals enrolled in the TAPP program. From the MHIS system, APS gathered that there are 1,558 enrollees within the TAPP program – not far from the 1580 reported by the Division of MHDDAD. Assuming that the data entered into the MHIS system is correct, APS analyzed the number of inmates released with a mental health diagnosis vs. the number of TAPP enrollees for fiscal year 2004. Statewide only 39% of individuals released from prison were enrolled in the TAPP program. Figure VII-1 illustrates a county breakdown of the number of releases who were served within the community program.

⁴¹ http://www.mayinstitute.org/about_may/map_of_locations/location_single.asp?id=138

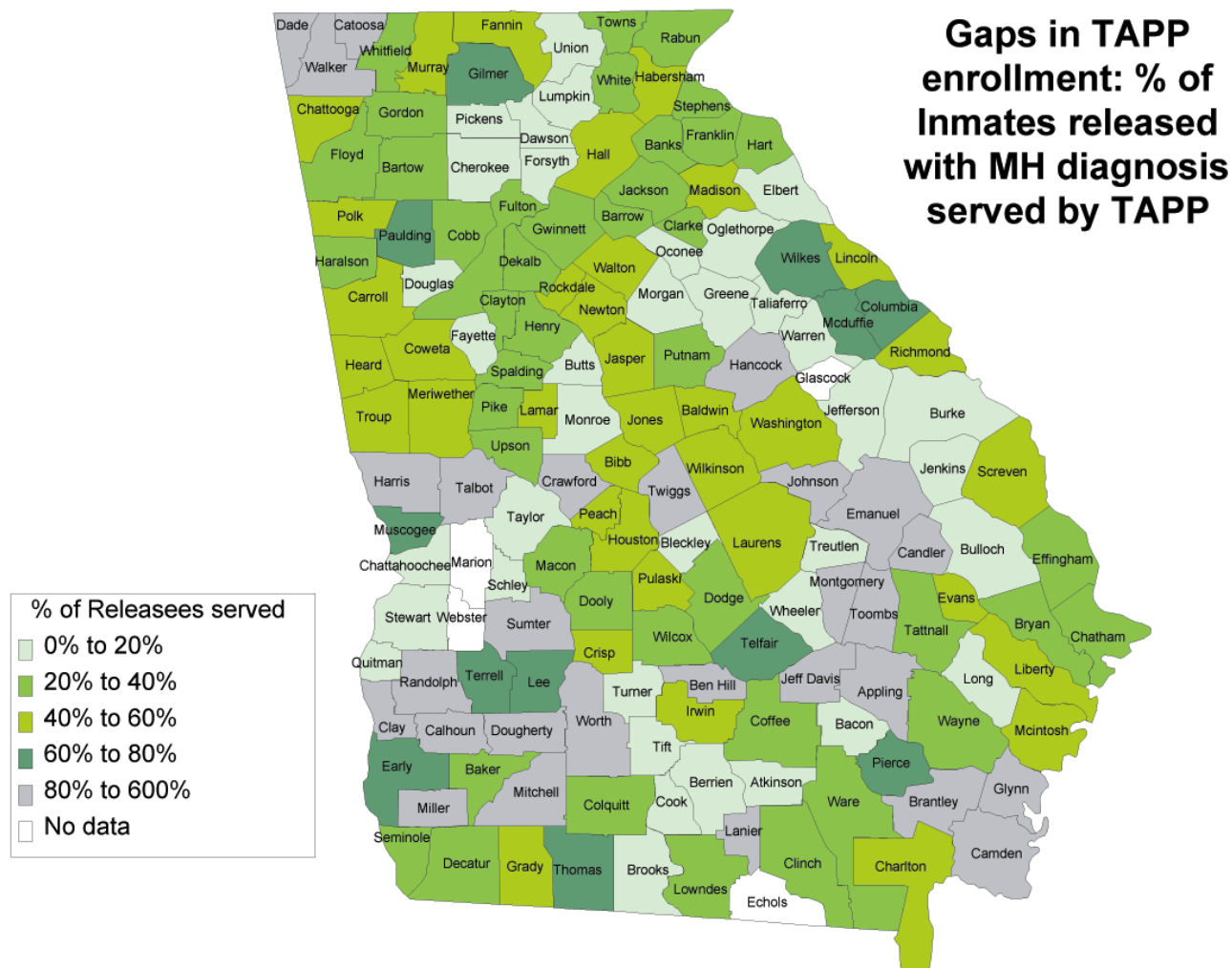


FIGURE VII-1

Additional Forensic Services operated by the Division of MHDDAD

The Division of MHDDAD operates forensic services within community and the state run psychiatric hospitals. In addition to the TAPP program, the Division has outpatient forensic teams stationed at each hospital site. The teams vary by hospital and by population, but they have between 3-5 Ph.D. level psychologists that work with the courts to assess individuals for mental illness. At times they may work on the inpatient forensic units at the hospital, but that comprises less than 5% of their time. The team members work primarily with adults, but do some work in the juvenile courts as well. The assessments for juvenile court are more of a general study and not a complete psychological exam.

If after the assessment individuals are found not to be competent to stand trial they are admitted to inpatient units for treatment where they receive services to improve their competency or if there is no improvement they may be committable to the state hospital indefinitely. The group of individuals who are committed is a growing population and is discussed in more detail in the hospital report.

The Division of MHDDAD has plans to start the operation of Forensic group homes in the community. There will be 7 homes opened – one associated with each state run hospital, with a maximum capacity of 6 residents each. For individuals that are currently in the state hospital and are being discharged – there are major barriers to obtaining housing and enough intensive supports. Most housing properties will not rent to people with criminal backgrounds, and the court systems will not release forensic patients until they have a stable place to live thus creating a challenging scenario. The DMHDDAD hopes that by opening state run group homes they will be able to support many long-term patients who have not had the appropriate community supports in place to support them.

Commitment Status of Individuals Enrolled in Community Based Services

The state has just begun to collect data on the commitment status of individuals who are enrolled in community-based services. Data collected from the first half of Fiscal Year 2005 (July 2004 – December 2004) indicates that 99% of service recipients are voluntary. Out of a total of 114,373 consumers enrolled in services in the first half of FY05, the table below indicates the number of individuals served by commitment status:

Table VII-2: Consumers Served by Commitment Type

COMMITMENT STATUS	NUMBER SERVED
Civil Commitment	528
Civil Probation	124
Clinical Evaluation Team – Court	79
Court Decision	491
DCYS Commitment	48
DCYS Probation	61
Juvenile Court Probation	179
Mandated Outpatient Treatment	283
Pre-Trial Decision	263
Prison Release (Parole)	365

C. Older Adults and the Elderly

My impression is that seniors who have mental health problems are not a priority, although people with severe mental illness who are growing older are served. Many seniors who need mental health services are unlikely to visit traditional mental health facilities.

- Survey Respondent

Fifteen to 25 percent of older adults in the United States suffer from significant symptoms of mental illness. Persons over 65 years of age represent approximately 12 percent of the total population of the United States, yet they account for over 20 percent of the suicides nationwide. Despite these statistics, fewer than four percent of individuals treated in mental health centers nationwide are over 65. And, less than 1.5 percent of the

direct costs for treating mental illness in this country are spent on behalf of elders living in the community.⁴² Reviewing the prevalence figures for older adults, the figures are actually lower for individuals over the age 65 who have SMI, however anecdotally we know that older adults do suffer from increased depression as loved ones pass, and other life changes create stress. We know from community members that older adults with mental illness have a harder time accessing services due to their mental illness. And there are multiple systemic barriers when a person with mental illness grows older and begins to experience dementia or other organic brain disorders as they may no longer qualify for mental health services. During FY 04, 5,254 individuals over the age of 65 were enrolled in services provided by the Division of MHDDAD, comprising less than 1% of the total population served.

The Division of Aging within the Department of Human Resources has the responsibility of providing services to individuals who are aging and offers a plethora of supports and services targeted to individuals across the state through many different programs. However, at the state level there are two programs that are geared specifically to older adults with mental health issues: SPRINTD and the partnership with the Fuqua Center at Emory:

SPRINTD – Specialty Providers in Teams for Dementia Care

Specialty Providers in Teams for Dementia Care is a grant with the Rollins School of Public Health at Emory University. SPRINTD addresses ways in which caregivers handle disruptive behaviors to people for whom they provide care. This helps delay people going into Nursing Homes because their caregiver could no longer deal with the stress of supporting someone. The program teaches caregivers new ways to provide support and intervention and so they don't get burned out. The training also helps caregivers understand that this is not behavior focused on them but rather is the disease process resulting in the challenging behaviors.

Fuqua Center for Late-Life Depression – at Emory University in Atlanta

The Fuqua Center is focused on improving access for older adults to treatment for depression and improving public awareness and understanding of depression in older adults in order to de-stigmatize and eliminate discrimination associated with mental illness.⁴³ The Division of Aging partners with the Fuqua Center to provide supports to older adults with late-life depression and to provide training for staff about late-life depression. Training has been provided to help care coordinators know how to talk with someone about depression and suicide, and what type of intervention may be provided. Additionally The Fuqua Center provides a variety of clinical services for the older adult. These include [outpatient services](#), [community clinics](#), [group therapy](#), [referral services](#), and telemedicine services.

⁴² These facts were extracted from a literature review conducted by the American Psychiatric Association, 1998

⁴³ <http://www.emoryhealthcare.org/departments/fuqua>

D. Homeless Mentally Ill

In 1996, it was estimated nationally that 637,000 adults were homeless in a given week. In the same year, an estimated 2.1 million adults were homeless over the course of a year. However, discerning exactly how many people are homeless in Georgia and who are in need of and receive mental health services is extremely difficult. The transient nature of individuals who are homeless leads to inconsistent data collection across the multitude of agencies that provide support to this population.

- The Division of MHDDAD information system for FY05 reports that 1,799 public mental health service system enrollees were homeless, or listed a shelter as their primary residence. However, the majority of these fields are not populated, so 1,799 out of 26,647 of those entries that were populated equates to 6.7% of the population enrolled in services as Homeless.
- From PERMES reports, which are sample surveys that are completed by consumers, the DMHDDAD reports regional percentages of homeless consumers from the samples that can then be applied to the greater numbers.
- The statewide information system tracking homeless individuals, titled “Pathways” collects information on homeless individuals throughout the state, though the primary focus is on the metro Atlanta area
- Reports from providers of PATH services report that they served 733 homeless clients during FY03 (the most recent year statistics were available)
 - o However reports to the federal program administrators report that there were 1,623 homeless clients enrolled in services during FY03

All of these differing methodologies for determining the number of homeless mentally ill served by the public system is evidence that there currently exists no exact way to calculate the total. Using one of the methodologies noted above, the PERMES surveys and sample results, APS predicted the number of homeless people served per region by applying the sample size percentage of homeless to the total number served as seen in **Table VII-3**.

TABLE VII-3: Estimation of Number of Homeless Individuals Served per Region

Central Region	East Central Region	Metro Region	North Region	Southeast Region	Southwest Region	West Central Region
1,228	789	3,427	1,156	1,004	712	1,189

Using this methodology the statewide percentage is 5.5% of all consumers are homeless, with regional variance across the state.

The Federal PATH Program in Georgia

Georgia receives federal funds in the amount of \$698,000 matched with \$512,380 state funds for a total of \$1.2 million to support the PATH program to serve persons who are homeless and have a mental illness throughout the state. Federal funding is based on a census formula. PATH funds are contracted through the DMHDDAD to provide

services. During FY2003 1,726 received services, and a total of 830 enrolled in the PATH programs, agreeing to ongoing treatment. Georgia's Path program primarily serves adults:

- 20% between 18-34 years
- 56% between 35-49 years
- 21% 50-64 years
- 2.6% over 65 years

Less than 3% of the clients served were over the age of 65 indicating that this population is even harder to reach than others. The majority of the clients fall between ages 35 – 49, however nearly one fourth are between 50 – 64 years. 70% of PATH clients are African American, making up a disproportionate amount of the population. 22% of PATH clients are white, while only 7% were of Latino background. However, serving 7% Latino clients, PATH serves a higher percentage than the total MHDDAD system (3%).

PATH programs are operated by the following providers within Georgia:

- Albany Advocacy Resource Center
- Central Fulton Community Mental Health Center at Grady Health System
- Community Concerns, Inc
- Community Friendship, Inc.
- Homeless Authority of Savannah
- Integrated Life Center, Inc
- MaySouth
- New Horizons Community Service Board
- River Edge Behavioral Health Care
- St. Joseph's Mercy Care Services
- Peer to Peer outreach
- MHP in homeless services

From the FY2005 Federal Budget - Funding for the PATH grants supporting mental health services for homeless people is expected to grow to \$55 million, an increase of \$5.5 million from FY 2004.

In addition to the PATH program operated by social service organizations throughout the state, there are other programs operated under the umbrella of the Department of Community Affairs (DCA). DCA is the lead housing agency within the 149 counties and administers the Section 8 program as well as the Shelter Plus care program. Both programs offer subsidized housing for people with low incomes. Shelter Plus care is specifically targeted to individuals with special needs such as mental illness or older adults who may be at risk for homelessness. The use of Shelter Plus Care housing subsidy to support individuals with mental illness is expanding with a partnership between Must Ministries in Marietta and the Cobb/Douglas Community Services Board. Services are delivered to individuals within the community setting, in this case their own apartment.

PATHWAYS

Congress has ordered the U.S. Department of Housing and Urban Development to make sure that each community across the country has implemented a system to:

- Provide an unduplicated count of people who are homeless
- Quantify use of homeless services
- Measure the effectiveness of their local homelessness assistance systems

In Georgia more than 160 homeless service organizations across the state are now linked through the state's Homeless Management Information System (HMIS) titled PATHWAYS⁴⁴. PATHWAYS is designed to compile data on homeless clients, has the ability to generate an unduplicated count of homeless persons across jurisdictions, calculates shelter turnover rates, develops client profile demographics, documents service use patterns, and details project and program outcomes over time. PATHWAYS also allows case managers to more effectively plan for the delivery of services, evaluate the appropriateness of the service based upon outcomes, and ultimately decrease duplication in service delivery. However, with the rapid increase of use of the system the training for its users has not maintained pace: critics site unqualified volunteers entering information into the system, making judgments on mental health assessments, and about substance abuse disorders. The users may not be skilled in assessment since many organizations are small volunteer shelters that don't have the education or experience to assess clients for the presence of mental illness. Additionally, for some shelters that don't receive state or federal funds, they have no mandate to use the PATHWAYS system, so consumers are not included in the statewide figures.

SAMHSA and the National Resource Center on Homelessness and Mental Illness offer suggestions for engaging the homeless mentally ill population in treatment and providing supports:

- Most can be voluntarily engaged or re-engaged in treatment, housing, and support services. Mobile outreach can provide access to basic services, treatment, and housing.
- Integrated mental health and substance abuse treatment delivered by multidisciplinary mobile treatment teams can reduce symptomology and improve functioning in the community.
- Providing supportive services to people in housing has proven effective in achieving residential stability, improving mental health, and reducing the costs of homelessness to the community.⁵

E. Individuals with Co-Occurring Mental Illness and Addictive Diseases

“SAMHSA's 2003 National Survey on Drug Use and Health shows that 27.3 percent of persons 18 and older in the past year with serious mental illness used an illicit drug. In

⁴⁴ <http://services.pcni.org/>

2003, the survey also found that 5.7 million persons ages 18 and over with serious mental illness engaged in binge alcohol use and 1.9 million were heavy drinkers. Overall, the survey showed that about 4.2 million adults aged 18 and older met the medical criteria for both substance abuse and mental illness.”⁴⁵

At the national level, SAMHSA is conducting research on and trying to support the expansion of programs that treat co-occurring mental health and substance abuse disorders. Information is being developed and distributed in “Tool Kits” on how to implement effective treatment programs for this growing population. Additionally, SAMHSA is working with the CMS (federal Medicaid agency) on how to use existing reimbursement mechanisms for services to people with co-occurring disorders; and convened two National Policy Academies on Co-Occurring Disorders to help states and communities enhance service capacity to this population. Georgia has conducted its own research on treatment of co-occurring disorders and adopted policies to support best practices in services: **GEORGIA MHDDAD BEST PRACTICE SUGGESTIONS PRINCIPLES AND STAFF CAPABILITIES FOR DAY SERVICES FOR ADULTS WITH COOCCURRING DISORDERS**⁴⁶ developed in conjunction with the Technical Assistance Collaborative. The report suggests that treatment for co-occurring disorders be integrated within the treatment plan and that staff should have additional credentials to provide the necessary supports. A full version of the report is attached as **APPENDIX VII-1: BEST PRACTICE SUGGESTIONS PRINCIPLES FOR COOCCURRING DISORDERS**.

In Georgia there are thousands of individuals that are currently enrolled in services that have a co-occurring mental illness and addictive disease. If the national percentage of 27.3% is applied to the statewide prevalence figures for adults with mental illness (348,040) the total number of individuals with co-occurring disorders is estimated to be 95,014. Additionally, one can examine the number of individuals with co-occurring disorders enrolled in services to understand how many people Georgia is serving. The following table represents the number of individuals with co-occurring mental illness and substance abuse as a primary disability or a secondary disability, broken down by region.

TABLE VII-4: Individuals with Co-Occurring mental illness and substance abuse enrolled in services within FY04

East Central Region	Metro Region	North Region	Southeast Region	Southwest Region	West Central Region
5,476	11,626	14,290	9,622	5,688	8,378

Across the state there are 55,080 individuals with co-occurring disorders enrolled in services in FY04.⁴⁷ These figures can be misleading however due to the subjectivity and definition of substance abuse: sources from the Division of MHDDAD and community providers believe that any consumer having any history of drug use are given a substance abuse diagnosis and would be included in these numbers. Additionally, it is challenging

⁴⁵ <http://www.oas.samhsa.gov/nhsda/2k3nsduh/2k3Results.htm>

⁴⁶ http://www.tacinc.org/cms/admin/cms/_uploads/docs/GAbestPrac.pdf

⁴⁷ Figures were extracted from the EARF reporting system within MHDDAD.

to determine what services are being provided to these individuals, as not all substance abuse providers do not use the MHMRIS system to capture encounter and service data.

Within the state there are several programs that integrate treatment for mental illness and substance abuse disorders. For the purpose of this report we will focus on several programs.

GATEWAY

One of the exemplary programs within the state of Georgia treating co-occurring Mental Health and Addictive Disease is the Gateway Dual Diagnosis Community Residential Treatment Program, out of Southwest State Hospital (SWSH). Gateway Dual Diagnosis Program was created from 20 beds of the Regional State Psychiatric Hospital in Southwest Georgia. It became a community residential program in 1996 and meets the needs of consumers with dual disorders (mental health and addictive diseases). Gateway's unique service delivery system interfaces with the service delivery system of the 24 rural counties in the Southwest Region of the state. The program is a model program that offers a multi-model treatment approach that includes conventional psychotherapy, psycho-education, case management, activity therapy, self-help, skill building classes, and training in relapse prevention. Outcome data supports the efficacy of its treatment approach by lowering subsequent hospitalization. Features of the program are listed below:

- A unique treatment model that integrates both psychiatric and substance abuse services and interfaces with community services, including self-help groups and a dual case management system
- Consumers elect program representatives and conduct a daily and nightly group to review issues of the milieu
- Received numerous positive appraisals from consumer groups and accreditation organizations (e.g., JCAHO, CLIP, GAO)
- SWSH received special funding by taking funds out of the hospital's budget.
- Used Dennis Daily's work from Hazelton catalog, clinical program, since 1996: education modules on coping with various mental illnesses and addiction, including personality disorders and behaviors that are self-defeating.
- Serves Adults (18 years and older)
- The two Single Point of Entry (SPOE) vendors conduct the admissions to the program. SPOEs receive referrals from agencies and all paperwork is gathered within a couple days and approved/denied. People who are in a crisis bed or hospital bed get priority admission status.

Gateway's outcomes have fared considerably better than those in programs treating just mental illness or addictive diseases. The integrated treatment has a favorable impact on re-hospitalization rates (e.g., lowering such rates) in the rural counties of South Georgia. Additional findings include:

- Dual case management and a special team of community treatment/case managers

(entitled “Next Step”) for aftercare has a favorable impact on recovery, especially with the limited resources in a rural catchment area

- Consumer empowerment is an essential component of the Gateway experience; consumers are generally satisfied with the various Gateway services available
- Volunteers are a key component of the program’s success

Since the initiation of the Gateway program the staff and administrators have developed several lessons and things to be considered in the development of a rural dual diagnosis program. Issues of importance are:

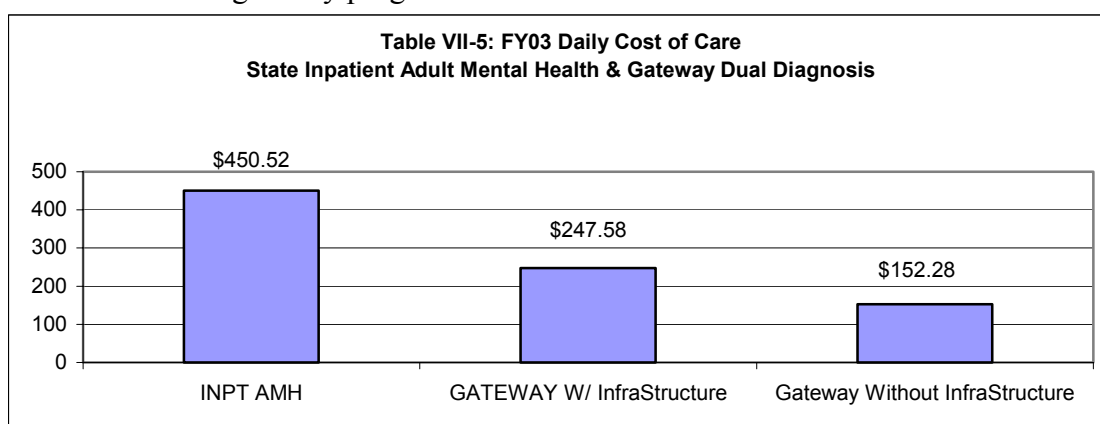
- Understanding the integrated approach to treatment with rural counties.
- Research data to demonstrate a decrease of State Hospital admissions following dual diagnosis treatment.
- Identify funding streams and available resources to obtain certification for addiction counselors for rural areas.
- Cost containment strategies with oversight by provider (comparison of Gateway’s cost vs. State Hospital’s cost per diem).
- Competence, cross-training and cultural sensitivity of staff who must have knowledge, skills and experience with dual diagnosed consumers from rural communities.
- Development of regional dual diagnosis training and credentialing for rural behavioral health providers. Working with regional colleges to provide training for interns/students and providing professional dual diagnosis training.
- Managed care and utilization review of services to manage costs of providing specialized services through a regional admitting authority. Authority controls approval for admissions.
- Funding stream through redirecting of hospital funding into a community budget.
- Explore creative ways to provide services to rural counties, including the creation of an intensive case management service for the dually diagnosed called “Next Step.”

The staff at Gateway are constantly training staff and trying to stay “cutting edge” with best practices. Other strengths about the program follow:

- Hospital advocate is a strong unofficial member of the program and treatment teams.
- Gateway staff attempt to determine and address why the program does not work for some
- Use of Dialectical Behavior Therapy for those with Borderline Personality Disorder
- Building is very different from the rest of the hospital; it “feels” different there.
- Consumers are given voice in the program and how to make it better.
- Alliances are/have been built with all programs and supports, including AA
- Weekend is typically leisure activities but sometimes family therapy is conducted for those whose family can only come at those days.

- Use and implementation of the GEORGIA MHDDAD – BEST PRACTICE SUGGESTIONS, PRINCIPLES AND STAFF CAPABILITIES FOR DAY SERVICES FOR ADULTS WITH CO-OCCURRING DISORDERS

Gateway does not generate revenue, however it has shown that it is cost-effective and has better outcomes than traditional treatment that does not treat both disorders simultaneously. The following chart illustrates the differences in cost of care of inpatient mental health and the gateway program.



Double Trouble in Recovery

The self-help movement has been gaining greater recognition for its value in helping people make positive changes and get support. Alcoholics Anonymous (AA) was the first organized self-help program to bring attention to the importance of individuals with similar issues who can provide each other with mutual support and solutions. AA started over 65 years ago and has helped millions of individuals to improve the quality of their lives. Because of the success of AA, many other self help groups have started using the same philosophy of self-help. An example is Double Trouble in Recovery (DTR). DTR is a self-help group based on the twelve steps of AA. DTR is unique because it is a self-help group for those who live with both mental illness and addictive diseases. DTR provides mental health consumers, who have a history of substance abuse, with an environment of acceptance and empathy that may not be available at other traditional 12-step groups that deal only with addictions, such as AA or Narcotics Anonymous (NA). Some mental health consumers may not be accepted or understood at AA or NA because of stigma, and the lack of education about mental health issues among its members. Also, members of AA or NA may feel that because a mental health consumer is taking medication, to remain stable, that the mental health consumer is not clean (without drugs in their system) or sober (in a sound state of mind). Stigma, stereotyping, and insensitive comments can make a person who is dually diagnosed feel disconnected to a group, even though they came to it for support.

Double Trouble in Recovery was introduced to the Atlanta metro area in 1996, for the homeless, so they would have a place to go during the Olympics. DTR was added to the drop-in centers shortly thereafter. Double Trouble originated in three churches in the

Ponce de Leon area of Atlanta, and became known as the Ponce Project. The Ponce Project is under the umbrella of the Georgia Mental Health Consumer Network. Since 1997, Double Trouble has grown by leaps and bounds and the project is expanding to include Dekalb County). At this time, there are twenty-three DTR meetings in the Metro Atlanta area, and serves between 900 and 1200 people each month. The facilitators of Double Trouble are also dually diagnosed; implementing the benefit of one dually diagnosed person helping another. All facilitators have between 3 to 22 years in recovery and are encouraged to take care of their mental health and work on their own personal recovery. Many of the facilitators are in fact former and current participants in the project. The current project director is a graduate of the program while another graduate has been hired to lead a statewide project to educate consumers on the Wellness Recovery Action Plan and is creating Wellness Communities.

In June of 2004, Georgia State University conducted a survey, on the effect of the Ponce Project on its participants. According to their research, 76% reported they were using substances less, 88% felt the project helped them focus on personal recovery goals, 91% agreed that DTR helped them deal better with stress in their life, 85% agreed they were becoming more stable, 74% felt better able to handle crisis, and 80% reported taking their psychiatric medications more regularly and felt better about themselves. Although DTR is taught in the Certified Peer Specialist training, metro Atlanta remains the only area in Georgia where DTR groups are available in the community.

F. Individuals Who are Deaf or Have Hearing Impairments

***“It can take a month to get an interpreter for deaf clients, leading to a delay in accessing care.”
– Focus Group participant***

Just as with other specialized populations, determining the exact number of individuals who are deaf or experience hearing loss is no easy feat. There are multiple resources that site the prevalence of deafness and hearing loss within the United States. According to the National Center for Health Statistics report in 1990 and the 1991 National Health Interview Surveys, .55 to .88% of the general population are deaf as defined as having occurred in childhood and rely primarily on visual rather than auditory signals for communicating. This translates to an estimated 46,000 – 73,000 deaf Georgians based on recent census figures for the state population, 50,000 of who use American Sign Language. The figure catapults to nearly 500,000 who are hearing impaired. Using the statewide percentage for prevalence of SMI or SED this would estimate between 2,900 – 4,600 individuals who are deaf and experience a mental illness. Information collected by the state MHIS system does not include indication of whether or not individuals are deaf, or have hearing impairments so it is nearly impossible to identify a specific number who are receiving services. From the PERMES reports, between 7.9% - 16.7% report having some type of sensory impairment, which also includes vision impairments so this is not an accurate indication of deafness or hearing impairment either.

The State of Georgia commissioned a study on mental illness and hearing loss in 2002 and was conducted by the Georgia Council for the Hearing Impaired. This study found that “persons with hearing loss experience mental health problems at the same general rates as the hearing population.” The Georgia study concluded that up to 883 persons with severe to moderate hearing loss should be seen by the public mental health system, and would need significant communication accommodations. South Carolina researchers report “...individuals, who are deaf, like other individuals, are subject to a wide range of mental illnesses. They experience Axis I mental health disorders at virtually the same rate as the general population. For Axis II disorders and childhood behavior problems, the prevalence rates in the deaf population are significantly higher than for the population as a whole.”⁴⁸ Deaf people have the same incidence of schizophrenic illness as the general population.⁴⁹ 12% to 15% of the hearing population reports experiencing some form of psychological stress; this is low compared to 38.1% of the deaf population reporting psychological stress.⁵⁰ Additionally, research indicates that the rate of physical and sexual abuse among children who are deaf are extraordinarily high compared with that of the general population: 40 percent of the deaf population report having been sexually abused by the age of 16, compared with fifteen percent of hearing people.

There is a tremendous lack of resources available to assist individuals with mental illness who are deaf or hearing impairments. Historically, deaf consumers were either denied treatment, were treated in inappropriate settings, or the people treating them used inadequate methodologies. Deaf adolescents and adults remain isolated in state hospitals, without means of communication, often misdiagnosed and inappropriately treated. Reports from one Georgia provider indicate that individuals are routinely misdiagnosed due to barriers in communications: during a recent interview the provider recounts how an individual was diagnosed as Schizophrenic because he reported hearing voices, however when a proper interpreter was used it became apparent that he was hearing sounds and had some hearing level, and indeed was not schizophrenic. A variety of federal laws require public mental health systems to provide effective services to consumers who are deaf: the US Constitution, the ADA, and Section 504 of the Federal Rehabilitation Act of 1973 all require states to offer the same mental health services to all people who are deaf or hard of hearing as they offer to other citizens. In fact, service rates for Medicaid services using an interpreter are higher to adjust for the increased cost of providing appropriate services.

- Within Georgia there are several private therapists that work with people who are deaf and have mental health issues. One provider agency titled DAYBREAK, subcontracts with various agencies to provide support to deaf adults and youth. Some common issues seen by trained providers who routinely support people with hearing impairments include: Traditional Providers did not schedule interpreters for appointments despite consumers requests, and then wait times could be up to 2 months for an appointment with an interpreter

⁴⁸ www.state.sc.us/dmh/deafnatrpt.pdf

⁴⁹ <http://apt.rcpsych.org/cgi/content/full/9/2/95#SEC6>

⁵⁰ <http://mhdeafintl.gallaudet.edu/proceedings1/proc1keynote2.htm>

- Providers claim that they don't have any interpreters, don't have clients who are deaf, or even request that consumers cover the costs of their own interpreters.

The lack of interpreter services across the state has a huge impact on the quality of services that can be provided to individuals who are deaf with mental illness. The Georgia research report found that individuals who are seen within the public mental health system are typically accommodated with interpreting services, however in many areas of the state there are no registered interpreters. Often, people who have a mental illness find it extremely difficult to express their most personal thoughts and feelings to a therapist. Considering the lack of mental health professionals who know American Sign Language, it is just that much more difficult to communicate interpersonal feelings, emotions, and symptoms for someone who is deaf.⁵¹ In South Carolina their Department Of Mental Health hired a director of Mental Health Services for Deaf and Hard of Hearing Children to support the unique needs of individuals with mental illness who are also deaf. In addition, South Carolina requires every region within the state to have an interpreter or a clinician that can communicate using sign language so that individuals can receive treatment. A similar policy has been adopted in Alabama. Georgia has adopted a Limited English Proficiency and Sensory Impaired Client Services Manual that outlines the most current civil rights statutes, including the Americans with Disabilities Act, Section 504 of the Rehab act, as well as information on immigration reform and the official code of Georgia barring discrimination in the provision of services to anyone when using public dollars. However, until these laws are adequately enforced Georgians who are deaf will continue to face barriers to mental health treatment across the state.

G. Individuals with Limited English Proficiency

Georgia is growing more diverse everyday, and in multiple ways. In 2004, 71,104 Georgia households were identified as linguistically isolated, and unable to speak or comprehend English⁵². While Latinos are the fastest growing immigrant population within the state, Georgia is also growing its Korean, Indian, Laotian, and other refugee populations. In 2004 there were 767,595 Georgians that are foreign born, with the majority coming from Mexico, Germany, Korea, India and Jamaica. There was a 300% increase in the Latino/Hispanic population in Georgia from 1990 to 2000. For this report we will address all populations with Limited English Proficiency, however the focus will be on the Latino community and individuals speaking Spanish since the most research has been conducted on this group. In the Surgeon General's report on Mental Health: Culture, Race and Ethnicity, it was highlighted that there are striking disparities in mental health services for racial and ethnic minority populations. The report states that minorities:

- Are less likely to have access to available mental health services,

⁵¹ http://www.state.sc.us/dmh/focus2_2001.htm

⁵² The Melting Pot report released by the Georgia Office of Minority Health, Department of Community Health in collaboration with the National Center for Primary Care at the Morehouse School of Medicine 2004.

- Are less likely to receive needed mental health care,
- Often receive poorer quality care, and
- Are significantly under-represented in mental health research⁵³

This research report will be no different in underreporting the number of ethnic and minority consumers because of the difficult nature in which it is to track and find minority populations. This should be considered a limitation in the data available. According to the most recent census figures, Georgia's Latino population comprises 6% of the total population. However when looking at statistics on who is receiving services within the state, Latino's represent only 2% of consumers served in each region.

**Table VII-6: Consumers Enrolled by Race/Ethnicity and Region
For FY 04**

REGION	White	Black	Hispanic	Asian	Native American	Other	Unknown	Total
North	35,175	5,925	1,313	139	71	221	78	42922
	81%	13%	3%	0%	0%	0%	0%	100%
Metro	13,060	19,750	1,260	406	37	254	207	34974
	37%	56%	3%	1%	0%	0%	0%	100%
West Central	12,402	9,209	206	58	23	122	24	22044
	56%	41%	0%	0%	0%	0%	0%	100%
Central	9,552	8,106	137	62	24	55	43	17979
	53%	45%	0%	0%	0%	0%	0%	100%
East Central	9,290	7,285	204	64	28	82	44	16997
	54%	42%	1%	0%	0%	0%	0%	100%
Southwest	9,447	8,844	208	26	17	51	17	18610
	50%	47%	1%	0%	0%	0%	0%	100%
Southeast	14,836	8,449	359	51	23	106	38	23862
	62%	35%	1%	0%	0%	0%	0%	100%
Total	101,695	66,635	3,636	798	216	874	444	174,298
	58%	38%	2%	0%	0%	0%	0%	100%

97% of the consumers surveyed through the PERMES process listed English as their Primary language.

⁵³ <http://www.mentalhealth.org/cre/toc.asp>

The Latino Population and mental health services

Linguistic and culturally competent mental health services for the Latino community are clearly absent in the state of Georgia. The lack of bi-lingual, bi-cultural providers presents a challenge. The current structure for the delivery of services in Georgia is not conducive to serve this population.

- Survey Respondent

*Much of this section has been adapted from the research report **Latino Mental Health and Substance Abuse Services in Georgia** completed by Pierluigi Mancini, Ph.D. with the support of the Department of Human Resources, **APPENDIX VII-2: Latino Mental Health and Substance Abuse Services in Georgia**.*

Georgia's "...Hispanic and Latino population in Georgia grew by 300% from 1990 to 2000. According to the 2004 Current Population Survey, there are now over a half of a million Hispanic or Latino persons in Georgia, representing 6% of the entire population."⁵⁴ Georgia became the fastest growing Latino state with a 17% increase in the Latino population from 2000 to 2002 bringing the total to 517,000 identifying themselves as part of this community.

- According to the U.S. Census, Latinos live in all of Georgia's 159 counties
 - Georgia has 25 counties with a 3,000+ or 10% of Latino population requiring consumer outreach with full-time bilingual staff and agency forms in Spanish
 - Georgia has 34 counties with a 1,000+ or 5% of Latino population requiring agency forms in Spanish and interpretation services to be provided by DHR agencies
 - Georgia has 100 counties with under 1,000 Latinos or less than 5% of population

Additionally, the Bureau of Immigration, in January 2003 reported that Georgia had approximately 220,000 undocumented Latinos. Latinos in Georgia come from Mexico, Guatemala, Honduras, Nicaragua, Costa Rica, Panamá, El Salvador, Colombia, Venezuela, Ecuador, Perú, Bolivia, Paraguay, Uruguay, Chile, Argentina, Dominican Republic, Cuba, Puerto Rico, Spain and the United States. Cultural dimensions that may be shared by Latinos include language, common history, socio-economic status, present-time orientedness, religion (nearly 70% of Latinos are Catholic), education, and communication styles. It is important to consider this diversity within the population when categorizing a large group of 'Spanish speaking' or 'Hispanic' people into one ethnic group called Latino. Latinos are not a racial category and may, in fact, be of many--usually mixed--race backgrounds. Americans have been criticized for this; however researchers and the census continue to categorize individuals into this subset for

⁵⁴ The Melting Pot report released by the Georgia Office of Minority Health, Department of Community Health in collaboration with the National Center for Primary Care at the Morehouse School of Medicine, 2004.

their convenience. The majority of data sets are reported in this way thus allowing a certain extent of consistency so they will be used within this section and report.

Latinos face the same barriers to services affecting all segments of our society (e.g., rising costs, system fragmentation, limited access, shortage of facilities, and geographic segregation) in addition to a myriad of other barriers. However, Latinos face the additional barriers of culture and language differences, poverty, immigration status, and racism at the individual, institutional and systemic levels. There are many destabilizing aspects of social adaptation in the United States for Latinos; they are a rapidly increasing population; residentially segregated; affected by shortfalls in educational attainment; waking up in a new country with a new language, and new medical, political, social, legal, financial, and educational systems. The legal status of immigrants was the number one barrier to services discussed in the Latino focus group that was hosted for the gap analysis. Additional barriers for the Latino population include:

- Organizational barriers such as providers not offering linguistically and culturally appropriate services,
- Systemic barriers within the structure of the health care system – long forms and procedures, with language being the primary barrier.
- Stigma associated with mental health and addiction in the Latino community,
- Availability and distribution of available resources,
- Consumer's uncertainty about the established educational, social, financial and medical system in the United States
- Latino's beliefs in spirits or sins as reason for illness or hardship.

“There currently exist unacceptable and inexcusable disparities in the mental health status and accessibility to services for Latinos.”
- An advocate for culturally competent mental health services

Since language is a primary barrier to receiving services, many providers try to make do with a friend or relative as a ‘chance interpreter.’ Utilizing a chance interpreter is not appropriate since the interpreter does not have the proper knowledge and training of the subject matter or of interpreting itself. Additionally, individuals may not feel comfortable sharing emotions with others. There is no better solution to the language barrier than a bilingual provider. There is a tremendous crisis in our state today with a shortage of licensed or certified bilingual, bi-cultural providers. Studies reveal that there are few Spanish-speaking and Latino providers. One survey found that there were 29 Latino mental health professionals for every 100,000 Latinos in the U.S. population. For whites, the rate was 173 white providers per 100,000 (Center for Mental Health Service [CMHS], 1999). Lack of cultural competence within the mental health workforce continues to be a major factor in the misdiagnosis and labeling of those seeking services. Until there is a competent, bilingual workforce this will continue to be an enormous barrier.

Latinos are more likely to seek mental health services in primary care settings and faith communities, improving detection and care within the general health care sector and reaching out to faith communities is important. The Division of MHDDAD and its provider agencies should provide outreach and information to Primary Care Physicians and Community Health Centers where many Latino's may go for healthcare.

One of the recommendations from the Latino Mental Health Services Report was to create alternative mental health services and modify the existing mental health structure to recognize and respond to the cultural needs of Latinos. Several of Georgia's providers are doing just that. Within the metro region there are several programs that are targeted to the Latino community: CETPA (Clinic for Education, Treatment, and Prevention of Addiction), and North DeKalb Community Services Board. Within rural communities in Georgia there are several other programs: Alianza Familiar, Georgia Behavioral Health in Dalton; Georgia Mountains Community Service Board, and Satilla Community Service Board. Georgia Mountain's Latino Outreach program is centered in Gainesville, Georgia, approximately 50 miles Northeast of Atlanta. Gainesville is located in the North MHDDAD region where the Latino population has been increasing at an astronomical rate over the last 5 years. Georgia Mountains employs bi-lingual administrative staff who can answer the telephones and make appointments for individuals, in addition to a Latino Outreach worker. Additionally, one of the therapists at Georgia Mountains is bi-lingual so that appropriate services can be delivered to Spanish speaking consumers.

“There is a high population of Latino and other foreign-born residents in this area, but few providers offer bilingual services. The problems become more sever when the patient is of other than Hispanic origin and has limited English.”

- A Survey Respondent

Moving Forward

The state of Georgia is becoming more and more divers by the minute. In order to respond to the service needs of a changing consumer demographic, the service delivery system must adapt with changing times. The analysis of community services illustrates that the individuals with special needs do not receive the individualized treatment necessary to fully promote recovery. Many age groups are underserved: transitional youth, the elderly, and many others with special needs are nearly lost in the shuffle between service delivery systems. Georgia should consider adding more emphasis at all levels of the system to Cultural Competency and hiring staff that are representative of the diversifying consumer population, and also look to improve coordination across agencies serving common customers.

CHAPTER VIII: INVENTORY AND ANALYSIS OF GEORGIA'S PUBLIC, HOSPITAL-BASED MENTAL HEALTH SERVICES

Within this chapter you will find:

- ❖ *Availability of Current Hospital Services*
- ❖ *Hospital Capacity*
- ❖ *Population Currently Enrolled in Hospital Services*



Highlights of significant findings in the analyses of hospital services are:

- ❖ *It is an extremely simple task to get a court ordered admission to a state psychiatric hospital. This adversely influences the state's hospitals' statistics on every level.*
- ❖ *Georgia's psychiatric hospitals operate at an average 96.61% Occupancy Rate, over 10% more than the ideal capacity rate of 85%.*
- ❖ *The statewide median length of stay is 5 days indicating a significant need for crisis stabilization services to be more readily available either in the hospital or the community.*
- ❖ *The penetration rate based on total unduplicated counts of consumers served in Georgia's hospitals of total population is 2.09 compared to the national average of 0.62. Thus for every 1,000 Georgians, at least two will receive hospital treatment, more than 3 times the amount than the national average.*
- ❖ *State hospital 30-day readmission rates exceed the national average by 55%.*
- ❖ *While prevalence estimates indicate a greater need among females for mental health services, Georgia's hospitals provide treatment to 50% more males than females.*
- ❖ *As many as 28% of hospital discharges were not seen in the community at all during FY04, either before or after their discharge; 41% of all FY04 discharges were not seen in the community after discharge. The implication is that this group did not receive the continuity of care needed after leaving the hospital.*

The State of Georgia operates seven (7) hospitals through the Division of Mental Health, Developmental Disabilities, and Addictive Diseases, one in each of its seven regions. In FY 04, these hospitals served a total of 16,627 individuals. The hospitals are diverse in that there is not a consistent array of services offered at each hospital. This section of the Mental Health gap analysis focuses on the capacity of the seven (7) hospitals to serve different populations and provides a comparison to national benchmarks.

A. Availability of Current Hospital Services

Data utilized for the hospital inventories originated from two primary sources: MHDDAD Division level reports and data extracts from each hospital Behavioral Health

Information System (BHIS). Data extracts included a record for each hospital admission with associated diagnostic and demographic information and the type of unit in which the consumer was served. The resulting count of unduplicated numbers of consumers served in Georgia psychiatric hospitals (for FY04) was 16,627. Those with a dual diagnosis of mental retardation or addictive disease were not excluded if they received treatment in a MH bed during FY04. MH bed counts included Adult Mental Health, Forensic, Child & Adolescent Short-Term and Child & Adolescent Long-Term. Bed utilization in Med-Surg, Special Care/Long Term Care/Skilled Nursing Facilities and/or Mental Retardation units were excluded. Detailed extract reports can be found in Appendices VI-1-10.

Broad comparison data for the purposes of the analyses were available for FY2002 state statistics from the NASMHPD National Research Institute and from the FY 2003 CMHS (Center for Mental Health Services) of SAMHSA's National Mental Health Information Center (which is within the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services) Uniform Reporting System Output Tables. More current and more specific points of comparison were sought through a targeted survey of several southeastern states' psychiatric hospital systems. Like in other parts of this report, the states of focus for comparison are North Carolina, Tennessee and Virginia for their similarity to Georgia in geographic size and socioeconomic and demographic makeup.

Despite attempts to standardize data sets for the purposes of analyses, much variation was found in the manner in which data is tracked state to state and at the national level, as well as in the infrastructure through which different states' services are offered resulting in difficult-to-compare data. Coffey, Graver, et al, (2001) confirmed this in their research finding that the number of hospitalizations varies markedly by state entity.

The following analysis presents an inventory of hospital services, an assessment of hospital capacity, a review of utilization by age, gender, race and marital status, and the presentation of the extent to which hospital services respond to the prevalence of mental illness in Georgia.

Observations on Data Collection Methodology and Barriers

1. Defining terminology is lacking or used inconsistently. The RFP suggests a certain categorization by which hospital inventory data is to be analyzed, i.e. Child, Adolescent, Adult, Crisis Stabilization, Acute Care, Extended Care, and 23-hour beds. It became clear after initial research that these were not commonly used categorizations. When an initial survey was distributed seeking counts by hospital by these categories, there was confusion about "what does 'crisis stabilization' mean?" and "how is 'extended care' to be defined?" Other categorizations such as "acute care" created consternation as well, since a hospital bed is not fully dedicated as an acute bed, but is used based on need, i.e., someone of adult age, who might typically receive treatment in an Adult MH unit, for either acute care or long-term purposes or individualized need may receive that treatment in a C&A bed. Additionally, most hospitals tracked Child and

- Adolescent together, not separately, where the RFP had requested them separately. Ultimately, the resulting data from the survey were not usable, due to varying interpretations of the survey categories at the local level that skewed the final categorization of data making it non-comparable when compiled statewide. Thus, much of the analysis relies on a categorization of services by programs (cost centers), which are commonly tracked by the Division and hospitals, rather than the suggested types in the RFP. However, the analysis does include some very specific, non-comparative data on those categories, for which sources and data were limited, such as Extended Care (see below).
2. Reliable national benchmark data is limited and what is available, mostly through CMHS (Center for Mental Health Services which is within the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services) as a result of the Data Infrastructure Grant (CMHS's Uniform Reporting System created for a national Data Infrastructure Grant) and NASMHPD (National Association of State Mental Health Program Directors), lacks the robustness that is ideally desired from two major perspectives: 1) That national data available results from 2002 real data and is thus two years old in comparison to the Georgia data from FY 2004, and 2) that the Georgia hospital episode data available for analysis provided insight to many measures that were not comparable because they were either not tracked or not reported nationally. For more current comparisons, APS surveyed several southeastern states on their public psychiatric hospital utilization patterns, primarily for standard measures related to staffing ratios, occupied bed days (inpatient days of care), average client load, and lengths of stay. However, this still proved a challenge due to the various methods and terminology used by different states to track hospital utilization.
 3. Data collection at the state level by cost center versus by program unit at the hospital level didn't always seem to match. For example, initially using similar parameters for assembling data extracts, the count of hospital episodes for FY04 originally provided by MHDDAD at the state level, differed in total from the combined extracts obtained through each of the hospitals.

Observations Regarding Atypical Service Categories

Georgia's hospital system collects data regarding utilization based on program units in which treatment was provided. For reporting purposes these unit categories are also referred to as cost centers.

Hospital cost centers include Adult Mental Health, Forensic, Child & Adolescent Short Term, Child & Adolescent Long Term, Med-Surg, Special Care, and Mental Retardation. Almost all of the data available to APS in conducting this analysis was based on such categorization. APS was advised that for the purposes of the Gap Analysis, attention should be focused on the first four categories only.

However, because the RFP suggested other categories, such as Acute Care, Crisis Stabilization and Extended Care, the findings below pertain to these categories. Some

findings are simply pieces of information shared by hospitals in response to a survey query for data related to these categories and the balance is the result of data available from the hospitals' BHIS database system.

Acute Care

In their survey responses, hospital personnel noted that the categories as presented would result in duplicated counts – that, for example, the Adult MH category was not mutually exclusive from Acute care. It was suggested that data presented by a total unduplicated count for Children, Adolescent and Adult beds, and another unduplicated count Acute, Crisis Stabilization, Extended and 23-hour beds as well, from which the total of the first count should equal the total of the second.

However, upon receipt of the data, what occurred most frequently was a presentation of data that gave counts for the first part (Children, Adolescent and Adult beds) but zero counts for the second part (Acute, Crisis Stabilization, etc.) One hospital submitted bed counts for Acute/Crisis Stabilization/Adult MH combined, indicating perhaps that Acute care and Crisis Stabilization were the same treatment. Two other hospitals listed all their Adult MH bed counts as Acute care beds, but differentiated between Forensic and Non-Forensic and another two hospitals made the distinction in Adult MH bed counts between Acute and Extended Care.

Such differentiation in responses could be the result of several factors including, but not limited to, a lack of sufficient definitions for categories provided in the survey and that each hospital varies to some degree in the types of treatment provided which either limited or expanded their ability to identify counts with certain categories. Statewide, a total of Acute Care beds were submitted by the following categories:

Adult: 480
Forensic: 166
Child & Adolescent: 49

Extended Care

In the analysis of all FY04 episode data collected from each hospital, two programs were identified as either “Extended Care” or “Extended Care – CSH & SAV.” As a result of consultation with hospital and Division staff, these episode data are not considered to be reflective of psychiatric inpatient utilization related to C&A, Adult or Forensic Mental Health services, and were therefore not included in total counts and analyses that make up the primary hospital inventory and analysis report. For the purposes of this review, “Extended Care” and “Extended Care – CSH & SAV” are combined and simply referred to as “Extended Care”:

- ❖ There were 84 recipients of Extended Care in FY04
- ❖ Extended Care was not utilized by/provided to children or adolescents

- ❖ Extended Care was predominantly used by Central State Hospital, serving 57 of 84 recipients
- ❖ Despite one of the categories of data collection being “Extended Care – CSH & SAV,” Savannah served only 1 consumer in Extended Care during FY04
- ❖ Only one (1) recipient of Extended Care was between the ages of 18-24 and was served at Augusta. 49 recipients of Extended Care were between the ages of 25-64, and 34 were over age 64
- ❖ Only blacks and whites are represented in this population: 31 extended-care consumers were black (37%) and 53 were white (63%)
- ❖ 47 were female and 37 were male.
 - 17 black females (20%)
 - 14 black males (17%)
 - 30 white females (36%)
 - 23 white males (27%)
- ❖ This utilization pattern differs from the statewide categorization of consumers in hospital mental health services by race and gender:
 - Black females – 15%
 - Black males – 27%
 - White females – 24%
 - White males – 34%

Crisis Stabilization

The Division of MHDDAD has twice removed funding from hospitals and transferred it to the community through the CSBs to provide crisis stabilization services. Thus it is

“Certain county CSBs would rather pay \$500 a day to keep patients in our hospital than take reasonable measures to serve them in the community.”
--Survey Respondent

truly not the hospitals’ role to provide crisis stabilization services. However, hospitals are still required to have emergency receiving operations. At the same time, there is no consistent infrastructure in place from region to region or CSB to CSB by which crisis stabilization services are accessed in the community and hospitals in turn continue to receive patients through emergency intake who could be received in community services. Some CSBs have inpatient wards; some use volunteer beds from private facilities, and others use transitional residential facilities (the latter for which there is skepticism about the appropriateness of there being both crisis stabilization and transition for discharged hospital patients provided in the same environment.) ***Exacerbating the issue, an estimated 70-80% of emergency admissions are for detoxification.*** A lack of sufficient interfacing and communication between hospitals and community providers is responsible.

In FY04, the statewide average of all Adult Mental Health discharges for consumers with a primary or secondary diagnosis of substance abuse was 45%. This discharge percentage was as high as 54.7% at East Central and as low as 33% at both Atlanta and Central State. The net effect was a drain on the hospitals resources, detoxification being a primary service intended for community crisis stabilization. Additionally, all analyses that look at hospital admission data, lengths of stay, etc., are skewed by this exorbitant percentage of admissions being related to substance abuse rather than psychiatric emergent needs. The hospital data extracts APS used did not allow for determining the exact percentage breakdown or for which of these admissions the presenting consumer had co-occurring diagnoses. In fact, based on APS's exposure to the BHIS data tracking system, this information is likely only available via patient paper files and not in the BHIS at all.

Division leadership encourages an understanding of the differentiation between the purpose and availability of 23-hour observation beds and crisis stabilization services. It is evident that there is not a clear understanding in the community or among the hospitals of the differentiation. The creation of additional community crisis stabilization units currently underway by the Division will certainly help to alleviate this problem, as treatment through crisis stabilization units is evidenced to a greater extent.

When surveyed, only one hospital specifically reported bed counts under the title Crisis Stabilization but it was presented combined with Acute Care and Adult Mental Health. Atlanta Regional did not specifically report out any bed counts under Crisis Stabilization, but in discussing 23-hour bed utilization, referred to consumers who utilized these beds as being "stabilized." The total count for both hospitals equals 62 beds, 52 and 10 respectively. The other five hospitals reported having no crisis stabilization beds.

Twenty-Three Hour Beds

Only Atlanta Regional uses 23-hour beds. The unit was created with 10 beds and began operation in September 2003. Twenty-three-hour beds are used for observational purposes only, not treatment, that can extend to 36 hours. Typically, a 23-hour bed is used for a "situational" crisis, i.e., to keep the consumer long enough for a situation to stabilize. While in a 23-hour bed, a physician assessment and other procedures are conducted for risk management purposes and to ensure health, safety, and readiness for discharge. A consumer's admission may be voluntary or involuntary. Following the observational period, the consumer may be discharged or recommended for admission for treatment.

Of all those served in 23-hour beds for FY04, the average time spent in the unit was 11.3 hours. The percentage of patients seen in the unit, stabilized and discharged was 63%. The percentage of patients seen in the 23-hour unit and admitted to the hospital to the Adult MH unit was 37%.

In addition to the data gathering and analysis, other initiatives or issues related to access to services and/or pertinent to increasing the system's capacity were shared for this report.

The tendency of the community providers to be hasty in seeking admissions to the hospital before completing a thorough assessment of needs was mentioned above. Similarly, some non-state hospital emergency rooms refuse to complete an adequate work-up before it processes one of the legal documents required to transfer an individual to a state hospital. This again ties to the ease with which Georgia code allows for an individual to be involuntarily committed. In fact, the Division estimates that over 90% of hospital admissions are involuntarily, although within a few days, many turn to voluntary. As a sample, Central State's admissions for FY04 included 837 for transfer from involuntary to voluntary, 1,692 who were transferred to an evaluation facility, 133 adults who were voluntarily admitted, 739 who were voluntarily admitted by a parent or guardian, 302 were involuntarily transferred from the Department of Corrections or from the juvenile justice system and 68 who were admitted for the first time under court order.

Both the Division and providers discussed the need for several solutions to inherent problems in the utilization of Certified Peer Specialists (CPS). Each hospital had only one designated CPS and could use more. Atlanta Regional Hospital had attempted to transport all discharged consumers directly to the community service center for their first community appointment, but only 20% actually entered the center when the van dropped them off. Additional CPSs could, for example, offer moral support and encouragement through escorting the patients to their first appointment, which might increase recovery outcomes and decrease readmissions. (Note: Feedback through the survey and focus groups indicated for example "3-hour waits for 6-minute appointments" with mental health center psychiatrists. This, too, would need to be corrected before a CPSs support could be effective in this manner.) The balance of employed CPSs needed to spend more time in the community, not in clinics with a revolving door of patients. Some CPS were still recipients of services themselves and there is an inherent conflict in providing Peer Supports to consumers of the same facility in which or through which the CPS's own services are being provided. Many CPSs had been trained and were not employed; yet there is a demand for good CSI (Community Support - Individual) staff in the community. Many believe CSI services would pay for themselves if enough CSPs were hired to provide thorough and adequate supports, but currently the caseloads are too high and thus the service could be viewed by some as ineffective. This is critical in the discussion of hospital services because additional consumer supports in the community would relieve hospital occupancy rates and decrease readmissions.

New opportunities and model programs are in effect that offers new methods for addressing the system's challenges. Technical colleges now have an approved curriculum for the purposes of training "Individual Support Professionals." Medicaid recognizes graduates of this curriculum and their work is billable and reimbursable.

Two model programs provide examples of best practice, the likes of which providers throughout the state could be encouraged to adopt. The Georgia Mountains CSB

provides residential services in a community apartment complex where CSI workers are placed on site during a large part of the day to provide general support, assistance with activities of daily living, and transportation to the consumers in the complex who are transitioning back or working to maintain their community placements. Georgia Mountains CSB also has the capacity for ambulatory detoxification treatment and both of these programs have resulted in lower readmission rates. This is a model program for how transition supports between the hospital and community should be provided that should be emulated across the state.

The Southwest Region has a model residential program specifically to support consumers with dual diagnosis post hospital discharge that could garner significantly positive results in highly populated areas.

Single Point of Entry contractors have not realized consistent efficacy across the state in decreasing inpatient admissions to the extent the Division intended. Some positive results have coincided with the advent of the 23-hour unit at Atlanta Regional so it is difficult to determine which variable had greater impact. Despite this, regional call centers that offer triage for those in need of services and through which face-to-face assessments can be conducted if needed are desirable in a consistent manner statewide as long as a decreased rate of admissions and appropriate diversions remain.

Certainly, the existence of appropriate and sufficient (programmatically and geographically) community treatment alternatives influences the ability of single point of entry call center representatives to appropriately divert callers. When appropriate, admissions to the hospitals should also be acceptable and supported through sufficient capacity. Further, for those consumers who tend to “bounce” between hospital and community treatments, a comprehensive and single record of their treatment plan should be in place. To meet these needs, the Division is working to redirect resources that will enable crisis stabilization, 23-hour observational units, and forensic unit services to be enhanced in targeted areas across the state. Additionally, the state is working to implement a data system that will allow for a centralized electronic record to exist for each consumer. Each record will incorporate both a comprehensive history of the consumer and a dynamic treatment plan that follows the consumer to all treatment settings.

“The standards of mental health care are all geared towards limiting the number of people in hospital beds as opposed to meeting a certain percentage of the need. For instance providers are fined money if they exceed [by] 10 people in hospital in a given day, but there is no reward or standard to say that if 20 people come in with acute paranoia that 15 of them must be given a safe place to be observed and have their medication changed and the others must be given assertive community treatment or supportive housing to allow them to be monitored during their acute phase.”

--Survey Respondent

B. Current Hospital System Capacity

INVENTORY OF HOSPITALS, UNITS/PROGRAMS, AND AVAILABLE BEDS

The State of Georgia operates seven (7) hospitals through the Division of Mental Health, Developmental Disabilities, and Addictive Diseases, one in each of its seven regions. The hospitals are diverse in that there is not a consistent array of services offered at each hospital. Capacity of each hospital in terms of total numbers of beds also varies.

The treatment units typical to the hospitals on a statewide basis for the purposes of this study are Child & Adolescent (C&A) Short Term, C&A Long Term, Adult Mental Health, and Forensic (including Maximum Secure, Secure With Holds, Secure Without Holds, and Forensic Inpatient). Note that the terms “unit,” “program,” and “cost center” are used interchangeably depending upon context and who is using the terminology (e.g. the Division tends to use “program” and “cost center”, where the hospitals tend to refer to “units.”) In this report, the terms “service” and “treatment” are also used. The RFP offered examples of types of service categories by which the hospital inventory and analysis were to be presented, however this report depends primarily upon the four categories above, largely due the limitations by which the hospital system tracks utilization data. The following table is presented to respond to the categories suggested in the RFP.

Table VIII-1: TYPES OF PROGRAMS AVAILABLE PER RFP CATEGORIES

FACILITY	CHILD	ADOLESCENT	ADULT	EXTENDED	CRISIS STABILIZATION⁵⁵	23-HOUR
Central State	YES	YES	YES	YES	NO	NO
East Central	NO	NO	YES	NO	NO	NO
Atlanta	NO	YES	YES	YES	YES	YES
Northwest	NO	YES	YES	NO	NO	NO
Savannah	YES	YES	YES	NO	NO	NO
Southwestern	NO	NO	YES	NO	NO	NO
West Central	NO	YES	YES	YES	NO	NO

The above indicators are based on individual hospital responses to a survey seeking numbers of beds in each category of treatment.

⁵⁵ Atlanta Regional did not specifically list their 23-hour beds as crisis stabilization beds, though they essentially function as such. Southwestern State Hospital reported the availability of “crisis stabilization,” however, it was cited as a catch-all category of “Crisis Stabilization/Acute/Adult MH.” Therefore, it Atlanta Regional Hospital’s 23-hours beds should be categorized as crisis stabilization beds, but Southwestern State’s should not.

Table VIII-2: FY04 EPISODES BY PROGRAM/COST CENTER

FACILITY	C&A SHORT TERM*	C&A LONG TERM	ADULT MH	FORENSIC	TOTAL BY HOSPITAL
Central State	990	0	1681	657	3328
East Central	0	0	2135	136	2271
Atlanta	783	0	2106	271	3160
Northwest	0	33	2812	283	3128
Savannah	305	0	1488	158	1951
Southwestern	0	0	1333	172	1505
West Central	0	35	1751	111	1897
TOTAL BY PROGRAM	2078	68	13306	1788	17240

*C&A Short Term defined by less than 30 days length of stay.

As mentioned above, the final count of unduplicated numbers of hospital recipients that populate the data extract upon which this hospital analysis is based is 16,627. The total duplicated count is 17,240: 2,078 in C&A Short Term, 68 in C&A Long Term, 13,306 in Adult MH, and 1,788 in Forensic. The difference between the total unduplicated and duplicated count of episodes is 613, representing an overall rate of multiple episodes for 3.7% of consumers seen in FY04. This figure does not capture admissions or discharge data for any year other than FY 2004. The Readmission Rates section below will review this in more detail.

A hospital bed count offers the most commonly used measure to define capacity. Georgia has 1,229 total beds, which are available and staffed for use. In terms of occupancy, this represents a capacity to provide 448,892 days of treatment (1,229 beds x 365.5 days). The designated 732 Adult Mental Health beds account for 60% of all available beds and Forensic beds (387) represent 32% of the total. Child & Adolescent beds combined for short and long term treatment account for 9% of all beds.

It is important to note, however, that a simple bed count does not often reflect the full story of capacity or utilization. Often, forensic unit occupancy overflows to Adult Mental Health beds, which in effect decreases the true capacity of Adult Mental Health beds. This is even more insidious in those hospitals that did not have a designated forensic unit at the time of this study, such as Southwestern.

Table VIII-3: FY04 AVAILABLE BEDS

FACILITY	C&A SHORT TERM	C&A LONG TERM	ADULT MH	FORENSIC	TOTAL BY HOSPITAL
Central State	28	0	148	130	306
East Central	0	0	95	52	147
Atlanta	28	0	120	90	238
Northwest	0	20	130	34	184

Savannah	14	0	69	35	118
Southwestern	0	0	65	6	71
West Central	0	20	105	40	165
TOTAL BY PROGRAM	70	40	732	387	1229

Available beds are budgeted and staffed beds.

The following table looks at how hospital beds were utilized. The following table represents the total count of duplicated episodes of care per program divided by the number of beds. One would expect by definition that bed turnover in C&A Long Term units would be low. In fact, during the course of FY04 each C&A Long Term bed was used 1.7 times. In comparison, a C&A Short Term bed was filled by almost 30 different treatment episodes and an Adult Mental Health bed turned over an average of 18.2 times during the year.

From the perspective of specific hospital rates rather than by program statewide, we see that Southwestern Hospital gets the most use out of its beds on average (21.2) whereas Central State has the least amount of turnover (10.9). The optimum rates of bed turnover both per program and per hospital are to be determined based on the DMHDDAD's hospital policies and treatment philosophies, and upon which treatment array each hospital offers.

Table VIII-4: FY04 AVERAGE EPISODES PER BED

FACILITY	C&A SHORT TERM	C&A LONG TERM	ADULT MH	FORENSIC	TOTAL BY HOSPITAL
Central State	35.36	0.00	11.36	5.05	10.88
East Central	0.00	0.00	22.47	2.62	15.45
Atlanta	27.96	0.00	17.55	3.01	13.28
Northwest	0.00	1.65	21.63	8.32	17.00
Savannah	21.79	0.00	21.57	4.51	16.53
Southwestern	0.00	0.00	20.51	28.67	21.20
West Central	0.00	1.75	16.68	2.78	11.50
TOTAL BY PROGRAM	29.69	1.70	18.18	4.62	14.03

Hospital Capacity

Determining capacity, and moreover excess capacity, has been a challenging and sore subject in the hospital industry. However despite initiatives to seek new methods and formulas for hospitals to consider capacity, most depend upon and believe that the occupancy rate is the most relevant measure and appropriate determinant.

In every hospital setting, regardless of type, there exist a number of beds that are either never used or used only to respond to fluctuations in need. Typical variations that effect a hospital's census include emergencies, and seasonal and weekend fluctuations. Hospitals may also retain excess, unused beds for future growth or even for the purposes of budget cuts in economic decline.

“The state hospital bed capacity is too low already. Adults with mental illness need a place to live so that their treatment has the greatest likelihood of success. Patients should not be discharged into the community with no resources, ...needing 24 hour watchful oversight—to protect both them and the ... public.”
--Survey Respondent

For private hospitals, the number of beds reserved to respond to such fluctuations is influenced by the hospital's policies regarding turn-away rates and admission delays. While all hospitals have to function in accordance with the Emergency Medical Treatment and Active Labor Act which prevents patient “dumping”, Georgia's state hospitals serve as the safety net for the most-in-need population who typically would not or could not be treated in private hospitals. Due to this virtual inability to turn consumers away, it is even more important for the state hospitals to keep some reserve of beds. Temporary staff is regularly utilized when additional beds need to be staffed; therefore staffing patterns fluctuate regularly as well. Nationally, an 85% average occupancy rate is believed to be the highest on average that hospitals should be expected to achieve (Schwartz). Similarly, the Division of MHDDAD staff relayed that state hospital administrators say that an occupancy rate above 85% becomes unmanageable and is an indicator of crisis due to stretched resources.

Table VIII-5: FY04 OCCUPIED BED DAYS AND OCCUPIED BED DAYS PER BED

FACILITY	C&A SHORT TERM		C&A LONG TERM		ADULT MH		FORENSIC		TOTAL BY HOSPITAL	
	OBD	OBD/ BED	OBD	OBD/ BED	OBD	OBD/ BED	OBD	OBD/ BED	OBD	OBD/ BED
Central State	9,438.0	337.1	0.0	0.0	52,675.0	355.9	44,472.0	342.1	106,585.0	348.3
East Central	0.0	0.0	0.0	0.0	36,955.0	389.0	21,448.0	412.5	58,403.0	397.3
Atlanta	6,845.0	244.5	0.0	0.0	38,873.0	323.9	32,209.0	357.9	77,927.0	327.4
Northwest	0.0	0.0	6,151.0	307.6	44,968.0	345.9	12,417.0	365.2	63,536.0	345.3
Savannah	7,715.0	551.1	0.0	0.0	27,565.0	399.5	11,334.0	323.8	46,614.0	395.0
Southwestern	0.0	0.0	0.0	0.0	21,239.0	326.8	6,645.0	1,107.5	27,884.0	392.7
West Central	0.0	0.0	5,720.0	286.0	32,483.0	309.4	15,407.0	385.2	53,610.0	324.9
TOTAL BY PROGRAM	23,998.0	342.8	11,871.0	296.8	254,758.0	348.0	143,932.0	371.9	434,559.0	353.6

The occupancy rate is determined by the total number of occupied bed days divided by the total capacity of beds days. Before even calculating the occupancy rate, the table above makes clear that hospital beds are on average regularly over capacity. For many categories, Occupied Bed Days per Bed exceed the 366 days in FY04. For example, the Occupied Bed Days per Bed for Adult Mental Health at East Central Hospital is 389,

reflecting that not only was each bed full for each of the 366 days in the year, but that overflow utilization required the use of additional beds.

Table VIII-6: FY04 OCCUPANCY RATE AND AVERAGE CLIENT LOAD

FACILITY	C&A SHORT TERM		C&A LONG TERM		ADULT MH		FORENSIC		TOTAL BY HOSPITAL	
	OCCUPANCY RATE	AVG CLIENT LOAD	OCCUPANCY RATE	AVG CLIENT LOAD	OCCUPANCY RATE	AVG CLIENT LOAD	OCCUPANCY RATE	AVG CLIENT LOAD	OCCUPANCY RATE	AVG CLIENT LOAD
Central State	92.1%	25.8	0.0	0.0	97.2%	143.9	93.5%	121.5	95.17%	291.2
East Central	0.0	0.0	0.0	0.0	106.3%	101.0	112.7%	58.6	108.55%	159.6
Atlanta	66.8%	18.7	0.0	0.0	88.5%	106.2	97.8%	88.0	89.46%	212.9
Northwest	0.0	0.0	84.0%	16.8	94.5%	122.9	99.8%	33.9	94.35%	173.6
Savannah	150.6%	21.1	0.0	0.0	109.2%	75.3	88.5%	31.0	107.93%	127.4
Southwestern	0.0	0.0	0.0	0.0	89.3%	58.0	302.6%	18.2	107.30%	76.2
West Central	0.0	0.0	78.1%	15.6	84.5%	88.8	105.2%	42.1	88.77%	146.5
TOTAL BY PROGRAM	93.7%	65.6	81.1%	32.4	95.1%	696.1	101.6%	393.3	96.61%	1187.3

Southwestern is the outlier at the high end for Forensics, with an Average Client Load of 18.2 for 6 beds affecting a 302.6% Occupancy Rate. Atlanta Regional experiences the lowest occupancy rate of any hospital program with 66.8% in C&A Short Term.

The statewide average occupancy rates and average client loads are presented in Table VI-6 by program and by hospital. The average statewide occupancy rate for four of five programs exceeds the 85% threshold. However, when considered by hospital, in four instances the occupancy rate actually exceeded 100%. This occurred most frequently in the Forensic Units at East Central, West Central and Southwestern.

Statewide on average across programs, only C&A Long Term falls below the 85% threshold with an 81.1% Occupancy Rate. Only two hospitals provide C&A Long Term treatment, Northwest and West Central, with Occupancy Rates of 84.0% and 78.1% respectively, both still below the 85% level. There are probably several factors that influence this, the most notable being the state's effort to keep children and adolescents with their families and only resorting to institutionalized care when absolutely necessary, therefore resulting in less demand. There are very few reasons that justify hospitalization for a child or adolescent—primarily when there is a risk of self-harm or harm to others or in cases of very serious illness. Otherwise, a hospital should not be considered “a placement” for children or adolescents. Another, perhaps less influential factor, is that since there are only two hospitals that provide C&A Long Term treatment, families may be less willing to place their son or daughter too far away from where they reside. However, if sufficient crisis stabilization units were available in the community, perhaps even fewer beds for Child & Adolescent Services, both short term and long term, would be needed, because parents and families would get the support they needed along the way to offset severe crisis.

While statewide reports from the Division reflect the above occupancy rates, they are based on a reported unduplicated C&A Long Term count of 51 consumers. However, the data source from the hospitals' BHIS extracts, displayed a count of 67 unduplicated consumers in FY04. For a different perspective, assuming for the moment that this was

the true FY04 unduplicated count, in looking at those 67 who were treated in the C&A Long Term units, their region of residence breakdown was:

Central – 5	Southeast -- 5
East Central -- 11	Southwest -- 5
Metro -- 12	West Central – 10
North -- 19	

Therefore, approximately 38 of 67 consumers were served outside their region of residence. That only two hospitals provide this service is perhaps the result of management initiatives such as budget reductions, administrative consolidation, and attempts to reduce administrative costs. It is uncertain whether demand would increase in total for the state if each hospital included a long term C&A unit. However, it is clear based on region of residence that there exists some level of demand per region.

With 67 unduplicated consumers in C&A Long Term, an estimated minimum occupancy rate is almost 92% rather than 81%:

The maximum number of bed days for FY04 C&A Long Term was 14,640 (366 days x 40 beds). The median length of stay, using the Division's data, was 363 days. So, half of the occupants had a length of stay of 363 days or more and the other half had fewer, but at least a stay of 30 days to warrant their placement in a Long Term unit. Estimating that the first half accounted for at least 12,432 occupied bed days (34 episodes x 363 days) and the second half for at least 1,020 occupied bed days (34 episodes x 30 days) for a total of 13,362 occupied bed days, the resulting occupancy rate is 91.3%.

Therefore, it could be argued that all units across the state, include C&A Long Term, on average exceeded capacity.

“Some of the hospital campuses have unused space that could be converted into dual diagnosis treatment units (ITR, Crisis) for adults and adolescents.”

--Survey Respondent

C. Population Currently Enrolled in Hospital Services

Demographic Characteristics of Consumers

By Age

Table VIII-7: Hospital Utilization by Age Group by Region of Residence

Region	Birth - 17	18-24	25-64	Over 64
Central	333	287	1459	120
East Central	275	378	1730	67
Metro	358	417	1901	26
North	424	548	2409	72
Southeast	278	269	1340	32
Southwest	126	238	1157	58
West Central	312	299	1484	35
Dept. of Corrections	0	82	141	0
Out of State/Country	13	91	510	11
Youth Detention Ctr.	13	2	0	0
Total	2,081	2,510	11,665	411

The above table represents the count of unduplicated hospital consumers by age by *region of residence*. Statewide, consumers aged 0-17 represent 12.5% of FY04 hospital utilization; Adults aged 18-24 represent 15.1%; Adults between the ages of 25 to 64 represent 70.2%; and older adults represent 2.5%. Southwest's youths are the fewest served and senior residents from the Metro are served the least. There is relative uniformity in the percentages of adults from each region who have been served by a state hospital: between 13% and 15.9% for adults between the ages of 18-24 and from 66% to 73% for adults between the ages of 25-64. Note that because the regions of residence of consumers who are transferred to hospitals for treatment from the Department of Corrections or Youth Detention Centers are not tracked, there are an additional 238 consumers who are not captured in these percentages; and neither are the counts of consumers who were listed as being from out of the state or out of the country.

Below is a count of consumers by age *by hospital*. The most significant variations are seen in the Birth-17 age group between region of residence versus the hospital in which they are served. Central State Hospital and Georgia Regional Hospital at Atlanta predominately serve the majority of children and youth with Georgia Regional Hospital at Savannah serving approximately half as many as either of those hospitals. Central State is the magnate hospital, serving a greater percentage of people in each age group than are residents of its region as compared to other regions. Georgia Regional Hospital at Savannah comes the closest to serving the same number of consumers in the hospital as those who reside in their corresponding region. Because Central State Hospital and Georgia Regional at Atlanta overall serve a relatively greater number of consumers than reside in their regions as compared to the other hospitals, we can conclude that a large

percentage of those whose region of residence was not identifiable are served in these facilities.

Other items of note related to age are that:

- 19 consumers below the age of eighteen were served in Adult Mental Health units, 14 of them from Georgia Regional Hospital at Savannah
- 18 consumers between the ages of 18-24 were served in Child and Adolescent units, with no single hospital (of those who did serve consumers of this age range in a C&A unit) demonstrating a significantly greater tendency to do so than another

Table VIII-8: Hospital Utilization by Age Group By Hospital Admission

HOSPITAL	Birth-17	18-24	25-64	Over 64	Total
Central State	995	403	1741	136	3267
East Central	2	380	1810	67	2257
Atlanta	779	430	1909	25	3134
Northwest	28	553	2433	70	3082
Savannah	315	250	1327	32	1919
Southwestern	0	244	1181	52	1474
West Central	33	305	1522	31	1887
Total	2,081	2,510	11,665	411	16,627

By Gender

Gender differences in the counts of total hospital episodes of care for FY04 by consumer region of residence are highlighted in the below table. Statewide, the split is 60% male and 40% female, though slight variations are seen from region to region. Therefore, 50% more males than females are receiving hospital treatment. The largest variation is in the Metro Region with 36% female and 64% male, and both East Central and North share the lowest split at 42% female and 58% male. Each region remains consistent in that there are always a greater percentage of males served than females.

Without considering county of origin, the percentage difference between genders rises slightly from 60% to 61.1% males on average statewide (see table below). This is probably due to a slightly higher rate of males being included in the counts of those for whom a county of origin was only identified as "Department of Corrections" for example. Central State, which provides treatment to the largest portion of forensic consumers statewide, also has the highest percentage of males, but only slightly higher than West Central and Southwestern.

Table VIII-10: Hospital Utilization by Gender (Percentage)

Hospital	Male	Female	Total	% Male	% Female
Central State	2,127	1,201	3,328	63.9%	36.1%
East Central	1,331	940	2,271	58.6%	41.4%
Atlanta	1,940	1,220	3,160	61.4%	38.6%
Northwest	1,855	1,271	3,126	59.3%	40.7%

Savannah	1,177	773	1,950	60.4%	39.6%
Southwestern	923	582	1,505	61.3%	38.7%
West Central	1,179	718	1,897	62.2%	37.8%
Total	10,532	6,705	17,237	61.1%	38.9%

For comparison, the gender split by hospital program is demonstrated below. Males still dominate the larger percentage in each category. A tendency in the community to equate violence with mental illness among males, coupled with the lack of 23-hour observation units and Forensic Unit capacity are significant factors in the higher male population. The most balanced split that aligns with the statewide breakdown of 60% Male, 40% Female is seen in Adult Mental Health, followed by Child & Adolescent Short Term Care. However, there is a significantly larger difference in genders among those served in Child & Adolescent Long Term Care with the number of males served 3.5 times greater than the number of females served.

Adult and Child & Adolescent

Adult Mental Health		Child & Adolescent Long Term Care		Child & Adolescent Short Term Care	
F	M	F	M	F	M
5380	7675	15	53	951	1073
41%	59%	22%	78%	47%	53%

Forensic

Forensic Inpatient		Maximum Secure		Secure with Holds		Secure without Holds	
F	M	F	M	F	M	F	M
17	134	41	570	154	566	35	270
11%	89%	7%	93%	21%	79%	12%	88%

By Race

Table VIII-11: Hospital Utilization by Race by Region of Residence⁵⁶

REGION OF RESIDENCE	Asian	Black	Hispanic	Native American/ Alaskan	Other	White
Central	6	1118	16	3	8	1043
East Central	11	1109	19	4	9	1293
Metro	39	1300	79	4	26	800
North	15	466	98	5	26	2840
Southeast	4	839	27	3	10	1031
Southwest	12	1086	31	3	7	880
West Central	9	863	15	0	13	1227
TOTAL	96	6781	285	22	99	9114
Percentage of TOTAL	0.59%	41.36%	1.74%	0.13%	0.60%	55.58%

Hospital service recipients are comprised of a majority of White consumers (56%). The second highest racial group represented among hospital users is Black with 41.36%. Those of Hispanic origin represent only 1.74% of hospital episodes. The Other category includes people who are categorized as “Other” or “Unknown,” as well as some who identified themselves as Multiracial or Native Hawaiian.

⁵⁶ Data includes duplicated counts of consumers for whom county of residence is unknown.

Table VIII-12: Hospital Utilization by Gender by Hospital

Region	Gender	Asian	Black	Hispanic	Native Amer/Alas	Other	White
Central	Female	5	433	7	1	4	421
	Male	1	685	9	2	4	622
East Central	Female	6	431	7	2	4	578
	Male	5	678	12	2	5	715
Metro	Female	15	460	37	2	5	302
	Male	24	840	42	2	21	498
North	Female	7	179	52	2	14	1205
	Male	8	287	46	3	12	1634
Southeast	Female	1	302	11	1	4	428
	Male	3	536	16	2	6	603
Southwest	Female	5	396	11	1	4	348
	Male	7	690	20	2	3	532
West Central	Female	3	301	5	0	5	501
	Male	6	562	10	0	8	726
Total	Female	42	2502	130	9	40	3783
	Male	54	4278	155	13	59	5330

The above table presents race utilization of hospital services by gender. Here a fairly large differential between the statewide percentages of Black females and Black males utilizing hospital services exists, with 171% more Black men being treated than women. The lowest differential is between Hispanic men and women, with 119% more men than women. In other racial groups statewide, more men than women were treated in hospitals by the following percentages: Asian-128%; Native American/Alaskan-144%; Other-147.5%; and White-141%.

Interesting differences that counter the normal trend can be seen in the Central Region among the Asian population where 5 females, yet only one male, received treatment. This is also true in East Central but by a smaller margin. A similar dynamic occurs in the North region by those of Hispanic origin with 52 females and 46 males having received hospital treatment.

By Marital Status

Table VIII-13: Hospital Utilization by Marital Status

Marital Status	CENTRAL	EAST CENTRAL	METRO	NORTH	SOUTH EAST	SOUTH WEST	WEST CENTRAL	Grand Total
Single	1792	880	1206	2551	1334	992	685	9440
Married	373	253	222	467	334	279	209	2137
Married and Separated	171	109	127	242	135	109	76	969
Legally	35	23	26	41	24	14	27	190

Separated								
Divorced	501	313	360	705	416	308	228	2831
Widowed	83	31	70	82	58	45	29	398
Other	5	1	3	8	1	1	3	22
Unknown	83	24	30	131	51	37	41	397

According to the marital status field tracked in the BHIS, which is updated upon every admission, the majority of all hospital consumers are single (58%), having never been married. Divorced are second with 17% followed closely by those who are married with 13%. Those who are married but separated represent 6%. Eighty-two percent have either never been married or have been unable to sustain a marriage.

There is little significant variation among regions in terms of the percentages of consumers served who fall into specific marital status categories. The proportion of those receiving hospital services that were single ranged from 53% in West Central to 60% in North. Those who were married ranged from 12% in the Central Region to 16% in both the Southwest and West Central Regions. The percentage of consumers who were divorced at the time of hospital treatment ranged from 16%-19%. Those who were widowed ranged from 2%-3% across all regions. North and West Central had the highest percentages of unknown marital statuses with 3.10 and 3.16 percent respectively while the other regions ranged from 1.47% to 2.73 percent.

U.S. Census (2000) figures for general population marital status statistics are significantly different from Georgia's rates among those who have been hospitalized:

	<u>U.S.</u>	<u>Hospitalized Georgians</u>
Married	54.4%	13.0%
Widowed, Divorced or Separated	18.5%	26.8%
Never married	27.1%	57.6%

This lack of alignment with U.S. marriage statistics is a simple, not scientific comparison, therefore no firm conclusions can be drawn about this phenomenon. However, in considering scientific research, which has found that there are fewer suicides among people who are married, there may be opportunity to affect divorce/widow rates positively.

Hospital Service Utilization

Unit Utilization

The table below illustrates the total duplicated and unduplicated utilization of mental health treatment in Georgia's state hospitals for FY04 by unit/program/cost center.

Table VIII-14: Hospital Utilization by Unit

Hospital	Adult Mental Health	Child & Adolescent Long Term Care	Child & Adolescent Short Term Care	Forensic	Total Unduplicated	Total Duplicated
Central State	1,681	0	990	657	3,267	3,328
East Central	2,135	0	0	136	2,257	2,271
Atlanta	2,106	0	783	271	3,134	3,160
Northwest	2,812	33	0	283	3,082	3,128
Savannah	1,488	0	305	158	1,919	1,951
Southwestern	1,333	0	0	172	1,474	1,505
West Central	1,751	35	0	111	1,887	1,897
TOTAL	13,306	68	2,078	1,788	16,627	17,240

The most utilized service is Adult Mental Health. Zeros demonstrate where some hospitals do not provide a full array of treatments. The difference between the total unduplicated and duplicated count of episodes is 613, representing an overall rate of multiple episodes for 3.7% of consumers seen in FY04. This figure is different from the Division reported readmission rates for two reasons. Firstly, it does not capture any admissions or discharge data for any year other than FY 2004. By only comparing multiple admissions from July 1, 2003 to June 30, 2004, consumers who were discharged in June 2003 and readmitted during FY04 only one time would not show up in this count. Secondly, the way in which APS queried all hospital episode data to determine the total count of 17,240 is different from the grand totals the Division uses to calculate fiscal year statistics. For example, APS' query did not include any episode data for a consumer whose primary and secondary diagnoses were both related to substance abuse. The Readmission Rates section below will review this in more detail relying on Division reported readmission rates that incorporate multiple admissions across multiple fiscal years.

Readmission Rates

As discussed previously, the ease with which consumers can be admitted to a state psychiatric hospital contributes largely to hospital utilization and adversely impacts comparisons of Georgia's hospitals to other states. From the perspective of Georgia's readmission rates this is no exception. According to the Division, there are several factors at play that should be considered in any discussion about readmission rates, or the hospital system in general. The first is the lack of an individually developed comprehensive planning process for each consumer in the system. Instead a consumer has a treatment plan for the community and a separate plan for the hospital. Second is a tendency following discharge for the community provider to force-fit the discharged patient into an existing treatment program rather than to provide the services that have been recommended by the hospital as the most beneficial based on that individual's unique needs. Third are the common circumstances with which an individual is discharged where community transition services are limited and a discharged patient will be expected to be acclimated to the community in the same facility in which crisis stabilization services are being provided. This exposure for the discharged consumer often aggravates his stability and serves as a predictable set up for failure. Finally, there is a lack of training among community providers that would enable them to better recognize and address a consumer's needs in advance of hospitalization. For example, a community provider typically is not able to make a distinction between misbehavior and behavior that is symptomatic of mental illness. Misbehavior leads too quickly and too often to readmission.

Table VIII-15: Hospital Readmissions Statewide by Program Unit

	Total Admissions	No Previous Admission	Any Previous Admission	Mean Days From Previous Admission	Median Days From Previous Admission
Adult MH	16,434	6,579	9,855	858	204
<i>Percent</i>		<i>40.0%</i>	<i>60.0%</i>		
C&A Short-Term MH	2,412	1,602	810	324	97
<i>Percent</i>		<i>66.4%</i>	<i>33.6%</i>		

Readmission rates are tracked for Adult Mental Health and Child & Adolescent Short-Term Mental Health admissions. The FY04 Readmission Rate for Forensic units statewide was 7.8%. However, because readmission rates are calculated to consider opportunities for improving continuity of care, and because readmission for those in forensic units is controlled by law enforcement, the breakdown is not presented here since it would not be comparatively analogous to the Adult MH and C&A Short Term.

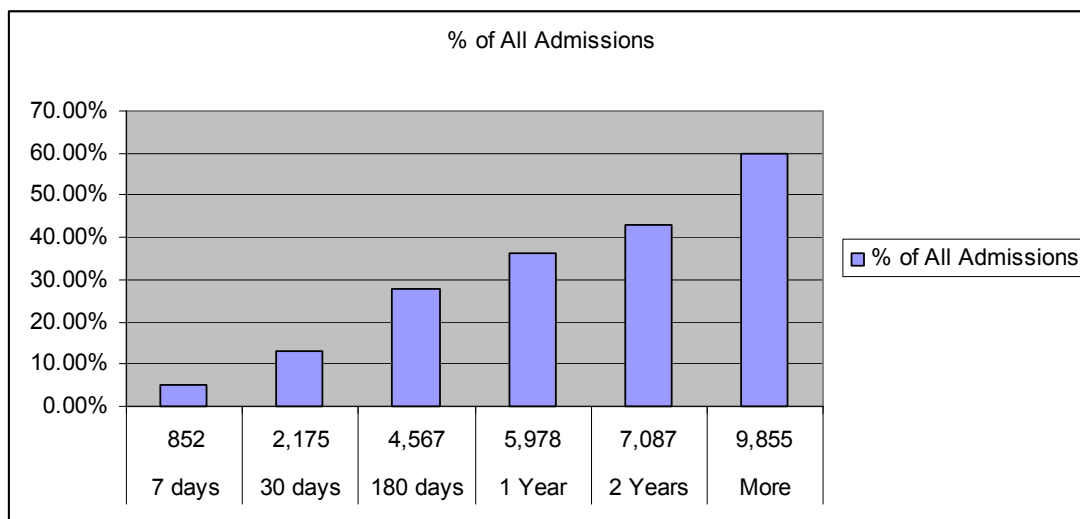
Adult Mental Health

Of all Adult Mental Health admissions in FY04, 852 or 5.2% were for consumers who had most recently been discharged within the previous 7 days; 2,175 consumers or 13.2% had been discharged within the last 30 days; 4,567 or 27.8% had been discharged within the last 180 days; 5,978 or 36.4% had been discharged within the last year; 7,087 or 43.1% had been discharged within the last 2 years.

In 2003, Georgia reported to the Uniform Reporting System a total readmission rate within 30 days of 13.2% of all discharges compared to a national rate of 8.5% (with 31 states reporting). This included a rate for adults age 18 and older of 13.4% compared to the national average of 8.7%. (Rates were calculated based on age subset groups provided). For the total population, the comparative rates are 13.2% for Georgia and 8.5% nationally. ***This reflects a readmission rate for Georgia that is 55% greater than the national average.***

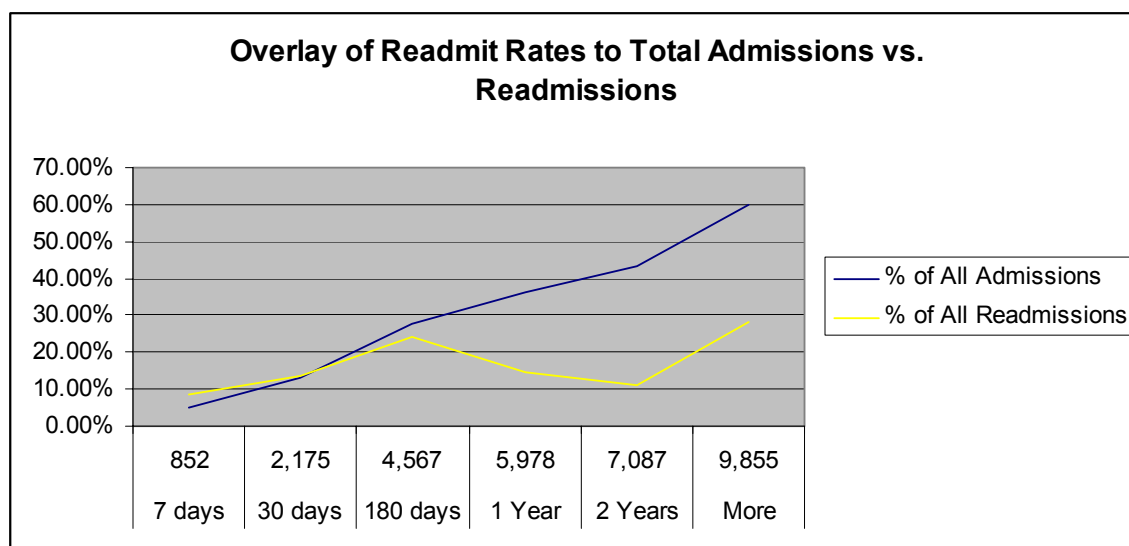
Chart VIII-1: Adult Mental Health Readmission Rates

Of all 9,855 Adult Mental Health readmissions, 852 or 8.6% were for consumers who had



most recently been discharged within the previous 7 days; 1,323 consumers or 13.4% had been discharged with the last 30 days; 2,392 or 24.3% had been discharged within the last 180 days; 1,411 or 14.4% had been discharged within the last year; 1,109 or 11.3% had been discharged within the last 2 years, and 2,768 or 28.1% had been discharged most recently over 2 years ago.

Chart VIII-2: Adult Mental Health Readmission Rates



An indicator of the most vulnerable periods for adults with Mental Illness occurs at two distinct ranges of time from the most recent hospitalization – in the period from 31-180 days following the previous hospitalization and after two years. This would perhaps indicate a need for follow up after discharge by the state’s mental health services system to determine stability and/or additional needs.

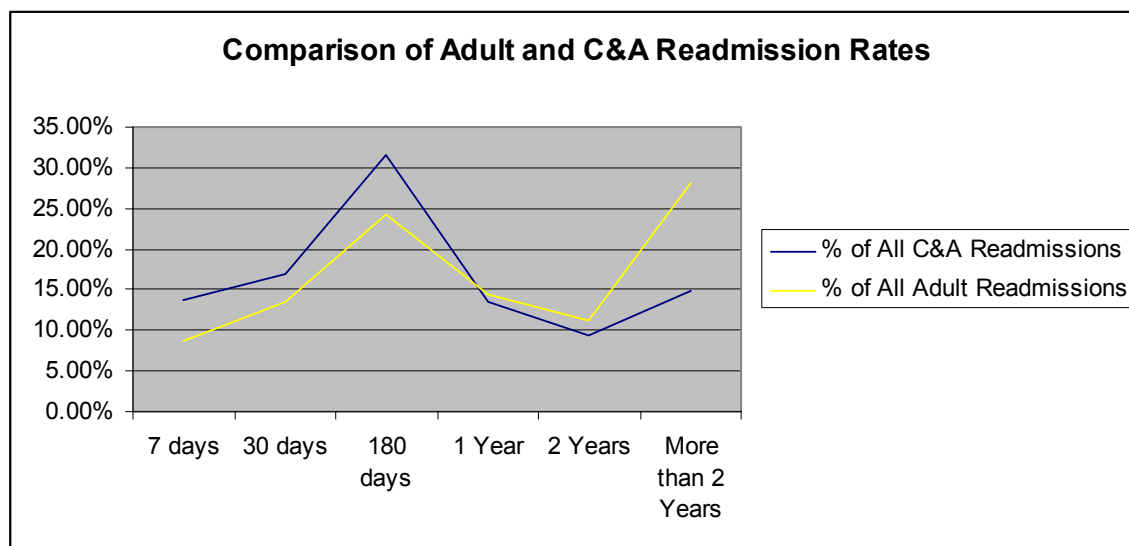
Child & Adolescent

There were 2,412 total admissions to hospital Child & Adolescent units in FY04. Of those, 1,602 (66.4%) had no previous admission and 810 (33.6%) had been admitted previously. Of all admissions, 111 or 4.6% had been most recently discharged within the last 7 days; 248 or 10.3% had been discharged within the last 30 days; 504 or 20.9% had been discharged within the last 180 days; 614 or 25.5% had been discharged within the last year; and 689 or 28.6% had been discharged within the last two years.

As a percentage of total readmissions (810), 111 or 13.7% were readmitted within 7 days; 137 or 16.9% were readmitted within 30 days; 256 or 31.6% were readmitted within 180 days; 110 or 13.6% were readmitted within a year; 75 or 9.3% were readmitted within 2 years; and 121 or the remaining 14.9% were readmitted over two years after the last discharge.

CMHS Uniform Reporting System data reflected FY03 Georgia 30-day readmission rates for Child & Adolescents as 11.2% of discharges. This compares to a national rate of 6.4% for children ages 0-17 for readmit rates within 30 days. The significance of the difference may again be due to the fact that many states do not offer short-term care in their state psychiatric hospitals.

Chart VIII-3: Adult Mental Health and C&A Readmission Rates



A comparison of readmission rates between Adult Mental Health and Child & Adolescent reflects a similar but less sharp trend for increased readmission during the 31-180 days period and for more than 2 years.

The ratio of discharges to admissions is consistent between C&A (Short-Term and Long-Term combined) and Adult Mental Health with rates of 97% and 96% respectively. Forensics has a discharge to admission rate of 75% for FY04. All discharges are included in this analysis regardless of reason and therefore will include discharges for transfers to another hospital, for example.

Table VIII-16: Ratio of Total Discharges to Total Admissions

	Total Admissions	Total Discharges	Ratio
Child & Adolescent	2556	2472	97%
Forensic	1763	1320	75%
Adult Mental Health	17532	16811	96%

Table VIII-17: Statewide Mean and Median Lengths of Stay by Program

	Adult Mental Health	Forensic	C&A Short - Term	C&A Long - Term
Mean LOS	30.4	64.0	10.2	494.7
Median LOS	5	9	5	363

Lengths Of Stay

Lengths of stay are calculated for all FY04 discharges during FY04. A review and comparison of the average and median lengths of stay in Georgia's psychiatric hospitals tell a compelling story. While the average length of stay in an Adult Mental Health unit statewide is 30.4 days in FY04, the median is 5 days. At the state's largest and most mature facility, Central State Hospital, one might not expect to see this trend, yet with an average length of stay of 139.7 days, the median there is only 6 days. The experience in Forensic units reflects almost double the lengths of stay, but still with a remarkably low median. The statewide average length of stay in a forensic unit was 64.0 days and the median was 9 days. C&A Short-Term by definition should have a low number of days for its length of stay (less than 30 days) and it does with a statewide average of 10.2 days and a median of 5 days. C&A Long-Term statewide average was 494.7 days and median was 363.

The FY 2003 CMHS Uniform Reporting System looks at lengths of stay in two categories for state hospitals, Children and Adults, for discharged patients. Georgia had reported an average length of stay for Children of 10 days and for Adults of 30 days. The median length of stay for Children was 5 days and for Adults, 6 days. The national averages for the same time period were significantly higher: evidence that other states tend to offer more long-term treatment:

- ❖ Children: Average LOS – 90 days; Median – 62 days
- ❖ Adults: Average LOS -- 187 days; Median – 59 days

Variables Influencing Length of Stay

In the private sector, length of stay has been correlated to type of insurance and guidelines for reimbursement as dictated by the payer. For example, lengths of stay for persons who have Medicare in the past have typically been longer than for those who use private insurance. However, this is not as strong a factor in the public psychiatric hospital system.

Given the occupancy rates of Georgia's hospitals, a likely factor in length of stay is the demand for bed space in addition to the hospitals serving as short-term stabilization facilities. Length of Stay (LOS) by program provides another perspective. While Atlanta Regional and Central State have a very similar LOS pattern, Savannah is an outlier with over two-and-a-half times the median number of days and over three times the mode on average. In forensic units, both Atlanta and East Central have much higher lengths of stay and modes than in comparison to the other hospitals. For Adult Mental Health, the mode ranges from 4 to 7 days, while the average length of stay ranges from 11.6 days to 19.1 days on average, with the outlier being Central State with an average length of stay of 139.7 days.

Penetration Rates

Table VIII-18: Mean and Median Lengths of Stay by Program

Program	Central State		East Central		Atlanta		Northwest		Savannah		Southwestern		West Central	
	Mean	Mode	Mean	Mode	Mean	Mode	Mean	Mode	Mean	Mode	Mean	Mode	Mean	Mode
C&A Short –Term	8.2	5	--	--	8.1	4	--	--	21.6	14	--	--	--	--
C&A Long – Term	--	--	--	--	--	--	718.1	664.5	--	--	--	--	306.6	259
Forensic	37.9	10	175.7	57	216.4	45	32.0	6	66.0	9	20.0	4	89.6	12
Adult Mental Health	139.7	6	11.9	4	13.8	7	14.8	4	14.0	5	11.6	4	19.1	5

Penetration rates are presented from two different perspectives: First, rates are computed based on a percentage of different population sets, primarily total state household population and/or Holzer prevalence estimates (Holzer estimates of prevalence are based on the percent of population with Mental Illness who are below 200% of poverty.) Second, rates are presented as a rate per 1,000 people of the total population so that national comparisons can be made since CMHS uses this as a common denominator.

Table VIII-19: Penetration by Region of Residence of All Hospital Consumers					
Region	Total Served	Total County Household Population	Hospital Penetration of Total Household Population	Holzer Estimates of Prevalence <200% Poverty	Hospital Penetration by Holzer Prevalence for <200% Poverty
Central	2194	577107	0.38%	19155	11.45%
East Central	2444	765072	0.32%	24789	9.86%
Metro	2692	2382085	0.11%	52664	5.11%
North	3450	1963297	0.18%	43716	7.89%
Southeast	1914	772650	0.25%	26891	7.12%
Southwest	1575	556503	0.28%	21850	7.21%
West Central	2127	936563	0.23%	27258	7.80%
TOTAL	16,627	7,952,631	0.21%	217,155	7.66%

Table VIII-19 represents a broad view of penetration rates for all persons by region of residence served in Georgia state psychiatric hospitals. Note: Due to variations by county in prevalence estimates, the subtotals by region will not equal the statewide total. Statewide, 0.21% of all Georgians (not including institutionalized population) received state psychiatric hospital treatment. The number of recipients of hospital services represented 7.66% of Georgians who were estimated to have Mental Illness and whose income placed them below 200% of poverty. It is common to correlate “most in need” with this component of the population. This comparison must be qualified by noting two factors:

- 1) The consumer counts included in “total served” may not meet the definitions for Mental Illness utilized for determining prevalence estimates, and
- 2) The consumer counts included in “total served” may not meet the criteria for income under 200% of poverty

Therefore, it is important to look at penetration rates from all relevant and available perspectives. To offer an “in-between” view of penetration rates, the following table considers the penetration rate of Total Served by estimated prevalence for all Georgians estimated to have Mental Illness. This reflects a low penetration rate of 1.91% by consumers from the Metro Region and a high penetration rate by consumers in the Central Region (coincidentally with the 2nd to fewest number of MHDDAD consumers of all regions) of 5.69%. Baldwin, Johnson and Bibb Counties are most highly represented in the Central Region with penetration rates of 3.09, 2.92, and 1.69 higher than the region’s total rate respectively. The standard deviation is 1.54%.

Table VIII-20: Penetration by Region of Residence of All Hospital Consumers for Total Population Prevalence and Household Population Prevalence

Region	Total Served	Total Population Prevalence	Total Household Population Prevalence	Penetration of Total Population Prevalence	Penetration of Household Population Prevalence
CENTRAL	2,194	44,784	38,526	4.90%	5.69%
EAST CENTRAL	2,444	54,904	51,316	4.45%	4.76%
METRO	2,692	149,929	141,027	1.80%	1.91%
NORTH	3,450	129,808	123,046	2.66%	2.80%
SOUTHEAST	1,914	57,855	52,443	3.31%	3.65%
SOUTHWEST	1,575	43,762	39,160	3.60%	4.02%
WEST CENTRAL	2,127	66,863	61,143	3.18%	3.48%
TOTAL	16,627	547,473	506,342	3.04%	3.28%

There are a substantial number of consumers served in the hospital system for whom county of residence information was not recorded. Rather, these 863 consumers were identified as either “Out Of State” (620 consumers), Department of Corrections (222), “Youth Detention Center” (14), “Out of Country” (5), or “County Not Specified” (2). Therefore, there is a higher margin of error in these estimates, although the remaining records with associated counties provide a reliable sample.

By Age

Table VIII-21: Number of Consumers Served per Hospital/Region to Prevalence of Mental Illness/Poverty of Region

Hospital	Birth – 17	Penetration Rate of Region by Total Household Population	Penetration Rate by Region of Poverty Prevalence	18+	Penetration Rate of Region by Total Household Population	Penetration Rate by Region of Poverty Prevalence	Total All Ages	Penetration Rate of Region by Total Household Population	Penetration Rate by Region of Poverty Prevalence
CSH	995	0.63%	14.96%	2280	0.54%	18.24%	3267	0.57%	17.06%
EC	2	0.00%	0.03%	2257	0.41%	13.33%	2257	0.30%	8.97%
ATL	779	0.12%	4.19%	2364	0.14%	6.94%	3134	0.13%	5.95%
NW	28	0.01%	0.21%	3056	0.21%	10.04%	3082	0.16%	7.05%
SE	315	0.15%	3.51%	1609	0.29%	8.97%	1919	0.25%	7.11%
SW	0	0.00%	0.00%	1477	0.37%	10.37%	1474	0.26%	6.75%
WC	33	0.01%	0.35%	1858	0.27%	10.52%	1887	0.20%	7.04%
Total	2,081	0.10%	2.84%	14586	0.25%	10.14%	16,627	0.21%	7.66%

Table VIII-21 represents penetration rates by hospital census. Table VI-22 below represents penetration rates by region of residence without regard to the hospital in which the consumer

received treatment. This is a better comparison for purposes of analyzing prevalence to penetration.

Table VIII-22: Penetration by Region of Residence

Region	Birth - 17	18+	Total	Total Household Population	Holzer Estimates SED/SMI Prevalence <200% Poverty All Ages	Hospital Penetration of Total Household Population Per 1,000	Hospital Penetration by Holzer SED/SMI Prevalence for <200% Poverty	Holzer Estimates of Prevalence <200% Ages 0-17	Hospital Penetration Rate, Ages 0-17 of Prevalence <200% Poverty	Holzer Estimates of Prevalence <200% poverty, Ages 18+	Hospital Penetration Rate, Ages 18+ <200% poverty
Central	333	1866	2194	577107	19155	3.80	11.45%	6653	5.01%	12500	14.93%
East Central	275	2175	2444	765072	24789	3.19	9.86%	7982	3.45%	17175	12.66%
Metro	358	2344	2692	2382085	52664	1.13	5.11%	14041	2.55%	25379	9.24%
North	424	3029	3450	1963297	43716	1.76	7.89%	13294	3.19%	30426	9.96%
Southeast	278	1641	1914	772650	26891	2.48	7.12%	8974	3.10%	18010	9.11%
Southwest	126	1453	1575	556503	21850	2.83	7.21%	12147	1.04%	22946	6.33%
West Central	312	1818	2127	936563	27258	2.27	7.80%	9452	3.30%	17353	10.48%
Total	2,055	13,683	15,738	7,953,277	217,155	1.98	7.25%	73347	2.80%	143808	9.51%

To compare to national trends, we find the penetration rate for all ages is 2.09 compared with a .62 national average according to CMHS figures. However, the national average may be affected by the fact that some states that have more strict guidelines about eligibility for hospital treatment. For example, some states do not provide any short-term treatment in hospitals at all, but rather provide those services in the community. Additionally, CMHS national figures are based on 2003 data whereas comparisons are to actual 2004 data.

As we look at regional penetration, we see the highest penetration rate is for those consumers who reside in the Central Region. This may be due to the awareness of Central State Hospital in that region and a greater propensity and/or willingness for treatment to be sought in that setting. This ranking as the region with the highest penetration is echoed in all the remaining penetration rates against Holzer prevalence numbers for all age groups totaled, and Child & Adolescents and Adults separately.

The lowest hospital penetration in comparison to total household population is the Metro Region. However, unlike the Central Region, this does not hold true for comparison to Holzer prevalence counts when broken down by age. For both Child & Adolescent and Adult breakouts, the Southwest Region has the lowest penetration rates.

The table below looks at penetration by age from another perspective, with a further breakdown of age groups and by considering penetration per 1,000 persons.

Table VIII-23: Hospital Penetration Rates by Age Groups

Age Group	By Total Household Population Penetration Rate per 1,000	By Total Prevalence of Mental Illness in Household Population per 1,000	By Holzer Mental Illness and Poverty Prevalence in Household Population per 1,000
0-17	0.97	13.15	28.37
18-24	3.34	38.95	74.09
25-64	2.71	46.77	126.56
65+	0.56	12.01	23.15
Total	2.09	32.84	76.57

Table VIII-23 illustrates that for every 1,000 non-institutionalized Georgians, approximately two (2) received state psychiatric hospital treatment in FY04; that nearly 33 of every 1,000 estimated to have mental illness received hospital treatment; and that for every 1,000 Georgians estimated to have mental illness and considered to be in poverty, more than 76 received hospital treatment. These penetration rates merely illustrate the extent to which services are provided based on numbers of persons served, not based on whether the numbers of persons served upon individualized research would meet the definitions of mental illness and poverty used to calculate prevalence rates.

National comparisons by age group require a different set of age grouping comparisons because CMHS uses a breakdown of Ages 0-17, 18-20, 21-64, and Over 65. They also calculate penetration by numbers served to the total population rather than to household population, or prevalence for Mental Illness. Table VI-24 displays the comparison penetration rates according to CMHS age breakdowns.

Table VIII-24: Hospital Penetration Rates by CMHS Age Groups

Age Group	CMHS 2003 National Average Rate of Penetration per 1,000 Population	Georgia Rate of Penetration per 1,000 Total Population	Georgia Rate of Penetration Household Population Prevalence for Mental Illness per 1,000	Georgia Rate of Penetration for Holzer Population Prevalence and Poverty for Mental Illness per 1,000
0-17	0.24	0.96	13.15	28.37
18-20	0.72	1.67	18.92	37.51
21-64	0.87	2.79	48.21	123.73
65+	0.25	0.52	12.01	23.15
Total	0.62	2.03	32.84	76.57

This comparison to national hospital penetration rates again illustrates how Georgia's rates far exceed the national average utilization of state psychiatric hospitals. While Georgia's hospital system differs in comparison to other states, the extent to which Georgia's rates exceed the national averages is worthy of note. ***The following percentages represent the rate by which Georgia's numbers exceed the national figures for each age group:***

0-17 -- 300%; 18-20 -- 132%; 21-64 -- 221%; 65 and over --108%.

Specifically to Child and Adolescent Services (represented primarily by those aged 12-18): The following table offers a comparison of both Short Term and Long Term Child and Adolescent services utilization to the total numbers statewide of those (all ages) who are estimated to have Mental Illness and fall under 200% poverty guidelines and per 1,000 of the total household population. These figures were extrapolated from county averages.

Table VIII-25: Comparison of Short and Long Term Child and Adolescent Penetration Rates	
Total Short Term Penetration Rate of Prevalence/Poverty per 1000 population	18.9
0-17 only: Short Term Hospital Penetration Rate of Prevalence/Poverty per 1000 population	27.5
Long Term Penetration Rate of Prevalence/Poverty per 1000 population	0.63
0-17 only: Short Term Hospital Penetration Rate of Prevalence/Poverty per 1000 population	0.82

Not all recipients of treatment in short and long term hospital units are under age 18. By reducing the counts to consider only those under 18 years of age, the penetration rate for Short Term treatment per 1,000 people of those who have Mental Illness and live in poverty between the ages of 0-17 rises from 18.9 to 27.5, and for Long Term from 0.63 to 0.82.

By Gender

The split of the percentages of hospital consumers by gender is 60% male and 39% female (11,132 of hospital episodes were attributable to males, while 7,184 were attributable to women). For less than 1% of the number of records, the gender was unknown. This differs from a total service population gender split of 45% male and 54% female nationally and from a similar breakdown in the split in gender in Georgia's community services. However, this type of split is seen in national gender figures, where on average males make up 63% of the hospital census and females 37%.

The next table depicts the penetration rate by gender against Holzer mental illness prevalence and poverty by region, also providing statewide median.

Table VIII-26: Comparison of Gender Penetration Rates by Region			
	Female	Male	Differential
Central	6.80%	16.33%	240.17%
East Central	6.03%	13.30%	220.68%
Metro	7.27%	21.01%	288.98%

North	5.22%	11.30%	216.60%
Southeast	3.87%	8.76%	226.77%
Southwest	3.89%	9.60%	246.66%
West Central	4.30%	11.03%	256.65%
Statewide	5.07%	12.00%	236.40%
Median			240.17%

The hospital penetration rate per region by gender demonstrates a much higher rate of penetration for males in the state's hospitals. One explanation for this may be that males, particularly single males, are less likely to have a support system in the community and/or are less likely to seek community services prior to reaching crisis. Males are therefore less able to avert crisis and subsequently use hospital treatment more frequently. For each region, the penetration rate for males (of Holzer Prevalence for mental illness, below 200% poverty) is more than 2 times greater than that for females. Given that the overall prevalence is higher for women in Georgia to have mental illness, this statistic is even more notable.

The penetration rates for gender according to Household population figures are 1.60 females (per 1,000 population) and 2.55 for males. In comparison to total population figures, the penetration rates drop slightly to 1.54 for females and more significantly to 1.64 for males (due to a higher rate of males not included in household population counts, e.g. incarceration). This compares to the national gender penetration rates of .45 for females and .87 for males.

For national comparison, the penetration rates by gender according to every 1,000 members of the total population are below:

Table VIII-27: Georgia Penetration Rates by Gender

	Count	Population per 1,000	Georgia's Penetration Rate	CMHS National Penetration Rate
Male	10,532	4027.1	2.62	0.87
Female	6,705	4159.3	1.61	0.45

Like national rates, fewer females are served in the hospital system. Interestingly though, the rate by which Georgia's men are served in a hospital setting over that of females (163%) is lower than the national rate at which hospital treatment for males exceeds that for women (193%).

By Race

To look at major racial groups, the more than a dozen race categories tracked by the hospitals' information systems, were clustered together. The penetration rate of Holzer prevalence counts for persons with mental illness and below 200% poverty for all "Other" race groups was cumulatively greater than any of the other clusters at over a 10% penetration rate. The lowest penetration rate was for Hispanics at 1.66% preceded very closely by a 1.74% penetration rate for Native American/Native Alaskans. The Asian cluster was next highest with 5.30%. The White and Black clusters were the 2nd and 3rd highest penetration rates at 8.53% and 7.34% respectively.

Average of Asian Penetration Rate		Average of Other Penetration Rate	
Region	Total	Region	Total
Central	6.78%	Central	10.43%
East Central	2.11%	East Central	3.30%
Metro	3.83%	Metro	22.03%
North	2.84%	North	21.55%
Southeast	0.40%	Southeast	7.31%
Southwest	19.27%	Southwest	5.21%
West Central	1.97%	West Central	10.67%
Grand Total	5.30%	Grand Total	10.79%

4 Decatur County/Southwest Asian consumers received hospital services, whereas there is only a prevalence for 1, thus a county penetration rate of 400%, and region rate of 19.27%. If Decatur County is considered simply to have reached 100% of prevalence, the Southwest region penetration would reduce to 6.77% and statewide total to 3.41%.

"Other" is catchall for any other race not included in primary breakouts.

Average of Black Penetration Rate	
Region	Total
Central	9.62%
East Central	8.83%
Metro	5.15%
North	6.46%
Southeast	6.20%
Southwest	8.05%
West Central	6.05%
Grand Total	7.34%

Average of White Penetration Rate	
Region	Total
Central	11.72%
East Central	9.25%
Metro	6.25%
North	8.33%
Southeast	6.17%
Southwest	8.26%
West Central	8.29%
Grand Total	8.53%

Average of Hispanic Penetration Rate	
Region	Total
Central	3.62%
East Central	1.12%
Metro	0.99%
North	1.31%
Southeast	1.95%
Southwest	1.94%
West Central	0.55%
Grand Total	1.66%

Average of NANA Penetration Rate	
Region	Total
Central	1.10%
East Central	1.81%
Metro	2.96%
North	3.05%
Southeast	1.43%
Southwest	2.60%
West Central	0.00%
Grand Total	1.74%

NANA is an abbreviation for Native American/Native Alaskan

In terms of outliers, the most notable is for the Asian cluster by the Southwest Region. Four Southwest Asian consumers from Decatur County received hospital services, whereas there is only a prevalence for 1, thus a county penetration rate of 400%, and region rate of 19.27%. If Decatur County is considered simply to have reached 100% of prevalence, the Southwest region penetration would be reduced to 6.77% and statewide total to 3.41%. This change would not affect the Asian cluster's ranking in penetration rates of all races.

The "Other" cluster shared two outliers in both the Metro and North Regions. This is not unexpected given the influx of population from culturally diverse backgrounds to the metropolitan Atlanta area. Primarily the Other category includes people who are categorized as "Other" or "Unknown," as well as some who are "Multiracial" or Native Hawaiian. Those inflating the "Other" cluster numbers from the Metro and North Regions tend to primarily result from the original subcategory code of "Other."

Whites from the Central Region are more likely to receive hospital treatment, where Blacks from the Metro Region are less likely to receive hospital treatment.

Penetration by race per 1,000 population are below. National comparison data was not included in available CMHS reports.

Table VIII-28: Georgia Race Penetration Rate

Race	Penetration Rate Per 1,000 Total Population
White	1.78
Black	2.91
Asian	0.56
Native American/Alaskan	1.25
Other	0.99
Hispanic	0.66

The split between genders among race is mostly consistent with the trend in the general population of hospital users with the exception of Asians and Hispanics for whom the differential in higher proportions of males is not as great. On the other end of the trend in the general hospital population, Black Males receive hospital treatment at an even higher percentage than the average.

Table VIII-29: Georgia Race Penetration Rate by Gender

Race	Total Counts	Male	Female
Asian	96	56.3%	43.8%
Black	6780	63.1%	36.9%
Hispanic	285	54.4%	45.6%
Native American/Native Alaskan	22	59.1%	40.9%
Other	99	59.6%	40.4%
White	9113	58.5%	41.5%

Members of the Mental Health Planning Council have attributed this to a persistent societal bias that thwarts access to services in the community and results in especially high percentages in the forensic hospital treatment of black males.

By Marital Status

The majority of hospital consumers have never been married (60.44%). The least common marital status is widowed (2.34%). Three percent of hospital consumers' marital status is unknown. Atlanta Regional has the greatest percentage of unknown marital status with over 30%. East Central hospital had the fewest percentage of Unknowns (1.93%). Over twelve percent of hospital consumers were married at the time they received treatment. Divorced persons made up 15.91% of the FY04 hospital populations and 6.65% were Separated. Northwest Regional had the highest percentages of the Now Married, Separated, and Divorced populations compared to the other hospitals (ranging from just over 21% to 27.5%). Central State Hospital had the highest percentages of both Never Married and Widowed categories with a little over 26% each. Savannah had the most even distribution across categories with low rates in the Separated (9.93%) and Widowed (7.24%) categories; the remaining three categories for Savannah were Never Married at 10.72%, Now Married at 13.11%, and Divorced at 10.64%. In terms of penetration,

Table VIII-30: Penetration Rates by Marital Status

Marital Status	Count Per Marital Status	Penetration Total Population per 1,000	Penetration Rate for Population Prevalence per 1,000	Penetration Rate for Population Poverty Prevalence per 1,000
Married	3106	0.91	19.92	83.47
Separated/Widowed/Divorced	3419	2.88	26.63	57.72
Single	9440	6.71	92.06	199.31

Table VIII-30 reflects these rates according to U.S. Census categories and considers the rates per 1,000 people for the total population, the number of the total population who are estimated to have mental illness and the number who are estimated to have mental illness and live in poverty. The most striking rate is that of every 1,000 persons believed to have a mental illness and have an income that places them below 200% poverty levels; over 199 will have been treated in a state psychiatric facility.

Cross Utilization of Hospital and Community Services

As a worker in the in patient hospital setting it has become apparent to me that the effort to redirect resources from the hospital to out patient services has failed. Patients are being sent into a revolving door situation where they are being sent to hospitals for stabilization and are discharged into the community where services are insufficient to care for them causing them to end up back in the hospital. There are not enough crisis beds, respite beds, stepdown programs, day programs, case management, wrap around services and mental health services available to track and follow up on and serve patients who leave the hospital. If they don't go to appointments their cases are closed.

- Survey Respondent

When discussing the MHDDAD's mental health system capacity, it is also critical to consider how capacity is affected not only by readmission rates for hospital services, but by admission rates from community services to hospital services as well.

Based on a comparison of active community mental health services episode records, 46.29% of Adult Mental Health consumers admitted to a hospital for the first time had already been seen in the community. This in itself is an indicator of insufficient single point of entry outreach and the lack of community-based alternatives that would pre-empt admission. There will be a percentage of the population for whom the onset of illness is without warning and emergent, however, for most of the population there is an expectation that at minimum there would have been some attempt to seek treatment or initial contact with the system in the community prior to admission.

Of all Adult Mental Health consumers discharged from one of the state's hospitals in FY04, 72.41% had also received community services at some point during FY04, but only 59.33% received community services after their hospital discharge. Thus, 28% of hospital discharges were not seen in the community at all during FY04, either before or after their discharge, and 41% were not enrolled in any service following their last discharge. Further, of those who were enrolled in community services at any point during FY04, 30% were not enrolled in any service other than diagnostic assessment services; 44% were not enrolled after their last discharge in any service other than diagnostic assessment services. The implications of these figures are that discharged consumers are perhaps not receiving the continuity of care they need after leaving the hospital.

Moving Forward

More effective and efficient treatment, or even a program of limited follow-up post discharge in the community designed to inhibit hospital admissions and readmissions might be

considered to aid in alleviating the situation of hospital over-capacity evidenced in occupancy rates. In the next Chapter Community Capacity is discussed in detail.

“Access to care for patients experiencing significant crisis (requiring hospitalization) is disappearing to those without resources. In South Carolina, the state has closed acute inpatient beds due to budget cuts and clients needing inpatient care now wait for days in emergency rooms. . . . Our local mental health center (also state operated) is trying to help and around the state local communities are coming up with some solutions, but it's all patchwork to off-set the lack of inpatient capacity. This problem is not limited to South Carolina—through my professional associations I've heard of similar problems nation-wide.”

- Community Case Manager, as reported in public comments for the President's New Freedom Commission on Mental Health

CHAPTER IX: ASSESSMENT OF AVAILABLE PUBLIC MENTAL HEALTH WORKFORCE

In this chapter you will find:

- ❖ *Workforce: State of Nation and State of Georgia*
- ❖ *Who is Working in Georgia's Public Mental Health System?*
- ❖ *Salary Comparisons*
- ❖ *Community vs. Hospital Workforce*
- ❖ *Opportunities to Strengthen Georgia's Workforce*
- ❖ *Other Findings and Implications*



Highlights of significant findings in the workforce analyses are:

- ❖ *Based on current productivity and inequitable distribution of resources across the state, community provider staffing ratios are insufficient to meet the minimum need for services. When prevalence of needs is considered, the gap is even greater.*
- ❖ *As a percentage of Georgia's healthcare workforce (health care professionals only), MHDDAD hospital and community-based mental health clinicians and paraprofessionals represent only 3.6% (and only 2.5% of Georgia's entire healthcare workforce).*
- ❖ *The supply of Certified Peer Specialists is not being used to its potential. Sample survey results estimate that 65% of trained Certified Peer Specialists are not employed by the MHDDAD system.*
- ❖ *An extrapolation of current staffing patterns indicates a needed increase in statewide staff of 799 licensed professionals (278 social workers, 217 nurses, 81 medical doctors/psychiatrists, and 19 psychologists) and 1,008 non-licensed professionals.*
- ❖ *Salaries of the public mental health service system staff are predominantly non-competitive in the marketplace. The availability of higher salaries through employment by private sector and other public agencies that provide mental health services presents a disincentive for the public mental health workforce recruitment and retention efforts.*

A. Workforce: State of Nation and State of Georgia

Consensus among experts affirms that there is a national drought of mental health workers that is negatively affecting access to services and catapulting states closer to workforce crises. Each state is experiencing the crisis, albeit slightly differently, depending on varying

socio-demographics in both the supply of and demand for mental health services. Despite inconsistent methods of tracking shortage data nationally, sufficient data is available to recognize that there is an inadequate supply and uneven distribution of mental health professionals across the country and between regions within states. Furthermore, it is recognized that the crisis is more acute for public mental health providers.⁵⁷

Several factors hinder the ability to accurately track mental health workforce shortages. First, some states are able to use substitution for certain services, so that the shortage of one type of provider can be replaced by utilizing another. For example, a shortage of mental health social workers could be substituted with a combination of psychiatric technicians and/or mental health nurses. While substitution will not be a solution in many cases, the use of substitution can mask the effect of workforce shortages. Another factor is influenced by the privatization of community mental health services. The use of contractors (contracted provider agencies) as providers of services limits, if not entirely eliminates, the ability of states to comprehensively track full time equivalent staff through a centralized repository or tracking system for workforce staffing data because the contractor-contractee relationship typically leaves personnel management to the contractor. A related factor is the use of independent contractor staff. Contractor agencies will differ in how they use and keep records on their use of contracted staff and there is little leverage a state can assert to enforce a consistent approach to tracking and assembling such data on contracted staff in any centralized way. A third factor is the varying rules in policy from state to state regarding licensure of mental health professionals. If the supply of licensed professional counselors was being tracked through a national association, the numbers would not necessarily translate to availability in some states because professional counselors are not licensed in certain states and, thus, the total numbers would be inflated.

There are many reasons for the shortage in the mental health workforce, including that fewer workers are entering the field in some professions and specialties, and lower paid workers in the public sector leave for opportunities of higher pay in the private sector. Additionally, academic institutions have not kept pace with the demand as the stigma of mental illness has been gradually whittled down and consumers are more proactive in seeking treatment. Too, while contemporary treatment models have evolved and are espoused as best practices, academic institutions and training programs have been slow to incorporate the most current changes leaving states with a mandate to provide best practice services, but with few, if any, resources to do so. Finally, these have all occurred in tandem to a backdrop of budget cuts and funds redirection, often to leverage Medicaid funding which comes with its own set of staffing regulations and limitations.

Exacerbating the shortage problems are situations that limit solutions, such as there being minimal state-to-state licensure reciprocity and the draw of professionals to more urban

⁵⁷ Grant Makers Health, "Turning the Tide: Preserving Community Mental Health Services," Issue Brief Number 16, February 2003.

areas. The war on terrorism has also affected the decline of available psychiatrists. A program by the United States Department of Agriculture formerly granted waivers to foreign-born psychiatrists to allow them to stay in the U.S. if they agreed to staff community mental health centers in underserved areas, but ceased doing so after September 11, 2001. In December 2002, the U.S. Department of Health and Human Services decided it would sponsor the waivers, but the 15-month lapse created a significant interruption of the program. The general supply of psychiatrists is dwindling as well, with only 3-4% of medical school graduates choosing psychiatry as their specialty although long-term studies show this as a cyclical pattern with most recent figures reflecting the low supply. Given that the need for psychiatrists who specialize in child and adolescent populations is estimated to increase 100% by 2020⁵⁸ alone, where the expected number of graduates (at the current rate) will only address 30% of the population in need, the outlook is one of the most dire for the future of the mental health workforce.

Ivey, et. al., stated that more social workers end up in the medical field. Few LPC's pursue that path leaving fewer licensed clinical social workers and more Licensed Professional Counselors for mental health. Nurse shortages are equally in effect for the healthcare field but even more so for nursing specialties. The number of nurses graduating in 1998 with psychiatric specialties equaled only 55% of the number that graduated in 1980.

As a subset of each profession, there is also a critical need to grow the percentage of mental health professionals of non-white origin. Twenty-five percent of the general population is of racial or ethnic background, but fewer than 10% of mental health providers are of racial or ethnic background. Only the growth of a diverse pool of mental health professionals will help to break down the cultural and linguistic barriers that currently constrain access to services.

Despite acknowledgement that the mental health workforce is currently in crisis, before embarking on initiatives to correct workforce shortages, states must take into account the movement toward managed care. In doing so, they should consider how managed care might serve as a disincentive for growing the mental health workforce due to changes in staffing pattern models and limits in the potential for reimbursement.

Overview: State of Georgia

In the proposal submitted for the state's Child and Adolescent State Infrastructure Grant, the Division of MHDDAD stated that it had barely half of the resources needed to adequately respond to the need for community-based mental health services for children and adolescents. Even fewer had the training necessary to address those with addictive disease issues, and almost none who can meet the complex needs of youth, particularly those with co-occurring disorders. Respondents to APS's stakeholder survey cited the limited

⁵⁸ Ibid.

availability of licensed behavioral health staff, the lack of access to continuing education, the unavailability of psychiatrists in rural areas, the need for provider development and increased competition, and low salaries as key workforce issues.

In November 2004, APS held a focus group discussion with provider representatives to better understand the scope of workforce issues from the field perspective. Four CSB provider agencies and one MHDDAD regional office was represented. Topics included recruitment, retention, training, and provider development. (See **APPENDIX IX-3: Workforce Focus Group Conference Call Notes.**)

All the providers had experienced difficulty in recruitment for clinical positions. One stated that the supply of individuals with psychosocial rehabilitation expertise was particularly sparse. If qualified individuals are available, they typically do not have a mental health background, but rather general social work or criminal justice. The providers must often rely on applicants right out of school and invest significant resources in training them. However, once trained, they frequently become commodities for recruitment from other social service systems that can afford more competitive salaries. Providers reported that while they wanted to be able to provide more Assertive Community Treatment (ACT), the staffing complement of professionals required for the teams was nearly impossible to sustain with turnover and without the ability to recruit at higher salaries. They also stated they can't afford to provide ACT to the extent it is needed. One agency reportedly had to eliminate one of its two teams, which reduced their capacity to provide ACT drastically. Another agency stated they were unable to provide Intensive Family Intervention services also because "staff doesn't get paid well enough."

In terms of recruitment methodology, there didn't seem to be a proven way in which the agencies acquired qualified staff and the methodology was different depending on the type of position. Some used professional journals to advertise but in a limited fashion for physicians, psychiatrists, and psychologists mostly; one CSB had budgeted funds set aside specifically for that purpose. Most used local newspapers but are beginning to seek new avenues such as local career fairs and partnering with career centers at local colleges and universities because newspaper advertisements are expensive and often don't produce a good selection of qualified applicants. The agencies that had taken advantage of Georgia's online human resources site called *The Job Site*, had found it very cumbersome to use because the Office of Human Resource Management and Development didn't screen applications before forwarding to the CSBs and they found that there was a higher percentage of non-qualified applicants who applied for positions through the job site. There was some additional discussion about the challenge of writing the appropriate job description to advertise for the position, especially those for which someone could be trained on the job, but a too-technical job description might not attract potentially qualified candidates or weed them out in screening. Some had engaged in an ongoing dialogue with local universities for recruitment purposes. One expressed some level of success with Yahoo™ and Hotmail™ for Assertive

Community Treatment Team Leader positions. Others had used staffing companies and headhunters with varying results.

Retention is also challenging, especially when salaries offered by other systems (criminal justice agencies, schools, and the Division of Family and Children Services) are higher than what MHDDAD's providers believe they can bear. The turnover rate is very high and constant system changes, as well as excessive paperwork requirements, exacerbate the issue. The providers believe adjustments to change would not affect as much turnover and other casualties if they were engaged by the Division in developing solutions.

Some providers offer incentives for licensure, but they have found that staff leave after they have invested in getting the staff trained and the staff have completed the number of hours required for licensure under the clinical supervision of a qualified CSB clinical professional. The providers find this happens most often with Licensed Professional Counselors. One stated that their turnover was highest in their Child and Adolescent programs. Specific incentives that have been utilized to benefit staff retention include:

- ❖ 10% salary increases with licensure or certification
- ❖ Bonuses every two years for licensure paid out in 1/24 increments over the two year period (\$3000 for an LCSW, \$2500 for LMSW, and \$2000 for an associate license)
- ❖ Educational leave to staff

One CSB expressed interest in the Office of Regulatory Services model, which offers support toward licensure in return for an agreement to serve the agency for a certain number of years of employment.

The participants agreed that productivity standards could be very useful if staff were rewarded for meeting or exceeding standards and not just penalized for failing to meet standards. Other retention techniques included membership with USPSR through the agency's organizational membership with which staff has access to all membership benefits. The providers had also considered paying for all or part of the annual dues for staff membership to licensure-specific professional associations, but no one currently offers this. Some CSBs have successfully used intrinsic incentives where funding was not available. Incentives such as flexible time and non-traditional hours are very valuable to staff.

Advanced training is also provided as a retention tool. One CSB provides all continuing education credits for staff by coordinating training workshops and bringing in speakers. The training is open to the public who are charged a registration fee that allows the CSB to break-even. The providers emphasized the need for there to be a simultaneous commitment of sufficient resources by the agency so that training is ongoing and thorough. Additionally, a need was expressed for the Division to enhance the training for certified peer specialists and offer CPRP (Certification for Psychiatric Rehabilitation Programs) training. CPRP is

required for an employee of psychosocial rehabilitation programs and currently only orientation to the exam is offered through the Georgia exam administrator. The participating providers concurred that leaving such training up to each individual provider was not an efficient use of resources, nor did it allow for statewide standardization. It was noted that DFCS has certification training for its entire bachelor's level workforce. This training raises their credentials and also serves as a retention incentive, as the acquired credentials make them eligible for promotions and raises. Providers suggested the Division provide the following certifications that would be of benefit to workforce development and retention efforts:

- A certification process for mental health professionals
- A certification process for psychosocial rehabilitation specialists
- A certification process for mental health service technicians and peer/parent advocates.

As for opportunities to tap existing resources for staffing shortages, such as “sharing” staff resources between agencies, divisions or between the hospital and provider community, the providers understood that there are many layers of licensure and compliance issues inherent in such a possibility. However, despite the fact that such partnerships for sharing staff would possibly open the door for more staff “stealing,” it would be worth it for the Department of Human Resources and the Division of MHDDAD to research whether some of the compliance issues could be satisfactorily addressed to ease the burden of the workforce shortage.

A concern in the realm of provider development was a contention that the playing field for current providers needed to be leveled before significant efforts to develop and recruit new providers commenced. The CSB providers readily identified differences in expectations between CSBs and private providers.

Examples include:

- CSB's have reporting requirements, such as for PERMES.
- CSB's are required to provide case management for all children in MATCH residential placements, which is extremely costly.
- Another example was in relation to the intake assessment requirements for CSBs, which are voluminous, whereas a private IFI (intensive family intervention) provider can provide services immediately without completing lengthy service entry procedures and forms.
- Private providers reportedly have the ability to “cherry pick” the consumers they choose to serve, where in practice, CSB's do not.
- With a finite availability of dollars for direct services, CSB providers shared that the more the budget is spread among providers; there is increased aggregate administrative overhead and fewer dollars to go to direct services.

The providers were supportive of opportunities to discuss the possibility of expanding the supply of potential staff by adopting precedents that have been set in other states as long as the ability to bill Medicaid would still be viable. For example, some states have made licensure available to those with Bachelor Degrees in social work and psychology.

Statistical Findings

Similar experiences across the country give credence to the workforce concerns shared by the CSB providers as a national matter. It is widely acknowledged that the troubles in supply of the healthcare workforce are not just endemic to specific healthcare settings, but to all. Research findings do substantiate, however, that Georgia is unique in comparison to other states of similar demographic composition and population and geographic size. According to the National Center for Health Workforce Analysis, in comparison to North Carolina, Tennessee and Virginia, Georgia regularly and consistently ranks lower in the quantity of clinical professionals. In Table IX:1, Georgia's struggle with low supplies of healthcare professionals is evidenced with a lower per capita count of registered nurses, psychologists, and social workers. The only two exceptions are in the per capita rates of licensed practical nurses and psychiatrists -- the latter only marginally above the state with the fewest psychiatrists (Tennessee). National ranking comparisons place Georgia:

- ❖ 48th in psychologists per capita
- ❖ 47th in social workers per capita:
- ❖ 42nd in RNs per capita
- ❖ 25th in LPNs per capita, and
- ❖ 25th in psychiatrists per capita

Many areas of the state are also designated as Health Professional Shortage Areas. The HRSA Bureau of Health Professions National Center for Health Workforce Analysis is the agency that designates whether or not an area is identified as a shortage area, as well as whether the area and/or its population are medically underserved. Many federal programs rely on the shortage designation for federal funding eligibility. The designated shortage can be in primary care, dental care, or mental health providers. An estimated 20 percent of the U.S. population resides in (primary medical care) Health Professional Shortage Areas. One-hundred-one (101) Georgia counties are designated as Health Professional Shortage Areas for primary care and even more towns and/or low-income areas of metropolitan cities are additionally designated; eighty-five (85) counties are designated as *mental health* shortage areas, a total of almost 54% of Georgia's counties⁵⁹.

Potentially, the numbers of clinically trained psychiatrists and psychologists are out there nationally, just not in Georgia. According to the Center for Mental Health Services'

⁵⁹ HRSA Bureau of Health Professions National Center for Health Workforce Analysis, <http://belize.hrsa.gov/newhpsa/newhpsa.cfm>

publication, *Mental Health, United States, 2000*, while the rate of growth in the number of clinically trained psychiatrists has decreased, the actual number have increased over the last two decades. Psychiatrists have generally worked in more than one service setting (60% of full time psychiatrists do so and 35% of part time), so the concept of staff “sharing” that requires providing services in more than one location and for more than one organization, would not be a foreign concept if the state looked to creatively tap the resources that do exist in Georgia.

Likewise, while growth for doctoral-level psychologists has been observed over the past twenty years, direct psychology services remain in shortage, especially for specific populations such as seriously emotionally disturbed children and adolescents, adults with serious mental disorders, rural residents with mental health needs, and the elderly. Where the numbers of psychiatrists and psychologists is not as alarming nationally, there is a continued decline in the number of enrolled nurses in psychiatric nursing graduate education. The number of graduates decreased from a conservative estimate of 781 nationally in 1979–80 to 426 in 1998.

On the upside, again nationally, psychosocial rehabilitation (PSR) has seen an upswing and, in fact, rapid growth. The importance and success of the field is evidenced by its rapid growth. Between 1988 and 1996, there was a 725% growth in the number of facilities surveyed by the Center for Mental Health Services that listed PSR in their service spectrum. The Center estimated in 2000 that this would translate to at least a PSR workforce of 100,000 nationally. With the effectiveness and efficacy of PSR now firmly established, the numbers by 2005 should well exceed 100,000. (Georgia might consider partnering with the Board of Regents to attract PSR schools and programs to Georgia to grow the workforce locally or implement a campaign to recruit staff from other states.)

National estimates of mental health staff turnover are high, indicating that the entire U.S. mental health care workforce turns over every five to seven years.⁶⁰ A study by Blankertz & Robinson (1997) cited reasons for turnover including stress, burnout, limited opportunities for advancement and low salaries. There was a higher correlation of turnover of professionals with the most intensive educational and licensure requirements such as psychiatrists and psychologists. Low salary was not a predictor of turnover, but lack of recognition and incentive structures were.

⁶⁰ McRee, Dower, et. al.

Table IX-1: National Center for Health Workforce Analysis
Highlights from the Health Workforce Profiles of Georgia, North Carolina, Tennessee and Virginia

<i>Indicator</i>		<i>Georgia</i>	<i>North Carolina</i>	<i>Tennessee</i>	<i>Virginia</i>	<i>National Rate</i>
# Of Health Services Sector Employees (of State's total workforce)		299,000 7.7%	328,000 8.5%	234,000 8.8%	257,000 7.5%	8.8%
Health Services Employment Growth 1988 To 2000		106%	81%	36%	44%	39%
Total Population Growth Between 1988-2000		30%	25%	18%	18%	15%
Net Per Capita Growth In Health Services Sector		58%	45%	15%	23%	21%
Projected Population Growth by 2020	Total	16%	13%	14%	15%	14%
	65+	78%	76%	65%	63%	52%
# Of Hospital Beds Per 100,000 Pop*.		290	285.6	360.5	237.4	292
# Active Patient Care Physicians Per 100,000 Pop.		167	176	190	191	198
# Of Physicians Assistants Per 100,000 Pop.		15	22.9	15.4	10.1	14.4
# Of RNs Per 100,000 Pop.		678.6 ⁶¹	854.4	870.1	708.7	780.2
# Of LPNs Per 100,000 Pop.		242.9 ⁶²	194.4	377.5	285.8	240.8
# Of Psychiatrists Per 100,000 Pop.		9.8 ⁶³	10.9	8.8	12.4	12.6
#Of Psychologists Per 100,000 Pop.		13.5 ⁶⁴	36.4	25.6	29.6	36.2
# Of Social Workers Per 100,000 Pop.		89.4 ⁶⁵	165.4	174.3	152.5	159.1
Source: 2004 publication based on 2000 Census Data http://bhpr.hrsa.gov/						
*Figure represents ALL Hospital Beds not just psychiatric beds						

⁶¹ Georgia's national ranking in RNs per capita: 42nd

⁶² Georgia's national ranking in LPNs per capita: 25th

⁶³ Georgia's national ranking in psychiatrists per capita: 25th

⁶⁴ Georgia's national ranking in psychologists per capita: 48th

⁶⁵ Georgia's national ranking in social workers per capita: 47th

Of import, too, in this discussion is that within the next few years, the first wave of baby-boomers will be reaching the retirement age. For example, the pool of clinically trained psychologists is aging—whereas the median age in 1989 was 44.2, as of 1999, it was 50.0 years, already six years closer to retirement. Indicative of the impact, 30% of the Federal workforce will be eligible to retire in five years and an additional 20% could seek early retirement⁶⁶. In Georgia's hospitals, of the 1853 staff, most of whom are clinicians, who are responsible for providing care in the Adult Mental Health, Child and Adolescent and Forensics units, 574 or 31% were employed prior to 1985 (14% before 1980) and, thus, succession plans will be needed as these professionals seek to retire from the system in the next ten years. This will take place while Georgia's population is estimated to grow by 16% by the year 2020, thus substantially increasing the need for additional mental health workforce providers, meaning that agencies and the state must start planning for the workforce of the future.

The remainder of this chapter will review available data to determine the extent to which these statements are true. The review will consider an analysis of the current workforce through contracted providers and of the hospital system. Staff to consumer ratios will be considered and the availability of licensed professionals will be considered quantitatively, qualitatively and geographically. Data sources include an extract of state hospital staff from the Department of Human Resources' Office of Human Resource Management and Development, community provider personnel data collected by APS's and hospital staffing pattern data resulting from a direct survey of all seven of Georgia's state mental health hospital facilities.

B. Who is Working in Georgia's Public Mental Health System?

APS obtained lists of five licensed professional categories from the Secretary of State's office, which provides administrative support services to 34 professional licensing boards that license more than 380,000 Georgians in 64 trades and professions. The total resources as represented by counts of those licensed in each category (Clinical Social Workers, Masters of Social Work, Licensed Professional Counselors, Licensed Practical Nurses, and Registered Nurses) allows us to demonstrate that in comparison to other states, Georgia has a low supply of these professionals and to illustrate the deficits in supply by region.

Statewide, there exists current licensure for 2,202 Clinical Social Workers, 31,291 Licensed Practical Nurses, 1,306 individuals licensed as Masters in Social Work, 2,661 Licensed Professional Counselors, and 92,998 Registered Nurses. Below, we look at how these individuals are spread over the state in terms of regional location, availability by square miles, ratio to consumers and in terms of how they compare to our estimates of professionals who work in the state's public mental health system (this analysis does not include licensed individuals for whom region of residence was unknown or who lived out-of-state).

⁶⁶ Federal Employee Labor and Standards Act: <http://www.opm.gov/workforceplanning/>

Due to the Metro Region's density of population in a relatively small geographic area, ratios of professionally licensed staff per 100 square miles are distinctively high. The Southeast Region, with the largest square mileage, stretches the available resources the most. With one exception, Master Social Workers, the Southeast has the fewest number of licensed professionals per 100 square miles per licensure category and ranks the lowest for all licensure categories combined. In looking at the remainder of the figures in the table, one overall observation is that there isn't much consistency in distribution among regions.

Table IX-2: Percentage of Licensed Workers in General Workforce per Region

Region	Clinical Social Worker	Master Social Worker	Professional Counselor	Licensed Practical Nurse	Registered Nurses
CENTRAL	1.12%	0.71%	1.28%	30.89%	66.01%
EAST CENTRAL	1.38%	1.33%	1.52%	28.06%	67.71%
METRO	3.08%	1.53%	3.30%	16.84%	75.26%
NORTH	1.52%	0.85%	2.20%	24.92%	70.51%
SOUTHEAST	1.04%	0.84%	1.20%	30.97%	65.95%
SOUTHWEST	3.08%	1.53%	2.74%	25.19%	67.45%
WEST CENTRAL	0.80%	0.62%	2.61%	27.44%	68.53%

Some consistency does exist in the distribution of each professional category within each region as demonstrated in the percentage breakouts for Table IX-2. For example, it is clear to see that nurses dominate the percentage of licensed professionals in each region, ranging from 65% to 75% in the number of Registered Nurses and 16% to 31% in Licensed Practical Nurses. We can deduce by virtue of the percentage split between the two nurse categories in the Metro Region, which is strikingly different from the other regions, that there is a positive correlation between Registered Nurses in metropolitan areas and, likewise, a similar correlation for Licensed Practical nurses in more rural areas. This theory, that we are more likely to find a greater number of credentialed professionals for licensure with more intensive educational and/or experience requirements in metropolitan areas, is not as evident in the field of social work. With the exception of the Southwest region, there is a higher percentage of Licensed Professional Counselors available in all other regions, but only slightly more so than Licensed Clinical Social Workers. A seemingly contradictory anomaly is found in the Southwest Region with an availability of LCSWs similar to the Metro region's and which is much greater than the supply of LPCs. This anomaly in the Southwest, which has the highest percentage of LCSWs per 100 square miles outside of the Metro Region, is a disproportionate amount of LCSWs compared to its like-size and like-demographic regions.

East Central has the greatest balance between the three social work categories with 1.52% LPCs, 1.38% LCSWs, and 1.33% LMSWs. In all other regions, the number of LMSWs

Table IX-3: Georgia Professional Licensure by Region per 100 Square Miles

	Square Miles Per Region	Clinical Social Workers per 100 Square Miles	Master Social Workers per 100 Square Miles	Professional Counselors per 100 Square Miles	LPNs per 100 Square Miles	RNs per 100 Square Miles
Central	8,573	1.35	0.85	1.54	37.29	79.70
East Central	8,331	2.17	2.09	2.39	44.18	106.61
Metro	1,808	35.23	17.48	37.72	192.70	861.45
North	9,520	4.10	2.30	5.91	67.13	189.98
Southeast	11,768	1.10	0.89	1.27	32.78	69.82
Southwest	9,452	5.96	2.96	5.30	48.70	130.41
West Central	9,178	1.22	0.95	3.97	41.76	104.31
Total	58,630	3.63	2.14	4.42	49.54	135.58
There were also counts of additional licensed professionals available statewide, for whom region of residence is unknown or who reside outside Georgia's borders. Thus there is an average additional capacity as follows.						
Statewide	58,630	0.29	4.22	0.14	0.30	24.64
Grand Total	58,630	3.76	53.37	2.23	4.54	158.62

is far below the numbers of LPCs and LCSWs, though less so in West Central which has an abnormally low supply of LCSWs, the fewest of all seven regions.

Another area of concern regarding workforce supply is around the availability of physicians who specialize in child and adolescent psychiatry. National estimates have shown a decline in medical doctor graduates who choose to specialize in child and adolescent psychiatry. Traditionally, much of the patient need for those with non-SED mental illness has been addressed by pediatricians, particularly for prescriptions of antidepressants and ADHD medications. However, with recent warnings associated with prescribing such medications, pediatricians may become more hesitant to continue to prescribe as they have in the past and reduce how much they prescribe, and to whom. This will shift an additional workload burden to child and adolescent psychiatrists who are already saturated.

APS obtained from the Georgia Board for Physician Workforce a listing by county of self-reported child and adolescent psychiatrists across the state and the results are sobering. In the data assembled by the Board for Physician Workforce, which is culled from Secretary of State Licensure rosters, only 88 psychiatrists in Georgia self-identified themselves as specializing in child and adolescent health. Many of the psychiatrists practice in multiple counties and this therefore results in a total “supply” of 134 across the state. Another source, the online referral directory of the American Academy of Child & Adolescent Psychiatry, lists a total of 101 unique child and adolescent psychiatrists, but does not provide an overlap of additional areas in which they practice. The count by the Georgia Board relies on current licensure in the state (though still on self-reported specialty) while the Academy lists those psychiatrists only who are members of the Academy. A third and final source, the Georgia Psychiatric Physicians Association, has in its database of over 800 psychiatrists:

- 130 psychiatrists who list Child Psychiatry as one of their subspecialties
- 191 psychiatrists who list Adolescent Psychiatry as one of their subspecialties
- 120 listed both Child and Adolescent Psychiatry as one of their subspecialties

The Director of the Association who provided the information noted the probable duplication among the three categories and also relayed that the database included both former (retired) and non-renewed members and that not all psychiatrists submit regarding subspecialty information. It is difficult to decipher which of these sources provides the most accurate information. According to Charles A. Zapf, M.D., a child psychiatrist with Emory University and former President of the Georgia Council on Child and Adolescent Psychiatry, it is not uncommon for child psychiatrists *not* to practice child psychiatry. While we acknowledge that a small percentage of psychiatrists may be additionally available, so as not to overstate the supply, we therefore conclude that using the lower number of those self-reported specialists has led us to a more conservative and accurate count.

The availability of psychiatrists is distributed unevenly across MHDDAD regions from both sources. Using the Georgia Board count, the distribution results in less than ¼ of a child and adolescent psychiatrist per 100 square miles on average. In relation to demand, there are 41,749 consumers under age 18 enrolled in community services. To include utilization of hospital services as well, we'll increase demand based on current system utilization to 42,288. Based on the unique count of self-identified child and adolescent psychiatrists, that results in 0.21 physicians to every 100 children/adolescents who are current consumers of Georgia's mental health system. If each of these 42,288 consumers were in need on average of only four hours of consultation/therapy annually, it would consume approximately an entire year of each of the 88 psychiatrists' time. And this hasn't even considered the demand by those in need of services from the private sector.

Region	Count of C&A Psychiatrists	Availability Per 100 Square Miles
Central	5	0.058
East Central	16	0.192
Metro	71	3.927
North	21	0.221
Southeast	4	0.034
Southwest	2	0.021
West Central	15	0.163
Grand Total	134	0.229

The unique count of AACAP members is regionally distributed as follows: Central-6; East Central-8; Metro-59; North-14; Southeast-10; Southwest-1; and West Central-3. The differences are interesting; particularly in an area like the Southeast where the count from AACAP reflects 6 more psychiatrists than did the count from the Georgia Board despite the duplication in that list. In terms of the difference between the total counts of 88

versus 101, where the ratio of child and adolescent psychiatrists to every 100 MHDDAD consumers was 0.21 using the 88 count, the average ratio is 0.24 using the count of 101. If the additional 13 individual psychiatrists are truly available and practicing child and adolescent psychiatry, that certainly is a plus, however, the picture remains fairly bleak.

Another point relayed by Dr. Zapf is that it is not unusual for a practice to become more adult oriented as the practitioner gets older, where the psychiatrist's patient load becomes mixed and not fully devoted to children and adolescents. Earlier in this chapter, national projections were cited that indicated that by 2020, there would only be sufficient child and adolescent psychiatrists available to meet 30% of the need. We estimate that Georgia's need would be on the higher end of the range that resulted in that projected national average. This is based on the current lack of supply in Georgia as well as the aging of Georgia's population (of which those who are 65 years of age and older is projected to grow by 78% by the year 2020).

Other Findings and Implications

Community

APS conducted a survey of 55 providers including all CSBs and private providers in which the numbers of licensed and certified staff associated with each provider were collected⁶⁷. The resulting counts were compared to each provider's service population for FY04 to determine the ratios of consumers to staff based on this sizeable sample. For the purposes of analysis, averages were primarily computed in terms of staff persons per 100 consumers. In global numbers, 1,964 licensed and certified staff and 3,323 non-licensed staff were compared to a total service population of 168,579. A minimum of 36% of the surveyed workforce is estimated to qualify as Mental Health Professionals given their licensure status. Others may be included in the Non-Licensed/Paraprofessional or Certified Peer Specialists categories, but we are not able to differentiate further based on the data collected. For a complete roster of the numbers and types of practitioners by provider, see **APPENDIX IX-1: Roster of Practitioners by Type**. The next section relies on this sample for extrapolated statewide estimates and for comparison to counts of licensure in the general workforce.

DMHDDAD's clinical workforce is depicted in Table IX-4, which combines the counts of clinicians from the state's hospitals and the counts of extrapolated estimates for community provider staff based on the average staffing ratios per licensure category per region. Hospital data was included in order to compare the utilization by select professions of MHDDAD's workforce compared to the general workforce. In comparison to the state's full complement of available licensed professionals, we find that the percentages of professionals per 100 square miles who work with MHDDAD system are:

⁶⁷ Counts consistent of a "body count" of available staff by licensure, certification or paraprofessional status and thus does not represent a full time equivalent count.

- ❖ 14.6% of LCSWs⁶⁸
- ❖ 11.7% of LMSWs
- ❖ 13.1% of LPCs
- ❖ 1.25% of LPNs
- ❖ 0.88% of RNs

Table IX-4: MHDDAD Community and Hospital Professional Licensure by Region per 100 Square Miles						
	Square Miles Per Region	Clinical Social Workers per 100 Square Miles	Master Social Workers per 100 Square Miles	Professional Counselors per 100 Square Miles	LPNs per 100 Square Miles	RNs per 100 Square Miles
Central	8,573	0.34	0.18	0.57	0.88	1.27
East Central	8,331	0.34	0.28	0.34	0.08	0.78
Metro	1,808	8.32	2.63	4.56	3.68	10.95
North	9,520	0.33	0.16	0.67	0.51	0.89
Southeast	11,768	0.18	0.12	0.22	0.35	0.76
Southwest	9,452	0.22	0.22	0.44	0.61	0.77
West Central	9,178	0.31	0.14	0.56	0.73	0.91
Total	58,630	0.53	0.25	0.58	0.62	1.20

Estimates have also been computed to compare the total numbers of staff working in MHDDAD's mental health system to Georgia's total healthcare workforce. (Note that this will not include hospital or community-based staff for the developmental disabilities population and perhaps some portion of staff for the addictive diseases population.) By adding the total projected number of direct clinical and paraprofessionals estimated in Table IX-5 of 5,625.3 to the total number of clinical mental health hospital staff, 1,853, a combined total of 7,478.3 results. As a percentage of Georgia's healthcare workforce (health care professionals only), MHDDAD hospital and community-based mental health clinicians and paraprofessionals represent only 3.6% (and only 2.5% of Georgia's entire healthcare workforce).

GAP:
MHDDAD does not sufficiently tap into existing workforce resources.

Table IX-4 above illustrates other notable comparisons in terms of licensed clinician groups. East Central has an abnormally low utilization of LPNs, which is not in direct proportion of the area's supply of LPNs. Southeast's utilization of LCSWs is low as well, but it does have the fewest supply per 100 miles of licensed clinical social workers. The

⁶⁸ Licensure data for hospital staffing numbers was not included in the data extract from the DHR-OHRMD. Estimates were made based on job title and job description.

Southeast Region makes up for this to some extent in its utilization of Masters Social Workers and Professional Counselors.

Looking beyond just the clinical social work and nursing positions discussed above, the following table reflects the computed estimates of all community clinical and direct care staff based on the average staffing ratios of all staff to consumers per region (from the sampling of 55 providers). The table compares the numbers of consumers per 100 square miles, the number of providers per 100 square miles, the average ratio of all clinical and direct care staff per 100 consumers, the estimated total staff in the region, and the average numbers of staff per 100 square miles. The “Estimated Total Staff in Region” is the product of the average staff ratio per 100 consumers and the total numbers of consumers served in the region. The “Total Average Staff per 100 Square Miles” is derived by dividing the total estimated staff by the number of square miles in the region.

Table IX-5: Estimated Total Community Provider Staffing					
	Consumers Per 100 Square Miles	# Of Providers Per 100 Square Miles	Average Clinical And Direct Care Community Staff Per 100 Consumers	Estimated Total Staff In Region	Total Average Staff Per 100 Square Miles
Central	209.7	0.35	2.79	501.59	5.85
East Central	204.0	0.32	2.34	397.18	4.77
Metro	1,934.4	4.76	4.36	1,526.31	84.42
North	450.9	0.49	2.30	988.36	10.38
Southeast	202.8	0.23	3.72	888.78	7.55
Southwest	196.9	0.32	3.08	573.42	6.07
West Central	240.2	0.34	3.40	749.71	8.17
Total	3,438.8	6.80	22.0	5625.3	127.2

In this format, we can see staff ratios from a different perspective. For example, in the Central Region there are an estimated 5.85 staff per 100 square miles for 209.7 consumers. Also, in comparing Central and West Central, which have similar numbers of providers per square miles (.35 and .34 respectively), there are 2.32 more staff on average in West Central per 100 square miles. This equates to 40% more staff for 15% more consumers. The same is true for East Central and Southwest which have exactly the same numbers of providers per 100 square miles (.32) but Southwest has 1.3 (27%) more staff per 100 square miles as compared to East Central, while East Central has more consumers per 100 square miles, 7.1 or 3.6%. The rationale may be that the Southwest is physically bigger, over 1,100 more square miles than East Central, and also has over 600 more consumers total than East Central.

From a more specific breakdown of the resulting licensure and staffing count data from the sampling of fifty-five providers, we have estimated that in the community, including

the total number of staff⁶⁹, on average there are 32 consumers to every staff person and 3.14 staff to every 100 consumers. Considering only those staff that are licensed or certified, the statewide average is 1.17 staff to every 100 consumers, but with a wide disparity across regions where the range is from 0.68 to 1.9 licensed staff to every 100 consumers. North Region's average is 0.68 licensed or certified staff per 100 consumers representing the low, compared to the high of Metro Region's 1.9. Both Central and West Central share the same ratio at 1.29 licensed staff per 100 consumers at the high end, while Southeast has the second to lowest ratio with 0.93 and Southwest and East Central are 1.22 and 1.12 respectively. The state average of non-licensed and paraprofessional staff is 1.97 per 100 consumers. We will look closer at this in terms of availability of staff in each region.

Table IX-6: Licensed and Non-Licensed Staff Ratios per Region		
Region	Data Measure	Ratio Per 100 Consumers
Central	Ratio of Non-Licensed Staff per 100 Consumers	1.50
	Ratio of Licensed or Certified Staff per 100	1.29
	Ratio of All Staff per 100	2.79
East Central	Ratio of Non-Licensed Staff per 100 Consumers	1.22
	Ratio of Licensed or Certified Staff per 100	1.12
	Ratio of All Staff per 100	2.34
Metro	Ratio of Non-Licensed Staff per 100 Consumers	2.47
	Ratio of Licensed or Certified Staff per 100	1.90
	Ratio of All Staff per 100	4.36
North	Ratio of Non-Licensed Staff per 100 Consumers	1.62
	Ratio of Licensed or Certified Staff per 100	0.68
	Ratio of All Staff per 100	2.30
Southeast	Ratio of Non-Licensed Staff per 100 Consumers	2.80
	Ratio of Licensed or Certified Staff per 100	0.93
	Ratio of All Staff per 100	3.72
Southwest	Ratio of Non-Licensed Staff per 100 Consumers	1.86
	Ratio of Licensed or Certified Staff per 100	1.22
	Ratio of All Staff per 100	3.08
West Central	Ratio of Non-Licensed Staff per 100 Consumers	2.11
	Ratio of Licensed or Certified Staff per 100	1.29
	Ratio of All Staff per 100	3.40
Total Ratio of Non-Licensed Staff per 100 Consumers		1.97
Total Ratio of Licensed or Certified Staff per 100		1.17
Total Ratio of All Staff per 100		3.14

Limitations of the Data: Analysis of all 55 providers' staffing patterns in relation to their respective MHDDAD service populations could be misleading. Many of the private providers who serve relatively small numbers of MHDDAD consumers, but may serve many others referred by other sources, had a greater proportion of staff to numbers of

⁶⁹ Total staff positions included non-licensed staff in addition to all licensed and certified professionals.

consumers than the CSBs. This has the potential to inherently skew the results. Thus, APS also conducted the same analysis as above but with CSB staffing patterns and service population only.

Rather than 32 consumers to every staffperson, using only the CSB data, there are on average 38 consumers to every staffperson⁷⁰. Where the statewide average of licensed or certified staff to every 100 consumers was 1.17, for the CSBs only, it is 1.04. The difference in the ratio of non-licensed and paraprofessional staff to every 100 consumers is 1.56 instead of 1.97. The total number of all staff to every 100 consumers for CSBs is 2.60 compared to the full provider sample average of 3.14. Given the relatively small numbers of consumers attributed to private providers of the entire service population (3,889), the ability of private providers to afford higher staffing levels is strikingly evident in this comparison.

Social Workers

The statewide average ratio of total social workers to every 100 consumers is 0.44, though the average per region ranged from 0.28 to 0.52. All social worker positions included Licensed Professional Counselors (LPC), Licensed Associate Professional Counselors (LAPC), Licensed Clinical Social Workers (LCSW), Licensed Masters of Social Work (LMSW), Licensed Marriage and Family Therapists (LMFT), and Licensed Associate of Marriage and Family Therapists (LAMFT).

The ratio of social workers and types of social workers typically utilized among the providers by region is diverse. In six of seven regions, the licensed position with the highest ratio among social workers is LPC and the range of the ratios begin with 0.12 in the North to 0.23 in West Central with the statewide average being 0.16. This low trend in the North Region has been emblematic of the region's having the greatest numbers of consumers in its service population, more than double the number of some other regions. Despite this, the North Region still has 0.01 more social workers per 100 consumers (0.29) than the Southeast Region which has 0.28. The only region not to have LPCs as its highest ratio is the Metro Region with 0.35 LCSWs per 100 consumers, though LPCs take second place with a 0.21 ratio. The second highest ratio in the other regions goes in four regions LCSWs and in two regions to LMSWs (with the East Central Region tying at 0.12 LCSWs and LMSWs per 100 consumers). In the North Region, the second highest ratio position is held by LAPCs, with 0.08 per 100 consumers.

In each region, there are fewer than 0.01 LAMFTs to every 100 consumers. In fact, four of the seven regions have none. Despite the fact, the statewide average remains 0.01.

Certified Addiction Counselors (CAC) were not included in the regional and statewide averages of total social workers. However, because they do play a role in the treatment of those with dual diagnosis, when taken into account, another 0.08 social workers (CACs)

⁷⁰ Referring to total clinical staff, both licensed and non-licensed, but not administrative staff.

to every 100 consumers is available (Central-0.12, East Central 0.06, Metro 0.06, North 0.04, Southeast 0.13, Southwest 0.11, and West Central 0.09). This adds up to a grand total of 0.56 per 100 consumers statewide although we acknowledge that only a percentage of these resources are necessarily available to the population of consumers with a primary mental health diagnosis.

Medical Staff

There are 209 Doctors of Medicine employed by or associated with the sample's 55 DMHDDAD community mental health providers. This count includes both general physician MDs and psychiatrists. This amounts to 0.12 MDs per 100 consumers in statewide average terms. Regionally, the M.D. ratio ranges from 0.02 in the Southeast to 0.24 in the Metro Region per 100 consumers (Central 0.17, East Central 0.09, North 0.09, Southwest 0.12, and West Central 0.14).

Physicians' Assistants (PAs) are used to a very small extent across the state—only 9 positions total from all 55 providers sampled resulting in 0.01 PAs per 100 consumers statewide and a total ratio of 0.13 MDs and PAs per every 100 consumers.

The statewide average ratio of nurses to 100 consumers is 0.36 and includes both 4 year and 2 year Registered Nurses (RN), Certified Nursing Specialists, Nurse Practitioners, and Licensed Practical Nurses (LPN). The statewide ratio is heavily influenced by a predominance of 4 year RNs which prevails in all regions except Southwest in which LPNs are more frequently used. LPN is the second most frequently used nurse position in six of the seven regions, but for the Southwest region in which the 4 year RN and LPN have swapped ranking. Each region differs in the ratios of remaining nurse positions. Where the Central Region has 0.06 2-year Registered Nurses for every 100 consumers, East Central, Metro and North use none, and Southeast, Southwest and West Central use between 0.01 and 0.03. This would seem to indicate a greater supply of 2 year RNs in the southern part of the state or a greater supply of 4 year RNs in the North who are perhaps more readily employed as having more appropriate and/or applicable qualifications.

Psychologists

The Georgia State Licensing Board of Psychologists currently licenses 1,709 psychologists across the state. Of those, we have identified 64 in the survey of community providers and 16 who work in the state's hospitals for a total of 80, or 4.7% of the total number of psychologists available in the state. In addition, community providers employ 71 Certified Psychiatric Rehabilitation Practitioners (CPRP) and 9 Registered Psychiatric Rehabilitation Practitioners (RPRP).

The statewide average ratio of psychologists to the community-based service population is 0.04, and ranges from 0.02 to 0.07 regionally. Central, East Central, North, and Southwest have 0.02 psychologists per 100 consumers, while Metro and West Central have 0.06, and Southeast has 0.07. Psychologists are predominantly employed or contracted by CSBs (49 of the 64 total). Gateway CSB in coastal southeast Georgia by

far employs the most of any other CSB with 12 psychologists of 17 in the region which contributes toward the Southeast Region having the highest ratio per 100 consumers.

Psychologists are supplemented with the use of Certified and Registered Psychiatric Rehabilitation Practitioners. It is probable that these practitioners are utilized to the extent they are due to Georgia's low supply of psychologists in the workforce (recall that Georgia ranks 48th in the nation in terms of the total number of psychologists per capita). The extent of utilization of these practitioners varies from region to region. With only a slightly higher total count of CPRPs than psychologists, the statewide average ratio is the same as for psychologists at 0.04 per 100 consumers. However, with only 9 RPRPs, who are all located in the Metro Region, while the statewide average ratio is 0.01 per 100 consumers, in all practicality the six other regions have no availability of this type of practitioner.

The Metro Region uses CPRPs to the greatest extent with 0.11 per 100 consumers and the Southeast uses them the least with a regional ratio of 0.01 per 100 consumers. The latter ratio for Southeast makes sense given the virtual plethora of licensed psychologists the region has available. Southwest and West Central are the regions that utilize CPRPs more than psychologists, with CPRP ratios of 0.05 and 0.06 respectively (compared to 0.02 psychologists in the Southwest Region and 0.04 in West Central.

GAP:

There is a critical shortage of licensed mental health professionals, particularly social service providers, both in terms of quantity and equitable distribution across the state.

Certified Peer Specialists

Peer Support is a nationally recognized evidence-based program that has been/is provided by an estimated 250 Certified Peer Specialists (CPS) who have served approximately 3,316 consumers across the state. There is a general acclaim for the role that CPSs play, though there is not consensus that the CPS training is adequate or that the application of how CPSs are used across the state is consistent.

TableIX-7: Estimated Certified Peer Specialists Ratio to Consumers per Region			
Region	(1) Average CPS Ratio to every 100 Consumers (All Community Mental Health Consumers)	(2) Weighted Average Staff Ratio for Every 100 Peer Support Consumers	(3) CPS Ratio Per 100 Peer Support Consumers
Central	0.06	8.54	4.99
East Central	0.09	20.49	9.83
Metro	0.05	8.28	10.04
North	0.04	7.29	3.63

Southeast	0.02	2.94	6.65
Southwest	0.05	7.07	6.88
West Central	0.03	4.66	4.31

The MHDDAD Office of Consumer Relations provided a count by region of Certified Peer Specialists⁷¹ and while their database held 265 names of CPSs, only 206 were specifically associated with a region, 10 were out of state, and the rest were unknown. Seventy-three employed CPSs are represented in the provider staffing survey sample APS conducted (59 of them associated with CSBs). Because CPSs are available primarily to serve a finite population (recipients of Peer Support Services) although they could be utilized in different capacities as well, and because there is some ambiguity in exact numbers of currently active and employed CPSs, APS chose to calculate staffing ratios in three different ways: 1) Calculating the average CPS to consumer ratio for all the consumers in a given region (per 100) just as the previous analyses have done, 2) Utilizing a generally accepted approximate total of 250 CPSs and estimating the staffing ratio per 100 consumers based on a weighted average of the distribution of the 73 specialists per region from the survey sample, and 3) Utilizing the data for the known distribution of the 206 CPSs from the Division of MHDDAD.

In the first scenario, the statewide average ratio of CPSs to every 100 consumers is 0.04, with a regional range of 0.02 to 0.09. Only two regions fall below the statewide average—Southeast with 0.02 CPSs per 100 consumers and West Central with 0.03 CPSs per 100 consumers.

In the second scenario, the East Central region has the maximum number of CPSs per 100 Peer Support consumers with 20.49, which is far outside the expected normal range. This is due to East Central having the fewest number of Peer Support services recipients of any other region. In the Southeast Region, there is an estimated 2.94 CPSs per 100 consumers representing the state's low in this model. The four regions in the mid-range, Central, Metro, North and Southwest have between 7.07 and 8.54 CPSs per 100 Certified Peer Specialists and in the bottom quadrant, West Central has 4.66. In this scenario, the inclusion of erratic data such as East Central's high ratio of 20.49, leads us to believe that the distribution of the 73 CPSs from the survey is not necessarily representative of the actual statewide distribution of resources.

From the third perspective, we used the personal addresses of the 206 CPSs listed in the Division's Office of Consumer Relations database to assign them to regions. Rather than utilizing the total count of 73 from the provider survey where region assignment was based on the regional location of the provider, we believe the utilization of known addresses for the 206 CPSs provides the most accurate depiction of CPS resource availability. The actual numbers of CPSs and Peer Support recipients are:

<u>#CPSs</u>	<u>#Peer Support Recipients</u>	<u>Ratio</u>
--------------	---------------------------------	--------------

⁷¹ Requested of Ms. Beth Filson and provided by Armishia Wiley, both of the Office of Consumer Relations and received on March 2, 2005.

❖ Central Region	20	401	0.05
❖ East Central Region	23	234	0.10
❖ Metro Region	54	538	0.10
❖ North Region	29	799	0.04
❖ Southeast Region	31	466	0.07
❖ Southwest Region	30	436	0.07
❖ West Central Region	19	441	0.04

This third calculation depicts a much higher concentration of CPSs in the Metro area, which would be expected given that it has 25 more CPSs than the median and 23 more than the region with the second to highest number of CPSs.

GAP:
The availability of Certified Peer Specialists is not being utilized to its potential by the MHDDAD service system.

C. Salary Comparisons

Outside of supply variables, low salaries are cited most often as the reason why workforce recruitment and retention of clinical professionals is so difficult. In this section, we will compare salaries for like positions between Georgia's systems that offer mental health services as well as to other states and national averages according to the U.S. Bureau of Labor Statistics.

Comparisons of salaries for public community mental health professionals is difficult due to providers being contractors and thus their employees are not state employees, nor does the state have the capacity to track such data. National data is limited for that reason as well, though NRI state profiling does report out some entry level and top salaries for community based positions of certain professions.

Because of Community Service Boards' unique status, they are able to perform recruitment and post job listings using the web-based "The Job Site" through the Department of Human Resources. If salary information is included, The Job Site postings typically include a salary range, which represents entry level salary at the low with minimal experience and the cap at the high end for maximum experience and qualifications. By searching for certain positions on The Job Site, we were able to make the following comparisons:

- ❖ The starting salary for an inpatient Licensed Practical Nurse is \$21,401 for East Central Hospital compared to \$25,410 for Roosevelt Warm Springs Rehabilitation Center (Department of Labor).
- ❖ A nurse position posted by the Department of Juvenile Justice had an entry salary of \$31,474, which is the same as the East Central CSB, while both RiverEdge CSB and Clayton CSB had a nurse position posted starting at \$33,500.
- ❖ A Behavior Specialist position for the Department of Labor (Meriwether County) and a DHR statewide position both started at \$28,543.

- ❖ A Certified Rehabilitation Counselor for the Department of Labor (Emanuel County) started at \$31,474 while a Certified Addiction Counselor at Highland Rivers CSB started at \$25,895.
- ❖ Social Services Provider I positions (Master's degree) reflected a difference among CSBs with both Cobb CSB and Douglas CSB offering entry positions at \$25,895 and Georgia Mountains CSB starting at \$28,530.
- ❖ For Social Services Provider II positions (requiring a Master's degree plus 2 years applicable experience), Cobb CSB offered a starting salary of \$28,543 and so did a position in DeKalb County listed by the Department of Juvenile Justice.
- ❖ The Albany CSB sought a Licensed Social Services Provider II for which there was a \$31,474 starting salary (with a cap of \$40,993) while the Georgia Mountains CSB sought the same position for \$35,550 (with a cap of \$39,105).
- ❖ A Social Services Technician started at \$19,455 for the Albany CSB and Cobb CSB, while Advantage Behavioral Services had a starting salary of \$21,500.

The Department of Corrections had no comparative listings, though on their contractor's website (Mental Health Management) they had ten openings for psychiatrists, 3 for mental health counselors, and 2 Child and Adolescent Counselors. (No salary ranges were provided.)

The above examples demonstrate that while it tends to be true that other service systems offer higher level salaries, it is not 100% consistently the case. It is also not consistently the case that geographic differentials and related costs of living for those areas drive differences in salaries, this is not always the case either. For the Social Services Technician example, both Albany CSB in southwest Georgia and Cobb CSB in the metropolitan Atlanta area offered the same starting salary, which would typically not be expected. In some instances, the CSBs, even those in more rural areas with typically lower costs of living, offered a higher starting salary than the Department of Juvenile Justice such as in the nurse example.

From the NRI State profiling system we have available some comparisons for psychiatrists, psychologists, social workers, licensed practical nurses, and registered nurses in both community and hospital settings.

Table IX-8: Salary Comparisons for Selected Positions in State Psychiatric Hospitals					
Hospital Position	Georgia	North Carolina	Tennessee	Virginia	Average
Psychiatrist - Entry Salary	44,556	110,817	88,396	77,837	80,402
Psychiatrist - Top Salary	152,698	179,776	130,992	159,747	155,803
Psychologist – Entry Salary	50,653	39,358	30,108	34,910	38,757
Psychologist -Top Salary	88,483	59,658	57,924	71,646	69,428
Registered Nurse - Entry Sal.	31,474	35,880	24,432	26,722	29,627
Registered Nurse - Top Sal.	55,072	59,658	57,924	54,842	56,874

Licensed Practical Nurse-Entry	19,455	26,421	19,080	20,455	21,353
Licensed Practical Nurse -Top	34,040	38,052	34,560	41,980	37,158
Master Social Work - Entry	34,553	35,080	27,660	26,722	31,004
Master Social Work - Top	54,093	49,799	49,704	54,842	52,110

In the hospital setting, Georgia's salaries compare most favorably to the other three states for psychologists, with an entry salary of almost \$12,000 more than the four-state average and a top salary of over \$19,000 more. Considering Georgia's ranking 48th nationally in the numbers of available psychologists, it is likely that the demand has driven the salary range so high. The starting salaries for Georgia's hospital Masters of Social Work compare favorably as well with the second to highest entry and top salary of the other states. Georgia's and North Carolina's registered nurses are mostly on par in comparison to each other, while both of the other states, Tennessee and Virginia, have significantly lower entry salaries for registered nurses. Georgia's starting salary for Psychiatrists is completely out of line compared to the other three states at almost \$36,000 less than the four state average. However, we do know from the Department of Human Resources' Office of Human Resource Management and Development hospital personnel data extract that all hospital physicians are paid on average between \$121,000 and \$130,000 and psychiatrists are included in the physician data. It is, therefore, likely that initial salary offers are never as low as is possible on paper and as is reflected in the above table.

Looking internally within the state at hospital salaries (See **APPENDIX IX-2: Average Salary Data**), we have computed average salaries for each position by hospital and can compare each hospital's average to the others. One of the most remarkable findings is that Georgia Regional Hospital at Savannah consistently has the highest average salaries regardless of the clinical position. At the other end of the spectrum, Central State tends to have the lowest with a few exceptions. In terms of specific positions, the psychologist position as discussed above stands out markedly due the disparity of the average salaries from hospital to hospital. While the statewide average is \$62,630, Southwestern is as low as \$50,199 and Northwest is as high as \$73,158. This is one of the few categories where Savannah's average is actually among the lower salaries with about \$3,000 less than the statewide average.

I. Table IX-9: Georgia Hospital Direct Care Staff Salary Comparisons		
Position Title	Statewide Average Salary	Notes
Behavior Specialist	\$47,706.57	Salaries range from a low at Central State of \$34,271 to a high of \$49,307 at Savannah. Three out of four hospitals' average salary is under \$40,000 and the other four hospitals are over.
Forensic Psychologist	\$64,851.15	Central State is lowest average and Savannah is highest. Atlanta Regional almost matches state average.

Inpatient Nurse	\$41,477.93	Northwest has lowest average with \$3,048 less than the next highest average at Southwestern.
Nurse Manager	\$53,764.48	All hospital averages are over \$50,000 except for Central State at \$48,601. Atlanta, Savannah and East Central averages are in the high \$50Ks, while Southwestern and West Central are in the low to mid \$50Ks.
Licensed Practical Nurse	\$26,673.57	These average salaries do not deviate very much with a low of \$25,334 at Southwestern and a high of \$28,391 at Savannah.
Social Service Provider 1	\$33,790.53	Both Northwest and Southwestern have salaries at \$25,895.28 while Atlanta's is over \$41,000 and West Central's is just above average at \$34,999.99
Social Service Provider Hosp (DHR)	\$37,662.29	Tracked separately without indication of whether provider level 1 or 2; here the range begins at \$31,078 at Northwest and maxes out at \$40,938 at Atlanta.
Social Service Tech Hospital	\$29,013.61	East Central has the highest average at \$37,437.28 and the lowest is almost \$14,000 less at Southwestern with \$23,613.60. Savannah and Atlanta both have averages in the \$31,000 range and the other three range between \$26,242 and \$29,728.

For community salary comparisons, there were states that reported entry and top level salaries, but Georgia did not, nor did any of the other three comparison states to which we've referred for other variables in this report. In lieu of those three states, we selected three other states, Louisiana, Oklahoma, and South Carolina, for the purpose of these community salary comparisons only. Of the states that reported community-based salary figures to NRI, these three were deemed to have the most in common with Georgia. Another data limitation in this perspective comparison is that the figures used for Georgia are based on CSB positions posted through the Department of Human Resources and thus comply with DHR's position grade salary ranges which are predetermined and therefore do not reflect market-driven compensation and which may also not be indicative of private provider salaries.

The position of Psychiatrist for Georgia has the lowest cap of all four states. With salary increases, once a psychiatrist is in the system, we see from **APPENDIX IX-2** (see "Physician") that the statewide average is over \$125,000, but this figure, too, is still almost \$20,000 less than the other states' caps.

Again, Georgia's psychologist salaries compare favorably. However, the above theory may not hold true in this comparison. Louisiana actually has fewer psychologists per capita than Georgia, but they have the lowest entry and top salary levels of all four states in this comparison. Therefore, either the low supply is not being considered in establishing salaries for psychologists or other factors are driving the low salary range.

Table IX-10: Salary Comparisons for Selected Positions in Public Community Services					
Hospital Position	Georgia⁷²	Louisiana	Oklahoma	South Carolina	Average
Psychiatrist - Entry Salary	44,566	95,000	120,000	106,825	91,598
Psychiatrist - Top Salary	114,507	150,000	162,500	148,369	143,844
Psychologist - Entry Salary	50,653	21,336	34,861	28,534	33,846
Psychologist -Top Salary	88,483	49,356	56,264	59,386	63,372
Registered Nurse - Entry Sal.	31,474	29,040	32,240	29,673	30,607
Registered Nurse - Top Sal.	55,072	56,724	54,058	59,386	56,310
Licensed Practical Nurse-Entry	19,455	---	19,801	19,292	19,516
Licensed Practical Nurse -Top	34,040	---	36,843	32,969	34,617
Master Social Work - Entry	25,895	23,904	23,233	26,378	24,853
Master Social Work - Top	49,908	63,480	50,835	48,804	53,257

For additional comparisons, mental health service provider contractors for the Georgia Department of Corrections have provided salary ranges for their clinical staff as well. Compared to the MHDDAD top salary for psychiatrists of \$114,507 (yet a statewide average of \$125,575 in the state's hospitals), salaries of psychiatrists working for the Department of Corrections earn \$160,000-\$190,000. This salary range is far above Georgia's average and the three comparison states. The national average according to the U.S. Bureau of Labor Statistics, Office of Mental Health Practitioners (November 2003), which lists the average salary of psychiatrists as \$115,230, would make Georgia's current hospital average salary above the national average and the community entry-level salary cap just \$1,000 below average. Other occupations as reported by the U.S. Bureau of Labor Statistics earn average annual salaries as follows:

- ❖ Clinical and Counseling Psychologists - \$77,250
- ❖ Marriage and Family Therapists – \$61,750
- ❖ Registered Nurses - \$53,260
- ❖ Mental Health Counselors - \$43,540
- ❖ Mental Health and Substance Abuse Social Workers - \$43,360
- ❖ Occupational Therapists - \$38,180
- ❖ Substance Abuse and Behavioral Disorder Counselors - \$35,130
- ❖ Licensed Practical Nurses - \$34,580
- ❖ Rehabilitation Counselors - \$34,440
- ❖ Psychiatric Technicians - \$31,250

⁷² Georgia community salary figures based on CSB job postings, since community figures were not submitted to NRI for state profiling system.

Further comparisons of Georgia's MHDDAD rates to Department of Corrections and the national labor bureau averages include Licensed Psychologists who earn between \$77,000 and \$90,000 annually with the Department of Corrections, which is on the high end compared to the national labor bureau average of \$77,250. The highest average salary among the state's hospitals for psychologists is just over \$73,000, so MHDDAD's psychologists' salary rates are about 5.5% lower in comparison.

The Department of Corrections employs (through its contractor) non-licensed mental health counselors who have Masters degrees in a mental health discipline at a midpoint salary of \$38,500 and licensed counselors, including Licensed Professional Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists at a midpoint salary of \$50,000. The national labor bureau average of \$35,130 for a non-licensed counselor, \$43,360 for Social Workers, and \$61,750 for Licensed Marriage and Family Therapists sets the parameters for comparison of the range to Georgia's figures. The broad range of MHDDAD's hospital Social Service Provider II's salaries (\$34,630 to \$54,049) and the variety of different credentialing levels this position encompasses indicate a need to tighten the range within the system. A set of more refined job descriptions with more narrow salary ranges would better enable comparisons to other states and national averages. Even with socio-demographic and geographic differences this large of a gap is not warranted, particularly when the low end at \$34,630 is below the national average for a non-licensed counselor.

For a final comparison to the Department of Corrections, we look at nurses. The average range of salaries for Registered Nurses is \$31,474 to \$55,072 in the state's MHDDAD system, where the DOC contractors offer an annualized amount of \$43,680 to \$52,000⁷³. The entry salary is 38% higher with the Department of Corrections. This higher salary gives the Department of Corrections powerful leverage for recruitment of RNs early in their career. While the cap of the DOC salary is less than MHDDAD's, once in the system it is possible that their salaries continue to grow, or after several years of growing their salaries, the RNs may then jump to other systems which offer even higher ranges, most probably in the private sector. The national labor bureau average is \$53,260, which at the top of the salary ranges we see for RNs in Georgia's public systems, indicates that Georgia's cap in both the Department of Corrections and DMHDDAD is far below the national average.

Licensed Practical Nurses with DOC are remunerated at a beginning range of \$27,040 to the top of the range at \$37,440 compared to MHDDAD's range of \$19,455 to \$34,040. Again the starting salary is significantly higher (39%) for LPNs with DOC, but differently from the case with RNs, the maximum salary for LPNs is also higher than MHDDAD's by almost 10%. The national labor bureau average for LPNs at \$34,580, like RNs, falls at the top of Georgia's range and is 29% greater than MHDDAD's range midpoint.

⁷³ The Department of Corrections provided hourly wages paid to nurses and these have been converted to annualized salaries based on 2,080 hours annually.

Overall conclusion: The availability of higher salaries through the private sector and other public agencies that provide mental health services does present a disincentive for DMHDDAD workforce and retention efforts.

GAP:

The availability of higher salaries through the private sector and other public agencies that provide mental health services does present a disincentive for the state's MHDDAD workforce recruitment and retention efforts.

D. Community vs. Hospital Workforce

During FY 2004, Georgia's public psychiatric hospitals had a statewide average client load total of 1187.4, meaning that on average on any given day there were approximately this many people who had been admitted to hospitals for treatment. Statewide personnel data was provided that included all hospital positions. APS eliminated records from the data table which were clearly not associated with Adult Mental Health, Child and Adolescent (C&A), and Forensics. It is possible that some records remain included that should have been eliminated as well, so there is a conservative estimated margin of error of up to 7%. Therefore, the numbers associated with this data source are referred to as estimates. As of the last day of FY 2004, there were an estimated 1,853 direct care employees (this does not include maintenance staff, etc.) in the state's hospital system, a count which included licensed professionals in both direct care and supervisory positions and non-licensed staff and paraprofessionals who worked for the hospitals' Adult Mental Health, Child and Adolescent, and Forensic Programs. Therefore, on average, there is an estimated direct care (and direct care management supports) staffing ratio of 1.56 staff per hospital consumer.

Each hospital was asked to provide staffing data per program/unit to compare hospital specific ratios as well as statewide average per type of program according to the following staffing categories:

- ❖ Nursing Staff: to include RNs, LPNs, HST (Health Service Technician) and CNA (Certified Nursing Assistant).
- ❖ Physicians, psychiatrists, doctoral level psychologists (Ph.D. or Psy.D.), and Advance Practice RNs.
- ❖ Social Service Providers to include MSW, LPC, LMSW, LCSW and those with Master Art or Master Science who function in this capacity.
- ❖ Other Professional clinical staff to include dietitian, speech/hearing, behavior specialist, certified teachers, OTR (registered occupational therapist), RPT (registered physical therapist), Certified Recreation Activity Therapist

- ❖ Other direct care staff to include SW techs, Activity Therapy staff (not certified), instructor/teacher aid, Occupational Tech, PT tech, etc.)

Statewide staffing ratios estimated through compilation of the each hospital's data submission, which included all direct care workers, both licensed and non-licensed, result in a total number of 1330 employees for all programs under analyses of this project. Compared to the statewide average client load of 1187.4, this gives an overall staff ratio for Adult Mental Health, Forensic, Child & Adolescent Short Term and Child & Adolescent Long Term of 1.12 staff per consumer. So, this leaves us with an estimated range of 1.12 to 1.56 (as cited above) staff per consumer.

Staffing ratios, based on individual hospital data submissions, were determined based on the total full time equivalent of professional staff as of the last day of FY2004 compared to the average client load for the year for each program.

Table IX-11: Hospital Staffing Ratios for Adult Mental Health					
Hospital	Nursing Staff	Physicians, Etc.	Social Services	Other Profess	Other Staff
Central State	1.01	0.08	0.02	0.04	0.10
East Central	0.23	0.05	0.10	0.10	0.10
GRH-Atlanta	0.32	0.05	0.09	0.04	0.08
GRH-Savannah	1.09	0.12	0.05	0.04	0.09
Northwest	1.02	0.06	0.06	0.02	0.13
Southwestern ⁷⁴	0.20	0.06	0.07	0.01	0.07
West Central	1.27	0.10	0.11	0.03	0.03
Statewide Average	0.73	0.07	0.07	0.04	0.09

Table IX-11 illustrates the disparity in staffing levels for Adult Mental Health programs. The disparity is striking among the nursing ratios in the gap between the three hospitals that have between 0.20 and 0.32 nurses for each consumer as compared to the other four hospitals that have over 1 nurse for each consumer. For the first three hospitals, East Central, Atlanta, and Southwestern, this equates to approximately 1 nurse for every four to five consumers. These lower nursing ratios are not augmented in higher staffing rates of other clinical professionals. For either condition (the overall high staffing rates at Central State, Savannah, Northwest and West Central or low nursing rates at East Central, Atlanta and Southwestern), there doesn't seem to be a unique variable that would influence the resulting rates. For example, if occupancy rates were a factor, we would expect that a low staffing ratio would be the result of high occupancy rates, and for example, that Atlanta would have experienced an elevated occupancy rate compared to the other hospitals to explain (perhaps in part) the lower staffing levels, but in fact it has one of the three lowest occupancy rates. Similarly, for East Central and Southwestern we

⁷⁴ The data presented for Southwestern Hospital is the combined staffing ratio for both Adult Mental Health and Forensic services. The source data couldn't be split to differentiate between the two because during FY04, Southwestern did not have a stand alone Forensic unit.

would expect both to have comparatively low occupancy rates, but East Central's is high, whereas Southwestern's is low.

For physicians and other medical staff, the range is from 0.05 staff per consumer to 0.12 staff per consumer. Savannah is the highest in this regard with the 0.12 while East Central and Atlanta share the low at 0.05. The statewide average is 0.07. There is less statistical deviation in the range of physicians as compared to the range of nursing ratios, though there are no outliers in any staffing category. Despite that fact, Central State's staffing ratio of social service providers, 0.02, seems particularly low in comparison to the other hospitals where West Central has the high at 0.11 and the mean is 0.07.

East Central has the highest ratio for Other Professional staff with 0.10 compared to the mean of 0.04, while the remaining hospitals have a ratio range from 0.01 to 0.04. For non-professional Other Staff, the statewide average is 0.09, but with a wide range from 0.03, the low at West Central, to 0.13, the high at Northwest. Consider the impact of the range in that the 0.03 rate equates to 1 Other Staff per 33 consumers versus the 0.13 rate which equates to 1 Other Staff per 7.6 consumers.

Table IX-12: Hospital Staffing Ratios for Child and Adolescent Long Term					
Hospital	Nursing Staff	Physicians, Etc.	Social Services	Other Profess	Other Staff
Northwest	1.41	0.07	0.00	0.18	0.41
West Central	1.35	0.08	0.10	0.05	0.23
Statewide Average	1.38	0.08	0.05	0.12	0.32

Only two of Georgia's state hospitals offer long-term care for children and adolescents. The nursing staff patterns between Northwest and West Central are very similar, as is the pattern for physicians; however, the similarity between the hospitals does not persist into the staffing categories of Social Service Providers, Other Professional Staff, or Other Staff. As an average among all hospital programs, the statewide average for nursing ratio for C&A Long Term care is 10% higher than C&A Short Term care, 89% higher than Adult Mental Health services, and 45% higher than Forensics.

Northwest does not employ or does not have sufficient social service staff allocated specifically for the C&A Long Term Unit to show up in this analysis. Northwest does have a higher percentage of "Other Professionals" and "Other Staff" than West Central that perhaps make up the difference, since both "other" categories include social work technicians and behavioral specialists.

Table IX-13: Hospital Staffing Ratios for Child and Adolescent Short Term					
Hospital	Nursing Staff	Physicians, Etc.	Social Services	Other Profess	Other Staff
Central State	1.00	0.24	0.12	0.04	0.20
GRH-Atlanta	1.39	0.11	0.21	0.00	0.09
GRH-Savannah	1.37	0.04	0.04	0.19	0.09

Statewide Average	1.25	0.13	0.12	0.08	0.13
--------------------------	-------------	-------------	-------------	-------------	-------------

Three of the seven hospitals offer short-term supports for children and/or adolescents. GRH-Atlanta provides the highest staffing ratio of the three hospitals in nursing but only slightly higher than GRH-Savannah (1.39 to 1.37 respectively). C&A Short Term as a program has the highest staffing ratio for physicians and social services staff compared to other type units. However, for physicians the statewide average of 0.13 is very much driven by Central State's utilization, which is comparatively high at 0.24 whereas GRH-Savannah's and GRH-Atlanta's physician ratios are commensurate (while on either end of the range with Savannah on the low end and Atlanta on the high end) with utilization across the state in other units. The range of ratios for Social Service providers is divergent as well with Central State representing the mean at 0.12, Atlanta at the high end with 0.21 and Savannah at the low end with 0.04. There is similar lack of alignment in staffing of Other Professionals while in the category of Other Staff, two of the three (Atlanta and Savannah) have the same ratio at 0.09 while Central State has 0.20.

Of the state hospitals that have Forensic Units, again the highest ratios are with the nursing staff. Interestingly, Forensic Units statewide have a higher nurse-to-patient ratio than any of the other cost centers/programs including Adult Mental Health. With the exception of C&A Long Term, which shares the same rate, the fewest social services staff are used on average statewide for Forensic Services with 0.05 social services staff per consumer. Again, we see the same pattern as in Adult Mental Health units, where the nursing staff ratios for Atlanta and East Central are considerably lower than for the other hospitals. (Note: While Southwestern is in that low category for the Adult Mental Health nursing staff comparison, Southwestern is not reflected in the Forensics category because they did not have a stand alone Forensic Unit in FY04.) Despite the absence of any staff that falls into the "Other Professionals" category at GRH-Savannah, the statewide average is 0.04 (i.e. the 0.00 ratio does not artificially reduce the statewide ratio). Forensics has on average the fewest "Other Staff" per consumer as compared to other programs statewide. The range of staff ratios is similar to that of Adult Mental Health with a low of 0.03 at Savannah and a high of 0.12 at Northwest. However the range is negatively skewed resulting in a lower statewide average than Adult Mental Health of 0.07 (compared to 0.09).

Table IX-14: Hospital Staffing Ratios for Forensic					
Hospital	Nursing Staff	Physicians, Etc.	Social Services	Other Profess	Other Staff
Central State	1.30	0.09	0.04	0.04	0.05
East Central	0.23	0.05	0.05	0.10	0.10
GRH-Atlanta	0.73	0.03	0.07	0.01	0.05
GRH-Savannah	1.09	0.06	0.03	0.00	0.03
Northwest	1.00	0.07	0.03	0.03	0.12
West Central	1.33	0.10	0.07	0.03	0.05
Statewide Average	0.95	0.07	0.05	0.04	0.07

Other Findings and Implications

When researching staff ratios, the Office of Regional Operations in the Division of MHDDAD provided APS with a set of proposed staffing guidelines distributed in February 2003 that had not been approved or officially adopted, but were in use to a variety of extents from hospital to hospital. The guidelines suggested staffing ratios for each type of unit:

<u>Program</u>	<u>Total Proposed Staff</u>	<u>Unit Capacity</u>	<u>Ratio</u>
Adult Mental Health	63	35	1.8
Adolescent Acute	40.5	20	2.025
Forensic-Secure w/Holds	65.5	40	1.64
Forensic-Maximum	68.75	40	1.72

In terms of total staffing ratios per hospital per unit, based on the numbers submitted in response to the survey, we can estimate to what extent each hospital's staffing aligns with the proposed guidelines. These estimates are calculated by dividing the total full time equivalent staff per hospital program by the average client load.

Table IX-15: Comparison of Total Hospital Staffing Ratios by Program				
Hospital	Adult Mental Health	Forensic	Child and Adolescent – Short Term	Child and Adolescent – Long Term
Central State	1.26	0.98	--	--
East Central	0.57	0.54	--	--
GRH-Atlanta	0.58	0.86	1.96	--
GRH-Savannah	1.39	1.22	1.74	--
Northwest	1.29	1.25	--	2.10
Southwestern	0.40	--	--	--
West Central	1.54	1.57	--	1.80

The program categories by which staffing data was collected do not match the staffing guidelines exactly as Forensic staffing ratios were calculated based on all units combined, not Secure with Holds and Maximum Security separately. The guidelines also did not propose long term unit staffing for children and adolescents, so those would not be directly comparable. However, we can directly compare Adult Mental Health and Child and Adolescent-Short Term. No hospital meets the proposed staffing ratio for Adult Mental Health or for Child and Adolescent-Short Term although staffing for the latter more closely approach the proposed ratio. While there is not a direct comparison, because the ratio recommended for Forensic-Secure with Holds is 1.64 and for Forensic-

Maximum Security is 1.72, we can safely assume that an average of the two combined should fall between the two. Only West Central comes close to the proposed ratio with 1.57 while Central State, Atlanta and particularly East Central fall well below the proposed ratio.

The fluidity of staffing patterns based on budget and fluctuations in demand for treatment calls for guidelines to be somewhat dynamic. And it is possible that the proposed guidelines have been or are being tested. But it is clear that was not the case for the entirety of FY04 based on the varied ranges of ratios between hospitals. It is up to the Division of MHDDAD with feedback from hospital leadership to decide whether the proposed guidelines remain appropriate, if they need to be customized based on location, or if they are in need of complete modification given the current economic climate of FY2005 and new initiatives to consolidate units (such as is the case with Child and Adolescent-Long Term care).

National Benchmarking

The Center for Mental Health Services (CMHS) publishes an annual report of statistical findings and state-to-state comparisons regarding public mental health and substance abuse services based on state reported data for various community and hospital service measures. However, at this time, no data is collected for the comparison of staffing patterns or ratios in community settings, nor are there any suggested ratios for the numbers of each type of professional that should be associated with mental health population other than agency specific or treatment specific guidelines such as a staff to patient ratio for hospital units or Personal Living and Residential Services. NRI state profiles do not track staffing patterns or ratios for community-based services either, but they do demonstrate staffing ratio comparisons by state for hospital direct and indirect staff based on the number of beds. These are the findings for Georgia in comparison to our three comparison states, North Carolina, Tennessee, and Virginia. (Georgia's submitted data was based on FY 2003 utilization and the other states' were based on FY2002 data):

Table IX-16: Broad Hospital Staffing Ratios between Comparison States							
State	Number of direct patient care staff in SMHA psychiatric hospitals:	# Beds	Ratio of Direct Staff to Number of Beds	Number of indirect patient staff in SMHA psychiatric hospitals:	Ratio of Indirect Staff to Number of Beds	Number of total staff in SMHA psychiatric hospitals:	Ratio of Total Staff to number of beds
GA	3279	1208	2.71	3108	2.57	6387	5.29
NC	3951	1994	1.98	1247	0.63	5198	2.61
TN	1709	971	1.76	946	0.97	2655	2.73
VA	3019	1804	1.67	1358	0.75	4376	2.43

Average	2990	1494	2.00	1665	1.11	4654	3.12
---------	------	------	------	------	------	------	------

In the comparison of all four states, Georgia has the highest staffing patterns. It must be noted that NRI data does not report separately based on hospital population, so Georgia's ratios have been calculated using figures for developmental disabilities as well as adult and child/adolescent mental health and forensics. However, it is still a ratio, so to some extent the higher figures are valid in comparison. For the ratio of direct care staff to hospital beds, Georgia ranks 36% higher than the four state average, 37% higher than the state with the next highest ratio (North Carolina) and 62% higher than the state with the lowest (Virginia). For the ratio of indirect staff to number of beds, Georgia's ratio is well above the norm, with 2.57 staff per bed compared to Tennessee's 0.97, Virginia's 0.75 and North Carolina's 0.63. Georgia's ratio for indirect staff to each hospital bed is 232% higher than the four state average. In terms of total hospital staff, again Georgia's figure is significantly higher than the other states with 5.29 staff per bed compared to Virginia's low of 2.43, a 218% difference.

Note: Data results are not fully comparative to other hospital staffing ratios in the Comparison of States Chapter because NRI calculated based on bed days rather than APS's use of Average Client Load. Too, because DD and Special Care units were not separated out for NRI reporting, the data results may be driven by higher staffing patterns in the those units. It would be worthy of further research to determine if this is the reason for the finding or if other variables are the cause.

Workforce Issues Regarding Special Populations

The Georgia Minority Health and Health Disparities Report produced by the National Center for Primary Care at Morehouse School of Medicine in collaboration with the Georgia Department of Community Health's Office of Minority Health estimates that by the year 2025, one-third of Georgia's population will be people of color. Currently there is significant health disparity between Georgia's white population and people of color, 767,595 (9% of Georgia's population) of whom are foreign-born, in terms of health insurance coverage, health outcomes, and mortality. Similar health statistics are still applicable to Georgia's 2,350,000 African-Americans who have been traditionally underinsured and who experience higher mortality rates. Over the last decade, Georgia has seen a 300% increase in the Latino/Hispanic population, 21% of whom live in poverty. An estimated 24.5% are linguistically isolated, which is a common barrier for foreign-born Georgians. The estimates for those who speak Asian and Pacific Island languages is even higher at 29.8%. There is an additional estimate of 12,885 more households that speak other languages that are isolated as well. However, Georgia's healthcare workforce does not proportionately align with this diverse make-up. With this level of growth in diversity, the Health Disparities report posits that "language skills and cultural knowledge may be as important as technical skills in the healthcare workforce" and in professional health workforce training programs and that new models of healthcare service provision that are culturally competent are severely lagging.

Georgia providers have been very creative in tapping limited resources to support their ability to offer culturally competent services. Much of the time, though, providers are grappling with the basics of simply being accessible to diverse populations—surpassing the language barrier. Language barriers, more pointedly, hiring clinical staff that understand and can provide quality therapeutic services to those who don't speak English is very difficult.

Provider participants in APS's workforce issues focus group discussed the resources they utilized to help them overcome this barrier, particularly in light of having few if any dollars budgeted for such purposes. Another challenge is that it does not just primarily

“Language is the primary barrier. The lack of interpreter services, bilingual providers or culturally and linguistically appropriate health education materials lead[s] to patient dissatisfaction, poor comprehension and adherence, and lower-quality care.”

-- Pierluigi Mancini, Ph.D., NCAC II, “Latino Mental Health and Substance Abuse Services In the State of Georgia: A report to avoid Misdiagnosis, Labeling and Misunderstanding,”

need Spanish speaking or translation resources. There is also a demand for staff and clinicians who speak Portuguese, one or more of several Asian dialects, Bosnian and Somalian, for examples. Some providers used the AT&T Language Line and others had used DHR interpreters to a limited extent.

The CSB of South Georgia had its brochure translated in order to conduct some outreach, but they acknowledge that utilizing the dollars that were available for the brochure reduced their capacity for providing the actual services when the outreach resulted in a consumer presenting for services. In these instances, they simply “do the best we can.” Sometimes, this means making do with a family member or friend of the consumer who can serve as an interpreter or an interpreter who is bilingual but doesn't understand the context of mental health services and is truly not able to facilitate the course of treatment adequately.

While limited access is better than no access, advocates encourage avoidance of using interpreters by “chance” especially those who are family members, because the single act of serving as an interpreter can shift the culturally sensitive locus of power within the family. With regard to use of interpretation by telephone, this is considered to be impersonal and not responsive to the very human nature of the need for an interpreter. Therefore, it is even more important that there be a system response to this issue and not simply left to the individual creativity of each provider.

Another population that suffers from lack of multi-cultural resources is the deaf community. Interpreters for the deaf are very expensive and just like foreign languages, there are many dialects within sign language. While we did not find that community providers or hospitals employed interpreters as part of their staff, we did identify that

there is a program for the Deaf and Blind at Central State Hospital (CSH). The program is staffed by one full time employee who provides consultation, staff training and direct services to hospital consumers, including orientation and mobility training, and interpreting services (or coordinates the services of a certified interpreter). The staff person is certified in mental retardation through special education, has her Master's in Blind and Deaf Education and is a certified Orientation and Mobility Specialist. The need for the program mostly stems from the DD population, but some Adult Mental Health clients are also served. Direct services are made available to patients who are specifically referred to the program. These amounted to approximately 60 patients with developmental disabilities and approximately 10 from Adult Mental Health, skilled nursing units and Child and Adolescent units (only 2 from the latter) although consultation is made available to a much larger extent. Specific examples of the scope of services includes orienting patients to hospital environment upon admission for mobility, assessing patient's ability to keep a walking/mobility cane on a unit, assessing the appropriate mode of communication for those who are deaf, and coordinating a certified interpreter when someone needs to be evaluated for a psychological. For unique cases, the program staff person has also researched special treatment facilities and found through contacts in South Carolina (which is known as a leader in mental health treatment for persons who are deaf), a treatment program in Minnesota that specializes in addiction treatment for people who are deaf when CSH didn't have the resources to address the patient's need. The program also provides orientation and cultural sensitivity training for staff.

In addition to the services provided through the Program for the Deaf and Blind, CSH also employs one audiologist. The audiologist conducts screenings and testing for consumers at Central State and her services are also contracted out to the Department of Corrections, which sends inmates from across the state to CSH for screening and testing as well. The audiologist also prescribes and dispenses hearing aid equipment as needed. Such equipment when dispensed to inmates is provided at cost to DOC. This past year, audiologist services began screening Child and Adolescent patients as well. It was estimated that over 500 screenings and more intensive tests are provided annually.

Some studies have shown that a common ethnic background of the provider and the patient results in greater compliance with treatment and ultimately more successful recovery results, so common ethnicity or at minimum the lack of language barriers is not just important to the access of services but to service outcomes as well. One researcher has estimated that less than 10% of the healthcare workforce is of color and that increasing the numbers of workforce providers who are of color would be of extraordinary value. Ivey (1998) however, cites research conducted by Briones, et al (1990) that found that socioeconomic status was more of a predictor of mental health service utilization than mere ethnicity. In Briones' study, Hispanics utilized mental health services in a pattern similar to Whites when poverty was not an issue.

Prevalence Estimates and Impact on Georgia's Public Mental Health Workforce

As discussed in earlier chapters of this report, APS has utilized prevalence estimates of Georgia's population in terms of those with mental illness and those with mental illness whose income indicates that they live in poverty according to federal poverty limit guidelines. The prevalence estimates indicate a total number of consumers in need by region of 19,155 in Central, 25,155 in East Central, 52,665 in Metro, 43,716 in North, 26,981 in Southeast, 21,850 in Southwest, and 26,802 in West Central.

APS estimated that the staffing ratios in community-based settings for direct care staff were 1.97 non-licensed staff for every 100 consumers, 1.17 licensed staff for every 100 consumers and a total of 3.14 staff for every 100 consumers. Utilizing these ratios, as well as the component ratios for specific professions by region, APS has projected the numbers of workforce that would be needed to at least sustain these ratios in order to expand treatment to the total numbers of those who are estimated to be in need, based on diagnosis and poverty. This projection does not take into consideration supply issues or uneven distribution of supply between regions, nor does it make any adjustment for more equitably apportioning numbers of staff and using subsequent adjusted ratios. It simply combines the perspectives of need versus supply and provides a broad estimate of gaps based on current staffing patterns.

Table IX-17: Estimate of Projected Additional Workforce Needs by Region							
	Total Staff	Licensed	Non-Licensed	Social Workers	Nurses	MDs	Psychologists
Central	33	25	18	6	5	3	0
East Central	209	114	109	46	27	9	1
Metro	1039	467	591	185	133	56	14
North	34	28	23	1	1	2	0
Southeast	103	31	78	6	12	-1	2
Southwest	127	60	76	15	15	4	0
West Central	180	75	112	21	25	8	3
Total	1726	799	1008	278	217	81	19

The estimates of projected workforce needed indicate a total net increase of direct care staff of 1,726, comprised of 799 licensed professionals and 1,008 non-licensed professionals. The greatest amount of unmet need is in the Metro Region, which is why projected additional workforce is so high for the region. The only silver lining is that at least the majority of the qualified workforce does reside in the greater Atlanta metropolitan area.

Specifically, some combination of licensed clinical social workers, licensed masters of social work, etc., for a total of 278 social workers would be needed, mostly concentrated in the Metro and East Central Regions. This need for social workers in the East Central and Metro regions indicates the largest gap in current and future staffing needs. Another

217 nurses comprised of registered nurses, licensed practical nurses, and nurse practitioners would need to be recruited. Eighty-one more medical doctors, psychiatrists being a significant percentage, would be needed. Finally, nineteen more psychologists would be needed, most of them in the Metro Region. Both Southwest and West Central would have significant recruiting to do for social workers and nurses, more so in West Central.

The number of zeros reflected in the column for psychologists is more indicative of a low ratio of utilization across regions rather than a lack of need. Another contributing factor is the tendency to contract out for psychological services. However, given a greater supply of psychologists statewide and the opportunity to employ them, the MHDDAD system would likely demonstrate a higher ratio and subsequently an increased need in all regions.

This projection also seems to indicate a saturation of MDs in the Southeast Region because the region would actually already have 1 more MD than would be needed to meet demands of additional consumers, but further research would be required to substantiate that conclusion.

E. Opportunities to Strengthen Georgia's Workforce

Strategic consideration of alternatives to increase the availability of qualified staff in the state could begin by looking to capitalize on the resources that are already natural to Georgia before embarking on new “start-from-scratch” initiatives. While Georgia's general supply of clinicians in the healthcare workforce is not as rich as other comparison states, there are still opportunities for accessing those workforce resources that do exist. This may necessitate adjusting our thinking about qualifications of staff to conduct certain activities, creating pathways for clinicians to be loaned across agency boundaries, and introducing incentives that would attract clinicians into the public mental health workforce.

Raising the Bar: Increasing standards through Licensure

One such possibility would be to research the potential of increasing the base of the qualified workforce by adjusting certification and licensure requirements. Master Level Social Workers represent a large group within the professional disciplines supporting people with mental illness, and within the community health service delivery system. Licensed Clinical Social Workers (LCSW) or Licensed Master Social Workers (LMSW) aside from nurses, constitute the majority of licensed professionals within the system ($N=318$.) Most of MHDDAD's community service requirements for staff credentialing are tied to Georgia's Administrative Practice codes as well as to state licensure rules and regulations. Georgia is unique in that it licenses only masters level social workers, where 38 other states license Bachelor level social workers, and several license individuals with Associate's degrees (ASWB, 2004). Of the 38 states, a Bachelor of Social Work is recognized for licensure in Alabama, Arkansas, Illinois, Kansas, Kentucky, Maryland,

Massachusetts, Ohio, South Carolina, Texas and Virginia. North Carolina allows certification. The Association of Social Work Boards, the National credentialing agency for social workers, states that the purpose of licensing “is to assist the public through identification of standards for the safe professional practice of social work.” By licensing social workers with undergraduate degrees, Georgia would raise the standards for this professional body (who are now employed as paraprofessionals), and broaden its pool of available workers.

Both the University of Georgia and Georgia State University offer Bachelor of Social Work programs and Dalton State University has also begun a Bachelor Program of Social Work, which is currently growing. Combined, they graduate over 120 students with Bachelors of Social Work annually. This is a new crop of early social work careerists who, if licensed, could be potential recruits for the state’s mental health system, in a higher capacity for which they can now be retained. There are also experienced social workers that have moved to Georgia who had licensure in their native states but are not able to practice here in the same capacity and this is an unfortunate missed opportunity. Additionally, there are other ways in which the state could better avail itself of these resources. For example, providers who participated in the workforce focus group indicated that eligibility and credentialing requirements for completing some clinical documentation and paperwork was mismatched, i.e. that time of clinicians could be better spent than filling out paperwork, but to meet Division standards, the licensure was required. As long as easing such requirements doesn’t interfere with the quality of services provided and the provider’s compliance with Medicaid and thus the ability to bill, this could present an opportunity to pull Bachelors of Social Work into the mental health field and cultivate them, while at the same time increasing efficiency and productivity of the licensed workforce.

According to members of the Georgia Composite Board for Licensed Counselors, Social Workers, and Marriage and Family Therapists, this would greatly increase the amount of licenses that would need to be processed within the state. However, the rewards may outweigh the risks after examining possible funding incentives: Medicaid rates and other funding sources could be altered to reimburse at higher rates if professionals providing services are licensed within the state. This is just one option that Georgia could exercise in order to increase the quality of the professional workforce providing services and supports to adults and children with mental illness.

Resources in Foreign-Trained Professionals

Similarly, there is a wealth of opportunity inherent in the qualifications of foreign professional counselors living in the state of Georgia. There is a significant population of those who are professionally licensed in their birth country or who have analogous credentials to the mental health professionals for which Georgia has such a high demand. However, they are unable to practice in Georgia because their licensure records are not available or not recognized, for example, or the Georgia licensing entity does not have the capacity to recognize such licensure or the procedures to acknowledge non-U.S.

educational institutions and accrediting bodies. The ability of the state's licensing entities to expand pathways to gaining licensure in the state or reciprocal licensure would serve as a tremendous boon to a culturally competent workforce. What would be of additional value is the availability of a certification or training course offered through or supported by the state that would engage such professionals who don't have mental health services experience and educate them on the nuances of the mental health system and prepare them to facilitate service provision. This would need to be a more specific and targeted curriculum as compared to the interpreter-training course for social services currently offered by the Department of Human Resources' Office of Limited English Proficiency.

Looking at Improvements to the Child Welfare System as a Model for Workforce Development

Throughout the past 10 years, the DHR/Division of Family and Children's Services has focused on improving the outcomes for children in protective custody and foster care by supporting improvements in professional development through education and training. The establishment of the Georgia Child Welfare Research, Education, & Training Consortium (GCWRETC) in 2000 launched an initiative to re-professionalize the public child welfare workforce in the state (Lyons, 2000).⁷⁵ Since the commencement of the GCWRETC, many developments have resulted in increased standards and credentials of DFCS workers. The list below samples several initiatives undertaken by DFCS:

- Tuition Reimbursement for bachelor's and master's degree candidates in Social Work agreeing to work at DFCS for a specified amount of time after completion of program.
- A partnership among DHR, training providers, and the University system was established to develop a minimum skill set for workers, titled the Child Welfare Competencies. Based on the skills needed, training and education programs have been implemented to support the development of workers to acquire such skills.
- Training incentives have led to the success of a statewide certification program. Workers are incentivized to complete the training because those with the certification are paid higher salaries than those without.

DFCS does rely on TITLE IV-E funds, which provide a 50/50 match to cover the workforce development programs it operates throughout the state. The Division of MHDDAD does not have a similar funding stream to rely on, yet this should not dilute the importance of these initiatives and the affect a better workforce will have on client outcomes.

Staff retention and recruitment study in child welfare

⁷⁵ Georgia Child Welfare Research, Education, and Training Consortium: An agenda to re-professionalize Georgia's public child welfare system.

In their study of social workers in child welfare, Ellet and Ellet find the following factors help to retain staff, and will also assist in recruitment of new workers:

- ❖ Staff benefits
- ❖ Flex time permitted
- ❖ Retirement benefits
- ❖ Supportive administrators and supervisors
- ❖ Variety of work, and exciting and challenging work
- ❖ Important and meaningful work
- ❖ Pre-employment internships or IV-E
- ❖ Informal and formal on-the-job training
- ❖ Commitment to child welfare and care about clients
- ❖ Requisite knowledge, skills, abilities, and strong self-efficacy beliefs
- ❖ Flexible and adaptable in thinking and behavior
- ❖ Don't take things personally
- ❖ Willing to listen and learn from others
- ❖ Sense of humor
- ❖ Self-reflective practitioners
- ❖ Find meaning in and value work, and can recognize their successes

Telehealth

Consumers, families, advocates and providers are all concerned about how the lack of transportation affects access to services. Regardless of transportation issues, outreach itself (promoting the availability of services) is extremely difficult in rural areas. Moreover, the specific schedule for a regulated course of treatment for those with mental illness is often interrupted and thus unsuccessful because consumers are not able to get to their appointments. The introduction and utilization of telehealth options in the mental health service delivery system could improve the productivity of the existing workforce and recovery success rates, thus reducing the impact of workforce shortages.

Telemedicine was first referenced with regard to the transmission of radiological images by telephone in 1948, then with regard to social work interactive video therapy in the 1950s, and by the 1970s, interactive video conferencing experiments linking patients who resided in remote areas to healthcare professionals proliferated the research field. Increased funding in the 1990s allowed a resurgence of technology that could take advantage of enhanced infrastructures such as cable (broadband, DSL, etc.,) lines, computer ownership and internet usage, for examples, used residentially, academically and commercially. Today, the more common term for telemedicine is telehealth representing a more global and contemporary perspective on the role of telemedicine.

While there is long history of using telecommunications as a part of counseling and therapy, there has been a lack of enthusiasm for interactive video due to the cost and technically poor imaging. In response to the cost side, effective October 1, 2001,

legislation passed expanding payment for telehealth services from Medicare, Medicaid and SCHIP (State Children's Health Insurance Program) where it was not allowed previously due to telehealth not being considered a "face-to-face" therapy. While private third-party reimbursement policy has in the past followed the lead of Medicare and Medicaid rules, it is hoped they too will follow suit and expand coverage for telehealth therapies. States have already begun to ease limitation for reimbursement. For example, Louisiana has mandated telemedicine reimbursement and California, Oklahoma and Texas have eliminated face-to-face requirements when telemedicine is deemed by the treatment team as an appropriate alternative. The imaging problem is temporary as technology improves everyday and already tele-imaging has improved both in increased quality and decreased costs.

Telehealth skeptics cite concerns about the ability to form a therapeutic relationship and ethical and privacy/security considerations that are valid. However, there are reliability studies and cost studies that indicate the use of telehealth is a viable method of reducing costs and the relationship between the patient and therapist is not jeopardized by use of video counseling. In fact, there is some research that suggests that even the use of online counseling, such as in a live interactive (and secure) chat room, and electronic mail counseling might have an added benefit that face-to-face counseling doesn't afford: use of the internet creates a "socially unstratified"⁷⁶ environment where the differences between the patient and therapist are de-emphasized and the patient may be more likely to open up to the therapist as more their equal. Reliability studies have indicated a perfect correlation between teleconferenced psychiatric diagnoses and face-to-face psychiatric diagnoses of acutely ill psychiatric patients who were involuntarily admitted. Another study suggested that relatively low-tech equipment using a desktop personal computer and a video camera was equally successful in diagnosing less severe conditions, but for accurately diagnosing conditions where the ability to pick up on the nuances of body language and facial movement is critical, more expensive and elaborate equipment was needed.

Other benefits have also been identified in the use of telehealth. More in depth responses by therapists are enabled through the use of electronic mail and are an improvement on answers previously rendered during short phone calls between appointments. Like such electronic mail transmissions, taped video sessions can be saved digitally and become part of the patient's record, allowing for an invaluable chronology of the patient's illness and recovery.

Some proponents of telehealth emphasize the need for the first visit to be face-to-face to ensure appropriate assessment and diagnosis has taken place, which is then followed by telehealth treatment.

However, telehealth may not be appropriate for everyone. There are concerns about inequitable access for consumers who don't have computer equipment or aren't

⁷⁶ McCarty and Clancy, "Telehealth: Implications for Social Work Practice," 2002.

intellectually, emotionally or physically capable of participating in their therapy in this manner.

Telehealth also increases the opportunities for improvement in workforce training. A 2002 study of telepsychiatry found that telehealth was commonly used for clinical supervision, trauma debriefing for remote mental health treatment teams, patient and family education, and provider education. Additionally, psychiatric educational workshops and continuing education classes were presented to community mental health workers and primary care physicians by telemedicine as part of a US National Rural Health strategy.⁷⁷

Other modes of psychiatric treatment such as through a telepsychiatric consultation-liaison service which uses the facility of a local primary caregiver near the patient, has been found to be a particularly meaningful way to provide access to specialty services in rural areas. The benefits cited include the human interaction for the patient and the added benefit of the training experience for the primary care physician who by the training can supply an added resource to the patient in times of crisis.

Some patient satisfaction studies with psychiatric telemedicine have been conducted. Compared to other specialty care via telemedicine, respondents rated the experience positively, both in terms of the patients' ability to speak freely when using telemedicine, their preference for using telemedicine on subsequent visits and their experience with the telemedicine physician. There was no significant difference in the satisfactions ratings between telepsychiatric care and other specialty care via telemedicine. In comparison to a traditional psychiatric visit, 57% of patients liked the telemedicine care better. The research pointed to more direct access to expert specialists and reduced travel times as reasons for the positive satisfaction rating.

Hospital Staffing Fluctuations

The state's hospital system, while deemed to be over-capacity among most programs, has some fluctuation in the demand of staff time influenced by changing patient loads that could be reviewed for the potential to share staff between hospital and community. The National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI) identified in their 2002 published study that 19 states said that either their staff from local community-based provider organizations also provided services in state hospitals and/or state hospital direct care staff also worked in community-based service provider organizations: CT, DE, HI, IL, KY, LA, ME, MN, MO, NH, NM, NY, OH, OK, SC, UT, WA, WV, WY. Thus, the precedent for doing so does exist. APS is aware of, if not familiar with, the work of the Public Consulting Group with whom the Division of MHDDAD contracted to make recommendations about how regulatory and administrative barriers could be eliminated to allow funding (and their supports) to follow consumers between hospital and community services. If opportunities have been

⁷⁷ Hilty, Luo, et. al., "Telepsychiatry: An Overview for Psychiatrists," 2002.

identified to do so, these would be seen by APS as one consideration for addressing workforce shortage issues.

Additional clinical resources indigenous to Georgia can be found in other systems that provide similar mental services such as in the Departments of Juvenile Justice and Corrections. These are systems in which the types and qualifications of clinician treatment teams are similar and who typically share common consumers—consumers who bounce back and forth between systems for treatment. It is in these systems, in addition to the state’s hospitals, that the opportunities for “sharing” or loaning staff, and reducing the barriers to doing so, might be considered.

Department of Juvenile Justice

The clinical workforce associated with the Department of Juvenile Justice (DJJ) may also be considered fertile territory for staff sharing or loaning programs. The DJJ employs a total of 271 clinical staff, of whom 38% or 103 are licensed and 169 or 62% are not. Due to the combined makeup of both full-time and part-time staff, the average available clinical hours of licensed staff is 22.5 hours per week. Actual hours worked were not available, only hours based on employment and contractual status. While hourly resources information was made available on the staffing extract tracked by the DJJ and shared with APS for this study, APS is not able to compare available hour resources with MHDDAD ‘s or other agencies’ staffing patterns as similar data was not gathered in this way.

Using an approximated matching crosswalk from DJJ office sites to MHDDAD regions, the availability of the licensed staff are split among the regions as follows:

Table IX-18: DJJ Estimated Count of Licensed Staff by Region	
MHDDAD REGION	Total
CENTRAL	26
EAST CENTRAL	7
METRO	21
NORTH	16
SOUTHEAST	13
SOUTHWEST	11
WEST CENTRAL	9
Grand Total	103

The staff are comprised statewide of 23 medical doctors, 29 doctorates of psychology, 19 registered nurses, 7 licensed practical nurses, 6 LCSWs, 6 LMSWs, 2 LMFTs and 1 doctor of education. The staffing ratio of these licensed staff to every 100 DJJ consumers is as follows:

Table IX-19: DJJ Licensed Staff Ratios

Staff License	Count	Staff Ratio
MD	33	0.14
PSY.D.	29	0.12
RN	19	0.08
LPC	7	0.03
LMSW	6	0.03
LMFT	2	0.01
LCSW	6	0.03
ED.D.	1	0.00

Considering the resources of both licensed and non-licensed staff, we have computed the staffing ratios per 100 consumers. The ratio of all staff to each 100 consumers is 1.14, while the ratio resulting from the count of 103 licensed clinicians is 0.43 and the ratio of non-licensed staff is 0.71.

Compared to MHDDAD, the overall staff ratio of DJJ staff to consumers is lower at 1.14 than MHDDAD's hospital ratio of 1.56 and 3.14 for the community. However, the MHDDAD community counts included positions such as Certified Peer Specialists, Psychiatric Rehabilitation Counselors, Occupational Therapists, and Registered Dieticians which are not utilized in DJJ as they are in MHDDAD services, and this is likely responsible, at least in part, for the ratio looking inflated in comparison to the DJJ.

Department of Corrections

The Department of Corrections provided APS with data regarding the utilization of mental health services in the correctional system and Dr. Jim DeGroot, Statewide Mental Health and Mental Retardation Program Supervisor, was also interviewed to discuss workforce and other issues. In the interview, Dr. DeGroot stated that the workforce within the system varies geographically throughout the state. Prisons in urban areas have a harder time keeping professional staff with extremely high rates of turnover. In the rural areas, staff are more likely to stay for a longer tenure. The Department of Corrections also experiences discrepancies as to how long different types of professional staff stay. They have found that psychiatrists, psychologists, and social workers stay with the Department for longer periods than professional counselors.

In FY03, the total number of inmates with a MH diagnosis was 12,847 or 28% of the total population. Of those, 5,491 were assessed at a Level 1, which means that they most likely received psychotropic medications and remained with the general inmate population. This left a balance of 7,356 mentally ill inmates within the correctional system of whom 6,714 individuals received mental health services, compared to 6,349 the year before. That means that at the end of FY03 approximately 14.5% of the total inmate population was on a mental health caseload, a number that has continued to increase at the rate of 1% per year. The one percent increase is evidenced in FY04 figures for which 7,076 inmates received mental health services in the correctional system, equaling 15.1% of the total inmate population. Despite growth in the total numbers of inmates served in

the system, the percent of inmates with mental illness requiring treatment has stabilized at 15.1% over the past year (since January 2004).

Staffing ratios in the Department of Corrections are dependent upon the level at which an inmate is assessed, where as discussed above, a level indicates the severity of need:

- ❖ Level 2: 1 Mental Health Counselor to 50 male inmates/40 female inmates
- ❖ Level 3: 1 Mental Health Counselor to 30 male inmates/20 female inmates
- ❖ Level 4: 1 Mental Health Counselor to 20 male inmates/15 female inmates

The Department of Corrections contracts with three different providers of mental health services. Between them they employ the following full time equivalent staff with the resulting staff to patient ratios:

Table IX-20: Department of Corrections Staff Ratio per 100 Inmates		
Professional Staff Position	FTEs	Staff Ratio
Masters Level Counselors	178	2.52
Psychologists	21	0.30
Psychiatrists	22	0.31
Clinical Nurse Specialist	1.5	0.02
Mental Health Nurses	82	1.16
Activity Therapists	30	0.42
Total	334.5	4.73

Because the clinical staffing from the Department of Corrections was not available by licensing credentials, we were not able to further identify whether the Masters Level Counselors were Licensed Masters of Social Work or non-licensed Masters of Psychology, for examples; or whether the Mental Health Nurses were all registered nurses or licensed practical nurses. The resulting staff ratio of all clinical staff per 100 consumers is 4.98 compared to the Department of Juvenile Justice's 1.14 and MHDDAD's community ratio of 3.14⁷⁸. Other Department of Corrections to MHDDAD comparisons include the nursing ratio for which DOC has 1.22 to MHDDAD's 0.36; DOC has 2.65 Masters Level Counselors to 0.44 Social Workers and DOC has 0.33 psychiatrists to MHDDAD's 0.12. Given the setting in which mental health services are provided, the expectation is that the staffing ratios would more closely resemble MHDDAD's hospital forensic unit staffing. Because the hospital staff ratios were calculated based on average client loads rather than total of consumers treated during the year, one set of figures must be recalculated in order to compare figures.

The Department of Corrections has a total staff ratio of 4.73 per 100 inmates, which is the equivalent of 0.047 staff to every inmate (including activity therapists) and the equivalent

⁷⁸ Note: MHDDAD ratios were derived by counts of available not FTEs.

of 0.043 staff to every inmate without activity therapists. This is compared to MHDDAD's ratio of 0.34 staff to every forensic patient. Therefore, overall DMHDDAD Forensics has a 623% higher staffing pattern than the Department of Corrections.

More specifically, the total unduplicated statewide count of MHDDAD Forensic Unit consumers during FY04 was 1,787, who were served by an estimated 417 FTE nurses, 98 physicians/psychiatrists, and 94 social service providers (plus other non-licensed staff). This equates to ratios of 0.23 nursing staff, 0.06 psychiatrists/physicians, and 0.05 social workers on average for all forensic units, all of which are far above the correctional system's staffing patterns. The total unduplicated count of FY04 inmates who were provided mental health services was 7,076. This equates to a total average staffing ratio of 0.047 staff to every inmate (including activity therapists; 0.043 without): 0.025 Masters Level Counselors, 0.003 Psychologists, 0.003 Psychiatrists, 0.012 Mental Health Nurses, and 0.004 Activity Therapists. Therefore, overall DMHDDAD Forensics has a 623% higher staffing pattern, with 1817% more nurses, 1900% more psychiatrists/physicians, and 100% more counselors/social service providers. It is posited that those who are in need of inpatient mental health treatment are of such intense need that the additional staffing is warranted. This seems logical given that a substantial percentage of inpatient days of care in the MHDDAD hospital system are provided to inmates who have been transferred from the Department of Corrections. The DMHDDAD should compare its Forensic program in more depth to the Department of Corrections to ascertain whether this is the primary variable for the difference or if there are DOC models of staffing that could garner greater efficiencies for treating consumers in Forensic units.

Provider Agency Development

“Opportunities should be given to new agencies, so as to promote health competition among providers and to promote good and innovative services.”

Most of our discussion has focused on workforce development rather than provider development. The contention of stakeholders is that the MHDDAD system needs to better support (through increased training and recruitment support, increased provider rates, and less system change) its current array of providers and grow quality before it embarks on growing the number of providers. As discussed earlier, there is also concern that growing the system of providers disproportionately to the growth of funding will only spread resources that much more thin. Despite concerns by current providers, it is recognized that competition is largely positive both as a motivational factor to increase quality and to increase choice for consumers. Over the last several years, the DMHDDAD has attempted to build better supports, such as by the creation of provider network developer positions at both the state and the regional levels. These initiatives have been designed to increase the quality and quantity of providers. As the state encourages new provider development, staff competency needs to go hand in hand with the growth.

Current Opportunities and Recommendations

The DMHDDAD has not been idle in attempts to rectify workforce shortages. The Certified Peer Specialists and the Peer Support Program are indicative of the Divisions creativity in combining best practices and workforce development efforts. The recent award to the Division for a Child and Adolescent Infrastructure Grant is predicated on the promise to build a comprehensive system of care to meet the needs of youth with serious emotional disturbance, substance abuse and co-occurring disorders and their families for which a primary strategy is the development of a trained workforce. Through the grant's implementation, a trained workforce with specialty knowledge of working with youth with SED, substance use disorders and co-occurring disorders will be developed with special focus on the development of a cross-system recruitment and training strategy to improve delivery of behavioral health services. Also to be developed is a curriculum for training front-line and supervisory staff on the provision of culturally competent services, which will be available in addition to specialty training on treatment of youth with co-occurring disorders and on evidenced-based practice interventions within systems. Further, core competencies and a related credentialing process for clinical staff will be established. Having these in place will complement the efforts going on in adult core competencies and set a more cohesive stage for solidifying a consistent message about who the target population is and what the best complement of workforce professionals is to respond to the needs of that target population.

From the DFCS model, we learn the importance of introducing incentives and encouraging career growth internally. The DMHDDAD might similarly consider the development and implementation of a career ladder with competitive salaries and professional qualifications.

Georgia might also learn from what other states have initiated to tackle workforce concerns as well as further research and test what some Georgia-based providers have successfully attempted. See Table IX-21 for a sample of other states' efforts.

In APS's focus group discussion on workforce issues, providers additionally made the following recommendations:

- ❖ Whatever course the state chooses to take, involve providers in the development of the systems change
- ❖ Develop a program to train paraprofessionals or parent advocates to do clinical casework (training is available for bachelor's level and above, but not at the paraprofessional level)
- ❖ Replicate an Ohio system model where a local mental health agency collaborated with the university to hold courses for continuing education, professional training, etc. at the agency; the collaboration allowed for the design and schedule of the educational program to consider staff work duties and times in development of coursework and course schedule and a special discount on text books was also incorporated.

- ❖ Have the DHR Office of Human Resource Management and Development conduct screening of CSB applicants to the Job Site and/or refine the job description posting process to eliminate unqualified applicants on the front end. (It is otherwise extremely unwieldy.)
- ❖ Streamline paperwork with electronic transmissions
- ❖ Revisit requirements of required reporting (is all of it still needed and used?) and paperwork of which credentialed staff are required to complete certain documentation.
- ❖ Create a universally accepted Mental Health Professional training curriculum and offer it. Cobb CSB has thoroughly researched and has a partnership with Kennesaw State University for training community support staff from which learning can be shared.
- ❖ Offer a Division promulgated training, statewide, for Psycho-social rehabilitation counselors, health service technicians, advocates, etc.
 - An existing curriculum is available related to PSR – created by San Diego County and Boston University for staff working in PSR – that provides good, basic fundamental training to meet a variety service levels and has wide applicability
 - S. GA CSB uses an in depth 3-year Clinical Proficiency Progress Review (CPPR) training, once a month for PSR, internal for staff
- ❖ State of Georgia should increase awareness of clubhouse models to operate within communities – they are cost efficient and provide quality services.

Table IX-21: Select examples of State's Initiatives to Address Workforce Shortages

State	Initiative
Georgia	Mentoring Program (Nurses) - Formalized program for new nurses. Nurses new to the state system are placed with seasoned nurses.
North Carolina	Increased salary upon entry and in-range adjustments; 6-month shift incentives for RNs and LPNs; modified scheduling
Kentucky	Statewide consortium to improve professional alignment of post-secondary ed. curriculum, state credentialing boards, and CMHC staffing needs. Statewide effort to increase the # of paraprofessionals to enable individuals to live in their communities.
Arizona	Developed draft legislation to establish a Behavioral Health Loan Repayment Program to repay tuition loan for practitioners who agree to serve in mental health professional shortage areas in the state. In addition, the new assessment process allows Behavioral Health Technicians to perform assessments under the supervision of Behavioral Health Professionals.
Missouri	Mentoring for direct care staff (retention)
Virginia	Specialized training for entry level direct care workers through distance education to enhance documentation and quantitative skills re: medication administration and nursing support. Partnership with regional staff to provide training. Specialized targeted recruitment materials and contracts.
Utah	Salary increases
Connecticut	Initiatives include cohort with universities and colleges to increase education

	levels of staff and to obtain minimum licensing requirements; recognition program for Connecticut registered nurses (RNs); union and state upward programs that include time off and tuition reimbursements.
New Mexico	Rural Psychiatry Network to address consultation and site needs in rural areas.
New Jersey	Alternative work program for nurses (3 day work week). Development of financial initiatives and educational training programs. Nursing scholarship program. Pre-payment of pre-requisite courses for nursing schools. Open house with dinner and speak for psychiatrists.
<i>Source: NASMHPD Research Institute, State Profiles, FY2002, http://www.nri-inc.org/Profiles02/keyworda02.cfm</i>	

The state is confronted with many challenging issues with regard to its workforce both internally and externally in terms of supply versus demand, high rates of turnover, comparatively low compensation, and cultural diversity, for examples. Internally, despite the challenges, there is a wealth of opportunity as evidenced by innovative providers to build a rewarding employment culture through the promulgation of intrinsic benefits and support for enhanced training and continuing education. On a broader level, the consideration of new system-wide initiatives could make a significant impact in decreased turnover, staff efficiency and penetration of those in need, such as replicating DFCS's welfare model and investing in technology to reach consumers through telehealth activities.

External issues such as shortages in the supply of licensed and allied health professionals in turn exacerbate internal challenges that do exist. For example, where level of compensation is not only constrained by the Department of Human Resources pay scales, low supplies of healthcare professionals drive salaries up in the competitive marketplace. This deepens the gap between the state's rates of compensation and current salaries being offered in the private sector as well as other state agencies. Additionally, because of the contractual relationship between the state and its community providers, the state has become disconnected from the role of staffing management. This is typical in that agencies and organizations rely on contracts to achieve the outcomes desired and whatever the staffing needed for the contractor to achieve those outcomes is up to them. However, as the state takes a closer look at gaps in the public mental health service system and considers its priorities for response, it may behoove them to track workforce data in the short term for the purposes of strategic planning, particularly related to the development of system capacity goals and productivity measures.

Moving Forward

The state is confronted with many challenging issues with regard to its workforce both internally and externally in terms of supply versus demand, high rates of turnover, comparatively low compensation, and cultural diversity, for examples. Internally, despite the challenges, there is a wealth of opportunity as evidenced by innovative providers to build a rewarding employment culture through the promulgation of intrinsic benefits and

support for enhanced training and continuing education. On a broader level, the consideration of new system-wide initiatives could make a significant impact in decreased turnover, staff efficiency and penetration of those in need, such as replicating DFCS's welfare model and investing in technology to reach consumers through telehealth activities.

External issues such as shortages in the supply of licensed and allied health professionals in turn exacerbate internal challenges that do exist. For example, where level of compensation is not only constrained by the Department of Human Resources pay scales, low supplies of healthcare professionals drive salaries up in the competitive marketplace. This deepens the gap between the state's rates of compensation and current salaries being offered in the private sector as well as other state agencies. Additionally, because of the contractual relationship between the state and its community providers, the state has become disconnected from the role of staffing management. This is typical in that agencies and organizations rely on contracts to achieve the outcomes desired and whatever the staffing needed for the contractor to achieve those outcomes is up to them. However, as the state takes a closer look at gaps in the public mental health service system and considers its priorities for response, it may behoove them to track workforce data in the short term for the purposes of strategic planning, particularly related to the development of system capacity goals and productivity measures.

CHAPTER X: CAPACITY OF CURRENT SERVICE SYSTEM

In this chapter you will find:

- ❖ *Introduction to Capacity of Georgia's Community Based System*
- ❖ *Workforce Issues*
- ❖ *Provider Productivity Rates*
- ❖ *Quality of Services*
- ❖ *Available Service Array*



Highlights of significant findings in this chapter include:

- ❖ *Service System Capacity is a function of number of staff and the direct Consumer contact hours available for each staff; a system needs measures of each in order to judge capacity*
- ❖ *The definition and delivery of a service should be consistent in order to determine capacity for a particular service. Otherwise, some providers may show greater capacity due to the fact they are not adhering to the basic requirements of the service.*
- ❖ *Accessibility is the dividend of a system that has adequate capacity*

A. Introduction to Capacity of Georgia's Community Based System

The American Heritage College Dictionary defines capacity as: “***The ability to receive, hold, or absorb; to measure this ability, or volume; the maximum amount that can be contained, the maximum or optimum that can be produced.***” The “capacity” of the mental health system can be an ambiguous or nebulous term with no set parameters to measure maximum or optimum services. Currently, in a Grant in Aid funded environment, the state has funding, then negotiates with the providers regarding number of people that they are capable of serving. If the provider meets that target then they are assumed to be at full capacity. Thus, funding limitations and the negotiation process between regional offices and providers currently dictate capacity. To a degree, as long as there are finite funds for mental health services, these funds will shape the amount of staff that providers will hire which in turn will affect the capacity, or amount of services delivered. In an ideal situation, funds would be unlimited to serve the target population and capacity would be a function of how many qualified staff an agency could hire and the availability of those staff over 365 days a year.

While many different indicators can define capacity, consistent data sets are needed to calculate and compare results in order to make conclusions about a system. Policymakers and stakeholders ultimately need to choose which indicators might serve as the definition for measuring capacity of Georgia's community mental health system. Several aspects

can shape our ability to define capacity for the state of Georgia's citizens in need of mental health services. When these aspects are aligned, capacity can be measured. However, when information is absent or defined differently among regions or providers, capacity measurement becomes solely a function of the number of people served or funding that was utilized and did not lapse. These measures alone would give the impression that most providers are always operating at 100% capacity. However, the following issues must be explored and aligned in order to accurately measure capacity:

Direct Contact Availability

- ❖ **Workforce Issues**
- ❖ **Provider Productivity Rates**
- ❖ **Quality of Services**
- ❖ **Available Service Array**

Excess capacity should result in easy access for a person in need of services. However, various stakeholders and consumers report that services are not always geographically accessible. Even when services are offered, wait times can prevent the right service from being delivered at the right time so that symptoms are reduced and recovery is initiated. In this chapter we will also address access to service issues that are frequently a result of provider capacity.

***“We call them gypsies – they will be working for different entities each week!”
- A consumer referring to psychiatrists in her region***

One major weakness in the state's current community based system is the method in which state funded services are contracted and reimbursed to providers. Each Regional DMHDDAD office generates “Performance Contracts” for contractors within that region, however the extent of the performance is questionable. Regional offices pay providers to provide Grant In Aid (GIA), or state funded, services to a certain number of consumers each month in different service categories. As long as the provider meets each target for the month they will receive the total GIA allocation for that month. There is no incentive to provide additional services, as the provider will get paid the same amount if a consumer received services one time that month versus receiving services three times per month.

Adding further to the void of information is the fact that the state MHMRIS system counts an enrollment in services as if someone actually received them. So, following an assessment if four services are recommended (and the consumer was enrolled in them) but the consumer only shows up for two, the MHMRIS system reflects that the person received all four services. Even if the person did show up for all services, there is no encounter data reflecting the number of hours the consumer received of each service. All of which is necessary for measuring capacity.

Regional offices require services providers to submit MIERS reports to them detailing the number of consumers that were served each month with GIA funding. Most regions, five out of seven, kept these reports as excel documents. Two out of seven, the Southeast and the Southwest regions, provided hard copies of their reports for this analysis allowing APS Healthcare to examine the contracted amount versus the actual number of consumers served for all providers for FY04. Based on these two regions, most providers were meeting their contracted amount by more than 100%. In the Southwest region, all of the contacted providers were serving more people than they were contracted to provide services for – in each service category. Providers served 110% - 250% of the contracted amounts consistently throughout the fiscal year.

In the Southeast region, two-thirds of the providers served 125% - 145% of the contracted amount of consumers for the year. The Grant In Aid funding analysis shows that providers could be considered ‘over capacity’ because they are exceeding performance standards as set by the regional offices. However, because amount of service delivered is not collected and the benchmark is a person served rather than hours of service provided, it is difficult to truly determine capacity. For instance, an agency may see 100 Grant in Aid funded consumers for one hour each during the month and be considered at 100% capacity. But if they saw 50 consumers for 2 hours each they would be considered under capacity despite the fact they provided the same hours of service. Similarly, once an agency meets their quota, or contracted amount for the month, there is no incentive to see more people since reimbursement is capitated at the contract amount. All of this results in the fact that capacity is extremely difficult to measure under the current contracting methodology.

B. Workforce Issues: Recruitment and Retention of Qualified Staff

Several workforce issues affect how we consider capacity. Georgia’s low supply of clinicians makes recruitment and retention efforts very challenging, of which a consequence is also increased wait times. In the general workforce, Georgia ranks 25th in the nation against other states based on a count of psychiatrists per capita, 47th for social workers, and 48th for psychologists. While most experts estimate that approximately 5% of the healthcare workforce in each state works in the public sector, our estimates for Georgia are under 3%.

Provider participants in a focus group on recruitment and retention issues stated that the most difficult positions to recruit were Certified Peer Specialists, Social Service Providers, Nurses and Psychologists. Moreover, providers have stated that some of the most successful treatments, such as Assertive Community Treatment, require professional teams that are difficult to assemble due to staffing requirements. Without a full complement of team members, the service cannot be offered.

Complicating matters is often the lack of sufficient financing (or low agency budget allocation) that is cited as the reason for the difficulty in recruitment because salaries are insufficient to be competitive in the marketplace. Providers frequently cite losing

qualified staff to the school system, corrections, and other public human services in Georgia. Few, if any providers offer incentives for high productivity or the delivery of high quality services by staff. This can create an environment where effective and efficient staff gets more responsibility without the rewards, while staff that cannot meet the minimum requirements are rarely terminated but frequently carried by the agency.

Georgia's consumers routinely state, "we don't always get ill during regular business hours."

The acquisition and retention of qualified staff have a major impact on the amount of people seen and services that an agency can deliver, or capacity. Productivity standards (i.e. guidelines that reflect the amount of direct service time between staff and consumer) should provide a reasonable formula that would help an agency define capacity. For instance, if an agency has 10 staff who are expected to deliver 20 hours of direct consumer contact a week, then that agency's capacity would be defined as 200 hours a week of direct service delivery. Thus, capacity is a function of number of staff and the direct consumer contact hours available.

A study by the New York State Commission on Quality of Care for the Mentally Disabled, "A Review of the Efficiency of Freestanding Clinics," identified several factors that might be considered in the development of capacity measures.

- Extended hours of operation (60 plus hours a week) reduced costs and increased productivity because patients were more likely to show up during hours that were more convenient for them.
- The per unit costs associated with salaried staff were double the costs of contracted staff, though contract clinicians were less likely to provide the same depth of comprehensive services as a salaried clinician.
- That the provision of five face-to-face patient therapy sessions on average daily per clinician was an optimum level of productivity (where in clinics that had an average of only two face-to-face sessions, the costs per 185% higher).

C. Provider Productivity

Capacity is a function of number of staff and the direct Consumer contact hours available for each staff.

Productivity within the mental health field is typically measured by assessing the amount of billable or direct time a full time employee spent with clients or consumers. Georgia currently has no consistent measurement for quantifying the productivity levels of its providers of mental health services. Information reported in the November 2004 Community Services Board audit indicates that all CSBs perform productivity reviews,

however, goals have typically not been set for productivity criteria, or if goals have been set, they are not consistent from provider to provider, nor is monitoring done on a routine schedule, and monthly reviews to identify trends are not planned or put into practice. Findings from a recent CSB Audit (performed by the Department of Audits, completed in November 2004) are particularly relevant because all CSBs combined serve 90% of Georgia's consumers.

According to David Lloyd, a nationally recognized consultant in community based behavioral healthcare, service providers should monitor monthly staff productivity reports for all clinicians categorized by service type or program as a primary measure for reviewing agency capacity. Lloyd suggests using a billable hour/service unit standard for supervisors, managers, and clinicians. By looking at this, agency administrators can review what services are non-revenue generating and realign their priorities so increase revenue. Lloyd recommends that staff productivity rates should be targeted at 65%; that means that 65% of an employee's time is spent in billable time, or direct with clients. The remaining 35% can be devoted to supervision, paperwork, and documentation of client services.

The Community Service Board Audit performed during fiscal year 2004 (of seven CSBs) found that only some of the CSBs used Lloyd's national standards, and none of them set the productivity standard as high as Lloyd suggested for community support staff. One CSB uses productivity measures developed by another consulting firm, but they are in the minority for adopting such standards. Another conclusion of the CSB audit was that CSBs do not perform formal analyses regarding whether or not their employees are billing enough services to cover their annual salaries. To quote the audit "only 29% to 41% of CSBs employees had billings and/or collections recorded in the billing system." In order to run a behavioral healthcare organization that stays in the black, billing percentages must increase in order to bring in revenue. Moreover, while the use of contracted clinicians is not only desired⁷⁹ but often necessary to accommodate fluctuations in demand and staffing vacancies, the audit found that only 21%-46% of clinical service contractors were being tracked in billing systems, and of those, from 6%-74% had billings sufficient to warrant contracted dollars paid. In terms of collections from contractors' billings, one CSB actually collected 47% of the contractors' billings, a second CSB collected 8%, and the third collected none.

This discussion of productivity rates and revenue generation by employees is an extremely important component when discussing capacity, as it is evident that productivity is a function of capacity. When asked, all providers state that they are filled

⁷⁹ The Veterans Health Administration (VHA) has used contracting as one vehicle for improving access to care finding that the "benefits of contracting for care in the community are: 1) it can add capacity and improve access faster than can be accomplished through a capital investment; 2) it provides flexibility to add or discontinue services as needed; and 3) it allows [the] VA to provide services in areas where the small workload may not support a VA infrastructure, such as in highly rural areas." The VA's Capital Asset Realignment for Enhanced Services Commission encourages the use of contractors as long as it is feasible to do so. The determination of feasibility is made by **closely tracking that the contractor's productivity equates to sufficient revenue to cover the cost of the contract.**

or over capacity to provide adequate services. However, inconsistent business models and measures of capacity make it challenging to accept this as a forgone conclusion. In order to justify such statements, MHDDAD could promulgate a consistent set of methodology parameters for all providers to follow in order to determine productivity and ascertain total state capacity to serve those with mental illness. Creating a consistent measure of capacity by using productivity rates multiplied by the number of available FTE's can at least provide a means to measure a critical aspect in assessing capacity.

This simple formula could provide a ratio that is used to help purchasers of services know when and where an agency is at maximum capacity. For instance, if a provider has a direct service capacity of 200 hours but only provided 100 hours of service, then one could conclude that service delivery is under utilized. This ratio could be used to reflect physician time, day service staff time and community support staff time, with customized productivity guidelines set for each staff group. While it may be beyond the scope and role of DMHDDAD to set productivity rates, as purchaser of services, assessing capacity is necessary in order to effectively allocate resources. At a minimum the providers could be required to construct their own productivity standards to be utilized by regional offices to calculate capacity by service type. Capacity should then be compared with prevalence data for planning purposes.

D. Quality of Services

The definition and delivery of a service should be consistent in order to determine capacity for a particular service. Otherwise, some providers may show greater capacity due to the fact they are not adhering to the basic requirements of the service.

The quality of services provided is compromised when capacity is maximized for any length of time. There are many variables that stretch the mental health provider's resources. Staff recruitment and retention issues, budget cuts, poor management and subcontracting decisions, new state requirements, and increased community needs, can all affect the quality of services. While State standards do exist for Medicaid Rehab option services, most providers struggle to meet some of the basic requirements. These include:

- Meeting staffing ratios
- Meeting requirements for direct face to face contact with a consumer
- Meeting requirements for the delivery of out of clinic services

When measuring capacity for a particular set of services, one must establish some sort of fidelity measure regarding the service being delivered. For instance, in trying to measure community support services where 60% of the services are to occur face to face with the consumer and 80% of the contacts are to occur in the community, and staff to consumer ratio's should not exceed 50, how does one account for capacity if all of these requirements that define the service are violated? In other words, the definition and delivery of the service should be congruent in order to determine capacity for a particular

service. Otherwise, some providers may demonstrate more capacity due to the fact they are not adhering to the basic requirements of the service.

SAMHSA has promoted the documentation of capacity measures in its prevention initiatives where such documentation is a component of the risk and evidence-based framework for maintaining and measuring preventive services. Through prevention of crisis episodes that demand more intense levels of care, quality is increased by virtue of reducing the demands on clinicians to respond to situations of crisis.

In the context of change, with which MHDDAD providers have had ample experience, national consultant, Dale A. Jarvis⁸⁰, Managing Consultant for MCPP Healthcare Consulting, recommends using a set of tools that enable managers to implement change while sustaining quality. Those tools focus on securing, understanding and integrating clinical, utilization management and financial and outcomes data for use in operational and clinical decision-making. Mr. Jarvis encourages managers to sustain (and even increase) quality by regularly testing clinical designs to maintain a balance between client demand and clinician capacity and understanding how clinician productivity and associated caseloads are critical parts of the equation.

A collaborative effort between the New York State Office of Mental Health, an Ulster County mental health center, and the University at Albany has resulted in the development of a decision support system that tracks clinician productivity (in a managed care environment) including face-to-face time with clients and other clinician activities. The system allows them to proactively secure quality by their ability to find the root causes of financial difficulty and intervene before a crisis situation arises. Ultimately, the collaborative effort resulted in the mental health care center being able to leverage the information system to improve management practices and effect increased quality and customer satisfaction.

Since capacity is often defined by most people as numbers served or ability to serve a defined number of people in a particular service, it is important to reframe this definition to include the definition of a service along with the amount of direct services hours an agency is capable of offering. Ultimately, the quality of the service, as evidenced by adherence to requirements, can be an important variable in determining capacity.

E. Analysis of Provider Pool and Array of Services Offered

Since each provider in Georgia frequently offers a different mix of services, it contributes to the difficulty of measuring access and capacity. As discussed in the Availability of Current Services Section, many providers are not providing all of the services that the State promotes and encourages. For instance, many providers have not maximized the

⁸⁰ Dale A. Jarvis, CPA, is a co-author of *How to Thrive in Managed Behavioral Healthcare: A workbook guide to organizational and clinical quality* and scheduled presenter of *Empowering Clinicians with the Tools to Plan, Monitor and Sustain Change* at the 35th Annual Training Conference: National Council for Community Behavioral Healthcare, March 2005.

extent to which they are providing Community Support Teams, Assertive Community Treatment teams, and other billable services. Two CSBs do not provide either of the aforementioned services, limiting their capacity and also limiting the revenue they are able to generate. Based on the prevalence figures discussed earlier many more people with SMI and SED should be eligible and would benefit from the services as they have been promoted by the DMHDDAD.

The EARF system identifies approximately 270 direct mental health providers across the state (including duplicated providers who contract for service provision in multiple regions). However, this represents an overstatement of the actual number of public providers for mental health services. The majority of the 270 providers are small providers of primarily residential services to individuals with developmental disabilities, and report in the EARF on the consumers with co-occurring mental illness and developmental disabilities. To get an accurate assessment of who provides mental health treatment services, APS Healthcare reviewed the providers and controlled to allow only providers funded with state MH dollars⁸¹:

- Grant In Aid funded only (state or federal block grant dollars) – Providers that have contracts with the state to provide treatment services to adults or children and adolescents (Program 100 and Program 200 respectively)
- Rehabilitation Option Providers – Providers that bill Medicaid for rehab option services

By controlling for these features, it narrows the number of providers to 112 state funded or Medicaid mental health providers. Larger providers receive both state dollars and use Medicaid. In addition, there are 13 Grant In Aid specialty providers that are neither Rehab Option providers, nor do they enter information into the EARF,⁸² so little information is known about them and the services provided.

Once looking at the funding streams narrows the provider pool, APS Healthcare stratified the service providers into the following categories:

- Core Service Providers: Providers that offer the following array of services: Diagnostic Assessment, Crisis Services, Medical Services, Community Support, Outpatient Counseling, and Peer Support
- Specialty Providers: Providers that offer 1 or more specialty services (i.e. Intensive Family Intervention)

⁸¹ This analysis was informed by data provided by reports of contracted versus expenditures for FY04 from the Uniform Accounting System at the Division of MHDDAD, APS Healthcare Rehab Option reports, and statewide EARF data for FY2004.

⁸² The 13 Grant In Aid only contractors were not in the EARF database, thus service region and utilization information could not be obtained.

Core Service providers offer all core services to their consumers. With the exception of pharmacy services and peer support services, all Community Service Boards provided each of these core services. In addition to the 25 CSBs, there are another 5 Core providers mostly in metro areas:

- Grady Hospital
- Northside Hospital
- Fulton County Board of MHDDAD
- Haralson County Board of Health
- Savannah Area Behavioral Health Collaborative

The following data describes the array of services offered by the 112 providers:

- 70% provide at least one Outpatient Service
- 51% provide Personal Living and Residential Services
- 54% of providers offer Day and Employment services
- 62% provide Screening Crisis and Outreach services
- Less than 1% provide Service Entry and Linkage

See APPENDIX X-1: Services by Provider FY04 for a complete analysis of services offered by provider.

The CSBs provide almost 87% of all services provided statewide (as a percent of unique recipients of services); this percent rises to almost 92% as a percent of all service enrollments (count of EARFs). The analysis below describes provider pool:

- 25 providers are Community Service Boards (CSB) located in one of the state's 7 regions
- Only three providers have contracts in all 7 regions
- Two providers have contracts in five regions
- Three providers have contracts in four regions
- Twelve providers have contracts in three regions
- Fifteen providers have contracts in two regions
- The remaining providers only serve one region

F. Issues of Access

Accessibility is the dividend of a system that has adequate capacity.

Access & Distance: Geographical Areas of Coverage

One aspect of capacity can be defined in terms of ability to cover the large geographic areas that make up each region's territory. The following tables below presents each

region and population served in terms of square miles per region, broken down by Core Service Providers, Core and Specialty Providers, and then by Service Provision: Outpatient, Day and Employment, and Residential Service.

Table X-1: Core Service Provider Availability by Square Mileage

Region	Total Providers Service Sites	Providers per 1,000 Population Prevalence	Total Square Miles	Providers Per 100 Square Miles	Square Miles per Provider	Consumers Per 100 Square Miles
Central	4	0.09	8573	0.047	2143.25	209.70
East Central	3	0.05	8331	0.036	2777.00	204.00
Metro	6	0.04	1808	0.332	301.33	1934.40
North	6	0.05	9520	0.063	1586.67	450.90
Southeast	4	0.07	11768	0.034	2942.00	202.80
Southwest	3	0.07	9452	0.032	3150.67	196.90
West Central	4	0.06	9178	0.044	2294.50	240.20

Table X-1 clearly shows the large geographic area served by each service provider: Metro Atlanta Region had the lowest square miles per provider with 301, while in the Southwest region there were 3,150 square miles of coverage per core service provider (roughly a 55 miles x 55 miles surface area.)

Table X-2: CORE and Specialty Service Provider Availability by Square Mileage

Region	Total Providers Service Sites	Providers per 1,000 Population Prevalence	Total Square Miles	Providers Per 100 Square Miles	Square Miles per Provider	Consumers Per 100 Square Miles
Central	6	0.13	8573	0.070	1428.83	209.7
East Central	13	0.24	8331	0.156	640.85	204.0
Metro	34	0.23	1808	1.881	53.18	1934.4
North	15	0.12	9520	0.158	634.67	450.9
Southeast	12	0.21	11768	0.102	980.67	202.8
Southwest	20	0.46	9452	0.212	472.60	196.9
West Central	12	0.18	9178	0.131	764.83	240.2

By looking at the Core and Specialty providers per square mile, one can see how the ratio changes in regions where they have sought out additional providers to increase capacity and to create a competitive market. For example, in the core provider table Southeast and Southwest are nearly similar in the square miles per provider, however because the Southwest region has contracted with additional specialty providers their overall square miles per provider is nearly ½ that of the Southeast region's rate. Again, metro Atlanta region is the lowest with 34 core and specialty providers giving it just 53 square miles per provider (approximately 7.5 by 7.5 miles.)

**Table X-3: Outpatient Service Provider Availability
by Square Mileage**

Region	Total Providers Service Sites ⁸³	Providers per 1,000 Population Prevalence	Total Square Miles	Providers Per 100 Square Miles	Square Miles per Provider	Consumers Per 100 Square Miles
Central	5	0.11	8573	0.058	1714.60	209.70
East Central	8	0.15	8331	0.096	1041.38	204.00
Metro	25	0.17	1808	1.383	72.32	1934.40
North	10	0.08	9520	0.105	952.00	450.90
Southeast	7	0.12	11768	0.059	1681.14	202.80
Southwest	16	0.37	9452	0.169	590.75	196.90
West Central	7	0.10	9178	0.076	1311.14	240.20

Outpatient service should be a good indicator of access because those services include medical services such as physician and nursing assessment, as well as individual and group counseling, and other community services that people should have access to in their local communities. Again, Metro Atlanta and the Southwest region have the lowest square miles per provider, with Metro being significantly lower with 73 square miles per outpatient services provider.

Table X-4: Day and Employment Service Provider Availability by Square Mileage

Region	Total Providers Service Sites ⁸⁴	Providers per 1,000 Population Prevalence	Total Square Miles	Providers Per 100 Square Miles	Square Miles per Provider	Consumers Per 100 Square Miles
Central	4	0.09	8573	0.047	2143.25	209.70
East Central	6	0.11	8331	0.072	1388.50	204.00
Metro	17	0.11	1808	0.940	106.35	1934.40
North	7	0.05	9520	0.074	1360.00	450.90
Southeast	6	0.10	11768	0.051	1961.33	202.80
Southwest	13	0.30	9452	0.138	727.08	196.90
West Central	7	0.10	9178	0.076	1311.14	240.20

The total number of Day and Employment providers for the state equals 60, or 54% of all providers provides this service. These services are not as available as Outpatient services, but generally more available than residential supports.

⁸³ The number of providers includes duplicated counts of providers who have contracts in multiple regions.

⁸⁴ The number of providers includes duplicated counts of providers who have contracts in multiple regions.

Table X-5: Personal Living and Residential Service Provider Availability by Square Mileage

Region	Total Providers Service Sites ⁸⁵	Providers per 1,000 Population Prevalence	Total Square Miles	Providers Per 100 Square Miles	Square Miles per Provider	Consumers Per 100 Square Miles
Central	4	0.09	8573	0.047	2143.25	209.70
East Central	5	0.09	8331	0.060	1666.20	204.00
Metro	12	0.08	1808	0.664	150.67	1934.40
North	8	0.06	9520	0.084	1190.00	450.90
Southeast	9	0.16	11768	0.076	1307.56	202.80
Southwest	11	0.25	9452	0.116	859.27	196.90
West Central	8	0.12	9178	0.087	1147.25	240.20

Note: these numbers are not intended to indicate that in any region is the number of providers either sufficient or insufficient—this would take more in depth study to consider the types of services offered by each provider. In fact, because we know that the count of providers doesn’t represent equitable access to like services across providers, these numbers should be considered inflated.

In looking at the total provider column in all of the tables, it is important to note that the count of a single provider does not necessarily denote one location per provider. The CSBs typically have several locations across their service area, while private providers typically do not. Further complicating this analysis is the fact that each CSB service site may offer a different mix of services. Most sites do not offer a full array of services at one single location. So a consumer may have to travel a significant distance to receive the appropriate service for their needs even though a CSB may have a site near the consumer.

For a region like Southeast, which has the largest amount of square miles to cover, despite the fact that the number of consumers per 100 square miles falls into the normal range, the numbers themselves don’t tell the whole story. If we look at square miles per provider, we get a different sense of the miles to be traveled for a consumer to obtain treatment. These figures could be indicative of issues related to access—if consumers must travel far beyond their county, there is less likelihood that services are easily accessible—and could be considered in the development of provider and workforce development initiatives goals. For example, if the DMHDDAD wanted to establish a goal for purposes of access as well as competition, that consumers should have a choice of at least two providers within a 200 square mile area, development efforts would be aimed at doubling or tripling the number of providers in each region except for Metro (since we see that in all other instances there is less than “half” of a provider per 100 square miles).

Geography needs to be considered a major factor if productivity standards are set for the state. For providers in rural areas, it may take the majority of their day to travel to areas

⁸⁵ The number of providers includes duplicated counts of providers who have contracts in multiple regions.

of the county where consumers may live and capacity cannot be optimized if consumers cannot reach treatment sites. Thus, productivity could be adjusted based on the amount of travel, or the miles traveled to provide services.

To get a better visual representation into the accessibility of the services offered by Core Services Providers, APS Healthcare created a map presented as **Figure X-1**:

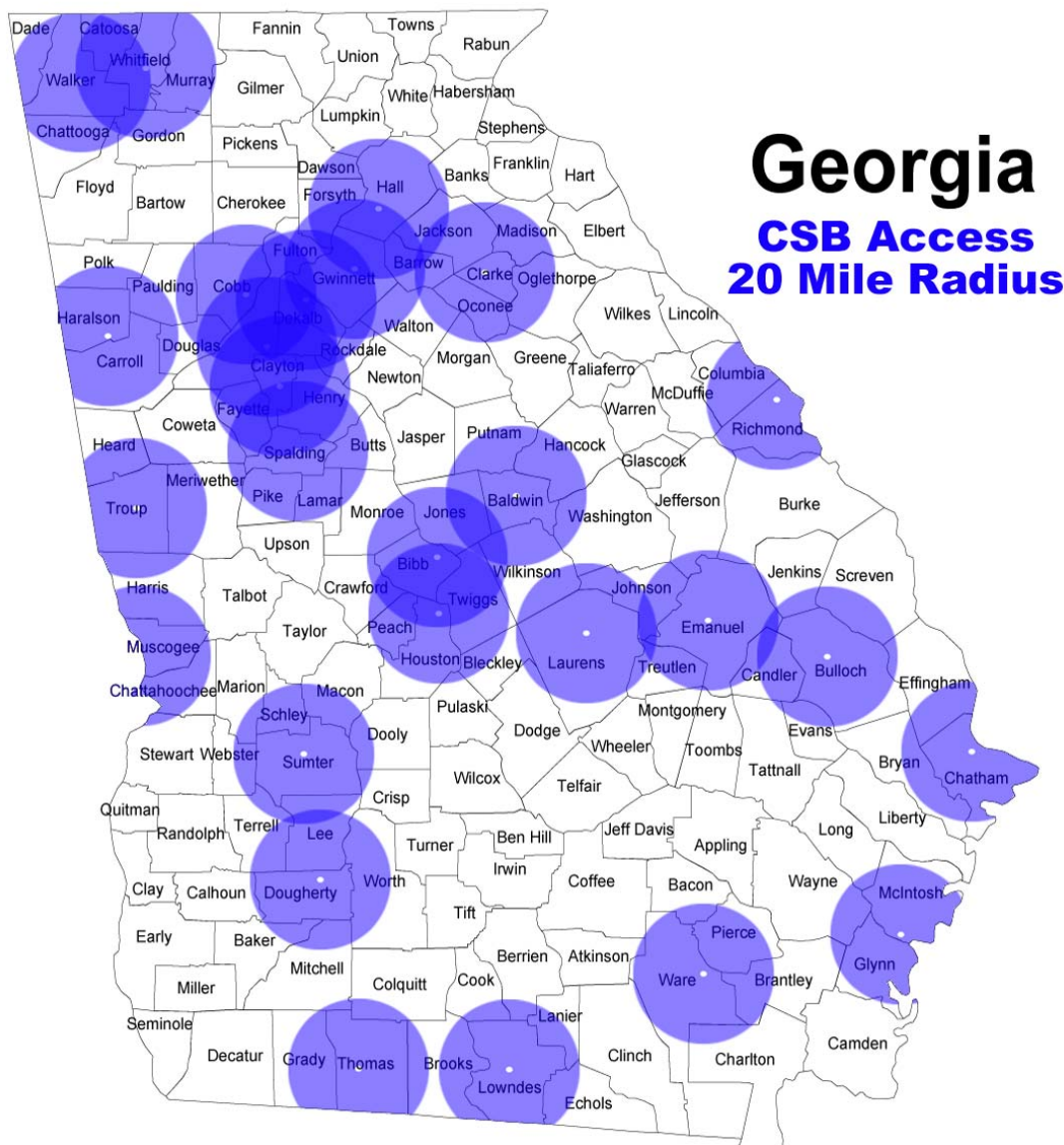


Figure X-1. Each circle on the map represents a 20-mile radius from the central office of each community service board (diameter = 40 miles).

Figure X-1 illustrates the geographical barriers in providing adequate access to services. The radius of the circle around the central CSB office shows 20 miles ‘as the crow flies’, actually getting to and from within that area could take up to 45 minutes by car.

Core Services Expansion

As discussed in the current initiatives section, the Division of MHDDAD is planning to implement changes that will expand the number and type of providers that will be eligible to offer essential services. The Division of MHDDAD is moving forward with a policy decision regarding who can provide Core Services which will attract additional providers and widen the provider pool, thus increasing the amount of people that can be served. Core Services are those services that have been determined critical components to the behavioral health service system:

- Diagnostic and Assessment
- Crisis Services
- Medical Services
- Community Support
- Outpatient Treatment
- Peer Support

Currently, in six of the seven regions throughout the state, only Community Service Boards are contracted to be Core Service Providers through the Division of MHDDAD. With the implementation of the Division’s new policy effective Fiscal Year 2006, MHDDAD Regional Offices will have the authority to contract with additional service providers to offer Core Services. The benefits of this initiative will broaden the provider pool and offer choice to consumers. Theoretically, competition should increase quality and decrease price. However, capacity will still remain a function of staff productivity and the funding each provider receives. So if overall state funding remains stagnant and productivity does not increase, capacity should remain the same but if funding or productivity increase then capacity should increase as well.

Access & Time: Wait Times to See Clinicians

Just as the measurement of capacity is multifaceted, access could be measured in multiple ways. For instance, most consumers have their first encounter with a provider through some sort of screening that may or may not lead to a diagnostic assessment. Once the diagnostic assessment is completed, a consumer is typically referred to a physician for a medication evaluation and then usually to a service that provides some sort of therapy and/ or training. The time between first contact and the delivery of a service or intervention designed to bring relief of symptoms and increased functioning may be considerable. A consumer who is significantly impaired may find it difficult to return to multiple appointments.

Further complicating the measurement of access is the fact that the state information system captures a referral to a service as synonymous with attendance. So a person may be referred to several services without ever attending but the MHMRIS system counts that enrollment as an encounter, making it more difficult to measure true access and capacity. Claims analysis from Medicaid rehab option reveals that 20%-30% of the consumers have only three contacts (representing any service) during a year. This means that many individuals are not remaining in services after an initial diagnostic assessment. Wait time to see a doctor can be a critical factor accounting for this trend.

By examining Medicaid Rehabilitation Option Utilization figures APS Healthcare performed an analysis of the time period between the first date of service, and the next date of service. The average days that a consumer must wait between their first visit and their second visit is 25 days. Statewide averages for length of time between 1st and 2nd visits are as follows:

Days Between Service	Percentage of Consumers Served
1-7 Days	36%
8-14 Days	17%
15 – 28 Days	20%
29-45 Days	10%
Over 45 Days	16%

From reviewing the table above one can see that 26% of first time consumers must wait more than 28 days to receive a follow up appointment. **APPENDIX X-1: Analysis of Time Between Service Dates** attached to this report details each providers time period between services. One indicator for wait times and engaging consumers in service is to examine the number of consumers who experience more than 45 days between their 1st and 2nd services. Across the state, the Community Service Boards have a high percentage of their overall cases that have to wait more than 45 days: the range is between 9%-31%, with most CSBs falling between 10-20% of all consumers having to wait 45+ days between services.

While there are no ‘planning or waiting lists’ for mental health services, individuals seeking services have been quoted up to a 5-week wait to see a psychiatrist⁸⁶. In the Southeast Coastal region, the wait to see the psychiatrist at one provider agency was reported as 6 weeks to 2 months. In fact, the shortage of psychiatrists is a common issue. Fortunately, some have been using clinical nurse practitioners or Physician Assistants to evaluate and prescribe psychotropic medications for consumers. With the proper training and tools, the ability to have other professionals prescribe medications can actually be a great way to increase the capacity of the service delivery system. One region has

⁸⁶ Stakeholder feedback during the focus groups quoted psychiatric appt wait times between 2 and 6 weeks depending on location

identified a strategy to combat the issue of physician wait times by having an ‘on call’ psychiatrist every Friday. The on call psychiatrist is available one day per week to see emergency patients that might otherwise have had to wait for several weeks to see a physician for a medication adjustment, or any possible crisis situation. By adjusting priorities and operations, this particular area within the state has been able to expand their capacity to meet the increased demands of the population within the community.

Most systems of care have access standards such as 2 hours for emergent needs, 72 hour for urgent needs, and 7 days for routine needs. While the public system is exploring the implementation of such standards, one would argue that it is important to measure access from the initial call or contact to the actual delivery of a service, other than diagnostic assessment. While quick access to assessment is important and is the first step toward a plan for recovery, most consumers do not begin to feel “helped” until contact occurs with a physician, therapist, or training staff. While we address the importance of geographic accessibility above, having service sites on every street corner may provide access to a screening or diagnostic assessment, but if the consumer has to wait three weeks to see a doctor or to begin a day program, then accessibility and the provider’s capacity must be questioned.

The current Medicaid Care Management Organization RFP cites access standards for mental health services as 45 minutes travel time for someone living in a rural area and 30 minutes for someone living in an urban area. A recent gap analysis conducted for the state of New Mexico states "individual and group counseling services, as well as medication administration and monitoring should be available within reasonable distances and reasonable amounts of travel time, generally no more than one hour."⁸⁷

As policy makers and stakeholders struggle with adequately assessing access in the future, they can incorporate a combination of consumer interview information, data gathered from chart reviews and audits, and geographic analysis. Additionally, they can begin to gauge capacity and access by requiring the providers who offer Single Point of Entry to track more information on wait times between initial call, diagnostic assessment and first contact with a doctor or therapist. However, when this function is operated by the agency itself, rather than an independent entity, the agency may be less likely to highlight access gaps associated with its own performance.

Recommendations for measuring capacity:

Measuring capacity requires the following steps:

1. Service fidelity needs to be evident in that the requirements of a particular service reflect the definition of the service being measured.
2. A direct contact hour standard needs to be set for staff, which would be based on the service, or category of service provided.

⁸⁷ State of Georgia Care Management Request for Proposal, Department of Community Health, 2005

3. Once a number of direct contact hours are established, an analysis of each provider's service array needs to occur.
4. Capacity for a service or category of services would be defined as the number of qualified staff multiplied by their direct contact hours for each type or category of service.
5. A scatter plot map by specific service could be created by region or table reflecting capacity of each county could be used to summarize capacity and compare to prevalence data.
6. Access measurement, which is a product of capacity, should reflect both time between first contact, diagnostic assessment, and initiation of service delivery and distance the consumer has to travel for services.

Moving Forward

The many components that formulate capacity are largely absent in Georgia's mental health service system. Where subcomponents do exist, such as providers who evaluate their own productivity, measures of productivity and targets for agency-wide productivity are not standard across the state nor do the providers' evaluative results inform system capacity on a statewide basis. Given earlier findings in this report on the public mental health system's penetration of those in need, it is imperative that the state establish how it wishes to define capacity, which measures and guidelines it will standardize from provider to provider, and how it will monitor and enforce standards. The state must have a defined capacity target in order to truly understand the import of gaps identified in the system. When the true measure of all gaps is known as compared to an aggregate total of needed capacity, the state will have the data variables it needs to calculate the amount of funding that is necessary to reach and successfully treat its core customers.

CHAPTER XI: PUBLIC FINANCING AND INFORMATION SYSTEMS

In this chapter you will find:

- ❖ *Financing Georgia's Public Mental Health System*
- ❖ *Analysis and recommendations for the Mental Health Mental Retardation Information System (MHMRIS)*



Highlights of significant findings within this chapter include:

- ❖ *The fragmented infrastructure of the State's many offices involved in financing, accounting and information management does not support Division goals for measuring utilization, trending and planning for system needs.*
- ❖ *Current State Data Management and Accounting Systems do not support the Division's goals to enhance continuous quality improvement or strengthen the link between community and hospital treatment services for continuity of care.*
- ❖ *There is no centralized accounting system for tracking all dollars from multiple funding streams within the Community Mental Health System.*

A. Financing Georgia's Public Mental Health System

There is currently no centralized accounting system for tracking all dollars from multiple funding streams within the Community Mental Health System. When calculating Georgia's budget for Mental Health Community Services there is not one single methodology that accounts for all dollars from multiple funding streams. APS found the task of actually compiling a report of expenditures challenging, and the figures varied upon the source of the information.

Federal, state, and local governments contribute substantially to the financing and delivery of mental health care. Public payers funded 58% of the federal mental health/substance abuse spending in 1997, a much larger share than the 46% of total health expenditures paid for through the public sector. Historically, state and local governments have assumed a particularly large role in financing mental health services, however with shifts in policy many states are taking advantage of Medicaid to pay for community mental health services thus moving much of the burden to the federal government. In 1997, state and local governments provided 28% of all MH/SA expenditures, while funding only about 13% of health care services overall. Mental Health Services are funded through a combination of Medicaid, state grant in aid dollars, the ADAMH block grant, and Title XIX. For each Medicaid dollar spent in Georgia, the Federal Government

pays 59 cents and the State matches the remaining amount (41 cents). The state match for most Medicaid outpatient services resides primarily in the DHR budget, although the Department of Community Health has the match for regular Medicaid inpatient psychiatric services and psychiatric pharmacy services. The Division of MHDDAD maintains control over hospital resources within the DHR's seven regional hospitals. This organizational structure has created a divided responsibility for members with chronic and persistent mental illness.

As stated above, in recent years, the federal government has increased its role in financing these services. Expenditures through the Medicaid and Medicare programs constitute 35 and 21%, respectively, of total public sector expenditures on mental health services nationally. In addition to Medicare and Medicaid, the federal government provides additional resources through various programs including the Community Mental Health Block Grant, Community Support programs, the PATH program for services to the homeless mentally ill, and Comprehensive Community Mental Health Services for Children⁸⁸

APS received information from several sources regarding the state's multiple funding streams:

- Expenditures are routinely reported to the federal CMHS department as part of regular grant block requirements.
- Information was collected from the State Office of Planning and Budget on the budgeted allocation for FY04; however when different figures were provided APS examined the issue at a closer level and determined that for the purpose of our analysis only expenditure data would be used.
- The State Division of MHDDAD provided figures from the Universal Accounting System on all contract dollars allocated to community mental health services, however these figures did not include federal Medicaid revenues that were generated through rehabilitation option services.

In order to get an estimated account of all of the resources allocated to the state's community mental health system, APS completed the following process: First, statewide figures were pulled from the Universal Accounting System (UAS), within Department of Human Resources. This includes all state dollars allocated to providers of Mental Health Services. Next, APS Healthcare pulled Medicaid Claims for rehab option services provided in FY04 (all claims billed by 12/31/04.) Both sources of data were aggregated by Adult and Child and Adolescent Services. The table below reflects the resources allocated for Georgia's Public Mental Health System.

⁸⁸ <http://hcs.harvard.edu/~epihc/currentissue/spring2001/barry.html>

Table XI-1: FY 04 DMHDDAD Expenditures

	State Expenditures from UAS	Medicaid Rehab State Dollars	Medicaid Rehab Federal	TOTALS
Adult Mental Health	\$ 109,595,765	\$ 22,607,407	\$ 33,323,833	\$ 165,527,005
C&A Mental Health	\$ 44,249,132	\$ 18,316,834	\$ 26,999,429	\$ 89,565,395
TOTAL STATE AND FED EXPENDITURES FY 2004				\$ 255,092,400

The public mental health spent \$255,092,400 during FY 04 to support public mental health services within the state.

Grant In Aid funds

Georgia has a long history of using state dollars to provide supports to its most vulnerable citizens. Before revenue maximization efforts began in 1999, Georgia's mental health system was almost completely state funded. Providers of services relied on these state funds as they were typically more flexible than federal dollars, and providers were given a grant each fiscal year. As part of the mental health gap analysis, APS requested information from Regional offices about their grant in aid contracts, and the numbers of consumers served by each provider. However, it was revealed that regional offices contracting policies are not conducive to collecting unduplicated utilization figures on services provided with state dollars. Since regional offices do not collect consistent reporting across the state, information on the dollars spent per consumer is unattainable. Payments are made to providers based on the number of consumers seen per month, however this does not represent an unduplicated number of consumers between service categories, nor does it reflect the number of units provided per service category. For example, services are allocated by the category of outpatient supports, and no additional utilization information is collected other than the number of people that received outpatient services that particular month.

The Mental Health and Mental Retardation Information System (MHMRIS) is thoroughly analyzed in the next section. However, one of the largest gaps in the system is the fact that one cannot identify the number of individuals who receive both Medicaid and State Grant in Aid funding (GIA.). According to the Division of MHDDAD in a report labeled Profile of Clients by Type of Funding Support, nearly 102,000 Mental Health consumers statewide received non-Medicaid state funded services. Data derived from Rehab option claims reveals that over 63,000 individuals received Medicaid rehab services during 2004. Unfortunately, limitations within the data system prevent the categorization of individuals who received Medicaid only supported services.

Per Capita Community Expenditures

Due to the lack of precision in calculating the utilization and encounter data for consumers receiving grant in aid funding, APS performed two separate analyses to get a better idea of the per capita expenditures for community mental health services: All services and Rehabilitation Option services. Looking at the total expenditures for the state along with the total number of consumers served, one can determine the total dollars spent (as described above) and divide that by the total number of consumers served to get the average per capita expenditures for FY04. Table XI-2 below demonstrates the figures for FY04: both rehab option and total dollars:

Table XI-2: FY 04 Expenditures per Person

Rehab Option Expenditures - Federal and State	State GIA and Federal Block Grant*	TOTAL EXPENDITURE S	TOTAL Served	Expenditures per person served	Rehab Option Consumers	Rehab Costs per consumer
\$101,247,503	\$153,844,897	\$255,092,400	174,298	\$1,464	63,865	\$1,585

From looking at the table, one can see that the difference between the total expenditures per person and rehab option expenditures are just over \$120, adding validity to the estimation since the rehab option size is about a 40% sample of the greater population. Using the figure for the total expenditures per consumer served, one can project the costs from serving additional people in need of services as portrayed in Table XI-3 below:

Table XI-3: Projected Costs of Serving Individuals In Need

200% Poverty In Need	Projected costs if 200% Poverty In Need served	Total # In Need of Services (not controlling for poverty)	Projected costs if Total # In Need served (not controlling for poverty)
217,155	\$ 317,815,409	547,896	\$ 801,868,671

The Division has referenced in several documents that individuals under 200% of the Federal Poverty Limit are those most in need of state funded supports, and the target population that should be receiving public services. Using the current expenditures per person to serve the total in need of public funded services under 200% of the FPL, the Division would need \$317,815,409, a net increase of \$62,723,009. The number grows significantly when expanded to the entire population (not controlling for poverty) in need of mental health services to \$801,868,671. Caveats to be considered when reviewing this analysis is that the system would only provide the same level of services that are currently being provided, and from previous chapters, APS has identified gaps in current services to include underutilization of some necessary services.

Other Funding Sources

During fiscal year 2003, the 25 Community Service Boards billed only \$2,220, 673 to private insurance companies for services, representing less than ½ percent of total revenue

As discussed in the sections above, Georgia's community based mental health system relies primarily on two sources of public funding to provide services to a diverse population of consumers: state and federal funds. In 2003, 84% of Community Service Board's Revenue came from state and federal governments; Local funds made up just 3% of total revenue. In other states where services are operated on a local level, counties have been successful in passing local levies to support and augment services. Additionally, only \$18,000 was brought in from community donations as revenue into the Georgia CSB system during 2003. This may be due to the unique nature of the CSB system – they are neither private nor public entities causing confusion as to whether gifts are tax deductible, etc. If gifts were more easily accepted, community services could focus on fundraising to support their budget by doing activities such as hosting a 5K road race and walk for Mental Health, coordinating a change drive with local businesses, or having silent auctions.

With the shortage of qualified personnel across the state, the public mental health system could be marketing themselves to private pay clients. However, during fiscal year 2003 the 25 Community Service Boards billed only \$2,220, 673 to private insurance companies for services, representing less than ½ percent of total revenue.

Other State Agency Funding

In previous chapters on community services, APS discusses the gaps in tracking common customers across multiple state agencies, more importantly tracking the continuity of care and the expenditures tied to these shared consumers. The Division of MHDDAD, the Division of Family and Children's Services, the Department of Juvenile Justice, the Department of Corrections, and the Department of Education all provide some level of mental health supports to individuals involved in their systems. Information was not available that prevented a calculation of a grand total of expenditures for mental health services for each of these agencies. However, it is estimated that more than \$120 Million alone are spent by the Division of Family and Children's Services on residential placements for children with severe emotional disorders. The Department of Juvenile Justice reports that an estimated \$20 Million are spent annually to support children and adolescents with mental health diagnosis in residential treatment programs alone. Until there is an accurate method for calculating the total costs of these shared clients, there are large gaps in determining the total public funding budget for mental health services within the state of Georgia.

While expenditures are not easily analyzed, the DHR is taking steps to share information with several of these agencies through the creation of a central data repository. This initiative should allow all participating divisions to track unique consumers and it will provide a natural foundation for calculating total expenditures for Mental Health within all DHR divisions. Furthermore, it should provide a basis for resolving continuity of care issues.

Hospital Funding Analysis

The total FY04 hospital expenditures for mental health treatment were \$166,867,850. This included \$99,328,629 for Adult Mental Health, \$51,106,343 for Forensic, and \$16,432,878 for Child and Adolescent Short Term and Long Term combined. The cost per Occupied Bed Day for Adult Mental Health was \$389.89; for Forensics, \$355.07; and for Child and Adolescent, \$458.14.

By episode, costs were \$7,464.95 for each Adult Mental Health episode, \$28,582.97 for each Forensic episode, and \$7,657.45 for each Child and Adolescent episode. Using unduplicated counts of recipients in FY04, we calculate per consumer costs of \$7,607.31 for Adult Mental Health, \$28,598.96 for Forensic, and \$7,855.10 for Child and Adolescent.

The total dollars spent for hospital treatment represent 43.77% of total expenses incurred by the Division of MHDDAD for mental health services. According to the FY2003 CMHS Uniform Reporting System Output Tables (which used FY2002 expense data), the national average state expenditure for hospital treatment was 30%. As discussed previously, the differences are seen in crisis stabilization types of services. The CMHS reporting system labels these as “Other 24-Hour Care” and indicates in its FY2003 report that while these types of costs represented 9% of Georgia’s expenditures, the national average was 18%.

B. The Public Mental Health Information Systems

“[We need]...a more coordinated and updated computer network system to work smarter not harder in the 21st century between agencies public and private. There are many successes going on but the lack of accurate and coordinated data gathering systems limits this information to get through. A state system of invoicing through computer rather than archaic hand written triplicate forms. A centralized abuse registry system that evaluates the calls the same way and then disburses to the individual offices with timeframes and required responses all on a computer system.”

- Survey Respondent

The Request for Proposal asked that Georgia's existing Mental Health, Mental Retardation Information System (MHMRIS) data be examined and gaps or deficiencies be identified in the MHMRIS data system. The *Limitations of Data* section of this report deals largely with APS' findings as a result of the examination of the data. This section will address the gaps and deficiencies in the MHMRIS data system that relies largely on information gathered by the Division of MHDDAD (Division) through a Business Process Re-engineering & Technology Viability Study conducted by Foundation Technology Services in January 2003.

Overview

The MHMRIS is a statewide system that collects consumer demographic and diagnostic information as well as service enrollment data. Service enrollment data is based upon the initial entry of a Basic Intake Form (BIF) upon which an Enrollment Addition & Release Form (EARF) is generated for each service in which the consumer is enrolled (or from which is released). The system supports the informational needs of community mental health (and mental retardation and addictive disease) programs through the production of routine reports and creation of ad hoc reports for the state office of MHDDAD. The system is used for the assignment of unique client identification numbers and it allows for multiple service enrollments per unique client. Limited hospital inpatient data is integrated in the MHMRIS from the hospitals' Behavioral Health Information System (BHIS).

House Bill 498 calls for a single point of accountability at a regional level for oversight of state hospitals, community service contracts, and service delivery. However, the fragmented system of multiple databases does not fully support such management ability, neither at the state nor the regional level.

Originally developed in 1974, the MHMRIS is a mainframe system (DB2 database) that processes input daily from 7 state hospitals and over 200 community service providers. There are an estimated 600 users and 5 support staff. Approximately 4,000,000 transactions are recorded and reported annually for over 180,000 consumers..

In the study provided by the Division of MHDDAD, the Division expressed a need to accomplish several goals in examining and designing improvements to the MHMRIS system. Generally, there is a desire to:

- ❖ Strengthen the link between community and hospital treatment services for continuity of care
- ❖ Enhance the Division's ability to perform continuous quality improvement
- ❖ Rely on the system for the purposes of strategic and operational planning and budgeting
- ❖ Integrate multiple systems in order to cross correlate information, interface between them, and avoid duplication inherent in multiple databases

- ❖ Develop a more efficient means of tracking, reporting and utilizing data but with bolstered security measures to comply with federal laws

In addition to the desire of the Division to operate more effectively and efficiently, legislative intent and enabling authority in law call for both broad accountability and specific operational components with which the Division is legally bound to comply. This last sentence needs to be reworded or deleted. Furthermore, federal funding sources are now requiring extensive, nationally uniform, reporting on an annual basis. The architecture and infrastructure of the MHMRIS has been stretched and add-ons fashioned to provide the full measure of reporting and data tracking for the service system's points of accountability. For example, House Bill 498 calls for a single point of accountability at a regional level for oversight of state hospitals, community service contracts, and service delivery. However, the fragmented system of multiple databases does not fully support such management ability, neither at the state nor the regional level.

The 2003 study identifies the primary issues with the MHMRIS system as follows: :

- ❖ The architecture of the system is not sufficiently flexible,
- ❖ The system did not meet business requirements
- ❖ The system is very expensive to maintain, requiring considerable personnel support that could be eliminated with use of newer technologies
- ❖ The design of the system required multiple data entry by providers which increased data entry error
- ❖ Stand-alone databases needed to be integrated
- ❖ Tighter security measures were needed

The recommendation by Foundation Technology Services was to replace the system through a phased-in approach that will enable historical data to be retained (following cleansing and migration). This phased-in approach will spread the workload and cost of such a transition, and will allow a graduated timeline for thoughtful research and decision-making about the design of the new system.

Issues, Inaccuracies, and Inadequacies

In this section, we include the components of the system's limitations that were encountered during the gap analysis work as well as specific technical and programmatic limitations identified in the Foundation Technology Services report.

ISSUE, INACCURACY, OR INADEQUACY	IMPACT
System Design: Infrastructure/Processes	
The Basic Intake Form (BIF) is entered once at intake and there is some doubt regarding how well the information	Primary consumer demographic information is captured in the BIF. Staff have conveyed a belief that contact information is typically not updated after the very first entry into the MHMRIS despite the fact that contracted providers

captured in the BIF is updated as changes in the consumer's life and condition occur.	sign a statement attesting that the data is both current and accurate. Therefore, contact info for communication with the individual or family for emergencies would not be updated (Division must rely on providers for this information), and any analysis that relies upon place of residence is likely to be wrong because all successive EARFs pull the county of residence data from the original BIF. Also, there are consumers still in the system who died as long ago as 1978.
There is only a single primary disability captured on the BIF	Data reports are flawed due to an inability to have more than one disability designated (particularly relevant for those with dual diagnosis served with cross-disability services); updating or changing the primary disability changes all previous designations and erases the consumer's history; if it needs to be changed and isn't, the data and reporting continues to be flawed. Similarly, there are no dates associated with diagnosis codes on BHIS which makes it difficult to determine which diagnosis is most current.
System can only accommodate one provider's information, but often a consumer has more than one provider	This limitation causes duplication in the system, different users changing data or adding conflicting data, or a consumer's service not being entered at all, because one provider thought the other provider had done it.
Unavailability of batching to MHMRIS and difficulty with data entry	Records can be completely rejected upon attempted upload which causes duplicate work; acceptance of data entries is fickle—the same data can get rejected over and over and then finally get accepted. This results in the perception that the system is not user friendly.
There is no standardized grouping of diagnostic codes by service disability	A cross reference table of dedicated diagnoses assigned to service disability would make queries and reporting more efficient and more consistent, rather than reprogramming for each ad hoc report.
Creative upgrades to the system and use of outdated fields	The utilization of data elements have changed over time to capture different information than what was originally intended for those fields; this has eliminated the ability to track some information that could be useful in favor of more significant and/or topical information about the consumer and his services
Funding sources not captured	The ability to track and calculate total expenditures by funding source for each episode of care would tremendously impact Division's ability to plan and project needs. (Identify source split between state funds, block grant funds, Medicaid funds, private pay)
Cannot distinguish between new and existing consumers or how long the existing	Inability to distinguish hinders the ability of the Division to consider length of stay in service system versus length of active episodes since first data entry and to track recovery

consumers have been in the system	outcomes.
Reliance on modality coding is perhaps outdated.	The use of modality code becomes part of the record key and limits efficient use of the record through updating or removal of the modality.
System Design: User	
User codes and input fields are not as error-proof as they could be	Because many fields are not restricted by either drop down options or numeric only formatting, there is a high proportion of records that due to input errors result in skewed and incorrect reporting. Similarly, because some fields are not required, or can be filled with text for which the field was not originally intended, a report of consumers by age, for example, may have counts of consumers of indeterminate age because the birth date was not filled in correctly
Provider/user data entry is cumbersome and often requires duplicate information to be entered on multiple stand-alone databases	Takes too long to enter a record which affects likelihood of user to correct an error if the record has to be re-entered; multiple entries required per consumer (examples: MHMRIS, UAS, monthly reports to region, BHIS, PERMES, and TRIGRS). This is simply inefficient and not the manner in which the Division would wish provider resources to be spent.
Data queries are limited and often incomplete and results in lack of trust in the data by providers.	An inquiry search of the database by consumer does not allow for the search to be narrowed by region, facility, or unit number. When a common name is queried, there are multiple pages of results which become time consuming to review to find the single consumer sought. Queries were demonstrated to be inconsistent in effective data retrieval in the field tests. Distrust of the data results in providers not wanting to invest their time in updating it. This gradually erodes the perceived quality of the data.
Record duplication	It is easy to accidentally enter the same person into the system twice due to the way the Soundex search mechanism works; an episode search by facility and unit number does not consistently show episode data as does a search for a consumer; also because the system does not give feedback about whether a record has already been entered, some users will resubmit—this is estimated to account for about 10% of submission duplicates. Some duplication also occurs because of the lack of historical trail in system.
Minimal data validation	Data validation upon entry is prone to errors; providers must call Division to resolve which is an inefficient use of human resources
Perception that MHMRIS is an “after-the-fact” system	As long as the there is no service unit or encounter data that has to match up to an enrollment, the integrity of the enrollment data is compromised due to a lack of concern in

	getting the data entry right since it occurs after payment.
Provider consequence of system replacement	Concern that replacing the MHMRIS will impose workload and cost burden to providers. This is to be avoided.
Need for Centralization of Multiple Data Sources	
Need a centralized way to consolidate consumer IDs in the system	Centralizing CID would reduce the replication of multiple CIDs for individuals as well as might protect privacy if fewer users had access.
MHMRIS disability, unit and subunit coding do not match UAS coding	If codes don't match, the head count for numbers of consumers served will be reduced as will the payment to the provider. Other related layers of "non-matching" between MHMRIS and UAS (beginning with very different purposes for which the systems were built) affect ability to successfully and accurately achieve head count.
Planning list records are tracked separately	A centralized database and reporting system are needed to track those on the planning lists for length of time and type of services for which they are waiting and at the same time assess the level of access to services they are receiving.
Regional offices cannot correlate consumer services to payment	Lack of this ability equates to a lack of incentive of the provider to enter all necessary data because they are being paid based on data submitted elsewhere that is not linked; the availability of such a link would enable analysis with much greater depth and would better enable the regions to accurately tie service outcomes to provider payments. Regional staff use MHMRIS to audit providers but the data submitted on paper or to the contracts or payment system doesn't match the data in MHMRIS.
Facility, unit and subunit codes cannot be properly maintained because of no linkage to contracts information or provider profile; Provider demographic information is not captured or linked	Not able to track movement of consumers from provider to provider accurately within the system and utilization/service provisions reports by provider would be inaccurate. Also cannot limit access to system or certain types of entry based on a current status of what services the provider is authorized to perform. With such limitations maintained, data input error would be reduced. With linked provider information, the scope of available reporting and analysis by provider would be expanded for both performance management and planning purposes.
Capturing and reconciling hospital outpatient services versus community services in MHMRIS	Until recently, and perhaps still not consistently, only hospital inpatient data was transmitted to MHMRIS, arguably leaving a whole segment (outpatient) of the service population unaccounted for in a centralized database, eliminating the option of easily cross-referencing for consumers enrolled in community services.
Programmatic Trending & Analysis	
Continuity of care is not track-able	The system cannot individually track the transition of a consumer back and forth between community and hospital

	treatment to the fullest extent needed. The ability to do this is important to assessing success of treatment options, for determining individualized and program results, and for outcome and results based initiatives.
Neither encounter level data or units of service are collected	A consumer can be enrolled in a service, but there is no data collected in the system to verify that the service was provided by such information as when it was provided, quantity of units provided, and how often it was provided. Encounter data is not only vital to contemporary analysis of utilization but the lack also inhibits the depth of analysis for PERMES reporting. A reference in the interim report from Foundation Technology Services indicates that a mechanism to do this does exist and works well, but is just not being used.
Lack of schematic that allows for flexibility for reporting to respond to changing regions	As the number of regions has gone from 19 to 13 to 7, and now potentially 5, much historical information has been lost and ability to analyze utilization over time, the ability to compare for example services provided in old region 1 to new region 21 is diminished if not totally eliminated.
Inability to track and report on Uniform measures	Homelessness has recently begun to be tracked, but other measures still need to be incorporated in to the system to meet Data Infrastructure Grant requirements, such as School Attendance, Adult and Juvenile Criminal Justice Contacts, Use of New Generation Meds-Hospitals and Community, Integrated Treatment for Dual Diagnosis, Family Psycho-education (if service offered), Supported Housing, Supported Employment, Living in Jails and Other Correctional Settings, and Living Situation. Need additional flexibility to allow for changing definitions. Also need for GPRA (Government Performance and Reporting Act), and Braddock Report (developmental disabilities).
Cannot determine count of consumer deaths	Inability to track deaths eliminates ability to identify trends related to disability, treatment and death, for example.
Maintenance/Security	
No audit trail for changes made to record; cannot identify which facility is responsible for submitting batch data.	Eliminates ability of IT maintenance to identify problem users and re-train. Lack of accountability raises security concerns.
No error codes are associated with Error Reports	Error codes associated with Error Reports for batch submittals to MHMRIS would facilitate correction of errors
Active users continue to grow and as a group could benefit from additional management	Effects security of system and results in inability to accurately release active enrollments
Continued specification changes for users require	Creates duplication of resources (resource expenditures)

Future Steps and Recommendations

APS understands that funds for the development and implementation of a new integrated hospital and community data system are in place and GTA will proceed with a Request for Proposals. The information gathered in this chapter should help shape the system that the Division ultimately purchases..

As indicated above, there are currently funds projected to be included in the Georgia Technology Authority FY06 Budget to build a new system for the Division. While these funds should help with the creation of a new system in the near future, the 2003 study listed several interim changes that could occur immediately which are outlined below:

Suggestions For Immediate Change (Offered by Foundation Technology Services in January 2003)

- ❖ Develop a standardized set of service codes to be used throughout the system (preferable consistent with Medicaid codes).
- ❖ In preparation of June 30, 2003 when all consumers are to be released and re-entered:
 - Design and develop a plan to perform data integrity review and audit of the entire consumer database.
 - Consider using a service to validate the addresses, etc. of all consumers.
 - Design and implement a business rule to eliminate possibility of having several open enrollments for the same consumer, same service, and same provider.
 - Design an edit that does not allow multiple residential services at the same time for the same consumer by separate providers.
- ❖ In lieu of using modality for “why did you get this service,” use “what disability was this enrollment intended to serve.
- ❖ Enhance the consumer inquiry screen to include region and/or facility/unit number to better qualify the query.
- ❖ Add additional edit rules to the online data entry screens to minimize submittal errors.
- ❖ Update the MHMRIS manual, incorporate the manual into ROBO HELP, and post the result on the web site.
- ❖ Reduce number of stand alone databases by initially reviewing content of existing databases to determine which ones should be rewritten, combined, eliminated.
- ❖ Complete descriptions of each system should be created including their purpose, types of data maintained, and a single point of contact should be identified.

- ❖ Develop and implement a plan to improve communications between state staff and the regions and between regions and providers to improve receipt of timely and complete communications, advance notification of impending changes, instructions for changes, and new systems being developed, as examples.
- ❖ Conduct a study and develop recommendations for assigning new CIDs.
- ❖ Develop a comprehensive list of MHMRIS reports to be established as standard reports and distributed regularly.
- ❖ Develop a liaison with other Departments/Divisions to determine opportunities for linking, current system capacity, future system direction and development.
- ❖ Review details of the Florida system and identify what their system does and doesn't do relative to Georgia's future requirements.

New Design Recommendations

- ❖ Global Development Considerations
 - Incorporate ability to maintain historical data online, while archiving selected data for warehousing and mining to allow for future trending and projections.
 - Consider the development of business rules and operational edits on the front end of system design to avoid unintentional limitations after it's too late.
 - System flexibility should support changing regional and provider profiles including providers with multiple locations and differing authorized services by region.
 - Consider generation of consumer records related to opportunities for linkages to SPOE system data, TRIGRS (Treatment Request and Integrated Georgia Reporting Survey) data, and WIS (Waiver Information System) data.
 - Develop target penetration rates for aggregate and subcategorical service populations which can be saved in a table and incorporated for comparison to current penetration rates based on service provision when generating routine/standardized gap analysis reports.
 - Create an extensive users' manual as part of training on new system and update at least semi-annually. Distribute to established user channels.
 - Data reporting needs to be manageable for the provider; use as opportunity to remove some of the burden of data entry
 - Dedicate extra technical support staff/resources for an elongated period of time through training and during and post implementation
 - Consider using enrollment and authorization data entry to create a consumer record with associated service authorization and then unit of service and encounter data (probably combined) to "draw down" utilization, and remove the necessity to release someone from a service; release will happen automatically (and report automatically generated) when all service units have been used.
- ❖ Standardized Reporting

- Establish current ad-hoc reports as standardized reports.
- Establish business process distribution channels and cover forms for distribution with explanation of report content.
- Post standard reports to web for researchers.
- Establish methodology for calculating age based on date of birth consistently across agencies.
- Consider compliance with and correlation to SAS, MISIP and DIG reporting requirements.
- Automatic reporting of deaths generated when entered (record released) in system by provider and distributed to appropriate staff.
- Establish predefined sorting tables for ease of reporting, for example a report that demonstrates service utilization by count of consumers by county and region should refer to an established cross reference table of county to region.
- ❖ Security and Maintenance
 - Develop audit logs to track changes and access to system and submission of batch files.
 - Each user has his/her own username and password; passwords to be updated regularly; passwords not updated after X amount of time (to be established) result in removal of user's access.
- ❖ Specific Business Rules
 - Standardize all data sets (e.g. standardized groups of diagnostic codes by service disability)
 - Allow only one unique identifier per consumer across service venues and all service agencies (if the latter can be coordinated with other divisions/departments)
 - Allow consumers to be served by more than one provider, as long as not for same service and same time period.
 - Disallow concurrent enrollments for same reason; allow only after released from first enrollment
 - Disallow multiple residential services at the same time by different providers
 - Providers only allowed to process enrollments for those specific services for which they are contractually authorized to provide
 - Allow records to be copied/converted, once all consequences are considered and history tracking in place, from outpatient to inpatient or from outpatient to community service, for examples.
 - Utilize preset drop down fields to minimize data entry error to greatest extent possible
 - Limit drop down option based on authorization level of user
 - Where drop downs are not appropriate or possible, limit possible entries by formatting the field to only accept a certain number of characters or only text or digits, for example

- Pop up flags are triggered or standard reports generated at login for notification of submission errors, consumer unit, service/service authorization expiration, and due dates
- Upon consumer enrollment in a new service or by a new provider, the system triggers to consumer demographics to confirm that current address and contact information, etc., are correct
- When first entered into the system, have system automatically assign a date to the creation of the record/consumer ID so that length of time in services from that point forward can be tracked
- ❖ Foundation Architecture/Database Components/Business Processes
 - One unique identifier per consumer
 - Replace or redesign to consolidate the BIF, EARF and SAS to one form
 - Link contractual and financials to service utilization
 - Require service encounter mechanism to be utilized and/or redesign to incorporate unit of service utilization (may be imminent with trend to fee for service which needs to be anticipated)
 - There should be a distinction in the data regarding the EARF's status that indicates and "active EARF" from a "non-active" one. For example, a possible alternative using existing MHMRIS infrastructure could assign the BIF (Basic Intake Form) to be used exclusively for enrollment in the system, and EARFs could be submitted *after the service has been provided*, in periodic increments. This way, enrollment data is not artificially inflated.
 - Centralized data system needs to have related provider demographics and detail including site(s) addresses, contact information for leadership and communications, counties, financial info (budget and payment history), units of services and rates, subcontractors, licensure and accreditation, staff licensure and certification data, and contract data, for examples.
 - Use an operating system that contains ability to manipulate, query, and export data easily and into different formats; preferably that communicates with commonly used statistical and data analysis applications
 - Include capacity for graphics without slowing down the system to enable consumer photo registry
 - Consider utilization of "Smart Data Cards" to be swiped by users of the system and/or for consumer data uploads (perhaps kept and brought in by the consumer and required to be swiped to load a service unit to the system, so units of treatment can't be added without the person actually being present)
 - Include some level of tracking for prevention services related to consumers in the system
 - Link consumer service records by provider to PERMES reporting
 - Consider service authorization for all consumers regardless of funding source and amount or for some proportion thereof
 - Include ability to track to other agencies for former, current, or future consumers of MHDDAD services

- Include ability to track planning lists concurrently with services received
- Avoid batch transmission of data if it can be avoided in favor of a secure and direct portal option that is easy to use and fast
- Incorporate fields to track (and require) funding source for service when entered into system

Moving Forward

Financing and information management are inextricably related – the ability to accurately analyze performance data and related costs drives financing needs. In a system where there is difficulty in obtaining performance and cost data that is consistent from multiple sources, accurateness is dubious and actual costs are best “guesstimates.” Georgia’s experience is not unique. Comparisons to other states, discussed in the following chapter, result in statements requiring many qualifiers as other states also struggle with fragmented and outdated information systems and financing challenges. While there is comfort in not being alone, Georgia must overcome these obstacles. There must be a stronger link between delivered services per consumer and cost of delivering service consumer, substantiated by the ability to track episodes of care by encounter and by funding source -- for all consumers regardless of funding source or mix.

CHAPTER XII: STATE TO STATE COMPARISON FOR COMMUNITY AND HOSPITAL UTILIZATION

In this chapter you will find:

- ❖ *Community Services: National Benchmarks*
- ❖ *Hospital Services: National Benchmarks*



Highlights of significant findings in this chapter include:

- ❖ *Georgia is getting mental health services to fewer of its Medicaid enrollees, and it is providing a lower intensity of services to those that do get services as compared to demographically similar states and a heterogeneous group of states and counties.*
- ❖ *Georgia's overall expenditures on MHDDAD community services are lower than in other states, although Georgia's penetration rates are relatively high compared to other states. This suggests that consumers are not receiving as much or as intensive services as those in other states.*
- ❖ *Maryland and North Carolina spend approximately \$5000 per mental health service user, Tennessee spends about \$2000, and Georgia spends about \$1100.*
- ❖ *Georgia's statewide hospital median length of stay is 5 days compared to an average length of stay of other state of 30.4 days. This suggests that hospital services may not be optimally utilized.*
- ❖ *Georgia spends considerably less per capita on its community mental health services than the other states that reported both Medicaid and non-Medicaid community services expenditures, South Carolina and Virginia. However, it spent more non-Medicaid funds on community services than Maryland and North Carolina.*
- ❖ *Georgia's Mental Health Administration has relatively high penetration compared to other states. It exceeds Maryland and Virginia's rates, approaches that of South Carolina, and compares favorably to most states in the 2000 16 State Study. This high rate of penetration comes mostly from a high adult penetration rate, which is higher than all but 2 of the 16 states. Children's penetration is not as high, falling near the median of the 16 states and at the bottom range of states participating in the Children's Mental Health Benchmarking study.*
- ❖ *For residential patients, Georgia is the outlier state with regard to children with a length of stay that is 756% above the national mean.*
- ❖ *Of the patients readmitted for adult mental health treatment in Georgia's hospitals, 13.2% were readmitted within 30 days of their previous discharge and 36.4% had been readmitted within a year.*

A. Community Services: National Benchmarks

Like most states, Georgia's mental health system has many unique characteristics that make comparisons to other states difficult and potentially misleading. However, in undertaking a review of the prevalence and utilization of mental health services it is critical to develop some sense of where Georgia stands relative to other states. Increasingly over the last decade, states have expanded the share of Medicaid financing for mental health services. Georgia is no exception to this. While this has increased the resources available, it has also increased the need to include Medicaid spending and utilization in preparing a comprehensive picture of the public mental health system.

One way to assess Georgia's provision of mental health services is to compare it to other states with similar demographic conditions and similarly structured service systems. In APS' original proposal, 3 states were identified as having similar demographic makeup:

- ❖ Virginia
- ❖ North Carolina
- ❖ Tennessee

However, because of initial difficulty in obtaining data from these states, we also sought data more widely and received data from Maryland and from South Carolina's Mental Health Authority. Most of these states also have similar MHA networks, built upon county or multi-county Community Mental Health Centers, with some variation in how they are operated. In addition, we will draw from several other multi-state studies that provide some relevant comparisons.

National Rates of Mental Health Treatment

Data from the National Survey of Drug Use and Health (NSDUH)) is useful in providing a beginning reference point of national access to mental health care. The 2002 NSDUH found that 13% of Americans receive some form of mental health treatment per year⁸⁹. This includes inpatient treatment (0.9%), Outpatient Treatment (7.9%) and behavioral medication (10%). It found that 8.2% of the population received either mental health specialty outpatient or inpatient treatment, leaving roughly 4.8 % of the population receiving behavioral health medications only, presumably from primary care physicians. Those individuals who received some form of public assistance had a significantly higher rate of receiving some type of mental health service, 18.6%. If these public assistance consumers have a similar pattern of service use as the overall population, we would expect that slightly more than one-third would be receiving medication-only treatment. Therefore, a range of 13% to 19% provides a means of comparison for Georgia's overall mental health service system.

⁸⁹ National Survey on Drug Use and Health, SAMHSA 2002

In order to produce a reasonable estimate of Georgia's provision of public mental health services, it is minimally necessary to consider both the services provided under the auspices of the Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) through Community Service Boards and State Hospital facilities, and Medicaid and PeachCare mental health services provided by other mental health specialty providers and by primary care providers. For these systems, we found a total of 174,298 unduplicated Medicaid consumers used mental health services, including primary care physician services and rehab option services. Another 110,430 non-Medicaid consumers received services from MHDDAD CSBs, for a total of **286,549** public mental health clients. We note that this estimate would exclude any state hospital clients who received no Medicaid or CSB services during the year, presumably a fairly small number. In addition, this calculation excludes adolescents served by the TRIS or Level of Care program, and children receiving mental health services through the child welfare and juvenile justice systems. These 286,549 public mental health clients constitute only 3% of Georgia's estimated population in FY2003. This is far less than the 13% in the national sample. However, unlike the national figure, our estimates exclude any services received by privately insured individuals. These clients constitute 13% of Georgia's estimated FY2003 population falling at or below 185% of poverty, the eligibility level for Medicaid. This figure is properly compared to the almost 19% utilization figure found by the NSDUH for individuals receiving some form of public assistance. **In comparison, Georgia appears to serve its poor population at considerably lower rates than the national sample.**

Medicaid

We will begin a cross-state comparison of Georgia by analyzing provision of mental health services within the Medicaid system, since in all states this system is the primary funding source for mental health. In addition, Medicaid eligibility standards also determine which mental health consumers are eligible for services such as rehab option mental health services from the MHDDAD system.

Characteristics of Medicaid System

Table XII-1 on the following page summarizes some key aspects of the Medicaid programs in each state for which some kind of comparative data were obtained. Income eligibility criteria are very much in the same range, with Maryland at the same level of 185% as Georgia. Virginia and North Carolina set Medicaid eligibility lower, at least for some age categories, and Tennessee is somewhat higher at 200% of poverty. Nationally, some states have set eligibility as high as 275% and 300% of poverty, while the minimum is 100% of poverty.

- North Carolina's Medicaid program is similar to Georgia's current program in operating a Primary Care Case Management (PCCM) program and excluding mental health services from managed care.

- Virginia operates a system similar to the system Georgia plans to implement. Virginia's plans are at risk and their benefits include mental health care other than those services provided by Community Service Boards.
- Tennessee and Maryland have carved out mental health from medical care and contracted with a specialized behavioral health entity to manage it.

Table XII-1
Characteristics of State Medicaid Mental Health Systems

	Georgia	Virginia	North Carolina	Tennessee	Maryland
Income Eligibility	185% of FPL	133% of FPL with co-payments	185% of FPL for pregnant women and infants 133% of FPL for ages 1-5 100% of FPL for ages 6-17	200% of FPL plus coverage for uninsured	185% of FPL
Percent of Medicaid enrollees in Managed Care	Has PCCM program (Georgia Better Health Care)	50% in Medicaid MCOs 14% in PCCM program in November 2004	76% in PCCM 1% in Medicaid MCO	100% in MCOs (both commercial and Medicaid only)	Approximately 70% in commercial MCOs
Behavioral health arrangements	Fee for service	MCOs are responsible for inpatient and outpatient MH. Community MH rehab services are billed directly to the Medicaid division by Community Service Boards.	Fee for service	Behavioral health carveout companies establish service networks and manage services. They pay fee for service for most services and case rates for case management	Carveout to Mental Hygiene Administration who partners with an ASO and Core Service Area providers to manage both Medicaid and non-Medicaid MH services
Covered services	MH Inpatient, outpatient, rehab option and clinical portion of TRIS	30 days Inpatient MH, 50 outpatient MH visits, CMHC rehab services (intensive in-home, case management, day treatment, 24 hour crisis intervention)	Inpatient and outpatient MH and area mental health services	Inpatient and Outpatient MH, Psych pharmacy, residential treatment, crisis intervention (regardless of TennCare Eligibility), case management, Psych-Rehab	Inpatient and outpatient MH, targeted case management, public mental health system rehabilitation services
SCHIP	Separate program, different benefit	Separate plan covers up to 200% FPL	Health Choices – separate plan covers up to 200% FPL	Included as part of TennCare	Same program, but premium charged for families above 185% and below 200% FPL
<p>ASO: Administrative Services Organization – a company that performs delegated managed care functions, such as network management, clinical authorization and claims payment, but is not at financial risk.</p> <p>FPL: Federal Poverty Level</p> <p>PCCM: Primary Care Case Management Program – a managed care program administered by Medicaid agencies that pays primary care physicians a nominal case fee for serving as gatekeepers for other medical services.</p> <p>Case Rate: A type of payment that pays a specified rate per consumer (can be based on intensity of need) rather than on service units.</p>					

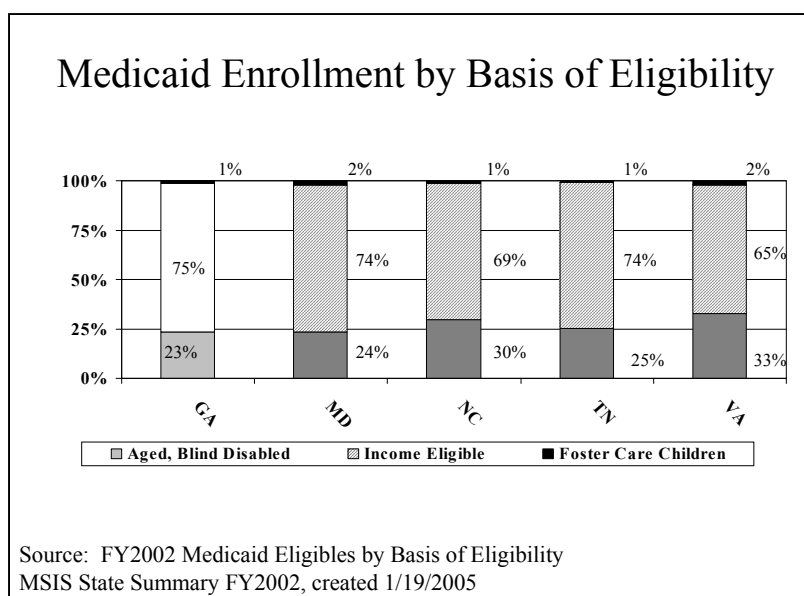
- Maryland has carved out the Medicaid mental health benefit to its Mental Hygiene Department who manages Medicaid resources in coordination with its own resources. It oversees an Administrative Services Organization and partners with its Core Service Providers. These providers are similar to Georgia's CSBs in that they are chartered by the county. However, in Maryland they exist in several forms, county operated, quasi-public, and private non-profits. The administrative services organization performs some of the managed care functions like eligibility determination, service authorization, claims processing, and reporting. However, it is not at-risk.
- TennCare and Virginia's MCOs are at risk for the mental health services they provide, giving them an incentive to manage services within their capitation payment.
 - Virginia's MCOs have the possibility of offsetting savings or overages between medical and mental health services, and the possibility of shifting costs to Community Service Board services.
 - In contrast, TennCare must manage mental health services alone and must pay for both standard inpatient and outpatient services and rehab option services.

Enrollment Comparisons

Since differing eligibility criteria can result in different enrollment profiles, we analyzed the percentage of each state's Medicaid enrollment that fell into the following major eligibility categories:

- Aged, blind and disabled – this group has the highest level of service utilization based on their age and disability status;
- Income eligible – this group is mostly women and children, overall a healthy group; and
- Foster children – this group has higher needs for mental health services than other children and this group's utilization falls between that of disabled and income eligible enrollees.

This chart shows that Georgia is similar to Maryland and Tennessee in its relative enrollment of income eligible and disabled eligibles. North



Carolina and Virginia both show higher levels of disabled enrollment and therefore would be expected to show more intensive utilization of mental health services with all other things being equal.

Methodology

Georgia Medicaid data is collected in three different databases, rehab option services, facility based services, and professional services. Since it is possible that a Medicaid eligible consumer may receive services in more than one category of care, a single individual may be counted more than once. We have been able to calculate an unduplicated total of all users, but in some cases we show rehab option services separately. Another important methodological consideration is that Georgia has used a more expansive definition of mental health services than the states to which we are comparing it. Table XII-2 summarizes the differences in the data of Georgia and its comparison states.

Georgia's data includes nursing home stays and primary care physician services provided for individuals with a primary mental health diagnosis. The Medicaid data from other states includes only mental health care provided by mental health specialty providers. In Tennessee's case, this also includes Medicaid substance abuse services which are included as part of the TennCare Partners program. North Carolina's data is somewhat restricted because it does not include inpatient or outpatient mental health services provided by hospitals. While this is a relatively small part of the whole, it means that North Carolina's data is somewhat understated. Finally, we note that while SCHIP – State Children's Health Insurance Program (PeachCare in Georgia) - services are an important part of the public mental health system, in general mental health issues have not yet been highlighted in the oversight of SCHIP and our data from other states do not include SCHIP mental health services.

**Table XII-2
Methodological Differences in Georgia and Comparison States**

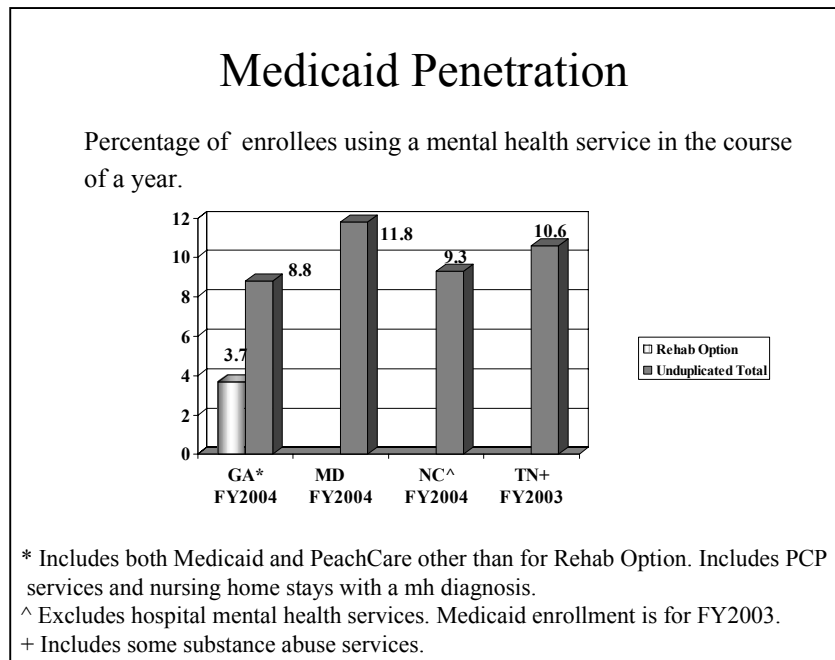
	GA FY2004	MD FY2004	NC FY2004	TN FY2003	VA FY2003
Specialty mental health services	X	X	X	X	X
Hospital mh services	X	X		X	X
Nursing home mh services	X				
Services provided by PCPs	X				
Substance abuse services				X	
SCHIP MH services	X				
Methodological			Use FY2003	Use	

Notes			Medicaid enrollment with FY2004 users and expenditures	expenditures from period 4/2002-3/2003 with FY2003 users and enrollment	
-------	--	--	--	---	--

Tennessee's Medicaid mental health services are overseen by its Mental Health Authority and incorporate all of Tennessee's publicly provided mental health services. TennCare would therefore be more appropriately compared to an unduplicated count of people receiving Medicaid services and MHA funded services.

Medicaid Penetration

The following chart shows Georgia's Medicaid penetration compared to penetration in Maryland, North Carolina and Tennessee. While the states fall in a fairly close range, between 8.8% and

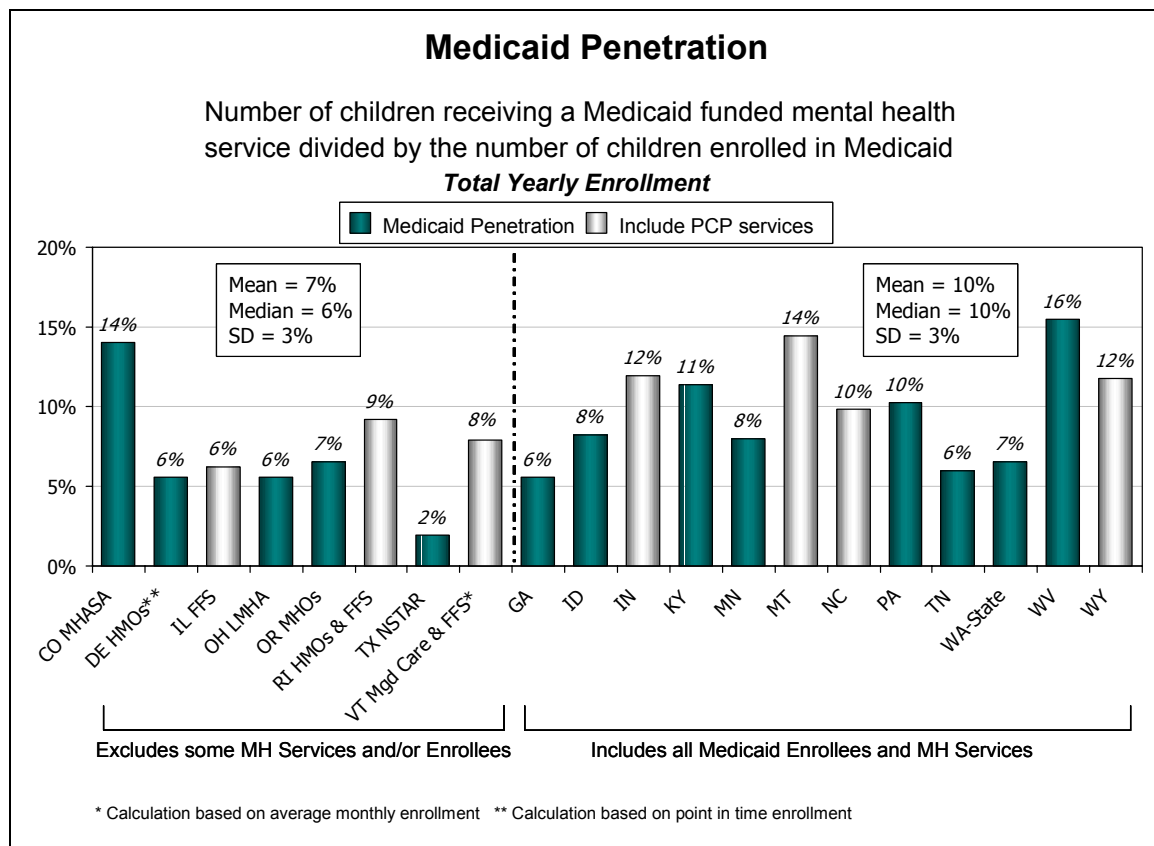


11.8%, Georgia's is the lowest. Given that it is measuring a more expansive definition of mental health services than the other states, including people receiving mental health services such as depression or ADHD medication from their PCPs, it is quite possible that Georgia would be somewhat low if only specialty care was counted. As indicated in the National Survey on Drug Use and Health cited earlier, up to a third of people receiving mental health services are receiving only psychotropic medications, many from PCPs rather than specialists. If this was the case for Georgia, we could estimate a penetration rate for specialty services of approximately 6%, notably lower than the range shown by the other states.

Medicaid Penetration by Age

A study conducted by Dougherty Management Associates, Inc., The Children's Mental Health Benchmarking Project, collected data from a large number of states and several counties. (Most of the counties were major metropolitan areas with populations greater than at least half the states included in the study.) Georgia supplied an unduplicated count of children served for that study, as

shown in the following chart. Georgia's penetration rate, which included all mental health specialty services including rehab option, was 6%, and fell at the bottom of the range compared to other Medicaid programs measuring penetration in comparable ways.

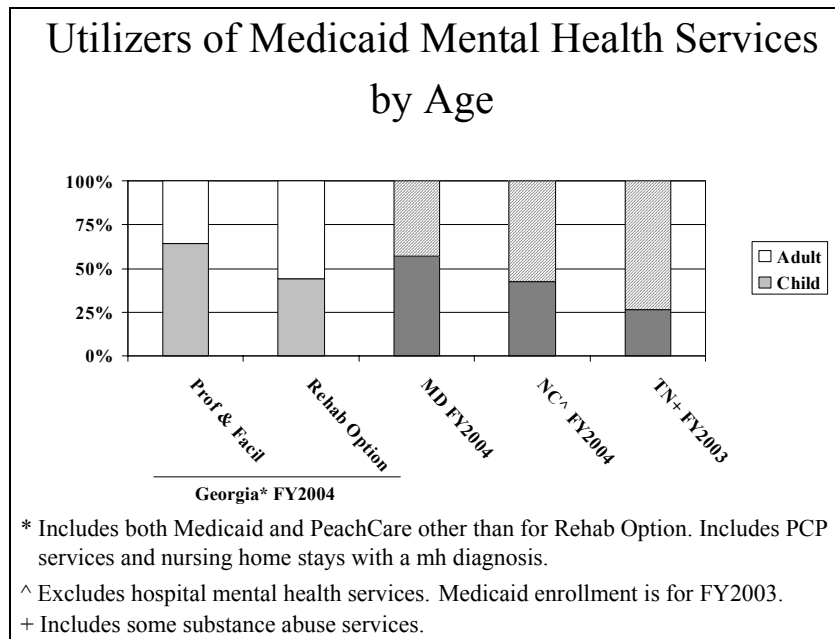


Footnotes to Medicaid Penetration Chart

Partial Medicaid Data

Colorado MHASA	Excludes small number of children who opt into fee for service Medicaid, foster children served solely in Residential Treatment Centers, and children served solely in community and private psychiatric hospitals.
Delaware HMOs	Includes only children using HMOs' 30 visit outpatient benefit.
Illinois FFS	Excludes HMO enrollees, approximately 15% of total enrollment and children receiving care solely in mental health clinics.
Ohio LMHA Services	Includes only community-based services provided through CMHCs. Excludes children receiving services in residential or inpatient programs and those receiving services from independent practitioners unless they also receive services in the CMHCs.
Oregon MHOs	Excludes approximately 13% of Medicaid enrolled children served in fee for service.
Texas NorthSTAR	Behavioral health carve-out serving seven counties around Dallas. Service population excludes foster children.
Washington	Includes Medicaid enrollees served in both HMOs and Regional Service

State HMOs and RSNs	Networks. Degree of duplication between HMOs and RSNs is unknown. Excludes any children served solely in Medicaid fee for service.
Vermont Managed Care and FFS	Excludes children served solely in CMHCs.
Complete Medicaid Data	
Idaho	Excludes any children receiving Medicaid residential care and no other mental health service.
Indiana	Includes children in any Medicaid residential facility who have a primary MH diagnosis, including those in Intermediate Care Facilities-Mental Retardation (ICF-MR).
Minnesota	Includes enrollees in MinnesotaCares, a state program similar to SCHIP financed by state and federal funds.
Wyoming	Includes services provided by mental health practitioners billing under a physician's provider number.



While we were unable to calculate age- based penetration rates, we were able to compare the relative proportion of Medicaid enrollees using mental health services between adults and children for Georgia and our comparison states. This chart shows that children use more than half of Georgia's facilities and professional mental health services, but slightly less than half of rehab option services. Maryland would appear to experience a similar pattern, showing children using slightly more than half of Medicaid mental health services. North Carolina and Tennessee, however, do not share this trend, as adults used somewhat more than half (NC) and almost 75% (Tennessee)⁹⁰.

⁹⁰ Tennessee has expanded Medicaid to cover uninsured adults and provides virtually all mental health treatment services for people with SPMI and SED through Medicaid

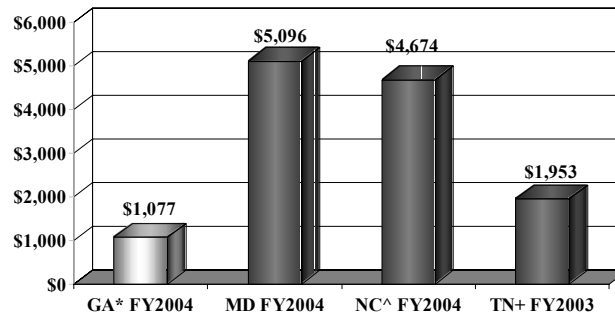
Medicaid Expenditures

We also calculated Medicaid expenditures per service user and saw similar differentials. Maryland and North Carolina spend approximately \$5000 per mental health service user, Tennessee spends about \$2000, and Georgia spends about \$1100. Georgia's inclusion of relatively low intensity mental health service users served by PCPs would tend to lower its per user average expenditure. However, the magnitude of these differences is so large that the differential cannot be explained solely by the inclusion of consumers receiving PCP services.

Analyzing the rate of expenditures per enrollee provides a different way of looking at expenditure rates. For this measure, the inclusion of PCP services on the expenditure side should make Georgia's rate relatively higher in comparison to the states that did not count these expenditures. Since the denominator of the measure is enrollees, not actual mental health service consumers, differences in how consumers are counted does not affect this measure.

Even with a more expansive calculation of expenditures, Georgia's Medicaid expenditures per Medicaid enrollee are considerably less than those of the four comparison states. Georgia's Medicaid expenditures per enrollee are less than \$100, while the next lowest expenditure rate, for TennCare, is over twice as high

Medicaid Expenditures per Service User

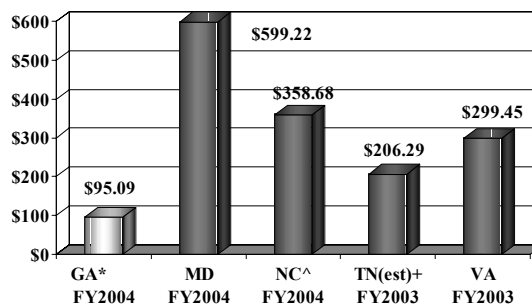


* Includes both Medicaid and PeachCare other than for Rehab Option. Includes PCP services and nursing home stays with a mh diagnosis.

^ Excludes hospital mental health services. Medicaid enrollment is for FY2003.

+ Estimated. Costs are for period 4/2002-3/2003. Users are for FY2003. Includes users and expenditures for substance abuse services.

Medicaid MH Expenditures per Enrollee



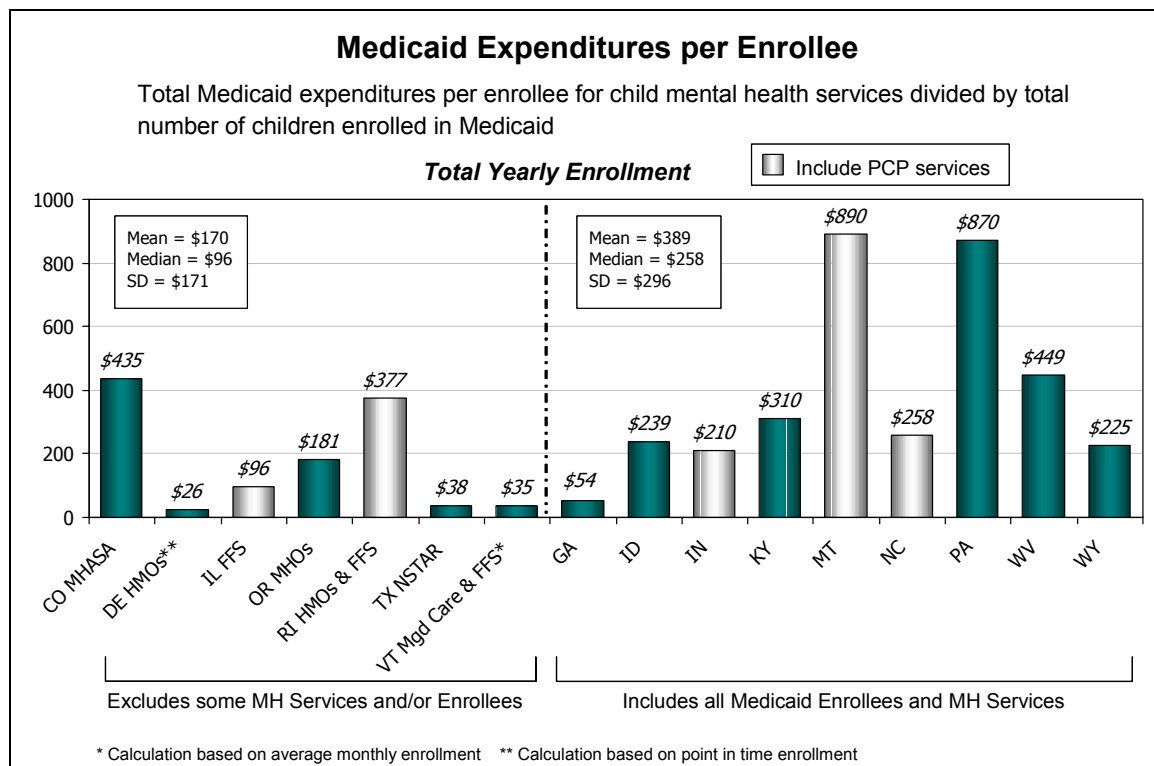
* Includes both Medicaid and PeachCare other than for Rehab Option. Includes PCP services and nursing home stays with a mh diagnosis.

^ Excludes hospital mental health services. Medicaid enrollment is for FY2003.

+ Costs are claims for period 4/2002 through 3/2003. Enrollees are for FY2003. Expenditures includes some substance abuse services.

and the highest rate, Maryland's, is over six times greater. This measure is related to penetration rates, since the fewer enrollees receiving services, the lower the expenditure rate with all else being equal. However, Georgia's differential in expenditures far exceeds its differential in penetration, suggesting that Georgia is providing a different intensity of mental health service under Medicaid than these other states.

The Children's Mental Health Benchmarking Study also provides comparison points for Georgia. Expenditures per enrollee of the all-inclusive programs varied widely, with a range of \$54 to \$890, more than a fifteen fold difference. In this comparison, Georgia falls at the lowest end of a larger group of comparison states.



Footnotes for Medicaid Expenditures per Enrollee

Partial Medicaid Data

Colorado MHASA	Excludes small number of children who opt into fee for service Medicaid, foster children served solely in RTCs, and children served solely in community and private psychiatric hospitals, and their expenses.
Delaware HMOs	Includes only children using HMOs' 30-visit outpatient benefit, and their costs of care.
Illinois FFS	Excludes HMO enrollees, approximately 15% of total enrollment. Costs of HMOs and of mental health clinics also excluded.
Oregon HMOs	Excludes children served in fee for service, and their expenses. Excludes costs of long term care in state hospital.
Texas	Behavioral health carve-out serving seven counties around Dallas.

NorthSTAR	Service population excludes foster children.
Vermont Mgd Care and FFS	Excludes CMHC services and costs.
Complete Medicaid Data	
Idaho	Excludes any children receiving solely inpatient care.
Indiana	Includes children in any Medicaid residential facility who have a primary MH diagnosis, including those in ICF-MRs and the costs of those services.
Montana	Excludes residential program room and board costs of children in state custody.
North Carolina	Excludes residential program room and board costs of children in state custody.
Wyoming	Excludes costs and clients served solely at state hospitals. Includes services provided by mental health practitioners billing under a physician's provider number.

Medicaid Financing

State financing by Medicaid varies from state to state which directly impacts the amount of state match the state must produce. Fiscal year 2002 figures were available for comparison through the NASMHPD Research Institute. These reflected that both North Carolina and Tennessee had a 36% match while Georgia's was 40.4% and Virginia's was 48%. The rate at which Medicaid match is provided to states is directly related to its financial health, specifically its poverty rate and per capita income, thus Georgia's wealth falls in between that of North Carolina, Tennessee, and Virginia giving it the 40% match rate. This rate fluctuates some, but has remained near 40% for several years in Georgia.

Overall, these comparisons suggest that Georgia differs from other demographically similar states and from a heterogeneous group of states and counties in its provision of Medicaid mental health services. Georgia is not only getting mental health services to fewer of its Medicaid enrollees, but also it is providing a lower intensity of services to those Medicaid enrollees who do get mental health services. A more detailed examination of the types of services provided and the characteristics of the enrollees receiving services could begin to describe the nature of the differences. However, detailed data that would allow such analysis was not accessible.

MHDDAD Services: Characteristics of State Mental Health Authorities

We have obtained comparison data from Maryland, North Carolina, South Carolina and Virginia on their provision of community services. All use a Community Mental Health Center model. While Virginia and Maryland are like Georgia in having a strong county administration for providing services, South Carolina's CMHCs are state operated. Virginia and Maryland each operate ten state hospitals, while South Carolina and Georgia operate seven.

Table XII-3
Characteristics of State Mental Health Authority Service Systems

	Georgia	Maryland	North Carolina	South Carolina	Virginia
Eligibility	Sliding fee scale for > than 185% of poverty		SMI and SPMI	Diagnosable mental illness	Established by each CSB
Type of CMHC	Community Service Board Quasi-governmental county chartered organizations	Core Service Areas operate as a unit of county government (e.g. health department), as a quasi-public authority, or as a private, non-profit corporation	Community Mental Health Centers. county or multi-county organizations with a local board closely affiliated with county commissioners. May directly provide or contract for outpatient services and contract for residential services.	17 State operated CMHCs	28 operating CSBs providing direct services 10 administrative policy CSBs use local government and contracted services, 1 policy advisory CSB advises a local government department, 1 behavioral health authority provides direct services
# of Counties, Service Areas	159 counties, 26 service areas		39 county or area programs	17 CMHC catchment areas	40 Community Service Board areas
Method of payment	Grant allocation from MHA.			Appropriation	Grant allocation from MHA. Must provide a 10% local funds match. Many provide more.
Medicaid arrangements	Can bill for rehab option and other Medicaid mental health services. Must pay state match if exceed target.	An Administrative Services Organization determines eligibility, manages utilization and pays claims under supervision of MHA. CSAs bill ASO on a fee for service basis.	CMHCs had been the only certified mh outpatient providers, sometimes billing for residential and outpatient services provided by other organizations. This	Receive Medicaid reimbursement for certain services.	Bill fee for service Medicaid, excluded from MCO benefit Medicaid agency responsible for state match.

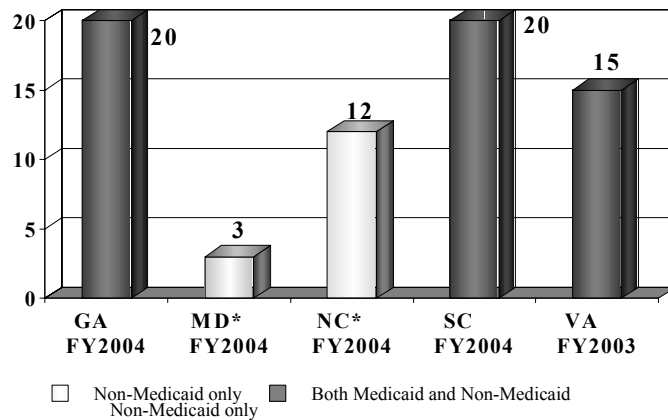
Table XII-3
Characteristics of State Mental Health Authority Service Systems

	Georgia	Maryland	North Carolina	South Carolina	Virginia
		Services for uninsured are also managed by ASO.	role is changing as other providers are now able to be certified.		
Services offered (and included in data)	Day and Employment Services Outpatient Services Personal Living and Residential Services Screening, Crisis and Outreach Services	24-hour crisis help Hospitalization Outpatient therapy Residential rehabilitation Supported living Other community-based outpatient mental health services Residential treatment Rehabilitation services Mobile treatment Day treatment	Community support, mobile crisis intervention, diagnostic assessment, ACT, inpatient hospital, child/adolescent day treatment, residential treatment, intensive in-home therapy, MST		6 core services. Emergency and case management are mandated. Others are Outpatient, Day Support, Residential and Early Intervention
State hospital	7 state hospitals	10 state facilities	148 Beds in 2002	7 State hospitals	10 state hospitals, most of which offer acute as well as long term services. State hospital services are paid by the state.

MHA Penetration

Georgia's MHDDAD reaches a similar proportion of state residents as South Carolina and about 25% more than Virginia. It also exceeds Maryland and North Carolina, but those two states did not include clients whose community services were covered by Medicaid.

MHA Clients Receiving Community Services per Thousand Population

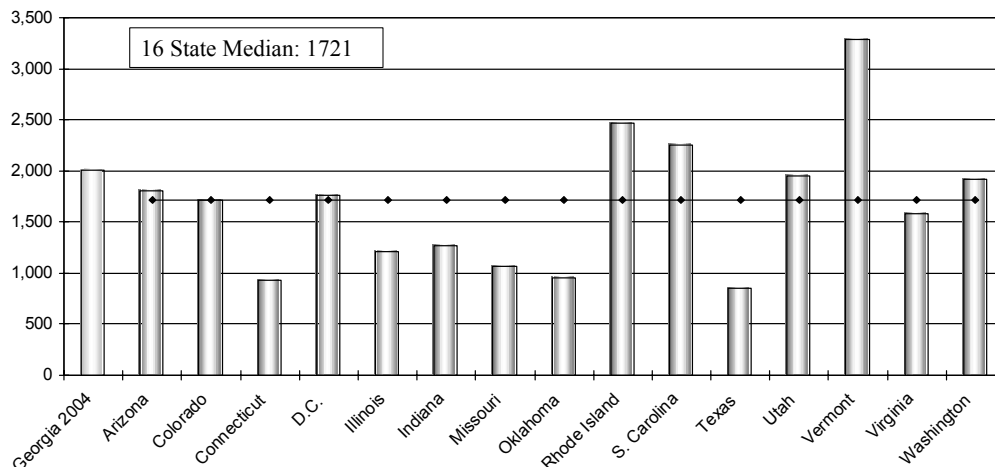


Population Data: US Census estimates

*Excludes Medicaid funded community services

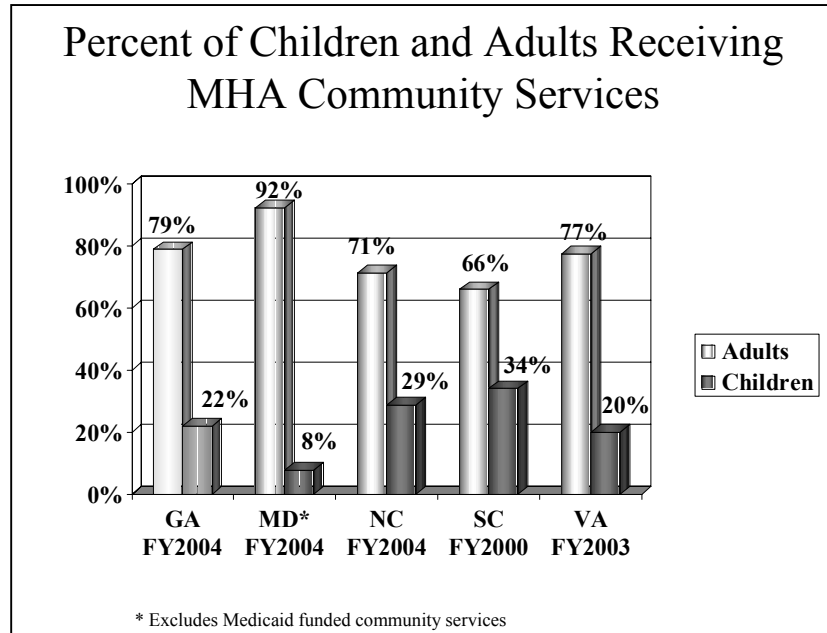
Another set of comparison points comes from the 16 State Project of SAMHSA and its Mental Health Statistics Improvement Program (MHSIP). In this comparison, Georgia's 2004 penetration rate for MHA services falls above the 2000 median and is exceeded by only three states--Vermont, Rhode Island, and South Carolina.

16 State Project Penetration Rates for Community-Based Programs Compared to Georgia
Rate per 1000,000 Population: FY 2000



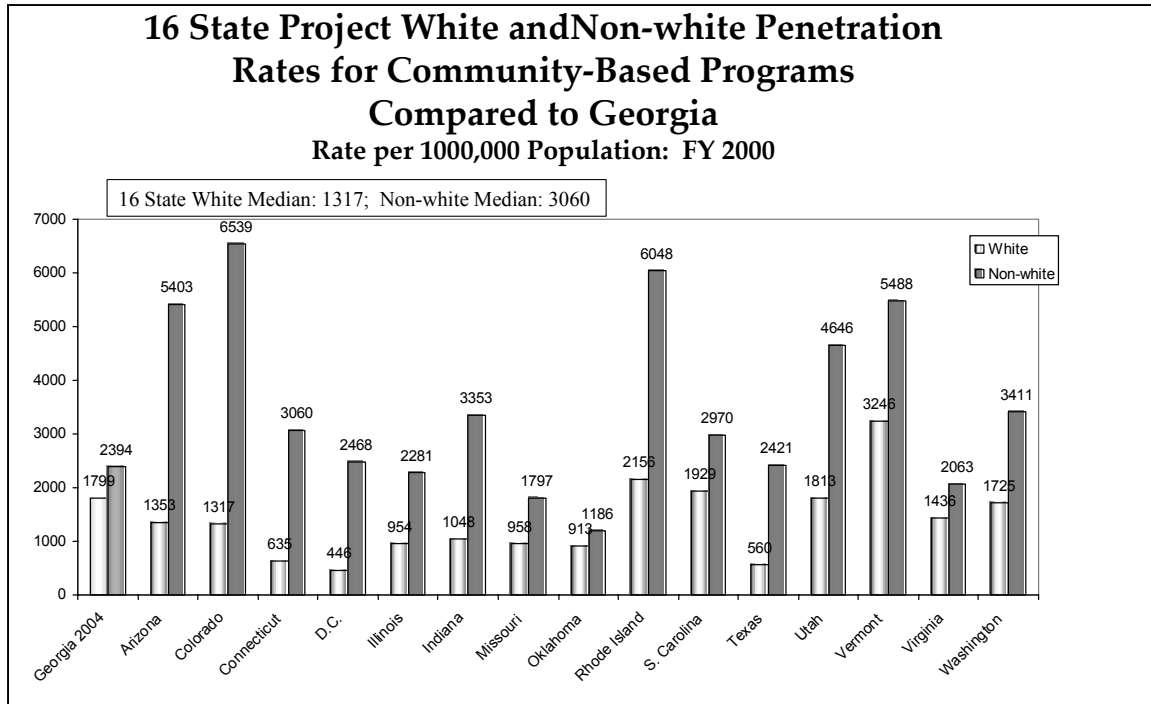
Penetration by Age

We are also able to compare the ages of consumers in the comparison states selected for this project. The following chart shows that Georgia's age distribution is very similar to Virginia's, with approximately 20% of service users being children. Maryland serves many fewer children, perhaps reflecting children's broader eligibility for Medicaid services (excluded from this chart). However, North Carolina, which also doesn't include Medicaid paid services, serves a higher percentage of children – almost 30%. Using older, FY2000, data from South Carolina, we see that state serving a significantly higher percentage of children than the others shown here. The examples of Maryland and Virginia suggest the possibility that Georgia may have an opportunity to finance a greater share of its children's mental health treatment through Medicaid than it currently does.

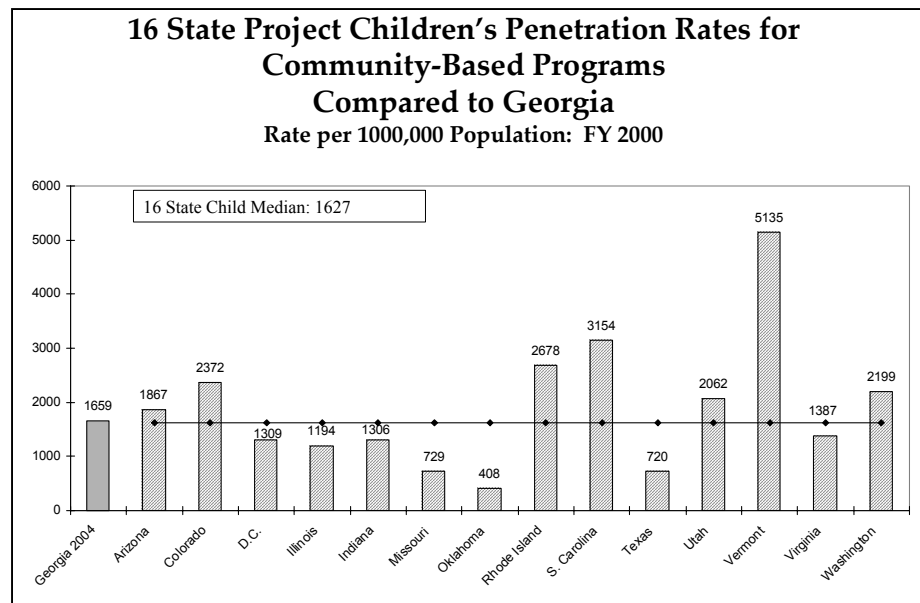


Penetration by Race

The 16 state project also allows for comparisons by major racial groups. The chart below shows that non-white penetration substantially exceeds white penetration for all states pictured, in some cases as much as 5 times. In comparison to the 16 states, Georgia somewhat exceeds the median penetration for whites, but falls considerably below the median penetration for non-whites.



The 16 state study also allows for comparisons by age and race categories. The chart to the side shows Georgia's 2004 penetration rate for children under 18 to be very near the 2000 16 state median. This is an area in which Vermont is a high outlier and South Carolina is the next highest state, itself



noticeably above the median. The children's mental health benchmarking project offers additional comparison points for the provision of mental health services to children. MHAs use a number of different structures to provide mental health services to children, including through comprehensive children's agencies that incorporate child welfare and juvenile justice services as well as mental health. However, comparing Georgia to other states illustrated by solid columns shows it to be in the lower part of the range in children served per thousand.

Footnotes for Children Served in the MHA Provider Network Chart	
Connecticut	Includes up to 1000 additional children receiving intensive mental health and related services paid for by DCF under a voluntary services statute. Includes children in residential placements for developmental disabilities, substance abuse and some for primarily medical conditions.
Indiana	Includes only children with SED.
Ohio	Excludes small number of children receiving only residential services or inpatient services.
Rhode Island	Excludes the children in state custody who are enrolled in HMOs

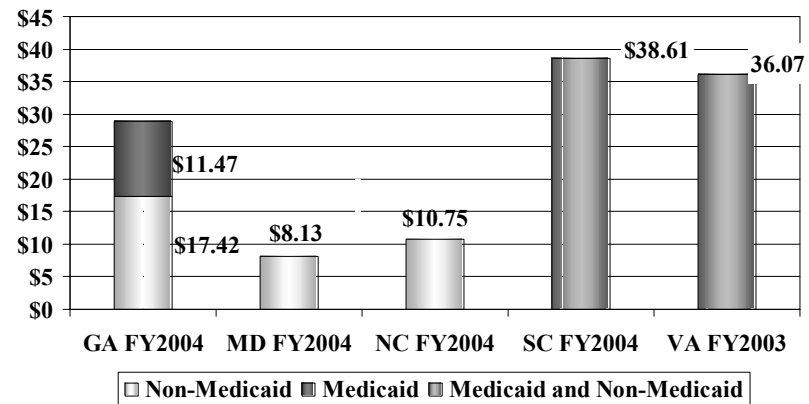
Mental Health Administration (MHA) Expenditures

On a per user basis, Georgia spends the same or less than the comparison states. Spending per non-Medicaid client is very similar to North Carolina, but considerably lower than Maryland. While Georgia's per client spending on rehab option services is higher, at almost \$1600 per client, it does not reach the levels of combined per client expenditures of South Carolina and Virginia at about \$1900 and \$2400 respectively. This pattern suggests that clients in Georgia are not receiving as much service or as intensive service as community mental health clients in most of the other states in our comparison group.

Georgia spends considerably less per capita on its community mental health services than the other states that reported both Medicaid and non-Medicaid community services expenditures, South Carolina and Virginia. However, it spent more non-Medicaid funds on community services than Maryland and North Carolina. These comparisons may suggest that Georgia has an opportunity to reduce its state-only expenditures by financing a greater share of its community services through Medicaid.

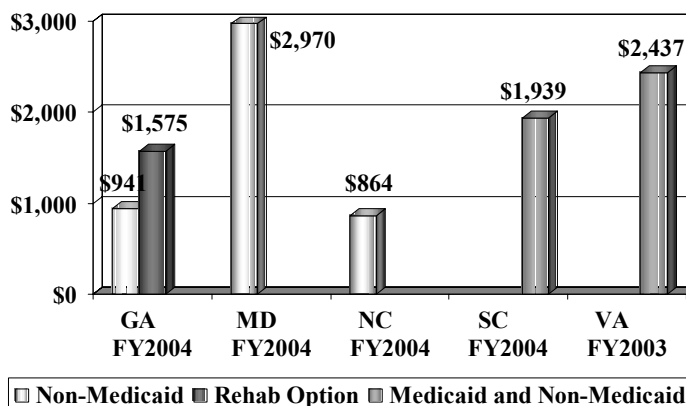
The children's mental health benchmarking project provides another source of comparisons on expenditure rates. The following chart shows that Georgia's MHDDAD mental health expenditures in 2001 for children fell below the mean but above the median compared to other states. The expenditures in this chart include not only community mental health expenditures, but also any inpatient and residential services paid for from MHA revenues. The group of states in the chart excluded any expenditures covered from Medicaid sources.

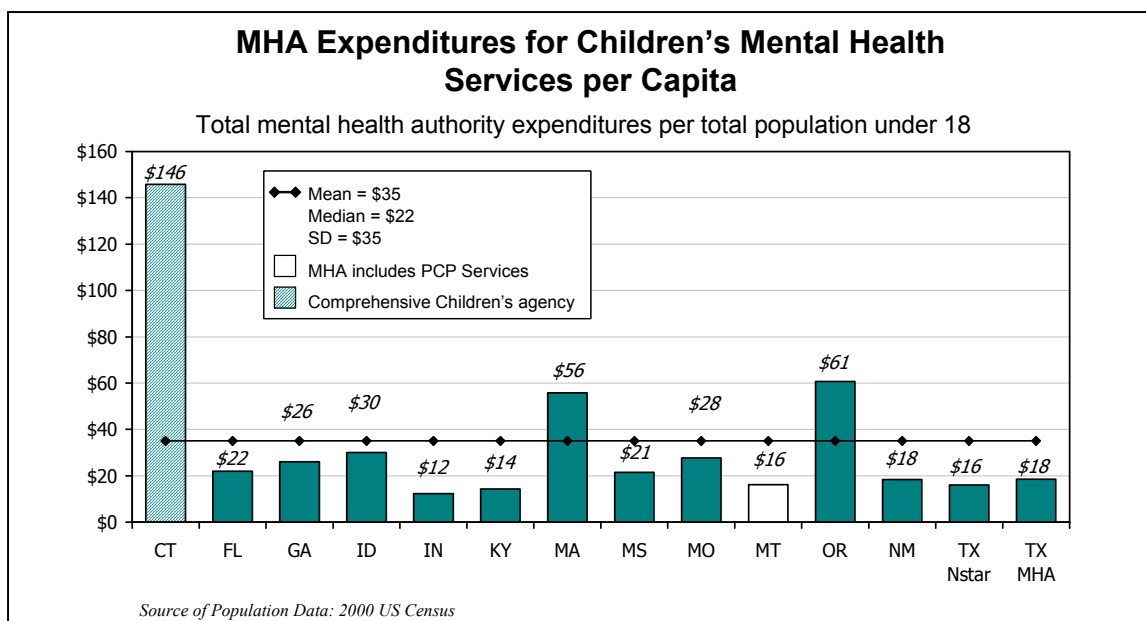
MHA Expenditures per Capita on Community Mental Health Services



Population Data: US Census estimates

MHA Expenditures per Community Mental Health Service User





Footnotes for MHA Expenditures per Capita Charts	
Connecticut	Includes expenditures for up to 1000 additional children receiving intensive mental health and related services paid for by DCF under a voluntary services statute and residential placements for developmental disabilities, substance abuse and some children placed for primarily medical conditions.
Idaho	Excludes funds supporting school day treatment programs and state hospital expenditures.
Kentucky	Excludes cost of therapeutic foster care and overnight care.
Montana	Includes residential room and board costs. Inpatient care is not a covered service.
Oregon	Expenditures are estimated.
Texas MHA	Includes Medicaid MH Rehab and Intensive Case Management revenues. Excludes county contributions for care provided. Excludes inpatient placements other than for state hospital.
Texas NorthSTAR	Behavioral health carve-out serving seven counties around Dallas.

A final source of information about expenditures is the Center for Mental Health Services at SAMHSA, which has summarized state mental health spending for a number of years. While these data do not entirely account for differences in the ways that states use Medicaid and resources other than Federal Block Grant and state general funds, they provide a source of comparison. Based upon 2001 data Georgia ranked 46th out of 51 in State Mental Health Agency expenditures per capita at \$46⁹¹. The range is from \$26 to

⁹¹ Source: Kaiser Family Foundation: State Health Facts.org. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Data as of 2001.

\$398 in the District of Columbia with the next highest rate being in New York at \$176 per capita.

Total Community Service Spending in Georgia was \$204,524,843 inclusive of state and federal match for FY2004. Public community costs per consumer are \$1,173. Inpatient state hospital spending including both regular and Forensic costs that carry a much longer length of stay and cost per admission, total \$165,585,181 or 45% of the total public spending. As can be seen from Table XII-4⁹² this level of inpatient spending as a percent of total state mental health authority spending is one of the highest in the nation.

Table XII-4
Mental Health Authority Spending by Major Function and by Region

Region	State Controlled Psych Hospital	Community- Based Pgms	Central/Regional Offices	Total
MidAtlantic	29.5%	67.8%	2.7%	100.0%
New England	30.0%	65.3%	4.7%	100.0%
Far West	20.8%	77.4%	1.8%	100.0%
Great Plains	38.1%	60.2%	1.7%	100.0%
Great Lakes	31.8%	66.2%	1.9%	100.0%
Mountain	42.3%	54.6%	3.1%	100.0%
South Atlantic	47.4%	48.9%	3.6%	100.0%
South Central	41.9%	55.4%	2.7%	100.0%
National Average	31.5%	65.9%	2.6%	100.0%

Conclusion

Georgia's MHA has relatively high penetration compared to other states. It exceeds Maryland and Virginia's rates, approaches that of South Carolina and compares favorably to most states in the 2000 16 State Study. This high rate of penetration comes mostly from a high adult penetration rate, which is higher than all but 2 of the 16 states. Children's penetration is not as high, falling near the median of the 16 states and at the bottom range of states participating in the Children's Mental Health Benchmarking study. Though Georgia's penetration rate for non-whites exceeds that of its white penetration rate, the white rate is more favorable in comparison to the rates in the 16 state study. Georgia's white rate exceeds the median penetration rates of the 16 state study for whites, but falls considerably below the median penetration rate for non-whites.

⁹² Source: "Funding Sources and Expenditures of State Mental Health Agencies in Fiscal Year 2001", National Association of State Mental Health Program Directors Research Institute, May 2003. Note that data in the NASMHPD report is solely for services and expenditures related to state mental health agencies (including Medicaid activity occurring in state mental health department directed sites, such as community mental health centers).

Overall, Georgia's expenditures on MHDDAD community services are somewhat lower than in other states, though not dramatically so. Again, this suggests the possibility that Georgia's mental health consumers are not receiving as much or as intensive services as those in other states. One reason may be the relatively high expenditures on state hospitals as a share of MHA spending, as shown in 2001 SAMHSA data. State hospital expenditures may offer an opportunity for transfer into the community if consumers can be moved into community settings. Another aspect of expenditures is the possibility that Georgia may be able to make more use of Medicaid to finance its rehab option and possibly clinic services. Data from other states provides indications that they may be enrolling more of their clients into Medicaid and billing more of their services to Medicaid. While our analysis was not sufficient to conclude this definitively, it certainly identifies this as an area to be further investigated.

Implications

While these comparisons have some limitations, the similar results from several different data sets suggest several opportunities for Georgia:

- The Medicaid mental health system is reaching a lower percentage of enrollees than most other states included in our comparisons. In addition, considerably less is expended for their mental health services, on average, than in other states.
- While the community services provided by Georgia's CSBs reach a healthy percentage of Georgia's population in comparison to other states, they do not serve children or non-whites with mental health needs as well as they serve white adults.
- While access to Georgia's MHDDAD community services is healthy overall, Georgia spends less on a per client basis than many other states.
- Georgia is likely overusing inpatient resources to the detriment of its ability to provide community services. A concerted effort to understand how state hospitals could be used less and what services are necessary to support state hospital clients in the community may possibly free resources to expand community services.
- Georgia may well be underutilizing Medicaid to finance community mental health services. Maryland's system, which is set up to ensure that Medicaid is billed before a person can receive uninsured services financed by MHA resources, has resulted in a relatively low percentage of clients served in the non-Medicaid category.

B. Hospital Services: National Benchmarking

For the purposes of state-specific national hospital benchmarking, APS chose three southeastern states for comparing utilization and penetration rates as well as other common indicators. The selection of these three states was based on relatively common socioeconomic and demographic characteristics to Georgia.

According to the most recent statistics available via the CMHS website, 2002 CMHS Uniform Reporting System Output Tables reflected the following comparisons related to

mental health services which are presented in terms of percentages of total population served. Total counts for recipients of any state mental health system authority services and inpatient counts are provided as well and are derived from the National Association of State Mental Health Program Directors Research Institute tables available for FY2002 at <http://www.nri-inc.org/Profiles02/keyworda02.cfm>.

The overview provided in Table XII-5 illustrates distinct similarities among the populations served by each state. In fact, the age makeup of Tennessee's recipient population replicates Georgia's percentages exactly and North Carolina's does not vary tremendously although their age spread is not as steeply peaked for adults between the ages of 21 to 64 as Georgia's. The variances in percentages of the population based on gender are low and the breakdown between racial/ethnicity groups is likewise fairly similar.

In looking at hospital capacity, we have compared the total number of beds to the total population based on 2002 U.S. Census resident population reports. Georgia, North Carolina and Virginia have between 1.2 to 1.9 child and adolescent beds per state resident population of 100,000 while Tennessee has 3.2. For adult mental health beds, the spectrum is much broader, ranging from Georgia's low of 17.8 beds per 100,000, followed closely by Tennessee's 18.9 and then with North Carolina and Virginia having a higher rate of beds to the total population at 30 and 31.6, respectively.

We will look more specifically at occupancy rates later in this section based upon the survey responses from each state. For the moment, using FY2002 figures, the comparison of average client loads for C&A to the number of beds indicates that each state had a higher occupancy rate than they had capacity for with the exception of Tennessee. For Adult beds, each state had a greater capacity than was utilized based on the average client load, although Tennessee comes closest with an average client load of 827 for 831 beds, whereas Georgia had 52 more beds than client load, North Carolina had over 500, and Virginia had 169 more.

**Table XII-5: Overview of Demographic Characteristics
Total Population Served, Community and Hospital**

	Georgia	North Carolina	Tennessee	Virginia
Age				
0 to 3	1%	3%	1%	0%
4 to 12	14%	15%	14%	0%
13 to 17	11%	13%	11%	11%
18 to 20	4%	5%	4%	0%
21 to 64	67%	58%	67%	4%
65 to 74	2%	3%	2%	3%
75 and over	1%	3%	1%	2%
Unknown Age	0%	0%	0%	79%
Gender				
Female	54%	52%	57%	50%
Male	46%	48%	43%	49%
Unknown	0%	0%	0%	1%
Race/Ethnicity				
Native Amer.	0%	1%	0%	0%
Asian	0%	0%	0%	1%
African Amer.	38%	33%	20%	29%
Pacific Islander	0%	0%	0%	0%
Caucasian	59%	62%	74%	62%
Hispanic	2%	1%	0%	3%
Multi-Racial	0%	0%	0%	0%
Other/Unknown	0%	4%	5%	7%
<i>0% in most cases denotes a percentage under 1% rather than no representation at all.</i>				
Total Population				
Consumers-C&A	36,094	85,777	Not Available	586
Consumers-AMH	94,526	148,006	Not Available	4,847
Inpatient Population				
Patient Counts				
# of Beds-C&A	88	119	140	64
# of Beds-AMH	1,120	1,875	831	1,740
ACL-C&A	107	153	107	82
ACL-AMH	1,068	1,296	827	1,571
Under Age 21	2,262	1,025	--	910
Age 21 and Up	14,123	11,788	--	5,494

Penetration rates of those consumers served in a psychiatric hospital setting based on FY02 CMHS reports reflected that all four states, Georgia and the three comparison states, had a rate above the national average penetration rate. Georgia's was the highest at 1.74 per 1,000 population, North Carolina's was 1.3, Tennessee's was 1.18, and Virginia's was 0.90, which at the lowest is almost 22% higher than the national average of 0.74.

The national mean length of stay of adults and children in state psychiatric hospitals was 66 days for discharged children and 76 days for discharged adults and 147 days for resident children and 985 days for resident adults. All resident numbers cited were based on the number of consumers who were receiving services in inpatient settings at the end of the reporting period. Georgia and the three comparison states experienced the following mean lengths of stay:

Table XII-6: Lengths of Stay in Days for State Psychiatric Hospitals

	Discharged Children	Discharged Adults	Resident Children	Resident Adults
Georgia	17	47	1258	2466
North Carolina	34	68	81	1094
Tennessee	12	11	40	985
Virginia	26	78	39	219
National Mean	66	76	147	985

For discharged patients' lengths of stay, only North Carolina and Virginia come close to the national average mean of 76 days for discharged adults with 68 days for North Carolina's discharged adults and 78 days for Virginia's discharged adults. Tennessee's lengths of stay experienced in FY02 were the shortest for discharged patients falling 5.5 times below the national mean for discharged children and 591% below for discharged adults. Georgia's short lengths of stay fall 288% below the mean for discharged children and 62% below for discharged adults. While North Carolina's length of stay for discharged children is 94% below the average, this state comes closest to matching the national average lengths of stay for both discharged children and adults. As we have discussed previously in the Hospital Inventory and Analysis chapter of this report, lengths of stay in Georgia are affected largely by two factors: 1) the ease with which hospital commitments are garnered, and 2) the lack of crisis stabilization in the community which increases hospitalization for that purpose even though that is not an intended service of the hospitals. Other factors include that many state psychiatric hospitals across the country don't provide short-term treatment at all interferes with the ability to precisely compare lengths of stay from state to state. In this comparison, we acknowledge that to some extent other factors are also driving the shorter lengths of stay in our comparison states.

For residential patients, Georgia is the outlier state with regard to children with a length of stay that is 756% above the national mean. Georgia is preparing to downsize its Child & Adolescent units from two to one, recognizing that institutional placement is not the right answer for children who could be supported with their families in the community, so it is likely that this figure for length of stay will drop significantly by FY07. The three comparison states evidently have system supports in place that allow their lengths of stay for resident children to be shorter than the national mean of 147.

North Carolina's length of stay is the longest of the three with 81 days, while Tennessee's is 40 and Virginia's is 39. Georgia has the longest length of stay for adult residents as well with 150% more days than the national average. Virginia has the shortest length of stay for resident clients with 219 compared to the national average of 985 days.

The final two comparisons we present from the CMHS FY2002 Uniform Reporting System Output Tables focus on financing, specifically State Mental Health Agency Controlled Expenditures for Mental Health (FY2001⁹³) and the Percentage of Mental Health Block Grant Expenditures for Non-Direct Activities (FY2002). The former allows a comparison of the percentage investment in hospital versus community and other categories and the latter speaks to efficiencies and the ability of the state to leverage federal block grant dollars.

Table XII-7: State Agency Controlled % Expenditures for Mental Health FY 2001

	Georgia	North Carolina	Tennessee	Virginia
State Hospitals	46	68	32	60
Other 24-Hour Care	2	2	7	10
Ambulatory/Community	47	30	60	25
Central Office, Research, Training, Prevention	6	1	2	6

As of FY 2001, Georgia fell in the mid range of the percent of expenditures for state hospitals with North Carolina and Virginia at the top and Tennessee below. Both Georgia and North Carolina expended 2% of the budget on Other 24-hour care which was at the low end compared to Tennessee's 7% and Virginia's 10%. Georgia ranks slightly above average in ambulatory/community expenditures, where Virginia expended the least amount for community services at 25% and Tennessee with the highest at 60%. North Carolina ranked below average with community expenditures of 30%. Both Georgia and Virginia expended 6% of the budget on Central Office activities, while North Carolina only spent 1% and Tennessee spent 2%.

In terms of non-direct activity expenditures associated with Mental Health Block Grant funding, the comparison of states shows great variation. In fact, there is not one category of expenditure, of a choice between Technical Assistance, Planning Council, Other, Administration, and Data Collection/Reporting, that we find any commonality. Each state has designated a different primary activity "beneficiary" by virtue of having expended the largest percentage of funding in different areas. Georgia's largest spending goes to Administration, North Carolina's to Other activities, Tennessee's to its Planning Council activities, and Virginia's to Administration, so only Georgia and Virginia are alike in this regard. All four states utilize a portion of the funding for Administration,

⁹³ Note: Attempts were made to obtain the most recent 2003 CMHS reports from each state for a more accurate and current comparison, however we were not successful in that effort.

Planning Council activities, and other activities at varying levels. However, each of the other states we are comparing to Georgia leverage block grant funds to cover technical assistance and data collection/reporting expenses whereas Georgia does none at all in either of these two categories. However, while not reflected in Table XII-8 below, the total dollars that each state spends in non-direct activities differs substantially, particularly between the amounts that Georgia (\$243,144) and Tennessee (\$238,400) spend versus the amounts that North Carolina (\$964,709) and Virginia (\$679,936) spend. Therefore, the funding itself can be more substantially spread among activities by North Carolina and Virginia, where Georgia perhaps chose to absorb technical assistance and data collection/reporting costs through other revenue streams.

Table XII-8: Federal Mental Health Block Grant Expenditures for Non-Direct Service Activities FY 2002, Percent of Total State Non-Direct Expenditures

	Georgia	North Carolina	Tennessee	Virginia
Technical Assistance	--	35.6	27.8	14.3
Planning Council	4.1	0.0	40.4	3.7
Other Activities	22.8	57.7	0.2	11.9
Administration	73.1	4.9	9.9	60.0
Data Collection/Reporting	--	1.8	21.8	10.1

Another comparison in utilization of Mental Health Block Grant Funding is found from the Uniform Reporting System State Profiles from FY2002 available through the NASMHPD Research Institute. Table XII-9 illustrates the allocation of mental health block grant funding between children and adolescents, adults, and older populations.

It is possible in looking at the allocation of Georgia's mental health block grant funds to assume that Georgia has chosen to prioritize block grant funding for children/adolescents since Georgia's expenditures reflect the opposite of how the other states split their allocations. Where Georgia allocates 59% of its funding to Children and Adolescents, North Carolina, Tennessee and Virginia place from 55%-80% of their funding in adult services.

A complete comparison is not possible, because neither Georgia nor Virginia track or submitted separate data regarding service recipients who qualify as elderly. However, utilizing Georgia's general FY2004 service utilization data collected as part of this report, we can make some assumptions for the purposes of comparison. The percentage of elderly recipients of Georgia's mental health services for FY2004 was 3.15% in hospital settings and 3.01% in community settings.

It can be assumed that this same general percentage of 3% would translate to how block grant funds are spent for Georgia's adult service population. If this is the case, then Georgia would spend the least percent of block grant funds as compared to North Carolina and Tennessee, but still within the expected range with only a one percent

differential between each state: Georgia – 3%; North Carolina – 5 %; and Tennessee – 4%.

In order to compare percents of expenditures in adult services, we would subtract the 3% from Georgia’s reported 41% for adults to arrive at 38%. At 41%, Georgia was already the lowest state in percentage of block grant funds for adults and this calculation makes it more so. While Virginia also has not separated its elderly from its adult services percentages, its allocation of 80% is so much higher than the other three states, that subtracting the percentage spent on the elderly, if we knew that figure, would likely not change the fact that Virginia still allocates the largest amount of its block grant funds to adults, even less the elderly population.

In summation, this comparison of block grant expenditures is perhaps only useful to the extent that it highlights how other states are leveraging their federal funding and that tracking expenditures by all three age groups to include the elderly separately from adults would facilitate a more complete comparison exercise.

Table XII-9: FY2002 Mental Health Block Grant Expenditures by Children/Adolescents, Adults, and Elderly

State	Approximate percent of the Mental Health Block Grant funds spent on children/adolescents	Approximate percent of the Mental Health Block Grant funds spent on adults	Approximate percent of the Mental Health Block Grant funds spent on the elderly
Georgia	59%	41%	Included in adults
North Carolina	40%	55%	5%
Tennessee	32%	64%	4%
Virginia	20%	80%	--

Comparison to other States’ Hospital Systems

The following section reviews hospital utilization based upon self-reported data submitted in response to direct survey results by each comparison state. Results have been compiled into *Appendix IX-2: State Comparison of Hospital Data Report*. We begin with an introduction to the comparison states’ hospital systems and data for background.

Comparison States

North Carolina: There are three state psychiatric facilities of four total in North Carolina that are members of the Southern States Psychiatric Hospital Association and which

provided state comparison data: Broughton Hospital (Morganton), Cherry Hospital (Goldsboro), and John Umstead Hospital (Butner). Umstead Hospital serves 16 counties in the north central region of the state and is a 593 bed hospital for persons 6 years of age or older. Cherry Hospital is a 662-bed hospital serving 33 eastern North Carolina counties. Broughton Hospital serves the 37 western most counties and is the largest of the four psychiatric hospitals operated by the State of North Carolina within the Department of Health and Human Services under the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Currently, Broughton serves approximately 3,600 patients annually.

Tennessee: There are five Regional Mental Health Institutes served by the Tennessee Department of Mental Health and Developmental Disabilities. Data was obtained for Adult Mental Health data from Lakeshore Mental Health Institute, which services the easternmost part of the state. Tennessee's hospitals are a mix of forensic, SPMI, and MR, though there are no ICF/MR beds. Mr. Lee Thomas, Superintendent of the Lakeshore Institute, believed Lakeshore to be representative of the state's average utilization for Adult Mental Health and therefore data from the other hospitals were not further sought. Forensic data for comparison was obtained from Middle Tennessee Regional Institute, home of the state's only Maximum Security Forensic unit. All other forensic services are not collected at the state level or in a centralized fashion for response to our survey.

Virginia: Southwestern Virginia Mental Health Institute is one of nine mental health facilities in Virginia operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. It is a 172-bed state-run psychiatric facility serving 24 counties and 8 cities in Southwestern Virginia. The other Virginia hospitals have from 130 to 600 beds though bed counts under 300 are more common, therefore the Southwestern Virginia facility is fairly representative. Strongly committed to a single, integrated system of care, the state is looking to create more effective and efficient use of state facilities. Seen as part of an array of the overall available continuum of care for Virginians with mental illness, Community Services Boards screen consumers and provide referral to a mental health facility if deemed appropriate. Pre-admission screening services are provided by CSBs on a 24-hour per day, 7 days per week basis.

Involuntary vs. Voluntary Commitments

The Centers for Medicare and Medicaid makes the following statement on their website:

“People generally have the right to consent to, or refuse, treatment. However, under certain conditions - such as when a person is considered a danger to self or others - he or she may be required to seek or receive treatment. This can include involuntary civil commitment, which can be for either outpatient or inpatient treatment, as well as forced medication. Laws about commitment vary by State.”

Because of the ease with which Georgia law allows psychiatric hospital commitments, admission and readmission counts and lengths of stay statistics are adversely affected in comparison to national averages. The rate of involuntary admissions in Georgia is estimated at 95% of all admissions. Of the total admitted involuntarily, 31% will convert from involuntary to voluntary admission; 50% of that number will do so by the fifth day of admission and 70% by the 10th day. This is an important system foundation to understand as other states' hospital utilization statistics are presented in the following sections.

Hospital Comparisons by Gender

Of Georgia's total hospital population, there is a gender differential of 61.07% males and 38.93% females. North Carolina's sample reflected a gender split of 64% male and 36% female which is a higher male percentage than we see in Georgia statewide on average, although the same split is mirrored in Georgia's Metro Region. Virginia's total population gender breakdown was 58.61% male and 41.39% female. (Tennessee did not submit gender data.) In terms of program specific gender statistics, Virginia's Child and Adolescent bed utilization provides the only perfectly even 50/50 breakdown between the sexes. North Carolina's FY04 hospital utilization by children and adolescents saw a 51% male and 49% female split, while Georgia's was 53.82% males and 46.18% females. For Adult Mental Health units, Georgia and Virginia were most similar with 58.79% and 59.40% male population makeup respectively, where over 65% of North Carolina's Adult Mental Health hospital population was male.

Hospital Comparisons by Occupancy

Acute Adult Mental Health units across states all had higher than optimal (85%) occupancy rates though the extent to which the rates were higher varies and Georgia's rate is the highest at 95.1%. Tennessee's rate comes closest to Georgia's with 93.9% while North Carolina's rate is 87.67% and Virginia's is 88.4%. It should be noted that North Carolina provides separate geriatric units, which experienced a 71% occupancy rate. If the counts of bed occupancy in the geriatric units were included in the state's adult mental health figures, the occupancy rates would differ. However, because the number of beds changed during the course of the fiscal year, it is not possible to recalculate for the difference with the data provided.

Forensic comparisons are available only to Tennessee (due to lack of data) and even so the comparison is of Georgia's statewide rates to Tennessee's rates in its Maximum Security units only which is the only Forensic data tracked by the state separately from Adult Mental Health. Both Georgia and Tennessee experienced occupancy rates of over 100%. Georgia's FY04 occupancy rate for all Forensic units was 101.6% and Tennessee's was 102.5%. (Tennessee's Maximum Security units include one evaluation unit and one treatment unit. The evaluation unit had an occupancy of 80.1% and the treatment unit had the 102.5% occupancy rate.)

For acute Child and Adolescent treatment, Georgia experienced a 93.7% occupancy rate. Comparatively, North Carolina's rate was 58.29%, Tennessee's rate was 85.5% and Virginia's was 62.4%. Thus, only Georgia and Tennessee experienced rates over the optimal 85%. In comparison to all three states, however, Georgia's occupancy was substantially greater.

Hospital Comparisons by Average Admissions and Discharges per Day

In the comparison of average admissions and discharges per day between states, we find that Georgia was the only state on average in FY2004 to experience more admissions than discharges per day in Adult Mental Health units, albeit only by 0.1 more. North Carolina had 0.61 more discharges than admissions per day, Tennessee had 0.03 more discharges, and Virginia had 0.5 more. Short term Child and Adolescent admissions and discharges were exactly the same for both Georgia and Virginia. North Carolina had a higher C&A admission rate than discharges (by 0.09) while Tennessee had a higher discharge rate (by 0.38).

Hospital Comparisons by Available Beds and Average Client Load

In considering average client loads, Tennessee data will have to be eliminated due to lack of comprehensiveness of data. Of the three remaining states, Virginia has the greatest hospital capacity with 1752 adult mental health beds statewide, compared to Georgia's 732, and North Carolina's 895 (plus 40 geriatric). North Carolina's data only represents three of the state's four state psychiatric hospitals. Georgia's average client load was 696.1, to North Carolina's 679.97, and Virginia's 1548.

For child and adolescent treatment units, Georgia had 70 short-term beds for an average client load of 65.6; North Carolina had 122 beds for an average client load of 76.50; and Virginia had 64 beds for 40 average clients per day. In this, Georgia's demand most closely matched its capacity.

Hospital Comparisons by Average Length of Stay

Georgia and North Carolina shared similar FY2004 average lengths of stay in their adult mental health units, 30.4 days and 31.51 days respectively. In contrast, Tennessee's average adult mental health length of stay was 6.79 days and Virginia's was 122 days.

Comparison between Forensic treatment units demonstrate a much shorter stay by Georgia for which all Forensic unit patients had an average length of stay of 64 days. Tennessee experienced a 35.49 days length of stay for its evaluation unit and a 445.63 days length of stay for its treatment unit (95 total admissions for FY2004 evaluation unit and 8 admissions for the treatment unit).

For child and adolescent acute services, Georgia experienced a 10.2 days average length of stay, whereas there was an average length of stay of 24.64 days for North Carolina,

17.85 days for Tennessee, and 28 days for Virginia. Georgia's shorter length of stay could be indicative of relatively simple commitment procedures and/or lack of sufficient support for families in the community.

Hospital Comparisons by Readmission Rates

Regrettably, the three comparison states did not or did not consistently track readmit rates as comprehensively as Georgia does.

In terms of average lapsed days from previous discharge, Georgia's adult mental health programs experienced a 60% readmit and an average lapsed time from the previous discharge of 858 days. The sample facility data we have from one Tennessee hospital indicates an adult mental health readmission rate of 45% with 29.38 average lapsed days from the previous admission.

Other adult mental health comparisons consider the intervals at which percentages of the readmission population are readmitted. **Of the patients readmitted for adult mental health treatment in Georgia's hospitals, 13.2% were readmitted within 30 days of their previous discharge and 36.4% had been readmitted within a year.**

Comparatively, one of North Carolina's hospitals had 14.5% of its adult mental health patients readmitted within 30 days and 31.1% within 365 days. Tennessee's hospital had a 14.54% readmit rate within 30 days and a 62.98% readmission rate within 365 days, approximately double Georgia's and North Carolina's experience. The balance of the readmitted population over 365 days for both Georgia and North Carolina was approximately 40%, whereas for Tennessee it was just under 12%.

Tennessee's forensic evaluation unit experienced an almost 12% readmit rate with 839.5 average lapsed days from the previous discharge and the forensic treatment unit had an 87.5% readmit rate with 253.5 average lapsed days from the previous discharge. Georgia's statewide forensic units were not analyzed because of the judicial system's control of forensic patients' admissions.

There is some additional level of data for comparison of Child and Adolescent short-term units. Georgia experienced a 33.6% readmit rate statewide with average lapsed days from previous discharge of 324 days. North Carolina's Broughton Hospital had a 32.6% readmit rate, similar to Georgia's. The average lapsed days from previous discharge was not known, however almost 15% of the patients were readmitted within 30 days and 32% within a year. Georgia's percentages were slightly lower with 10.3% readmitted within 30 days and 25.5% within a year. Virginia had a C&A readmit rate of 39.66% while sample data from Tennessee indicated that the facility had a 0% readmit rate for C&A in FY2004.

Hospital Comparisons by Staffing Ratios

The possibilities for variability in staffing patterns for psychiatric facilities are great and it is interesting that there are actual commonalities in staffing ratios from state to state. We identified commonalities within certain ranges in Georgia's staffing ratios, yet in the largest portion of all staffing--nurses--there was a clear gap in the ranges between four hospitals that had over a 1:1 nursing ratio per consumer in Adult Mental Health Units and the other 3 hospitals that had approximately .33 of a nurse per consumer. A similar split is observed in North Carolina's hospitals where 2 hospitals have between .25 and .33 of a nurse per consumer where the third hospital has 1.58 nurses in its Adult Mental Health unit per consumer. Sample data from Tennessee and Virginia also indicate 1.17 and 1.24 nurses per consumer in their Adult Mental Health units respectively. Across all hospitals, Georgia's average staff ratio of nurses to consumers in Adult Mental Health Units is 0.75; the estimated statewide average for nursing staff in North Carolina Adult Mental Health Units is 0.88, Tennessee is 1.17 and Virginia is 1.27. Therefore for nurse staffing, Georgia's is the lowest statewide ratio for nursing.

Physicians are spread from 0.04 per consumer in two of North Carolina's hospitals to 0.12 in North Carolina's third hospital and one of Georgia's. Tennessee's physician count is 0.10 per consumer and Virginia's is 0.06. Georgia's other hospitals range from 0.05 to 0.10. State to state averages range from Virginia's 0.06 physicians per consumer to Georgia's 0.07, to North Carolina's 0.08 to Tennessee's 0.10—not an overly large spread.

In the arena of Social Service providers, North Carolina is the outlier with 0.38 social service providers per consumer compared to Georgia's low of 0.07, Virginia's 0.08 and Tennessee's 0.09. This is approximately the difference of 1 social service provider to every 2.6 Adult Mental Health consumers in North Carolina as opposed to 1 to every 12.5 consumers in the other three states including Georgia. This higher staffing pattern may be part of the reason the cost per Adult Mental Health unit occupied bed day for North Carolina is considerably higher than Georgia's.

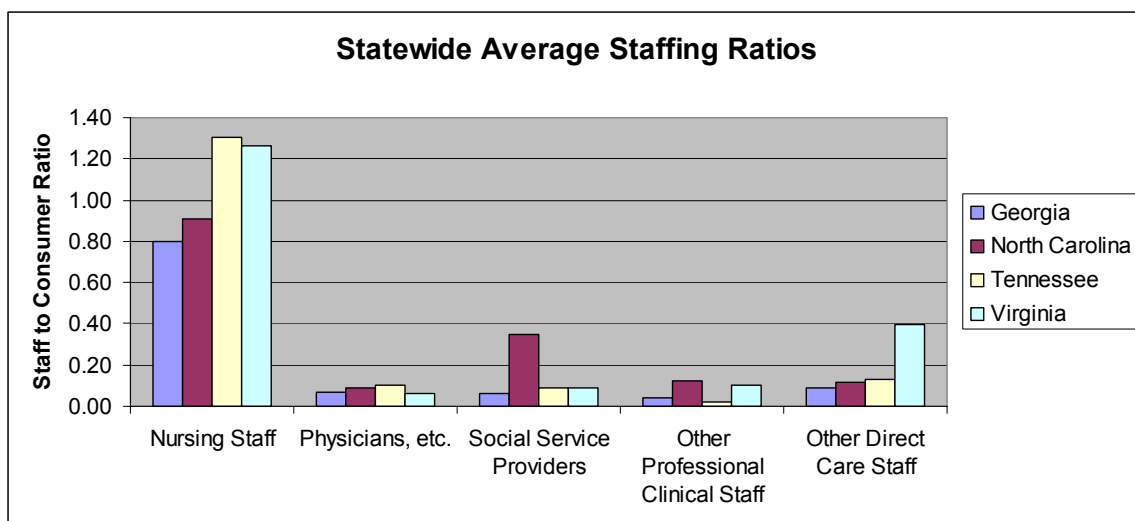
The highest statewide average for Other Professional Clinical Staff assigned to Adult Mental Health units is also observed in North Carolina. Both Tennessee and Virginia data have 0.01 Other Professional Clinical Staff, Georgia has 0.04 and North Carolina has 0.11. The same pattern does not hold true for Other Direct Care Staff (non clinical). In this case, Virginia is the outlier, providing 0.39 Other Direct Care Staff per consumer in an Adult Mental Health unit. The next highest is 0.14 in Tennessee, followed by 0.12 in North Carolina, leaving Georgia the lowest average at 0.09.

Neither of the three comparison states offered long-term child and adolescent (C&A) hospital services, so the comparison of staffing patterns among states is applicable to C&A acute or short-term units only. Each state had elevated nursing staff patterns as compared to other units. Georgia and North Carolina are somewhat similar with 1.38 and

1.10 nurses per consumer respectively. Tennessee and Virginia are similar to each other but have almost double the nurse staffing of Georgia and North Carolina with 2.38 in Tennessee and 2.28 in Virginia. In terms of physician staffing, Georgia's rate remains the same as that for Adult Mental Health while the other states' physician rates are slightly elevated to significantly elevated above Adult Mental Health rates. Georgia's statewide average physician ratio per C&A consumer is 0.07 (although of the two Georgia hospitals that offer C&A treatment, one had 0.04 and the other had 0.11, which is quite divergent), while Tennessee's and Virginia's are both 0.13 and North Carolina's is 0.16.

For social service providers, three states share some commonality—Georgia, North Carolina, and Tennessee have either 0.12 or 0.13 social service providers per consumer and Virginia has 0.33. Other Professional Clinical Staff for C&A is more dissimilar than it was for Adult Mental Health. Rates per consumer begin with Georgia's 0.10 at the low, followed by 0.15 in Virginia, 0.17 in North Carolina, and 0.38 in Tennessee at the top. For the final staffing category, Other Direct Care Staff, there is more of a two and two split between the four states. Georgia and North Carolina have relatively low staffing in this category, 0.16 for Georgia and 0.10 for North Carolina, where Tennessee has 0.63 staff per consumer and Virginia has 0.53.

In terms of total staffing across hospital programs, statewide averages are computed but offered with the following qualifiers: North Carolina's data represents utilization and staffing from 3 of 4 total hospitals. We believe the averages to be representative but they will not be as specifically accurate as they would be had data from all four hospitals been available. For Tennessee, the statewide averages are based on sample data from only two of five hospitals. Virginia statewide averages utilized actual statewide data for Adult Mental Health staffing patterns, while the remaining data for each program are based on single facility-specific staffing and utilization.



As is depicted in the chart above, staffing levels for physicians is most common between the states. Another commonality is the tendency to have many more nurses on staff than any other professional category, but otherwise there is little similarity between the four states in nursing. For social service providers, three of four states have similar patterns. In the two “other” categories, more similarity exists in the staffing of non-clinical other direct care staff where again three of four states have relatively common staffing. Unfortunately there is no trend because the fourth outlier state is different in both cases. For social service providers the outlier is North Carolina and for Other Direct Care Staff it is Virginia.

For total hospital staffing (all professionals across unit type), each state has at least 1.07 staff per consumer (Georgia, the lowest) and less than 2 per consumer. North Carolina has 1.58, Tennessee has 1.65 and Virginia has 1.91. Georgia’s low staffing in comparison certainly plays a role in consumer costs being so controlled in comparison to the other three states.

Hospital Comparisons by Observational Data

Hospital patients are observed at different intervals and intensities based on the individual need and condition of the patient. Observation is usually by a nurse and common observational levels typically include 1 to 1 which is a dedicated nurse to the patient at all times; Line of Sight which means that the patient must be in the line of sight of a nurse at all times; Q-15 requires that a nurse observe a patient’s status every 15 minutes; and Q-30 and Q-1 hour similarly require observation at 30 minute or 1 hour intervals.

The comparison of observational level utilization can provide insight into the management of staffing levels and time utilization. The comparison to follow presents average observations across unit types for all hospital patient days. The figures were calculated based on the FY04 count for each observational level (i.e. the total of bed days where patients had a 1:1 observational level assigned) per 100 patient days of care/occupied bed days. If a hospital did not track these observational levels routinely, they manually conducted a sample of 20 days of care and then extrapolated the findings for annual averages. Ranges are given when multiple hospitals contributed data.

Table XII-10: Counts of FY04 Special Observational Levels per 100 Occupied Bed Days										
	1:1		Line of Sight		Q-15		Q-30		Q-1 Hour	
	Range	Mean	Range	Mean	Range	Mean	Range	Mean	Range	Mean
GA	0 – 5	1.81	0 – 22.1	6.29	0.07 – 26.9	11.9	0 – 93	54.17	50.6 – 89.02	69.8
NC	4.2 – 11.13	7.67	--	--	--	--	88.87 – 95.8	92.34	--	--
TN	--	0.58	--	6.11	--	0.43	--	22.54	--	--

VA	--	2.4	--	10.0	--	--	--	--	--	--
----	----	-----	----	------	----	----	----	----	----	----

The extent to which states use 1:1 observation varies widely. While two of Georgia's hospitals utilize Q-1 hour observation frequency, no other hospitals in this comparison do.

Acknowledging that Georgia's hospital utilization patterns are influenced by a high population of patients in need of short-term crisis stabilization, we would expect Georgia's 1:1 levels to be fairly high, but North Carolina's use of 1:1 is significantly higher than Georgia's.

North Carolina hospitals only use 1:1 as a special observational level, otherwise every other patient is observed every 30 minutes, and thus it is not a special observational level. However, for comparison to Georgia's counts, we have calculated and included it in the table below. North Carolina and Tennessee data do not include Forensic levels, though North Carolina data does include both Adult Mental Health and Child & Adolescent services. The Virginia facility submitting data on this measure only uses 1:1 and Line of Sight as special observational levels. They experienced an average count of 2.4 for recipients of 1:1 observation and 10.0 for line of sight. The 1:1 count at 2.4 falls below the lowest point on the range of counts per hospital for North Carolina and falls in the middle of Georgia's range, although it is higher than Georgia's mean. It is a high count compared to the Tennessee example. As for Line of Sight, both Georgia's and Tennessee's means are comparable while Virginia's is significantly higher with almost 4 more instances of Line of Sight observations per 100 occupied bed days.

While the above comparisons can be noted, the differences in how each state's policy directs observational level activity, and in some cases each hospital's policy, limit the conclusions that can be drawn in the comparison of observational level counts.

Hospital Comparisons by Financing

The bulk of our financing comparisons have used state level expenditure data, particularly for Georgia's hospitals. The total FY2004 expenditures for Georgia's hospitals for mental health programs are as follows in Table XII-11:

Table XII-11: Hospital Expenditures FY04			
Cost Center/Program	Total	State Funds	Federal Funds
Adult MH	\$99,328,629	\$64,305,358	\$35,023,271
Forensic	\$51,106,343	\$37,051,565	\$14,054,778
C&A MH	\$16,432,878	\$10,597,211	\$5,835,667
Total	\$166,867,850	\$111,954,134	\$54,913,716
<i>*Source: Governor's Office of Planning and Budget, FY04 MH Community and Hospital Expenditures Report</i>			

Cost Per Inpatient Day of Care

Georgia's costs for Adult Mental Health are below the average costs incurred for an inpatient day of care by North Carolina, Tennessee and Virginia.

Utilizing the total dollars reported by the Governor's Office of Planning and Budget, we have computed an average statewide cost per inpatient days of care for each cost center:

Adult Mental Health, 254,758 days	\$389.89
Forensic, 143,932 days	\$355.07
Child & Adolescent, 35,869 days	\$458.14

Central State Hospital provided a breakdown of cost per inpatient days of care (occupied bed days) for FY04. These figures include direct and allocated costs and because of the scope of CSH's operations and the size of the campus, the amount of overhead elevates the allocated costs more than it will at other hospitals. Therefore, Central State's figures should represent the high end of costs per inpatient day of care.

Adult Mental Health	\$380.47
Forensic, Medium Secure with Hold	\$271.71
Forensic, Maximum Secure	\$407.89
Child & Adolescent Short Term	\$482.03

The higher nursing levels associated with Child & Adolescent services are likely a significant factor in the cost per inpatient day being more than \$100 higher than for Adult Mental Health and more than \$200 more than Forensic Medium Secure units.

In comparison, Tennessee reported an average cost per inpatient day of \$440 for Adult Mental Health of which 6.4% was federal, 92.6% was state, and 1% was private pay. North Carolina hospitals reported a rate range of \$583-\$596 of which the average split between payer sources ranged from 0%-3.4% federal, 95% - 96.22% state, and 0.38 – 5% private pay.

Virginia's Southwestern Mental Health Institute had a cost of \$525.17 per occupied bed day. What differentiates Virginia most is the stratification of funding sources covering costs. Southwestern Mental Health Institute's costs break down to 5% federal funding, 78.33% state funding and 21.62% private pay. This is not a single facility phenomenon. Statewide, the percentages of Virginia's funding sources break out on average like so:

Medicare – Federal funded	7.82%
Medicaid – Federal funded	19.29%
Medicaid – State funded	19.29%
Social Security benefits	33.23%

Private insurance/individual assets 20.37%

The Georgia DHR Office of Planning and Budget Services reported a total FY04 dollar amount collected through Third-Party Billing of \$754,220. This results in a statewide average private pay amount of 0.45%, which places Georgia on the low end of private pay receivables in comparison to the other states.

Separate cost figures for any other state by program type, outside of Adult Mental Health, were only submitted by Tennessee's Forensic Maximum Security Unit. Where Georgia's cost per occupied bed day for all forensic unit services was \$355.07, Tennessee's was \$560 for its Maximum Security Unit.

Construction budgets are typically directed and/or authorized by state statute where set dollars are allocated for building, renovation, physical plant upgrades, and/or significant equipment purchases. A comparison of capital construction budgets is not overly telling given the variety of purposes for which the funding can be used which could include updating of institutional facilities, deinstitutionalization initiatives, or an investment in regional community offices. With such a spectrum of possibilities and without further information on the purposes of such budget, a comparative analysis between states is dubious. However, insofar as the budget reflects an investment by the state in enhancing its mental health system, it is worthy of mention.

In the comparison below, while all amounts were not available, we see that only Georgia and Tennessee in FY02 had funding designated for capital construction. It is interesting to note that either no dollars had been made available for community services or such data was not available. Most states certainly rely on contracted providers to initiate capital construction as needed based on their contracts and payment for services from the state. However, it could be argued that this lack of funding from the state level or the inability to demonstrate knowledge of such budget items is telling in that if building the community infrastructure were deemed important enough, the state would certainly be investing some level of dollars in it and/or be tracking the data.

State	FY2002 Combined State Hospital Construction Budget	FY2002 Combined State Community Construction Budget
Georgia	\$20,478,176	\$0
North Carolina	\$0	Not Available
Tennessee	\$0	\$0
Virginia	\$26,320,311	Not Available

Moving Forward

The state of Georgia's penetration is high in comparison to other states, yet total expenditure per capita is low in comparison. This juxtaposition leads to the conclusion that while Georgia is reaching more people, they aren't being served as well, or at least to the extent that would be indicative of the intensity of treatment traditionally recommended for those most in need. Other comparisons indicate that there is some validity by similarity to other southeastern states, such as in the breakdown of demographic characteristics of those served and higher utilization of hospital treatment as compared to the national average. However, the comparisons also demonstrate that Georgia may not be fully leveraging supplemental resources for funding that would expand the state's ability to increase its outreach and the intensity of services provided. Other states exhibit more success in obtaining private insurance and other third-party payments for services in both community and hospital services and in serving a greater percentage of consumers for whom Medicaid funding can be leveraged. These findings are but a sample of many that lead to our recommendations for addressing the gaps in Georgia's mental health service system in the following chapter.

CHAPTER XIII: RECOMMENDATIONS FOR STEPS TO ADDRESS MENTAL HEALTH SERVICE GAPS

In this Chapter you will find the following:

❖ ***Ongoing Gap Analysis should include the following components:***

- *Stakeholder Feedback*
- *Service Utilization Data Analysis*
- *Prevalence and Service Penetration Rates for state, region and county*
- *Workforce Analysis*
- *State to State Comparison*



❖ ***Establishing the Foundation to Address Mental Health Service Gaps***

- *Strategy*
- *Structure*
- *Systems*
- *Staffing*
- *Skills*
- *Rewards*

Throughout Georgia’s Mental Health Gap Analysis, APS Healthcare has identified gaps and opportunities for improvement of the service delivery system capable of meeting the growing population in Georgia. This chapter presents broad gaps within the system and provides recommendations to address those gaps. It also lists recommendations for the Mental Health Planning and Advisory Council (MHPAC) to continue the Mental Health Gap Analysis Process.

The initial Gap Analysis should be considered a baseline of information, a “point in time” snapshot of service delivery within Georgia. In order to reap the benefits of this information and data analysis, Georgia must conduct similar analysis on an ongoing basis. This will enable Georgia to measure the extent of success in improving access and quality of services both in the community and in the state run hospitals.

A. Perform an Ongoing Mental Health Gap Analysis

Georgia has a unique opportunity to fill a substantial planning gap and to strengthen the mental health system through ongoing gap analyses. Informed Planning is based on a uniformly accepted set of goals against which activity is measured. The process of

performing periodic gap analyses supports the Mental Health Planning and Advisory Council and Division of MHDDAD to make informed decisions. Information from ongoing gap analyses could be used to:

- Measure the impact of policy and funding changes on serving Georgia's most vulnerable population
- Strategic planning for service expansion or modification at the local level
- Make policy changes to ensure that targeted populations needs are met

While the Mental Health Gap Analysis provides information on prevalence, utilization, workforce, and comparison to other states, several changes need to take place before Georgia can get a true sense of the Capacity of Mental Health Services within the state.

The Division has already established a high bar in regard to its data collection and analysis of such items as hospital utilization. It has already made adjustments to the type of data collected on community utilization in order to conform to Uniform Reporting System requirements. There are, however, several gaps in the system's infrastructure that impede the collection of data necessary for performing regular gap analyses. These issues need to be addressed if the state wishes to collect appropriate and sufficient data and perform ongoing gap analyses routinely.

In order to complete an ongoing gap analysis for the State of Georgia, the MHPAC will need to review the current baseline of information collected and analyzed by APS Healthcare. A sample Matrix of Elements of An Ongoing Gap Analysis is provided as **APPENDIX XIII-1: Matrix for Ongoing Gap Analysis** so that the MHPAC can use it as a planning tool to move forward.

The following outline details the critical components that should be addressed in an Ongoing Gap Analysis, and provides some methodology support in order to move forward.

Critical Components to be Addressed in an Ongoing Gap Analysis

I. Stakeholder Feedback

Stakeholder feedback collected in several different formats during the Gap Analysis proved to be invaluable in soliciting information from community members, and measuring the climate of the service delivery system in Georgia. The MHPAC should exercise the following tactics to collect stakeholder feedback:

- Community Focus Groups – The regional offices currently conduct focus groups. It is recommended that these become more prominent with Division level staff participation.
- Electronic surveys that can be administered online with minimal staff resources allocated to data collection.
- The Planning Council could expand member representation to include more providers and consumers so that stakeholder feedback becomes a regular process rather than an annual event.

II. Service Utilization

Service utilization is a foundation benchmark for measuring improvement in the state mental health system. For the purpose of an ongoing gap analysis, and to compare the information from the original gap analysis, the Division should stratify data as identified below:

- Service Enrollment and Service Provision/Intensity: Pull data for one complete fiscal year and stratify by the demographic characteristics such as diagnosis, age, and race.
- Analyze data to look at services by each provider, in each county, and in each region to review for trends, etc.
- Identify users of both hospital and community treatment to discern average lengths of stay, provider, cost of services, and movement between hospital and community services.

III. Prevalence Penetration

Measuring the Penetration (or how much of the targeted population is served) against the Prevalence (or the estimated number of those with Mental Illness) provides a ratio that indicates how well the state is meeting needs within the population. By obtaining the detailed county guide for Holzer's estimates on prevalence, APS Healthcare was able to calculate the number of people in need of services at the county level. It is highly recommended that Penetration rates are utilized as part of an ongoing measure for regional planning purposes. Penetration can be calculated by completing the following steps:

- Obtain up to date prevalence figures from the University of Texas Medical Branch – UTMB on an annual basis. These figures will be updated with the latest census data and economic indicators. If this data is not available, Holzer's percentages can be applied to the most recent census estimate, with the understanding that this is just an estimate.
- Once the prevalence figures are calculated by county, the penetration rates can be completed by dividing the prevalence numbers by the number of consumers served per county. Sample spreadsheets providing this information have been included as part of the original Gap Analysis.
- Repeat the penetration rate calculations by race, age, sex, etc. with the stratified utilization data by county.

IV. Capacity Measurement

As indicated above several system modifications will need to occur in order to adequately measure capacity. Below are recommendations for establishing a process for measuring capacity.

- Service fidelity needs to be evident in that the requirements of a particular service reflect the definition of the service being measured, e.g. provide example.

- A direct contact hour standard needs to be set for staff, which would be based on the service, or category of service provided.
- Once a number of direct contact hours are established, an analysis of each provider's service array needs to occur.
- Capacity for a service or category of services would be defined as the number of qualified staff multiplied by their direct contact hours for each type or category of service.
- A scatter plot map by specific service could be created by region or table , reflecting capacity of each county, and could be used to summarize capacity and compare to prevalence data.
- Access measurement, which is a product of capacity, should reflect both *time* between first contact, diagnostic assessment, initiation of service delivery, and *distance* the consumer has to travel for services.

V. Workforce

APS completed a significant analysis of the current mental health workforce in Georgia. In order to complete an ongoing analysis, several measures that should be fairly simple have been developed to enable the collection of data on an ongoing basis:

- Keep an updated registry of General State Supply of Workers: Total healthcare workforce numbers are available through the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, publication: State Health Workforce Profiles, updated every two years.
- Provider Utilization – Track the ratio of which certain types of professional providers are utilized across the MHDDAD service recipient population in total and separately by hospital and community. Upgrade collection of community provider data by gathering by FTE information and not just numbers of individuals.
- Track Community and hospital staff by licensure and compare to total available workforce identified in national publications. Also the state can look at total number of healthcare workforce including paraprofessionals and compare to national statistics to look at percentage of MHDDAD utilization of professionals as a percentage of total state's available workforce.
- To consider the extent to which the level of compensation for MHDDAD hospital and community staff are competitive in the marketplace, compare the average salaries of hospital staff by position type and the entry, mid-point, and maximum salaries of community staff as publicized by CSBs to:
 - a. Average Salary Information for public mental health workforce by type of position as reported by the United States Labor Bureau.
 - b. Entry, midpoint and maximum salaries by position type of other state agencies including the Department of Corrections, Department of Juvenile Justice, and Division of Family and Children Services.
- Track Intrinsic Benefits provided to mental health workers for promotion of replication to reduce turnover.

- Research Educational/Professional Incentives offered by providers and other systems for potential replication.

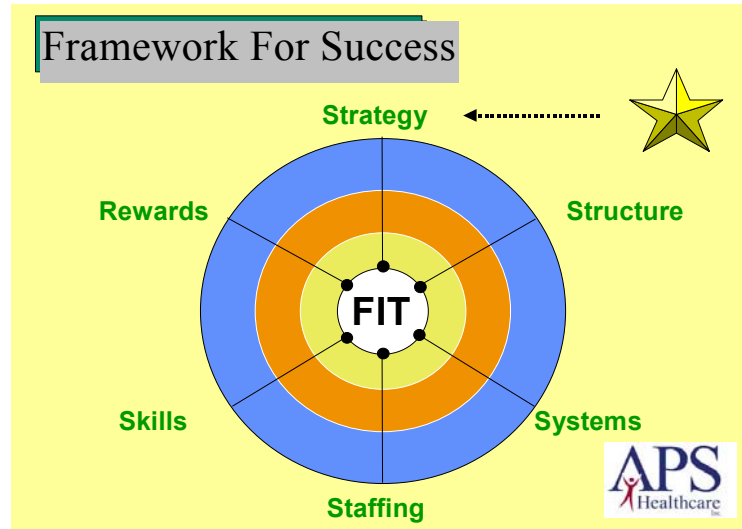
VI. State to State Comparison

The initial Gap Analysis compared Georgia to other states in order to get a relative picture of the service system. For the ongoing Gap Analysis the following methods for comparison are recommended:

- a. National CMHS Data:
 - Use national CMHS data that is published annually to compare Georgia's service population according to demographic characteristics and hospital utilization by admission and readmission rates and lengths of stay.
 - Use national CMHS data to measure how Georgia's direct and indirect spending allocations compare to national averages and change from year to year.
- b. Comparison to other states: Collaborate with select states (either the three from whom data was sought for this first analysis or others of the Division's choosing) to commonly define data elements and tracking and trending data with the agreement to share data routinely at intervals and depth to be agreed upon.
 - The State must first define scope of components to be compared and commonly define them.
- c. Comparison to other state agencies within Georgia--compare the scope of mental health services provided and the associated costs to the following agencies which also provide mental health services:
 - Department of Corrections
 - Department of Juvenile Justice
 - Division of Family and Children Services

B. Establishing the Foundation to address mental health service gaps

While dedicated individuals may have the capacity to make incremental improvements in the public mental health system by following the road map presented above for conducting on-going analysis, radical system transformation may require a major paradigm shift. The Framework for Organizational Success, presented by APS, provides six key components that must be aligned in order to achieve a radical system transformation (see below.) These components are: Strategy, Structure, Systems, Staff, Skills, and Rewards.



Strategy

The MHPAC has the responsibility to set a course of action for the delivery of Mental Health Services in Georgia. While political agendas and funding strategies provide an ever-changing landscape for the service delivery environment, the Planning Council can set unwavering strategy, mission and objectives that guide administrators within the Division of MHDDAD. A common strategy or vision provides the foundation for all planning and policy decisions. This strategy should withstand personnel changes, funding cuts and other distractions that can frequently derail the execution of a unified plan. Questions that may shape strategy include:

- What are the roles of the MHPAC and Division?
- Who is the target customer the state is seeking to serve?
- What is, and is not, within the scope of responsibilities of the MHPAC, Division, and providers that make up the public mental health system?
- Given perpetual funding limitations, what is the definition of success for the MHPAC, Division and providers that make up the public mental health system?
- How will any of these entities know they are successful or have made progress toward an unwavering objective?

Structure

In any successful organization the structure needs to support the mission or strategy. Thus, the MHPAC and Division should consider how its organizational structure supports its unified strategy. Questions that may drive structure are:

- What structural adjustments need to occur so that the MHPAC creates strategies that elicit positive outcomes, beginning at the Division level and ending at the provider level?

- What structural modifications would strengthen the Division's ability to reflect the established strategy?
- Would structural changes between the central office and the regional offices benefit lines of communications and the cohesiveness of a unified voice for DMHADDD?
- What changes to structures between the Division and providers of services are needed (i.e., what is the role of CSBs regarding providing the public safety net)?

Systems

When a clear and unified strategy or mission is identified and the organizational structure reflects those objectives, systems must be implemented to support these objectives. Systems refer to policies or the use of technologies that support the goals of the Public Mental Health System. Questions to consider regarding the alignment of systems include:

- Are policies current or do they reflect a different mission at a different time?
- Are policies so contradictory or confusing that they offer little guidance toward the current mission or are they congruent with the vision of the MHPAC and Division?
- Does technology support attainment of objectives or is it antiquated or irrelevant?
- Does technology support and measure what is needed to know for measuring objectives, outcomes and planning purposes?

Staff

Staff is the most valuable asset of any organization. Employing the right person for a task is critical to attaining the goals set forth by the MHPAC, Division and Public Providers. Too often organizations change directions or mission only to find that their staff may not be the best equipped for the new objectives. Questions to consider regarding staff include:

- Is this staff in the right position?
- Are they engaged in the right activities to attain organizational goals?
- Do they have the right skill set to contribute to organizational goals?
- Does the organization need to hire different staff with different skills that match goals?

Skills

The Division and providers of the public mental health services do an exceptional job equipping staff with necessary skills to adapt to a changing system. For instance, when new rehabilitation services were introduced, the Division invested considerably in ensuring that providers offered services in a manner that reflected the new vision. The

right skills are necessary in order to execute any new vision. Questions to consider regarding skills include:

- Does staff have the necessary information in order to perform a new task?
- If training is provided, how does one know if a new skill was acquired?
- Are there continuing education opportunities to update skills?
- Are there regular evaluations to assure training is effective and new skills are employed?

Rewards

Individuals associated with the public mental health system in Georgia are motivated by a number of external and intrinsic rewards. Such rewards are critical in keeping the right staff engaged in the right activities in the right place so that organizational objectives are attained. Rewards may include: compensation, retirement benefits, recognition, professional development, flexible work schedule, helping others who are suffering, belonging in an environment with caring coworkers, etc. Questions to consider when evaluating a reward system include:

- Does the reward system in the public mental health system reflect its mission?
- Is staff rewarded for providing services in an innovative and effective manner?
- Is staff rewarded for achieving certain productivity standards or is everyone awarded the same salary increase regardless of performance?
- When monetary compensation is not available, what other rewards are utilized to keep good staff?
- Does the reward system attract the best staff or are they easily recruited to other opportunities outside of the public mental health system?

If there is any misalignment in the six components of the Framework for Organizational Success, the public mental health system will not achieve its maximum potential. For instance, changing strategies or mission requires a realignment of all other five components in order to achieve success. Complicating this issue is the fact that the public mental health system is comprised of multiple entities that may have responsibilities for different components as follows:

Key Components	Responsible Entity
Strategy	MHPAC, DHR, Division of MHDDAD
Structure	Division of MHDDAD
Systems	Division of MHDDAD
Staff	Providers
Skills	Providers
Rewards	Division of MHDDAD, Providers

The table above illustrates the interdependence of the different entities comprising the Public Mental Health System in Georgia. Thus, any meaningful or long-term system change will require commitment from all organizations involved.

Additional steps to address the service gaps in Georgia are put in the context of the Framework for Organizational Success below:

STRATEGY

- ❖ **The MHPAC should continue to provide leadership that includes all stakeholders in promoting a focused, clear vision for the direction of Georgia’s public mental health service system.**

The MHPAC should continue to provide leadership to facilitate the development of a focused, clear vision for the future of mental health services in Georgia. As an example, the State of New Mexico utilized the findings of a Gap Analysis, which revealed a fragmented system, to transform its system. Upon the recommendation of their Gap Analysis, New Mexico released a system change Request For Proposals and announced the following:

“The State of New Mexico is designing a single behavioral health delivery system in which available funds are managed effectively and efficiently; the support of recovery and development of resiliency is expected; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers are assisted in participating fully in the life of their communities. The primary purpose of this model is to develop an efficient quality-driven statewide system of behavioral health care that promotes behavioral health and well being of children, adults and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes health promotion, prevention and early intervention, resiliency, recovery and rehabilitation.”

This purpose statement developed by New Mexico state policymakers set the foundation for system transformation in that state. Georgia might consider development of a similar guiding principle, against which all decisions could be judged.

The MHPAC has the capacity to provide leadership in developing a unified vision with key values that is unwavering. This vision should supersede staff turnover and changing political agendas. It should provide the foundation for future policy development based on what is best for individuals with mental illness in Georgia. When a vision is clear, priorities become clearer to all parties and agendas can be developed for change and improvement. Additionally, advocates within the MHPAC have the potential to further develop campaigns for a prioritized agenda for change.

The communication of a unified vision is an important step in system transformation. The state and the Mental Health Planning Advisory Council (MHPAC) should continue to be proactive in their communication channels and information sharing to ensure stakeholders are informed at all levels. Keeping stakeholders informed about progress regarding unified goals will aid in establishing a trusting relationship among all parties. Suggestions for strategies include requesting regular reports from the state that can be shared with consumers and family members, information about budget requests, etc. Information can be posted to websites, and shared over information email distribution lists. Additionally, conducting a periodic “town hall meeting” would be a mutually beneficial way to share information and discuss changes in policy direction.

The MHPAC could also provide a source of information to the Division by sharing new treatment models and best practices. Emerging best practices could be employed in pilot areas through research and grant opportunities, allowing all parties to see an impact of a new treatment method.

❖ Consistent leadership should be reflected by unified goals and outcomes for the entire service delivery system.

Additional opportunities lie within the state’s role to promulgate the shared vision through its regional offices and into the community. The state has begun to make strides towards this recommendation, however there continues to be considerable variances in regional operations, and disconnect between policy and practice. Much opportunity exists to promote recovery, consistency and quality at all levels of the system, which can be achieved by further refinement of the state’s strategies.

For instance, as cited in the Gap Analysis, there continues to be a discrepancy between the state target population and those actually being served. This is demonstrated by the wide variance in responses from all stakeholders regarding the target population for public mental health services. The state and the MHPAC need to align their views about where public dollars should be targeted. Recommendations for this alignment include:

- Further refinement and enforcement of the core customer policies set by the state. Make a policy recommendation regarding the target population. For instance, is it MHDDAD’s intention to serve either 1) the entire population with SED/SMI, or 2) population with SED/SMI who are uninsured, or 3) population with SED/SMI whose earnings result in income less than 200% of federal poverty limit, or 4) individuals with Medicaid only, or 5) any person who presents for services (who may not be SED/SMI).
- Consider establishment of a formal policy decision around eligibility based on income (and/or insurance coverage). The state could consider requiring providers to collect income information at intake/enrollment as part of eligibility determination.
- Continue to evaluate the role of Community Service Boards as the safety net. Charge service providers with identifying local resources for serving those who may not need services targeted to the SED/SMI.

The state should continue to standardize operations to ensure consistent application of its vision throughout the mental health system:

- Standardize reporting methodologies across regions (MIERS, Regional Annual Plans, etc.).
- Standardize application of performance based contracts throughout each region.
- Apply consistent terminology and policy interpretations across all levels of the system (i.e. further define hospital unit terms to be applied consistently, further refine grant in aid funded service definitions for consistent application).

The lack of readily accessible information makes it difficult to track overall success related to number of people served, expenditures, and outcomes.

The state should consider production of an annual report that is widely distributed and summarizes the following:

- **Number of individuals served by age, race, location, service, and special population, etc.**
- **Utilization information by provider, summarizing units of services per consumer detailed by each service**
- **Expenditure data by state, region, and provider**
- **Hospital admissions by category, including length of stay data by hospital**
- **PERMES outcome data**
- **Consumer Satisfaction data**

STRUCTURE

- ❖ **The Structure of the Service Delivery System needs to reflect and be responsive to the Vision and Strategies.**

The state has demonstrated its commitment to recovery by establishing an office of consumer relations that has been instrumental in developing the Certified Peer Specialist workforce in Georgia. This is an example of a structural change resulting from evolving strategies. Similarly, if serving special populations (minorities, homeless, deaf, elderly, forensic, etc.) is a priority for the state, it could consider establishing an office of special populations or cultural competency charged with promoting cultural competency and workforce development as it relates to underserved populations throughout the state.

- The MHPAC could play an advisory role to this office.
- The state has made some movement in this area by establishing a committee, however additional emphasis could be placed on this important foundation to service provision in a diverse state such as Georgia.
- Goals of this initiative should include:

- Tracking and embracing the value of staff diversity to respond to consumer diversity.
- Overseeing establishment of a training curriculum to be adopted by providers that focuses and on special populations.
- Ensuring qualified professionals are available to provide culturally competent services to:
 - Bilingual consumers
 - Individuals who are deaf or hearing impaired
 - Youth
 - Elderly
- Additional options include the assurance that providers have adequate access to interpreting agencies, TTY line, or other resources need to serve special populations.

SYSTEMS

Policy Design

- ❖ **Policy development needs to reflect the target population, and support the goals and outcomes desired by the state and all of its stakeholders.**

The gap analysis found discrepancies between the scope of services, the extent to which services are being provided, and the intensity of treatments known to garner better and more long-term outcomes. In short, the state claims that Individual Community Support (CSI) is the “Hub of the wheel” in terms of service delivery; yet only 7% of people in need of services are receiving Individual Community Support.

Consequently, the state might revisit policies regarding service array and reformat policies to ensure those who receive services will get the services they need. Policies set in this direction and put into practice will further the state’s achievement of its desired outcomes. This may include enhancing provider incentives that, not only encourage evidence-based practices, but also focus resources in services with most successful outcomes. The majority of services provided by the public mental health system remain clinic-based, and perhaps there is a lag in effect of new policy implementation. However, if the state truly wants to change outcomes and provide more community based, innovative services, then policies must incentivise this shift.

- Introduce methodology to more successfully engage consumers in their individual recovery plan, especially those that are hard to reach or considered special populations such as homeless, minority populations, and individuals with co-occurring disorders.
- Utilize the Child and Adolescent Infrastructure Grant to enhance positive systems change, and create a truly seamless system of care for children and adolescents. The state should continue working to coordinate services across agencies and service systems

- Track treatment and costs across placements (DJJ, DFCS, DHR).
- Partner with education to provide outreach through schools.
- Support family centered treatment.
- Work with DFCS to increase availability of therapeutic foster care homes to avoid costly residential placement.
- Enhance data tracking mechanisms so that an individual is not lost when they enter another division within DHR.

❖ **The state should implement policies that facilitate continuity of care between community and hospital services.**

State Hospitals appear to fill the void of community-based crisis services, putting strain on an overcrowded hospital system. The state should consider creating a bridge of accountability for transitional services between the community and hospital (bridge would provide oversight, tracking, technical assistance, etc.) Tactical considerations could include:

- Developing a role for Certified Peer Specialists in hospital/community continuity of care.
- Development of a test pilot program for hospital/community staff who provide support in both settings.
- Creation of a single, centralized electronic recovery plan that follows the consumer into the community.
- Create a centralized utilization reporting system for each hospital that benchmarks length of stay by population and analyzes variances between hospitals and over time.

In order to improve any continuity of care between the hospital and community, it is imperative that a Single Point of Entry TRULY manages entry to and enrollment in the system in every region. The state should consider using objective entities to fulfill this role in every region.

In order to facilitate the more appropriate hospital admissions, the state should consider the following:

- Further develop crisis stabilization resources for equitable access across regions
- Further develop crisis stabilization protocol to enhance communications between community service providers, hospitals and regional staff to facilitate appropriate utilization of treatment services.
- Examine policies regarding treatment in the same crisis stabilization facility of those transitioning from hospital treatment to community, and those receiving crisis stabilization to prevent hospitalization.
- Consider additional policies that could reduce the ease with which hospital commitments can occur.

Technology

- ❖ **The state should proceed with development of a new information system that will collect comprehensive information on each consumer, no matter where they are being served.**

The fragmented infrastructure of the State's many offices involved in financing, accounting and information management does not support Division goals for measuring utilization, trending and planning for system needs. It is recommended that the following suggestions be considered for adoption:

- Develop a formal mechanism and process for consolidating and reconciling budget and expenditure reports from MEIRS, UAS, BAS, ROCS, OPB, and OBPS into one centralized report on a pre-determined schedule (semi-annually); assign single office of accountability. Ideally, consensus would achieve movement of responsibility to a single centralized source, or minimally, established paths for information flow of data to a single accountable source.
- Proceed with development of new electronic data system that enables enhanced interoffice and interagency connectivity for tracking consumers across systems and encounter data. The development of a new system would eventually support tracking of workforce productivity (linking consumers, their utilization and staff assigned to treat).
- Define how funding sources should be identified for tracking expenditures through MHMRIS system (if the Division will consider proceeding to modify the current system to track encounter data prior to implementing a new system).

Other system efficiencies and successful treatment outcomes could be realized with the use of technology. For examples:

- Research the possibilities of providing distance learning through available technologies to encourage continuing education of workforce.
- Test pilot a telehealth demonstration of providing treatment.

STAFF

- ❖ **In order to accurately measure service needs against available resources, capacity must be defined. The lack of measurable standards prohibits a true assessment of system capacity**
- Define Capacity of the Service System and Operationalize measures so it can be evaluated on an ongoing basis.
 - Develop standards for access to services, and availability of services.

- Recommend standards for expected productivity by professional mental healthcare workers and the agencies for which they work.
- Measuring capacity requires the following steps:
 - Service fidelity needs to be evident in that the requirements of a particular service reflect the definition of the service being measured, e.g. Individual Community Support may be implemented incorrectly in which case its measures would not reflect those of the true service definition
 - A direct contact hour standard needs to be set for staff, which would be based on the service, or category of service provided.
 - Once a number of direct contact hours are established, an analysis of each provider's service array needs to occur.
 - Capacity for a service or category of services would be defined as the number of qualified staff multiplied by their direct contact hours for each type or category of service.
 - A scatter plot map by specific service could be created by region or a table reflecting capacity of each county could be used to summarize capacity and compare to prevalence data.
 - Access measurement, which is a product of capacity, should reflect both *time* between first contact, diagnostic assessment, and initiation of service delivery and *distance* the consumer has to travel for services.
- ❖ The state mental health system should employ the right staff, with the right qualifications, for the right positions – everywhere from frontline workers to high-level administrators.

Based on current productivity and inequitable distribution of resources across the state, community provider staffing ratios are insufficient to meet the minimum need for services. When prevalence of needs is considered, the gap is even greater. The state and providers should consider the following suggestions for implementation with Georgia's system:

- Consider staff sharing agreements with other providers that might serve hard to reach populations: i.e. mobile crisis units, homeless/transition teams, etc. Other states have been successful in utilizing staff in both hospital and community settings (floaters).
- Promote wider usage of Certified Peer Specialists.
- Consider the benefits of promoting a range of acceptable staffing to consumer ratios on average and/or for different types of services, acuity, and service setting.
- Consider contract agreements that will require providers to report staffing levels (FTE and contract staff) by defined role and/or by licensure title. Minimally, ensure that the design of the new information system tracks staff-related data for every encounter (once encounter data is tracked either in MHMRIS and/or in the new information system).

- Consider adding more emphasis at all levels of the system to Cultural Competency and hiring staff that are representative of the diversifying state consumer pool.

SKILLS

- ❖ **The state mental health system should promote greater opportunities for its workforce to attain higher mental health certification and credentialing and enhance the ways in which such credentials can be exercised.**
 - The state mental health system could invest in the productivity and success of its workforce and subsequent quality outcomes through the provision of comprehensive training and certification programs.
 - Build on the Direct Support Training and customize an add-on curriculum component for mental health.
 - Continue to enhance training for Certified Peer Specialists.
 - Develop training and certification programs for all Mental Health Professionals.
 - Establish a collaborative effort with a university system or technical college to offer a training and certification process for psychosocial rehabilitation specialists.
 - Create a certification process for mental health service technicians and peer/parent advocates.
 - Establish a task force comprised of academicians, provider representatives, licensing board representatives and appropriate MHDDAD staff to consider the possibility of licensing, certification and standing for Bachelors of Social Work and Psychology, who would have been licensed in other states.
 - Explore more flexible reciprocity from other states and or countries for licensed professionals.
 - Revisit the alignment of staff credentials required to complete certain types of documentation and perform certain types of treatment that takes into account the best use of professionals' time.

REWARDS

Individuals associated with the public mental health system in Georgia are motivated by a number of external and intrinsic rewards. Such rewards are critical in keeping the right staff engaged in the right activities in the right place so that organizational objectives are attained. Both state policies and provider practices shape the reward system in Georgia. Thus the state should consider employing a system of rewards. Rewards may include: compensation, retirement benefits, recognition, professional development, flexible work schedule, helping others who are suffering, belonging in an environment with caring coworkers, etc.

- Consideration of strategies to make salaries and benefits (intrinsic and fringe) more competitive.
- Introduce Incentives that build quality and morale:
 - Entertain the award of continuing education credits, certification and standing for Bachelors of Social Work and Psychology, who would have been licensed in other states.
 - Consider a model such as the one promoted by DFCS where staff tuition is paid in return for commitment of years of service.
 - Mentoring has been successful in other states for decreasing turnover; it also builds loyalty among staff and when the Mentor receives recognition and compensation (intrinsic or monetary) it boosts morale.
 - Look at ways to offer more flexible work hours or to work from home.
 - Create opportunities for staff recognition within newsletters, employee of the month, etc.
- Learn from other states where productivity has been successfully tied to salary.
- Enhance retirement or 401k packages to attract and keep staff.
- Tie a portion of compensation to consumer progress or outcomes toward goals and satisfaction with services.

This Mental Health Gap Analysis conducted by APS Healthcare provides a foundation for system transformation. As the state of Georgia moves forward, it must do so with unwavering objectives that are based on consumer recovery, empowerment and independence. Strategies that include these goals should be articulated. The Structure of Public Mental Health services and the Systems (policies and technology) that provide guidance should all support these unified objectives. Finally, for Georgia's system to be successful, it needs to attract and retain the right Staff, equip them with the right Skills and provide them with the right Rewards to ensure the mission of the public health system is met. A breakdown in any one of these key components requires realignment so that the multiple entities that comprise the Public Mental Health system work in unison toward a common purpose.