2013

A Report of the Behavioral Health Coordinating Council

Submitted by:

Georgia Department of Behavioral Health & Developmental Disabilities

Frank W. Berry, Commissioner

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REPORT OF THE BEHAVIORAL HEALTH COORDINATING COUNCIL
MARCH 2014

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 went into effect 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.

AUTHORITY, POWERS AND FUNCTIONS

The Behavioral Health Coordinating Council (the "Council") performs four categorical functions: it makes recommendations, sets goals, monitors and evaluates, and develops measures. The council is specifically tasked with:

- ***Developing solutions*** to systemic barriers to or problems with the delivery of behavioral health services by making recommendations that implement funding, policy and practice changes, and evaluation of specific goals designed to improve service delivery and outcomes for individuals served by the various state agencies;
- ***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 Council is comprised of following persons:

- The Commissioner of Behavioral Health and Developmental Disabilities
- The Commissioner of Community Affairs
- The Commissioner of Community Health
- The Commissioner of Corrections
- The Commissioner of Human Services
- The Commissioner of Juvenile Justice
- The Commissioner of Labor
- The Commissioner of Public Health
- The State School Superintendent
- The Chair of the State Board of Pardons and Paroles
- The Disabilities Services Ombudsman
- 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 Georgia House of Representatives
- A member of the Georgia State Senate

The various agency commissioners, the state school superintendent, the chair 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 and was 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 chair, vice-chair, secretary, and two members-at-large. The Commissioner of the Department of Behavioral Health and Developmental Disabilities (DBHDD) serves as the chair of the executive committee. The vice-chair and secretary are elected by and by the members of the Council and serve two-year terms; they may succeed themselves. The chair, vice-chair and secretary, and two members appointed by the chair make up the five-member executive committee.

Council Initiatives

The Council maintained a quarterly meeting schedule in 2013. Meetings were open to the public and well attended by a variety of stakeholders. Meeting minutes and supporting 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.

Interagency Directors Team (IDT)

A multi-agency leadership effort to design, manage, facilitate, and implement an integrated approach to a child and adolescent system of care is necessary 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.

Transition Care Workgroup

Co-Chairs

Jay Neal, Director, Governor's Office of Transition, Support and Reentry
Terri Timberlake, Ph.D., Director, Georgia Department of Behavioral Health and Developmental Disabilities, Office of Adult Mental Health

The Transition Care Workgroup is charged with exploring interagency barriers and developing a plan to coordinate services between agencies to better facilitate access to community mental health services and supports for individuals transitioning from the correctional system into the community. The workgroup initially convened in May 2013 and has held 14 meetings.

Committee Representation

Governor's Office of Transition, Support and Reentry
Georgia Department of Behavioral Health and Developmental Disabilities:
 Division of Developmental Disabilities
 Division of Mental Health: Office of Forensic Services; Jail Diversion and Trauma Recovery; Adult Mental Health; Child and Adolescent Mental Health
Georgia Department of Community Affairs
Georgia Department of Community Health
Georgia Department of Corrections
Georgia Department of Juvenile Justice
Georgia Department of Veteran Services
Georgia Vocational Rehabilitation Agency
State Board of Pardons and Paroles
City Of Atlanta Solicitor's Office
Emory University Fuqua Center for Late-Life Depression

Accomplishments

- Each partnering agency within the correctional system (i.e. Department of Corrections, Department of Juvenile Justice, Board of Pardons and Paroles) has educated other members of the workgroup on its processes for diagnosis, treatment, pre-release planning and discharge.
- Identified barriers to successful transition into society
- Developed recommendations to address top four priority barriers as identified by the workgroup.

- The Aging & Disability Resource Connection gave a presentation on how to use its website (www.georgiaadrc.com) to members of the workgroup; the presentation included information on searching for and accessing information, and how to find available services.
- Established process for monthly data sharing between state agencies on total population of incarcerated individuals who have mental health problems

Barriers and systemic challenges

The workgroup identified eight categories of barriers.

1. Lack of mental health services in rural areas; linking consumers with appropriate aftercare is a challenge, particularly for those consumers who have dual diagnoses.
2. Lack of cultural competency with trauma-informed care
3. Awareness and access to information; training is needed to help ensure that the Department of Corrections planning staff are aware of services available during the pre-release and reentry process.
4. Access to medication; difficulty obtaining prescriptions and doctor's appointments because services are not readily accessible to the reentry population
5. Lack of housing; the issue is further complicated for people with a history of substance abuse and sexual offense because many housing providers are not willing to accept them; need for more specialized placement and use of Transitional Housing for Offender Registry (THOR)
6. Transportation
7. Stigma creates barriers to housing and employment.
8. Difficulty linking persons to appointments prior to release; often, notice of the decision to release an individual on parole does not occur more than a week from the release date.

Four of the barriers above were selected as priorities.

- Stigma: This creates a barrier to employment and housing.
- Capacity and access: Community assessments are often inadequate, and many providers do not understand how to serve individuals transitioning into society.
- Awareness and access to information: Parole officers need to know which providers are able to address the unique needs of the reentry population.
- Housing: More resources are needed.

Recommendations

I. Stigma

- Integrate forensic peer mentors into the pre-release and transition process; create a forensic peer mentor curriculum and a peer advisory committee.
- Include speakers from the RESPECT Institute in meetings, orientation and trainings across all agencies. Staff will benefit from hearing personal experiences from individuals with mental health challenges.
- Add stigma training to new employee orientation and ongoing training with the Georgia Juvenile Services Association. The Department of Juvenile Justice (DJJ) currently has an 8- to 10-hour training on stigma that includes videos and exercises on adolescent growth and development under both normal conditions and environmental trauma. It also identifies healthy and unhealthy development. DJJ is one of ten systems in the country that offers this curriculum.
- Include a segment on mental health stigma during Department of Corrections (DOC) new staff orientation and standard training. Suggestion: each warden may choose which topics are presented during the two hours allocated to mental health training.

- Incorporate skills for community supervision into the 8-hour mental health first aid certification course for DOC's level 3 training. A segment on mental health stigma should be a standard component for Pardons and Paroles and DOC new officer training. Pardons and Paroles has a newly integrated training module that can incorporate these trainings. For DOC, no additional funding is needed if these trainings can be incorporated by the Georgia Public Safety Training Center.
- Connect with the judges' councils for Juvenile, State and Superior Court systems. Training could be included in existing annual training for judges. Reach out to Chief Judge Herman Sloan (Municipal Court of Atlanta, Community Court Division) and Judge Brenda Weaver (chair of the Judges Council for the Appalachia Court system, which covers Pickens, Gilmer and Fannin Counties).
- Partner with the Georgia Sheriff's Association to train sheriffs in mental health first aid and transition from jails.
- Continue to work with the National Alliance on Mental Illness to coordinate trainings.
- Recommend to the Peace Officer Standards and Training Council (P.O.S.T) that annual mental health stigma training be required for all certified P.O.S.T. officers, and that this training count for P.O.S.T. credit.

II. Capacity and access

- Implement the Department of Behavioral Health and Developmental Disabilities' (DBHDD) Transition Action Plan during the pre-release process to aid comprehensive assessment of needs, eligibility, and risks. Share information between agencies.
- Improve data sharing between DOC and community service boards (DBHDD).
- Ensure that transition reentry specialists complete benefits applications early in the pre-release process.
- Require a certain number of priority appointment slots for persons with mental illness and psychotropic prescriptions who are transitioning out of prison.

III. Awareness and access to information

- Create a directory (called "Georgia Helps") listing state agencies and housing, health care, and vocational support resources. Georgia Helps would be linked to state agency and partner (e.g. the Georgia Sheriff's Association and clinicians in the court system) websites. Promote via hospitals, public areas (such as MARTA stations), and peer specialists.
- Distribute a survey to all government agencies to solicit feedback on other areas for improvement.

IV. Housing

- Support of a concept proposal for the Department of Community Affairs (DCA) and DOC to place transitional case managers in five prisons. These case managers would locate housing for individuals and facilitate their transition into the housing. They would also arrange meetings between providers and prisoners before they are released from jail.
- Use reentry specialists and/or multifunctional officers to help identify problems and barriers before a person is released. This would help to address treatment, medication needs, and appointments prior to release.
- Create a benefits specialist position in transition centers and other state agencies to assist in the preparation of applications to mainstream resources (e.g. Supplemental Security Income (SSI/SSDI), Medicaid, and Supplemental Nutrition Assistance Program) upon release. On average, it takes 118 days to receive SSI/SSDI benefits after reentering the community if the

process is started before release and processed under the SSI/SSDI Outreach, Access, and Recovery Technical Assistance model.
- Expand the number and/or capacity of transitional centers. (There were 500 people on a waiting list as of September 2013).
- Extend duration of reentry partnership housing, and increase per diem for providers. The daily cost of housing an inmate is $50* while the cost of supervising a parolee is $4.43. During fiscal years 2011–2013, the state saved $20.9 million by transitioning individuals from jail to parole. *This cost does not include any medications for individuals with mental health conditions.
- Build strong evaluation component into all data collected (utilization/access, etc.)

The above recommendations were presented to the Behavioral Health Coordinating Council Executive Committee in December 2013 and March 2014. The Council approved the following: integration of forensic peer mentors into the pre-release and transition process, and creation of a training module and peer advisory committee. To that end, a sub-group of DBHDD and DOC representatives have been working with the Georgia Mental Health Consumer Network and an out-of-state consultant who has developed a forensic peer initiative in Philadelphia. Implementation will include identification of one urban and one rural pilot DOC facility; development of a training curriculum; and implementation of the module. The Council also approved all recommendations for increased mental health training to address stigma, including incorporation of RESPECT Institute speakers, standardizing new employee/new officer mental health stigma training, and recommendations for mandatory P.O.S.T. training. Another sub-group has formed to research and offer recommendations for training curricula. Additional housing recommendations which have not been presented to the Council are listed below.

Housing recommendations:

- Provide housing assessments and increased training for DOC staff on available community resources.
  - ✓ The housing planning process must include an assessment of the feasibility, safety and appropriateness of an individual living with family members.
  - ✓ Individuals must receive information and training on strategies for finding and maintaining housing, and on their legal rights as tenants. Prison counselors/reentry specialists and parole and probation officers could benefit from training regarding housing laws.
- Prioritize individuals classified as level 3 and level 4* by DOC. This might include creating a different type of transitional center that focuses on independent living skills and vocational training, rather than specific job placement.
- Establish a pilot site for level 3 and 4 to implement the Transition Action Plan and categorize as high risk and high need.
- For DOC, request funding to provide housing options (transitional and/or permanent)

*The Department of Corrections classifies incarcerated persons by level of functions. Individuals at level 3 live in specialized units and supervision and assistance with activities of daily living. Individuals at level 4 need greater supervision and are lower-functioning.

Recommended next steps
This workgroup will continue to work in concert with Governor’s Office of Transition, Support and Reentry and will move forward with agency collaboration to support initiatives identified and approved by the Behavioral Health Coordinating Council.

Interagency Collaboration

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 care professionals. This workforce shortage poses a challenge to the state's current and future health care delivery system. Georgia faces a critical juncture at which it must determine its needs and 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 Georgia's workforce.

Ben Robinson, Executive Director of Academic Affairs at the Georgia Board of Regents, presented the realities of Georgia's public sector workforce crisis and recommendations for consideration. A summary of the presentation appears below:

The Departments of Behavioral Health and Developmental Disabilities, Public Health and Community Health provide much of the public health care services available in Georgia. However, many state agencies, including the Departments of Education, Corrections, Juvenile Justice and Human Services, share this responsibility. Federal and state laws, as well as public expectations, require the provision of high-quality care regardless of available resources. An adequately trained and licensed workforce is critical to providing the health care services required by the public. Substantial workforce shortages exist for many health care professions in Georgia. Yet, the supply of workers is even more scarce in the public sector due to budgets that are generally constrained even in good times and the high level of responsibility demanded by the public.

The presentation is attached as Appendix B.

Recommended next steps

Establish a Workforce Development Task Force to begin the implementation of the process described by Mr. Robinson.

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 began 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 agencies represented on the Council:

- Sharing of health information
- Partnerships
- Workforce development

Recommendations

The Behavioral Health Coordination Council has identified as one of its targets the need to explore barriers, infrastructure, staffing, services, housing and educational needs for diverting and transitioning individuals with behavioral and developmental issues under the jurisdiction or care of the Department of Corrections, Pardons and Parole, Department of Juvenile Justice, and the Department of Behavioral Health and Developmental Disabilities' forensic services. This workgroup will provide regular progress reports and updates to the Council, and as an outcome of this transition workgroup, a plan and an interagency agreement will be developed encompassing all institutional and/or community-based entities needed to successfully transition persons into the community.

The Council supports a robust discussion of the multiple barriers impeding individual's transition from the Corrections/Justice System into appropriate community behavioral health services and access to necessary supports including housing and transportation.

2014 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. The proposed meeting dates for 2014 are:

March 26, 2014
June 25, 2014
September 24, 2014
December 17, 2014

Contacts

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Appendix A

History of Behavioral Health Coordinating Council Executive Committee

YEAR/OFFICE	CHAIR	VICE-CHAIR	SECRETARY	MEMBERS-AT-LARGE
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 *(January–August)* ------------------------------ **Frank W. Berry** DBHDD Commissioner *(August–December)*	**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 *(January–July)* DCH Commissioner *(July–December)*	**Corinna Magelund** Ombudsman - Disability Services	**Albert Murray** PAP Chairman & **Brian Owens** DOC Commissioner

Public Sector Health Workforce

- Usual Suspects
  - MDs, RNs, APRNs, DMDs,
- Some less than usual suspects
  - Laboratory personnel
  - Therapy professions

- Unusual settings
  - Greater legal and budget constraints
  - Public expectations
  - Heavier Behavioral Health Focus
  - More difficult "patients"

Appendix B

Context: Extensive Shortages

Georgia struggles with health workforce

- **Growth in demand:**
- Rapid growth in Population
- Aging of population
- Increases in capabilities of workforce
- **Supply concerns:**
- Aging workforce
- Historic short supply of key professions
- Declines in production from academic pipeline (under correction)
- **Shortages exist at national level**

Change in Hospital, Nursing Home and Home Health Staffing 2000 – 2010

	FY 2000	FY 2010	Change
Profession	Budgeted Positions	Budgeted Positions	FY 2000 - 2010
MD	1,157	1,196	39
RN	30,527	39,755	9,228
LPN	10,555	11,306	751
Pharmacy	1,397	1,581	184
Other*	43,175	46,583	3,408
Total	86,811	100,422	13,611
* Includes nurse aides and allied health			

Ranking of per capita number of Behavioral Health Professionals in Georgia	
Counselors	28th
Marriage & Family Therapists	31st
Psychiatric APRNs	28th
Psychiatrists	30th
Psychologists	42nd
RNs	40th
Physicians	40th
Social Workers	41st

Appendix B

Context:
Public vs. Private Sector

- Public Sector competes with private settings for trained health Workforce personnel
  - Shortages of Personnel mean **Seller's market**
  - Salary, benefits, scheduling…. Issues at work
  - Challenges of work in public sector contribute to difficulties
  - Challenges of work in public sector at work
  - Public sector agencies also compete with each other

Appendix B

Aspects of Public Sector can inhibit growth

- Unique aspects
  - Service oriented
    - Personnel heavy
  - Budget disconnect
    - Size of budget not reflective of service demands
    - Budgeting driven by external considerations
  - Inelastic expectations
    - Provide services as demanded regardless of budget…..

- Perverse Response
  - Cut staffing
  - Downgrade credentials
  - Staff-up on lower skilled personnel
  - Push duties down the professional network
  - Pray nothing goes wrong

Appendix B

Unique aspects of the Health Workforce

- Elements of health profession legal, academic and practice constructs can restrict access to these professionals
  - Licensure requirements
  - Practice constraints
  - Education
- However, these can also provide unique ways to connect

Appendix B

Results in Workforce Problems

- General shortages of personnel and challenges of public sector employment have produces major shortages in public sector
  - Corrections:
    - Worsening Staffing Ratios in key behavioral Health Professions - Psychology
  - Mental Health:
    - Heavy reliance on low skilled workforce
  - Public Health
    - Oral health and laboratory personnel shortages
  - K-12 Education
    - High impact of early health interventions difficult to access (DOE not necessarily employer)
      - Therapy personnel
      - Pediatric subspecialties
      - Vision and oral healthcare
  - Nurses in short supply across the public sector

Appendix B

Goal for Public Sector

- The right professionals
- Doing the right job
- For the right people
- With the right needs

Appendix B

Solutions:
How to get there

- This is **not** simply an HR problem
- Many issues at work
  - Employer concerns exist – benefits, salary
  - Sector problems Exist – Constraints of public sector and personnel shortages
  - Pipeline Problems exist
  - Peculiarities of healthcare personnel exist
  - Scope of Practice problems exist

Appendix B

Solutions

- Build internal DBHDD workforce knowledge
- Strengthen the education pipeline:
  - Create more education programs as needed (or enlarge existing ones)
  - Establish high quality clinical education experiences for students
  - Establish residency/internship/post doctoral programs/experiences for medicine, nursing, psychology and others
- Develop existing workers into needed professionals
  - Establish career pathways
  - Enhance supports (salary, stipend and supervisory) for students engaged in supervised clinical practice prior to full licensure

Appendix B

Solutions

- Increase appeal of work in the public sector
  - Appropriately reduce work burden placed on clinical professionals
  - Maximize appropriate substitutions of work/professionals across the system. Apply training and workforce education efforts to this endeavor as needed.
  - Establish systems that attract needed clinicians to public sector
- Improve the efficacy of the workforce
  - Properly align state law/rules governing workforce to align with public sector needs
  - Modernize knowledge and skills of existing clinical professionals through continuing education systems
  - Establish/enhance training pathways that target newer skills/professions that align with state of the art practices

Appendix B