2009-2012

A Report of the Behavioral Health Coordinating Council

Submitted by:

Department of Behavioral Health & Developmental Disabilities

Frank W. Berry, Commissioner

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Report of the Behavioral Health Coordinating Council
January 2013

Background

In 2009, the 150th Georgia General Assembly established the Behavioral Health Coordinating Council (O.C.G.A. § 37-2-4) when it passed HB 228, which reorganized and reestablished Georgia's state health and human services agencies. HB 228 was signed by Governor Sonny Perdue and the act was effective on July 1, 2009. The Behavioral Health Coordinating Council is administratively attached to the Department of Behavioral Health and Developmental Disabilities as provided by O.C.G.A. § 50-4-3.

The Council convened for its first meeting on December 3, 2009 and has regularly consulted with various stakeholders around the state to understand the realities, needs and resources of/for individuals living with behavioral health challenges. For the purposes of the Council, "behavioral health" has the same meaning as "disability services" as defined in O.C.G.A. § 37-1-1. Disability services are therefore services to the disabled or services which are designed to prevent or ameliorate the effect of a disability (mental or emotional illness, developmental disability; or addictive disease).

Authority, Powers and Functions

The Behavioral Health Coordinating Council performs four categorical functions: it recommends, it sets goals, it monitors and evaluates, and it develops measures. The council is specifically tasked with developing solutions to the systemic barriers or problems to the delivery of behavioral health services by making recommendations that implement funding, policy changes, practice changes, and evaluation of specific goals designed to improve services delivery and outcome for individuals served by the various departments; focusing on specific goals designed to resolve issues for provision of behavioral health services that negatively impact individuals serviced by at least two departments; monitoring and evaluating the implementation of established goals; and establishing common outcome measures.

Council Composition

By statute, the BHCC is comprised of following persons:

- The Commissioner of Behavioral Health and Developmental Disabilities
- The Commissioner of Community Affairs (added by statute in 2010)
- The Commissioner of Community Health
- The Commissioner of Corrections
- The Commissioner of Human Services
- The Commissioner of Juvenile Justice
- The Commissioner of Labor (added by statute in 2010)
- The Commissioner of Public Health (added in 2011)
- The state School Superintendent (added by statute in 2010)
- The Chairperson of the state Board of Pardons and Paroles (added by statute in 2010)
- The Disabilities Services Ombudsman (added by statute in 2010)
- An adult consumer of public behavioral health services
- A family member of a consumer of public behavioral health services
- A parent of a child receiving public behavioral health services
- A member of the House of Representatives
- A member of the Senate

The various agency commissioners, the state school superintendent, the chairperson of the state board of pardons and paroles, and the ombudsman are members of the Council as a matter of law. The adult consumer of public behavioral health services; the family member of a consumer of public behavioral health services, and the parent of a child consumer of behavioral health services are appointed by the governor. Representative Katie Dempsey (13th) represents the House of Representatives as appointed by Speaker David Ralston and Senator Renee Unterman (45th) represents the Senate as appointed by Lieutenant Governor Casey Cagle. All members serve at the pleasure of their appointing authority with no term limit.

LEADERSHIP

The Council is led by an executive committee comprised of a chairperson, vice-chairperson, secretary and an executive committee. The Commissioner of Behavioral Health and Developmental Disabilities serves as the Chairperson of the Council. The Vice-Chairperson and Secretary of the Council are elected by and from the membership of the Council and serve two (2) year terms; they may succeed themselves. The chair, vice-chair and secretary, along with two (2) members appointed by the chair make up the five member executive committee. The most recent elections were held December 2012. The following individuals have shared in the Council's leadership since its inception.

History of Behavioral Health Coordinating Council Executive Committee

Year/Office	Chair	Vice-Chair	Secretary	Members-at-Large (2)
2009	**Frank E. Shelp, MD, MPH** DBHDD Commissioner	**Albert Murray** DJJ Commissioner	**BJ Walker** DHS Commissioner	N/A
2010	**Frank E. Shelp, MD, MPH** DBHDD Commissioner	**Brian Owens** DOC Commissioner	**BJ Walker** DHS Commissioner	**Clyde Reese** DHS Commissioner & **Brian Owens** DOC Commissioner
2011	**Frank E. Shelp, MD, MPH** DBHDD Commissioner	**Brian Owens** DOC Commissioner	**Clyde Reese** DHS Commissioner	**Amy Howell** DJJ Commissioner
2012	**Frank E. Shelp, MD, MPH** DBHDD Commissioner *(thru August)* ----------------------------- **Frank W. Berry** DBHDD Commissioner	**Brian Owens** DOC Commissioner	**Clyde Reese** DHS Commissioner	**Albert Murray** PAP Chairman & **Corinna Magelund** Ombudsman – Disability Services
2013	**Frank W. Berry** DBHDD Commissioner	**Clyde Reese** DHS Commissioner	**Corinna Magelund** Ombudsman - Disability Services	**Albert Murray** PAP Chairman & **Brian Owens** DOC Commissioner

From 2009 – 2011, the Council met bi-monthly. In late 2011, it chose to move to a quarterly meeting format. Meetings are open to the public and have been well attended by leaders from various sectors of the state's disabilities community. Those in attendance have benefited from the Council's collaborative discussions and planning. Meeting minutes and documentation are posted in accordance with the Open Meetings Act (O.C.G.A § 5-18-70 et. seq.) and can be found on the DBHDD website at http://dbhdd.georgia.gov/georgia-behavioral-health-coordinating-council.

Understanding the ongoing needs of those living with behavioral health challenges and the resources available to support them has been the primary focus of the Council since 2009. The Council has heard presentations and updates from several state agencies and a variety of community stakeholders including:

- **Department of Community Health** - electronic medical records, Medicaid pharmacy
- **Department of Behavioral Health and Developmental Disabilities** – agency legislation, DOJ Settlement Agreement and housing
- **Department of Transportation** - rural and health services transportation
- **Georgia National Guard** - behavioral health programs and initiatives for soldiers and their families
- **Department of Community Affairs** - housing supports for those living with serious and persistent mental illnesses [SPMI] as prioritized by the Olmstead/DOJ Settlements
- **National Alliance on Mental Illness** - Opening Doors to Recovery Project
- **Lutheran Social Services** -children transitioning from child-supporting systems into adult systems
- **Children's Freedom Initiative** - housing for children with disabilities
- **Holly Tree Services** -supportive alternative housing for those with behavioral health issue and past criminal involvement
- **RESPECT Institute of Georgia** - a personal story of recovery

In addition to learning about the needs of those living with behavioral health disabilities, the supports available to them, and the gaps in service delivery, coordination and resources, the Council has considered and discussed a range of issues to guide the prioritization of its efforts. Issues under consideration have included:

Transportation
Transportation is essential to service access and recovery. In areas outside of metropolitan cities, transportation continues to be a significant obstacle for individuals trying to access behavioral health services, housing and other community supports. The needs of consumers are likely to be more effectively addressed when state agencies collectively define and coordinate their transportation their initiatives and resources.

Children and Adolescents
A multi-agency leadership effort to design, manage, facilitate, and implement an integrated approach to a child and adolescent system of care is needed to support the developmental needs of Georgia's children. Shared funding and resources and informed policy and practice will help to create and sustain a responsive child and adolescent system. The current work of the Interagency Disciplinary Team (IDT) is addressing these challenges and has requested to partner with the Council.

Sharing of Health Information
Georgia's health and human service agencies and law enforcement agencies serve the same individuals. The appropriate sharing of health information between entities (physicians, health departments, prisons, jails, and community supervision) would benefit the individual as well as the service agencies. Shared health information fosters coordination, standards utilization, efficiency and cost saving measures.

Housing
Adequate housing is essential to recovery and living a meaning life in the community. The housing needs of individuals receiving behavioral health care and the availability of housing resources is of ongoing concern. Collective efforts to conduct inventories of the state's housing capacity (1915i waivers, TANF Stimulus, etc.) and developing strategies that can be successfully implemented will reduce the need for crisis intervention, enhance service coordination and benefit consumers of behavioral health services and their communities.

Funding
Georgia stands to improve its funding potential by the use of federal and state opportunities through the identification of duplicative and/or redundant services. The Council is in a position to advise on how to identify and access funding sources, improve coordination of services so that additional federal dollars can be used to help achieve Olmstead and DOJ compliance.

Partnerships
State bureaucracy can lead to silos of policy, practice and communication. The work of state agencies can be strengthened by identifying approaches and solutions that address inefficiencies, gaps, challenges and effectiveness in Georgia's health and human service delivery systems.

Workforce Development
Georgia has a shortage of licensed health professionals. The professional shortage is a challenge for the state's current and future health care delivery system. Georgia is at a critical juncture to determine its needs and to address its challenges. Agencies working together around training, professional development, recruitment and retention, increasing job satisfaction, and networking/coordination will help address the growing shortage and develop its workforce.

OUTCOMES AND RECOMMENDATIONS

Outcomes

1. Enhanced Council Governance –
   Amendments were made to the Council's by-laws in October 2010 and November 2011 to reflect its growth and development.

2. Enhanced Interagency Collaboration –
   The inception and work of the Council has enhanced interagency communication and relations. Synergy and shared interests have been created and identified through open discussions and dialogue between state agency heads and community stakeholders.

3. Identified Priority Areas –
   Three issues have been identified by the Council as focal points for 2013. The Council will begin addressing these shared priority areas in January 2013. Work towards these priorities will be accomplished through ad-hoc groups comprised of staff from the various Council agencies.
   - Sharing of health information
   - Partnerships
   - Workforce development

2013 Meeting Dates

The Behavioral Health Coordinating Council meets at the Department of Behavioral Health and Developmental Disabilities on the 24th Floor in the Board room unless otherwise noted. Meetings begin at 10:00 a.m.

* March 27, 2013
June 26, 2013
September 25, 2013
December 12, 2013 (tentative)

* To be held at the Georgia State Capitol, Room 216.

Contacts

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