Behavioral Health Coordinating Council Meeting

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

August 8, 2023

D·B·H·D·D

Agenda

Roll Call / Call to Order

Recovery Speaker

Action Items

BHCC Initiatives

- Mindworks Update
- SPMI Definition Committee
- MATCH

Maternal Mortality Report

- DPH Report Findings
- DBHDD Data Review
- North Georgia Pilot Update

Next Meeting Date

Roll Call

Chelsee Nabritt
Community Outreach Manager

Call to Order

Kevin Tanner
Commissioner

Action Items:

- May 11, 2023, Meeting Minutes

BHCC Initiatives

Mindworks Georgia

Renee Johnson, Executive Director, Mindworks GA
Center of Excellence for Children's Behavioral Health
August 8, 2023

Georgia Department of Behavioral Health
& Developmental Disabilities

Overview

Health Systems Coordination Project

SOC State Plan Implementation Highlights

Health System Coordination Project

Overview:

A coordinated and collaborative approach to analyze, recommend, and monitor meaningful solutions for complex. Youth.

Goals:

- Recommend solutions that address system gaps.
- Build shared accountability and transparency.
- Maximize limited resources.

Examples:

- Gaps in coverage
- Emergency Department Boarding
- Hoteling
- Out-of-home placements
- Single-case out of state agreements

Project Updates

Project Team

- Mindworks BH Mapping Workgroup Members
- Center of Excellence (COE)

In-Progress

- Developing a plan to map gaps in coverage geographically, including racial disparities.
- Conducting a scan or previously completed research and evaluation to leverage prior methods and information.
- Working with MATCH Team to reduce the duplication of efforts.

Challenges

- Ability to get identifiable DCH data.
- Reservations from other agencies to share data without the availability of Medicaid data.

Implementation Highlights

5.4 - Strategically increase the use of remote platforms within child-serving systems

- Telehealth workgroup is expanding upon the telehealth provider map to create a product showing telehealth utilization before and after the COVID-19 pandemic.

SOC Implementation Highlights

5.7 – Ensuring services are delivered based on culturally and linguistically appropriate standards

- The Cultural & Linguistic (C&L) Workgroup has developed a Train-the-Trainer (T3) series on delivering culturally responsive care for providers.
- Since March 2023, over 110 providers have been trained.
- 200+ providers are registered for upcoming training dates.

Implementation Highlights

5.8 Identify and promote strategies that support the recruitment and retention of clinical staff to address workforce shortages, especially in rural areas.

- The workgroup is creating a behavioral health workforce factsheet that highlights accomplishments over the past few years, touches on challenges like provider turnover and reimbursement rates, and offers recommendations that support the workforce.

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Michael Smith, LCSW, MBA, MHA

Director, Behavioral Health, Medical Assistance Plans
Department of Community Health

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SPMI Definition Committee

To identify a common language and agreeable definitions able to be used across agencies for the following:

- Serious and Persistent Mental Illness
- Homelessness
- Recidivism

Interagency Committee Members

DJJ: Dr. Christine Doyle; ChristineDoyle@djj.state.ga.us

GDC: Randy Sauls; randy.sauls@gdc.ga.gov

DHS: Brian Pettersson; brian.pettersson@dhs.ga.gov

DCA: Libby Tyre; libby.tyre@dca.ga.gov

DCH: Michael Smith; michael.smith4@dch.ga.gov

DPH: Liz Head; Elizabeth.Head@dph.ga.gov

DBHDD: Brenda Cibulas; brenda.cibulas@dbhdd.ga.gov

Current Working Process

- Submission and review of agency definitions
- Committee research on definitions for consideration
- Identification of process for review within committee
- Using clear basic definition with complexity achieved through special considerations by population
- **Working definitions** are currently under review within original committee (enclosed)
- Once internal agreement, plan to distribute to sample of stakeholders for input
- Internal consideration for modification
- Determine process for adoption

Working Definitions in Process-Review at Committee Level

Serious and Persistent Mental Illness:

- Persons, age 18 and over, 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, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. (SAMHSA)

- SMI may also include co-occurring substance use disorders.
  (SAMHSA Forensic Assertive Community Treatment/eligibility criteria)

“Children with a serious emotional disturbance” as 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 that resulted in functional impairment which substantially interferes with or limits the child’s role or functioning in family, school, or community activities.

“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 skills. (SAMHSA)

Severe persistent mental illnesses (SPMIs) are those that are prolonged and recurrent, impair activities of daily living, and require long-term treatment. (National Institute of Health-NIH)

Recidivism

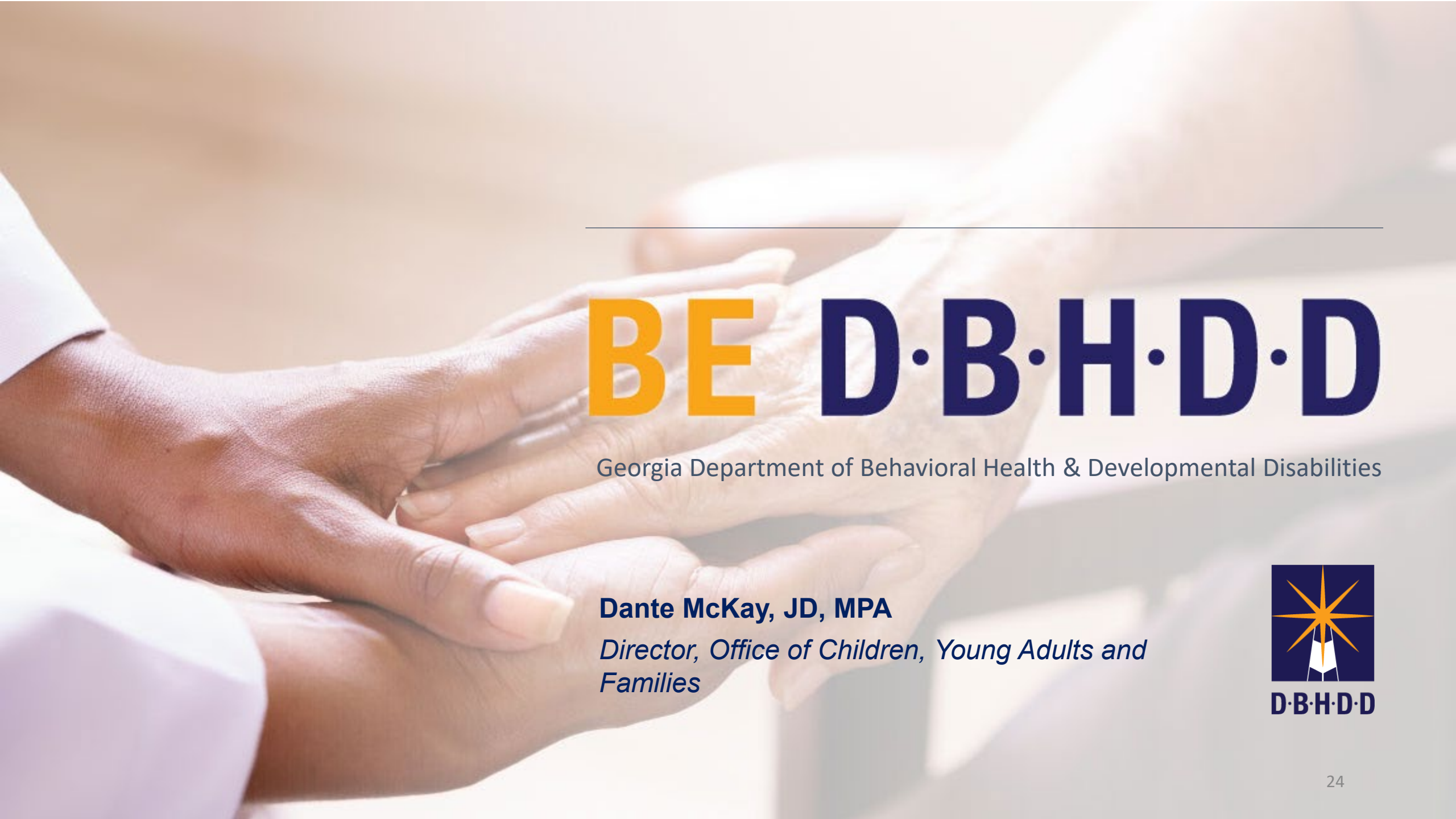
Repetition of criminal justice involvement by a person with previous criminal conviction.

(SAMHSA Forensic Assertive Community Treatment/eligibility criteria)

Homelessness or Unhoused

Homeless individual means a person who has no access to or can reasonably be expected not to have access to either traditional or permanent housing which can be considered safe, sanitary, decent and affordable.
(GA SB 62)

(How to add 'housing insecurity'-maybe add the word 'secure' to be final word)



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Dante McKay, JD, MPA

Director, Office of Children, Young Adults and Families

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Multi-Agency Treatment for Children (MATCH)

Recap: MATCH Legislation (House Bill 1013)

- *Shall **facilitate collaboration across state agencies** to **explore resources and solutions** for complex and unmet treatment needs for children in this state and to **provide for solutions**, including both public and private providers, as necessary.*

- *Will **accept referrals** from local interagency children's committees throughout Georgia for children with complex treatment needs not met through the resources of their local community and custodians.*

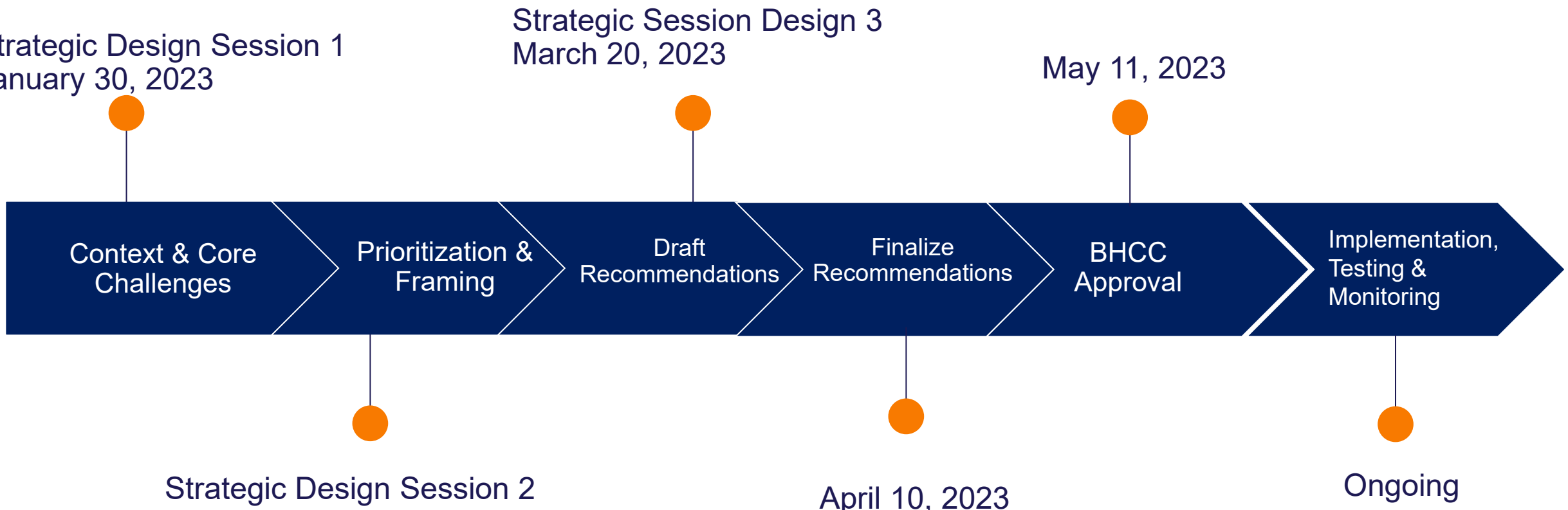
- *The state agencies and entities represented **shall coordinate** with each other and **take all reasonable steps necessary** to provide for collaboration and coordination to facilitate the purpose of MATCH.*

Recap: MATCH Committee

- Mandated committee members:
  - Division of Family and Children Services of the Department of Human Services (DFCS)
  - Department of Juvenile Justice (DJJ)
  - Department of Early Care and Learning (DECAL)
  - Department of Public Health (DPH)
  - Department of Community Health (DCH)
  - Department of Education (GaDOE)
  - Office of the Child Advocate (OCA)
  - Department of Corrections (DOC)

- DBHDD Commissioner, as chairman of the BHCC, can serve as MATCH chairman or appoint a designee
  - Barbara (Bobbi) Cleveland, former Executive Director of the Tull Foundation, appointed as chairwoman

Recap: MATCH Design



Recap: MATCH Vision

Georgia's children and youth with complex behavioral health challenges, and their families, will receive the services and supports **when, where and how they need them**, with attention to cultural and linguistic needs.

When this occurs, Georgia will see a **sharp reduction** in the number of children and youth with complex behavioral health needs that require state-level attention.

(The children and youth to be served by MATCH are those with a serious mental illness who receive SSI Medicaid, CMO Medicaid or who are uninsured. Per SAMSHA, for people under the age of 18, the term "Serious Emotional Disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.)

Recap: MATCH Vision Continued

- MATCH must have **access to a pool of available funds** to enable the provision of treatment services in a timely manner for children and youth with complex treatment needs that are not met at the local level.
- MATCH must have **designated authority to make temporary exceptions** to those identified state policies and regulations that create barriers to accessing the most appropriate treatment options for children and youth with complex treatment needs that are not met at the local level.
- **Ongoing documentation** is essential of those state policies and regulations that are found to create barriers to needed treatment options in order that exceptions to these policies and regulations do not become the default solution to accessing treatment needs vs. the implementation of system change.
- Adequate investment in the MATCH **infrastructure (staff and technology)** is essential in order for MATCH to fulfill its mandate.
- MATCH structure and process must be tested using **pilot projects** prior to full roll-out.
- The **voices** of all key state and local stakeholders must be incorporated into the design of MATCH for it to succeed.
- The design of MATCH must **avoid creating an alternate or additional bureaucracy**.

Recap: MATCH Implementation

Phase I
State-level MATCH Infrastructure

- Behavioral Health Coordinating Council
- State MATCH Team
- State MATCH Clinical Team

Phase II
Pathway to Care

O.C.G.A. § 49-5-225
Local Interagency Planning Teams (LIPTs)
Mandated members:

- Community mental health agency
- Division of Family & Children Services
- Department of Juvenile Justice
- Department of Public Health
- Local Education Agency
- Georgia Vocational Rehabilitation Agency

MATCH Implementation - State MATCH Clinical Team

Vision > Designated authority to make temporary exceptions.

Standing Members

- DBHDD (BH) - Heather Stanley, Chair
- DBHDD (BH) - Danielle Fish
- DBHDD (IDD) - Tawanda Scales
- DCH - Michael Smith
- DJJ - Dr. Christy Doyle
- DFCS - Audrey Brennen
- GaDOE (State RESA) - Matthew Cardoza
- F.A.V.O.R. - Carmen Coates
- Center of Excellence for Children's Behavioral Health, Georgia State University - Ursula Davis

Ad Hoc Members

- Care Management Entities
  - Aspire - Meranda Bice
  - Bridge Health - Kevin Godfrey
  - CSB of Middle Georgia - Meredith Conner
  - View Point Health - April Befort

State MATCH Clinical Team - Guiding Principles

Guiding Principles

- All MATCH eligible children/youth get their needs met;
- The right time, right place, for the correct length of treatment;
- No wrong door to access services;
- Services/supports should occur in the least restrictive setting that is safe; and
- Rapid response to children and youth in need.

State MATCH Clinical Team - Eligibility Criteria

Age 17 or younger

Co-occurring diagnosis - serious emotional disturbance, intellectual/developmental disability, Autism Spectrum Disorder (any combination of these would qualify a youth)

Public multi-system involvement (2 or more)

- DFCS
- DJJ
- Special education services in local school
- Intensive community services with Tier 1 or Tier 2/2+ providers

Multiple re-admissions in the past (must meet 1 of the options below)

- 2 in the past month
- 4 in a quarter
- More than 3 in a calendar year

State MATCH Clinical Team - Review Criteria Continued

No housing options to meet youth's needs:
(must meet 1 of the options below)

- Boarding in the emergency department - demonstrated by youth being assessed, 1013'd placed on bed board more than three days
- Inability to pick up from emergency department (ED) - parental, custody agency, no safe place for youth to be placed upon discharge

Challenging discharge planning history resulting in readmissions to ED/crisis stabilization units evidenced by:

- Lack of engagement post discharge -
  - Parental, youth, and/or appropriate services available
- Disruptions to community services, family, and/or school
  - Lack of services to address youth's needs in their community
  - Lack of access to the appropriate level of services to support community placement
- Discharge planning recommendations not available in local communities

MATCH Implementation

Vision > Ongoing Documentation

- After Action Report (Web based)

Vision > Infrastructure (Staff and Technology)

- Staff
  - Heather Stanley, MATCH Program Director
  - Danielle Fish, MATCH Clinical Specialist
- Technology
  - Exploring care coordination and case management IT solutions

Proposal to Fill Gaps for Complex Needs

Urgent Care Coordination

MATCH facilitates collaboration across agencies, programs, and/or interventions, to explore solutions for complex and unmet treatment needs for children.

This pilot will address gaps within the current service system.

MATCH Implementation: Vision > Test Pilot Projects

Devereux Transitional Home Pilot

This pilot will serve males between the ages of 18 and 21 with a diagnosis of an intellectual disability with concurrent serious behavioral and psychiatric concerns and/or Autism Spectrum Disorder.

Treatment goals include:

- increase communication and activities of daily living skills;
- reduce/eliminate/stabilize psychiatric and behavioral concerns; and
- prepare for transition to the community with waiver services and supports.

MATCH Implementation: Vision > Test Pilot Projects

View Point Health Emergency Department Pilot

This pilot will embed care coordinators within three Children's Healthcare of Atlanta emergency departments (ED) to reduce youth spending excessive length of times in EDs.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Maternal Mortality Report

MMRC Report 2018-2020

Behavioral Health Coordinating Council/ Katie Kopp, MPH & Courtney Daniels, LCSW/ August 8, 2023

The Role of the MMRC

	CDC – National Center for Health Statistics (NCHS)	CDC – Pregnancy Mortality Surveillance System (PMSS)	Maternal Mortality Review Committees
Data Source	Death certificates	Death certificates linked to fetal death and birth certificates	Death certificates linked to **fetal death and birth certificates, medical records, social service records, autopsy, informant interviews…**
Time Frame	During pregnancy – 42 days	During pregnancy – 365 days	During pregnancy – 365 days
Source of Classification	ICD-10 codes	Medical epidemiologists (PMSS-MM)	**Multidisciplinary committees**
Purpose	Show national trends and provide a basis for international comparison	Analyze clinical factors associated with deaths, publish information that may lead to prevention strategies	**Understand medical and non-medical contributors to deaths, prioritize interventions that effectively reduce maternal deaths**

Source: St Pierre A, Zaharatos .J., Goodman D, Callaghan W.M., Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. Obstetrics & Gynecology, 2018. 131(1): p. 138-142.

MMRC Overview and Review Process

Process Changes

- Greater diversity of disciplines represented on committee.
- DPH began to conduct informant interviews in the middle of 2017 case review.
    - Interviews give the committee more information to enable them to determine pregnancy-relatedness.

Informant Interviews

Purpose:

- To increase knowledge about the deceased person's life, including social determinants of health, her feelings and perceptions, and her experiences with healthcare and community resources.
- To facilitate a more comprehensive maternal mortality case review with enhanced understanding of contributing factors and more effective recommendations for prevention.

In some cases, "interviews provide insight that substantially shifts the conversation of the committee and has direct bearing on decisions".

~ MMRC Committee Member

Value of Interviews in Mental Health Related Deaths

Filling information and gaps in records	Capturing the decedent's feelings and experiences	Enhancing recommendations
Informants can provide the names of mental health providers or agencies where services were received. This facilities request and receipt of missing records and a more comprehensive MMRC case review.	Informants speak directly about the decedent's thoughts and feelings prior to, during, or after pregnancy. Knowledge of specific statements or actions of a decedent can assist the MMRC in determining whether the death was pregnancy related.	Informants provide details on contributing factors and the chain of events leading up to a death. Based on lived experience, they share what would have been helpful in preventing their loved one's death or in preventing future deaths.

Informant Feedback

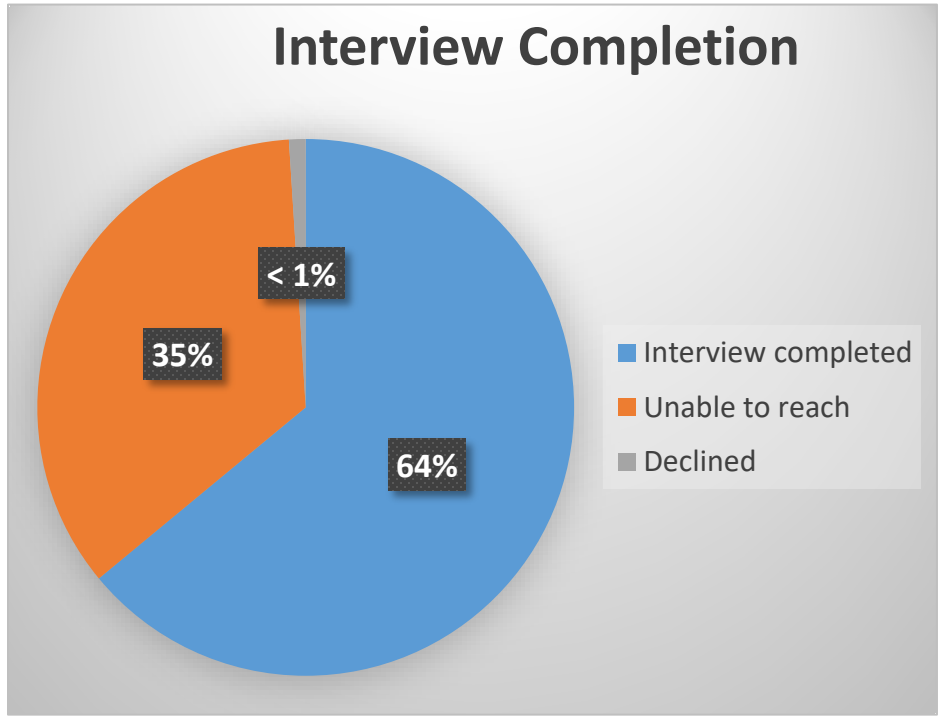
"I can't even explain the happiness I felt when I received your letter and call. To finally know that even one person cares means so much."

"I want to tell you how much I appreciate being able to have this conversation. On behalf of my whole family, it's important for us to know that Georgia really does care."

"I am grateful for the opportunity to share her story if it can help other women and save lives."

- Honors their loved one
- Instills a sense of purpose in their loss
- Empowers families
- Educates families and communities on maternal mortality
- Provides linkage to needed community resources

Informant Interviews August 2020 – August 2023



- Keys to success include culturally sensitive outreach and use of translation services, dedicated LCSW trained in motivational interviewing, trauma, grief and bereavement, and maternal mental health
- Incorrect contact information is the main barrier to success
- Declines are most often due to family's involvement legal proceedings

Pregnancy-Related Deaths by Year of Death

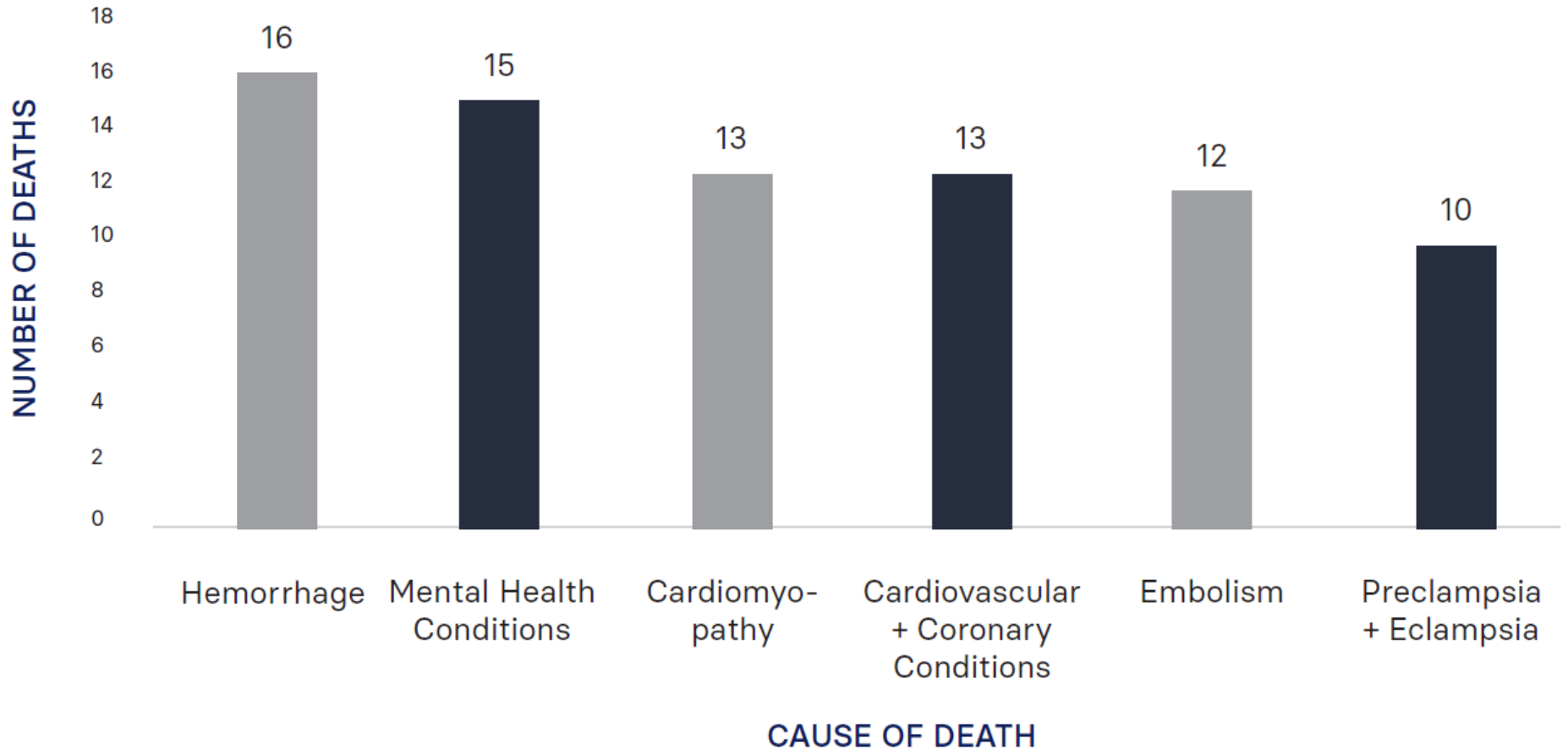
The MMRC uses the question, "If she had not been pregnant, would she have died?" to determine whether the death was pregnancy-related.

YEARS	FREQUENCY	LIVE BIRTHS	RATIO*
2012-2014	101	389399	25.9
2015-2017	98	390431	25.1
2018-2020	113	374680	30.2

*Deaths per 100,000 Live Births

Due to changes in the review process, years are not comparable.

Leading Causes of Pregnancy-Related Deaths, Georgia, 2018-2020 (n=79)



Leading Causes of Pregnancy-Related Deaths by Race, Georgia, 2018-2020

Non-Hispanic, Black

Cause of Death	Number (%)
Cardiomyopathy	10 (16%)
Embolism	9 (14%)
Cardiovascular and Coronary Conditions	8 (13%)
Preeclampsia and Eclampsia	8 (13%)
Hemorrhage	7 (11%)

Non-Hispanic, White

Cause of Death	Number (%)
Mental Health Conditions	10 (27%)
Hemorrhage	8 (22%)
Cardiovascular and Coronary Conditions	4 (11%)
Cardiomyopathy	3 (8%)
Embolism	3 (8%)

Criteria for Pregnancy-Relatedness

- Pregnancy complications
  - Increase in pain directly attributable to pregnancy (e.g. cesarean incision) leading to use of drugs implicated in death
- Chain of events initiated by pregnancy
  - Postpartum depression, anxiety, or psychosis resulting in destabilization and self-harm
  - Recovery achieved during pregnancy or postpartum with clear statement that pregnancy was motivating factor with subsequent relapse/overdose due to decreased tolerance
- Aggravation of an unrelated condition by the physiologic effects of pregnancy
  - Worsening of underlying depression, anxiety, or other psychiatric condition in pregnancy or postpartum

Pregnancy-Related Deaths Due to Mental Health Conditions

- Mental health conditions are the underlying cause of death; the manner of death is either suicide or accident.
- Suicide was the manner of death for a majority (11;73%) of deaths due to mental health conditions.

Preventability and Timing of Death

- A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system, and/or community factors.
- Between 2018-2020, 100% of pregnancy-related deaths due to mental health conditions had at least some chance of being prevented.
- A majority (13;87%) of deaths due to mental health conditions occurred in the postpartum period.

Contributing Factors for Pregnancy-Related Deaths

- Mental health conditions, other than substance use disorder, contributed to 20 (18%) pregnancy-related deaths
    - Example: Mental health conditions made it difficult for individual to adhere to plan of care for chronic conditions
- Substance use disorder contributed to 14 (13%) pregnancy-related deaths
    - Example: Substance use disorder exacerbated cardiac conditions

Contributing Factors for Mental Health Deaths

- Case management services not adequately provided
- Inadequate social support during the perinatal period
- Lack of knowledge of safety of psychotropic medications during pregnancy
- Lack of care coordination
- Lack of outreach to community resources
- Patients declined referrals to mental health care
- Standardized assessment tool for depression and suicide not used
- Histories of trauma, abuse, and social stressors
- Families did not know how to recognize signs of depression or risk of suicide

Recommendations for Mental Health Deaths

- Insurers should offer case management during pregnancy and postpartum
- Communities should offer peer support groups / Providers should refer patients
- Georgia should increase access to mental health care
- Hospitals and providers should refer patients with pregnancy loss to grief therapy and conduct close follow-up
- Providers should consult with PEACE for Moms to manage mental health conditions
- Providers should refer patients to treatment
- Providers should conduct a suicide risk assessment and use validated screening tools
- Providers should develop safety plans with individuals and families
- Communities should offer education
- Providers should follow patients up to one year postpartum
- Providers should include family and support system in care plans

Findings on 2018-2019 Pregnancy-Associated Deaths

Mental Health and Substance Use Treatment

- Most individuals received some mental health treatment over the life course.
- Individuals received various types of mental health treatment, including prescription medications, outpatient therapy, and inpatient hospitalizations.
- Some individuals experienced challenges with mental health treatment adherence.
- Some individuals with mental health symptoms did not receive mental health treatment.
- Only some individuals had evidence of any substance use treatment.
- Substance use treatment was described as insufficient and relatedly unsuccessful for some individuals.

Findings on 2018-2019 Pregnancy-Associated Deaths, continued

- Health Care Utilization
- There was little evidence of mental health screening during the prenatal period.
- Most individuals with postpartum care had a documented mental health screening during postpartum care for the sentinel pregnancy.
- ED visits occurred during and after pregnancy but were more common during the prenatal period.
- Individuals with no record of prenatal care utilized the ED.
- Mental health and substance use were not the primary reasons for most ED visits.
- Mental health screenings or consults occurred during ED visits for more than half of individuals but were frequently negative.

Findings on 2018-2019 Pregnancy-Associated Deaths, continued

Health Care Barriers (Financial, Structural, Cognitive)

- Cost was a financial barrier to individuals in need of health care during the perinatal period, particularly mental health and substance use treatment.
- A lack of health insurance was a financial barrier to individuals in need of mental health or substance use treatment.
- Inadequate health insurance was another financial barrier some individuals faced.
- Individuals faced geographic barriers to care due to either their location to a provider or because they moved.
- Individuals faced additional structural barriers to health care due either to delays in getting insurance or due to limitations of treatment providers.

PEACE for Moms

- Perinatal Psychiatry, Education and Community Engagement (PEACE) for Moms
- OB provider training, phone consultations, face-to-face assessments, and treatment consultation
- Skills groups to prevent perinatal depression
- 351 prescribing providers are enrolled

https://www.peace4momsga.org/

Other Mental Health Programs

- Postpartum Support International, Georgia Chapter (PSI-GA)
  - PSI-GA provides perinatal mental health certificate training
  - DPH has contracted with PSI-GA to train 350 providers in 3 years
- Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBGA)
  - Provide virtual peer support groups
  - Online education courses for the community on maternal mental health and maternal substance use

Questions?

For more information, please contact:

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Mental Health Need and Services for Pregnant/Post-Partum Women

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Roadmap

Estimating Mental Health Need Among Pregnant Women

Current Use of DBHDD-Funded Services Among Pregnant Women

Lingering Questions to measure need

Next Steps and Additional Questions

Discussion and Questions

Estimating Need

Data Sources Used

- Department of Public Health OASIS – Live Births
- Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System Prevalence Indicators
  - "Self-Reported Post-Partum Depressive Symptoms," Prevalence estimates, 2018-2020
  - "Health Insurance for Prenatal Care," Prevalence Estimates 2018-2020

Estimated Number of Women with Post-Partum Mental Health Need by DBHDD Region

DBHDD Region	Estimated # Women with Post-Partum MH Need			
	2018	2019	2020	Total
Region 3	5,493	5,823	5,175	16,492
Region 1	4,254	4,524	4,108	12,886
Region 6	2,255	2,439	2,181	6,875
Region 2	2,149	2,279	2,048	6,477
Region 5	1,961	2,123	1,890	5,974
Region 4	1,030	1,117	997	3,145
Grand Total	17,143	18,306	16,399	51,848

Estimated Number of **Uninsured** Women with Post-Partum Mental Health Need by DBHDD Region

DBHDD Region	Estimated # Uninsured Women with Post-Partum MH Need			
	2018	2019	2020	3-Year Total
Region 3	1,450	1,351	885	3,686
Region 1	1,123	1,050	702	2,875
Region 6	595	566	373	1,534
Region 2	567	529	350	1,446
Region 5	518	493	323	1,333
Region 4	272	259	171	702
Grand Total	4,526	4,247	2,804	11,577

Areas with high maternal mortality rates and high mental health need rates are highlighted in **Violet**

Orange fill represents high mental health needs rates, but low rates of maternal mortality, or regions where the number of deaths reported was fewer than 5.

Estimated 3-Year Post-Partum Mental Health Need Rate

DPH Region Name	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Albany				59		
Athens		49				
Augusta		59				
Clayton			59			
Coastal					61	
Cobb & Douglas	49					
Columbus						60
DeKalb			59			
Dublin					55	
Fulton			46			
Gainesville	50					
GNR/Lawrenceville			51			
LaGrange						49
North Central/Macon		54				56
North Georgia	51					
Rome	53					
Valdosta				60		
Waycross					59	
Regional Mental Health Need Rate	51	54	52	59	60	53

Current DBHDD-Funded Service Use Among Pregnant Women

DBHDD Administrative Services Organization Authorizations Data (2020-2022)

Number of Pregnant Women Served by Year (Distinct Count)

Level of Service	2020	2021	2022	Grand Total	Percent Total
CSU/Community Inpatient	45	40	51	135	7%
Outpatient	946	538	541	1867	94%
Grand Total	985	575	588	1989	100%

Overall, 34% of pregnant women served had Medicaid coverage – of which 93% had Medicaid fee for service. The other 7% had managed care coverage.*

DBHDD Region	Have Medicaid Coverage	State-Funded	Grand Total	Medicaid Percent by Region
Region 4	67	96	162	41%
Region 3	222	325	538	41%
Region 5	82	159	228	36%
Region 2	86	181	257	33%
Region 6	89	194	276	32%
Region 1	120	383	494	24%
Unknown	4	31	34	12%
Grand Total	670	1369	1989	34%

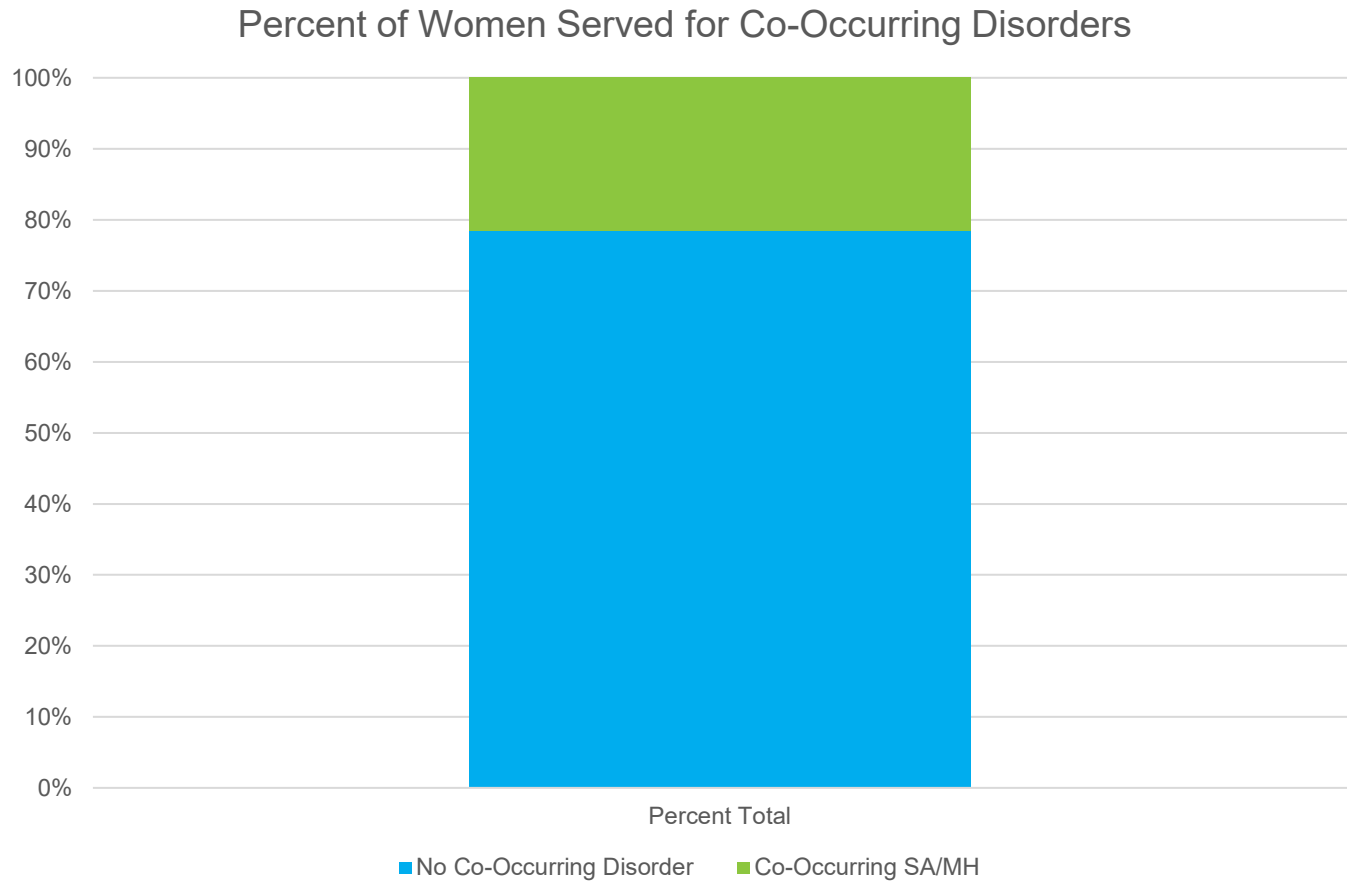
Major Depressive Disorder is the number 1 single diagnosis for which pregnant women were served

However, 30% of pregnant women served were treated for a substance use disorder

61% of women served had multiple diagnoses

Diagnosis Category	2020	2021	2022	Grand Total	Percent Total
Major Depressive Disorder	205	119	124	428	22%
Bipolar I or II	200	103	109	372	19%
Stimulant Abuse/Dependence	96	72	79	236	12%
Schizoaffective Disorder	96	43	49	175	9%
Opioid Abuse/Dependence	64	54	45	156	8%
Other Mental Illnesses	74	33	43	141	7%
Post-traumatic stress disorder	56	30	27	100	5%
Anxiety Disorders	47	24	33	99	5%
Schizophrenia	40	23	24	80	4%
Cannabis Abuse/Dependence	40	26	10	72	4%
Cocaine Abuse/Dependence	34	13	13	57	3%
Alcohol Abuse/Dependence	26	13	21	54	3%
Adjustment disorders	22	19	13	52	3%
Other psychotic Disorders	17	10	12	37	2%
Other Substance Use Disorders	6	11	1	18	1%
Grand Total	985	575	588	1989	100%

Approximately 1 in 5 pregnant women served had a co-occurring mental health and substance use disorder



Number of pregnant women served in DBHDD-funded services from 2020-2022, by DPH District and DBHDD Region.

DPH District	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Unknown	Grand Total	Percent Total
Fulton			228					228	11%
Rome	176							176	9%
LaGrange						160		160	8%
DeKalb			154					154	8%
Cobb & Douglas	146							146	7%
GNR/Lawrenceville			102				34	136	7%
North Central/Macon		85				30		115	6%
Albany				113				113	6%
Waycross					113			113	6%
Athens		101						101	5%
Gainesville	99							99	5%
Coastal					93			93	5%
Columbus						86		86	4%
North Georgia	73	5						78	4%
Augusta		66						66	3%
Clayton			54					54	3%
Valdosta				49				49	2%
Dublin					22			22	1%
Grand Total	494	257	538	162	228	276	34	1989	100%

Lingering Questions to Measure Need

Additional Questions of Need

Estimating need for substance use treatment beyond alcohol and cigarette use

Estimating need mental health beyond post-partum depression

Understanding service engagement in current service landscape

Understanding barriers to engagement with current services and specific needs of pregnant/post-partum women

Direct measure of “Post-Partum” in DBHDD Service Data?

What types of tailored services do we need to have for pregnant/post-partum women who have serious mental illness, without substance abuse disorder?

Closing Comments

Next BHCC Meeting:

November 9, 2023

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

D·B·H·D·D