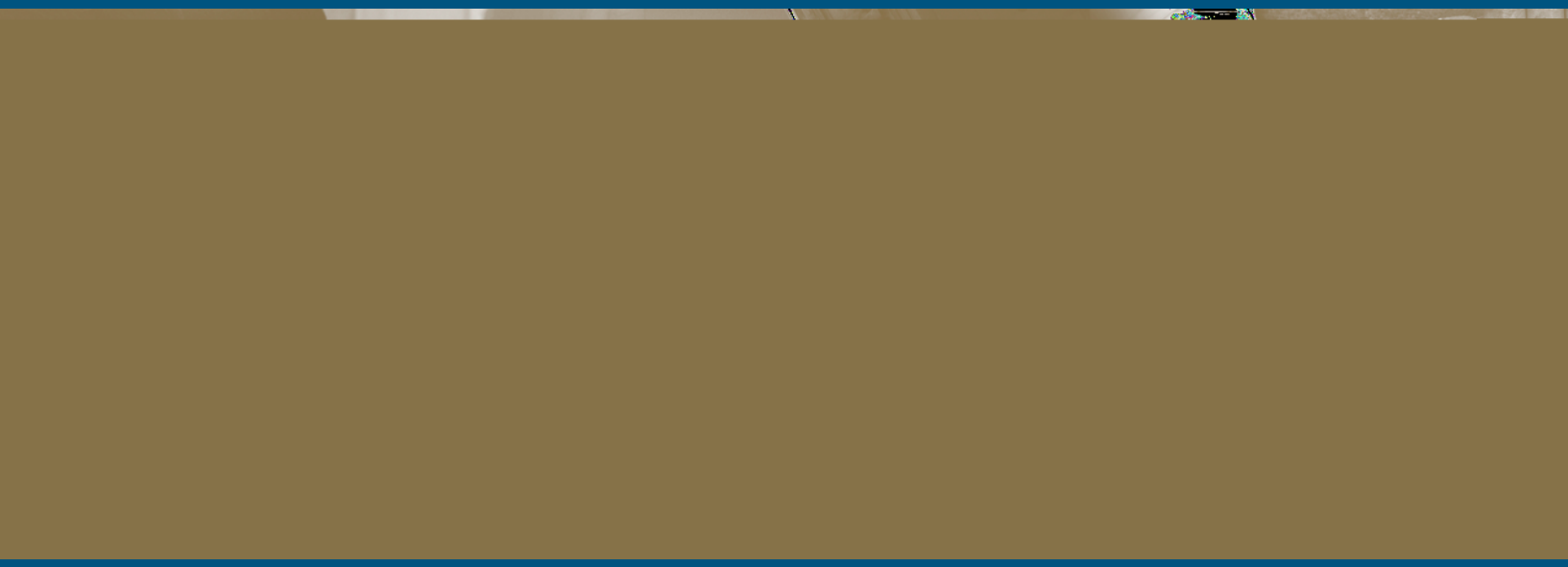
Georgia's Mental Health Gap Analysis: Building an Action Agenda



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

Currently, there are dozens of federal class-action lawsuits against state agencies for failure to meet the needs of our children. Mrs. Carter mentioned the wonderful report that APS Healthcare did, the Mental Hea

APS

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

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

One reason is that phy

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

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

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medication. We need to do a systematic assessment of the medications we use, assess benefits and risks in the community, and, again, pay particular attention to the issue I call “ethno-psychopharmacology.”

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

We have managed care in Georgia now, and managed care, in theory, is not necessarily a bad thing. Some of the risks to managed care in

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

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

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

I hope I have been able to tell you a little bit about what I believe is a good foundation for the future of systems of care UcZWdXGW-[DuP]au-[GWGáe[DdP]e

percent of consumers receiving mental health services were identified as Latino in fiscal year 2009.

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

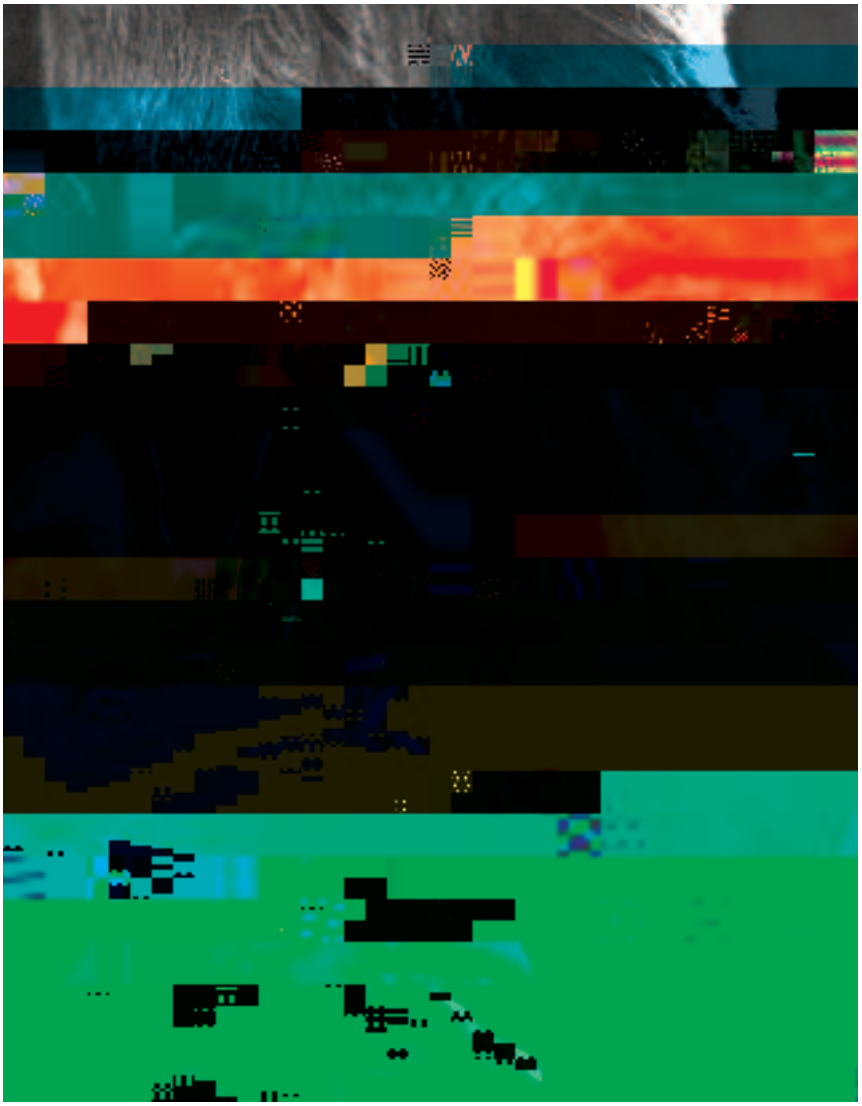
The prevalence rate for mental illnesses in Georgia is 6.7 percent. With adults, there is a somewhat lower rate at 6.43 percent. Approximately 94 percent of adults living with mental illness are living without much, if any, hope of having access to mental health services. This picture is even bleaker in special populations – for instance, the aging and Latinos. Fifteen to 20 percent of older adults in the United States live with a mental illness, yet the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Diseases provided services to less than 1 percent of the total population of adults over the age of 65. And only 2

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

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

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

We must come together as an advocacy community with a solid voice saying, "This can go on no longer." Human beings have the right to have access to quality, effective, recovery-based services in the communities of their choosing. We must challenge legislators to fund the services needed for those of us living with a mental illness to live full, productive, and contributing lives.



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

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

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

Q: Dr. [Patrice] Harris, yo[illegible]

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

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

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

Q: Ms. [Linda] Buckner, I would like to ask you about returning to work, if you can share with us whether you were on Social Security disability and

Panel Discussion

Elly

ne of the most exciting things I have the opportunity to do right now is work in seve

work force competencies and skills, (d) changing programs and service

Regarding transitioning kids: Yesterday I went to my staff and said, “Who wants to make a private arrangement with a 20-year-old, and who has a room they would be willing to rent until I can find appropriate placement?” When it comes to transitioning kids, we cannot get involved because they are 20. So we have to look at transitional services as children move in. We have to look at parity when we mean

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

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

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

When we have someone sent on a 1013 [involuntarily committed] to one of our state hospitals, these are the three t

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

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

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

Eventually, he went to a camp and managed to escape the second day. He walked eight miles to the interstate and hitchhiked home, so I took him back to the jail the next day, which was hard. He served the first part of his sentence, and the psychiatrist working with the jail was very helpful and said, "I think he needs to be in a safe place for a while." We worked it out that he would go to the forensic unit at Atlanta Regi

Today, Georgia ranks 43rd in per capita expenditures for mental health, a

To compound this, let's look at where we will be tomorrow. Georgia will be the eighth largest state in 2010 with a population of 9.2 mi[illegible]

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

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

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

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

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

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

Historically, our division has had a fair amount of trouble with that top layer, the breadth, and we have struggled with there being crevices and peaks and valleys in that top layer. We have not had consistency across the state in terms of access. So one of the things we are pleased about is

> that we have created the momentum over the past year or so to pull together funds and look at a statewide access center. A "single point of entry," as

Anna [McLaughlin] was reflecting, is more the term that we have all gotten used to using for an access center where we have a single phone number, a single entity that will help us begin to offer consistent and standard access to the people w oso

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

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

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

A: Wendy Tie

We thought that it would be nice to build a unified vision with a plan. We started by brainstorming what a good vision would include. Then we wanted to see if we could come up with something that could overarch all those statements. We want a vision statement such as: Create and contin-

Ron Koon: At the last Mental Health Planning and Advisory

sold the Legislature on the fact that the system was no good and we needed to fix it. Unfortunately, through the years since then, we have spent a lot of time analyzing how bad it is and what needs to be done. If we are to build an approach to advocacy for the future, I think it is time we begin to look at how organizations may be like individuals, that we may get further quicker if we use a wellness-OsP‡u-

About the Speakers

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