GEORGIA BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

2025 Annual Report

Prepared by:
The Center of Excellence for Behavioral Health & Wellbeing
Georgia Health Policy Center

Date:
December 2025

ACKNOWLEDGEMENTS

This report was prepared with support from Georgia State University's Georgia Health Policy Center and the Center of Excellence for Behavioral Health & Wellbeing.

Thank you to the Department of Behavioral Health and Developmental Disabilities, the commission's chair, and the subcommittee chairs for their work throughout the year and in preparation for this final report.

Behavioral Health Reform and Innovation Commission Leadership

- Commissioner Kevin Tanner, Chair, Behavioral Health Reform and Innovation Commission
- Dr. Brenda Fitzgerald, Subcommittee Chair, Hospital and Short-Term Care Facilities
- Dr. Eric Lewkowiez, Subcommittee Chair, Children and Adolescent Behavioral Health
- Justice Verda Colvin, Subcommittee Chair, Mental Health Courts and Corrections
- Judge Lindsay Burton, Advisory Subcommittee Chair, Forensic Competency Advisory Committee
- Dr. Carol Britton Laws, Subcommittee Chair, Intellectual and Developmental Disabilities
- Taylor Peyton, Subcommittee Chair, Addictive Diseases

2025 COMMISSION APPOINTEES, COMMISSION MEMBERS, AND SUBCOMMITTEE MEMBERS

Governor's Appointees

Commissioner Kevin Tanner, Chairperson
Dr. Sarah Yvonne Vinson,
Dr. DeJuan White
Miriam Shook
Melanie Dallas
Dr. Karen Bailey
Nora Lott Haynes
Carey Parrott
DeAnna Julian

Lieutenant Governor's Appointees

Sen. Brian Strickland
Sen. Sally Harrell
Anne G. Hernandez
Dr. David Bradley
Cindy Levi
Gus Walters
Dr. Harry Hamm

Speaker of the House's Appointees

Rep. Mitchell Scoggins
Rep. Mary Margaret Oliver
Gwen Skinner
Kim Jones
Chief Judge Jason J. Deal
Donna Ritter
Joe Marchase

Commissioner Tanner's Appointees and Ex Officios

Judge Bedelia Hargrove
Judge Kathleen Gosselin
Donna Hyland
Dr. Brenda Fitzgerald
Dr. Eric Lewkowiez
Dr. Garry McGiboney
Taylor Peyton
Laurisa Guerrero
Dr. Carol Britton Laws
Ron Wakefield
Commissioner Shawanda Reynolds-Cob
Commissioner Tyrone Oliver
Commissioner Dean Burke
Commissioner Michael Nail
GBI Director Chris Hosey
Commissioner Candice Broce
Commissioner Christopher Nunn

Chief Justice's Appointees

Justice Verda M. Colvin
Judge Stephen Kelley
Judge Sara S. Harris

Note: Members for each subcommittee are identified in their respective subcommittee reports included in the appendices of this report.

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ABOUT THE BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION

Georgia House Bill 514, in the 2019 legislative session, created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. In the 2022 session, the Georgia General Assembly passed House Bill 1013, the Georgia Mental Health Parity Act, which was informed by the **commission's first report**. The act includes provisions for comprehensive behavioral health reform, specifically elements that align Georgia law with the federal Mental Health Parity and Addiction Equity Act and help monitor compliance with the federal act. BHRIC includes 40 appointed members and is chaired by former state representative and current Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Commissioner Kevin Tanner. The commission is currently due to sunset on Dec. 31, 2026.

As outlined in the Official Code of Georgia (OCGA) Section 37-1-111, BHRIC is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues facing children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; the impact that untreated behavioral illness can have on children into adulthood; aftercare for persons exiting the criminal justice system; accessing behavioral health care among aging adults; and the impact of behavioral health on the state's homeless population.

In the 2025 legislative session, SB 233 replaced the Subcommittees on Workforce Development and Involuntary Commitment with an Addictive Disease Subcommittee and Intellectual and Developmental Disability (IDD) Subcommittee. The legislation also required the addition of individuals with lived experience and extended the commission for an additional 18 months.

The commission has five subcommittees tasked with reviewing these focus areas:

Subcommittee	Chaired by	Icon
Children and Adolescent Behavioral Health (CABH)	Dr. Eric Lewkowiez	
Hospital and Short-Term Care Facilities (HSCF)	Dr. Brenda Fitzgerald	
Mental Health Courts and Corrections (MHCC)	Justice Verda Colvin	
Forensic Competency Advisory (FCA) Committee	Judge Lindsay Burton	
Addictive Diseases (AD)	Taylor Peyton	
Intellectual and Developmental Disabilities (IDD)	Dr. Carol Britton Laws	

EXECUTIVE SUMMARY

This report is the product of the meetings held by the commission's five subcommittees, and the expert testimony heard by its members. This report does not cover the depth and breadth of testimony heard across all subcommittees but instead aims to highlight the most pressing challenges identified. The chair and the preparers of this report met with each subcommittee chair to identify and refine their priorities to be presented to the commission and for inclusion in this report. The full commission was convened on Nov. 21, 2025, and each subcommittee reported its findings and recommendations. This summary includes those priority recommendations and is followed by appendices for each subcommittee that provide more detail on their individual work.

The compilation of priorities and actions identified by the commission's five subcommittees resulted in the following priority areas for behavioral health reform:

- Build capacity to provide a full continuum of behavioral health services and supports through leveraging funding supports; cross collaboration between agencies and community partners; and continued oversight, implementation, and committee work around BHRIC and its recommendations.
- Build a robust and skilled workforce by addressing both immediate needs and long-term solutions to improve network adequacy and improve the pipeline of behavioral health care and direct support professionals.
- Expand effective, community-based programs, practices, and services to ensure that access to supports that are proven to be successful can be maximized.
- Streamline existing policies and statutes to ensure Georgia laws promote best practices in working with people with behavioral health conditions.

Supporting documentation for each of these recommendations can be found in the repository of meeting recordings, presentations, and agendas on the **commission's page** on the Georgia General Assembly's website. Additionally, each subcommittee has provided additional information about its activities in 2025, its proposed recommendations, and supporting documents for those recommendations, which are documented in the appendices to this annual report. Each subcommittee may have additional recommendations beyond the ones included here. The recommendations compiled here are considered the most pressing and most actionable for addressing behavioral health system reform.

RECOMMENDATIONS FOR BEHAVIORAL HEALTH REFORM AND INNOVATION

The following recommendations were crafted from the testimony heard across the five subcommittees of BHRIC. All recommendations are endorsed by the full commission. The recommendations are grouped by target areas for systems improvement.

I. BUILD CAPACITY TO PROVIDE A FULL CONTINUUM OF BEHAVIORAL HEALTH SERVICES AND SUPPORTS

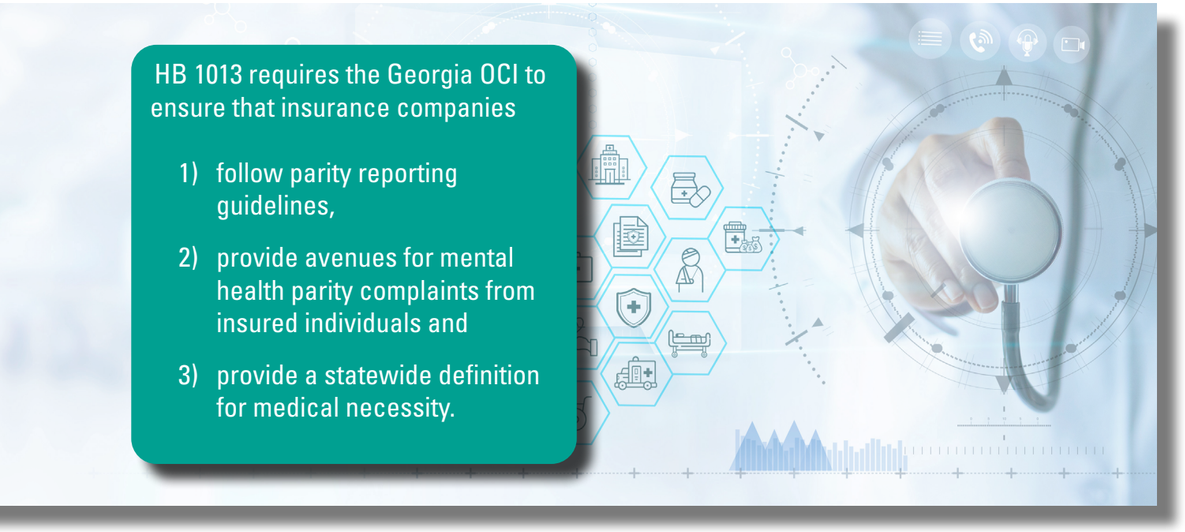
A connected continuum of care ensures Georgians can access behavioral health services that are coordinated, timely, and effective across all stages of care. Gaps in this continuum often lead to delayed care, higher costs, and poor outcomes, particularly for individuals with complex needs.

- Complete a study of Georgia hospitals to identify specific number and types of beds needed. (HSCF)
- Continue to encourage pre-admission mental and behavioral health evaluation programs at both public and private emergency rooms. Correct the problems with admissions from freestanding facilities using the Georgia Crisis & Access Line (GCAL) board — as reported by Willowbrooke in Carrollton. (HSCF)

Strengthen Parity Enforcement

Georgia passed the Mental Health Parity Act, **HB 1013**, in 2022. The bill was designed to improve access to mental health and substance abuse treatment by requiring health insurers to cover these services comparably with physical health services. This means there should be no difference in deductibles, copays, or limits on the number of visits or days of hospitalization between mental and physical health services. HB 1013 also requires the Georgia Department of Insurance to ensure that insurance companies follow parity reporting guidelines, providing avenues for mental health parity **complaints from insured individuals** and providing a statewide definition of medical necessity.

- Support passage of SB 131, which establishes a parity compliance review panel and requires health care providers to report suspected behavioral health parity violations (this is Senate version of HB 612). (HSCF)



- Provider network adequacy — grounded in current data and active state enforcement — is the linchpin of true parity: without enough in-network clinicians available to see patients, no definition of "medically necessary" and no promise of equal coverage has practical meaning. Ensure this is a top priority of the medical review panel. (HSCF)

Increase Agency, Practice, and Community Cross-Collaboration

Improving cross-collaboration between agencies, practitioners, and community was identified as a necessity to improve the delivery of behavioral health services. The commission recognizes the value of aligning the delivery of services financially, legislatively, and practically to improve behavioral health care in Georgia.

This year, upon hearing expert testimony across various subcommittees, the commission recommends the following:

- Improve communication between Georgia Vocational Rehabilitation Agency (GVRA), schools, and providers and strengthen GVRA partnerships with the Department of Education, DBHDD, and workforce development organizations. (IDD)
- Increase coordination of the IDD system and behavioral health system to ensure that the needs of people with co-occurring diagnoses are being addressed. (IDD)

- Create a pilot project where individuals who are charged with criminal offenses and who have been found not competent, not restorable, and not meeting criteria for civil commitment are reviewed by a panel of participants including DBHDD, Department of Human Services, probate court, state/Superior Court, prosecutor, and defense counsel. The pilot would involve monthly interagency meetings to improve coordination of services and give each participant the opportunity to offer resources that may safely resolve the case. (FCA)

Continue Data Sharing and Integration

The commission recognizes the importance of data sharing and integration as essential to strengthening the continuum of care. Effective data sharing and integration can allow providers, organizations, and systems to coordinate services, reduce duplication, and respond more effectively to individuals' needs across settings. Recommendations from the previous year emphasized the need for efficient data sharing and integration for timely exchange of information. To build on the momentum of previous recommendations and continue to ensure Georgians experience seamless transitions and consistent care, the commission recommends the following:

- Explore the possibility of creating an alert system or data linkage that will link systems so that when someone encounters a person who chronically suffers from mental health issues, electronic systems would identify such persons. This would then allow the person who encounters them to alert the noted therapist and/or health care facility who could then intervene. (MHCC)

Continue Oversight and Implementation of BHRIC Committee Work and Recommendations

As the commission approaches its sunset date, it recognizes the importance of identifying remaining gaps and continuing the work that has been established over the past five years and therefore recommends the following:

- DBHDD should oversee the continued rollout of BHRIC recommendations by creating and overseeing advisory committees where necessary to complete recommendations, as well as further evaluations and research surfaced by BHRIC.

- Conduct an evaluation of all recommendations issued. Document progress, implementation status, measurable outcomes, and barriers encountered.
- Using the assessment results along with stakeholder input, data analysis, and recent system developments, identify ongoing gaps within the behavioral health system that require further policy attention, funding, or program development.

Increase Access to Support for People with Intellectual and Developmental Disabilities

A consistent focus across the subcommittees was enhancing the continuum of care specific to people with IDD. Specifically, recommendations aim to enhance access to care and remove barriers for children, adolescents, and adults with IDD, autism, or dual diagnoses. The commission recommends the following:

- Examine opportunities for health insurance companies, health care providers, and Community Service Boards to embed the Social Communication, Emotional Regulation, Transactional Support (SCERTS) framework into case management and provide SCERTS training for educators through Georgia Regional Education Service Agencies. (CABH)
- Screen for trauma and suicide ideation in autistic youth and use trauma-informed care practices in all health care settings as part of Safety Planning Intervention. (CABH)
- Increase the number of providers who are trained to work with autistic and developmentally disabled youth by promoting awareness training in medical, nursing, dental, and allied health programs. (CABH)

- Utilize the urgency criteria created by the DBHDD IDD subcommittee on Assessment and conduct a validation study of the new assessment instrument. (IDD)
- Utilize the three-tier structure, as recommended by Guidehouse, but with a revision to the original time frames. (IDD)
  - Immediate list — individuals who need services within the current fiscal year
  - Planning list — individuals who will need services within the next one to five fiscal years
  - Forecasting list — individuals who will need services in the next six or more fiscal years
- Set aside an amount of state dollars to continue capacity to serve individuals who do not need as intensive services as New Option Waiver Program and Comprehensive Support Waiver Program (NOW/COMP). (IDD)
- Fund appropriate home- and community-based services for all Georgians with disabilities starting at the time when they need those services. This includes but is not limited to funding NOW/COMP waivers (designed for individuals who need less intensive support; provides services that help people live more independently, such as community living support, job coaching, day services, and respite care) along with the necessary staffing for DBHDD to administer NOW/COMP and other services. (IDD)

- Provide early intervention and ongoing support for individuals with IDD who become involved in the justice system and their families. Look to the Arc Pathways to Justice initiative as a best practice. (FCA)

II. BUILD A ROBUST AND SKILLED WORKFORCE

A skilled and dynamic behavioral health and direct support professional workforce is essential to meeting Georgia's growing mental health and substance use needs. Well-trained professionals are critical for providing timely, culturally responsive, and evidence-based care to meet the unique needs of Georgia's communities. A strong workforce can improve access to services, reduce treatment delays, and support better outcomes for individuals and families. The commission recognizes the need to invest in recruitment, training, and retention so that Georgia can build a resilient behavioral health system that ensures access to high-quality care.

Modernize Licensing Practices Across All Levels of the Behavioral Health Workforce

The commission recognizes the importance of modernizing licensure practices to expand opportunities for behavioral health professionals to provide services across the continuum of care. To expand licensure opportunities for professionals providing addictive disease treatment, the commission recommends the following:

Well-trained professionals are critical for providing timely, culturally responsive, and evidence-based care to meet the unique needs of Georgia's communities.

- Expand the code of the Drug Abuse Treatment and Education Program (DATEP) licensure to be inclusive of alcohol-only substance use patients. (AD)
- Provide licensure for addiction counselors to allow them to bill insurance. (AD)
- A Motivo study shows only 54% of Georgia Masters level Behavioral Health professionals complete licensure process. Evaluate causes and then simplify and correct problems in licensure process while concurrently developing innovative workforce pathways for all levels of education. (HSCF)
- Create a central interactive data hub that can be used to predict the supply and demand of Georgia's behavioral health workforce. Georgia should look to model the innovative dashboard created by the University of South Florida. (HSCF)
- Increase the number of participants enrolled in the Direct Support Professional Certification programs who are self-directed. (IDD)
- Explore ways to sustain the Direct Support Professional Certification projects via the Medicaid rate by including them in the next rate study. (IDD)

Strengthen Georgia's Peer Support Workforce

Peer support is an evidence-based practice that utilizes people with lived experience in behavioral health interventions. Proven benefits of the use of peers include lower hospital readmission rates, reduced number of days in an inpatient stay, greater use of outpatient services, improved quality of life indicators, increased rates of provider engagement, improved whole health, lower cost of services, and reduced mental health and substance abuse issues.

The commission recognizes that peers are a critical part of the behavioral health workforce and recommends that Georgia dedicate resources to ensuring sustainable funding for peer support programs and increased accountability in the training provided to peers to ensure their success in the workplace.

Specifically, the commission recommends the following:

- Enhance the peer support workforce (Certified Addiction Recovery Empowerment Specialist Academy and certified peer specialists–youth). (CABH)
- Expand neonatal intensive care unit (NICU) peer recovery coaching provided by the Georgia Council of Recovery. (CABH)
- Expand and fund forensic peer mentorship programs in partnership with the Department of Community Supervision to reach inmates of every Georgia prison and returning citizens in mandated substance use services across the state. (AD)
- Consider dedicated funding for peer-based programs to extend services for Department of Juvenile Justice youth to reduce recidivism. (CABH)

III. EXPAND EFFECTIVE, COMMUNITY-BASED PROGRAMS, PRACTICES, AND SERVICES

Upon hearing from service providers and state agencies responsible for the delivery of behavioral health services throughout the state, several subcommittees identified specific programs that have clear evidence of

supporting practices, programs, and services within the behavioral health system of care. These programs often reach only small geographic regions of the state and would benefit from additional funds to expand their reach to more areas.

Expand Effective Programs and Services for Children and Adolescents

The commission recommends building on several past recommendations to continue the expansion of the following services aimed at improving behavioral health outcomes for children and adolescents:

- Establish more DBHDD clubhouses across Georgia to reach more areas and communities. (CABH)
- Increase funding for the regional perinatal center outreach educators, coordinated by the Georgia Department of Public Health, for training of NICU staff to engage families in the care of their infant while in the NICU and during transition home. (CABH)

- Establish a Georgia Mental Health Consortium. Use state funding to strategically leverage the work and partnerships between Georgia medical schools, Georgia nursing schools, health care leadership, and already established Georgia programs. (HSCF)

Additionally, the commission recommends the expansion of the following services:

Expand Effective Programs and Services for Adults

- Expand and support co-response teams. (MHCC)
  - Conduct a survey among Georgia Sheriff's Association to determine how programs are organized, funded, and locally supported, and explore what the deterrents are to starting a team.
- Enhance post-program support for individuals who have completed accountability court by implementing regular follow-up. (MHCC)

IV. STREAMLINE EXISTING STATUTES AND POLICIES

Subcommittees also identified specific statutes and policies that need refining to support system reform. The commission recommends the following changes be made to the noted statutes and policies:

Refine Policies and Practices Impacting Adults

- Remove punitive action from nurses who self-report seeking treatment or recovery services and create separate pathways for those with reportable incidents versus those who self-report. (AD)
- Establish a statewide licensure for recovery residences, which are locations where individuals experiencing addictive disease can seek long-term supportive housing. Recovery residences provide peer-supported alcohol and drug-free living environments for individuals transitioning back into their communities following treatment programs, release from prison, probation, or parole. (AD)

Refine Policies Impacting Access to Services for Children and Adolescents

- Revise state agency policies and practices to recognize the Department of Juvenile Justice as a referral source for psychiatric residential treatment facilities. (CABH)

Refine Policies and Practices Impacting Services for Persons Involved in the Criminal Justice and Behavioral Health Systems

- Continue to work with Superior court judges and district attorneys to ensure there is a clear understanding of OCGA 17-7-130 to work toward expeditiously shortening the time to complete competency evaluations. (MHCC)

These recommendations are endorsed by the full commission and were informed by corresponding recommendations from the five subcommittees. For more details on the subcommittee's aligned recommendations, please see their respective appendices.

APPENDIX A: SUBCOMMITTEE ON ADDICTIVE DISEASES

Georgia Behavioral Health Reform and Innovation Commission

Addictive Diseases

2025 Annual Report

Chair

Taylor Peyton

Members

Laurisa Guerrero

Gus Walters

Donna Ritter

Dr. Carey Parrott

November 2025

This report was prepared with assistance from the Georgia Health Policy Center's Center of Excellence for Behavioral Health & Wellbeing at Georgia State University

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Introduction

House Bill 514 (from the 2019 General Assembly session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

In 2025, on a recommendation from the commission, the legislature passed Senate Bill 233, adding two subcommittees to its initial five to review the additional focus areas of Intellectual and Developmental Diseases and Addictive Diseases. The Subcommittee on Addictive Diseases is chaired by Taylor Peyton (2024-2025).

During 2025, the Subcommittee on Addictive Diseases held six public meetings on topics related to the promotion of new recovery modalities, access to treatment, prevention of addictive diseases, and the regulation of recovery residences.

List of Presenters to the BHRIC Subcommittee on Addictive Diseases 2025

BHRIC Subcommittee on Addictive Diseases

Taylor Peyton, Chair
Laurisa Guerrero, Gus Walters, Donna Ritter, Dr. Carey Parrott

Support to the BHRIC Subcommittee on Addictive Disease

Ana LaBoy, Sarah Small, Ashlie Oliver, and Susan McLaren, all from the Georgia Health Policy Center

Presenters to the BHRIC Subcommittee on Addictive Diseases 2025

Date	Topic	Presenter
Aug. 11, 2025	Standardization of Recovery Residences	Georgia Association of Recovery Residences **Candice Whitaker**, Executive Director **Cody Davis**, President Elect and Chair of Education **Steven Carter**, Ethics Chair **Andrea Connolly**, Secretary of Georgia Alliance for Recovery Residence **Alexis Williams**, Policies and Procedures Chairperson **David East**, President of the Board of Directors
	Access to Medication-Assisted Treatment Services	Practitioners for the Recovery of Opioid Use Disorder **Joelyn Alfred**, President and Georgia Program Director of Lakeland Centers
		A Better Way Recovery Residence **Andrea Connolly**, Executive Director
Sept. 8, 2025	The Role of Recovery Community Organizations (RCOs)	Georgia Council for Recovery **Brian Kite**, RCO Development Coordinator
		Unified in Recovery, RCO **Shelly Roach**, Director
	Limitations of the Drug Abuse Treatment and Education Programs Licensure: Alcohol Only Diagnoses	Riverfront Recovery Center **Kris Shock**, Clinical Director
Sept. 23, 2025	Forensic Mentorship Programs	Department of Community Supervision

		Amy Smith, Manager of the Recidivism and Reduction Unit
		Coastal State Prison **Tony Bennett**, Forensic Peer Mentor, CPS, CARES
		iHope Inc. **Tarusa Stewart**, CEO and Founder
		Shane Sims, Executive Director of People Living in Recovery, RCO, Co-Founder of Modern Pathways to Recovery, and Founder of Principles over Passions Consultancy
		REBOOTjackson **Sunshine McCoy**, Peer Support Specialist **Jennifer Langston**, Executive Director
Oct. 7, 2025	Collegiate Recovery Programs	Center for Young Adult Addiction and Recovery at Kennesaw State University **Blake Schneider**, Director
		CWC Alliance **Cammie Wolf Rice**, Founder and CEO
	Access to Treatment Concerns	Medicine Wheel **Adriana Chiknas**, Chairman for Region 2
		Advantage Behavioral Health **Catherine Mills**, Director
Oct. 9, 2025	Alternatives to Discipline for Nurses in Recovery	Northeast Georgia Health System **Mary Lou Wilson**, Women's Service Line Administrator, MSN, RN, NE-BC **Courtney Robinson**, MSN, RN
		Georgia Nurses Association **Michelle Cooper**, Nurse and Peer Support Facilitator
	Prevention Initiatives	Georgia Prescription Drug Abuse Prevention Initiative at the Council on Alcohol and Drugs **John Bringuel**, Director
Nov. 5, 2025	Maternal Health and Substance Use	Rollins School of Public Health, Emory University **Rebeca Bonilla**, Research Coordinator for the Echo Study
		Motherhood Beyond Bars **Amy Ard**, Executive Director
		Northeast Georgia Medical Center **Aubrey Williams**, Coordinator of Neonatal Community Outreach
	Licensure for Certified Addiction Counselors	Georgia Addiction Counselors Association **Starling Bridges**, President **Taylor Hagin**, CAC, Member

Summary of Presentations to Subcommittee

Standardization of Recovery Residences

Candice Whitaker, Executive Director; Cody Davis, President Elect and Chair of Education; Steven Carter, Ethics Chair; Andrea Connolly, Secretary; Alexis Williams, Policies and Procedures Chairperson; and David East, President of the Board of Directors of Georgia Association of Recovery Residences

Executive director Ms. Whitaker and the team at Georgia Association of Recovery Residences (GARR) gave an overview of GARR, its role in Georgia recovery services, and its position that recovery residences should be regulated and have standards. Thirty-seven years ago, GARR was originally a group of owners and operators that decided regulation and standards were necessary. Georgia was the first state to have regulations for residential residences and helped create the National Alliance for Recovery Residences, a national agency that serves to model alliances like GARR for other states. In terms of services, there are detox and inpatient services that have state oversight, but recovery residential services and post-treatment services have very little. Recovery residences ensure that there is a homelike environment and community to help someone in recovery reintegrate and reengage in responsibilities that may have been affected by their recovery. GARR certifies these services, including a variety of programs such as 12-step and faith-based programs. GARR ensures that there are services for everyone with a framework to regulate and keep those in recovery safe and supported. It provides certifications and education, conducts fundraising, and puts on events. It also provides references and investigates potential ethics violations. There are many people with big hearts wanting to help in recovery services who need additional education and knowledge of ethics in order to provide ethical services. GARR is there to strengthen service delivery and keep recovery residential services up to date.

Mr. Davis, the president elect and chair of education at GARR, shared his own experience. He was mandated by the state of Georgia to live in a sober residence, which was not safe and did not encourage sober living. His background included crime and drug use, and at the time, he did not expect anything more from sober living. When he became a provider, he educated himself on the standards for sober living and joined GARR. Once educated on the standards, he reported his sober living facility, but the facility was not standardized, so there was no regulatory body to hold them accountable. As a board member, Mr. Davis said he has witnessed stories similar to his over and over again. Only two counties in Georgia require sober living facilities to register with GARR. As a clinician, Mr. Davis is required to be certified by several governing bodies, but the same standards are not applied to sober living facilities. Without oversight, these businesses invite predatory behavior of vulnerable residents in recovery. These residences, without oversight, represent hundreds of beds and hundreds of people in recovery who have spent large amounts of money on services that are not standardized and are often unsafe for them in their recovery. Without standards, it is hard to keep all residential services up to date in terms of the best standards of care and to verify the quality of care. Some unregulated residences provide a safe and supportive environment, and some do not.

The GARR certification process ensures that recovery residences meet the highest standards of safety, ethics, and quality care. GARR evaluation includes a thorough review of policies, procedures, and required documentation, an on-site inspection of the residence, and verification of compliance

with GARR's operational and housing standards. GARR assesses areas such as resident rights, staff training, program structure, health and safety, and overall environment to confirm that each home provides a supportive, well-managed, and recovery-focused setting. The checklist for certification is very thorough and ensures that the policies for individual programs are also very thorough. GARR assesses the business license, the "good neighbor" policy, and the intake policies. Paperwork for each program should reflect its program and should be standardized to support residents; for instance, the grievance policy should be visible to residents, and the building should be up to code. Every residence in every area comes with its own needs and program techniques. The individuality of different programs will be respected and celebrated, while standardizing base needs and policies to ensure safe recovery.

Numbers certified by GARR:

- 107 certified residences; and
- More than 3,000 beds.

The GARR Ethics Team is responsible for upholding the integrity and accountability of certified recovery residences. They review and investigate complaints, concerns, and potential violations of GARR's Code of Ethics, ensuring all programs operate with honesty, fairness, and respect for resident rights. The team works closely with owners and operators to address issues, provide guidance on ethical best practices, and, when necessary, recommend corrective actions and disciplinary measures. The GARR mission is to protect residents, maintain public trust, and ensure that all certified programs reflect the highest standards of professionalism and ethical conduct. GARR's goal is to require all operators to come under the GARR best practices certification process and to create stable environments. GARR has an open-door policy and goes above and beyond to hold operators' hands to improve their programs. It is very important to foster trust between programs and the communities, being intentional about GARR's image and bringing awareness to services provided. Commitment to education and transparency bring awareness of services provided. GARR is a leadership in this industry. GARR would like to spread awareness of their services to make regulation necessary for all recovery residences.

Ms. Guerro asked if there would be any negative impacts to the availability of housing through GARR's work. Mr. Davis responded that with more oversight of residences, an increased number of beds would become available to the state with a benefit to those in need of housing. Members of GARR discussed the volatility of bed numbers depending on the time of year but agreed that most beds are usually full. In response to a question from Mr. Walters, GARR members discussed their ongoing work with the legislature to create standardization of recovery residences, similar to legislation already existing at the local level in Dublin County, specifically Senate Bill 311, introduced by State Senator Randy Robertson and the Recovery Residences study committee he chairs. GARR members also further discussed their continuing education requirements of residences and the kinds of certifications they would require of staff. GARR is currently open to multiple certifications, but Ms. Ritter stated that members of staff should be certified addiction counselors (CACs).

Access to Treatment and Recovery Services

Drug Abuse Treatment and Education Programs' Inclusion of Treatment for Patients with Alcohol Use Disorder Diagnoses

Kris Shock, Clinical Director of Riverfront Recovery Center

Kris Shock is a certified LPC and addiction counselor with the Georgia Addiction Counselors Association (GACA). She has been a clinical director at various levels of care. Including residential, the Partial Hospitalization Program, and the Intensive Outpatient Program level, and she had her own residence for 10 years. She is currently the clinical director at Riverfront Recovery Center but gave testimony relevant to a prior experience as a clinical director of a different treatment center, an outpatient detox facility. She describes how when her outpatient detox center was having its annual licensing appointment licensure, it was told that it was in violation for serving alcohol use disorder patients.

Shock stated her belief that excluding alcohol use disorder patients for Drug Abuse Treatment and Education Programs (DATEP) licensures is archaic. At the time that this meeting occurred, the licensing rep instructed Shock to discharge all her alcohol-only patients. There was no one for her to refer them to. Shock herself has struggled with addiction to alcohol. She described alcohol dependency as a slow death that allowed her to keep her job and her kids but not her dignity. In 2022, the average number of deaths from excessive alcohol use in Georgia was 5,214 people, compared to 1,734 opioid-related deaths. Georgia ranks ninth in the nation in terms of alcohol-related deaths in women aged 18-36. In 2022, $6.2 billion in cost was associated with alcohol addiction in Georgia. That is higher than the country's median average. Unlike Georgia, neighboring states include alcohol-dependent patients in their detox treatment centers. Shock stated that Georgia has chosen its licensing requirements and that those licensing requirements are not medically appropriate. Quality treatment facilities in Georgia are denying alcohol use disorder patients, who will not be able to access the care they need.

In consultation with Dr. Schiller, a staff attorney for DBHDD, the subcommittee members discussed the code in question responsible for the exclusions of the DATEP licensure. Dr. Schiller reiterated that DATEP stands for Drug Abuse Treatment and Education Programs and is not currently inclusive of alcohol use disorder treatment patients. Ms. Schiller shared that DBHDD will be taking over enforcement of the DATEP licensure starting in January 2026 but clarified that DBHDD is still bound by the rules of the statutory language in the code. Commissioner Tanner spoke regarding the future role of DBHDD in the enforcement of DATEP, specifying that it is outside of DBHDD's jurisdiction to change the applicability of the DATEP licensure in terms of alcohol use disorder patients, and that for alcohol use disorder patients to be served by DATEP treatment facilities, the legislature would need to pass legislation. He recommended that BHRIC recommend to the legislature an expansion of the DATEP licensure to be inclusive of patients with an alcohol use disorder diagnosis.

Medication-Asisted Treatment Availability in Residences

Joelyn Alfred, Georgia Program Director of Lakeland Centres, President of Practitioners for the Recovery of Opioid Use Disorder

Ms. Alfred spoke in support of the medication-assisted treatment (MAT) modality and its inclusivity of nurses, physicians, pharmacists, and counselors. She spoke to the essential nature of treatment for individuals recovering from opioid use disorder and substance use disorder. Using a multimedia presentation, Ms. Alfred sought to demonstrate the pain and discomfort of substance use withdrawal. She says that during times of imbalance, people will undoubtedly seek a way to make themselves feel better, and that MAT provides a modality for individuals to enter recovery safely and maintain recovery despite adversity. Ms. Alfred advocates for MAT services by stating that MAT is a lifesaving treatment and should be used and made available to those needing treatment.

Andrea Connolly, Secretary of GARR and Founder and Executive Director of A Better Way Recovery Residence

Ms. Connolly gave an overview of her experience running a recovery residence while prioritizing the needs of residents receiving MAT treatment. She stated that MAT may not be the tool for everyone, but it should be an option for everyone in recovery, just like mental health medication is. Ms. Connolly spoke to her own experiences in recovery and with withdrawal. At the time, she said that few resources were available. Following her own experiences, Ms. Connolly said she initially had a bias against MAT. She did not feel she needed MAT in her recovery, so why would it be needed for someone else? She said watching her peers struggle and die from substance use opened her mind to more recovery support tools like MAT and described how as a provider it is her responsibility to address her own biases and then the biases of her staff and the biases of her residents through recovery education and support tools. Key points of education include the understanding that all pathways to recovery are valid, and everyone has a right to privacy.
As a non–medical professional, Ms. Connolly does not prescribe or handle medication herself. She describes a collaborative relationship with residents where she supports residents in accessing resources without making decisions for them. Connolly is a certified addiction treatment specialist, and so she can counsel residents and help them with their treatment plans within her scope of care. Residents self-medicate as there is no medical staff, but their doses are observed. Residents are welcome to start or stop MAT support as they choose.

Connolly would like to see MAT normalized on all levels. GARR allows every residence to decide if they will offer MAT, but Connolly believes it saves lives and that having more MAT beds available saves lives.

Additional Access Concerns in Georgia

Adriana Chiknas, CEO of Medicine Wheelhouse and Chair of Opioid Abatement Region 2 Advisory Council

Ms. Chiknas gave an overview of her work at the Medicine Wheelhouse and some of the substance use access issues she sees in her community. Ms. Chiknas' mother first started the clinic she is running now helping patients addicted to opioids. There are real positives to report: overdoses are going down. As of April, overdoses had gone down 24%. Ms. Chiknas reports that she believes that this is due to the seizures of fentanyl and investment in recovery. She also reports there have been a lot of different trends, and the last four federal administrations have supported MAT medications. On MAT medications, a person is 76% less likely to have an overdose in the first 90 days of care. She said stigma is a barrier to people getting what they need and is the reason why not everyone has access to MAT medications. Every individual has individual needs and individualized referral

options to succeed in recovery. Ms. Chiknas received Georgia Opioid Crisis Abatement Trust funding the year prior, with the focus of the grant on transportation. Through the grant she obtained a van called the Wellness Wagon. She is using this van to bring treatment to rural areas of Region 2. Beyond bringing treatment, she said she "transports folks where they need to go." For example, she recently picked someone up from jail and brought them to rehab using the Wellness Wagon.

Transportation Issues
Ms. Chiknas stated that there are two different strategies to circumvent transportation difficulties: mobile medication units (MMUs) for MAT and mobile clinics. If the addiction is severe enough, the individual may need access to medications that need to be kept secure, such as methadone, a powerful medication that can be used improperly when not prescribed. Currently, in Georgia, there is not funding for an MMU, but there are federal grants available. Ms. Chiknas also stated that MMUs are not currently a legal option in Georgia, so to take advantage of these federal grants, there would need to be a state policy change. Currently, patients have to be physically transported from rural areas rather than transporting the medication. Ms. Chiknas believes MMUs are the solution.

Integrated Care
Ms. Chiknas advocates for more integration with hospitals and emergency departments through referrals to treatment and distribution of naloxone. There are many strong, dangerous drugs on the market that are difficult to stop without medical intervention. Hospitals also have an opportunity to educate families of loved ones on patient care.

Carceral Settings
Ms. Chiknas advocated for MAT medication access in carceral settings through partnerships with local opioid treatment programs (OTPs). She stated that every prison should have an OTP, but that it is unlikely. There are many OTPs across the state, but they need a strengthened relationship with their local prisons in order to collaborate. When someone is first released from prison, they are 129% more likely to overdose. Ms. Chiknas advocated for more regulations around what inmates are allowed to access in prison. She said that there is a need for the substance use community to work closely with prisons to find solutions and make a safer community for everyone.

Medicaid
Most places in the nation have bundled rates, but in Georgia, every charge is a-la-carte, which makes Medicaid charges far more challenging. Ms. Chiknas stated that some Medicaid limitations do not make sense. She believes that people in the Medicaid program should get full treatment benefits and should not be limited, for example, in their ability to take home medications.

Drug Testing and the Good Samaritan Law
Ms. Chiknas advocated for everyone to have safe and legal means to test their substances. Ms. Chiknas stated that stigma keeps people from getting treatment and making the right choices. She also advocated for the strengthening the Good Samaritan Law to allow someone to call in the case of a medical emergency without penalty for drug paraphernalia.

Catherine Mills, Director of Addictive Disease for Advantage Behavioral Health Systems

Ms. Mills gave an overview of the work of the Addictive Disease Department of Advantage Behavioral Health Systems and access to service issues she encounters. Advantage's Addictive

Disease Department received two Georgia Opioid Crisis Abatement Trust grants. They also receive government funding.

Role of Peers in Community
Advantage Behavioral Health has 40 peers in recovery on staff in various roles. She spoke about the role of peers in connecting with and listening to the community in order to figure out what needs need to be met. Ms. Mills is advocating for the work of peers in every level of treatment and service facility. She said that peer support is a big part of person-centered care, and obtaining peer support for new clients is always the first step at Advantage so that the client is comfortable and feels understood.

Forming Relationships and Trauma-Informed Care
Ms. Mills stated that forming relationships with the community, particularly communities impacted by substance use traumas and other traumas, requires trauma-informed communication and consistency. She said the language used is important because labels can be powerful. She also outlined how consistent time in a community allows providers such as herself to identify those most in need and brainstorm solutions in partnership with the community.

Misinformation and Mandated Trainings
Ms. Mills shared that misinformation has been a rampant part of the addictive disease landscape since she began the work 15 years ago. Though people do not mean harm, the narratives created are not evidence-based. Consistent education efforts and trainings are required to prevent harm. There is also consistent turnover in the industry that requires consistent re-education efforts. She stated that each organization and type of provider needs mandated individualized training specific to what they need to know. She advocated for MAT education specifically, saying that she would like it to be as pervasive as naloxone administration education so that people in recovery achieve access to the medications they need. She also cited the reduction of overdose deaths following naloxone training as evidence of these potential trainings' efficacy. She said that misinformation around MAT is so pervasive that she has even heard employees of the Department of Community Supervision touting MAT misinformation.

MAT in Jails
Ms. Mills reaffirmed the opinion of Ms. Chiknas that every jail provide MAT. She also believes that provision of MAT in carceral settings is one of the biggest challenges in addictive disease work. She said that beyond funding, this will require coordination of up-to-date prescriptions and registrations with the Drug Enforcement Administration and the Prescription Drug Monitoring Program. She also discussed the difficulties of continuum of care for those entering and exiting a carceral setting, especially with the complication of changing needs and supports due to experiences in a carceral setting and the many potential short-term stints of people in recovery in jail given the illegality of their substance use. When MAT access is taken away, those in stable recovery experience withdrawal and can relapse even over short periods of time. Carceral providers can be particularly difficult to convince to participate in treatment, but Ms. Mills said she consistently works to form partnerships with prisons.

Advantage Programs

- PROUD Team

- In 2017, Ms. Mills created the Peers in Recovery from Opioid Use and Dependency (PROUD) team with the first round of State Targeted Response funding. During the first five years of operations, there were no overdose deaths, but following the spread of fentanyl in Georgia, members began to overdose. She talked about the changes in MAT programming that had to occur to accommodate users of fentanyl due to its unique metabolism.

- Lockset Emergency Toolkit
  - Ms. Mills presented a toolkit Advantage built in partnership with local emergency medical technicians (EMTs) to address substance use emergencies in real time. The kit is modeled after a similar service provided by the Department of Health and Human Services. It includes a dose of Narcan, gloves, a breathing mask for rescue breaths, fentanyl test strips, and information on local treatment resources. She said that prior to the partnership with Advantage, EMTs could not afford to distribute Narcan outside of a present emergency, but now those who experience a regular risk of overdose will be prepared. Advantage also donated 200-250 kits to the local Jackson County jail to distribute. Each box costs $24.

New in Recovery: Spotlight on Modalities of Care

Recidivism and Reduction: Spotlight on Forensic Peer Mentors

Amy Smith, Manager of the Recidivism and Reduction Unit of the Department of Community Supervision

Ms. Smith gave an overview of the work of the Department of Community Supervision (DCS) and its programs for returning citizens and justice-involved people in recovery. DCS began in 2015. It takes on a person-centered supervision model, basing response on individual needs of persons in recovery. Smith is manager of the Recidivism and Reduction Unit, which includes a re-entry unit. It employs community coordinators to facilitate re-entry. DCS has 155 full- and part-time counselors who work in day reporting centers and field offices. Field office counselors conduct substance use assessments, some of them court-ordered. Based on the results, they may be referred to the Field Matrix program by the Substance Abuse and Mental Health Services Administration (SAMHSA) or day reporting centers or other alternatives to incarceration programs, such as Residential Substance Abuse Treatment or Integrated Treatment Facility programs. Each program necessitates a different level of supervision and has a slightly different population of focus, but collectively these programs form a continuum of care that allows individuals to receive needed substance use treatment outside of correctional facilities.

The goal of DCS is to have subject matter experts facilitate groups and courses to ensure the best treatment possible. With this goal in mind, DCS has a Counselor Certification Prep Program based on criteria from DCS, the Alcohol and Drug Abuse Board of Georgia, and the International Certification and Reciprocity Consortium. DCS provides training and clinical supervision to counselors and facilitates certification and maintenance of credentialing. In addition to its certification program, DCS has become a trauma-informed agency. All employees received trauma-informed training specific to justice-informed responses through the SAMHSA curriculum.

Tony Bennett, Forensic Peer Mentor, CPS, CARES

Mr. Bennett gave an overview of his experience as a forensic peer mentor. Mr. Bennett is a person in long-term recovery and a returning citizen. He was released from incarceration in 2011. He is a forensic peer mentor at Coastal State Prison as well as a certified peer specialist and a certified addiction recovery empowerment specialist. Mr. Bennett described his lived experience as a superpower that allows him to offer hope in prison. Through the forensic peer mentor model, he sits with peers and offers advice and guidance for reintegration into society. Mr. Bennet says that when you conquer addiction you become responsible for your past and access modalities to improve your life. He says the process is one step at a time but that the forensic peer mentor program is a pillar of support. He is proud of his own transition from incarceration and his role as a mentor. He wants everyone incarcerated to know that they are being fought for.

Shane Sims, Executive Director of People Living in Recovery RCO and Co-Founder of Modern Pathways to Recovery and Founder of Principles over Passions Consultancy

Mr. Sims gave an overview of his own experiences with substance use as a returning citizen, and the role of his experiences in informing his work in recovery. Mr. Sims stated that addressing substance use requires addressing drivers of addiction. He says there must be (1) a confrontation of trauma — "in order for us to be healers, we must first heal ourselves," (2) a communication of context and feelings and living in the present; he says that this is often achieved through helping others, and (3) connection to community and peers. He said that his own trauma and exposure to use of crack cocaine within his community led to his behavioral issues and incarceration despite the relative stability of his own home. He attributes his criminalization to his substance use. Mr. Sims received a felony sentence of armed robbery following his final year of high school and received a sentence of life in prison. He spent 20 years in prison.

Mr. Sims presented on the ability of recovery community organizations (RCOs) to be individualized to communities. For example, in Athens, there is a great need for services for people who are unhoused and returning citizens, and RCOs are able to customize offerings based on that information. Mr. Sims said that through the Opioid Crisis Abatement Trust grant, his services have expanded from men-only to women-only services, as well. He believes that it is necessary for participants to share their trauma and the impact of their trauma with their peers. The cure for what Mr. Sims calls the "poison" of addiction is processing and talking about the drivers of addiction and traumatic experiences. He says that peer support and collective sharing and processing are the ways to achieve sobriety. He also described some of the stories shared by individuals receiving services at his recovery organizations.

Tarusa Stewart, CEO and Co-Founder of iHope Inc.

Ms. Stewart gave an overview of the work of iHope. iHope is a nonprofit RCO. The RCO is in 16 sites, most of them prisons and diversion centers. She described forensic peer mentorship as a model of mutual respect that fosters trust and reduces stigma. She then gave an overview of iHope's work (1) inside diversion centers, (2) inside prisons, and (3) in partnership with accountability courts. Ms. Stewart also described iHope's role transporting participants in mandated treatment and the way the organization compensated for the challenges of the COVID-19 pandemic. Key benefits and outcomes of iHope presented included reduced recidivism, increased treatment engagement, cost

savings due to decreased incarceration rates, and a positive social impact resulting from breaking the cycle of criminal justice involvement.

Sunshine McCoy, Peer Support Specialist, and Jennifer Langston, Executive Director at REBOOTjackson

Ms. McCoy and Ms. Langston gave an overview of REBOOTjackson and their work as forensic peer mentors. Started in 2018, REBOOTjackson's primary partner was the Accountability Court of Jackson County. They have since received a grant from DBHDD and have expanded to collaborate with more community services and organizations. So far, REBOOTjackson has had 176 interactions with peers in prison, 72% of which are justice-involved. Forensic peer mentors enter the prisons and provide Moral Reconation Therapy, group check-ins, goal-setting, GED assistance in partnership with Lanier Tech, social assistance to obtain documentation, exit planning and placement in recovery housing, and connection to MAT services upon release. As someone with a prior experience of incarceration, Ms. McCoy says her time in prison is when she needed support, so she is happy to provide services to peers in prison.

REBOOTjackson receives referrals from the accountability court. The organization helps inmates fill out applications for services and funds treatment. Ms. McCoy and Ms. Langston described the difficulties inmates face accessing services upon release, including housing limitations and MAT access. The speakers reported that more people are mandated to Transitional Housing Opportunities for Re-entry than is feasible in the current system. Additionally, Ms. Langston says accountability courts are not familiar with GARR certification of recovery houses in Georgia but need to be able to refer participants to appropriate locations. Another barrier individuals who are incarcerated face is the inability to access their MAT prescribed treatment. There is an opportunity for the jail systems to collaborate with treatment services. Ms. Langston says it is especially difficult for pregnant women to receive MAT. Ms. Langston reports that she understands that the priorities of jails are not recovery but says there should be a peer who comes into every jail to support the recovery of those incarcerated. REBOOTjackson is the sole peer-support provider to the Jackson Country prison system. She says they have built trust within that system and that it is a relationship they treasure. Finally, she says all services necessitate more funding and state budgeting beyond individual grants.

Young Adults in Recovery: Spotlight on Collegiate Recovery Programs

Blake Schneider, Director of the Center for Young Adult Addiction and Recovery at Kennesaw State University

Mr. Schneider gave an overview of the Center for Young Adult Addiction and Recovery (CYAAR) collegiate recovery program at Kennesaw State University (KSU). There are 170 collegiate recovery programs (CRPs) in nation, and the KSU program is the longest-standing in the Southeast. The Southeast has a saturation of collegiate recovery programs. If students are not well, they are unable to learn. Among KSU students, 30% stated anxiety, 25% stated depression, and 35% said stress negatively impacted their academics. Seventy-one percent of students indicated increased stress and anxiety due to COVID. Students report self-medicating with substances.

Collegiate Recovery Program
Mr. Schneider refers to CRP as the "core" of the CYAAR program and its original design. A longer-term program, students must apply to join CRP. Once a part of CRP, students receive peer support, academic advising, recovery housing and programming, and even potential scholarships.

Recovery Support Services
For students with less than six months' sustained recovery, Recovery Support Services allows students to discover recovery. Recovery Support Services offers services like counseling, case management, addictive disorder assessments, referrals, mutual aid meetings, etc. Recovery Support Services builds students skills without requiring them to commit to a longer-term program.

Recovery-Informed Education
CYAAR focuses on peer educational models, which are highly effective in engaging students. Events include workshops and trainings, classroom presentations, educational tabling, and awareness campaigns that include season events. Mr. Schneider stated that recovery-informed education equips students with resiliency.

Recovery Science Research
Mr. Schneider stated that the science of addiction has traditionally focused on why people get sick but that CYAAR is more focused on strengths-based research and learning how students can get well. CYAAR engages in interdisciplinary, evidence-based research to inform its practices.

CYAAR by the Numbers

- Founded in 2007 — first recovery support program on a Georgia campus
- Eight staff: five in recovery, four CYAAR alumni, all experienced and certified
- Four program areas: CRP, Recovery Support Services, Recovery-Informed Education, Recovery Science Research
- Two campuses: programs and services are available on both the Kennesaw and Marietta campuses
- 52,000 students at KSU, and CYAAR is a resource for all, not only those in recovery

Broader Impact

- 60% have graduated or are still in the program
- 51% of those who graduated did so with honors
- 6% increased their GPA
- Alcohol and substance use rates have been lowered on KSU's campus 5-10%, depending on the substance referenced

Following Mr. Schneider's presentation, Ms. Ritter asked how CYAAR is funded. He responded that CYAAR is funded through a variety of sources. The University System of Georgia covers the vast majority of costs. CYAAR also has a revenue fund from trainings that is directly reinvested into the program. CYAAR also receives a grant from DBHDD and has a foundation for scholarships and general operations. Mr. Schneider stipulates that most collegiate recovery programs are likely to have less diverse funding streams.

Recovery in Community: Spotlight on RCOs

Brian Kite, RCO Development Coordinator at the Georgia Council for Recovery

Mr. Kite gave an overview of Georgia Council for Recovery's (GC4R's) RCO program in Georgia. RCOs are nonprofit organizations run by peers that focus on advocacy and education, but more importantly, peer support in their community. GC4R focuses on advocacy for peer-based recovery. GC4R has been in operation for about 10 years and has grown with the financial support of policymakers. Peers in recovery help their community through a participatory process that keeps services community-led. There are gaps in services, and GC4R is in attendance to amend that. RCOs integrate services in a grassroots way so that services for people in recovery are not duplicated but integrated and complementary. GC4R is advocating to put into statute what an RCO is so that it can strengthen the integrity of the RCO network. Mr. Kite reports there are Opioid Crisis Abatement Trust funds available. GC4R wants other forms of support to be strengthened and available, while keeping RCOs about peer support and community-driven work. In 2015, there were only a handful of RCOs. There are now over 30, many funded by the state of Georgia. GC4R has a fantastic network of RCOs and great relationships with legislators.

RCOs are an integral part of the continuum care for behavioral health. They fill critical gaps in communities where resources are limited. RCOs address gaps in prevention, crisis, intervention, treatment, and post-treatment services and often bridge the gap between service providers in communities where services are limited. RCOs mobilize relationships to promote recovery. Resources commonly included: recovery coaching, peer-led support groups, naloxone distribution, family support, employment support, transportation, housing support, advocacy, and community and social activities. RCOs help prevent return to use, prevent hospitalization and incarceration, and strengthen communities. Last year, 33,600 individuals were served 390,000 services by RCOs. Since 2018, the Georgia General Assembly has appropriated $6 million for RCOs. RCOs have also sought Opioid Crisis Abatement Trust and local funds. With the rapid growth of RCOs, statutory definitions and standards are essential for quality enforcement and oversight. Minnesota, Colorado, Michigan, Maine, Indiana, New Hampshire, Rhode Island, Oregon, and other states have instituted binding standards for their RCOs, and GC4R thinks Georgia should follow suit.

Following Mr. Kite's presentation, Ms. Guerrero asked if there are any services offered comparable to RCOs by other organizations. Mr. Kite stated that there are not. Ms. Guerrero expressed the opinion that RCOs are a bargain in terms of their per capita cost. Subcommittee members discussed the impressive work of RCOs and their support for RCOs.

Shelly Roach, Director of the RCO Unified in Recovery

Ms. Roach gave an overview of the work of Unified in Recovery and its relationship to her own experiences in recovery. Ms. Roach's use of opioids began with back surgery when she was prescribed medication without any warnings concerning the side effects of the medications. In 2010, she sought treatment at a mental health facility unsuccessfully. In 2013, she was incarcerated, which she said was a huge blessing. She said that during her two years of imprisonment she found a purpose in helping others through her sobriety. She was using again in 2018 and violated her parole, but that led to her participation in rehabilitation and treatment. Through her rehab in Rome,

Ms. Roach was introduced to the RCO Living Proof. She considered living at the RCO because it was such a positive influence in her life, but she decided to move home to be close to her sons.

Returning to her home environment was a struggle, and Ms. Roach realized that she needed more than a weekly meeting to maintain her recovery. She said she needed a recovery community to support her. One day, Jennifer Jenkins, who led the meetings at Living Proof, invited Ms. Roach to start a new RCO. Ms. Roach said starting Unified in Recovery is when her recovery started to thrive. She said that her connections with others in recovery helped her learn how to help others and helped her better learn how to help herself, which is why she says peer support is the best kind of support for people in recovery. Unified in Recovery is still growing five years later. When a peer sits down with someone, their shared lived experience gives others hope. She shared that Unified in Recovery has connected with the local sheriff's office and the local accountability court, despite several members' history of incarceration. She says in community partnership, they are saving lives. Ms. Roach stated that having an RCO sooner in her recovery to help her build a recovery plan would have changed her life for the better, and she is determined to empower others in recovery through the provision of that support.

Prevention of Addictive Diseases

Spotlight on Lifecare Specialists in Hospitals

Cammie Wolf Rice, Founder and CEO of CWC Alliance

Ms. Rice gave an overview of the work of the CWC Alliance, which is named after the son she lost to an opioid overdose. She shared that her brother similarly overdosed from fentanyl. It's estimated that 15 million Americans use substances every day. Ms. Rice states that 80% of heroin users enter into use following the prescription of an opioid. Ms. Rice's own son began his substance use in middle school after being prescribed opioids for ulcerative colitis.

CWC Alliance is built on a coaching framework. Ms. Rice says that coaching is essential to many roles and activities in society: lactation, work-outs, sports teams, and executives. Ms. Rice says that she invented the lifecare specialist, a new position in the health care system for the bedside. She tailored this position to what her son did not have, and what she believes would have benefited him as a patient. It is educating patients to know what they need and advocate for themselves. Most people in the hospital are in pain — the lifecare specialists have techniques to distract themselves from their pain and to deal with the mental side of being ill without relying solely on a pain medication.

CWC's work started at Grady. She asked health care experts what her business needed and they said funding. When they found funding and piloted at Grady, she found that 75% of patients did not know they were being prescribed opioids. Lifecare specialists educate patients, listen to them at bedside, and check in with them post-discharge. The patient shares knowledge of comorbidities with their lifecare specialists, so that they can be referred to resources. There are eight lifecare specialists across Georgia, focusing on rural areas. These eight lifecare specialists have now had 4,000 patient encounters.

The key to CWC's success is partnerships. They are partnered with Mercer School of Medicine where there is coursework taught on lifecare specialists. Lifecare specialists do not need to have a college degree. Harvard University has conducted a case study to study the impact of lifecare specialists. The goal is to have a lifecare specialist in every hospital in Georgia. Ms. Rice concluded by stating her belief that education, empathy, and a simple conversation can rewrite a patient's trajectory.

Containment of Addictive Substances and Preventing Substance Use Through Building Youth Resilience

John Bringuel, Director for Georgia Prescription Drug Abuse Prevention Initiative at the Council on Alcohol and Drugs

Mr. Bringuel gave an overview of the Georgia Prescription Drug Abuse Prevention Initiative at the Council on Alcohol and Drugs. He started doing work to help people 37 years ago, beginning his career in treatment, moving to interventions, and now focusing on prevention. Though he himself is not a person in recovery, he said he thinks the best preventionists are people in recovery because they can empathize.

Mr. Bringuel stated that the Council on Alcohol and Drugs has been empowering and transforming lives for 56 years by equipping communities with tools necessary to prevent substance misuse and its associated challenges. This is achieved through education, advocacy, and the use of evidence-based strategies. The council's vision is to establish itself as the leading resource for substance misuse prevention education, ultimately changing lives through safeguarding futures.

Mr. Bringuel highlighted several concerning data points for Georgia. In 2024, the United States saw a nearly 24% decrease of overdose deaths, dropping from approximately a 110,000 in 2023 to 80,424 in 2024, according to provisional data from the Centers for Disease Control and Prevention. He said this encouraging trend translates to 70 lives saved per day nationally. However, Georgia's overdose rates remain alarmingly high. Even though there were 481 fewer fentanyl-related overdose deaths recorded in 2024 in Georgia, there were still 976 fentanyl-related overdoses in total. Mr. Bringuel said that unless the number is close to zero, there is still to work to do because every death is personal to someone. He also said that methamphetamine-related overdoses remain tragically high: more than 1400 deaths in 2024 alone, many of which are linked to fentanyl contamination. Mr. Bringuel works closely with the DEA and the High Intensity Drug Trafficking Areas (HIDTA) program, and they report alarming numbers. According to the Atlanta HIDTA, there is critical work to be done. There is a need for robust prevention strategies both on the individual and environmental levels to save lives and significantly mitigate and reduce the devastating toll of substance misuse in our state.

Georgia Prescription Drug Use Prevention
The Georgia Prescription Drug Use Prevention Initiative has been funded by DBHDD for the last 14 years. The initiative is a comprehensive statewide prevention effort that focuses on four core principal areas with 17 deliverables designed to prevent and reduce prescription drug misuse and addiction, particularly involving controlled substances like opiates and stimulants. Stimulants are frequently used in schools as study drugs. Benzodiazepine is often misused in combination with alcohol, and gabapentin is used in combination with opiates and depressants. The core priorities of

the initiative are substance misuse prevention awareness and education and safe medicine storage. For the past 14 years, this initiative has been driven by individual environmental strategies and fueled by assertive high-impact partnerships with more than 300 organizations, agencies, and individuals. Some of these high-impact partners include but are not limited to grassroots advocates like Cammie Rice of CWC Alliance, Doreen Bar of In Ryan's Name, the Georgia Family Connection, Georgia drug-free community coalitions, the Department of Public Health, the Department of Education, the Georgia Sheriffs' Association, and the Georgia Society of Addiction Medicine. The initiative's mission is clear: to prevent prescription drug misuse and addiction and to assist in overdose-prevention efforts across the state and lifetime continuums with targeted support for vulnerable populations, including youth, pregnant women, veterans, active-duty service members, older adults, people in recovery, and other high-risk and underserved communities. Prevention efforts don't stop at awareness. They include promoting practical science-based solutions through proven education.

Public Prescription Drug Receptacles
Georgia is a leader across the nation in the proliferation of prescription drug receptacles. Georgia has 248 collection receptacles and dropboxes for prescription drugs. Funding is needed to advertise the receptacles and continue to expand their use. Twelve years ago, the Council on Alcohol and Drugs made an investment of $100,000 to implement receptacles statewide. Without taking a salary from that funding, Mr. Bringuel utilized the funding to proliferate 248 receptacles believing that they would remove prescription drugs from individual's homes and protect Georgia's children. He said that this initiative and the work of partners has greatly reduced the incidence of overdoses, but that more work, funding, and dropboxes are needed. Mr. Bringuel stated that dropboxes are one of the most effective, low-cost strategies for preventing prescription drug use, and that funding is needed to advertise these receptacles so the public is aware of where to find them in their communities. Mr. Bringuel stated that unused medications, both prescription and over-the-counter, pose a serious risk when they are left unsecured in the homes. They become a gateway to misuse for youth, visitors, and vulnerable family members. They also can become a target of theft and diversion, especially during times of crisis and during the holidays. Finally, unused medications are an environmental hazard when flushed or improperly discarded. Over 60% of people who misused prescription painkillers report obtaining them from a friend or family member, often from homes, bathroom, or kitchens.

Mr. Bringuel stated that use of someone else's medication is serious and can lead to long term addictions and even death. Georgia's network of 248 receptacles are primary located in law enforcement agencies, which is limiting. Particularly in rural areas and underserved communities, where law enforcement locations maybe few and far between. Despite best intentions, Mr. Bringuel stated that many Georgians do not have practical, consistent access to safe medication disposal. By expanding access to secure collection receptables in the public spaces like public health departments, community service boards, hospitals, urgent care centers, civic centers, colleges, universities, and technical schools campuses, Mr. Bringuel stated that receptacles can greatly reduce the prevalence of unused medications in Georgia homes. By making medication disposal more convenient, receptacles reduce access to addictive substances, which Mr. Bringuel stated is particularly important in terms of opiates, stimulants, and toxic substances, especially among young children and older adults, disrupting the pathway to addiction. Mr. Bringuel also believes receptacles support law enforcement and first responders by reducing the need for crisis intervention. The cost to install and maintain a drug collection receptable is about $3,500 a year. The dropboxes disintegrate substances within five minutes, leaving no opportunity for diversion.

The five gallons of fluid inside of them only needs to be replaced after the disposal of about 10,000 doses of medication.

Mr. Bringuel stated that community members are willing to use these boxes when available. Public access campaigns combined with expanded locations have been shown to significantly increase disposal rates and reduce home-based stockpiling of prescription drugs. He believes that expanding Georgia's drug collection receptacle network is a strategic low-barrier, high-impact prevention measure that is available today, and that it complements broader efforts in education, early intervention, and treatment access by reducing the very presence of addictive substances in our homes and communities. Mr. Bringuel believes this is a critical opportunity to close the access gap, protect Georgia youth, support families, and save lives.

Universal Statewide Emotional Literacy Campaign in Georgia Schools
Mr. Bringuel also advocated for the implementation of a universal statewide emotional literacy campaign in Georgia schools. Emotional literacy is the ability to manage your emotions and influence those around you. It includes a person's ability to self-assess and have empathy for (1) themselves and (2) for others. Empathy is necessary for recovery and social awareness to manage relationships, stay motivated, and make healthy decisions.

Mr. Bringuel stated that emotional literacy, the ability to manage one's emotions, is a single most important protective factor for our children, young adults, adults, and our seniors. As an internationally certified prevention specialist, Mr. Bringuel specializes in the science of prevention. He believes that with the protective factor of emotional literacy in place, other risk factors will have little impact. He said that research has consistently revealed that emotional literacy builds resiliency and refusal skills, reduces experiences of peer pressure, reduces suicidal ideations, and significantly decreases the risk of early onset of drug use.

Mr. Bringuel also highlighted existing programs for emotional literacy in Georgia, such as Sources of Strength, GA Past Project, Prime for Life, Resilient Teams, GPS for Success, Connections Matter, and school-based social-emotional learning programs, though he believes they are insufficient, as they are not inclusive of the entire state's population of school-age children. Mr. Bringuel believes a universal program is necessary.

Following Mr. Bringuel's presentation, Mr. Walters asked him to delineate the price of a dropbox. He said the initial year is $3,500 because it includes the kiosk and that every year after it's $1,250 for a new container. Mr. Walters shared that he used to work in the independent pharmaceutical industry and that at the time he and his colleagues believed that they were not allowed to keep receptacles at the pharmacy. Mr. Bringuel corrected this assumption and stated that pharmacies are now encouraged to keep receptacles for medication, but that he is in need of more pharmacy contacts and requested the contact information of Mr. Walters' previous colleagues and any interested parties.

Maternal Health and Substance Use

Rebeca Bonilla, Research Coordinator, Echo Project, Rollins School of Public Health, Emory University

Ms. Bonilla gave an overview of the project, which is a National Institutes of Health–funded project designed to generate evidence to prevent overdoses and drug-related harms to pregnant or

postpartum women in three regions of Georgia: South Georgia, metro Atlanta, and North Georgia. The study also investigates regional service needs. The project interviews participants every three months one-on-one. There are 30 participants in each region. In order to be eligible for the study, participants must be either pregnant or in the first quarter of their postpartum period and must have used an illegal substance at least once in the three months prior to learning they were pregnant. Project recruitment and maintenance has been guided by a community advisory board in each region. Recruitment for the study has concluded. Many of the participants who will be included in the study are facing significant financial hardship: 39% of participants included are unhoused and 41-42% are WIC or TANF/SNAP recipients. Initial findings of the study, including participant-identified barriers to treatment and participant delivery experiences, are outlined below.

Barriers to Treatment among Pregnant Women — Barriers to Entry
Participants of the study have described long travel distances to treatment, which becomes more difficult as their pregnancy progresses. When there are programs close by, a lot of those programs do not accept Medicaid, the insurance of many pregnant and postpartum women using illegal substances. Pregnant women are also often not accepted into treatment due to their pregnancy because providers feel ill-equipped to treat women who are pregnant.

Barriers to Treatment among Pregnant Women — Barriers to Retention
Participants have different harm-reduction goals. Participants who were satisfied with their treatment received housing support and child care support and other wraparound services. In terms of retention, participants expressed a need for more individualized services. Treatment can have rigid requirements around promptness that may not be available due to transportation difficulties. Requirements around sobriety can also eject participants, which can push women to withdraw, which is extra dangerous if the woman is pregnant, both for the woman and her fetus. Transportation is also a barrier to treatment retention.

Barriers to Treatment among Pregnant Women — Barriers to Medications to Treat Opioid Use Disorder Treatment
Medications to treat opioid use disorder (MOUD) is the first line of treatment for opioid use disorder (OUD), but it has unique barriers, particular for pregnant women. In Georgia, there are rules about when a caregiver can be reported to the Georgia Division of Family and Children Services (DFCS). In Georgia, it is not legal to report a caregiver for the use of a prescribed substance, including MAT medications, but despite its illegality, women who are pregnant are being reported by their treatment facilities. One woman shared that the drug treatment counselors at her drug treatment facility were drug testing and reporting pregnant women who had methadone in their system, even though this is legal according to Georgia law.

Delivery Experiences of Women with Substance Use
Obstetricians may not have the training necessary to properly administer MOUD medication for pregnant women. One woman recalled being underdosed during her delivery, which led her to going into withdrawal. Her partner advocated for her use, leading to an increased dose and the cessation of her withdrawal symptoms, but hospital security was called, and security officers monitored the rest of her birth. Another woman described being overdosed during her birth, which led to her semiconsciousness during birth. Pregnant women participants have also described high levels of anti-MOUD stigma during their hospital experiences.

Barriers to Treatment for Postpartum Women
DFCS workers may or may not view MOUD treatment as legitimate treatment for pregnant women. Some participants have described being discouraged from breastfeeding due to their use, which Ms. Bonilla ultimately attributes to a lack of education around its efficacy and safety.

Potential Next Steps
As the coordinator of a federally funded project, Ms. Bonilla cannot make policy recommendations, but she did describe feedback from participants in the context of Georgia policy. Four states, Kentucky, Missouri, Tennessee, and West Virginia, prohibit discrimination against pregnant women by any agency that receives state funding. Georgia is not one of those states. Though it is not legal to report women to DFCS for their use of prescribed substances, women are being reported for their use of MOUD anyway. Rather than changing the law itself, interventions could focus on the existing code's implementation. Increased education and training for leaders in the MOUD space, service providers, and women in their own communities would strengthen women's ability to advocate for themselves and their treatment needs.

Amy Ard, Executive Director, Motherhood Beyond Bars

Ms. Ard gave an overview of the work of Motherhood Beyond Bars. Ms. Ard was a doula for 10 years and founded Motherhood Beyond Bars seven years ago in response to the crisis of maternal incarceration. She stated that over the last decade, there has been an 800% increase in incarceration of women, and it is not reported how many of these women are pregnant. The three goals of Motherhood Beyond Bars are (1) to keep infants safe, (2) to support women during periods of separation, and (3) to reunite families.

Ms. Ard stated that deep listening is the key to her work at Motherhood Beyond Bars, and that the organization seeks to take what they learn from communities and implement those teachings. She described the first time that she visited Lee Arrendale state prison, formerly Georgia's largest women's prison. The women were gathered in a circle, sharing their highs and lows. One woman said it was her child's birthday and she was making her a present similar to a crafted present that her own mother had made her when she was incarcerated. Ms. Ard learned that day that of the 14 women she was speaking with at the time, 13 had mothers who were in prison. Infants born to women in prison are more likely to end up in prison themselves — Ms. Ard stated that parental incarceration is not only a risk factor but it has a causal relationship with an individual's incarceration. To contextualize the additional risk factors experienced by the children of incarcerated mothers, Ms. Ard referenced the Adverse Childhood Experiences Scale (ACES). ACES is a measurement tool used to describe traumatic experiences an individual may have had during childhood that are expected to have long-term impacts on their health and wellness through a summative score. Infants born to women incarcerated are born disadvantaged with two ACES scores: they have a parent who is incarcerated and their primary caregiver changes at birth. ACES scores can be counteracted by resiliency factors; however, once they leave the hospital, infants with parental incarceration are not tracked by DFCS or any support system.

Holistic Family Support Program
In 2019, Motherhood Beyond Bars launched its Holistic Family Support Program to support whole families, including 360 infants and over 1,000 family members currently in the state of Georgia. They provide several services designed to build resiliency factors, including $112,000 worth of free diapers this year. Ms. Ard stated that the cost of diapers alone can lead to a child being surrendered

to foster care. Motherhood Beyond Bars hires women who are peers and have lived through the experience of incarceration themselves. Ms. Ard stated that hiring peers in incarceration is one of Motherhood Beyond Bars' most important strategies to building family resiliency because they are best equipped to support women experiencing incarceration.

Substance Use and Incarceration
Women have described the horrors of detoxing in jail and wanting to die due to the exposure and medical difficulty of detoxing without support. The formerly incarcerated employee who shared her story with Ms. Ard was pregnant at the time and described grief, guilt, and a lack of support. Ms. Ard stated that this co-worker was actually lucky because the statistics show that 10% of pregnant and postpartum deaths in the United States are related to OUD. Motherhood Beyond Bars has sought to track the number of women incarcerated with OUD, but despite two prior recommendations, the legislature has not approved collecting this data. Instead, Ms. Ard referenced a 2020 academic study by Sufrin et al. that estimates that there are 55,000 pregnant jail admissions in the United States every year and that about 14% of those women have OUD.

Motherhood Beyond Bars in County Jails
This year, with financial help from the Opioid Crisis Abatement Trust, Motherhood Beyond Bars has expanded its work into county jails to provide evidence-based childbirth education to women in jails and to collect enumeration data on pregnant women in jails. In just a few months, Ms. Ard stated that Motherhood Beyond Bars has encountered 93 pregnant women in jails. The goal of the county jail program is to provide birth education to women in jail and connect them to their community on the outside of their carceral setting to secure a safe birth. Ms. Ard stated even if women spend only a few days in jail, if they have OUD and are pregnant and are released to no support system, the risk of death to both mom and baby are greatly increased. The program also seeks to identify women who would be a better fit for a treatment program to prevent separation of the mom and the baby, and the cycling of the women through the carceral system. Once identified, Motherhood Beyond Bars presents a case for diversion to the relevant judge and court system.
The staff peer who shared her own story of detoxing in jail also shared a story with Ms. Ard about a woman who had previously sought treatment for OUD unsuccessfully. Ms. Ard stated that women who receive treatment as an alternative to incarceration are dedicated to treatment. Working with Fulton County jails, Motherhood Beyond Bars connected this woman to MOUD treatment right away, as well as wraparound services, connecting her to Hope House, a recovery residence in Augusta. Ms. Ard says this mother is now employed, thriving, and together with her child. Through this work, Motherhood Beyond Bars avoided the separation of mom and baby and built the family's resilience.

Motherhood Beyond Bars recommends that supports are offered to pregnant women in carceral settings. Researchers at Johns Hopkins have created a decision tree for pregnant women in carceral settings, which Motherhood Beyond Bars recommends implementing. They recommend installing a peer specialist in every carceral setting, a voluntary screening for the distribution of MOUD meds, and that the decision tree is implemented in every carceral setting. Ms. Ard stated that women who are suffering acutely due to substance use withdrawal need to be transferred to a hospital and that their ability to retain MOUD medication should be guaranteed. Women currently are not offered MOUD meds if they have not used these medications previously. Motherhood Beyond Bars also recommends a warm handoff and a continuum of care for women in carceral settings. Women who Motherhood Beyond Bars have diverted are often reported to DFCS, which can lead to the illegal separation of the family. Motherhood Beyond Bars also recommends education around the Georgia

law that states that someone cannot be reported to DFCS for taking a prescribed medication to prevent the future separation of families. Motherhood Beyond Bars is happy to share their educational resources that they distribute to carceral settings. Resources are available at motherhoodbeyond.org.

Aubrey Williams, Coordinator of Northeast Georgia Medical Center Neonatal Community Outreach

Dr. Williams gave an overview of the work of the neonatal intensive care unit (NICU) at Northeast Georgia Medical Center (NGMC) and the substance use programming that sets it apart from other NICUs.

Neonatal Abstinence Syndrome
Dr. Williams first contextualized the work of NGMC's NICU by describing neonatal abstinence syndrome (NAS). NAS is an expected outcome of MAT. The priority of the neonatal unit is to support mom and baby through the symptoms. The baby is experiencing a form of withdrawal and will need support. They are not addicted to the substance in the mother's system as addiction requires awareness of use, but they are experiencing withdrawal from the substance.

Program Origins — Transitioning from Finnegan to Eat, Sleep, Console
Initially, NGMC's NICU saw a length of stay for NAS of 37 days, but the program sought to standardize care and reduce length of stay, including distributing morphine instead of methadone for infants and educating providers. They reduced length of stay to 19 days. The NICU then sought to integrate peer services. Peer services assisted with the new protocol of Eat, Sleep, Console. This protocol sought to determine if the infant was able to function normally prior to the prescription of a medication or if the medication was necessary for the infant to be able to feed, sleep, and function normally. Though Eat, Sleep, Console slightly increased the length of stay of infants, by focusing on nonpharmacological care and the mother/child dyad, Eat, Sleep, Console decreased morphine prescriptions and has saved the hospital money. The NICU also integrated creative programming, such as bringing music into the NICU to soothe the infants and inviting caregivers to participate in more ways in patient care. The NICU includes caregivers in every step of infant care.

Recovery Language and Culture
Implementing peers in the NICU has created a culture shift. The NICU has implemented recovery language. Dr. Williams shared that beyond education for staff, integrating peer recovery coaches has necessitated a holistic mindset shift. Following this cultural shift, Dr. Williams stated that even the most resistant providers have become recovery allies. Even moms who denied their substance use until delivery are now seeking treatment through NGMC's NICU peer recovery coaches. Dr. Williams said that everyone is touched by substance use in their personal lives, which leads to biases that need to be addressed in order to prioritize patient care and experiences.

Peer Implementation in the Hospital
Peer support implementation started in the NICU, but now whenever a patient mother is identified as in recovery, a peer coach will be referred. Peers meet with patients outside of the hospital through their recovery, including meetings with DFCS and court dates. Dr. Williams says that recovery happens in community and that peers connect moms and families with recovery resources.

Impact of Integrating Peer Recovery Coaches

- 1,423 mothers supported since 2018
- 10,577 follow-up conversations
- Reduced length of stay by 2.2 days

Next Steps
Following the success of peer recovery coaches in the NICU, NGMC is planning to expand the integration of peer recovery services beyond perinatology offices to obstetrician offices in the hospital and in the community. Peer recovery services are not entered into medical records, but Dr. Williams said they are building out a portion of EPIC for peer coaches that will be kept separate and allow peer coaches to ensure follow-up without endangering a patient in recovery's confidentiality. NGMC's NICU is actively seeking new partnerships in communities with recovery resources for patients.

Workforce Concerns

Licensure of Certified Addiction Counselors

Starling Bridges, President, and Taylor Hagin, Member of Georgia Addiction Counselors Association

Mr. Bridges introduced himself as the president of Georgia Addiction Counselors Association (GACA) and the clinical director of a residential program called Serenity Grove in Athens, Ga. He gave an overview of the work of GACA, which certifies peers to work in substance use through 180 hours of education, 100 hours of supervision, and two years of full-time work in the field, as well as a certification exam. There are three levels of certified addiction counselors (CACs) for each level of education received: associate's, bachelor's, and master's. In Georgia, it is a credential and not a licensure. In other states, there is a licensure specific to addiction counselors, but it is a licensure. GACA is advocating to become a licensure in the state of Georgia. In Mr. Bridges' own experience, his lack of a licensure inhibited him from billing insurance as a CAC. He gained his master's degree and his licensure as a licensed professional counselor (LPC) in order to be compensated for his clinical work but stated that he feels his LPC program was lacking in comparison with his CAC certification in terms of gaining knowledge of addiction sciences. Mr. Bridges stated that as a clinical director, he has faced barriers to care due to the limitations placed on the work of CACs by insurance companies. He stated his belief that the behavioral health workforce would be stronger with a licensure specific to CACs, as he is currently employing less experienced staff with master's of social work and LPCs at a higher level than CACs even though they have less experience working with patients in recovery. Even though Georgia law allows CACs to provide professional counseling, insurance companies are often uncooperative, leading to difficulties for CACs seeking adequate employment and payment for their services, treatment facilities seeking staff, and ultimately the provision of treatment.

Mr. Hagin gave an overview of the behavioral health landscape and the role of CACs in lessening the burden of addictive disease treatment. He emphasized the cost of addictive diseases on communities and the dire need for addictive disease treatment. He says that CACs are best equipped to treat SUD. Mr. Hagin highlighted that CACs meet national standards and log thousands

of hours of work, stating his belief that they should be able to bill insurance for services, both Medicaid and private insurance. He stated his belief that current policies regarding CACs do not recognize their value in the behavioral health workforce and their potential to alleviate the adverse effects of addictive disease on communities. Mr. Hagin stated that the provider index for CACs is 17.3, which he said is half of the national average of 32. He also highlighted that Georgia ranks 46th in access to mental health and substance use treatment. He also stated that 20% of CACs leave the field every year, and within four years half of them leave the workforce. He stated that by 2030, the need for behavioral health professionals will increase 32%, creating nearly 900 new job openings every year, without the built capacity to train, retain, and license sufficient professionals to fill each role. He stated that workforce concerns increase recidivism of returning citizens and challenge the continuum of care, and that untreated addiction will have impact across sectors including health care, law enforcement, education, and the economy. Mr. Hagin advocated for the creation of a CAC licensure, stating that it is a cost-effective measure that will alleviate behavioral health workforce concerns without further bureaucracy or the creation of new taxes. He also stated that GACA is prepared to offer the licensure, and that they are already aligned with NADEX standards of ethics, education, and examination. A CAC licensure would increase professional parity by allowing CACs to bill for services they are already providing within their defined scope of responsibilities. Thirty-one states have already licensed addiction counselors. Mr. Hagin stated that licensing the addiction counselor improved access to care, reduced turnover, and improved public trust in the field in implementing states. Mr. Hagin referenced policy in Colorado, Utah, and Oregon specifically, stating that since implementing this policy change, these states have seen an increase in the addiction workforce of 27% in three years. Mr. Hagin advocated that Georgia implement a similar policy before the gap between the need for addiction counselors and their availability grows too wide. Mr. Hagin also stated that every taxpayer's dollar spent on addiction treatment saves $11 in criminal justice and health care expenditures. The principles taught to CACs include personal responsibility, recovery, and restoration, values consistent with bipartisan views and priorities. Recovery benefits everyone — when the behavioral health workforce is strengthened families and communities benefit as well.

Ms. Guerrero asked Mr. Bridges and Mr. Hagin to further describe the problem, and Mr. Hagin stated that though he can hire a CAC at his business, they must bill under someone else's licensure. CACs therefore cannot practice independently or open their own facilities, and there are limited pathways for CACs to advance their careers, so CACs therefore leave the workforce. Subcommittee member Donna Ritter joined the conversation as the executive director of GACA, commenting that since GACA's founding 45 years prior, the CAC certification has been a limitation for the behavioral health workforce. A CAC licensure can only be instituted by the legislature. Ms. Ritter shared that GACA hopes to propose a licensure to the legislature this upcoming session for the first time.

Alternatives to Discipline for Nurses in Recovery

Mary Lou Wilson, Women's Service Line Administrator, Northeast Georgia Health System

Ms. Wilson gave an overview of Georgia's disciplinary response to nurses self-reporting a substance use problem, advocating for the expansion of the Alternative to Discipline program for Georgia nurses. If a nurse self-reports that they are in use, they will lose their license. By law, if they report their use to a supervisor, they will be reported or their supervisor will lose their license. Forty-one states have an alternate to discipline program, but Georgia is not one of them. Nurses in Georgia

need help with recovery that does not endanger their employment. Ms. Wilson stated that the state of Georgia needs every nurse it can get. Once a nurse is reported, they have to pay thousands of dollars for treatment, counseling, screening, etc., and it comes out of pocket because employer insurance is lost when they lose their licenses. Unlike nurses, physicians are covered when they seek treatment. Ms. Wilson advocated for a change in this policy, stating that the difference in response to the substance use of doctors and nurses is unfair.

Ms. Wilson also advocated for a new GAINS program run by nurses in recovery in Gainesville, so that nurses can repurpose their recovery journey to support the reentry of returning citizens. Gainesville would be interested in piloting this program with support from Georgia Council and the legislature. If the hospital system hired nurses in recovery, they would help with the nursing shortage.

Following Ms. Wilson's presentation, Ms. Guerrero sought to clarify if there is not an Alternative to Discipline program in Georgia. Ms. Wilson replied that though there is technically an Alternative to Discipline program in Georgia, she does not consider it an Alternative to Discipline program because the nurse's license is revoked rather than suspended and the nurse is forced to pay for their own treatment out of pocket. Ms. Ritter asked which organization revokes nurses' licenses and Ms. Wilson stated that it is the responsibility of the Board of Nursing in Georgia, but that the policy surrounding the Alternative to Discipline program would need to be changed by the legislature.

Courtney Robinson, Nurse, Northeast Georgia Health System

Courtney Robinson testified concerning her experiences as a nurse in recovery who reported her substance use problem. She said she was working as a nurse and actively using alcohol in a problematic way. Her license expired because she was distracted by her use. Her employer at the time noticed, and she was no longer able to work. She said she had lost the most important thing to her in the world. She self-isolated and drank to cope. She then decided to seek help at a hospital where she used to work because her withdrawals were so bad. While she was there, she met her peer coach Greg, who she said is part of the reason she was able to recover enough to be testifying. She dove into a 12-step program because recovery was the most important thing to her: she wanted her license back but was terrified of the consequences.

Prior to losing her license, Ms. Robinson stated that she had never gotten in trouble, committed a crime, or endangered a patient. For five months after becoming sober, Ms. Robinson said she waited without employment because she was afraid of the consequences of reporting herself. There is a question when a nurse reapplies that asks if they have been in active addiction or if they sought treatment in the last five years. She said she knew there would be consequences for answering that question honestly, but she decided to be honest because it was the right thing to do for her in her recovery. It took between 11 months to a year to get her license back, despite never being in trouble or causing harm. She had to do an intensive psychiatric evaluation and pay for it out of her own pocket. The tests cost $2,000, and she was unemployed for a year. She paid for a therapist on my own. She got recommendations from everyone in her recovery support system. After a year, she got consent orders. Despite reporting herself, she received the maximum requirements for five years. She still has to attend meetings, be drug screened, and have quarterly evaluations, and all of the costs come out of her pocket. There are certain jobs she is not allowed to hold such as travel nursing or research pool. She has to be supervised at all times. She is not allowed to go back to school during her time of supervision, though she would like to become a nurse practitioner to help

others like herself. She has also had great difficulty finding a nurse job. She reported that many employers will not speak to nurses with consent orders. The hospital system where she now works at Northeast Georgia would not meet with her until Ms. Wilson intervened on Ms. Robinson's behalf. Typically, what is available to nurses on consent orders are jobs that Ms. Robinson considers not safe, jobs that "no one wants."

As part of her testimony, Ms. Robinson described trying to get sober for five years before she "hit bottom." She said she was not able to. In the months leading up to her "bottom," she knew that she needed help, but there were no nurses she knew who were going through the same thing. She believes that if she had had peer support, it would have made a huge difference for her. Ms. Robinson advocated to make the response to nurses reporting a substance use problem more supportive and less punitive for people, saying that more nurses are more likely to come forward and seek treatment if they expect a supportive response. Ultimately, she said that Alternatives to Discipline will serve hospitals. Nurses will not be diverting drugs and harming patients, because they will seek the help they need. She said that she waited for five years to get help and that she would have felt a lot more comfortable asking for help if she knew that the system would support her. She said that Alternatives to Discipline would help others like herself.

Finally, Ms. Robinson advocated for hiring nurses on consent orders, stating that nurses in recovery are the best nurses. She said she is the most honest and careful nurse at her hospital because she has more to lose. She described how she checks and double-checks herself, and she stated that other nurses with consent orders would be the same way and should be given the opportunity to prove themselves to employers.

Following Ms. Robinson's presentation, Ms. Guerrero asked her if therapy had been a part of her consent orders. Ms. Robinson replied that therapy was not a part of her personal consent orders, but that it can be. Typically, consent orders include professional meetings, random screenings, and quarterly reports. Ms. Guerrero compared consent orders to a typical treatment plan, and Ms. Robinson confirmed that follow and evaluation, consent orders are requirements of nurses in recovery made in consultation with an addictionologist or a psychiatrist focused on addictive diseases.

Michelle Cooper, Nurse and Peer Support Facilitator, Georgia Nurses Association

Ms. Cooper gave an overview of her experiences as a nurse in recovery and a peer support facilitator through the Georgia Nurses Association. She is also advocating for a less-punitive Alternatives to Discipline program for nurses in recovery. She has been in recovery since 2018. She testifies to having lots of arrests and DUIs on her record, stating that they were the result of her inability to ask for help, fearing financial consequences as a single mom. When she was caught diverting drugs as a nurse, it was the first time she had ever gotten in trouble. She was heavily addicted to narcotics. At the time, she was a soccer mom of five kids, and she said that she taught them not to use drugs and alcohol even though she was in active use herself. She then lost her license and became homeless. She checked herself into treatment assuming she could never be a nurse again. Her identity was being a nurse and a caretaker, but she said that when she needed help, there was no one to care for her. She stated that it is an unrealistic expectation for nurses to cope with everything they see at work and not be able to ask for help with their substance use. Ms. Cooper stated that 74% of nurses report working with chemically dependent medical professionals who they will not report because they are afraid of the consequences to that

individual's livelihood. Now that she is a facilitator, Ms. Cooper witnesses nursing struggling with disciplinary measures — she has a nurse in her group who cannot get a clinical position after four years of recovery. Ms. Cooper described mental health as a disease process. When the brain is not working properly, it is expressed as a behavior. She believes that it is inappropriate medically for the response to substance use to be punitive.

When Ms. Cooper first received her board order, she was practicing as a travel nurse in Florida, Texas, and Georgia; all three states have punitive measures in place for nurses in recovery. She said that following her loss of licensure, she had to wait tables and pay $28,540 in costs for treatment without insurance. She lost the home she raised her children in. In advocating for Alternatives to Discipline, Ms. Cooper stated that nurses should not "be disposed of" when they most need help. She believes that in any other profession, people would just walk away following the treatment they receive for acknowledging their substance use problem. Despite their passion, even nurses are walking away from nursing due to the punitive response to their substance use, and the nation is facing a nursing shortage. Ms. Cooper asked, "Who is going to take care of your families?" She said that she is not compensated as a peer facilitator because she does not want the money of nurses in recovery. She did go back to school; she just was not allowed to pursue a clinical degree, so she got a master's in nursing administration and health care education and is now working on her doctorate. In advocating for Alternatives to Discipline, Ms. Cooper asked the audience, "Would you rather your family be taken care of by someone who has been helped or someone who has been punished or who is afraid to get help?" She said, yes, it is important to protect the public from health care providers who are impaired, but she believes the health care system will be more effective if nurses feel comfortable reporting their substance use problems and receive the help they need.

Additional Content to Highlight — Recovery Residence Policy in Other States

The National Alliance for Recovery Residences (NARR) is a national association for recovery residence standards that GARR helped create. Now, 30 states have an affiliate branch of NARR. States use different methodologies to regulate recovery residences and sober living facilities that range from completely voluntary to mandated licensures. Hawaii and Arkansas have a registry and a directory respectively of residences that are certified or meet minimum standards. Participation is entirely voluntary, but only residences in compliance are eligible to be listed. In Florida, there is a voluntary certification but noncertified residences are not eligible to receive licensed service provider referrals, thus heavily incentivizing participation. Similarly, in Texas, accreditation of recovery residences is not mandated but nonaccredited residences are not eligible for state funding. Some states, like Massachusetts, differentiate between recovery residences and sober homes, requiring licensing of recovery residences but not sober homes.

Recommendation Priorities

The Addictive Diseases Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action.

Recovery Residences

1. **Establish a statewide licensure for recovery residence and establish the Department of Behavioral Health and Developmental Disabilities (DBHDD) as the licensing body.**
2. **Georgia Association of Recovery Residences (GARR) certification will act as a "gold standard" certification and will have higher quality standards than the state licensure.**
    a. GARR will serve a critical advisory role developed to avoid potential conflicts of interest. This may include contracting for technical assistance and trainings for DBHDD compliance staff and licensed providers.
    b. GARR will perform annual quality checks, escalating cases of "noncompliant" recovery homes to DBHDD.
    c. Annual continuing education unit trainings, required to maintain licensure, can be offered through GARR.
    d. Legislation will mention National Association of Recovery Residences and their subaffiliate. Provide funding for the designated recovery residence association to provide training, technical assistance, continuing education, and grievance board to recovery residences.

Licensure

3. **Expand the code of the Drug Abuse Treatment and Education Program licensure to be inclusive of alcohol-only substance use patients. Change definition of "drug abuse" to *include* alcohol and its derivatives, removing excluding language.**
4. **Provide licensure for certified addiction counselors (CACs) through the Georgia Licensed Addiction Counselor Act, empowering CACs to bill insurance and expanding the mental health and substance use disorder therapeutic system without creating new bureaucracy or new taxes.** The Georgia Licensed Addiction Counselor Act will:
    a. License Georgia's CACs through the Georgia Addiction Counselors Association (GACA) — A 45-year-old addiction counselor credential association is requesting a two-tiered licensing system similar to the Indiana Model that includes GACA continuing the credentialing of nonlicensed CAC I and CAC II levels of addiction counselors. This process is in alignment with NAADAC's national standards for ethics, education, and examination.
    b. Expand access to treatment by allowing these licensed professionals to bill Medicaid and private insurance for the services they already provide.
    c. Elevate professional parity, putting addiction counselors on the same playing field as licensed professional counselors, licensed clinical social workers, and licensed marriage and family therapists. Addiction counselors are licensed in 31 states.

It has been proven that licensing addiction counselors improves access to care, reduces turnover, and strengthens public trust in the therapeutic field.

Criminal Justice

5. **Expand and fund forensic peer mentorship programs in partnership with the Department of Community Supervision to reach inmates of every Georgia jail and prison and returning citizens in mandated substance use services across the state.**
    a. Implement initial pilot program to fund five addiction recovery support centers to integrate forensic peer mentors in various local jail and prison settings ($250,000).
6. **Expand access to medication-assisted treatment (MAT) services, particularly for inmates of Georgia's jails and prisons.**
    a. Access to MAT for pregnant women shall be mandatory in accordance with prevailing medical advice — non–medically supervised opioid withdrawal can cause fetal demise.
7. **Require prisons and jails to allow DBHDD-funded organizations to provide telephone services to inmates free of charge to individuals and organizations.** Currently, carceral phone calls are charged by minute increments — remove the charge for phone calls.

Nurse Practice Act

8. **Amend the Nurse Practice Act and strengthen Alternatives to Discipline for Georgia nurses such that when they report a substance use problem, their license is suspended rather than revoked, their substance use treatment is covered, and they are supervised for two years rather than three, resembling the nurse Alternatives to Discipline measures enacted by the state of Arkansas.**
    a. There should be two clearly defined pathways for nurses with substance use determined by their behavior at work:
        i. Care, treatment, and job protection should be paramount for nurses who self-report their substance use without any prior incident.
        ii. The pathway for nurses who have a reportable incident at work should prioritize the protection of patients and employer.
    b. Nurses who have not been involved in a reportable incident at work, and are attending services (i.e., a 12-step meeting, therapy, or a recovery meeting), should not be reportable to the Board of Nursing or other relevant licensing boards based upon their attendance of services alone. A health care provider must be allowed to seek some levels of assistance and support while maintaining anonymity. Currently, nurses are obligated to report each other for anything related to alcohol use disorder (AUD) or substance use disorder (SUD).
    c. Nurses described by point a.i. who have self-reported an alcohol, substance, or mental health disorder should be assessed to determine whether their substance/alcohol use should be reported to the Board of Nursing or relevant licensing board. In some states that have alternative to discipline programs, not all nurses are reported to the Board of Nursing or relevant licensing board, depending upon the extent of AUD, SUD, or other mental health disorder. Currently, a nurse

does not have any options for seeking potential help that do not include interference from the board of nursing.

d. A new Behavioral Health section should be added to the Nurse Practice Act. All questions related to alcohol use and substance use should be removed from the Criminal and Disciplinary sections of the legislation and added to the Behavioral Health section.

9. **Certified peer specialist support should be provided for all health care providers, including nurses, pharmacists, etc. Policy should support early substance use intervention without the requirement of clinical treatment. Expand the eligible treatment provider list for health care workers.**

Overdose Prevention and Medication-Assisted Treatment

10. **Expand educational trainings in MAT services for service providers across sectors.**
11. **Conduct study of states implementing the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2024 Opioid Treatment Program recommendations, specifically its pharmacy guidance allowing 'take-home' doses of MAT, the weekly bundling of Medicaid reimbursement to include telehealth management, and the standardization of payer rules to prevent utilization controls that undermine clinician-directed take-home care. State programs studied should include Texas, Virginia, and North Carolina.** If successful, these SAMHSA recommendations will maintain diversion controls and patient safety while improving retention and access in rural and underserved areas of the implementing states.
12. **Allocate funding for more mobile MAT clinics and mobile medication units in rural Georgia**
13. **Strengthen the Good Samaritan Law so that individuals need not fear punitive measures for the possession of an illegal substance when calling emergency services.**
    a. Potential language: "A person who, in good faith, without gross negligence or willful misconduct, seeks or renders emergency medical assistance by calling 911, administering naloxone or other lifesaving intervention for a person reasonably believed to be experiencing an overdose of a controlled substance or alcohol, shall be immune from criminal prosecution or civil liability for possession of a controlled substance, drug paraphernalia, under-influence, or violation of parole or probation, to the extent that the only evidence of such offense arises from the 911 call or medical assessment. The person experiencing the overdose is similarly immune. Such immunity shall not extend to manufacturing, distribution, trafficking, or offenses committed independent of the overdose event."
        i. Expands immunity to cover both civil and criminal liability for anyone who seeks or provides overdose aid in good faith.
        ii. Explicitly names overdose response and naloxone use as protected actions.
        iii. Extends protection to trained peers, nonprofits, and property owners providing emergency aid.
        iv. Removes the "no payment" clause so responders acting in professional or funded roles are still protected.

        v. Adds education, reporting, and enforcement mechanisms so the protections are widely known and consistently applied.

Prevention

14. **Fund an expansion of the public prescription drug receptacles program implemented by the Georgia Prescription Drug Abuse Prevention Initiative at the Council on Alcohol and Drugs to include more receptacles in rural areas of Georgia and an advertisement budget.**
15. **Fund the expansion of emotional literacy programs in Georgia for youth, such as Sources of Strength, GA Past Project, Prime for Life, Resilient Teams, GPS for Success, and Connections Matter to build resilience toward the misuse of illicit and dangerous substances.**

Georgia Health Policy Center

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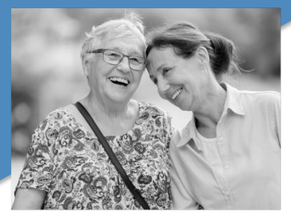



Addictive Disease State Scan: Recovery Support Housing

Behavioral Health Reform and Innovation Commission

November 2025

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
Wyoming	Wyoming — Chapter 7, Section 3. Supportive Transitional Drug-Free Housing Services. (a) Services must meet all applicable standards, Chapters 1, 2 and 4, Section 6, and Chapter 6, Section 15, Physical Plant, including the following service level requirements. (b) Description of Services. Supportive transitional drug-free housing services are non–clinically staffed, low intensity, peer-supported, life skills development living or housing environments. Supportive transitional housing services are independent facilities certified to provide supportive housing services with access to peer support, which include independent living skills development and stable functioning level in the community.	Wyoming Department of Health, Substance Use Disorders and Community Mental Health Services	The Wyoming Mental Health Professional Licensing Board may be contacted via information found on their website at https://mentalhealth.wyo.gov, by email at wyomhplb@wyo.gov, or by phone at 307-777-7788.		https://health.wyo.gov/wp-content/uploads/2016/06/SAChapter7RecoverySupportServices.pdf Rules and Regulations https://health.wyo.gov/behavioralhealth/mhsa/rules-and-regulations-2/
Maryland	Maryland — H.B. 1411 from the 2016 session. The law, enacted under Article II, Section 17(c) of the Maryland Constitution, Chapter 711, requires the Department of Health and Mental Hygiene to approve a credentialing entity to develop and administer a certification process for recovery residences; requiring the certification entity to establish	Maryland Behavioral Health Administration, Department of Health and Mental Hygiene		In the fiscal and policy note, Maryland estimated that when this was enacted it would cost at least $100,000 annually for the reporting and credentialing mechanism.	Legislation https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB1411?ys=2016rs Fiscal and Policy Note https://mgaleg.maryland.gov/2016RS/fnotes/bil_0001/hb1411.pdf

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
	specified requirements and processes, conduct a specified inspection, and issue a specified certificate of compliance; providing that a certificate of compliance is valid for one year; requiring, on or before Nov. 1, 2017, the department to publish on its website a list of each credentialing entity and its contact information; and so on. The law references selection of private entities to perform certification, but that has not been done. Certification will be performed according to National Alliance of Recovery Residences (NARR) standards by the Maryland Behavioral Health Administration of the Department of Health and Mental Hygiene.				
Hawaii	Chapter 11-178 established Hawaii's Clean and Sober Homes Registry, a voluntary registry of "clean and sober home[s] in good standing," and sets minimum standards.	Hawaii Department of Health, Alcohol and Drug Abuse Division	Hawaii State Department of Health, Alcohol and Drug Abuse Division: Richard D. Le Burkien, Program Specialist, Quality Assurance & Improvement Office Phone: 808-692-7530 Email:	The Clean and Sober Homes Registry is completely voluntary. The state prefers that its employees refer to homes on the registry first, but that is not enforced. Minimum standards for inclusion in the	Chapter 11-178 Regulation: https://www.law.cornell.edu/regulations/hawaii/title-11/subtitle-1/chapter-178 Hawaii Department of Health, Alcohol and Drug Abuse Division Orientation: https://health.hawaii.gov/substance-abuse/files/2019/03/CLEAN-SOBER-HOMES-REGISTRY-Orientation.pdf

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
			Richard.leburkien@doh.hawaii.gov Angela Bolan, Manager, Quality Assurance & Improvement Office Phone: 808-692-7518 Email: angela.bolan@doh.hawaii.gov	registry: (1) administrative standards, (2) fiscal management standards (e.g., code of ethics, house rules, residents' rights, and screening criteria), (3) operation standards (e.g., insurance), (4) recovery support standards (e.g., sober environment), (5) property standards, and (6) good neighbor standards.	
Arkansas	Unlike other behavioral health facilities, recovery residences are not formally regulated by the state of Arkansas beyond normal business regulations.	The Arkansas Alliance of Recovery Residences (AARR) is the new NARR affiliate organization in Arkansas. It is completely voluntary.	AARR austincoats@narrarkansas.org Contact Form: https://www.narrarkansas.org/contact 101 N. 11th St. Suite 251 Fort Smith, AR 72901	AARR was only established as of 2024. So far, AARR has certified 17 residences or 300 beds. Completion of AARR certification is completely voluntary but comes with certain benefits, such as	AARR: https://www.narrarkansas.org/

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
				joining the statewide directory, utilization of AARR resources, and overall referral credibility.	
Arizona	Title 9 Chapter 12: Department of Health Services — Sober Living Homes: All sober living homes are required to seek a license from the Arizona Department of Health Services (ADHS).	ADHS licenses sober living homes.	ADHS: Main Office Phone: 602-364-2536 Behavioral Health Facilities Licensing: 602-542-3422; behavioralhealth.licensing@azdhs.gov 150 North 18th Ave. Phoenix, AZ 85007	Arizona Recovery Housing Association (AzRHA), an affiliate of NARR, also provides a voluntary certification for recovery residences, but this is not recognized by the state of Arizona. Having a certification from AzRHA may expedite the mandated ADHS licensing process for sober living homes. ADHS is responsible for annual compliance inspections, complaint investigations, and enforcement of licensure	Title 9, Ch. 12: https://www.azdhs.gov/documents/licensing/special/sober-living-homes/sober-living-rules.pdf ADHS Licensing Fact Sheet: https://www.azdhs.gov/documents/licensing/special/sober-living-homes/sober-living-fact-sheet.pdf ADHS Sober Living Regulations: https://directorsblog.health.azdhs.gov/how-adhs-regulates-sober-living-homes-and-behavioral-health-residential-facilities/ AzRHA: https://www.myazrha.org/policy-statement-1

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
				deficiences; however, the following complaints are outside of their authority: location; billing; abuse, neglect, and exploitation; and criminal activity.	
Florida	Voluntary certification of recovery residences, Title XXIX, Chapter 397.487	The credentialing agencies are approved by the Florida Department of Children and Families, Office of Substance Abuse and Mental Health. For residences themselves, the Florida Association of Recovery Residences Inc. (FARR) is the credentialing agency and for residence	Contact for FARR: info@farronline.org 561-299-0405 Corporate mailing address: 2240 Woolbright Rd., Suite 413 Boynton Beach, FL 33426 Contact for Department of Children and Families: Phone: 850-487-1111 Web form: https://www.myflfamilies.com/contact-us/dcf-inquiry	As of 2015, certification of recovery residencies is not mandated, but licensed service providers are not permitted to refer patients to noncertified residencies. FARR is responsible for ensuring that at least one member of staff is certified at each residence, for inspecting the residence and interviewing staff and residents, for developing a code	Florida statute 397.487, voluntary certification of recovery residences: https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0397/Sections/0397.487.html Florida statute 397.4873 (referrals clause): https://www.leg.state.fl.us/statuTes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0397/Sections/0397.4873.html Credentialing bodies info:

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
		administrators, the Florida Certification Board is the credentialing entity.	Office of Substance Abuse and Mental Health Florida Department of Children and Families 2415 North Monroe St., Suite 400 Tallahassee, FL 32303-4190	of ethics, for developing an application process, for requiring certain policies and procedures, for ensuring that the residence is sober in nature, for establishing a "good neighbor" policy, and for running background checks. Owners and operators are prohibited from running a residence if they have certain charges on their record. There are also specific rules for visitations from minors written into Florida law. Certifications expire every year. Receiving medication-assisted treatment services and prescribed medications are not allowable reasons	https://www.myflfamilies.com/services/samh/recovery-residence-administrators-and-recovery-residences#:~:text=The%20Department%20of%20Children%20and%20Families%20(DCF),Monroe%20Street%2C%20Suite%20400%2C%20Tallahassee%2C%20Florida%32303%2D4190 FARR website: https://www.farronline.org/

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
				for denial of services. Local ordinances are not able to determine the duration or frequency of a resident's stay.	
Massachusetts	Chapter 165, Section 37 of the Acts of 2014 required the Department of Public Health (DPH) to establish a voluntary certification process for alcohol- and drug-free housing. House Bill 1828 of 2014 established that certification is not required of sober homes, but state agencies and vendors with statewide contracts are not allowed to refer to residences that are not certified.	Massachusetts Alliance for Sober Housing (MASH) (an affiliate of NARR) is the certifying body and technical assistance vendor, as awarded by Massachusetts DPH	MASH Email: office@mashsoberhousing.org Phone: 781-472-2624 Contact form: https://mashsoberhousing.org/contact-us/ 5 Edgell Road, Suite 30, Framingham, MA 01701	In Massachusetts, recovery residences are different from sober homes. Recovery residences provide treatment and are therefore licensed. MASH certifies sober housing, units governed by peers who do not provide treatment. Standards of MASH describe (1) mission and vision, (2) adherence to ethics and best business practices, (3) financial transparency, (4) data for quality improvement, (5)	Massachusetts Sober Homes Law: https://mashsoberhousing.org/certification/ma-sober-homes-law/ MASH Standards: https://mashsoberhousing.org/standards/

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
				communication of resident rights, (6) protection of resident info, (7) Involvement of residents in governance, (8) promotion of resident involvement, (9) staff application of the social model, (10) credentialing of staff leaders, (11) cultural responsiveness of staff, (12) job descriptions, (13) supervision, (14) comfort of the residence, (15) community living space, (16) sobriety of the environment, (17) safety of the home, (18) health promotion, (19) emergency planning, (20) meaningful activities, (21) recovery	

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
				planning/recovery capital, (22) access to community supports, (23) peer support, (24) respectful environments, (25) resident community responsibilities, (26) ethical relationships, connection to the community, (27) neighborhood concerns, and (28) courtesy rules.	
Texas	Title 25, Part 1, Chapter 571 — Voluntary Recovery Housing Accreditation	Texas Recovery Oriented Housing Network (TROHN), an affiliate of NARR, is the main accrediting agency in the state of Texas. NARR and the Oxford House Inc. are considered the only accrediting	TROHN Web contact form: https://trohn.org/contact/ P.O. Box 1173 Elgin, TX 78621	According to Chapter 571.4, accreditation is not required, but as of September 2025, if the recovery house is not accredited by an accrediting organization, it will be ineligible to receive funding from the state of Texas.	Chapter 571: https://regulations.justia.com/states/texas/title-26/part-1/chapter-571/ TROHN: https://trohn.org/about/trohn/

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
		organizations by the state of Texas.		In order to provide "chemical dependency treatment" or therapeutic community model treatment, the residence must obtain a separate license.	
Dublin, Ga.	Article VI — Recovery Residences Section 12-150. Recovery Residence Permit Required (a) Effective May 1,2022, a recovery residence permit must be obtained from the city clerk to operate any recovery residence within the corporate limits of the City of Dublin, Georgia. Said permit shall be effective for one year from the date of application. A new permit is required and new application for each year or part of any year a recovery residence operates. Facilities which meet the definition of a recovery residence, as defined herein, which are currently in operation shall have 90 days from the effective date of this ordinance to obtain the permit required herein or cease operation. (b) The city clerk shall establish an	Mayor's office and city clerk of Dublin		City clerk's office maintains a list of all recovery residences and manages applications.	https://cms2.revize.com/revize/dublinga/Ordinance%2022-10%20New%20Permitting%20Requirement%20for%20Recovery%20Residences.pdf

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
	application form which requires identifying information for the entity operating the facility; a primary point of contact for the facility; proof of the certification required herein, as well as attestation to compliance with the minimum standards as required herein. The city clerk shall also request any other information needed to ensure this ordinance is given full effect. Prior to issuance of any permit herein, the city clerk shall verify the building has been inspected by a building inspector, fire inspector, or other designated personnel of the city and that all of the criteria required herein are met and satisfied. Section 12-151. Standard compliance and certification requirement (a) All recovery residences located in the City of Dublin, Georgia, shall comply with the standards established by the National Alliance for Recovery Residences, as amended; (b) All recovery residences shall submit in its application for a				

State	Legal Regulation	Enforcement Agency	Contact Information	Notes	Link
	permit from the city clerk proof of certification from the Georgia Association of Recovery Residences. No permit may be issued without the submission of proof of certification as provided herein. Said certification shall be maintained and effective at all times of operation within the city.				

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APPENDIX B: SUBCOMMITTEE ON CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Children and Adolescent Behavioral Health

2025 Annual Report

Chair

Eric Lewkowiez, M.D.

Members

David Bradley, DMD
Garry McGiboney, Ph.D.
Gwen Skinner, Ed.S., LMFT
Sarah Vinson, M.D.
Miriam Shook
Commissioner Shawanda Reynolds-Cobb

November 2025

Report prepared with assistance from the Georgia Health Policy Center and
the Center of Excellence for Behavioral Health & Wellbeing at Georgia State University

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Introduction

House Bill 514 (during the 2019 General Assembly session) created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the that impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, including the Subcommittee on Children and Adolescent Behavioral Health chaired by Dr. Eric Lewkowiez (2022-2025).

During 2025, the Subcommittee on Children and Adolescent Behavioral Health held seven public meetings on topics including adolescent substance use prevention and treatment; autism and developmental disabilities; suicide prevalence, ideation, and risks among children and adolescents; children and adolescent mental health issues in rural Georgia; and services for high-acuity, transition-age youth.

This report includes information and recommendations to address child and adolescent behavioral health in Georgia from testimony by mental health experts including state agency representatives, pediatricians, social workers, community-based providers, and others with expertise in children and adolescent behavioral health.

List of Presenters to the BHRIC Subcommittee on Children and Adolescent Behavioral Health 2025

BHRIC Subcommittee on Children and Adolescent Behavioral Health

Eric Lewkowiez, Chair
Garry McGiboney, David Bradley, Gwen Skinner, Miriam Shook, Sarah Vinson, Commissioner Shawanda Reynolds-Cobb

Support to the BHRIC Subcommittee on Children and Adolescent Behavioral Health

Dr. Ann DiGirolamo (Georgia Health Policy Center/Center of Excellence for Behavioral Health & Wellbeing (GHPC/COE)), Ashlie Oliver (GHPC/COE), Courtnee King (GHPC/COE)

Presenters to the BHRIC Subcommittee on Children and Adolescent Behavioral Health 2025

Date	Topic	Presenter
Feb. 20, 2025	Substance Use/Abuse and Prevention	**Chuck Wade** Executive Director, the Council on Alcohol and Drugs **Kay Manning** Program Director, the Council on Alcohol and Drugs **Michael Mumper** Executive Director, Georgians for Responsible Marijuana Policy **Britt Parramore** Executive Director, Pathlight Counseling
March 13, 2025	Autism and Developmental Disabilities	**Emily Rubin** Executive Director of Communications, Crossroads **Lori Cole** Director, Autism Unit, View Point Health **Dr. Teal Benevides**

		Professor, Public and Preventive Health, Medical College of Georgia
April 17, 2025	Treatment of Adolescent Substance Use	**Lynn Honeycutt** Director of Recovery Support Clubhouses, View Point Health **Violetta Dominguez** Program Manager of Recovery Support Clubhouses, View Point Health
May 22, 2025	Updates on the Center for Behavioral and Mental Health at Children's Healthcare of Atlanta; Individuals with Developmental Disabilities	**Dr. John Constantino** Chief of Behavioral and Mental Health, Children's Healthcare of Atlanta; Professor of Psychiatry, Emory University **D'Arcy Robb** Executive Director, Georgia Council on Developmental Disabilities **Dr. Erin Vinoski Thomas** Director of the Center for Leadership in Disability, Georgia State University (GSU) **Justin Gold** GSU Graduate
Aug. 21, 2025	Suicide Prevalence, Suicide Ideation, and Suicide Risks Among Children and Adolescents	**Dr. David Jobes** Director of the Suicide Prevention Center, Professor of Psychology, Catholic University of America **Britt Parramore** Executive Director, Pathlight Counseling
Sept. 25, 2025	Children and Adolescent Mental Health Issues in Rural Georgia	**Brenda Cibulas** Executive Director, Division of Behavioral Health, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) **Christy Doyle** Director, Office of Children, Young Adults & Families, DBHDD

		Jennifer Dunn Deputy Commissioner, Field Operations, DBHDD
Oct. 16, 2025	Services for High-Acuity, Transition-Age Youth	**Ron Koon** Chief, Psychological Services, Georgia Department of Juvenile Justice (DJJ) **James Freeman** Chief, Psychiatric Services, DJJ **Kimbolic Hamilton** Director, Office of Behavioral Health Services, DJJ **Cati Stone** President and CEO, CHRIS 180 **Rick Aranson** Chief Operating Officer, CHRIS 180

Summary of Presentations to Subcommittee

February 20, 2025: Substance Use/Abuse and Prevention

Presentations from Chuck Wade, Executive Director, the Council on Alcohol and Drugs; Kay Manning, Program Director, the Council on Alcohol and Drugs; Michael Mumper, Executive Director, Georgians for Responsible Marijuana Policy; and Britt Parramore, Executive Director, Pathlight Counseling

Kay Manning introduced her presentation by highlighting the importance of substance abuse prevention, stating that Georgia should sustain prevention efforts to support youth, young adults, and adults as they face challenges. The Council on Alcohol and Drugs was founded in 1969 and has been providing prevention resources across Georgia for more than 56 years. The council has 55 staff members across Georgia, including six internationally certified prevention specialists. The central office is in downtown Atlanta. Although Georgia is the primary state that the council provides services for, they also serve Alabama, Florida, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia. The mission of the council has remained the same since its inception: "change lives by empowering communities to prevent substance abuse and its related problems at home, school and work with proven, practical resources, prevention education, and advocacy." The CEO, Chuck Wade, was an undercover officer for many years prior to working for the council and brings firsthand experience around how drug abuse affects Georgia. Livedrugfree.org is the council's website.

The council's prevention efforts are science-based, using the Strategic Prevention Framework. This framework includes needs assessment, capacity building, planning, implementation, and evaluation, and incorporates sustainability and cultural competence throughout.

The council is currently working on programs and services including overseeing four grants from the National Drug Control Policy for Drug Free Communities programs. In addition, there are several programs and projects funded by the Department of Behavioral Health and Developmental Disabilities, including the Partners in Prevention Project in 10 of Georgia's counties, the Peer Assisted School Transition Project, Voices for Prevention, Community Showcase Events, the Georgia Prescription Drug Abuse Initiative, and the Strategic Prevention Framework Suicide Prevention Project. The ultimate goal is to weave prevention into all aspects of life to create healthier communities.

Manning shared that in her opinion there are several reasons that individuals may start using substances, including mental health challenges, pain, boredom, or prescription dependence. She shared that those who start using drugs prior to 21 are four times more likely to develop a substance use disorder.

Alcohol is a drug and is often overlooked as such. Six percent of Georgia high school students had their first drink "other than a few sips" before the age of 13. Alcohol is often

easily accessible at home. Education surrounding alcohol is a challenge. Most adults cannot answer how much is "one drink," what is "normal," what is "binge drinking," and at what age the brain is fully developed. The drinking age is 21, but brains do not fully develop until 25. Youth who drink frequently may never be able to developmentally catch up. Developing coping skills or strategies to deal with daily stressors is a challenge for those in recovery.

Marijuana concentration is much higher than in the past, with THC concentration as high as 90%. Leaf marijuana can have as much as 20% THC due to cultivation and farming practices. There is not enough research that shows the full effect that THC can have. There are unintentional consequences of marijuana use, including its effect on the developing brain of children, teens, and young adults. Roughly one in three people who uses marijuana has some degree of marijuana use disorder. In Colorado, where recreational marijuana use is legal, a marijuana-related traffic fatality occurs every two and a half days on average. For every $1 the state collected taxing marijuana sales, it has to pay $4.50 to deal with the health and social effects of the legislation. Some other challenges include the demand for new products, which continues to grow. The message "stronger without it" is being shared in schools, but in local convenience stores or gas stations there are displays of marijuana because they have the highest percentage of profit. There are concerns around one particular strain of marijuana, Delta 8. Delta 8 is being marketed as therapeutic or to have medical uses, but has not been approved by the Food and Drug Administration. It claims to help with various symptoms, including nausea, vomiting, headaches, and insomnia. Delta 8 uses three times as much marijuana as the average joint to meet the consumer demand. The dosage recommendation for Delta 8 products is inconsistent, causing concern. Fourteen states have banned Delta 8, but in Georgia Delta 8 is legal.

The misuse of prescription drugs, particularly opioids, is more prevalent than the use of cocaine, methamphetamine, MDMA, and PCP combined. Opioids constitute 70% of overdose deaths. The rate of overdose deaths involving opioids increased by more than 285% between 2019 and 2023. Opioid deaths for adolescents aged 10-19 increased by 273% from 2019 through 2023. More than 195 Americans are dying from fentanyl every single day.

Tobacco is often not considered a drug, but it is. In 2025, the revenue from tobacco products in Georgia is projected to be $734.1 million. One in four high school students reports vaping, but cigarettes make up the largest segment of the market. Smoking is the leading cause of premature and preventable death in Georgia. Annually, 11,700 people are dying from tobacco-related causes. There are proven strategies to prevent smoking, including raising taxes on cigarettes. A 10% tax increase has the potential to reduce youth smoking rates by 6.5% or more. Georgia has the second-lowest tax in the United States at 37 cents per pack of 20. Georgia has attempted to raise taxes on cigarettes by 20 cents and vape products by 8%. Profitability is a challenge in combatting tobacco use. In 2025 the revenue of e-cigarettes amounted to $11 million, and the profit margin is expected to grow by more than 2%.

Americans are 4% of the world's population and consume two-thirds of the world's illegal drugs. The demand for these products is increasing. There were more fentanyl pills seized

at the U.S.-Mexico border in Nogales the first six months of this fiscal year than the last five fiscal years combined.

Addiction is complex and associated with changes in brain chemistry that lead to a powerful craving for the substance or behavior, making it difficult for individuals to control their urge to use or engage in the addictive behavior. Prevention works, according to Substance Abuse and Mental Health Services Administration: $1 of prevention can save $30 on the backend of substance abuse. Building coping skills and emotional intelligence also works. There are several existing programs that work. Sources of Strength training is a peer-led campaign that focuses on eight pieces of a wheel representing physical health. There are eight components of the program, including physical health, mental health, family support, positive friends, spirituality, generosity, healthy activities, and mentors. Participants are trained to find the strengths within themselves, and then develop campaigns to educate the school system about these strengths. It is an individual strategy that turns into an environmental strategy. It is proven to reduce substance use and suicide by 21%. A past project is a peer-assisted school transition program that is in the process of getting certified as an evidence-based strategy. This project looks at the high-risk times for students, including the transition from elementary to middle school and middle school to high school. The program works with adult advisers who train peer leaders to work with students during these transitions. The program builds resiliency skills with 14 lessons. There are also campaigns in schools around positive social norms. The Georgia Rx Drug Abuse Prevention Initiative is a statewide drug drop box program for proper disposal of prescription medications. There is also a Medicine Safe program to encourage parents to properly store their medications to prevent children from having access.

During the Q-and-A, someone mentioned kratom as a point of discussion during the previous legislative session. Manning shared that kratom is being advertised as a miracle cure and is unregulated. It also similarly has inconsistent dosage recommendations, but Manning was not sure where it legally stood in Georgia.

Following a question about how the Council on Alcohol and Drugs is related to the Georgia Council for Recovery, Manning shared that they are another provider for the state, and they focus on advocacy and recovery, whereas the Council on Alcohol and Drugs is focused on prevention. However, the two organizations share information and attend many of the same conferences.

Eric Lewkowiez shared that one thing he learned as a physician is that “if something treats everything, it treats nothing.” He sees several patients who use cannabis, and it is clear to him that it is a dangerous substance for the developing brain.

Lewkowiez introduced the next speaker, Michael Mumper, the executive director of Georgians for Responsible Marijuana Policy.

Mumper introduced Britt Parramore, a licensed therapist and owner of a private practice in Woodstock, Ga. The practice provides several programs for youth and adults, including intensive outpatient programs for individuals struggling with substance use disorder, a

mental health diagnosis, or a dual diagnosis; treatment services for juvenile treatment courts; treatment services for detention courts; and substance use programs in jails.

Parramore shared several Pathlight case studies to show the causal links between high-THC products and the development of psychological disorders in teenagers. The national average for the amount of THC is about 16%. THC is in the same classification as LSD; it is a psychoactive substance. In the early 2000s, illegal labs in California started figuring out a way to isolate the THC and put it in oil form to put it in vape pens and other products. Some of these products can have as much as 98% THC in them.

The case studies shared include youth coming in showing psychotic symptoms and using high-THC products. Parramore shared that he saw about 14 different teenagers who had developed schizophrenia-type symptoms, and the only drug use was high-THC products.

Considerable clinical evidence between 2018 and 2024 shows support for the hypothesis that adolescent neurodevelopmental exposure to high levels of the principal psychoactive component in marijuana, THC, is associated with a high risk of developing psychiatric diseases later in life. The causal link between marijuana use and development of psychosis is the most well-replicated high-impact finding in schizophrenia research today. Parramore concluded that high THC use in teenagers is causing the development of schizophrenia and it is thought that it may be permanent. An important note is that this is only seen in the developing brain. The younger a patient starts to use these products, the higher the likelihood that they will develop these disorders. The best guess from the top researchers is that about 10% of teenagers using this more than 20 times will develop a permanent variant of schizophrenia resistant to medication.

During the Q-and-A, Parramore shared that this type of schizophrenia is not responding to typical medications prescribed for schizophrenia. It is some of the worst cases of schizophrenia in any atmosphere, and it is not responding. He also shared that right now, teenagers can experience an acute psychosis event from smoking these products and will go to the emergency department, and it will resolve in between 12 and 24 hours. The data beyond anecdotally is if they never use THC again, they should be OK. If they continue to use THC products, it is thought that 50% of them will develop schizophrenia. Right now, it is not known how many acute psychosis events are occurring.

Kelly Turner is a peer and advocate and shared her personal story with the committee. Her son only had a one-time use of Delta 8. He vaped it three times and passed out at the wheel. 911 was called, and the paramedics said he was in a life-threatening condition where he was going into cardiac arrest. He made it to the hospital but was in complete psychosis. This was in 2021. In 2025, four years later, they do not know what it did to his brain, but he has acute agoraphobia. He is in weekly intensive care and is on a waiting list for another program through Emory University.

Mumper then presented on behalf of Georgians for Responsible Marijuana Policy on the current Georgia landscape of marijuana policy and considerations. Right now, in Georgia, recreational marijuana use is not legal, but medical marijuana use is. Hemp consumables

were legalized last October and are regulated, except for Delta 8 which is legal through a loophole.

In a 2023 survey, 30.4% of youth self-reported marijuana use in the past year, and 11.4% of U.S. 12th-grade students reported Delta 8 use. The Georgia Poison Center has received more than 250 calls since 2021 concerning Delta 8 for children under 6 years old. More teens in Georgia enter treatment for marijuana than all other drugs combined. This is concerning as THC concentration is rising. According to a 2019 study, youth who use cannabis have increased risk of depression, suicidal thoughts, and suicide attempts.

Of 19 cities that have decriminalized marijuana, only two offer extensive marijuana education, assessment for cannabis use disorder, and treatment referrals. Of people who perceived a need for treatment, 24% did not know where to find treatment, and 21% did not have health care coverage and could not afford it.

There is pressure to increase the legality of marijuana in Georgia. As of July 2024, there were 20,592 people on the registry for low-THC oil. Three-quarters of them are on the registry for pain and post-traumatic stress disorder. Requirements are only going to loosen for who is eligible for a medical marijuana card.

Sixteen of the 17 medical associations support more research being done before further legalizing medical marijuana use.

It will become more important to increase access to treatment. As many as one in three people who uses THC products has a cannabis use disorder (CUD). The policy drivers are in four buckets, including ensuring CUD insurance coverage, reducing CUD legal and stigma barriers, expanding CUD treatment programs, and improving CUD treatment access.

Lewkowiez noted that another symptom of use of cannabis in youth is lack of motivation, which is troubling for youth in high school and college. He noted that it is clear to him that what is driving this is the profitability associated with marijuana use. The amount of money available for treatment is miniscule compared to the need for treatment.

March 13, 2025: Autism and Developmental Disabilities

Presentations from Emily Rubin, Executive Director of Communications, Crossroads; Lori Cole, Director, Autism Unit, View Point Health; and Dr. Teal Benevides, Professor, Public and Preventive Health, Medical College of Georgia

Emily Rubin presented on the SCERTS framework. The SCERTS framework advocates for the unique needs and processing differences of neurodivergent learners to be respected so that the primary focus of change is on the environment and the interactive partners. SCERTS provides an evidence-based set of developmental and relationship-based guidelines for helping an individual become actively engaged in their learning environment. Pupil-centered outcomes are matched with the role of the interactive

partners. Partners adapt to a pupil's developmental level and neurodivergent learning style.

The "SC" in SCERTS stands for social communication. When children communicate for many reasons and in many ways, it is an indicator of well-being. The SC domain includes *why* and *how* an individual communicates. The "ER" stands for emotional regulation. In general, we learn how to cope from people who recognize our needs and model strategies to either alert or soothe our regulation system. The ER domain includes mutual regulation, how we maintain active engagement and cope with the help of others, and self-regulation, how we maintain active engagement and cope on our own. The "TS" stands for transactional support, which reflects the way we interact with the environment and help learners feel safe and connected. The TS domain includes interpersonal support, how we change our communication style, and learning support, how we modify the environment to be developmentally responsive. When the SC, ER, and TS are put together, you see active engagement.

Understanding neurodivergent learners is essential for providing transactional support. The first big phase of brain development is different for a neurodivergent child than for a neurotypical child. All children need to feel safe and connected with the people around them in order to build "the social brain." Many neurodivergent children have less dopamine and opioid release in response to people and social interactions. So, building trusting relationships can be more challenging. Oxytocin, a hormone produced when interacting with others, can be controlled. Research shows that children who communicate at high rates and are feeling safe and connected will move forward developmentally by seeking out social connections with words or language, building the "language regions." Language could be words, sign language, picture communication, or other forms of communication. Once the child can talk about the present, past, and future, they move on to learning how to meet their needs in a range of situations, called "executive functioning."

Autistic individuals tend to show differences in neurochemistry related to social engagement. Processing social information such as facial expressions, gestures, touch, and speech is different in autistic learners. These differences should be appreciated and adjusted in learning environments. Autistic children's brains are wired differently, as they have different levels of oxytocin, dopamine, and opioids. They tend to process people in the same way that they process "things." Autistic children can engage with what people are thinking or feeling, but they are using the intellectual part of the brain, which is exhausting for them.

Social interactions need to be desirable and predictable, and partners must strive to understand lived experience and respect it as if it is their own.

There are three developmental stages in the SCERTS framework. The first stage, the social partner stage, is spontaneous nonverbal communication and sensory-motor behaviors for regulation. The second stage, the language partner stage, is using language to represent peoples' names and actions and for the purpose of regulation. The last stage, the conversational partner stage, is building self-efficacy and metacognitive regulation and

self-advocacy. There is a stage checklist and a formal assessment document for partners to use to help guide their assessment of a child's stage.

There is efficacy to the SCERTS framework. The publication of the manuals occurred in 2006; then they applied for grants for their Early Social Interaction project. The Early Social Interaction project is a randomized trial in the home setting that provides evidence of how addressing key objectives and supports can have a statistically significant impact on positive outcomes for language and social adaptive functioning with parent coaching and implementation in home settings. The Classroom SCERTS Intervention, a randomized trial in school-age settings, highlighted how these key objectives and supports improved outcomes by increasing active engagement and access to the curriculum and by reducing behavioral challenges in both general education and special education classrooms. These programs were implemented with fidelity.

During the Q-and-A, Rubin shared that Whitfield County schools are using the SCERTS framework the most, and Fayette County and Cobb County have also used it in the past.

Eric Lewkowiez then introduced Lori Cole, the director of the autism unit at View Point Health.

View Point's autism spectrum disorder (ASD) crisis stabilization unit (CSU) has an average 30-day inpatient program that uses a trauma-informed, multidisciplinary approach to stabilize the clients and discharge them back into the community safely and efficiently with the hope of their not going back into crisis. The ASD unit is an assessment-type of program because the children in Georgia are often not diagnosed correctly, so they must be assessed to determine if ASD is the correct diagnosis. Following the assessment, they offer a behavior plan. They offer applied behavioral analysis therapy, dialectical behavior therapy, medication management, 24/7 nursing, 24/7 direct care monitoring, registered behavior technician–driven data tracking, academic support, daily psychiatric follow-up, crisis planning, parent training, seven-day treatment team meetings, discharge planning, and individualized diets and schedules.

Most of the children that come to the ASD unit are nonverbal and very aggressive. They come from environments and families that do not recognize that their aggressiveness is stemming from their inability to communicate. View Point is trying to get the stakeholders to understand this.

The only exclusionary criterion is if they have a medical need that cannot be supported at the CSU. When a new client comes in, they go through a variety of assessments and individual sessions to determine which therapies will be best for them and help the team determine the best way to serve them. In addition to assessments, each client is placed on an individual schedule track personalized to them upon arrival. All of their activities of daily living are supported, which is different from other CSUs.

Throughout the day, the clients are participating in a variety of therapies and activities such as Skills Based Treatment, which teaches communication, toleration, and contextually

appropriate behaviors. Discoverer, Noticer, Advisor, and Value is an evidence-based model that promotes psychological strength. Dialectical Behavior Therapy is a skills-based therapy that has been proven to support individuals who experience intense emotions. View Point has a specific curriculum that relates to intellectual or developmental disabilities and autism. Interoception therapy is a curriculum of activities that leads to the connection between the physical body and the emotional mind that provides awareness of how one feels and how one acts. There are phone calls with parents daily to ensure that the treatment coincides with what the parent wants and to keep them in the loop of what is going on with the child.

Lewkowiez then introduced Teal Benevides, an associate professor in the School of Public Health at Augusta University.

Benevides opened her presentation sharing that autistic people are at disproportionate risk for mental health problems compared to the general population. The lifetime prevalence of an anxiety disorder is 20% to 42%. The lifetime prevalence of depressive disorders is 11% to 37%. Autistic individuals are a particularly high-risk group for suicide. Compared to the general population, autistic individuals are up to nine times more likely to experience suicidal ideation, up to five times more likely to attempt suicide, and more than seven times more likely to die by suicide.

Of transition-age autistic youth, 47.5% have at least one co-occurring mental health condition, and there are very high rates of racial and ethnic disparities. Mental health emergency visits are high across the life span for autistic people of all ages. For those with autism, 20% of emergency department visits are for a mental health reason, compared to around 5% in the general population.

The important questions to have in mind are what do autistic people think is important to understand for research and practice and what evidence do we have to support mental health needs.

The priorities shared during this presentation emerged from a 2017 project called Autistic Adults and Other Stakeholders Engaged Together (AASET), which is a participatory action research project that is co-led by people with autism. People with autism were convened to inform all aspects of the project. They received funding to conduct two clinical trials. The first is AASET-SP, which compares two ways to prevent suicide among autistic youth. The second is AASET-MHTP, which compares cognitive behavior therapy and mindfulness-based therapy for adults with autism. These projects are currently ongoing.

In the priority-setting projects, autistic adults wanted research and practice changes on (1) mental health interventions and outcomes, (2) access to health care and the needed accommodations to get care, and (3) gender inequalities in diagnosis, treatment, and sexual and reproductive health. These priorities are not unique to this specific project, as other researchers have found similar priorities in their research.

The first mental health priority focused on answering the questions, What is the impact of trauma on mental health outcomes in autistic individuals? What are the best indicators or measures of post-traumatic stress disorder, trauma, and adverse childhood experiences in autistic individuals? What approaches can be used to effectively address trauma among autistic adults? The survey respondents shared several examples of trauma, including medicalized trauma, a specific traumatic event, and traumas over time.

The second mental health priority focused on answering the questions, What is the impact of social isolation, stigma, discrimination, and other forms of marginalization on mental health and well-being in autistic individuals, and, conversely, what is the impact of radical inclusion, such as being part of a social movement, on mental health and well-being? The survey respondents noted that there is not positive representation of people who have been successful with autism; society is not trained to include, accept, accommodate, and value neurodiversity; and trying to be "normal" affects a neurodivergent person's mental health.

The third mental health priority focused on answering the questions, When, for whom, and under what conditions do self-managed interventions and preferred activities result in improved quality of life and reduced mental health symptoms? What is the effect of employing community-available approaches, such as peer-led approaches, exercise/physical activity, yoga, mindfulness and meditation, tai chi, animal-assisted therapy, and art- and music-based approaches to well-being? Autistic people responded that they want to be in control of the things that they are choosing to help themselves. In addition to that, they wanted interventions that were community-based and accessible, and they wanted evidence determining their effectiveness.

The fourth mental health priority focused on answering the question, What are the long- and short-term negative side effects or adverse outcomes of currently recommended therapies and interventions (including behavioral and pharmacological) as measured in autistic individuals across the life span? Respondents wanted to know if negative self-image can occur due to childhood therapies and if the long-term use of depression drugs increased the risk of fractures in autistic people.

The fifth mental health priority focused on answering the question, How can we develop better measurement tools for autistic quality of life, depression, anxiety, social well-being, and sleep as experienced by autistic adults?

To address community, organizational, and policy environments, priority health outcomes were identified across four groups, including people with intellectual or development disabilities, care partners of people with intellectual and developmental disabilities, clinicians, and payers and regulators.

Ideal outcomes related to workforce development include that the workforce is empowered to address need; clinician attitudes and beliefs enhance care priorities; clinician knowledge, skills, and preparation support their work with people with

intellectual or developmental disabilities; clinicians partner in all aspects of care; clinicians have time to address care needs; and inclusion is essential.

Ideal outcomes related to system supports include identified referral networks that patients can be sent to, navigation supports between multiple sectors of care and services, a colocation of services, effective reimbursement models, social determinants of health, and distrust and racism being addressed at the system level.

Payers and regulators shared that they wanted information related to the best investment of resources, better data sharing and alignment, and innovative payment solutions.

Following a question of whether people with autism are more likely to self-medicate or abuse substances, Benevides shared that she does not know of any quantitative support for this, but she has heard about this qualitatively. Autistic adults said they wanted intervention research on medical marijuana because autistic people were using it to self-medicate their anxiety. There is some preliminary evidence from claims data that there might be increased rates of substance use disorders, but it is being looked at from a clinical perspective. It is not clear what is happening to people who are not seeking medical supports.

April 17, 2025: Treatment of Adolescent Substance Use

Lynn Honeycutt, Director of Recovery Support Clubhouses, View Point Health, and Violetta Dominguez, Program Manager of Recovery Support Clubhouses, View Point Health

Chad Jones shared that View Point Health is a community service board in Georgia. It primarily serves Gwinnett, Rockdale, and Newton counties, with about a dozen programs that are outside those counties. Some are all over the state, but most are centralized to DeKalb and Fulton counties. Jones introduced Lynn Honeycutt and Violetta Dominguez.

Honeycutt and Dominguez work for recovery support clubhouses. Honeycutt shared that they have been working in the clubhouses for a while and are seeing a lot more severity in substance use, specifically with drugs like fentanyl. Members enter recovery support clubhouses due to issues with alcohol and drug use. Members receive psychoeducation about substance use and its effects, goal setting to reduce or quit substance use among other life goals, educational support, career development and job readiness, nutrition and whole-health education, prosocial activities, life skills, and outings. Recommended evidence-based therapies for adolescent substance use disorder include cognitive behavioral therapy, motivational interviewing, the Seven Challenges treatment program, and family-based therapies such as multidimensional family therapy.

View Point has been using Seven Challenges for many years. Challenge 1 is being honest about the use of alcohol or drugs. Challenges 2 and 3 weigh the pros and cons, or harms, of

substance use. Challenge 4 asks what are their responsibilities? Challenge 5 asks what their goals in life are. Challenge 6 asks if their decision-making aligns with their goals. Challenge 7 is to see how the decisions they make affect their lives. The point of the seven challenges is to practice good decision-making skills. The Seven Challenges program can be done in groups, but there are also journals that ask specific, guided questions that the teens can fill out individually.

Eric Lewkowiez noted that in his practice he sees teenagers who use substances because they have anxiety, not knowing that there is evidence that substance use worsens symptoms of anxiety.

Honeycutt responded that the psychoeducation tries to educate members on those kinds of things.

Additional considerations for clubhouse services include ensuring that services are culturally appropriate. All staff are bilingual in Spanish and English. They also prioritize hobbies and activities, which are important for recovery because they provide substitutes for substance use.

Programs that are proven to work are those that embrace various factors in recovery for adolescents, such as the importance of peers and status and the stages of brain development. One qualitative study highlighted the importance of "sense of belonging" with peers in recovery. Teen participants have a desire for program activities and the journey through the stages of change to be "fun."

Clubhouses have six deliverables:

1. Decreased substance use;
2. Decreased Department of Juvenile Justice (DJJ) involvement;
3. Decreased behavioral problems;
4. Increased positive social interactions;
5. Increased school attendance and performance; and
6. Improved family involvement and relationships.

The Center of Excellence for Behavioral Health & Wellbeing at Georgia State University collects data and evaluates the clubhouses' effectiveness related to the six deliverables. For example, for deliverable 1, decreased substance use, 64.7% of members had improvement in overall substance use, 65.2% improved in severity of use, 75% improved stage of recovery, and 73.1% had more recovery support in the community. For those who come to the clubhouses with mental health issues, anxiety improved by 71.4%, depression improved by 68.8%, and suicide risk improved by 57.1%.

Lewkowiez noted that providers tend to not want to treat cannabis use.

Honeycutt responded that cannabis use has changed over the last decade, with shifts in the way it is consumed; now teens are consuming cannabis from cartridges rather than smoking. Cannabis-induced psychosis is increasing, and it is resistant to treatment.

Following a question asking whether there is data related to decreasing DJJ involvement, Honeycutt shared that anecdotally speaking, teens are getting off probation and finishing juvenile drug court. Sometimes they end up getting more charges. Ten percent of youth considered high-risk saw a reduction in DJJ involvement, while the remaining 90% remained stable.

Honeycutt commented that remaining stable is ideal, as many members come to the clubhouses with existing charges and they are hoping to see the members not gain new charges.

Honeycutt responded to a question asking if View Point is contracted at all with DJJ, saying that they are not contracted but they have a memorandum of understanding with the court that they are the provider for the drug court and take referrals from probation.

Gwen Skinner commented that the opioid settlement dollars should be able to be used to expand clubhouses. Garry McGiboney agreed. Skinner noted that the subcommittee should consider this in the recommendations.

Jones commented that Gwinnett is averaging six to seven deaths due to fentanyl per year, which has gone up 700% over the last six years. He asked if there was a way that BHRIC could leverage the state to put money directly into the contracts of the clubhouses? Lewkowiez responded that the opioid settlement money for the Department of Education is being contemplated to be coordinated by the Regional Education Service Agencies (RESAs). McGiboney followed up that the subcommittee is in a position to accept any recommendations that can generate discussion with the full commission. Jones stated that he will draft a recommendation for the subcommittee.

Jones asked if the money that is going to the RESAs the $20,000 that will go to each middle and high school for social work services and school security grants? McGiboney responded that he believed so. There is about $108 million each year for school security grants, but mental health is an allowable expense for that money as well.

During the Q-and-A, Honeycutt shared that the admission criteria for the clubhouse includes children aged 13-17 who have an issue with substance use (not necessarily a diagnosed substance use disorder) and area of residence. There are other rule-outs, such as

individuals with high risk of suicide due to the nature of the clubhouse activities. They also look at the legal charges and determine if they may harm the other members or the staff. Some admission criteria are determined by individual clubhouses.

May 22, 2025: Children's Mental Health and Individuals with Developmental Disabilities

Presentations from Dr. John Constantino, Chief of Behavioral and Mental Health, Children's Healthcare of Atlanta and Professor of Psychiatry, Emory University; D'Arcy Robb, Executive Director, Georgia Council on Developmental Disabilities; Dr. Erin Vinoski Thomas, Director of the Center for Leadership in Disability, Georgia State University (GSU); and Justin Gold, GSU graduate

John Constantino introduced that he would provide updates on the Zalik Center for Behavioral and Mental Health at Children's Healthcare of Atlanta and how it can work as a model for other efforts around the state.

The Lancet Psychiatry Commission on Youth Mental Health published a report that shows the trend of increasing incidence and prevalence of mental health conditions in youth in various countries. Various factors contributed to the intensification of the conditions that affect the mental health of children. A report by the Rollins School of Public Health at Emory shared the results of a survey of the status of child health and well-being in Georgia. Parental concerns include the prevalence of mental health conditions in children. Seventeen percent of parents reported their child has been diagnosed with attention deficit and hyperactivity disorder, 15% with anxiety, and 5% with depression. Among those children, 63% are not receiving mental health services. Other concerns include food insecurity, opioids, gun safety and school safety, and disruptions in insurance coverage. A total of 13% of children with Medicaid/PeachCare lost coverage in the past year. More than 200,000 children are uninsured at a given time in Georgia.

A report that organized information from databases including the Georgia schools, the National Plan and Provider Enumeration System database, and Medicaid claims data showed that 34% of the demand for mental health services for Medicaid-insured children in Georgia remained unmet.

Children's Healthcare of Atlanta analyzed the first year of data from the Zalik Center and learned that the proceeds spent from the endowment on the outpatient side have enabled them to provide care to around 10,000 new children per year. This project aims to establish a model of care that delivers evidence-based services to a representative subpopulation of children, subsidizing true cost over insurance reimbursement through the behavioral and mental health quasi-endowment at Children's Healthcare of Atlanta. It is a model for the transformation of U.S. health systems to resolve fragmentation of care, minimize loss of follow-up, and resist "sprinkling." There is a rigorous evaluation of

improvement in outcome and cost-efficacy over care as usual among children in the transformation model. Children's Healthcare of Atlanta documents the extent of gaps for children in care as usual in order to enforce/fulfill mental health parity law. Seventeen million dollars from the endowment is going toward enhancing existing capacity in primary care and schools and enhancing the existing specialty outpatient mental health services, while $15 million is going toward community crisis, and inpatient and residential care.

Children's Healthcare of Atlanta reaches around 400,000 Georgia children per year which creates an opportunity to select and monitor patients who are participating in this model of care compared to the rest of the kids in the Children's Healthcare of Atlanta system.

The population reached is representative of the population of Georgia. For race and ethnicity, the population is 48% Black/African American, 35% white, 15% Hispanic/Latino, 2% Asian, and 2% other. Medicaid care management organizations are the primary payer for 43% of the population.

In terms of the Zalik Center's impact on the occurrence of behavioral and mental health crisis, a behavioral and mental health crisis is averted for every 17 patients enrolled in the behavioral and mental health program at the Zalik Center. After an emergency department crisis, patients enrolled in the Children's behavioral mental health program have a 21-39% lower chance of subsequent emergency department crisis visits in the next 100 days than unenrolled patients with similar risk. There is a growth opportunity. There were 482 children enrolled after the first behavioral and mental health crisis compared to 4,328 not enrolled. If Children's had been able to enroll the remaining 4,328 patients not reached from August 2023 through July 2023, they could have potentially prevented an additional 255 behavioral and mental health crises.

The Zalik Center has also had an impact in reducing the need for inpatient hospitalization for patients presenting to the emergency department with suicidality. After the Zalik Center opened, there was a significant reduction, approaching 10%, in the proportion of children who were hospitalized.

Network adequacy is a large factor in the mental health parity problem for children. About 50% of mental health conditions are unattended to due to a lack of availability of services. Those going without services are not being tracked. The insurance companies submit data on patients who were taken care of, not those who were not. This is an invisible group. Self-pay is also 15 times more prevalent for mental health conditions than for medical conditions for outpatient care. This is also not tracked by insurance companies. At the Zalik Center, it is tracked if a recommendation is made whether there was follow-through. A qualified clinician must document which treatments are necessary and are accountable to determine whether treatment is received. If not, they are accountable to document whether the treatment is accessible. Children's took a representative sample to track follow-

through. For patients who had informative treatment plans within the electronic health record, 60% of those kids two months after the crisis were not getting any recommended services.

Eric Lewkowiez mentioned that the Georgia Council did a survey of child psychiatrists and found that about 80% of child psychiatrists in Georgia did not accept Medicaid. He asked, given the current climate, are there any suggestions that can make it more amenable to treat this population around the state? Constantino responded that Children's wants to take their data back to the insurers and show what it costs to attract the workers that they do not have in their provider directory as well as the benefit and cost savings. If they paid that same cost, then people will start taking their insurance. Children's uses nurse practitioners, which cost half of what it takes to attract a physician. Nurse practitioners represent an important arm of extending physicians and making things cost-effective for provider networks to build appropriate groups to take their insurance. Medicaid reimbursement will cover more of the costs of the group if it is not just physicians. There are ways to model this so that it is clear what the financial proposition should be. If that does not work, there is the "parity card," which emphasizes that insurance companies are obligated by federal law to do these things. Children's is accumulating data on the gaps which it will present to the insurance companies. By the end of this year, there will probably be 2,000 documented, auditable instances of those gaps.

Vinoski Thomas introduced Justin Gold, a self-advocate and recent graduate of the IDEAL program at GSU to share his story. Gold shared that he was diagnosed with autism at 3 years old. He shared that people with disabilities need guidance. He does speech, occupational, and physical therapy. He shared that speech therapy helps him speak clearly, not be repetitive, and do independent activities as an adult. The program at GSU taught him about people with disabilities, autism, and ableism, which he had never had the opportunity to learn about before. He wants people with disabilities to know that it is OK to ask for help, but it is important for the help to be provided.

Vinoski Thomas then shared that developmental disabilities (DDs) are defined as a group of conditions that occur due to impairments in physical learning, language, and behavior areas. DDs begin early in life, they impact daily functioning, and they last throughout a person's lifetime. DD is an umbrella term that encompasses many conditions, including autism spectrum disorder (ASD), attention deficit hyperactivity disorder, intellectual disability, developmental delay, cerebral palsy, and hearing and vision impairments. The most recent data from the Centers for Disease Control and Prevention shows that one in six U.S. children has a DD. There is a significant variation in prevalence rates for the specific conditions that fall under the umbrella term. Boys are more likely than girls to be diagnosed with ASD and intellectual disability. Black children are more likely than other racial groups of children to be diagnosed with intellectual disability.

It is estimated that there are about 515,214 children aged 0-18 with DD in Georgia. This is based on the national prevalence of DD and the U.S. Census population of children and youth living in Georgia in 2024.

D'Arcy Robb shared that the Georgia Council on Developmental Disabilities conducted a 2025 community survey that had 398 respondents. The goal was to gather community feedback about unmet needs for Georgians with DD. Respondents were people with disabilities, family members, service providers, and educators. The survey was representative of all age groups. The self-advocates were asked what the biggest challenges in their lives are, and the top two challenges were finding people to support them, like direct support professionals, and making friends and building relationships. Other challenges include making a long-term plan for finances and support, having a place to live that meets their needs, having enough money, and maintaining their health. Family members were also asked what the biggest challenges in their lives were. The top responses were finding services or supports for their family members with DD and making sure their family members with DD are supported when they can no longer provide care. All survey participants were asked what areas need the most attention to improve the lives of Georgians with DD and their families, and the most common identified need was services and supports, including waivers. Other identified needs include community connections and relationships, health and health care, education, child care, and early intervention.

Robb then shared some qualitative quotes collected from the open-ended questions related to services and supports in the survey. One respondent said, "one of the biggest barriers we face is battling insurance (Medicaid) to get the therapy services needed for my autistic child. There are a handful of places who accept his insurance, which all have a wait of six months or more. Once we finally get into an appointment, insurance wants to request all the hoops to jump through to make sure he needs it, then for them to just not agree with the recommendations from physicians that he needs it — and not pay for it anymore. So, we then are left with not doing therapy, paying out of pocket, trying to find another facility, or enduring the waitlist and trying again."

Survey respondents indicated the more specific needs around services and supports, with 55% of respondents indicating the need to make it easier to get a New Option Waiver Program waiver or a Comprehensive Support Waiver Program waiver and 44% of respondents indicating the need for training and tools on how to get services. Four in 10 indicated the need for better-quality services, and 39% indicated the need for more services for people who do not qualify for a waiver.

Robb shared qualitative quotes collected from open-ended questions related to community connections and relationships. One respondent said, "inclusion of individuals with severe and profound disabilities — many of those individuals are excluded due to incontinence, medical fragility, challenging behaviors." Another respondent said, "there are tons of

options when your loved one is younger than 18, but once they graduate from high school and enter the adult world, the resources and options are nearly gone."

Survey respondents indicated more specific needs around community connections and relationships. Sixty-five percent of respondents indicated the need for more community organizations and ones that include people with DD. Forty percent of respondents indicated the need for building friendships for adults, compared to just 15% indicating the need for building relationships for children. The quantitative data align with the previous quote shared, indicating that children have opportunities to socialize in school, but once they are transitioned out of school, those opportunities decrease.

Robb shared qualitative quotes collected from open-ended questions related to health and health care. One respondent said, "Once my daughter turned 18, she was no longer allowed to have mental health care. Because she had IDD [intellectual and developmental disabilities], she was discriminated against in receiving mental health care. It was wrong and horrifying. A person doesn't cease to be a person and need mental health care just because they turn 18 and have IDD." Another respondent said, "the biggest barrier I encounter is for those who are dually diagnosed. Some get help for their mental health issues, others are left undiagnosed due to already having been labeled intellectually disabled."

For health and health care, 45% of survey respondents indicated that there is a need to teach health care providers how to work with people with DD, and 30% indicated the need for training and tools for people with disabilities and families to work with health care providers. Thirty-eight percent indicated that there is a need for more medical providers for people with DD, 36% indicated the need for more dental providers for people with DD, and 26% indicated the need for more behavioral health providers for people with DD. The least commonly chosen indicated need was for learning healthy life skills such as nutrition and exercise, with only 11% selecting this. There is a mismatch between what the community is selecting as the needs and what the funding opportunities are. Most funding opportunities are to promote healthy life skills.

A qualitative quote regarding education noted, "our son who has Down syndrome had been out of sight from school personnel for about 30 minutes and was found almost 1½ miles away from the high school. During an IEP [Individualized Education Plan] meeting two days later, we pressed for answers and were told he was left on the school field without direct supervision and started walking the wrong way when he heard the teachers say it was time to go. One coach told him to stop but then let him keep going. Just like last year when he wasn't properly supervised, a school gate was left open and he walked out, and it was a student who found him. This is why school inclusion is so important and why cuts to education and Medicaid, which will limit inclusion opportunities, keep us up at night."

In the area of education, 42% of respondents indicated the need for more support for meaningful transition planning, including different options after high school. Forty-two percent also indicated the need for trainings and tools for families on supporting their student throughout school. Thirty-eight percent of respondents indicated the need for training and tools on 504 plans and IEPs. Thirty percent indicated the need for more support for inclusive postsecondary education, and 23% indicated the need for trainings and tools for teachers.

A qualitative quote regarding child care and early intervention noted, "we were fortunate enough to be able to start early intervention services and the diagnosis process and fund it ourselves, but I see many local families delaying any early intervention because they cannot afford [it] or insurance doesn't cover [it] and we have little to no options for early intervention services. We are failing children in our area. Even with Katie Beckett Medicaid for my child, I still travel 650 miles a week to get her therapies she needs at 3 years old and I have quit my job as a veterinarian to better care for her needs."

In the area of child care and early intervention, 49% of respondents indicated the need for having more daycares that include children with DD. Forty-two percent indicated the need for increasing the quality of early intervention services. Thirty-eight percent indicated the need for having more summer camps that include children with DD. Thirty-three percent indicated the need for increasing the number of early intervention providers and 25% indicated the need for increasing awareness of early intervention.

In summary, Georgia's children and youth need:

1. Better coordination of systems and services centered around people with developmental disabilities and their families;
2. Increased funding for DD services and supports; and
3. A culture where all children and youth with disabilities are valued, included, and belong.

Robb shared during the Q-and-A that she has concerns about the Mercer facility opening. The positive part is the partnership with Mercer for training clinicians to support patients with DD. There will also be services provided by clinicians. The part that worries her is that people with DD are going to get stuck there. A lot of people with DD go into crisis and are meant to stay short-term but end up staying for years. She hopes to continue to work with the Department of Behavioral Health and Developmental Disabilities (DBHDD) and different advocates.

Regarding the issue of waivers, Robb shared during the Q-and-A that there is some work being done by DBHDD. Guidehouse was brought in and did some research and produced a plan for steps moving forward with the waiting list. There is currently a committee of

DBHDD staff, advocates, and providers. The group has three subcommittees that are working on a potential new waiver, better ways to manage the waiting list, and an overhaul of the assessment process that is used for waiver eligibility. In terms of the waiver funding, she and her team presented to the General Assembly and looked at the investment over the last 12 years. The two years prior to this last session were pretty successful. There were 519 waivers added one year and 500 waivers the next. In other years they have gotten 75 to 200 new waivers a year, and throughout that time the waiting list has consistently been 6,000 to 10,000 people. The rates paid to DD providers were increased last year, meaning that there is more provider capacity. The big problem that needs to be addressed is funding. Georgia puts in one of the lowest fiscal efforts in the country when it comes to investment into adults with IDD. That is reflected in the consistently long waiting list. There is funding needed for the waivers and DBHDD staff to administer the waivers. They also need a system that is user-friendly to navigate.

August 21, 2025: Suicide Prevalence, Suicide Ideation, and Suicide Risks Among Children and Adolescents

Presentations from Dr. David Jobes, Director of the Suicide Prevention Center, the Catholic University of America and Professor of Psychology; and Britt Parramore, Executive Director, Pathlight Counseling

In 2024, there were 16,900,000 total Americans with serious suicidal thoughts. 2024 Substance Abuse and Mental Health Services Administrative data notes that 2,600,000 adolescents harbor serious thoughts of suicide. In 2023, it was 3.3 million in teens, however the number is up 900,000 in terms of the overall population. There is a history that contextualizes this conversation. There is a tradition of carceral solutions to mental illness and primitive interventions that were not therapeutic. This is important because we are still shouldering the legacy that a person with suicidal ideation belongs in a hospital and that is in their best interest. We know that they leave the hospital with an increased risk.

A University of Michigan research team found a much more severe suicidal trajectory was associated with rehospitalization. A second hospitalization was significantly associated with increased suicide attempts. It is reasonable to question what is happening in inpatient settings, which does not seem to be therapeutic and in which risk seems to be increased.

The Action Alliance advocated for other evidence-based approaches, such as screening for suicide risk and assessment of suicide risk, management of acute risk, treating the causes of suicidal ideation and behavior, clinical follow-through, and possible caring contacts. These are evidence-based practices that are not expensive and are not hard to train.

A Joint Commission-Pew survey recommended safety planning, warm handoff to outpatient care, caring contact follow-up post-discharge, and lethal means safety planning. Findings from the survey found that only 8% of Joint Commission–accredited hospitals use all four interventions.

Recent data on involuntary hospitalization found an increased risk of suicide for people admitted involuntarily, and one study found that involuntary admission was associated with a greater risk of all-cause mortality. It is more evidence-based, more cost-effective, and less stigmatizing to treat people in an outpatient setting with some exceptions.

The Collaborative Assessment and Management of Suicidality (CAMS) is a framework that is focused on empathy, collaboration, and honesty. The goal is to build a strong therapeutic alliance that increases patient motivation. CAMS targets and treats patient-defined suicidal "drivers." The provider asks all patients, even children, "what are the things that make you want to kill yourself?" Invariably they will describe relationship issues, being bullied, conflicts in the family, and self-esteem. It is very rare that a child will respond that they are depressed. These are all treatable psychological constructs. CAMS uses a suicide status form (SSF) that has a multipurpose assessment, stabilization planning, drive-focused treatment planning, and Health Insurance Portability and Accountability Act documentation. It functions as the progress note medical record. There is a different version for interim care and another for the outcome/disposition final session. There is a form-fillable PDF of the SSF for telehealth CAMS sessions. The documents are sent to patients and families.

A National Institute of Mental Health–funded randomized controlled trial is looking at CAMS 4 Teens vs. safety planning vs. treatment as usual. There is an early on recruitment crisis for the study because the safety plan intervention is indexed to a specific suicide attempt or acute crisis. However, many of the children in the trial do not have an attempt or crisis. The crisis was parents discovering their child was thinking about suicide, prompting them to do everything possible to stop the behavior, such as calling the police, rushing them to the emergency department, and having them admitted to an inpatient unit. However, most of these patients had already been suicidal for months.

The current approach to suicide risk is a reductionistic model, where suicide is treated as a symptom of depression. Depression and suicide are not synonymous. Suicide is a symptom of psychopathology. Traditional treatment is inpatient hospitalization, treating the psychiatric disorder, and using no-suicide contracts.

CAMS identifies and targets suicide drivers as the primary focus of assessment and intervention. CAMS assessment uses the SSF to deconstruct the "functional" utility of suicidality. CAMS as an intervention emphasizes a driver-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient. The assessment meets

criteria for a “therapeutic assessment,” and the treatment significantly increases hope and decreases hopelessness. CAMS is a therapeutic framework that is used to manage suicidal thoughts and feelings and establish behavioral stability. Adherence to CAMS requires a thorough suicide-focused assessment and treatment of patient-identified suicidal “drivers” and the pursuit of life worth living with purpose and meaning. The CAMS philosophy includes empathy for suicidal states, collaboration with the patient in all aspects of care, and honesty and transparency throughout clinical care. CAMS as a therapeutic framework has a focus on suicide from the beginning, the middle, and the end. It is outpatient-oriented and is flexible and “nondenominational.”

The CAMS SSF first session assessment and treatment is completed collaboratively in session with the patient. The patient always gets copies of their SSF after each session. The patient benefits therapeutically from being assessed in this way. The form includes coping strategies, and resources like the 988 crisis phone number. It identifies problems, develops goals and objectives, and implements interventions. The interim session begins with the core assessment and ends with a treatment plan update. The typical course runs between six and eight sessions. The goal is for the overall risk score to get down to a 1 or a 2. When that occurs, there is an outcome/disposition which is the final session.

There are 11 correlational/open trials that show support for SSF/CAMS. A 2021 meta-analysis of nine CAMS clinical trials shows that CAMS is a “well-supported” intervention for suicidal ideation as per the Centers for Disease Control and Prevention criteria.

A randomized controlled trial in Germany showed that CAMS shows significant results for suicidal ideation, better alliance, and decreased suicide attempts post-discharge, which is a high-risk period.

The biggest challenge in working with teens is the parents. The parents are met with before the child. Parents are given thorough informed consent to help set expectations. CAMS is a patient-focused treatment, so the parent’s role is to support the child’s suicide-focused treatment. They complete the stabilization support plan.

The Louisiana State University Psychology Department’s Mitigation of Suicide Behavior Lab is conducting a study where they are using the CAMS Brief Intervention (CAMS-BI) in the emergency department. Forty-seven percent of the sample were committed against their will, and 40% of the sample were African American. There was increased motivation to live among the sample after only one session. This is 100% delivered by graduate students under supervision.

Emerging benefits of CAMS-BI include that it provides a “therapeutic assessment” by using the SSF; patients engage in a structured, collaborative conversation to determine patient-identified “drivers” of suicide risk and they serve as “co-authors” of their suicide-focused

treatment plan; a CAMS stabilization plan is developed (including lethal means safety) and a CAMS stabilization support plan can also be developed with significant others; and there are optimal discharge dispositions and facilitated referrals to outpatient care that can break the cycle of crisis.

The benefits of CAMS-BI for hospitals include cost-effectiveness, flexible workforce, proven results, exceeding standards, and improved staff morale.

Benefits of CAMS-BI for clinicians include that the model is relatively easy to learn, empowers treatment teams, ensures competence and confidence, and helps decrease liability exposure.

The benefits of CAMS-BI for patients are clear. It can eliminate the need for costly inpatient admissions, patients and families feel listened to and validated, and patients can quickly stabilize and leave with a therapeutic assessment experience, a CAMS stabilization plan, a stabilization support plan, and dispositional clarity about their suicidal drivers that can be treated in follow-up care with a facilitated referral.

Most psychiatric patients who come to emergency departments are suicidal. Referral to an emergency psychiatric assessment, treatment, and healing (EmPATH) unit is a key first step to a much more therapeutic crisis response than the typical emergency department experience. The use of CAMS-BI within the EmPATH model is compelling in ensuring optimal clinical care that benefits hospitals, clinicians, and patients who suffer with serious thoughts of suicide.

This data is currently being replicated at Children’s Healthcare of Atlanta. There are already reductions in stress. The final data collection will be in November. Seventy percent of the sample were people of color, which is important as people of color have increased risk for suicide.

The MQ foundation, a nonprofit focused on transforming mental health, funded a neuroimaging study of CAMS 4 Teens participants to study the neuroscience of the intervention with a special focus on the formulation of hope. The Hope Institute uses CAMS and dialectical behavioral therapy to stabilize patients who are suicidal with suicide-focused care. This is now in Children’s as well.

A Stepped Care Model for suicide care includes suicide-specific care at each step from the least to most restrictive intervention. It is evidence-based, least restrictive, and cost-effective. Jobes hopes the model is replicated nationally.

Eric Lewkowiez shared that he is concerned with what happens when people are hospitalized; it seems like hospitals are more interested in discharging patients to get

reimbursed. There are no CAMS or EmPATH units in Georgia. Jobes responded that Children's does not have an inpatient unit. They see people in the emergency department, then refer them to other hospitals. John Constantino said he has amazing data on recidivism. The CAMS clinic there is really effective.

During the Q-and-A, Jobes shared information related to telehealth. He said that the study from San Diego was 100% telehealth and has great results. There is evidence that telehealth can be as effective, if not more effective, if people have the technology to use it. There is a way that CAMS-BI can be grouped into collaborative care models that health plans are now reimbursing for. In California, there is a per diem approach to intensive outpatient treatment. There are different systems and different payer models. Some places are able to get EmPATH units established. Brief interventions and hybrid interventions are where we will see things go in the near future.

Pathlight started in 2017 as a private practice. Pathlight has adult and teen outpatient programs for substance use disorders and mental health. Pathlight programs include adult and intensive outpatient programs for teens, veterans, and those in foster homes. Parramore is a Division of Family and Children Services provider and provides for Cherokee County Family Treatment Court, a Forsyth county residential substance use treatment program, and offers private counseling and psychiatry practice for children, teens, and adults.

Parramore shared several case studies to show the causal links between high-THC products and the development of psychological disorders in teenagers. In 2022, 30.7% of U.S. high school 12th-graders reported using cannabis in the past year, and 6.3% reported using cannabis daily in the past 30 days. In the past year, vaping of cannabis declined from 2020 to 2021 and remained steady in 2022 following large increases in 2018 and 2019. Research led by Oregon Health & Science University reveals adolescent cannabis use in the United States has increased drastically by about 245% since 2000, as alcohol abuse among teens has steadily declined.

Georgia passed medical marijuana with a 5% THC limit. There was a bill proposed to increase that to 50% with no medical evidence to support that higher levels of THC helped. Forty-seven states allow the use of cannabis for medical purposes. THC is the chemical responsible for most of marijuana's psychological effects (National Institute on Drug Abuse). Different delivery systems include dry herbal marijuana (flowers), marijuana oil or wax, and synthetic forms of marijuana. Liquid THC is applied to a vaping device the same way that flavored nicotine liquid is. Use of hash oil is also becoming more common.

Dabbing is a method used to convert marijuana into a concentrate. The concentration of THC can be up to 98%.

THC is in the same classification as LSD. The national average of THC in the plant is about 16%; the remaining components include CBD, which has an anti-psychotic effect.

Considerable clinical evidence supports the hypothesis that adolescent neurodevelopmental exposure to high levels of the principal psychoactive component in marijuana, THC, is associated with a high risk of developing psychiatric diseases, such as schizophrenia later in life.

Use of high-potency cannabis at age 16 or 18 was associated with twice the likelihood of experiencing incident psychotic experiences from age 19 through 24. The medical director of the Best Practices in Schizophrenia Treatment Center, Dr. Erik Messimore, stated that the causal link between marijuana use and the development of psychosis is the most well-replicated, high-impact finding in schizophrenia research today.

This happens only in the developing brain; it is not seen happening in adults. The endocannabinoid system (ECS) is a complex cell-signaling system identified in the early 1990s. It plays a crucial role in regulating various physiological and cognitive processes, including mood, memory, appetite, and pain sensation.

The anandamide hypothesis revolves around the role of anandamide in the ECS. Anandamide, often called the "bliss molecule," is a key endocannabinoid that binds to CB1 receptors in the brain and central nervous system, influencing mood, pain, appetite, and other physiological functions.

The current theory postulates that the use of high-THC products in the developing brain causes "runaway pruning." Between ages 11 and 18 is when pruning is most prevalent. There is a strong link between excessive pruning and schizophrenia. Pruning of certain pathways in the brain is permanent. Pruning happens in the dopamine system, which is also involved in schizophrenia. The overactivation of certain receptors from marijuana use mimics the symptoms of a person with schizophrenia.

Lewkowiez shared that he is seeing a lot of psychosis related to synthetic cannabinoids, and when patients come in, they don't test positive for cannabis, so it is hard to know what is going on. Usually, they share that they used a vape or Delta 8.

Skinner echoed that she is also hearing a lot about this. She heard from someone that Delta 8 was recommended to them by a medical professional and that they could just buy it over the counter and it would help them sleep.

During the Q-and-A, someone brought up kratom; Parmore shared that Georgia did a great thing by banning 7 hydroxymitragynine. The kratom plant has different alkaloids. The one that has the most affinity on the mood receptors is called 7 hydroxymitragynine. There is

less than 0.1% in the plant, but what they've done is synthesize it so that there is 100%. It is 13 times stronger than morphine. Georgia has outlawed this, but there is still kratom.

Parramore stated that he is looking into the amount of money behind legalization. In Georgia, it looks like it is around $50 million.

September 25, 2025: Children and Adolescent Mental Health Issues in Rural Georgia

Presentations from Brenda Cibulas, Executive Director of the Division of Behavioral Health, Department of Behavioral Health and Developmental Disabilities (DBHDD); Dr. Christy Doyle, Director, Office of Children, Young Adults & Families, DBHDD; and Jennifer Dunn, Deputy Commissioner, Field Operations, DBHDD

DBHDD is Georgia's safety net for mental health care, substance use treatment, and developmental disability services. Jennifer Dunn explained that she got very involved with agricultural partners following Hurricane Michael, which was the biggest hurricane to hit the continental United States in 2018, and it hit South Georgia. Georgia's agricultural communities face realities such as natural disasters, foreign animal diseases such as avian influenza, and annual stress due to uncertain crop production and trade embargos.

Mercer conducted a farmer mental well-being study in 2022. It surveyed agricultural farmers in Georgia and got about 1,600 respondents. It found that 82% of farmers reported moderate levels of stress, and 29% reported thoughts of dying by suicide at least once a month. Following this survey, a pilot program was implemented in partnership with local health care organizations to talk with farmers about suicide prevention. The 988 crisis phone number is promoted in these communities.

988 data from the last six months showed that rural South Georgia is reaching out for help at higher rates than urban areas. Seventeen of the top 20 counties of usage are rural. The suicide death rate in rural Georgia counties increased by 7% between 2017 and 2022. Suicide death rates in rural areas of Georgia are 26% higher than in suburban and urban areas. As part of the 988 awareness campaign, targeted materials for rural communities were created.

Farm Stress Summits started in 2022. This is an event where farm families, farm lenders, and state agencies come together. The 2026 summit had a significant number of youth attendees, so they are thinking of creating an event specifically targeted at youth.

A qualitative study was conducted to evaluate interest in learning stress-management skills among rural southwest Georgia's youth. Sixty-one children ranging from age 8 through 16 were given surveys asking about their interest in stress-management skills. Sixty percent of

respondents were male and 40% were female. There was a diverse representation of race and ethnicity. The results of the surveys showed that there is a notable interest in all stress-management skills listed on the survey but especially in creating routines, time-management skills, healthy habits, and handling feelings. From this, a pilot program was developed. The program consists of a stress-focused icebreaker and two parts of activities. The first half of the lesson is devoted to learning different coping skills. The second half of the lesson teaches active listening skills through role-playing scenarios and graphic organizers. The participants gave very positive feedback about the program. Activities included stress ball activities, mindfulness scavenger hunts, coping skills activities, and art therapy.

The Georgia Agricultural Wellness Alliance was formed with members including DBHDD, the University of Georgia (UGA), Mercer, the Georgia Department of Agriculture, the Georgia Farm Bureau, and the Georgia Foundation for Agriculture.

Eric Lewkowiez asked if gun safety is addressed in the rural communities. There is large gun ownership in those communities, and he assumes there is a connection between stress and gun safety. Dunn responded that at all of the adult meetings, she took gun safes and gave them out to anyone who wanted them. Some people take them, and some don't. She also brings them to law enforcement events and would love to see a good campaign about how to properly store and lock up weapons.

Dunn then passed it to Christy Doyle to provide updates on the Office of Children, Young Adults & Families (OCYF). DBHDD's OCYF highlights the Georgia Apex Program, Project ECHO (Extensions for Community Healthcare Outcomes), and clubhouses. If mental health is addressed in schools, students can thrive academically and emotionally.

HB 268 aims to enhance the safety, health, and well-being of students and school communities across Georgia. The bill includes mandates around student records, mental health support, behavioral threat assessment and management processes, school safety infrastructure, and interagency collaboration. Behavioral threat assessment when operationalized can help identify a child who may be showing signs of early stress, and pulls together a multidisciplinary team to identify supports for the child and the family to provide a better environment, while also decreasing the risk that the child could become a threat to the safety of the school. DBHDD's role in the process includes serving as subject matter experts regarding qualifications and training for student advocacy specialists, who have been designed to serve as care coordinators and resource builders — they do not provide direct services to the student. DBHDD is responsible for reviewing and providing input on school safety plans and direct assessment and management plans. This is a new task for DBHDD as it has historically been the responsibility of Georgia Emergency Management and Homeland Security Agency, but DBHDD will also provide input on the behavioral health components of those plans. DBHDD will also provide expertise and

support through training and technical assistance provision and providing recommendations to sister agencies and local school districts.

Regarding what is next in the process of implementing HB 268, DBHDD is in the process of defining the role of student advocacy specialists. These roles will be fully developed by the end of the 2025 calendar year. These specialists will work as care coordinators who connect students to behavioral health supports. They will be new positions and will not add duties to existing school staff. DBHDD is reviewing standards to guide schools regarding behavioral health in school safety plans and will create a submission and feedback process to ensure plans are reviewed constructively. DBHDD will provide support with development, provision, approval, and consultation for training and technical assistance on a range of behavioral health topics, including student behavioral health, suicide prevention, and behavioral health functions of behavior threat assessment and management.

Additionally, there have been several items recommended from the BHRIC workgroup on school-based behavioral health, including the safe school enhancement plan, behavioral health training clearinghouse, behavioral threat assessment and management, in-house Tier 2 skills classes, expansion of the Georgia Apex Program, and improved school social worker ratios.

The Georgia Apex Program, which is a program funded and designed by DBHDD to strengthen access, coordination, and early intervention for students, is celebrating its 10th year. The Apex Program operates on a tiered support model. Tier 1 is universal prevention, which involves schoolwide activities to promote mental health awareness; Tier 2 is targeted early intervention, which includes support for at-risk students with emerging needs; and Tier 3 is intensive intervention, which includes focused support for students with mental health disorders.

In 2024, the Apex Program delivered 264,940 behavioral health services, which is a 26% increase from the previous year. It reached 15,617 students individually and expanded its reach from 808 schools last year to 868 schools this year. Many of the programs are concentrated in more rural areas of the state to enhance the available options for the children in those areas. Access and care are improved when the child is met where they already are, especially in rural areas, where transportation can be a barrier.

One of the primary goals of the Georgia Apex Program is to improve access. During the 2024-2025 school year, 7,243 children received behavioral health services for the first time from an Apex clinician, providers made 12,453 referrals for Apex services, and 71% of parents reported that their child was better able to handle daily life after receiving Apex services. In addition, 83% of parents reported that they felt access to care was improved after having access to Apex services.

One of the biggest challenges that Apex faces is staffing challenges. Last year, 72% of Apex providers reported significant clinician turnover for reasons including salary, workload, or other opportunities. DBHDD is exploring potential solutions including leveraging a federal grant partnership with the Center of Excellence for Behavioral Health & Wellbeing at Georgia State University to create a school-based mental health internship program within schools working with Apex providers. The internship program trains master's-level social work students from three Atlanta universities in school-based mental health services across the continuum. Interns receive stipends and tuition and travel expenses in exchange for a commitment to work in high-need school districts following graduation. Following the success of this internship program, a statewide supported internship program is expected to roll out in 2026, with a focus on rural areas.

Additionally, there was $1 million appropriated in fiscal year (FY) 2025 to support Apex telehealth initiatives. There are also ongoing expansion efforts including expanding partnerships with DBHDD-enrolled providers to enhance service delivery, expanding school support by providing direct grants to schools to facilitate telemedicine infrastructure and access, and expanding regional collaboration by exploring partnerships with Regional Education Service Agencies to further expand service reach.

For several years, DBHDD has provided a series of ECHO trainings, which are trainings designed to increase the number of pediatric primary care providers in Georgia trained to address behavioral health disorders, with a focus on rural and underserved areas. Lewkowiez noted that this is also happening at the Medical College of Georgia through the Georgia Mental Health Access in Pediatrics Program and the Georgia Chapter of the American Academy of Pediatrics. There are also 18 statewide mental health resiliency clubhouses across the state operated by 11 providers. The clubhouses serve youth aged 6-21 and provide a range of services, including educational programs, employment support, peer support, family engagement, and social activities. There are also eight substance use recovery support clubhouses statewide, which are focused on supporting youth in reducing or abstaining from alcohol and substance use. Lastly, there is an annual teen suicide prevention summit, which is designed to promote awareness, prevention strategies, and support for teens facing mental health challenges. The 2025 summit attracted more than 200 children and their families.

The Muli-Agency Treatment Team for Children Committee (MATCH) was developed as part of HB 1013 and has been operating for about 18 months in terms of programmatic support. The goal of MATCH is to serve the highest-need kids who were falling through the cracks. The MATCH State Committee is charged with identifying the specific system gaps and what services are needed to fill those gaps. In addition, the state committee develops policy recommendations for participating agencies. There is also a budget for MATCH to pilot programs that could potentially fill the gaps and meet the needs of the children it is meant to serve. The MATCH Clinical Team (MCT) is the group that MATCH kids are referred to.

Doyle shared that the MCT is almost like a state-level local interagency planning team in that they bring expertise to identify a child's needs and determine how their needs can best be met. MATCH is offered statewide. It is anticipated that MATCH will play a large role in HB 268 implementation.

DBHDD is partnering with the David Ralston Institute at the University of Georgia to develop best practices and recommendations related to rural mental health, substance use, and intellectual or developmental disabilities.

Brenda Cibulas shared that there is more work needed to understand the gaps in Georgia, and DBHDD is working with a consultant to address that. Another important component is addressing parity among different payers and how they will ensure adequate levels of care and credentialing in both urban and rural areas. They are also looking into the age requirements at several crisis stabilization units to help eliminate as many barriers as possible. DBHDD is creating a lot of partnerships and looking to continue to expand.

During the Q-and-A, Doyle shared that one of the functions of MATCH is to do everything possible to locate the necessary resources for a child in state, and a big part of MATCH's mandate is to figure out what is needed so that it can be developed in the state.

Regarding tele–mental health, Cibulas shared that DBHDD supports tele–mental health. They are also concerned with broadband access and what is available when that is a barrier, but tele–mental health has to be part of how people are able to receive services.

Dunn commented that in rural communities, often even if they have access to broadband, they are not fans of telehealth, but youth under 18 love it and don't have a problem with it. So, it is mostly adults who prefer in-person services. Doyle echoed Dunn, saying that children are more comfortable communicating via technology, and we should be strategic about leveraging that.

Lewkowiez commented that telehealth is helpful, but when you are seeing patients from somewhere else, you are not seeing them where you are. It works great for adolescents but for kids younger than 6, they can have trouble. Access to telehealth has to improve due to shortages, especially across Southwest Georgia. Not only is there a shortage of mental health providers but there are areas in Southwest Georgia that do not even have a pediatrician.

October 16, 2025: Services for High-Acuity, Transition-Age Youth

Presentations from Ron Koon, Chief of Psychological Services, Department of Juvenile Justice (DJJ); Dr. James Freeman, Chief of Psychiatric Services, DJJ; Kimbolic Hamilton,

Office of Behavioral Health Services Director, DJJ; Cati Stone, President and CEO, CHRIS 180; Rick Aranson, Chief Operating Officer, CHRIS 180

Georgia has a state-run juvenile justice system with 25 facilities throughout the state. Nineteen are regional youth detention centers with an average daily population of 814. These are short-term, readjudication centers with an average length of stay of three days to three months. There are six long-term youth development campuses, with an average daily population of 191 youths. The average stay in these facilities is one to three years. Each facility has a behavioral health team and offers psychiatric and psychological assessments, mental health screenings and assessments, suicide and safety protocols, individual and group counseling, family education and counseling, crisis intervention and support, and service and treatment planning.

The percentage of youths placed on the mental health caseload following assessment is increasing. In fiscal year (FY) 2023, the percentage of youths on the mental health caseload for regional youth detention centers was 58.8% and for youth detention centers was 70.6%. In FY 2025, the percentage of youths on the mental health caseload for regional youth detention centers went up to 71.6%, and for youth detention centers went up to 77.8%.

Demographically, white and Black youth make up the largest percentage of the population placed on the mental health caseload. In the overall population, the highest percentage of the population is Black, followed by white and Latino. Typically, white youth placed on the mental health caseload come in with a history of treatment and are already prescribed medications more often than other demographic groups.

The total number of youths on the mental health caseload followed by psychiatry has increased over time. There has also been an increase in the number of youths on medications. In general, over the last few years there has been an increased use of psychotropic medications.

There has been an increase in polypharmacy, or youths taking multiple medications, which was noted as a concern. The Behavioral Health Placement Review Panel is a committee authorized to receive and review referrals for placement and assign placements or services for youths who have been identified, through established criteria, as potentially needing more intensive treatment services than the current placement can provide. The referrals for polypharmacy have increased from 57 in FY 2023 to 77 in FY 2024 and 82 in FY 2025. Anti-psychotics are also being used more due to changes in diagnoses. During the Q-and-A, James Freeman clarified that the Behavioral Health Placement Review Panel is not for placement issues typically; if youths are in the system and they have severe mental health needs or are on multiple medications or an anti-psychotic, the panel reviews them no matter what facility they are in and makes recommendations based on that. If a youth is seen with severe needs that the facility cannot handle, they may be referred elsewhere.

In terms of diagnostic trends, depression, behavior disorders, and substance use disorders have remained stable. Neurodevelopmental disabilities, notably autism, have been

increasingly diagnosed. Trauma has increased, but screening for trauma has improved. The individuals referred to DJJ tend to have more trauma in their environments. Bipolar disorder is diagnosed more frequently, which in part explains the increased use of anti-psychotics. There is also a significant increase in psychotic disorders.

Behavioral Health Placement Review Panel referrals for significant diagnoses have increased. In FY 2023 there were 59 referrals, and 149 in FY 2025.

The Augusta Youth Detention Center has four specialized living units. The first is a dedicated mental health unit and is tailored to youth whose mental health needs cannot be met by other facilities due to reasons such as severity, complex psychotropic medication requirements, and others. There are two residential substance abuse treatment (RSAT) units. The average length of stay is six months, and they serve youths whose substance use treatment needs are moderate to severe and chronic in nature. The shelter unit serves youths who are at high risk of victimization for reasons including cognitive disabilities, gender identity, and medical vulnerabilities.

There is also one specialized living unit, the Eastman Youth Detention Center, which is a dedicated RSAT unit. The Macon Youth Detention Center is a mental health unit that serves females whose mental health needs cannot be met by other facilities due to severity, complexity, level of risk, or psychotropic medication requirements. There is also specialized programming for sexually harmful behaviors. The sexually harmful behavior intervention program is mandatory. There is also a Healthy Boundaries program for kids who have lower-level sexual offenses.

Substance use intervention and treatment programs use the Seven Challenges treatment program. There is a Brief Challenges Interventions program for the detention centers, which is more prevention-oriented.

There are several access and capacity issues, including caseload and staff-to-youth ratios, which have increased for routine therapy and assessments. Telehealth has expanded with psychiatry, psychology, and other behavioral health services, but capacity is limited. There is an effort to keep psychologists on site as opposed to doing telehealth. Psychiatric residential treatment facility (PRTF) bed capacity is also a challenge. DJJ refers youths to PRTFs through the MATCH committee. They have referred five youths so far, and none of them have been placed yet.

Generally, there is limited PRTF availability, and PRTFs are hesitant to accept DJJ-involved youth. Residential treatment centers are often hesitant to take DJJ-involved youths because they are perceived to be a greater risk than non–DJJ-involved youths. They also may be screened out based on having a sex offense or fire setting in their background, which makes it harder to get placements for those kids. DJJ has also had issues getting youth into crisis stabilization units (CSUs), but this has improved. This year, 12 individuals were referred to a CSU, and eight have gotten in.

In alignment with HB 242 Juvenile Justice Reform mandates, DJJ is required to implement and deliver more rigorous, evidence-based services and treatment for youths in care. Sustaining adequate staffing levels is essential to ensure program fidelity, maintain quality service delivery, and support positive youth outcomes.

Salaries for clinicians have been on the rise for many years, a trend accelerated by the pandemic. DJJ has struggled to attract and retain clinicians and has operated at a 30-40% clinician vacancy rate for the past year and a half. Over the past two years, behavioral health staff have received significant salary increases.

Several gaps and challenges exist, including expanding the ability to engage families in treatment. Outcomes are improved when families are involved, but DJJ facilities have had trouble involving families. Often the kids are placed far from where their families live, which makes it difficult to engage them. Clinicians also need training to work with families. DJJ has a working group to work on training clinicians in family-informed treatment.

There is a need for mental health beds for youth in acute crisis. The Department of Community Health and DBHDD are working with DJJ and emergency receiving facilities to develop a direct referral process for crisis stabilization placements. There is a collaborative proposal, the Youth Innovation Project, with DBHDD, Division of Family and Children Services, and the Department of Community Health for a Milledgeville treatment facility to serve kids in DJJ and Division of Family and Children Services due to similar needs. There is a “no eject, no reject” policy in which they have the capacity to serve DJJ and Division of Family and Children Services kids in a more secure environment than a private-provider residential treatment facility. This is not expected to be completed at any time soon.

Department of Community Health and DBHDD should revise policies and practices to recognize DJJ as referral sources for PRTFs. Additionally, there are workforce issues, the need to enhance capacity for telehealth service, and budget increases to sustain evidence-based treatment interventions and practices.

Gwen Skinner commented that Devereux’s population is currently made up of about 23% DJJ-involved youth. The reason that it is difficult for DJJ to get kids into PRTFs is the liability and insurance issues for providers in Georgia who are risk-averse. This is something that the state is working on. Together Georgia, provider groups, and others are talking about it and would love to have DJJ partner on the issue.

Eric Lewkowiez mentioned that at the Medical College of Georgia they try to reduce polypharmacy by teaching residents and fellows that less is more and not to be so quick to prescribe multiple medications at the same time.

Freeman stated that one of the advantages of seeing youth in DJJ facilities is that they see the kids over several months and can monitor how they are responding to medications.

Garry McGiboney asked if there is recidivism data on those who have been in treatment while in the detention center. Ron Koon explained that this is an issue that DJJ and other

correctional systems are thinking about. There is not a good answer for how to compute recidivism when they leave DJJ at the end of their adolescence and enter the adult system because they are not connected. Kimbolic Hamilton added that DJJ does not track recidivism in the facility side, but there may be an opportunity to track it on the community side.

McGiboney asked what can be done to change the environments and conditions that kids are returning to when they leave DJJ facilities and if there is prevalence data on what is being done with parents and families. Koon responded that in the last few years, there has been a reentry unit added to prepare youth and families for reentry into the community. Plans are made to connect kids and families with resources in the community. Hamilton added that transitional plans are designed with providers, the parent, and the child, and this process starts four months prior to release. There is a challenge getting parents to participate and be consistent throughout the process.

Skinner commented that DJJ is one of the best organizations that Devereaux works with. The DJJ kids are no more complicated than the other youth they encounter.

Cati Stone and Rick Aranson then presented on behalf of CHRIS 180.

The mission of CHRIS 180 is to heal children, strengthen families, and build community. It starts with a trauma-informed approach to care and a focus on prevention to avoid crisis situations and to set individuals up for long, happy lives.

CHRIS 180 was founded in 1981 and started as the first specialized group home in Georgia for youth with behavioral health and emotional challenges. It is focused mostly on the metro Atlanta area but offers services across Georgia and some nationally. CHRIS 180 remains deeply rooted in mental health and committed to children, youth, and families. CHRIS is an acronym for creativity, honor, respect, integrity, and safety.

CHRIS 180 core impact areas include mental health counseling and therapy delivered in schools and in community, foster care and adoption placements, support for youth experiencing homelessness including independent living support, and wraparound services where individualized, holistic support is provided for those facing complex challenges.

CHRIS 180 has five counseling centers in Dekalb, Atlanta, Gwinnett, North Fulton, and Adamsville. There are community-based locations including the Fulton County clubhouse, @Promise Centers, places of worship, and workplaces. There are 80 school-based mental health locations in Atlanta Public Schools and in Fulton, Dekalb, and Clayton counties. The Eastside headquarters has the Center of Excellence for Training, Education, and Connections, a 41-unit Summit Trail apartment complex, and a drop-in center for homeless youth.

Aranson opened drawing parallels to DJJ's presentation sharing that CHRIS 180 is also experiencing significant staffing challenges with its clinical workforce. They have had to invest in retention efforts and are still unable to compete with the private sector in terms of

matching salaries. CHRIS 180 is also delivering multisystemic therapy services in Gwinnett County for DJJ-involved youth. They are also serving DJJ youth through a partnership with the Fulton County district attorney.

In 2024, CHRIS 180 provided 44,000 school-based services in 85 schools. These services included therapeutic services, educator training, and parent forums. In 2025, nearly 12,000 community-based services have been provided year to date. These include therapeutic services, supported employment, supporting people transitioning from foster care, and wraparound services.

CHRIS 180's success measures include an improved quality of life, improved mental health, maintained or improved independence/self-sufficiency, achievement of treatment plan or individual service plan goals, satisfaction of persons served, and satisfaction of partners.

During the Q-and-A, Aranson shared that CHRIS 180 is one of the largest Apex providers, and they hope for more Apex funding. It is a model where providers are directly in the schools providing services. It is a unique value that is being provided to the kids and connects them to other services that CHRIS 180 provides.

In terms of funding, Apex is a combination of third-party funding and fee-for-service funding. Many of the kids in the schools are not on Medicaid. Often CHRIS 180 has served a child for months before they are able to get on the state insurance plan.

Turnover for school-based mental health services is lower than in community-based mental health programs. Community-based care is harder to staff because it requires people to be where the clients are and not in a designated location.

Aranson shared that tele–mental health is offered at all of the Apex schools, but they also see the value in face-to-face interventions, particularly for school-age children.

Recommendation Priorities

The Subcommittee on Children and Adolescent Behavioral Health identified the following recommendations from the testimony heard during 2025 as priorities for immediate action:

1. Examine opportunities for health insurance companies, health care providers, and community service boards to embed the Social Communication, Emotional Regulation, Transactional Support (SCERTS) evidence-based framework into case management and build the capacity of provider networks to implement the SCERTS framework to support member outcomes.
2. Establish more Department of Behavioral Health and Developmental Disabilities clubhouses across Georgia to reach more areas and communities.
3. Utilize Opioid Settlement Fund dollars to increase the number of substance use disorder recovery clubhouses.

4. Invest in more intensive outpatient-level treatment for teens that includes opioid use and related substance use disorders.
5. Invest in supporting residential inpatient facilities for complex cases and include substance use disorders.
6. Improve integration of pediatric and adult systems of care to support the transition to adulthood for individuals with intellectual and developmental disabilities.
7. Engage payers and regulators by sharing information, including return on investment, to help them identify the best investment of resources; improving data sharing and alignment of systems; and developing technology supports and innovative payment solutions for services that benefit the developmental disabilities population.
8. Encourage hospitals to use interventions such as safety planning, warm handoff to outpatient care, caring contact follow-up post-discharge, and lethal means safety planning (suicide-prevention strategy that focuses on reducing access to methods a person could use to harm themselves).
9. Revise state agency policies and practices to recognize the Department of Juvenile Justice (DJJ) as a referral source for psychiatric residential treatment facilities.
10. Explore options to address the 30-40% clinician vacancy rates at DJJ.
11. Enhance the capacity to deliver telehealth services to youths who are in community programs and reduce barriers to accessing telehealth services by modifying implementation policies, such as removing the requirement for visual access and allowing cellphone access.
12. Earmark funds to sustain evidence-based treatment interventions and practices for youth.
13. Consider dedicated funding for peer-based programs to extend services for DJJ youth to reduce recidivism.
14. Create a public information campaign around the risk of adolescents developing schizophrenia from high THC use.

The Children and Adolescent Behavioral Health Subcommittee identified the following as past recommendations to reemphasize in 2025:

1. Increase funding for the Regional Perinatal Center outreach educators, coordinated by the Georgia Department of Public Health, for training of neonatal intensive care unit (NICU) staff to engage families in the care of their infant while in the NICU and during transition home.
2. Examine opportunities for health insurance companies to provide resources (e.g., lodging, food, transportation) that proactively support families' presence and engagement in the care of their infants in the NICU.
3. Increase funding to expand training and implementation of NICU peer recovery coaching provided by the Georgia Council for Recovery.

A full list of recommendations is included in the appendix of this report.

More detailed notes from each of the 2025 presentations can be made available upon request. Please contact Dr. Ann DiGirolamo (adigirolamo@gsu.edu).

APPENDIX C: SUBCOMMITTEE ON HOSPITAL AND SHORT-TERM CARE FACILITIES

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Hospital and Short-Term Care Facilities
2025 Annual Report

Chair
Dr. Brenda Fitzgerald

Members
Kim Jones
Donna Hyland
Emily Anne Vall
Jason E. Downey
Sen. Brian Strickland
Dr. Michael Robert Yochelson
Sen. Kim Jackson
Commissioner Candice Broce
Commissioner Christopher Nunn

November 2025

Report prepared with assistance from the Georgia Health Policy Center and
the Center of Excellence for Behavioral Health & Wellbeing at Georgia State University

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Introduction

House Bill 514 (from the 2019 session of the General Assembly) created the Georgia Behavioral Health Reform and Innovation Commission (BHRIC). The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, including the Subcommittee on Hospital and Short-Term Care Facilities, chaired by Dr. Brenda Fitzgerald (2020-2025).

During 2025, the Subcommittee on Hospital and Short-Term Care Facilities held seven public meetings on topics related to mental health innovations in emergency departments and reports of parity compliance issues, as well as a strategy for mental health care for youth.

List of Presenters to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities 2025

BHRIC Subcommittee on Hospital and Short-Term Care Facilities
Dr. Brenda Fitzgerald, Chair
Commissioner Christopher Nunn, Commissioner Candice Broce, Sen. Brian Strickland, Sen. Kim Jackson, Dr. Michael Robert Yochelson, Kim Jones, Donna Hyland, Jason E. Downey, Emily Anne Vall

Support to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities
Ana LaBoy, Georgia Health Policy Center; Sarah Small, Georgia Health Policy Center; and Ashlie Oliver, Georgia Health Policy Center

Presenters to the BHRIC Subcommittee on Hospital and Short-Term Care Facilities 2025

Date	Topic	Presenter
May 28, 2025	Mental Health Workforce	National Mental Health Workforce Acceleration Collaborative Dr. Andrea Meyer Stinson, Director of Workforce Strategy & Initiatives at Resilient Georgia
	ImPACT Treatment Model and UrgentPsych	**Dr. Sofia Khan**, Co-Founder UrgentPsych
June 25, 2025	Mental Health Parity	The Carter Center **Sarah Phillips**, Associate Director of Public Policy
	South Carolina EmPATH Update	South Carolina Department of Health and Human Services **Shadda Winterhalter**, Strategic Initiatives Specialist **Eunice Medina**, Director
July 23, 2025	Behavioral Health Urgent Care	Willowbrooke Urgent Care **Paula Gresham**, Vice President Behavioral Health Services **Dr. Kenneth Genova**, Executive Medical Director
	Grady Health System Crisis Intervention Service	Grady Health System **Anne Hernandez**, Vice President, Behavioral Health at Grady Health System
	Trauma-Informed Design for Behavioral Health Services	Trauma-Informed Design Society **Janet Roche**, Co-Founder and CEO
Aug. 20, 2025	ED Psychiatric Assessment, Diversion, and Continuity of Care	**Christine Cowart**, Co-Founder and COO **Adrienne Erdman**, Vice President of Research and Development Highland Rivers **Melanie Dallas**, Chief Executive Officer **Lyndsey Morda**, Senior Director of Intensive Services
	Community Behavioral Health Clinics	Certified Community Behavioral Health Clinics (CCBHCs) **Sarepta Archila**, Director
Sept. 17, 2025	Mental Health Care Consortium and Consultation Programs	Texas Child Mental Health Care Consortium (TCMHCC) **Dr. David Lakey**, Vice Chancellor for Health Affairs, CMO of University of Texas System and Presiding Officer of TCMHCC **Dr. Laurel Williams**, CMO of TCMHCC
Oct. 15, 2025	Discussion of the Potential for a Georgia Mental Health Consortium	**Dr. Eric Lewkoviez**, Assistant Professor of Child, Adolescent, and Family Psychiatry at Augusta University, Adviser and Champion of GMAP **Dr. Kathryn Cheek**, Chairman of the Georgia Composite Medical Board **Dr. Kathryn Martin**, Associate Dean of Regional Campuses at Augusta University **Rep. Mary Margaret Oliver** **Pamela Mason**, Affiliation Operations Director, Children's Healthcare of Atlanta **Lynn Pattillo**, President of the Pittuloch Foundation **Dr. Jean Sumner**, Dean of the Mercer University School of Medicine **Dr. Michele Smith**, Director of Collaborative Care in the Wellstar Atlanta Medical Center Family Medicine Residency Program **Bonnie Hardage**, Executive Director of the Jesse Parker Williams Foundation

Nov. 19, 2025	Mental Health Parity	**Angela Snyder**, Director of Health Policy and Financing, Georgia Health Policy Center **Dr. Eve Byrd**, Senior Adviser, Rosalynn Carter Mental Health and Caregiver Program **Denise Hines**, CEO of Georgia Health Information Network **Dr. Daniel Salinas**, Chief Medical Officer and Chief Quality Officer of Emory Healthcare Network **Melanie Dallas**, Chief Executive Officer of Highland Rivers Behavioral Health **Sarah Phillips**, Associate Director of Public Policy at the Carter Center **Whitney Griggs**, Director of Health Policy, Georgians for a Healthy Future Center **Roland Behm**, Co-Founder of Georgia Mental Health Policy Partnership

Summary of Presentations to Subcommittee

HB 1013: Mental Health Parity Implementation Barriers, Facilitators, and Opportunities

Sarah Phillips, Associate Director of Public Policy, the Carter Center

Ms. Sarah Phillips provided an overview of the Carter Center's role in promoting mental health parity, including its involvement with the Georgia Parity Collaborative. The Carter Center has led the Georgia Parity Collaborative since 2020 in partnership with Georgians for a Healthy Future, a coalition advocating for and educating the public on mental health parity. The collaborative assesses implementation and education related to parity, bringing together voices from across sectors, including those who serve historically marginalized communities, to address inequities. The collaborative regularly shares findings with state agencies such as the Department of Insurance (DOI) and the Department of Community Health (DCH) so that compliance is meaningful in practice. The collaborative conducts trainings on how to interpret compliance reports, which is especially important given the difficulty of complaint reporting processes. Ultimately, the collaborative supports collective advocacy to reflect the needs of real-world consumers.

Outside of the Carter Center's role with the Georgia Parity Collaborative, the Carter Center is advocating for mental health parity in Georgia through the Mental Health Parity Day at the capitol and the Georgia parity-awareness campaigns. Mental Health Parity Day presents an opportunity to elevate conversation around parity by convening stakeholders under the Gold Dome, hosting speakers from Georgia leadership. The Carter Center also regularly presents Georgia parity-awareness campaigns, the most recent of which was called, "Georgia is Covered: It's Now the Law." Campaign materials included billboards, print-outs, radio ads, and email campaigns, all of which lead back to georgiamentalhealth.com, which includes educational materials around parity.

Ms. Phillips presented the Carter Center Recommendations to Agencies during this presentation, including recommendations that DOI use standard reporting templates, issue summaries of findings from data reports, and share data follow-up to ensure parity compliance. They also recommended that DCH refine their parity reporting template and maximize enforcement tools for accountability. Ms. Phillips stated the Carter Center position that there is not enough staff dedicated to meaningfully monitor and enforce HB 1013. The Carter Center means to (1) build consumer awareness of mental health parity, (2) build employer engagement to ensure compliance of employer-managed coverage, and (3) increase the accessibility of current resources for consumers, such as compliant portals.

Ms. Phillips gave a second presentation to the subcommittee in November to update the subcommittee on the status of parity implementation in Georgia. Since her last presentation, Commissioner of Insurance John F. King announced $20 million in fines taken against Georgia insurers for parity violations. Ms. Phillips stated she had never seen fines of this size levied against insurers for parity in any state. She also stated that the Carter Center is unsure at this time how these fines will be levied and of the process of the corrective action plans.

Public awareness was the topic of Ms. Phillips' November presentation. She stated that though the state has made progress in parity enforcement, similar progress had not been made toward the implementation of prior public awareness recommendations. Ms. Phillips previously presented on

the impact of the Carter Center's first parity public awareness campaign: 48% of respondents felt they noticed an increase in information around parity within the two months following the campaign and 2 in 5 community members indicated that they had been exposed to information from the campaign, 33% of respondents say they would look for this type of information if they needed it, and worries that insurance would not pay for care dropped from 30% to 13% post-campaign. Campaign materials included text in graphics in English and Spanish. They have since launched and completed a second campaign, named "Your Body and Mind: Equally Covered." This campaign helped participants navigate the parity complaint website and the Carter Center parity resource hub, GeorgiaMentalHealth.com. This secondary campaign, despite lasting only three months, reached more than 2 million individual impressions. These campaigns were sustained through private donations, which Ms. Phillips stated is a limitation of these campaigns and their longevity. Ms. Phillips advocated for more sustained funding to educate individuals regarding parity.

In several other states, funds are earmarked for consumer awareness, including Illinois, Maryland, New York, California, Minnesota, Delaware, Arizona, Colorado, New Hampshire, Pennsylvania, Rhode Island, Washington, and West Virginia. This funding arises either from fines levied due to parity violations, time-bound grants, or general appropriations. In Illinois, the state does not just fine parity violations, it funnels the funds from these fines into consumer education, including billboards, hotlines, trainings, printed materials, etc. Ms. Phillips highlighted this funding model as the most sustainable use of parity funds and advocated for adopting a similar funding model in Georgia using a statute or appropriation law, creating an Office of the Commissioner of Insurance (OCI) and Department of Community Health (DCH) annual parity consumer outreach campaign. Ms. Phillips also recommended the creation of a dashboard dedicated to parity enforcement and complaint volume.

Ms. Phillips advocated for the inclusion of parity information as resources on the state website. She shared a webpage of the Georgia DCH website and stated that OCI should have similar resources on its website. She stated that OCI has shared that it is developing new resources and that the Carter Center will monitor their progress. Ms. Phillips concluded the meeting by inviting attendees to participate in the Carter Center's Mental Health Parity Day at the capitol in February 2026.

Following Ms. Phillips' presentation, Dr. Brenda Fitzgerald asked Ms. Phillips if the Carter Center has plans for a third consumer awareness campaign around parity. She stated that the Carter Center is working on storytelling efforts. The next campaign will be more human-centered, highlighting the experiences of people who have been previously denied, as well as people who did achieve coverage. The Carter Center is also working to educate corporate partners, highlighting that human resources departments should be enforcing coverage within the workplace. Dr. Emily Anne Vall asked Ms. Phillips if the Carter Center has had discussions concerning consumer awareness with DOI. Ms. Phillips stated that DOI has indicated that they are working on some more consumer guides, but the Carter Center does not know the focus of these guides. She also stated her belief that funding is a limitation of creating a statewide awareness campaign. Dr. Fitzgerald also asked Dr. Roland Behm, another subcommittee presenter on mental health parity, if there is any state money earmarked for awareness campaigns. Dr. Behm stated that he is not aware of any appropriations request that is specific to a parity-awareness campaign. Dr. Behm also stated that none of the fines levied toward parity enforcement deals with compliance for individuals, so none of the money goes back to individual consumers. Dr. Behm stated that there has been discussion of an appropriated fund that would do more for individual consumers seeking parity coverage.

Whitney Griggs, Director of Health Policy, Georgians for a Healthy Future

Dr. Whitney Griggs shared the results of the Georgians for a Healthy Future's (GHF's) analysis of DOI's comparative analyses of parity data and DCH's parity workbooks. Dr. Griggs also stated that GHF is launching a project to demystify what parity is for leaders and individual people to improve implementation of HB 1013, including the creation and publication of a dashboard.

Dr. Griggs stated that there are different ways to measure parity. GHF focused on what was required by HB 1013 and the ways other states measure parity. They started by referencing the comparative analyses published by DOI in 2022 and 2023, as well as DCH's managed care organization (MCO) parity workbooks from 2023 and 2024. To evaluate the data submitted, GHF utilized the Kennedy Forum's six-step framework for parity analysis. The framework identifies things like nonquantitative treatment limitations, factors, evidence, operationalized versus on-paper parity decisions, and conclusions. Dr. Griggs stated that it is very difficult to measure the way parity is operationalized, such as with network adequacy standards.

GHF also measured medical necessity decisions and verified plans' use of generally accepted standards of care (GASC). Dr. Griggs stated that the decisions of medical necessity should demonstrate clinical interpretations of medical necessity rather than the insurers' own cost-benefit analysis. Beyond the Kennedy Forum framework analysis and the analysis of medical necessity, GHF assigned "red, yellow, and green lights" to the compliance rates of each carrier.

Department of Insurance's Comparative Analyses
There were improvements in DOI reports from 2022 to 2023: The number of carriers rated green increased by 9%, and the number rated red decreased by 6%. Common issues included a lack of clear, in-operation, parity data. The reports do not represent medical necessity decisions based off of clinical standards rather than insurer cost-based decisions. DOI has increased enforcement but relies heavily on insurer self-reporting. None of the 22 carriers was in full compliance.

Department of Community Health's Parity Workbooks
GHF found that nearly all Medicaid and PeachCare plans now complete parity analyses. Most rated green or yellow on six-step completeness according to the Kennedy Forum framework. Areas for improvement include separate as-written and in-operation rules. Wait-time and reimbursement data is limited. Reports do not clearly show that coverage decisions are tied to GASC-based medical necessity decisions versus cost-based determinations by the payers.
GHF recommendations:

- Make reporting consistent and public.
- Build capacity for enforcement.
- Require transparent reporting of clinical standards.

Roland Behm, Co-Founder of Georgia Mental Health Policy Partnership

Dr. Behm gave an overview of parity enforcement in Georgia, beginning the presentation by stating that the parity law is strong but enforcement is weak. Dr. Behm advocated for a statewide parity review panel. He stated that Georgia has the necessary data to enforce parity but needs a centralized Parity Compliance Review Panel to compare plans side by side and identify patterns

and corrective actions. He also stated that the Parity Compliance Review Panel would need access to electronic health record (EHR)-based data to determine parity compliance.

Dr. Behm stated that the statutory definition of *medical necessary* is the backbone of parity enforcement because it guides every parity decision made. Strengthening Georgia's definition of medical necessary would make medical necessity enforceable and evaluable. Insurers and MCOs openly admit to using a narrower definition of *medical necessity* because there is not a statewide definition in the law, and it is determined by the payer. Dr. Behm again advocated for the availability of EHR data to parity reviewers, stating that keeping EHR data confidential hides these decisions.

Children's Hospital of Atlanta (CHOA) has developed and deployed an EHR-based monitoring system to monitor in real time when a child's behavioral health treatment is delayed or denied. Mr. Behm stated that this is the future of parity enforcement.

According to a CHOA preprint paper titled *Health System Surveillance to Advance Mental Health Parity for Children* (Beinenson, Joyce, Henderson, et al.), in-network providers make up less than 40% of medically necessary behavioral health care for children in Atlanta, and 1 in 5 families must pay out of pocket for mental health treatment for their children. CHOA treats 25% of all children brought to emergency rooms in Georgia with a mental health crisis, and therefore, their data is representative of children's behavioral health care in Georgia.

Dr. Behm referenced several other data points, illustrating the lack of parity enforcement in Georgia. According to a 2025 University of Georgia study, 34% of Medicaid-insured children have unmet mental health needs. A study using Centers for Medicare & Medicaid Services (CMS) payer-transparency data found that United paid its subsidiaries anywhere from 17-61% more than independent providers.

According to Dr. Behm, there are two major gaps in the behavioral health care workforce: (1) the aggregate workforce gap, the fact that there are not enough providers in behavioral health, and (2) the provider network gap — the lack of providers that are in-network.

In terms of network adequacy, Dr. Behm referenced discrepancies between the provider directories presented to parity reviewers and the directories operationalized for families. Dr. Behm stated that provider directories present a deep network to regulators, but outdated directories, when tested by families in need of care, reveal that much of the information is no longer relevant.

Dr. Behm stated that Georgia risks paying for parity enforcement failures. Two-thirds of Georgia Medicaid funding, $12 billion, is provided by CMS and can be recouped from Georgia, not the MCOs, if parity is not enforced.

Following Dr. Behm's presentation, Dr. Fitzgerald stated that CHOA is able to track all recommended therapies electronically, so that they can follow up with patients and meaningfully track parity implementation for their patients.

Mental Health Care Consortium

Dr. David Lakey, Presiding Officer, and Dr. Laurel Williams, Chief Medical Officer of Texas Child Mental Health Care Consortium

Dr. David Lakey and Dr. Laurel Williams presented several public health programs under the Texas Child Mental Health Care Consortium (TCMHCC). One of the biggest public health challenges in Texas is child mental health. Dr. Lakey saw a need to work with all medical schools in Texas in order to improve the system. The Texas chair of Senate Finance, Sen. Jane Nelson, supported the effort on the House floor, creating a consortium to work across sectors and partners to improve the system and address the mental health challenges of children in Texas.

Established through Senate Bill 11 of the 86th legislative session in 2019, the consortium provides a platform for providers to work together to improve the quality of the health care system for child mental health.

The presenters say that they believe all Texas children should have the best mental health possible. The consortium is a partnership between nonprofits, hospital systems, education service centers, health-related institutions (HRIs), and any other entity designated by the Executive Committee. Funding is provided through the Administrative Support Entity of the University of Texas System and the Texas Higher Education Coordinating Board. Dr. Lakey is the presiding officer. There is also the Centralized Operational Support Hub (COSH), which is responsible for administrative needs of the consortium.

The presenters explained that core programs of the consortium include Child Psychiatry Access Network (CPAN), Perinatal Psychiatry Access Network (PeriPAN), Texas Child Health Access through Telemedicine (TCHATT), Child and Adolescent Psychiatry (CAP) Fellowships and Community Psychiatry Workforce Expansion (CPWE), and Children's Mental Health Resource. The consortium recognizes that there will likely always be a shortage in the workforce and wants to strategically leverage the professionals in the space.

Child Psychiatry Access Network
The presenters also introduced CPAN, which is a program that existed in other states prior to its adoption in Texas. CPAN gives timely and free support to caregivers who have children with mental health needs. The program offers one-time consultation between a psychiatrist and the child's primary pediatrician. The program also provides resource referrals and virtual continuing medical education (CME) on pediatric and perinatal mental health topics. Pediatricians have the ability to call the CPAN number to receive consultation from a behavioral health expert. So far, 4,506 CPAN physicians have enrolled, and there have been 55,466 total provider consults.

PeriPAN — Perinatal Psychiatry Access Network
The presenters explained that mental illness is a leading cause of death for perinatal women. CPAN has expanded its network to include PeriPAN, a program designated to serve perinatal women. Through this program, primary physicians, midwives, obstetric gynecologists (OB-GYNs), and other perinatal service providers are matched with reproductive psychiatrists.

Texas Child Health Access Through Telemedicine
TCHATT is a free program that provides mental health support and care for pre-K through 12th-grade-age children. It requires parental consent. It included virtual appointments that often occur at school and includes therapy, psychiatry, and case management support. The program is meant to support five sessions, and then children are typically referred to other services unless the child is in a rural area that does not have other service providers.

Community Psychiatry Workforce Expansion
CPWE funds full-time academic psychiatrists as directors and residents to incentivize psychiatrists to work for the state rather than private institutions. As of June 2024, the program has partnered with 26 of 45 community mental health providers. The program has supported 475 residents. The program provides an opportunity for residents to serve as child psychiatrists in the community rather than at the hospital.

Child and Adolescent Psychiatry Fellowships
CAP Fellowships increase the number of medical professionals in Texas who specialize in the diagnosis and treatment of psychiatric and associated behavioral health issues affecting children and adolescents to:

- Increase the ratio of child and adolescent psychiatrists to the child population;
- Reduce the number of designated mental health professional shortage areas; and
- Reduce wait times to see a child and adolescent psychiatrist.

Other Workforce Expansion
The consortium supports a variety of other ARPA funded workforce expansion initiatives to increase the number of trained professionals in mental health care.

Research Initiatives: Learning Health Care System
The presenters also gave examples of the following learning networks:

- Youth Depression and Suicide Research Network;
- Childhood Trauma Research Network; and
- New and Emerging Children's Mental Health Researchers.

These networks are used to bring in necessary funding and encourage other and emerging researchers to focus on children's mental health in their future research plans.

With the menu of services provided by the consortium, there are multiplicative benefits. The programs support and refer to one another to create an ecosystem of benefits and to encourage a system of child mental health. The consortium is of particular benefit in the face of Texas tragedies such as the recent Texas floods and the events at Uvalde.

Dr. Eric Lewkoviez, Assistant Professor of Child, Adolescent, and Family Psychiatry at Augusta University, Adviser and Champion of GMAP; Dr. Kathryn Cheek, Chairman of the Georgia Composite Medical Board; Dr. Kathryn Martin, Associate Dean of Regional Campuses at Augusta University; Rep. Mary Margaret Oliver; Pamela Mason, Affiliation Operations Director, Children's Healthcare of Atlanta; Lynn Pattillo, President of the Pittulloch Foundation; Dr. Jean Sumner, Dean of the Mercer

University School of Medicine; Dr. Michele Smith, Director of Collaborative Care in the Wellstar Atlanta Medical Center Family Medicine Residency Program; Bonnie Hardage, Executive Director of the Jesse Parker Williams Foundation; Angela Snyder, Director of Health Policy and Financing, Georgia Health Policy Center; Dr. Eve Byrd, Senior Adviser, Rosalynn Carter Mental Health and Caregiver Program; Denise Hines, CEO of Georgia Health Information Network; Dr. Daniel Salinas, Chief Medical Officer and Chief Quality Officer of Emory Healthcare Network; and Melanie Dallas, Chief Executive Officer of Highland Rivers Behavioral Health

Chair Dr. Brenda Fitzgerald introduced an open discussion of potential programs that would benefit the mental health of children and mothers in Georgia. This discussion was prompted by the prior presentation by Dr. Lakey and Dr. Williams on the Texas Child Mental Health Care Consortium (TCMHCC) and the Child Psychiatry Access Network (CPAN), Perinatal Psychiatry Access Network (PeriPAN), and Texas Child Health Access Through Telemedicine (TCHATT) programs. Dr. Fitzgerald proposed that a similar program could benefit Georgia and sought feedback from invited participants of the discussion. She discussed the comparison between Texas and Georgia in terms of behavioral health and Texas' approach to the health of the maternal-child dyad. According to the routine screenings conducted by Children's Healthcare of Atlanta at Hughes Spalding, 27% of mothers during the first-year postpartum are depressed in Georgia. In Georgia, Medicaid covers mothers for a full year postpartum, and the state is not utilizing that funding to treat those mothers. One of the invited participants, Dr. Eric Lewkowiez is an adviser and champion of Georgia Mental Health Access in Pediatrics (GMAP), a program with similar goals to TCMHCC, through a Health Resources and Services Administration (HRSA) grant, so he was invited to speak about the GMAP program and how it could be expanded and improve upon the TCMHCC model to meet Georgia's mental health needs. The discussion involved representatives from Mercer School of Medicine, Augusta University, Children's Healthcare of Atlanta, Wellstar Atlanta Medical Center, and the Georgia Composite Medical Board.

The GMAP Program and Potential Funding
Dr. Lewkowicz gave a brief overview of the work of GMAP. He described his role working on GMAP's Project ECHO as a psychiatrist. Project ECHO is an educational program as well as an opportunity for pediatricians to collaboratively consult with psychiatrists. Dr. Lewkowicz stated that GMAP is funded by a $5 million grant. Dr. Fitzgerald asked Rep. Mary Margaret Oliver if funding could be secured from the state budget. Rep. Oliver stated that she would support a funding initiative to appropriate funds from the state budget and also mentioned the Georgia Abatement Funds as a potential funding source. Dr. Fitzgerald mentioned that though Texas' program is primarily funded through the state budget, it has diversified funding for new programs utilizing partnerships with the philanthropic community. TCMHCC has not utilized Medicaid funds. Dr. Fitzgerald mentioned that mothers in Georgia are covered for a full year postpartum, and so there would be Medicaid funds available for health care services for children and mothers.

Maternal and Child Health and the Continuum of Care
Dr. Fitzgerald stated that though GMAP is an existing program similar to the Texas consortium, she does not believe it to be sufficient in scope to meet Georgia's needs. She believes the program should service all providers related to maternal and child health, not just pediatricians, including obstetricians, local public health departments, rural clinics, etc. Dr. Lewkowicz added that 55 counties in Georgia did not currently have a local pediatrician. Dr. Fitzgerald stated her appreciation for Texas' ability to provide follow-up for each client despite their heightened volume. She said this was achieved through standardized referral patterns. Ms. Donna Hyland and Dr.

Fitzgerald discussed pregnant women as a priority population in Georgia and the inclusion of obstetric gynecologists (OB-GYNs) in the program. Dr. Michele Smith mentioned that Survey of Well-being of Young Children (SWYC) questions could be utilized by OBs and primary care physicians to identify caregivers with mental health concerns. Dr. Lewkoviez, Dr. Fitzgerald, and Dr. Eve Byrd all agreed that nurse practitioners should be included as providers under the proposed program.

Educational Partnerships
Dr. Fitzgerald pointed out that one difference between TCMHCC and GMAP is that TCMHCC partners with Texas medical schools, and he asked Dr. Jean Sumner if she thinks the academic medical community would be interested in a consortium. Dr. Sumner stated that she expected interest from the academic medical community, though she also expects organizational difficulties. Dr. Byrd mentioned her connection to the Emory School of Nursing and her belief that nursing schools would also be interested contributors to the program.

Telehealth Potential
Dr. Fitzgerald also mentioned that she would like the program to evolve beyond what is provided by TCMHCC's CPAN program through telehealth capabilities, providing consultations to patients in real time and not just their providers, and asked other members of the discussion if they thought this would be feasible. Dr. Kathryn Cheek said that if the service is as quick as CPAN and provides consultation within 30 minutes, that live consultations with the patient would be within the bandwidth of a pediatrician to facilitate. One of the challenges of this program enhancement would be simultaneously scaling the volume of patients seen; however, GMAP's lower volume of participants may be an advantage to enhancing the program at its onset. Ms. Hyland mentioned that CPAN services 30,000 consultations. GMAP's numbers are comparatively very small and average 200-300 provider consultations a year. Ms. Melanie Dallas highlighted the difficulties of providing telehealth in rural areas with limited bandwidth but offered the telehealth capabilities of Highland Rivers and other community service boards (CSBs). Dr. Emily Anne Vall mentioned that each Department of Public Health (DPH) clinic is also equipped with telehealth capabilities.

Data Sharing
Dr. Fitzgerald asked Dr. Denise Hines of the Georgia Health Information Network (GaHIN) to speak on the potential for sharing medical information collected through the consortium with other providers. Dr. Hines described the work of GaHIN, stating that GaHIN works in partnership with service providers like Children's Healthcare of Atlanta (CHOA), the Georgia Division of Family and Children Services (DFCS), and the Department of Behavioral Health and Developmental Disabilities (DBHDD) to coordinate the delivery and sharing of medical information, including the medical information of children. Dr. Hines asked how the GMAP electronic data is shared and what screening tools are used. Dr. Lewkowicz stated GMAP's electronic data is not currently incorporated with GaHIN, though he agreed that sharing medical information with other providers across the state would facilitate patient care. Dr. Lewkowicz mentioned that the medical information for foster care children in particular is always difficult to obtain, even as a member of the Georgia Families 360 steering committee, and Dr. Fitzgerald underlined the importance of making foster children's health information available.

Provision of Services to Children in Schools
Texas Child Health Access Through Telemedicine (TCHATT) was also discussed as a model for providing health care consultation for Georgia's children through schools. Ms. Hyland asked how

Texas staffed TCHATT. Dr. Fitzgerald stated that TCHATT is also funded through medical schools, and that they started with a few schools and expanded as providers and resources became available. She also stated that on a small scale, CHOA providers are already providing this service. As the CEO of CHOA, Ms. Hyland expressed excitement at the idea of expanding these services throughout Georgia. Dr. Hines mentioned that school records would require navigating additional data protections with the Family Educational Rights and Privacy Act (FERPA); however, Dr. Fitzgerald corrected that TCHATT is not a school program but a program that takes place at schools, so FERPA would not need to be involved. Dr. McFaddin and Dr. Johnson were two individuals named as potential collaborators due to their school-based work. Dr. Smith underlined the importance of keeping the program separate from school records to protect the privacy of children and families. Ms. Bonnie Hardage named telehealth in schools as a way to provide care to children who have not been able to navigate Medicaid.

Mental and Behavioral Health Innovation in the Emergency Room

Representatives from Grady Health Systems and Highland Rivers were asked to present about the innovative programs in their emergency departments to serve patients with mental and behavioral health issues. The South Carolina Department of Health and Human Services was invited to present its emergency psychiatric assessment, treatment, and healing (EmPATH) integration plan for hospitals across South Carolina seeking to divert behavioral health patients from the emergency department.

Anne Hernandez, Vice President of Behavioral Health at Grady Health System

Ms. Anne Hernandez gave information on the Crisis Intervention Unit (CIS) at Grady as well as CIS centers Grady partners with in the community, Grady's community coresponse team, and Grady's integrative behavioral health services. This is Ms. Hernandez's second year presenting the CIS to the subcommittee. The CIS is a smaller behavioral health unit within but somewhat removed from the emergency department. The CIS was added in 2015 but renovated in 2024 to improve upon the unit's environment with privacy walls, light, and nursing stations. The Grady emergency room (ER) is always on diversion because it is always at capacity, but 12 beds are reserved for psychiatric concerns. The goal of the unit is to remove psychiatric patients from the chaos of the ER. When a psychiatric patient enters the ER, they will be evaluated quickly to determine if they should be sent to the CIS or if they can be sent home. There is an open milieu with 28 chairs and a nurses' station. It is staffed by psychiatrists, licensed behavioral health therapists, mental health technicians, a certified peer specialist, and a substance use counselor. The CIS provides an opportunity to spend time with the patient and work with them to identify their goals and next steps. Some people leave right away and are connected with more care options and transportation options; some people stay and access more care at Grady. Care at the CIS involves (1) a quick assessment by the psychiatrist, (2) individual and group activities, (3) individualized treatment, and (4) discharge planning.

Grady has about 11,000 psychiatric visits in the ER every year. The CIS allows the ER to not go on diversion for psychiatry and reduces overall length of stay. In 2017, average length of stay in the ER was 6.32 hours. In 2024, it is 3.2 hours. The CIS unit also results in fewer admissions to the hospital. Forty-seven percent of patients are discharged home, with a low readmission rate of 6.52%. The CIS unit is staffed by about 15 people per day. For hospitals with lower volume, a similar unit might be difficult to sustain and finance.

Fulton County has also opened a crisis stabilization unit in partnership with Grady. The Fulton County CIS is allowing people in South Fulton to receive urgent psychiatric care. It is 24/7, has a walk-in area, as well as a more intensive crisis stabilization unit, and has a temporary observation area. One of the priorities of the CIS is to divert those who get picked up by police and to decriminalize substance use. Ms. Hernandez stated that people who are picked up for small poverty-driven crimes do not need to be in jail; they need resources. In January 2025, through city of Atlanta and Fulton County funds, a new Center of Diversion opened that allowed anyone picked up for a misdemeanor to be served by the center. The Center of Diversion is a social service hub rather than a mental health treatment facility but can connect those who have mental health or substance use needs to appropriate care. Ms. Hernandez stated that most of the people who end up in Fulton County jail have committed low-level offenses and do not have the funds to post bail. This allows those people the opportunity to get connected to resources such as housing, medical care, and substance use treatment. They can also be connected to personal contacts and family members. These units prevent continued incarceration for quality-of-life crimes and mental health disorders.

Grady also presented on its community coresponse team for psychiatric emergencies, which is a nonpolice response that includes a paramedic and a behavioral health clinician who respond to emergency calls. Ms. Hernandez shared that while the Georgia Crisis and Access Line (GCAL) has mobile response units, they unfortunately cannot reach all the 911 calls in Fulton County. To supplement GCAL Grady has its own coresponse team to allow for greater ability to respond. Grady's collected data has shown that about 65% of the time, there is no need for further medical care — the situation can be de-escalated on the scene and the individual can be connected with resources and transported to a safe place.

Ms. Hernandez stated that Grady is only beginning to integrate behavioral health into OB-GYN care. While they have not integrated behavioral health care, Ms. Hernandez shared that Grady has taken other efforts to ensure mental and behavioral health services at their locations. For example, Grady has installed behavioral health therapists in all nine of its neighborhood health centers with consulting psychiatrists. Additionally, there are licensed therapists and consulting psychiatrists in the Grady cancer center, the burn clinic, and the sickle cell and trauma centers. Ms. Hernandez stated that by Grady integrating mental health care into other services, behavioral health can be accessed early and in one place to help prevent an escalation or crisis.

Eunice Medina, Director of the South Carolina Department of Health and Human Services, and Shadda Winterhalter, Strategic Initiatives Specialist

Ms. Eunice Medina gave an overview of the South Carolina initiative to integrate and fund EmPATH units in South Carolina hospitals. Back in 2023, the EmPATH grants were announced as part of a far bigger initiative in South Carolina to enhance access throughout the state and address rural areas and the workforce shortage. The South Carolina Department of Health and Human Services (SCDHHS) contributed $45 million to the EmPATH grant to fund the programs. For the initial round of funding, the focus was on providers with statewide presence. Ms. Medina shared that 13 applications were received, and all were awarded. When the grant was initiated, SCDHHS was unsure of how many hospitals could be funded, as funding needs were dependent on infrastructure already developed in each hospital. As a result of this funding opportunity, hospitals created EmPATH units or EmPATH-like units in regions with high numbers of Medicaid recipients. In order to qualify for funding, hospitals had to show the need of the communities they serve. Hospitals were also required to seek funding from other sources outside of Medicaid to support the

implementation of their EmPATH units. Ms. Medina said that it was also important to ensure that an EmPATH unit would have an impact and would serve the targeted population. In South Carolina, Medicaid predominantly serves children, with more than 600,000 of 1.1 million recipients being children. Other recipients include pregnant moms and disabled adults.

To manage the grant implementation, SCDHHS formed an advisory committee and a learning collaborative with participating hospitals. Through the learning collaborative, hospitals are able to work together as a group to have discussions with insurance providers to standardize service codes and reimbursements. Hospitals are also required to participate in the learning collaborative so that implementation of the EmPATH program is uniform across recipients. The hospital groups must come to a consensus about any pertinent issues in order for any hospital to receive funding. The learning collaborative invites nonleadership staff to take part so that there is a universal understanding of what is contractually obligated. The learning collaborative is also an opportunity to educate staff on billing guidelines and differences between public and private insurance and understanding billing systems. Through the learning collaborative, SCDHHS discovered policy limitations for some billing providers and was able to adapt the billing system to better accommodate the EmPATH units.

Melanie Dallas, Chief Executive Officer, and Lyndsey Morda, Senior Director of Intensive Services at Highland Rivers

Melanie Dallas and Lyndsey Morda presented on the Highland Rivers Behavioral Health Emergency Department (ED) Psychiatric Assessment, Diversion, and Continuity of Care program, which integrates behavioral health services directly into hospital EDs. The program aims to divert patients from unnecessary psychiatric hospitalizations by providing thorough in-person assessments and case management. The program began with a single hospital in Rome that had too many behavioral health patients in the ED that staff were trying to connect with the CSB. Highland Rivers built this program out of two concerns:

1. Patients who cycle through behavioral health services at different hospital systems often end up in crisis at other hospitals, and there was not continuity of care; and
2. The ED is not the best place to get psychiatric care. In the ED, the presenters found that there were too many 1013s being seen without patients meeting the true criteria required of a 1013. The presenters reported that they believe that 1013s were being used for transporting patients rather than for the services needed. It was stated that if patients are mandated to receive treatment not suited to their needs, it will affect their willingness to participate in further treatment.

Ms. Dallas shared that Highland Rivers is doing the hard work of diversion with the ED. The presenters explained that at least 35% of admissions to catchment hospitals should be diverted because they were being discharged within 72 hours. Diversion allows patients to be engaged in more meaningful ways. The presenters relayed that Highland Rivers has a large population that they serve in their catchment areas, serving 17% of Georgia's population. To meet the need, Highland Rivers has 2,718 med-surg beds, which is 12% of all the beds in the state.

Highland Rivers' mission is to provide quality behavioral health assessments and refer individuals to the next level of care as quickly, safely, and efficiently as possible. Highland Rivers integrates within hospitals and provides thorough assessment and facilitation of care management. Highland

Rivers preliminary data has shown that staff from Highland Rivers spends more time with the patients on the front end, and they have found that about 50% of the time the patient can be diverted. Data at a hospital that has integrated the Highland Rivers program shows that the average length of stay was 4.4 hours for behavioral health patients vs. a national average of eight to 11 hours. The presenters stated that the need in rural hospitals is great, as mental health patients will often be sent to intensive care because they are the only place with appropriate staffing, and patients can stay for several days and even weeks, which is not beneficial to the patient or hospital.

The Highland Rivers program in EDs serves all populations regardless of age or diagnoses and follows up with 100% of patients. Presenters relay that staff report that they believe that their success with continuity of care is due to their physical presence in the hospital. The program has had success in referring all patients to Highland Rivers behavioral health appointments within one week. As of the time of the presentation, the program has conducted 13,455 assessments with a 50% diversion rate. Savings to date due to diverted patients total $19,257,750.

Mental and Behavioral Health Innovation Urgent Care

Representatives from Willowbrooke at Tanner Health and UrgentPsych were asked to present about their innovative behavioral health urgent care models, designed to serve patients with mental and behavioral health issues at a lower level of care than the emergency department.

Dr. Kenneth Genova, Vice President of Behavioral Health Services, and Dr. Paula Gresham, Executive Medical Director at Tanner Health

Dr. Kenneth Genova and Dr. Paula Gresham gave information about Willowbrooke Urgent Care at Tanner Health, a facility where individuals needing mental health services can go instead of the emergency room (ER) to gain access to services. This is Dr. Genova's second presentation to the subcommittee concerning Willowbrooke. Tanner Health is located in the rural West Georgia and sees a high volume of patients in need of mental health care in the ER. Tanner, similarly to other hospitals, will often find a group of individuals who come to the ER in a mental health crisis. While the ER may be able to triage the individual, the ER is not the appropriate level of care for individuals in this scenario. Patients can go to Willowbrooke as an access point of care. Individuals can review decisional screening free of charge to determine what level of care would be appropriate for their context. Of those who are screened, 30% need to be hospitalized, with the majority needing to be stabilized without a need for an inpatient stay.

Willowbrooke has been running Tanner's internal network for about three months. No appointments are required at Willowbrooke Urgent Care. There are clinicians, therapists, and providers on staff. Current hours are Monday through Friday, 8:30 a.m.-8:30 p.m., and 9 a.m.-3 p.m. on Saturday and Sundays, but the center's intent is to become available 24 hours a day, seven days a week. Willowbrooke currently sees populations throughout the age spectrum, including those with substance use disorder, and provides services in English and in Spanish. The initial screening is free, and then patients have the opportunity to (1) see a counselor, (2) see a provider, (3) see both, (4) be admitted to the hospital, or (5) be referred to another facility. Services beyond the initial screening are provided at cost.

Willowbrooke is steadily seeing 350-400 patients per month in the urgent care center. Willowbrooke currently manages three hospitals within the Tanner system and two outside of the

Tanner system and has collected the behavioral health admissions data from the Tanner ERs. Willowbrooke has surpassed the volume of behavioral health admissions seen in Tanner hospital ERs. The majority of Willowbrooke Urgent Care patients are government-pay or no-pay patients. Accessing urgent care rather than ER health care decreases the bill for these patients. Urgent care also provides immediate access to patients who may or may not be in a crisis. Willowbrooke works closely with crisis teams as well as the ERs in its community so that they can bring patients to the urgent care center directly. The opportunity to redirect mental health patients in crisis decreases chances of incarceration for those individuals in crisis or using substances. There is not additional funding for this program. All of the Willowbrooke funding is through Tanner — hospital services and all of the free screenings, as well as services for those individuals who are indigent and seeking care.

Dr. Sofia Khan, Emergency Physician and Co-Founder of UrgentPsych

Dr. Sofia Khan gave an overview of UrgentPsych, a psychiatric treatment facility that follows the ImPACT treatment model. The ImPACT treatment model, which stands for Immediate, Psychiatric Assessment, and Compassionate Treatment, is similar to the EmPATH patient treatment model; however, it is outpatient urgent care. The ImPACT model delivers care in a therapeutic environment outside of the hospital for a shorter amount of time, typically eight hours. Proponents of the ImPACT model have found that patients experience more rapid de-escalation of their symptomology outside of the hospital environment, and Dr. Khan as an ER doctor herself does not feel that ER patient care is what is best for mental health patients. The ImPACT model is designed to stabilize the patient through compassionate care without necessitating hospital admission or forced separation from loved ones.

Dr. Khan reviewed three case studies of patients who received care from UrgentPsych: a 14-year-old female, a 19-year-old female, and a 36-year-old male. The 19-year-old female was experiencing auditory and visual hallucinations and mania. The 14-year-old female and the 36-year-old male were both expressing suicidal ideologies. The patients were provided with one-to-one crisis therapy, access to medication, a safety/risk assessment, and a supportive environment. The 19-year-old female and 36-year-old male were both discharged within 24 hours, while the 14-year-old female was referred to a hospital for further care. All patients were followed-up with and experienced continuity of care regardless of discharge. Overall, 10% of UrgentPsych patients are admitted to an inpatient psychiatric hospital, 13% are partially hospitalized, and 77% are discharged home with care coordination. No patients are referred to the ER.

UrgentPsych receives a high level of adolescent patients, with 52% of referrals coming from pediatricians, and is looking to expand its capacity for adolescent patients in future UrgentPsych locations. UrgentPsych is expanding to 20 sites across the state and looking to extend its hours to 12 hours a day. UrgentPsych is also integrating artificial intelligence predictive analytics for diagnoses, risk stratification, and personalized treatment. UrgentPsych has current partnerships with Emory Healthcare, Kaiser Permanente, and Children's Healthcare of Atlanta.

Community Behavioral Health Clinics

Sarepta Archila, Director of Certified Community Behavioral Health Clinics at DBHDD

Sarepta Archila gave an overview of Certified Community Behavioral Health Clinics (CCBHCs) and its implementation in Georgia. The model aims to improve access to behavioral health services through a prospective payment system and standardized care. CCBHCs are part of a national model being pushed out to states and customized. CCBHCs are clinics that provide a comprehensive range of mental health and substance use services, as well as primary health screening and monitoring. The lynchpin of the model is care coordination across services and between agencies in the community, including schools, law enforcement, and hospitals. CCBHCs receive flexible funding to match services to the needs of the community — utilizing a prospective payment funding model instead of fee-for-service. Goals of the CCBHCs include:

1. Ensuring access to behavioral health care; and
2. Meeting stringent criteria regarding timeliness of care, quality reporting, and coordination with social service, criminal justice, and education systems.

CCBHCs provide a range of trauma-informed, evidence-based, person-centered services aimed at everyone throughout their life span. Requirements for CCBHC certification are federally determined. To be considered a CCBHC, a facility must have either an active Substance Abuse and Mental Health Services Administration grant or be certified by the state. There are more than 500 throughout the nation and more than a dozen candidates in the state of Georgia, with three launching in 2026. Certification received from the state lasts three years.

There are also state requirements for CCBHC certification. Georgia-specific criteria include the requirements that there be designated service areas, that there be a standardized agreement with mobile crisis response service providers and the Department of Behavioral Health and Developmental Disabilities, that CCBHCs be NADD-accredited, that they include someone with peer services credentials on staff, that there be regular performance monitoring, and that the services provided are evidence-based.

Georgia plans to launch three CCBHCs in early 2026, with the goal of statewide expansion. Initial locations include Advantage in Athens, RiversEdge in Macon, and New Horizons in Columbus. Once all CCBHC candidates receive certification, roughly half of Georgia counties will be part of the service area. CCBHCs are required to serve everyone regardless of payer.

The Prospective Payment System is the payment method used, a method of Medicaid reimbursement that involves calculating the costs of required services of a CCBHC and dividing them by daily visits to establish a rate unique to that clinic. All services are charged that daily bundled payment rate to support the cost of that provider operating as a CCBHC. It is supported by a cost report filled out by the CCBHC that names historical and expected costs.

Trauma-Informed Design and Behavioral Health

Janet Roche, Co-Founder and CEO; Christine Cowart, Co-Founder and COO; and Adrienne Erdman, Vice President of Research and Development at the Trauma-Informed Design Society

Ms. Janet Roche, Ms. Christine Cowart, and Ms. Adrienne Erdman collectively gave an overview of the work of the Trauma-Informed Design Society (TiD), which centers around the definition of trauma put out by the Substance Abuse Mental Health Services Administration. There are three

elements to the definition: (1) a difficult event, (2) the person experiencing the event perceives it to be physically or emotionally harmful or life-threatening, and (3) lasting impacts of the event occur over time. Trauma is not just the significant thing that happened but its long-term effects. By self-report, 90% of Americans have experienced a trauma over the course of their lifetime. TiD would posit that trauma should inform all design, but particularly medical and mental health facilities. TiD recognizes three realms of trauma: household or personal, community, and environmental. Most of TiD's work revolves around stressors in the environment, because stress is the mechanism that turns adversity into a trauma. Stress should be addressed when it is "tolerable" and no longer "positive" or healthy, before it becomes "toxic stress" or stress becomes traumatic. Addressing stress in the environment before it becomes "toxic stress" allows TiD to prevent traumas and retraumatization.

To illustrate their work, TiD presented a case study in the form of a building on the Westside of Chicago, the Intimate Partner Violence (IPV) center building, which will provide emergency intake services, but is also a place for residents, family services, and work offices. TiD prefers to come into the design process early to anticipate and mitigate any issues that may arise from not using trauma-informed design principles. TiD identified issues with the project plans from the start of work. The intake office was too exposed. The solution was to have the intake office deeper in the building and to split it into an office and an area for children to play in and decompress, with a window in the middle so that the parent can keep an eye on their children, as they may have experienced a threat of separation from their child as part of their traumatic experience. These changes to the existing building plan apply principles of trauma to create a sense of security and account for the needs of the children and of the mothers.

Mental Health Workforce

Dr. Andrea Meyer Stinson, Director of Workforce Strategy & Initiatives at Resilient Georgia

Dr. Andrea Meyer Stinson gave an overview of the National Mental Health Workforce Acceleration Collaborative (NMHWAC) initiative and what they have learned, as well as next steps for expansion and replication of the program. The primary goals of NMHWAC are to increase the behavioral health workforce, particularly in shortage areas, and to make the behavioral health workforce more representative of the people they serve. NMHWAC is specifically focused on master's-level clinicians. The pilot program launched in 2023 in Georgia and Colorado and has since expanded to other states. NMHWAC is a public and private partnership between the National Council for Mental Wellbeing, the Georgia Association of Community Service Boards, AATBS, Motivo, and Kaiser Permanente, of which Resilient Georgia is a state co-chair.

The NMHWAC program focuses on two separate workforce populations: premaster's fellows and post-master's clinician candidates. Benefits from the program include financial support, technical assistance, trauma-informed mental health and substance abuse trainings, Motivo supervision services, monthly mentorship and cohort meetings, and AATBS licensure exam support for post-master's candidates. NMHWAC prioritized recruitment of Spanish-speaking participants but did not identify a representative number of candidates.

The NMHWAC pilot program boasts an 80% retention rate of clinicians following their first two years of patient care. Typically, retention rates of U.S. master's graduates in behavioral health are

low enough that only 57% achieve licensure. NMHWAC participants logged 35,920 clinical hours and served 9,231 clients. Overall, the program found that behavioral health workers are concerned by their caseload, burnout, and safety concerns that are heightened for female clinicians.

Summary of the Findings of the Subcommittee

In addition to the summary of the presentations to the committee, the following section highlights findings that the subcommittee would like to emphasize, which relate to their recommendations. This includes additional findings and reports that may not have been formally presented at committee hearings. Additional reports and information are attached in the appendices of this report.

Bed Shortage

The subcommittee has heard testimony since its inception on the need for new psychiatric beds and forensic state beds. In 2023, the Department of Behavioral Health and Developmental Disabilities commissioned a bed capacity study done by Alvarez and Marshal. The number and location of beds needed were identified and monies appropriated by the legislature to meet the needs.
Even with the increase of the state beds, the remaining bed needs in Georgia needs to be evaluated, especially with the challenges of serving children with complex behavioral health needs or a combination of severe behavioral health and physical health needs.

Admission Practices

Testimony this year confirmed findings from previous years that an "evaluate and admit" versus a "direct admit" from the emergency room (ER) is more efficient. Other states have utilized various methods of creative solutions, including EmPATH units. Several versions of this idea have been implemented in Georgia, and the subcommittee believes that these methods should be encouraged and bolstered.

The subcommittee heard from Grady Hospital in Atlanta. Grady sees about 140,000 ER visits yearly, with 11,000 for possible behavioral health admission. They have a 28-chair open milieu unit similar to EmPATH units that triages and treats mental health concerns for patients who enter the ER. After their unit was established, the average ER length of stay was reduced by 50%, and readmission rates were reduced by 66% (from 19% in 2013 to 6.52% in 2024). Of patients served in the new unit, 47% were discharged home from the unit and not admitted to the hospital at all.

Another program in Georgia at the Highland Rivers Community Service Board reported similar success rates for their ER diversion program. Highland Rivers Community Service Board reported 2,875 ER assessments in fiscal year 2025, 50% of patients seen were not admitted to the hospital, the ER length of stay reduced was 50%, and 60% of patients kept follow-up appointments.

Additionally, Willowbrooke at Tanner Health System in Carrollton has a well-established direct access program that avoids the ER entirely. Willowbrooke has had great success with its program. However, due to regulations with the Georgia Crisis and Access Line (GCAL) board, individuals who are seen at Willowbrooke who require admittance must be transferred to the ER to be matched with a bed. This policy should be changed so direct admissions are possible from Willowbrooke.

The subcommittee also heard testimony from South Carolina about their state-funded EmPATH units. The units are still at beginning stages and do not have outcomes achieved yet.

The subcommittee recommends exploring and funding ER diversion programs like EmPATH units in Georgia to reduce ER wait time for all and decrease unnecessary hospital admissions.

Payment Concerns

Inadequacy and difficulty with compensation from public and private insurance providers have been ongoing issues for behavioral health providers in Georgia.

Georgia has recently undergone a fee study and has increased reimbursement for behavioral health providers in Georgia. In previous years, the subcommittee heard testimony from psychiatric residential treatment facilities (PRTFs) that reported that 60% of their patients were out of state. The subcommittee conducted an informal survey of PRTFs and found that of those who reported, there was a decrease to 30% of state children. The subcommittee hypothesizes that the efforts to change insurance reimbursement rates are the cause of this.

Table 1: Number of Youth Served at PRTFs in Georgia

	PRTF	Georgia	Out of State
Hillside	400	318	82
Youth Villages	304	137	167
Laurel Heights	482	342	140
Coastal Harbor	413	324	89
Totals	1,599	1,121	478
Percentages		70%	30%

The subcommittee heard and also received documents indicating that there are still challenges to payment reimbursement due to concerns around parity. In the appendices are recorded evidence of parity violations reported in Georgia. Service providers report serving individuals without insurance reimbursement due to issues around prior authorizations and insurance denials or limitations, which result in underpayments. The subcommittee recommends that the state continue to examine and fund modifications to the current system in Georgia to regulate parity compliance and address network adequacy concerns and shortcomings.

Serving Individuals With Complex Medical Needs

The subcommittee has heard repeated testimony that certain types of patients are very difficult to place, even though beds may be available. Patients with autism, violent behavior, and compounding medical problems like heart disease or diabetes were given as examples of patients who are difficult to place in appropriate placements.

The Georgia Alliance of Community Hospitals has agreed to survey its members to provide information about admissions from their hospitals. The questions asked on the survey include number of behavioral health patients seen per year, average ER wait time, and the number and type

of patients who have been difficult to place. The subcommittee believe that a general increase in the number of behavioral health beds may not be needed, but specific types of beds are probably very needed.

Workforce

In a report to the subcommittee attached, Motivo recently reported that 54% of mental and behavioral health master's-level clinicians never make it through the licensure process in Georgia. State leaders and partners need to continue to work to reduce barriers to the licensure process.

Continue to identify ways that Georgia can utilize populations without a master's degree in innovative ways to support the mental and behavioral health (MBH) workforce. While Georgia leads the nation with peer support specialists, there are many other opportunities for bachelor's-level, associate's-level, and high school graduation–level MBH professionals that will build MBH access. According to data collected by the University System of Georgia, psychology is one of the most popular undergraduate degree programs in Georgia, yet it is difficult for graduates to find employment within the MBH field with just an undergraduate degree. Other states have identified innovative ways to utilize this population in the MBH sector.

Georgia lacks an MBH workforce central data hub. Without this, it makes it very difficult to identify gaps in the MBH workforce. Florida recently instituted a hub that Georgia could emulate.

Promising Practice

The subcommittee heard testimony from Texas about the Texas Child Mental Health Care Consortium (TCMHCC), which was created in 2019 by the Texas legislature. TCMHCC works to match the expertise at Texas medical schools to address mental health challenges. Emulating Texas' relationship with medical schools would be beneficial for Georgia.

TCMCC has five different components:

- Child Psychiatry Access Network (CPAN);
- Perinatal Psychiatry Access Network (PeriPAN;)
- Texas Child Health Access Through Telemedicine (TCHATT);
- Child and Adolescent Psychiatry (CAP) Fellowships and Community Psychiatry Workforce Expansion (CPWE); and
- Children's Mental Health Research.

Georgia has some similar programs to that of Texas, exemplified in the table below.

Texas Child Mental Health Care Consortium Program		Georgia Programs[1]	Georgia Description
Child Psychiatric Access Network 4,506 physicians enrolled More than 17,000 consults annually	CPAN	GMAP (Georgia Mental Health Access in Pediatrics) 200-300 consults annually[2]	**In Georgia now:** GMAP currently offers provider-to-provider consultations related to specific patients or general questions, care coordination, and Project ECHO training to pediatric clinicians to assist with identifying and treating mental health issues in their young patients.
Perinatal Psychiatry Access Network	PeriPAN	PEACE for Moms (a partnership between Emory Medical School and the Georgia Department of Public Health[3])	**In Georgia now:** PEACE for Moms connects Georgia health care professionals (physicians, nurse practitioners, midwives, and physician assistants) with psychiatrists who specialize in perinatal mental health. In addition to clinician-to-clinician teleconsultations, PEACE for Moms also provides referrals to community resources and community education.
Texas Child Health Access Through Telemedicine 81% student coverage	TCHATT	Geogia Apex Program covers 37%, or 868, of Georgia's public schools[4]	**In Georgia now:** The Georgia Apex Program promotes collaboration between community mental health providers and schools to provide school-based services and supports, including training for school staff. Georgia Apex increases access to mental health services for school-age youth, prekindergarten to 12th grade, throughout the state, by connecting uninsured and underinsured students to therapy and mental health services.
Child and Adolescent Psychiatry Fellowships	CAP	Rural Critical Need Accelerated Track (RCN-ACT) Program at Mercer School of Medicine[5]	**In GA now:** Mercer School of Medicine Rural Critical Need Accelerated Track Program–Psychiatry.

[1] More specific information on these programs can be found in the appendices.
[2] Georgia Mental Health Access In Pediatrics https://ghpc.gsu.edu/coe/gmap/
[3] PEACE For Moms https://www.peace4momsga.org/
[4] Georgia Health Policy Center https://ghpc.gsu.edu/project/georgia-apex-program/
[5] Mercer School of Medicine https://medicine.mercer.edu/academics/doctor-of-medicine/special-programs/rcn-accelerated-track-program/

The subcommittee recommends that Georgia take meaningful steps to incorporate aspects of the Texas programs into existing program structures. In addition to creating more mental and behavioral health access, it would also build meaningful relationships throughout the state. This would enable the state to take advantage of additional national grants and funding streams while continuing to build mental and behavioral health access.

Additionally, once medical school relationships are established, additional departments could be included, providing the state with capacity including but not limited to public health expertise, epidemiology expertise, and nursing expertise.

Mental Health Parity

Georgia passed the Mental Health Parity Act, HB 1013, in 2022, designed to improve access to mental health and substance abuse treatment by requiring health insurers to cover these services comparably with physical health services. This means there should be no difference in deductibles, copays, or limits on the number of visits or days of hospitalization between mental and physical health services. Among other things, HB 1013 also requires the Georgia Department of Insurance to ensure that insurance companies follow parity reporting guidelines, providing avenues for mental health parity complaints from insured individuals and provides a definition for *medical necessity*.

Children's Healthcare of Atlanta systematically captures data on access to mental health care in the electronic health records of patients in its Center for Behavioral and Mental Health. There are extremely limited availability of in-person outpatient dialectical behavioral therapy (a treatment of choice for many patients with suicidality) for youth covered by CMO Medicaid. Sixty percent of youth remain unconnected to recommended mental health services 30-75 days after ER discharge. Among the hundreds of youths with recurrent behavioral health crises in a given year, 1 in 5 (20%) have received no recommended outpatient mental health care at the time of either the first or second visit.

Recommendation Priorities

The Hospital and Short-Term Care Facilities Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action:

1. Establish a Georgia Mental Health Consortium. Use state funding to strategically leverage the work and partnerships between Georgia medical schools, Georgia nursing schools, health care leadership, and already established Georgia programs.
2. Support passage of SB 131, which would establish a parity compliance review panel and require health care providers to report suspected behavioral health parity violations (this is the Senate version of HB 612).
3. Provider network adequacy — grounded in current data and active state enforcement — is the linchpin of true parity: without enough in-network clinicians available to see patients, no definition of "medically necessary" and no promise of equal coverage has practical meaning. Ensure this is a top priority of the medical review panel.

4. A Motivo study shows only 54% of Georgia master's-level behavioral health professionals complete the licensure process. Evaluate causes and then simplify and correct problems in the licensure process while concurrently developing innovative workforce pathways for all levels of education.
5. Create a central interactive data hub that can be used to predict the supply and demand of Georgia's behavioral health workforce. Georgia should look to model the innovative dashboard created by the University of South Florida.
6. Continue to encourage preadmission mental and behavioral health evaluation programs at both public and private emergency rooms. Correct the problems with admissions from freestanding facilities using the GCAL board — as reported by Willowbrooke in Carrollton.
7. Complete study of Georgia hospitals to identify specific number and types of beds needed.

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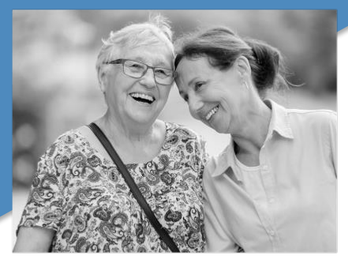



Continuum of Care: EmPATH Units Research Request 2025

Presented to Behavioral Health Reform and Innovation Commission

June 2025

SUMMARY

The Behavioral Health Reform and Innovation Commission's (BHRIC's) Hospital and Short-Term Care Facilities Subcommittee asked the Georgia Health Policy Center to conduct an environmental scan of the ways other states incorporate emergency psychiatric assessment, treatment, and healing (EmPATH) units into their mental and behavioral health continuums of care.

This report includes pertinent presentations and documents including:

- An environmental scan conducted by the Georgia Health Policy Center of EmPATH units;
- A presentation created by Roland Behm on EmPATH units;
- The 2023 report from the Hospital and Short-Term Care Facilities Subcommittee including recommendations on EmPATH units;
- A presentation from the Department of Behavioral Health and Developmental Disabilities (DBHDD) about the Certified Community Behavioral Health Clinics (CCBHCs); and
- Medicaid state plan amendment approval from June 2025.

Based on the information obtained from these resources, the following recommendations may serve as potential next steps and contacts for the Hospital and Short-Term Care Facilities Subcommittee:

1. Continue conversations about EmPATH units, including —
   - Potential conversations with representatives from Iowa. Iowa has had an EmPATH unit since 2018 and has successfully calculated a return on investment for hospitals that engage with an EmPATH.
   - Potential conversations with representatives from Kentucky. Kentucky has had an EmPATH unit since 2024 and has been able to calculate outcomes for neighboring hospitals.
2. Learn more about the impact of certificate of need (CON) regulation changes on the feasibility of EmPATH units.
   - CON regulations have changed since the BHRIC *2023 Annual Report,* which may have changed the ability of hospitals to stand up EmPATH units. In South Carolina, EmPATH units are considered crisis stabilization units and thus are exempt from CON requirements.
3. Learn more about the CCBHC model from DBHDD representatives.

- With the passage of the CCHBC model for Medicaid reimbursement in June 2025, there may be additional avenues to provide EmPATH or EmPATH-like units.

EMPATH STATE SCAN

In 2023, BHRC's Hospital and Short-Term Care Facilities Subcommittee recommended that EmPATH units be added into the continuum of care in Georgia, including modification for the CON and pathways to ensure that all individuals have access to EmPATH units through their private insurance payers. Since the recommendations were made, the CON law in Georgia has been modified. Additionally, other states have implemented EmPATH units. The following research report reviews the updates to the CON law along with additional information on EmPATH units to inform future recommendations from the committee.

Certificate of Need

In 2024, the Georgia Legislature made changes to the CON statue with HB 1339. The changes streamline the CON applications and appeal processes. Additionally, HB 1339 removes the threshold of hospitals' capital expenditures and exempts hospitals from CON review for an increase of 10 beds or 20% increase (whichever is greater) in a three-year period as long as hospitals maintain an occupancy rate of 60% in the previous year. Additionally, facilities providing psychiatric and substance abuse inpatient programs may qualify for an exemption. These changes may reduce the burden for hospitals submitting CON reviews.

EmPATH Units

Evidence shows EmPATH units provide more effective stabilization services for individuals experiencing mental health crisis who visit emergency rooms. The milieu provides a calming and stable environment that allows for shorter times for stabilization and decreases the number of hospitalizations. Throughout the United States, numerous EmPATH units have been created, some through private funds from hospital systems, while others are funded by partnerships of multiple agencies or university systems. In some states, units have been funded from state procurements.

In places with EmPATH units, they function as another kind of crisis stabilization unit at accessible locations at known emergency rooms. CON laws have been a barrier for some hospitals to open EmPATH units. In South Carolina, the Department of Public Health released guidance exempting the opening of EmPATH units from CON regulations in the state.
The following table gives examples of EmPATH units throughout the United States, with information about the unit, any documented outcomes, and funding mechanisms.

States	Website and Contact Information	Information about the Unit	Funding
Kentucky	University of Kentucky Health Services EmPATH Unit Outcomes: Lexington, Kentucky First Emergency Psychiatric Assessment Treatment Led by Dr. Andrew Cooley of UK Healthcare System, Kentucky College of Medicine andrew.cooley@uky.edu	The University of Kentucky Healthcare (UK Healthcare), Kentucky Cabinet for Health and Human Services, and New Vista Community Mental Health collaborated on the opening of a 12-bed EmPATH unit in 2024 at Eastern State Hospital. Since opening, it served 2,700 patients. From the first year of opening, the patients served stayed an average of 15 hours with a primary chief concern of suicidality. Eastern State Hospital experienced a decrease in hospital readmission. Additionally, locally there has been a decrease in the number of patients in a neighboring hospital. About 25% of individuals visiting the EmPATH unit are hospitalized. The hospital has seen an increase in compliance with follow-up appointments, from 29% to 61%.	The EmPATH unit is funded by the University of Kentucky. It cost $750,000 for renovations before opening, and the University of Kentucky will pay Eastern State Hospital $200,000 to lease the space every year.
Connecticut	Griffin Health	Griffin Health is attempting to get an EmPATH unit up and running in their emergency department at one of their locations.	The hospital is funding the EmPATH unit to start, with requests for charitable donations.

South Carolina	South Carolina Department of Public Health South Carolina Hospital Association Learning Series South Carolina Department of Health and Human Services Awards	The South Carolina Department of Health and Human Services funded 13 hospitals with EmPATH centers. South Carolina provided additional technical assistance for grantees. The South Carolina Hospital Association created a learning series around the EmPATH model, helping with standards of measurement and reimbursement for individuals in the EmPATH units. Recipients of the grant are required to participate in the learning collaborative. The South Carolina Department of Public Health released guidance that EmPATH units do not require a CON to establish a hospital-based crisis stabilization unit, as they are not considered hospital beds.	South Carolina awarded 13 hospitals $45.5 million in grants to build or renovate EmPATH units through the South Carolina Department of Public Health.
Tennessee	McNabb Center Opens EmPATH Unit Candace Allen, Clinical VP for McNabb Center candace.allen@mcnabb.org.	Tennessee McNabb Center in Knoxville opened an EmPATH unit in a vacant hospital facility in 2024. The EmPATH program has 16 beds with an estimated 6,000 individuals served annually.	The EmPATH unit was funded from a total of $2 million from the city of Knoxville and Knox County. Additionally, $6 million in funds were received from the state.
New Jersey	Atlanta Health Opens EmPATH Unit Overlook Medical Center Stephanie Schwartz	The hospital system, Atlantic Health, opened a six-bed EmPATH unit in 2024.	The EmPATH unit is funded by the hospital system.

Iowa	Contact Information: Jodi Tate jodi-tate@uiowa.edu University of Iowa EmPATH Outcomes Paper Economic Evaluation of the EmPATH Model	The University of Iowa Hospitals and Clinics opened a 12-bed EmPATH unit for individuals 18 years or older in 2018. They accept referrals from rural Iowa, Missouri, and Illinois. The EmPATH unit has reduced psychiatric admission, any kind of emergency room admission, incomplete admissions, and returns to an emergency room. On average, emergency room times were reduced by two-thirds with the introduction of the EmPATH unit. Additionally, those who were seeking psychiatric care had a 60% increase in recommended 30-day follow-up care. The hospital has also had an increase in revenue annually of $860,165 from complete admissions with the opening of the unit.	The EmPATH units were funded by the hospital system.

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Parity Research Addendum

Presented to the Behavioral Health Reform and Innovation Commission

September 2025

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EXECUTIVE SUMMARY

The Behavioral Health Reform and Innovation Commission's Subcommittee on Hospital and Short-Term Care Facilities requested that researchers at the Georgia Health Policy Center expand on previous work related to state regulations to ensure mental health parity. The following report outlines information about medical necessity, network adequacy, and nonquantitative treatment limitations (NQTLs). The table below summarizes recommendations from states on what to include in parity laws and regulations.

Summary of State Scan on Medical Necessity, Network Adequacy, and NQTLs in Parity Laws
Medical necessity: States use various terms in their medical necessity definitions, including: • Clinical review guidelines • Generally recognized standards • Evidence-based sources can include clinical practice guidelines and recommendations • Variation by insurer • If there is a denial for medical necessity, insurers can request an expedited external review.
Network Adequacy: Network adequacy measures an insurance plan's ability to provide accessible care to in-network members. Network adequacy can measure number and type of providers, accessibility, and timely access: • Limited wait time — two weeks or 10 business days for first appointment • Geographic standards for maximum travel time and distance based on county size and population. Most states used standards such as "large metro," "metro," "micro," "rural," and "counties with extreme access considerations" to determine geographical location.
Nonquantitative Treatment Limitations: NQTLs are limits or scopes that are present in what is covered in insurance coverage: • Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative • Preauthorization or ongoing authorization requirements • Concurrent review standards • Retrospective review standards • Examining health care claims that fall outside of the predetermined range of eligibility through outlier review criteria • Medical necessity criteria • Formulary design for prescription drugs • Standards for provider admission to participate in a network, including reimbursement rates and the average time to obtain, verify, and assess the qualifications of a health practitioner for purposes of credentialing • Criteria utilized for determining usual, customary, and reasonable charges for out-of-network services, including the threshold percentile utilized and any industry software or other billing, charges, and claims tools utilized • Standards for providing access to out-of-network providers

- Standards for providing access to out-of-network providers
- Provider reimbursement rates, including rates of reimbursement for mental health or substance use services in primary care, provided, however, that any proprietary information collected shall not be subject to disclosure
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols)
- Exclusions of specific treatments for certain conditions
- Limitations on inpatient services for situations where the participant is a threat to self or others
- Exclusions for court-ordered treatment and involuntary holds
- Experimental and investigational treatment determinations
- Exclusions based on the probability of improvement
- Exclusions based on failure to complete a course of treatment
- Exclusions for services provided by clinical social workers
- Provider credentialing, certification requirements, and unlicensed provider or staff requirements
- Restrictions on applicable provider billing codes
- Service coding and coding edits
- Written treatment plan requirements
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for in-network and out-of-network services

MEDICAL NECESSITY

Many states simply reference the federal standards of medical necessity, stating in their state parity bills some variation of “as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.” Other states explicitly do so in their state laws but explicitly state necessity in their listed NQTLs for review. However, a few states strengthen their definition of medical necessity in their state parity bills by defining it separately from the definition present in the Mental Health Parity and Addiction Equity Act of 2008, including New York, New Mexico, Illinois, and Georgia. Their definitions are listed below.

New York

Medical necessity is described by the New York State Department of Financial Services (DFS) with the following statement: “Your insurer may deny services as not medically necessary (including experimental or investigational services) through its utilization review process. Insurers use clinical review criteria (medical guidelines), which may vary among insurers, to make these determinations.”

New York DFS further describes the insured’s rights in terms of clinical review criteria: “You have a right to ask your insurer for a copy of the clinical review criteria (medical guidelines) that your insurer used to make a medical necessity decision. For mental health and substance use disorder treatment, insurers are required to use State-approved tools to decide if care is medically necessary.”

New York DFS also describes the insured’s rights in terms of clinical peer reviewer: “A clinical peer reviewer is the health care professional who decides if a service is medically necessary. For determinations involving mental health or substance use disorder treatment, the clinical peer reviewer must specialize and have experience in mental health or substance use disorder treatment.”

New York DFS also breaks down the insured’s rights in terms of medical necessity for five different categories of services: Medical Necessity for Inpatient Services for Individuals Under 18, Medical Necessity for Inpatient Services for Individuals 18 or Older, Medical Necessity Review for Inpatient Substance Use Disorder Services, Medical Necessity Reviews for Outpatient Treatment of Substance Use Disorder, and Medical Necessity for Prescription Drugs to Treat a Substance Use Disorder. In each category, what the insurance company is and is not allowed to

do in terms of preauthorizations, concurrent reviews, and retrospective reviews is described; for instance for Inpatient Mental Health Services for Individuals Under 18, New York DFS states that, "If you are under the age of 18, your insurer can't require you or your provider to request pre-authorization for mental health treatment in an in-network facility that is licensed or operated by the NYS Office of Mental Health." Clinical review criteria of services not explicitly protected by medical necessity is determined by insurers and may vary.

New Mexico

New Mexico Senate Bill 273 states that insurers are to apply "generally recognized standards of care" in evaluating the medical necessity of services. "'Generally recognized standards' means standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including: 1) psychiatry; 2) psychology; 3) social work; 4) addiction medicine and counseling; or 5) family and marriage counseling."

Illinois

Illinois House Bill 2595 made a number of expansions to the definition of medical necessity, including the provision that "Provides that an insurer shall not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public program. Provides that an insurer shall base any medical necessity determination or the utilization review criteria on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care. Provides that in conducting utilization review of covered health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, and nervous disorders or conditions in children, adolescents, and adults, an insurer shall exclusively apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Provides that an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in the treatment criteria."

In terms of substance use, "Medical necessity determinations for substance use disorders shall be made in accordance with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make medical necessity determinations for substance use disorders. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for substance use disorders in accordance with the most current edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine. The treating provider shall base all treatment recommendations and the health benefit plan shall base all medical necessity determinations for medication-assisted treatment in accordance with the most current Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions established by the American Society of Addiction Medicine."

Medical necessity determinations must be made available to participants, beneficiaries, and providers upon request. If a covered person receives an adverse determination, they may request an expedited external review. "An expedited external review may not occur if the substance use disorder treatment provider or facility determines that continued treatment is no longer medically necessary. Under this subsection, a request for expedited external review must be initiated within 24 hours following the adverse determination notification by the insurer. Failure to request an expedited external review within 24 hours shall preclude a covered person or a covered person's authorized representative from requesting an expedited external review. If an expedited external review request meets the criteria of the Health Carrier External Review Act, an independent review organization shall make a final determination of medical necessity within 72 hours. If an independent review organization upholds an adverse determination, an insurer shall remain responsible to provide coverage of benefits through the day following the determination of the independent review organization. A decision to reverse an adverse determination shall comply with the Health Carrier External Review Act."

Insurers are also required to "Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurance staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria" and "Conduct interrater reliability testing to ensure consistency in utilization review decision making that covers how medical necessity decisions are made."

Georgia

In parity House Bill 1013, Georgia expands on the definition of medical necessity as follows: "'Medically necessary' means, with respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

(A) In accordance with the generally accepted standards of mental health or substance use disorder care;

(B) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(C) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider."

NETWORK ADEQUACY

Across states, network adequacy is typically addressed within a state bill separate from parity legislation, though some states loosely describe standards of network adequacy in the NQTLs they purport to review. State bills that describe network adequacy focus on both behavioral and nonbehavioral medical health standards. Network adequacy standards are divided into two main categories: wait times and geographical standards that are sectioned by medical specialties. The most thorough network adequacy geographical standards measure distance in both minutes and miles and have distinct maximums for different geographical categories, such as "large metro," "metro," "micro," "rural," and "counties with extreme access considerations." States with strict network adequacy standards may also have built-in opportunities for exceptions, such as West Virginia's policy that only 90% of an insurer's providers need to meet network adequacy standards for the insurer to be considered to have met the standards.

Texas

In Texas, House Bill 3359 amended the Insurance Code Subdivision 6-a to require that preferred provider benefit plans meet certain requirements. In terms of wait times, those insured seeking care for a behavioral health condition must receive an appointment within two weeks. Geographic standards are broken down into five geographic categories: large metro counties, metro counties, micro counties, rural counties, and counties with extreme access considerations. Three types of behavioral health providers and services have prescriptive geographic standards: psychiatrists, behavioral health facility services, and behavioral health (licensed, accredited, or certified) urgent care, which are listed below. For any specialty not listed, the maximum distance for any provider in any county is 75 miles. To waive a network adequacy requirement, an insurer must participate in a public hearing. All preferred benefit plans must be reviewed by the insurance commissioner for standards compliance before they are offered to clients, and every insurer's preferred provider benefit plans must receive a qualifying examination at least once every three years.

- Maximum Distance to Psychiatrists:
  - Large metro counties — 10 miles or a 20-minute drive
  - Metro counties — 30 miles or a 45-minute drive
  - Micro counties — 45 miles or a 60-minute drive
  - Rural counties — 60 miles or a 75-minute drive
  - Counties with extreme access considerations — 100 miles or 110-minute drive
- Maximum Distance to Behavioral Health Facility Services:
  - Large metro counties — 15 miles or a 30-minute drive
  - Metro counties — 45 miles or a 70-minute drive
  - Micro counties — 75 miles or a 100-minute drive
  - Rural counties — 75 miles or a 90-minute drive
  - Counties with extreme access considerations — 140 miles or a 155-minute drive
- Maximum Distance to Behavioral Health Urgent Care:
  - Large metro counties — 5 miles or a 10-minute drive
  - Metro counties — 10 miles or a 15-minute drive
  - Micro counties — 20 miles or a 30-minute drive
  - Rural counties — 30 miles or a 40-minute drive
  - Counties with extreme access considerations — 60 miles or a 70-minute drive

West Virginia

West Virginia's network adequacy standards greatly resemble those of Texas. In Title 114 of West Virginia's Legislative Rule for the insurance commissioner, Series 100 "Health Benefit Plan Network Access and Adequacy," West Virginia sets network adequacy standards for all insurance carriers offering health benefit plans. In terms of wait times, the insured should not wait more than 10 business days for a behavioral health appointment. Geographic standards are broken down into the same categories as those of Texas — large metro, metro, micro, rural, and counties with extreme access considerations — and describe specialists in psychiatry, outpatient clinical behavioral health, and inpatient or residential behavioral health services.

Unlike Texas's bill, there are no geographic standards for behavioral health urgent care. Also, unlike Texas, West Virginia requires that only 90% of providers meet its geographic accessibility standards in order for the insurer to be in compliance. Insurers must file their access plans with the insurance commissioner, and every provider of their directory should be audited at least once every 18 months. There is no waiver system in West Virginia's legislation, but if an insurer cannot meet network adequacy standards, they must ensure that the covered person obtains the same in-network benefit from a nonparticipating provider or make some other arrangement to the satisfaction of the commissioner.

- Maximum Distance to Psychiatrists:
  - Large metro — 10 miles or 20 minutes
  - Metro — 30 miles or 45 minutes
  - Micro — 45 miles or 60 minutes
  - Rural — 60 miles or 75 minutes
  - Counties with extreme access considerations — 100 miles or 110 minutes
- Maximum Distance to Outpatient Clinical Behavioral Health:
  - Large metro — 5 miles or 10 minutes

- Metro — 10 miles or 15 minutes
- Micro — 20 miles or 30 minutes
- Rural — 30 miles or 40 minutes
- Counties with extreme access considerations — 60 miles or 70 minutes

- Maximum Distance to Inpatient or Residential Behavioral Health Facility Services:
  - Large metro — 10 miles or 20 minutes
  - Metro — 30 miles or 45 minutes
  - Micro — 60 miles or 80 minutes
  - Rural — 60 miles or 75 minutes
  - Counties with extreme access considerations — 100 miles or 110 minutes

New York

Rather than focusing on geographic access, New York's Insurance Regulation 230, which delineates on the expansion of behavioral health network adequacy, focuses on wait times and directories. New Yorkers with qualifying health insurance plans must receive an outpatient behavioral health appointment within 10 business days of the request and within seven calendar days of a hospital or emergency room discharge. Insurers must also provide clear details on provider locations, telehealth availability, and languages spoken by the provider. Insurers must have dedicated employees to help patients find in-network providers. Information for contacting these employees must be on the website. Employees must send info on in-network providers within three days. If a covered person cannot find an in-network provider that is able to schedule an appointment within seven to 10 days within a "reasonable distance" from the insured, they have a right to schedule an out-of-network appointment at no additional cost.

Illinois

The Illinois 215 ILCS 124/ Network Adequacy and Transparency Act directly references the federal Mental Health Parity and Addiction Equity Act of 2008 in codifying that "the network adequacy standards for timely and proximate access shall equally be applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions and specialists providing medical or surgical benefits." Illinois names specific counties in which the covered person shall not have to travel longer than 30 minutes or 30 miles for outpatient behavioral health treatment. In all other counties, covered persons shall not have to travel more than 60 minutes or 60 miles for an outpatient behavioral health appointment. No covered person shall have to wait more than 10 business days for an initial appointment related to behavioral health or more than 20 days for a follow-up appointment. Illinois also has the provision that 90% of providers must meet geographic standards. Insurers are required to file an access plan to the commissioner and are required to provide electronic and print directories to covered persons, which are audited every 18 months.

Georgia

Georgia has set geographic and network accessibility standards for its care management organizations (CMOs). First, in-network providers must cover the full spectrum of behavioral health needs, which is determined by the commissioner. The Department of Community Health requires quarterly network adequacy reports from CMOs with member access data. Covered persons under CMOs must not wait more than 14 calendar days to receive an appointment from a "mental health professional," though mental health professional is not further defined. Its geographic standards are very simple in that it has standards broadly for "mental health providers" and divides geographic areas into "urban" or "rural," stating that in urban areas, covered persons must not travel more than a maximum distance of 15 miles or 30 minutes to access a mental health professional, and in rural areas covered persons must not travel more than 45 miles or 45 minutes to access a mental health professional. Georgia also has the provision that only 90% of providers need to meet these geographic standards. In counties where access is below 90%, CMOs are required to provide a corrective plan to address the deficiency.

NONQUANTITATIVE TREATMENT LIMITATIONS

Across state parity bills, there is an expectation that all NQTLs within a policy in effect will be reported to the commissioner, along with the results of a comparative analysis showing that NQTLs applied to mental and behavioral health are comparable to those applied to other forms of health care. A quoted example of this policy from West Virginia's Insurance Code §33-16-3ff is described in detail below. Other states will name specific examples of NQTLs to include in the report, including Indiana, New York, Tennessee, Texas, and Georgia. A compiled list of each NQTL named by these five states is below.

West Virginia

"The Insurance Commissioner's report of the analyses regarding nonquantitative treatment limitations shall include at a minimum:
(A) Identifying factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;
(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;
(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, mental health, and

substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;
(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and
(E) Disclose the specific findings and conclusions reached by the Insurance Commissioner that the results of the analyses indicate that each health benefit plan which falls under the provisions of this section complies with subsection (c) of this section."

NQTL examples named by Indiana, New York, Tennessee, Texas, and Georgia

1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
2. Preauthorization or ongoing authorization requirements
3. Concurrent review standards
4. Retrospective review standards
5. Outlier review criteria
6. Medical necessity criteria
7. Formulary design for prescription drugs
8. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design.
9. Standards for provider admission to participate in a network, including reimbursement rates and the average time to obtain, verify, and assess the qualifications of a health practitioner for purposes of credentialing
10. Criteria utilized for determining usual, customary, and reasonable charges for out-of-network services, including the threshold percentile utilized and any industry software or other billing, charges, and claims tools utilized
11. Standards for providing access to out-of-network providers
12. Provider reimbursement rates, including rates of reimbursement for mental health or substance use services in primary care, provided, however, that any proprietary information collected shall not be subject to disclosure
13. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols)
14. Exclusions of specific treatments for certain conditions
15. Limitations on inpatient services for situations where the participant is a threat to self or others
16. Exclusions for court-ordered treatment and involuntary holds
17. Experimental and investigational treatment determinations
18. Exclusions based on probability of improvement
19. Exclusions based on failure to complete a course of treatment
20. Exclusions for services provided by clinical social workers
21. Provider credentialing, certification requirements, and unlicensed provider or staff requirements
22. Restrictions on applicable provider billing codes
23. Service coding and coding edits
24. Written treatment plan requirements
25. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for in-network and out-of-network services
26. Such other limitation identified by the commission.

SOURCES

Georgia

- HB 1013: https://legiscan.com/GA/text/HB1013/2021
- Network Adequacy Reports: https://dch.georgia.gov/medicaid-managed-care/network-adequacy
- The Surprise Billing Consumer Protection Act: https://www.legis.ga.gov/api/legislation/document/20232024/219966

Illinois

- Illinois HB2595, introduced in 2021 to amend the Illinois Insurance Code: 10200HB2595
- Section 370c of Illinois Parity Act: Mental and emotional disorders: 215 ILCS 5/370c
- Section 370c.1. Mental, emotional, nervous, or substance use disorder or condition parity: 215 ILCS 5/370c.1
- Network Adequacy and Transparency Act (Insurance 215 ILCS 124) Illinois General Assembly - -

Indiana

- HB1092: Bill Text: IN HB1092 | 2020 | Regular Session | Enrolled | LegiScan
- HB1092 Report to Indiana General Assembly: 2021-report-on-compliance-with-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-act-of-2008-hea-1092-2020.pdf

Maryland

- Parity Act: Maryland Insurance Code Section 15-144 (2020) — Certain Carriers to Issue Report on Certain Health Benefit Plans — Information Included — Comparative Analysis of Nonquantitative Treatment Limitations and Data — Form :: 2020 Maryland Code :: U.S. Codes and Statutes :: U.S. Law :: Justia
- Network Adequacy, Health Insurance General Provisions legislation: Maryland Insurance Code Section 15-112 (2024) — Provider Panels :: 2024 Maryland Code :: U.S. Codes and Statutes :: U.S. Law :: Justia

Mississippi

- Senate Bill No. 2678: SB2678IN.pdf
- Network Adequacy Guidelines for Health Insurance Carriers: Mississippi Issues New Network Adequacy Guidelines for Health Insurance Carriers — ReSource Pro Compliance | Insurance Licensing Services

New York

- Timothy's Law: Bill Search and Legislative Information | New York State Assembly
- New York State Mental Health Parity and Addiction Equity Act Compliance: New York State Office of Mental Health Parity Compliance Toolkit
- Department of Financial Services Description of Medical Necessity: Mental Health and Substance Use Disorder Information | Department of Financial Services
- Network Adequacy 230 Insurance Regulation: Regulations — Insurance: Final Adoption for New Insurance Regulation 230 (11 NYCRR 38) — Network Adequacy and Access Standards for Mental Health and Substance Use Disorder treatment Services
- Summary of Network Adequacy Expansion of Rights: Network-Adequacy-Consumer-Factsheet
- New Network Adequacy Legislation Announcement 2025: Governor Hochul Expands Access to Mental Health and Substance Use Disorder Treatment for New Yorkers | Governor Kathy Hochul
- Preexisting Network Adequacy Standards for Managed Care Organizations: NYS Contracted Health Plan Network Adequacy Standards

New Mexico

- Senate Bill 273: SB0273
- Mental Health Parity Committee Presentation: Mental Health Parity
-

Tennessee

- Parity Bill: pc1012.pdf
- Network Adequacy Bill 56-7-2356: https://law.justia.com/codes/tennessee/2021/title-56/chapter-7/part-23/section-56-7-2356/
- Dead network adequacy bill which is now with the General Subcommittee of Senate Commerce and Labor Committee: https://www.capitol.tn.gov/Bills/114/Bill/SB1372.pdf

Texas

- Texas Administrative Code Rule, Title 28 Insurance, Part 1 Texas Department of Insurance, Chapter 21 Trade Practices, Subchapter P Mental Health and Substance Use Disorder Parity, Division 3 Compliance Analysis for MH/SUD Parity, Rule §21.2409 Nonquantitative Treatment Limitations Generally: Home — Rules & Meetings
- Texas Administrative Code Rule, Title 28 Insurance, Part 1 Texas Department of Insurance, Chapter 21 Trade Practices, Subchapter P Mental Health and Substance Use Disorder Parity, Division 1 General Provisions and Parity Requirements, Rule §21.2406 Definitions: Home — Rules & Meetings
- Network Adequacy House Bill No. 3359: 88(R) HB 3359 — Enrolled version — Bill Text

- Texas Department of Insurance Data Collection Forms and Templates: Mental Health and Substance Use Disorder Parity Rules
- Mental Health Parity: History and overview presentation: PowerPoint Presentation
- House Bill No. 10: 85(R) HB 10 — Enrolled version — Bill Text
- House Bill No. 2595: 87(R) HB 2595 — Enrolled version — Bill Text

West Virginia

- §33-16-3ff. Mental health parity. West Virginia Code | §33-16-3FF
- Network Adequacy 114CSR100

Georgia Health Policy Center
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ghpc.gsu.edu

Brenda Fitzgerald, MD

BHRIC Hospital and Short-term Care Subcommittee Chairperson

tcmhcc
Texas Child Mental Health Care Consortium

Texas Child Mental Health Care Consortium

David Lakey, MD
Vice Chancellor for Health Affairs and Chief Medical Officer
The University of Texas System

Presiding Officer, TCMHCC

Laurell Williams, DO
Baylor College of Medicine

Chief Medical Officer, TCMHCC

9/17/2025

Texas Child Mental Health Care Consortium

tcmhcc Texas Child Mental Health Care Consortium | CPAN Child Psychiatry Access Network | PeriPAN Perinatal Psychiatry Access Network

The Texas Child Mental Health Care Consortium (TCMHCC) was created in 2019 by the Texas Legislature to leverage the expertise and capacity of Texas medical schools and other health-related institutions of higher education to address urgent mental health challenges and improve the mental health care system for children and adolescents.

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Texas Child Mental Health Care Consortium Initiatives

Strengthening systems and increasing access to care through interconnected programs

Learn more:
www.tcmhcc.utsystem.edu/

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- Child Psychiatry Access Network (CPAN)
- Perinatal Psychiatry Access Network (PeriPAN)
- Texas Child Health Access Through Telemedicine (TCHATT)
- Child and Adolescent Psychiatry (CAP) Fellowships & Community Psychiatry Workforce Expansion (CPWE)
- Children's Mental Health Research

4

What is CPAN?

- Rapid clinician-to-clinician **consults** with a psychiatrist or other mental health clinician.
- Convenient and quick access by **phone or text.**
- **Free** evidence-based support. No insurance needed. Consults may be billable.
- Timely, one-time direct **patient-psychiatrist consults**.
- Vetted, individualized patient **referrals & resources** for clinicians who want to learn about a certain topic.
- Free and frequent virtual **CMEs** on pediatric & perinatal mental health topics & ethics.

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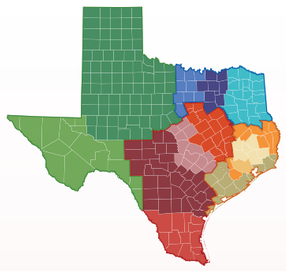
How Does CPAN Work?

PCP or Pediatrician Seeks Advice

Call **888-901-CPAN** Or Text Your Local Hub

A knowledgeable behavioral health specialist is standing by to assist.

Possible Outcomes:
- Psychiatrist consult
- Guidance to PCP to assess or treat patient
- Local, vetted referrals or resources
- Direct patient consult may be recommended



To ensure a rapid, expert response, CPAN can draw upon its **12 program hubs**

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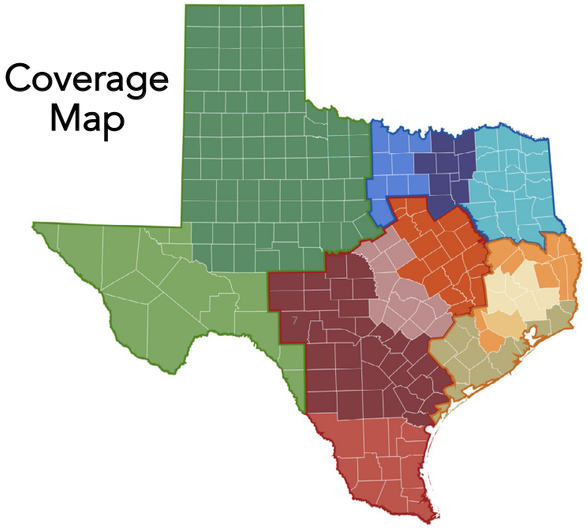
Coverage Map



Dial 1 North and Northeast Regions
1. The University of North Texas Health Science Center at Fort Worth
2. The University of Texas Southwestern Medical Center
3. The University of Texas at Tyler Health Science Center

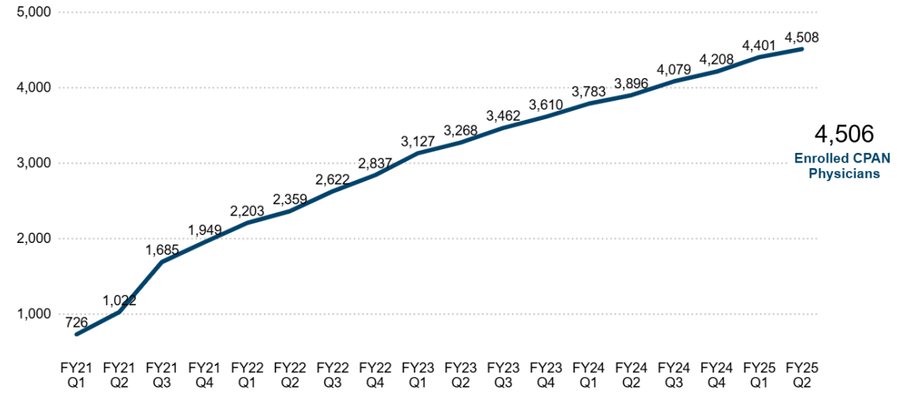
Dial 2 South and Southeast Regions
1. Baylor College of Medicine
2. The University of Texas Health Science Center at Houston
3. The University of Texas Medical Branch at Galveston

Dial 3 Valley and Central Regions
1. Dell Medical School at The University of Texas at Austin
2. The University of Texas Health Science Center at San Antonio
3. The University of Texas Rio Grande Valley School of Medicine
4. Texas A&M University System Health Science Center

Dial 4 West Region
1. Texas Tech University Health Sciences Center
2. Texas Tech Health El Paso

7

Growth in Enrolled CPAN Pediatricians & General/Family Physicians



4,506
Enrolled CPAN Physicians

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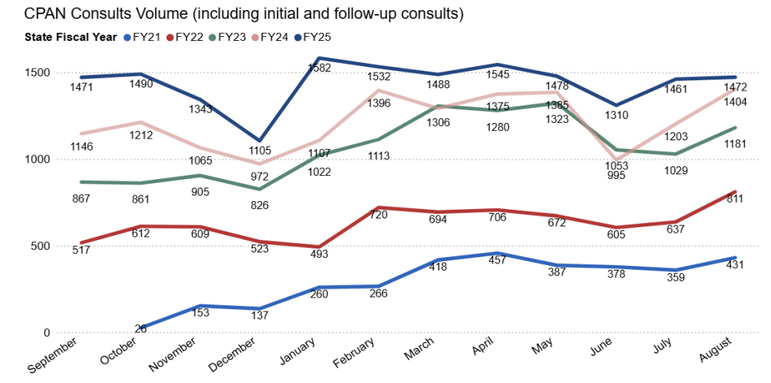
CPAN Monthly Provider Consultations - Annual Trends

October 2020 – August 2025

55,466
Total Provider Consults



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Texas Perinatal Psychiatry Access Network (PeriPAN)

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PeriPAN works exactly like CPAN and is focused on the mental health needs of prenatal, pregnant, and postpartum women.

- Access to **reproductive psychiatrists** and other mental health experts for consultation, guidance on screening and care, resources, and referrals.
- Free mental health CMEs and collaborative ECHOs on **maternal mental health** topics.
- For **all clinicians who see perinatal women**, including OB/GYNs, family doctors, pediatricians, midwives, PAs, NPs, and residents.

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One-Time Direct Patient Consultations

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Our experts may suggest a direct patient consult, a service that includes:

- A one-time, child / adolescent psychiatrist telehealth visit for the patient and family.
- Support for the primary provider.
- Assessment results or follow-up care recommendations sent to referring physician, clarifying diagnosis or treatment options.
- Scheduling and coordination by our team.

CPAN does not provide ongoing patient care but can continue to provide guidance and support to the primary care team.

No charge to the clinic or patient/family, no insurance needed.

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PeriPAN Enrollment

As of August 31, 2025

- 1,071 OB/GYNs
- 273 OB clinics
- 70 Women's or Maternal Health clinics
- 30 Midwifery practices

**This data is preliminary and subject to change*

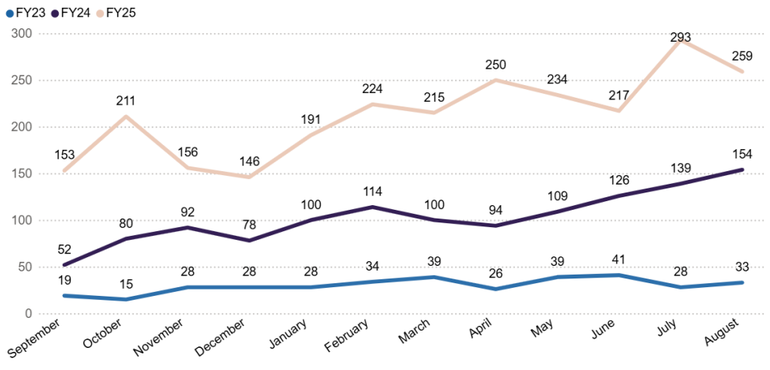
12

12

PeriPAN Monthly Consultations - Annual Trends

As of August 31, 2025

4,152
Total PeriPAN Consults



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Texas Child Mental Health Care Consortium

TCHATT

Texas Child Health Access Through Telemedicine

14

What is TCHATT?

- Focused mental health support & care for students in pre-K to 12th grade.
- Free, no insurance needed.
- Parent/guardian consent required.
- Virtual care (computer or smartphone).
  - Most appointments occur at school.
- Services may include therapy, psychiatry, case management support.
  - TCHATT is not a crisis service.
- Our licensed, local clinicians assess and address a student's mental health needs.
- We offer a limited number of sessions.
  - If a student needs more care, we help the family connect to community services.
- TCHATT is not a school program.
  - TCHATT is a separate, confidential mental health program for students.
- We can help students reduce anxiety, manage emotions, and cope with challenges to be more confident and successful in school.

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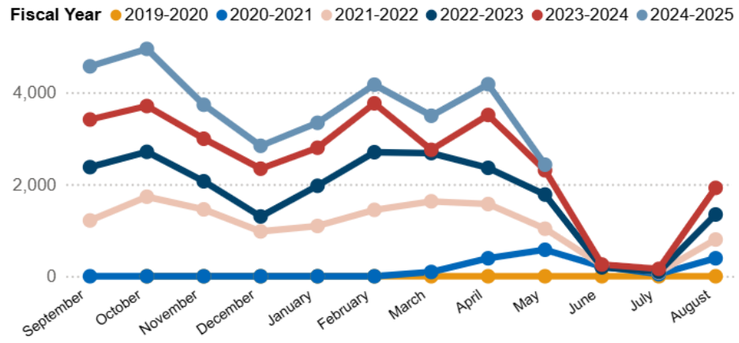
TCHATT Referrals By Month, FY2021–2025

as of August 31, 2025



100,224
Students Referred

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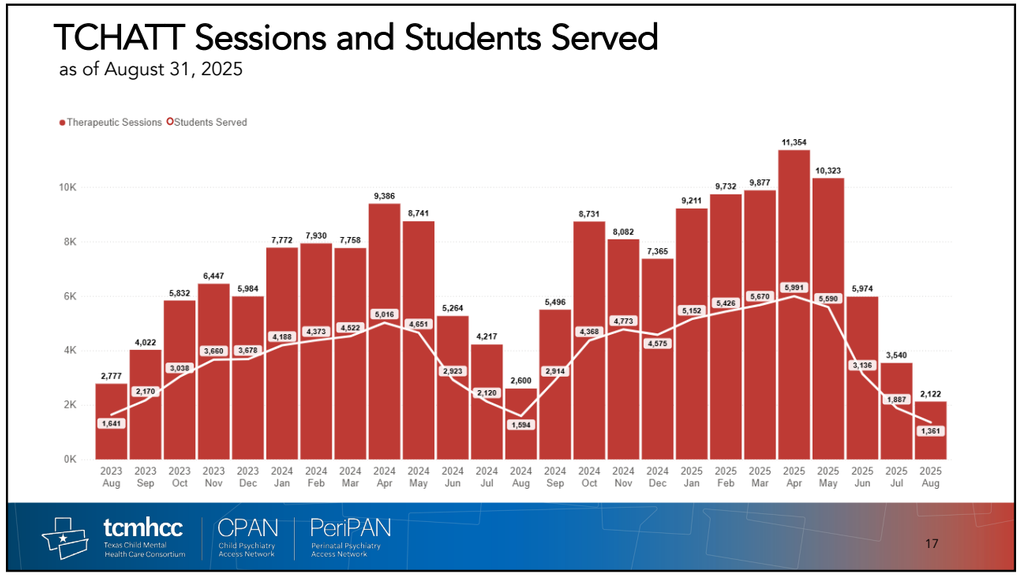
16



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EVIDENCE OF POTENTIAL PARITY VIOLATIONS

A. CHOA Data

Researchers at Children's Healthcare of Atlanta and Emory documented that **no outpatient Dialectical Behavior Therapy (DBT) providers** in Georgia's Medicaid networks were available for children being discharged from CHOA from **June-December 2024,** despite DBT being a front-line, evidence-based therapy widely regarded as the gold standard for treating suicidality and self-harm for decades. The study also found **sixty percent** of youth discharged following behavioral crises received **no recommended follow-up care** within 75 days. These failures reflect systemic noncompliance with state and federal Medicaid network-adequacy requirements and EPSDT obligations to ensure timely access to medically necessary care.

B. Georgia Medicaid Access Data (2025)

Peer-reviewed data from 2018 on psychosocial services for Medicaid-insured children in Georgia show that **34% of the need** for counseling, therapy, and related behavioral health services **was unmet statewide**, and that **roughly one in four Georgia census tracts had less than half of the provider capacity required**. The shortfall was **not driven by an absolute shortage of licensed clinicians**; rather, too few were willing to participate in Medicaid, and those who did often maintained small Medicaid panels because of chronically low reimbursement and high administrative burden. Modeling in the same study found that even a modest increase of about **15%** in either the number of clinicians accepting Medicaid or their Medicaid caseloads would close most of the gap—underscoring that the access crisis is a product of MCO and State policy choices, not an immutable workforce deficit.

C. RTI International & Bowman Family Foundation (2024)

RTI International and the Bowman Family Foundation found that in Georgia, behavioral health office visits are reimbursed at only about **94%** of Medicare rates, while comparable medical/surgical visits are paid at roughly **141%** of Medicare—a gap that widens further at the 75th and 95th percentiles. In practice, this underpayment operates as a parity-violative nonquantitative treatment limitation: it **systematically depresses provider participation**, drives higher out-of-network use for mental health and substance-use care (at least for those with financial resources), and produces the predictable **collapse of in-network behavioral health capacity** even as medical/surgical networks remain comparatively robust.

C. Amerigroup Access Failures: Georgia Families 360°

Investigative reporting by the Atlanta Journal-Constitution and KFF Health News, together with a formal complaint letter from the Georgia Department of Human Services (DHS) to the Department of Community Health (DCH), further documents that Georgia's Medicaid managed care insurers—Amerigroup in particular—have failed to provide timely, medically necessary care, especially for behavioral health and for children in state custody.

One AJC investigation found that Medicaid insurance companies in Georgia frequently denied or delayed coverage for needed care, including mental and behavioral health services, and that denials were often reversed when patients or providers pursued appeals. The reporting described patterns in which managed care plans rejected or slow-walked requests that treating clinicians viewed as medically necessary, indicating that denials were driven by internal cost-control and utilization-management policies rather than clinical judgment.

A separate AJC investigation focused on Georgia children in foster care enrolled in the Georgia Families 360° program, for which Amerigroup serves as the managed care contractor. That reporting described foster children with significant mental and behavioral health needs who could not obtain timely access to psychiatrists, therapists, or higher levels of care, even when treatment had been recommended or ordered. Caseworkers, caregivers, and child advocates reported that providers listed as "in-network" were unreachable, not accepting new Medicaid patients, or unwilling to work with Georgia Families 360°, and that children instead cycled through emergency departments, hotels, and DFCS offices for lack of appropriate services and placements.

On August 12, 2022, the Commissioner of the Georgia Department of Human Services, Candace Broce, wrote to DCH Commissioner Caylee Noggle to formally document these failures under Georgia Families 360°. Commissioner Broce stated: "**Simply put, the State's most vulnerable children cannot access the physical, mental, or behavioral health treatment they need – and deserve – in state custody or through post-adoptive care, and there is little accountability for Georgia Families 360° failures**." She further concluded that Amerigroup's "**narrow definition for 'medically necessary services' is — on its face — more restrictive than state and federal standards**." In other words, the State's own child-welfare agency expressly notified DCH that Amerigroup's medical-necessity criteria and networks were unlawful and inadequate for foster children and post-adoptive families, including children entitled to EPSDT and parity protections..

D. U.S. Office of Inspector General (2025)

The U.S. Office of Inspector General found that Medicaid managed care and Medicare Advantage plans nationwide—including those operating in Georgia—routinely list inactive or unavailable clinicians in their directories and **capture fewer than 25% of the local behavioral health workforce**, with some counties falling below 10% and at least one county showing no in-network behavioral health providers at all. Providers cited **low reimbursement and administrative burden** as primary reasons for not participating in plan networks, confirming that these "ghost networks" are the result of plan and State policy choices, not a lack of clinicians in the community.

E. The HealthNet Settlement (Centene Corporation)

In October 2025, California's Attorney General and the City Attorney of San Diego announced **a $40 million** settlement with Health Net of California, Inc., a Centene subsidiary, resolving claims in *City of San Diego v. Health Net of California, Inc.*, Case No. 37-2021-00027383-CU-BT-CTL (Cal. Super. Ct., San Diego Cty.), that Health Net misled consumers through materially inaccurate provider directories. The settlement requires **weekly online directory updates**, quarterly print verification**, independent audits**, and **public error-rate reporting**. Peach State Health Plan uses the same enterprise directory systems and corporate compliance framework as Health Net.

F. U.S. Office of Inspector General (2025)

The U.S. Office of Inspector General found that Medicaid managed care and Medicare Advantage plans nationwide—including those operating in Georgia—routinely list inactive or unavailable clinicians in their directories and **capture fewer than 25% of the local behavioral health workforce**, with some counties falling below 10% and at least one county showing no in-network behavioral health providers at all. Providers cited low reimbursement and administrative burden as primary reasons for not participating in plan networks, confirming that these "ghost networks" are the result of plan and State policy choices, not a lack of clinicians in the community.

G. Health Affairs Study on Insurer–Provider Vertical Integration and Intra-Company Pricing (2025)

A **November 2025** Health Affairs study examined UnitedHealth Group's vertically integrated structure, under which it sells insurance through UnitedHealthcare while owning a large physician organization (Optum). Using Centers for Medicare & Medicaid Services payer-transparency data for the employer-sponsored and individual markets, the authors found that UnitedHealthcare's relative payments to Optum providers were, on

average, **17% higher** than those of competing insurers, **increasing to 61%** in markets where UnitedHealthcare's market share was at least 25%. The study concluded that such elevated intra-company transfer prices allow vertically integrated health companies to **report higher medical spending** and meet medical loss ratio (MLR) thresholds on paper, while keeping value inside the corporate family **rather than increasing the volume or quality of care delivered.**

UnitedHealth is an active carrier in Georgia's ACA individual market and, as of December 2024, was one of four companies selected to receive a Georgia Medicaid managed care contract award.

H. Patient Care Decision Support Tool (PCDST) Rule (effective January. 1, 2026)

In May 2024, the U.S. Department of Health and Human Services issued a final rule implementing 45 C.F.R. § 92.210, which requires health insurers and Medicaid managed care organizations to disclose, for any adverse coverage determination based on a patient-care decision support tool (**such as InterQual or MCG**), the specific clinical criteria, data sources, and decision rationale used. These transparency and nondiscrimination obligations apply to all federally funded health programs, including Georgia Medicaid and subsidized ACA plan.

The new rule codifies what the Georgia Mental Health Parity Act already requires—coverage determinations must be based on evidence-based, generally accepted clinical standards and cannot rely on proprietary, undisclosed algorithms. The continued reliance by Georgia MCOs and health insurers on undisclosed, commercially developed tools and their failure to disclose decision logic in parity and EPSDT contexts demonstrate ongoing noncompliance and deliberate disregard of both federal and state law.

Strengthening Youth Mental Health:

Essential Strategies for Georgia's Future

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OVERVIEW

The youth mental health crisis is real. Since before the pandemic, we have been seeing a doubling of children aged one to 17 across the U.S. entering the hospital for suicide, suicidal ideation, and self-injury[1] and ER visits for behavioral and emotional crises doubling in Atlanta since 2015.[2] One in four young people ages 18 to 24 say they've considered suicide because of the pandemic. Rural teens in Georgia have a higher prevalence of behavioral health problems, anxiety, and depression than their urban counterparts.[3]

Mental health and substance abuse disorders are the leading causes of disease burden in the U.S. - more than cancers or circulatory diseases. And this is a uniquely American phenomenon - we lose twice the number of people to mental health and substance abuse disorders than comparable countries.[4] But Americans and American children did not suddenly become twice as mentally ill or genetically predisposed to substance abuse than their counterparts.

We must address the root of this crisis and reimagine mental health as a support for healthy development. While there will always be severely mentally ill children for whom pathology is that root, for most of our children, they are facing adversity in the form of abuse, neglect, household dysfunction, economic instability, and more. It is a uniquely difficult time to be a child today.

Fortunately, **Georgia has been doing extraordinary work to support youth mental health.** HB1013, the Mental Health Parity Act, is a groundbreaking piece of legislation that already starts to consider the social determinants of health, holding Care Management Organizations (CMOs) accountable, and addressing the workforce issue. Georgia was the first in the nation to have Certified Peer Specialists reimbursed by Medicaid, established a 988 Suicide & Crisis Lifeline in 2022, and has school-based health in 750 schools across the state. More recently, Georgia has made school nurses eligible to be reimbursed by Medicaid, is increasing reimbursement rates for mental health workforce by converting its Community Service Boards (CBBs) to Certified Community Behavioral Health Clinics (CCBHCs) and has coded child-parent psychotherapy so that parents can receive mental health services alongside their young children.

This is phenomenal work. However, Georgia has a last mile problem: **these efforts are not reflected in the reimbursement policies and practices from Care Management Organizations (CMOs).** Medicaid, CMOs, and Georgia's public system holding these CMOs accountable are the key to driving transformational change for Georgia's children.

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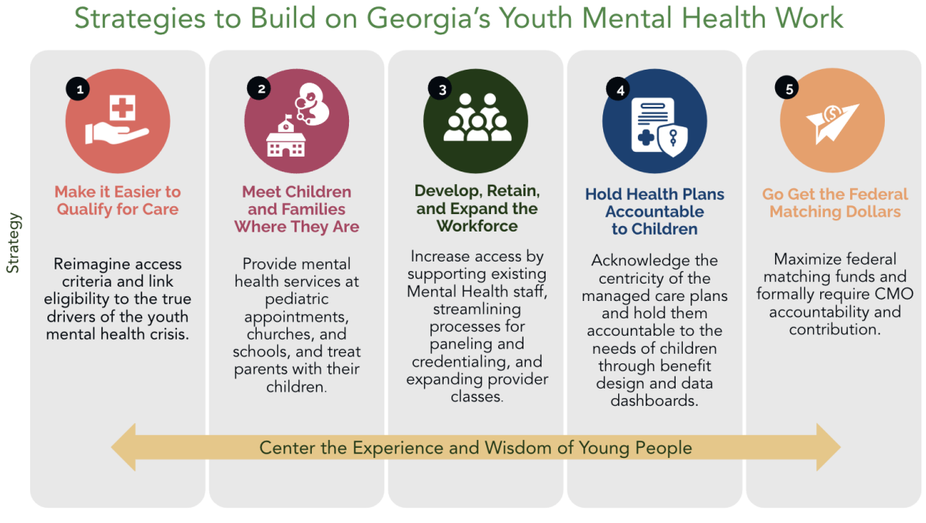
[1] https://pubmed.ncbi.nlm.nih.gov/25444653/
[2] https://www.choa.org/give/vision/care-and-experience/behavioral-and-mental-health
[3]https://www.ruralhealthinfo.org/toolkits/mental-health/4/population-considerations/youth#:~:text=Recent%20research%20highlights%20that%20rural,mental%20health%20of%20rural%20youth
[4]https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

When we talk about Medicaid as it currently exists in Georgia, we are talking about children. Fifty-three percent of all children in Georgia are covered by Medicaid and the Children's Health Insurance Program (CHIP). When you look at all enrollees of Medicaid, 69% are under the age of 18. Children and adults in rural Georgia are enrolled in Medicaid at almost double the rates of Georgians in cities. If we are going to accomplish mental health change for children, Medicaid needs to not only be part of the conversation but is the main lever.

Through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), a Medicaid program, children are uniquely entitled to have everything they need to grow up healthy. This entitlement can be accessed to provide preventive and therapeutic services for children and has an uncapped federal match as long as Georgia provides the state expenditure.

CMOs are more and more playing a central role in administering benefits to youth. Given that Georgia is currently undergoing a re-procurement process for its CMO contracts, there is a unique opportunity to ensure that benefits and accountability for youth mental health are explicitly defined.

Conversations with over 100 stakeholders from public systems, advocacy organizations, clinical providers, philanthropy, and the state legislature on both sides of the issue - has led to a distillation of five strategies. These strategies build on the incredible work that Georgia is already doing, the clear passion and care stakeholders on both sides of the aisle have for children and have specific and achievable opportunities.



The next section outlines the specific opportunities Georgia can take immediately, assigned to system players. None of these opportunities require legislative action - all can be done administratively (though appropriations would support efforts).

TOP 7 OPPORTUNITIES

1. **DCH:** Create a CHIP-HSI (Health Service Initiative).
2. **Governor's Office, DCH, DBHDD** & **DFCS**: Create a Directed Payment Program for foster youth and high acuity youth.
3. **FQHCs**: Submit State Plan Amendments (SPAs) to Add AMFTs, ASWs, and MFTIs as billable provider types.
4. **DFCS, Dekalb County** & **Mental Health Providers**: Obtain federal matching dollars by doing Medicaid Administrative Claiming (MAC) through benefits design, directed payments, time tracking, and claiming consultants.
5. **DCH:** Submit 1115 Waiver for Medicaid Services for Youth in Correctional Settings.
6. **Governor's Office & State Legislature:** Create a Health Care Tax on CMOs to generate state share of Medicaid expenditures.
7. **DCH:** Explore Tobacco and Opioid Settlement funds as source for state share of Medicaid expenditures (including CHIP-HSI).

OPPORTUNITIES BY SYSTEM

Governor's Office

A. Support High Acuity Youth with Care Coordination and Wraparound Services.
B. Create a Health Care Tax on CMOs to generate state share of Medicaid expenditures.

DBHDD (in collaboration with DCH)

A. Support High Acuity Youth with Care Coordination and Wraparound Services.
B. School-Based Mental Health: Require Reimbursement & Standardize Claims Infrastructure.

DCH

A. CMO Contracts: Make It Easier to Qualify for Care.
B. CMO Data & Accountability.
C. Submit 1115 Waiver for Medicaid Services for Youth in Correctional Settings.
D. CHW State Plan Amendments.
E. Create a CHIP-HSI.
F. Partner with Philanthropy to Streamline Paneling & Credentialing.
G. Partner with Philanthropy to Support Data, Accountability, and Oversight for CMOs.
H. Explore Tobacco and Opioid Settlement funds as source for state share of Medicaid expenditures (including CHIP-HSI).
I. Enhanced Payments for Pediatric Primary Care Offering Child-Parent Psychotherapy.

FQHCs

A. Submit State Plan Amendments (SPAs) to Add AMFTs, ASWs, and MFTIs as billable provider types.

DFCS

A. Obtain federal matching dollars by doing Medicaid Administrative Claiming (MAC).
B. Create a benefit under the CMO contracts for foster youth and high acuity youth.
C. Create a Directed Payment Program for foster youth and high acuity youth.

Philanthropy

A. Uplift the wisdom, experience, and agency of young people.
B. Capacity Building for Paneling & Credentialing at DCH.
C. Capacity Building for Data & Accountability at DCH.
D. Funding FQHC initial adoption of Associates and Interns.
E. Support CMO Benefit Design for High-Need Youth.
F. Support education/outreach to providers about how to bill for child-parent psychotherapy and dyadic models.
G. Explore S-CHIP Health Service Initiative (HSI) for early childhood.
H. Build a network for providers to be able to do administrative claiming.

Providers

A. **Pediatric Providers:** Utilize child-parent psychotherapy CPT codes for parents of children ages 0-3.
B. **School-Based Providers**: Provide Community Health Worker (CHW) Telehealth for APEX & School-Based Health.
C. **Care Providers & CMOs:** Use GaHIN to exchange health information and electronic clinical and social care referrals.
D. **Community Providers**: Training for pre-psychosis signs and symptoms (aka "first break work").

OPPORTUNITIES IN DETAIL

DBHDD, DCH, DFCS & CMOs

Support High Acuity Youth with Care Coordination and Wraparound Services

Background

Youth with the highest and most complex needs pose a particular challenge for Georgia's care systems. Approximately 65% of children in the Department of Juvenile Justice's long-term facilities have a mental health diagnosis severe enough to require ongoing treatment. Georgia is already making strides to address this crisis with the establishment of the Multi-Agency Treatment for Children (MATCH) through HB1013, and the exploration of the Georgia Youth Innovation Campus to reimagine the continuum of care for system involved youth.

This work can be further amplified and supported through benefit design in CMO contracts. Directed payment strategies dictate a bundle of services and direct CMOs to pay providers according to specific rates or methods, for example through minimum payment rates for certain types of providers or required participation in value-based payment arrangements.

Opportunities

1. **Create a Care Coordination/Wraparound benefit, or Directed Payment Strategy, for high-acuity youth in CMO contracts that encompasses:**
   - **Assertive Community Treatment (ACT):** DBHDD provides ACT, a community-based alternative to hospitalization, for people who have a severe and persistent mental illness. Research shows that ACT "reduces hospitalization, increases housing stability, and improves quality of life for people with the most severe symptoms of mental illness."
   - **Discharge support for all children transitioning from residential care**: this is a standard of care that CMOs provide in many states. A residential bed, without wraparound discharge support, will inevitably be filled again with those that were discharged; 30-60-90 day support at a minimum is critical to reduce recurrence.
   - **Tiered Care Coordination:** this is a fundamental part of wraparound support, particularly for youth that are a part of multiple systems (behavioral health care, child welfare). DBHDD provides tiered care coordination.
   - **In-lieu-of services including transitional housing or nutrition**: states can submit 1115 Waivers to address health-related social needs.

- **Primary Care Physician (PCP) communication for all crisis, emergency department (ED), and inpatient stays**: Georgia physicians have shared that when a patient has an ED visit that results in referral or medical stabilization at an inpatient facility, the primary care home gets lost in the process. Once the patient re-engaged with their PCP, the physician does not have the context or information to support the patient. A requirement for communication back to the PCP from these facilities and services can be written into CMO contracts.

2. **In collaboration with DJJ and DFCS, embed the use of this package of benefits into the Georgia Youth Innovation Campus and other residential care settings serving these high-acuity youth.**

Examples

- As of February 2024, four states (Arizona, New York, Oregon, and Washington) have 1115 waivers approved to cover rent/temporary housing and utility costs for up to 6 months.

- NY has had a State Plan Amendment approved to add high fidelity wraparound for children and youth in their Health Homes Program. This includes medication management, crisis response, therapy, care coordination case management, and parent and peer partner work. The rates can be found here.

DBHDD

School-Based Mental Health: Require Reimbursement & Standardize Claims Infrastructure

Background

The Georgia Apex Program (Apex), funded by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), strives to build capacity and increase access to mental health services for school-aged youth, Pre-Kindergarten to 12th grade, throughout the state. Apex operates in over 500 schools across the state, 78% of which are in rural areas - and rural adults and children have higher rates of Medicaid enrollment. The majority of students using Apex have managed care.

Opportunities

1. **Require reimbursement from all insurers for school-based mental health services.** These services are already taking place at school-based health centers across Georgia - including telehealth in some places. Making these centers, schools, and districts in network with insurers and requiring reimbursement from CMOs, while requiring initial administrative cost and burden, would ultimately bring a significant amount of dollars back to these systems.

2. **Standardize the Claims Infrastructure.** Currently Apex sites do not use a standardized Electronic Health Record (EHR) system. This makes it difficult to coordinate care, plug into existing systems at hospitals and care providers such as GaHIN.

Examples

- California's Multi-Payer Fee Schedule establishes the minimum rates at which Care Management Organizations must reimburse school districts and school-linked providers for the provision of services to a student under the age of 26 at a school site, including on-campus, off-campus and mobile clinic locations.

GA Department of Community Health (DCH) & Care Management Organizations (CMOs)

Make It Easier to Qualify for Care

Background

Children on Medicaid must wait for a psychiatric diagnosis before being referred to mental health care, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) diagnosis is the sole authorizing condition for Medicaid funded mental health care. Data shows that youth are harming themselves at double the rates from ten years ago - a trend that existed before the pandemic and that is uniquely American. This data points out that the current youth mental health crisis is not pathological, but rather, linked to adversity. And thus, medical necessity to receive services must be linked to adversity to address the crisis. This work is already well underway in Georgia through HB1013, which directed DCH to study CMO authorization denials for child and adolescent behavioral health services. The Behavioral Health Commission is also considering how Social Determinants of Health (SDoH) can be linked to services provided.

Opportunities

1. **Redefine what qualifies as medical necessity to be consistent with EPSDT entitlements, which could include use of Adverse Childhood Experiences (ACES), social determinants of health, "suspected" diagnosis, housing instability.** CMOs can open Z-codes to allow billing for Adverse Childhood Experiences (ACEs) and Social Determinants of Health (SDoH) - these codes already exist but the CMOs need to "open" them to allow providers to bill for them.

2. **Remove the discretion of a CMO to deny a claim based on the absence of a qualifying diagnosis.** DCH can include this provision in CMO contracts and instead have them link child and adolescent behavioral health claims to a Z-code or "otherwise unspecified" code.

Examples

- California's Family Therapy Benefit allows families to obtain preventive therapy for an unlimited number of sessions if parents are experiencing stress that affects their children. Eligibility for the benefit also applies to youth under the age of 21 who have experienced a wide range of stressful events, including being "separated from a parent due to incarceration or immigration," experiencing the "death of a parent; foster home placement; exposure to domestic violence or other traumatic events, and lacking sufficient food and/or access to stable housing.

Resources Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes, CMS.

GA Department of Community Health (DCH) & Care Management Organizations (CMOs)

CMO Data & Accountability

Background

HB1013 has already laid a strong foundation for gathering and monitoring CMO data including the compliance with mental health parity, a minimum 85 percent medical loss ratio (MLR), the establishment of a Behavioral Health Care Workforce Data Base, and implementation of a state-wide system for sharing data relating to the protection of Children. But there are several areas where DCH can write more metrics and accountability measures into contracts.

Opportunities

1. **Write into CMO Contracts that they must track who gets what service, when, and where.** The first step towards understanding how well a CMO is serving its population is to measure which children and families are receiving what services, in what settings. Reporting on these basic metrics is written into CMO contracts in many states and is the first step towards both understanding how well your CMOs are serving their populations, and also holding them accountable.

2. **Create benchmarks for those metrics and accountability mechanisms if metrics are not met.** DCH can write into CMO contracts expectations for these metrics - for example, the 85% MLR benchmark exists because of HB1013. Similarly, DCH can set benchmarks for the percent of children they expect to receive mental and behavioral health services from CMOs. This can get specific as well: for example, DCH can write into contracts that 90% of youth leaving residential care receive wraparound services. The final step is ensuring that there is an accountability mechanism for CMOs that do not reach these benchmarks. Several states have innovative ways of holding CMOs accountable, including a minimum guaranteed spend, withheld capitation, and an indigent tax on CMOs.

Examples & Resources

- Exemplar CMO Contract Templates: North Carolina, Oregon, Nevada, Arizona

- Accountability mechanisms
  - Arizona: Minimum Guarantee Spend
  - Oregon: Withhold Capitation

- CMO Data Dashboards
  - **Iowa** – includes children's behavioral/mental health treatment and services by managed care plan as well as information on children's mental health waiver

services in the state's MCO Quarterly Performance Reports. It also outlines more general provider network access metrics such as provider count, number of members with access, and average distance in miles for both outpatient and inpatient behavioral health services.

- **New Hampshire** – shows a wide range of behavioral health measures including child-specific health measures like follow up after hospitalization for mental health-related conditions, readmissions for mental health conditions, care coordination, and polypharmacy metrics.

- **Virginia** – provides an interactive dashboard including vital financial information such as total amount paid, and average amount paid per member receiving behavioral health services. These metrics can be disaggregated by age group as well as program (managed care or fee-for-services) and type of behavioral health service.

GA Department of Community Health (DCH)

Medicaid Services for Youth in Correctional Settings

Background

Justice-involved youth report high rates of adverse childhood experiences that research demonstrates is linked to poor health outcomes, and approximately two-thirds of justice-involved youth have diagnosable mental health or substance use disorders. The SUPPORT Act prohibits states from terminating Medicaid eligibility for individuals under age 21 or former foster care youth under age 26 while incarcerated. The Consolidated Appropriations Act (CAA) of 2023 extended this requirement to CHIP as well and says that states are required to implement 12-month continuous eligibility for children in Medicaid and CHIP as of January 1, 2024. **Some states are using 1115 waivers to provide pre-release services to incarcerated youth beyond minimum CAA requirements.**

Opportunity

Submit a Section 1115 Waiver to allow pre-release services for youth in correctional settings. This waiver provides an opportunity to test transition-related strategies, the robust service array and reentry program that DJJ already has been in place, for youth in correctional settings,

Examples

- As of August 2024, 13 states have approved waivers (CA, IL, KY, MA, MT, NH, NM, OR, UT, VT, WA), and 11 have submitted waivers that are pending (AR, AZ, CO, CT, DC, HI, MD, NC, NJ, NY, PA, RI, WV).

Resources

- KFF: Section 1115 Waiver Watch: Medicaid Pre-Release Services for People Who Are Incarcerated.

- CMS guidance on the new Medicaid Reentry Section 1115 demonstration opportunity.

- "Medicaid's New Role in Advancing Reentry: Key Policy Changes." The Health and Reentry Project. Fall 2024.

GA Department of Community Health (DCH)
Add Community Health Workers

Background
Community Health Workers (CHWs) are frontline health workers who often share life experiences, language, ethnicity, and socioeconomic status with the community in which they serve, making them uniquely qualified to address social determinants of health. Several studies have shown that CHWs can improve the management of chronic conditions and help patients navigate access to care, but they also reduce health care costs.

Opportunity

Submit State Plan Amendments (SPAs) to add Community Health Workers (CHWs). Fifteen states across the US have SPAs for CHWs, and a SPA was recently submitted to add CHWs to CCBHCs in Georgia, but that only represents a small portion of where community members receive behavioral health services. Submitting SPAs for other service settings would allow CHWs to reach more individuals and widen the pipeline to increase the behavioral health workforce.

Examples

- 15 States have SPAs for CHWs: Arizona, California, Indiana, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Nevada, New York, North Dakota, Oregon, Rhode Island, and South Dakota.

Resources

- Updates and FAQs: Developing and Implementing a Medicaid State Plan Amendment to Authorize Community Health Worker Reimbursement. National Academy for State Health Policy (NASHP). August 2024.
- State Approaches to Community Health Worker Financing through Medicaid State Plan Amendments. National Academy for State Health Policy (NASHP). December 2022.
- Community Health Workers: Evidence of Their Effectiveness. Association of State and Territorial Health Workers.

GA Department of Community Health (DCH)
Create a CHIP-HSI (Health Service Initiative)

Background
Through the Children's Health Insurance Program (CHIP), states can develop Health Services Initiatives (HSIs) to improve the health of low-income children and youth- specifically, children under age 19 who are eligible for CHIP and/or Medicaid. HSIs are funded using a portion of a state's existing CHIP administrative dollars - up to a 10% cap of the total CHIP allocation. The federal share of the HSI project cost is funded at the state's CHIP match rate upon approval by the Centers for Medicare & Medicaid Services (CMS) of a state plan amendment (SPA).

Opportunity

Explore the creation of a CHIP Health Services Initiative (HSI). Georgia currently does not have any HSIs. DCH could explore creating an HSI focused on a specific youth mental health strategy. Some of these include wraparound services for high acuity youth, or dyadic care and child-parent psychotherapy for low-income families. The state would need to provide the state share of the funds to access the federal shares.

Examples

- 24 states have HSIs, with some states having multiple HSIs.
- These HSIs include programs around poison control, school health services, lead poisoning, maternal care, child nutrition, reproductive health and behavioral health.
- Florida used its CHIP-HSI to fund "Comprehensive School Health Services and Full Service School Programs."
- Arkansas used its CHIP-HSI to provide "intensive home and community-based support services to children/youth who are involved in the child welfare system and have serious mental challenges."

Resources

- MACPAC CHIP-HSI Fact Sheet, July 2019.

GA Department of Community Health (DCH):

Partner with Philanthropy to Streamline Paneling & Credentialing and Support Oversight

Background

The current paneling and credentialing system in Georgia is inefficient and cumbersome, creating significant obstacles for behavioral health providers seeking to serve Medicaid populations. The lack of streamlined processes and the duplication of registration requirements result in provider shortages and limiting care for Georgians. Additionally, despite legislative efforts aimed at addressing the behavioral health provider shortage, the structural inefficiencies within the system hinder their effectiveness.

Opportunities

1. **Partner with Philanthropy and Consultants to Streamline Paneling & Credentialing.** There are several national organizations that support streamlining this process, and philanthropy is uniquely positioned to support that type of work. Philanthropy can bring in these experts to analyze the current process and support implementation of improvements.

2. **Partner with Philanthropy and Consultants to Support Data, Accountability, and Oversight for CMOs.** The governor's budget includes 20 new oversight positions at DCH to monitor, evaluate, and support improvements in CMO performance. However, in addition to oversight, DCH will need to define what is being measured, including which children and families are receiving what services, in what settings.

Resource

- GHF legislative update: Wrapping up Georgia's 2024 legislative session.

GA Department of Community Health (DCH)

Explore Tobacco and Opioid Settlement funds as source for state share of Medicaid expenditures (including CHIP-HSI)

Background

Georgia stands to receive approximately $638 million under the settlement agreement, to be distributed among the state and local governments. Georgia has established the Georgia Opioid Crisis Abatement Trust to receive and administer these funds.

Opportunity

Explore Tobacco and Opioid Settlement funds as source for state share of Medicaid expenditures (including CHIP-HSI). These funds could serve as the state share of a Medicaid expenditure and can be put up for the federal match. For Georgia, this could be used to generate the state share of the funds for a Health Service Initiative.

Examples

- AL passed legislation that would send some of their settlement money to their Department of Mental Health for state Medicaid match.

- WI approved the use of settlement money to pay for room and board of Medicaid patients in need of SUD residential treatment.

- MI previously allocated opioid funds toward a Medicaid contingency management pilot (a recovery incentives program) (which launched on October 1st).

Resources

- "State Opioid Settlement Spending Decisions." National Academy for State Health Policy.

GA Department of Community Health (DCH)

Enhanced Payments for Pediatric Primary Care Offering Child-Parent Psychotherapy

Background

Child-parent psychotherapy is an evidence-based practice that treats the child and the caregiver(s) together, improving positive parenting skills through observation, coaching, and treatment through assessment, traditional therapeutic services, and rehabilitative services. Georgia's Infant and Early Childhood Mental Health Taskforce's Policy and Finance Working Group, convened by the Georgia Department of Early Care and Learning, has done incredible work to codify child-parent psychotherapy, and the Georgia Association for Infant Mental Health (GA-AIMH) has trained over 100 mental health clinicians across the state in Child-Parent Psychotherapy, but many providers are still not aware of this work, do not have the administrative capacity or incentive to implement this work. States can require CMOs to provide enhanced payments to providers, which can help improve provider participation.

Opportunity

Provide Enhanced Payments for Pediatric Primary Care Offering Child-Parent Psychotherapy. This can be done by providing an extra payment for each well-child visit that utilizes child-parent psychotherapy, or on a per-member-per-month (PMPM) basis.

Examples

- Maryland provides a $15 dollar payment for every well child or sick child visit in pediatric primary care for primary care practices that have achieved fidelity scores for healthy steps.
- Arkansas takes a PMPM approach ($3.44) for all pediatric primary care sites doing patient centered medical home with integrated BH. The payment mechanism was created by House Bill 1574.
- California pays fee for service (FFS) for a new set of qualifying codes, including Z-Codes under a new "Dyadic Benefit" that includes Z-Codes. This mechanism is closest to the work Georgia has already done coding of child-parent psychotherapy.

GA Division of Family and Children Services (DFCS)

Medicaid Administrative Claiming, Benefit Design, & Directed Payment Program

Background

Medicaid Administrative Claiming (MAC) reimburses for the linking, educating and planning related to services covered by Medicaid: Medicaid outreach, referral, coordination and monitoring, Medicaid eligibility intake and arranging transportation. State agencies need to put up an unmatched state dollar, called a Certified Public Expenditure (CPE), to draw down a federal match, called the Federal Financial Participation (FFP). This can be done in two ways: by amending contracts with providers (direct charge), and/or by tracking staff's reimbursable time (time-tracking).

In some cases, the services state agencies pay for through state dollars can and should be paid for by CMOs. One of the ways to hold CMOs accountable to providing these services is through benefit design: grouping a set of services or CPT codes, calling that a "benefit", and tracking utilization and outcomes. State agencies can also require CMOs to pay providers according to specific rates or methods, referred to as state directed payments.

Opportunities

1. **Obtain federal matching dollars by doing Medicaid Administrative Claiming (MAC)** DFCS's current budget is $1.3B, of which $639M is state funding. It does not appear that DFCS participates in MAC for these state dollars.
2. **Create a benefit under the CMO contracts for foster youth and high acuity youth** DFCS should determine for itself which set of services should be bundled into a benefit for foster youth. Opportunities include wraparound services and Assertive Community Treatment (ACT) teams.
3. **Create a Directed Payment Program for foster youth and high acuity youth.** In addition to creating a specific benefit for foster youth, DFCS can direct CMOs to pay providers under DFCS based on quality of care and predetermined measures.

Examples

- New Mexico increased annual revenue for its state Children, Youth and Families Department (CYFD) by more than $4million annually by tracking and claiming for reimbursable Medicaid administrative activities.
- Ohio's Department of Medicaid launched OhioRISE specialized managed care program for youth with complex behavioral health and multisystem needs featuring coordinated and integrated care for Ohio's behavioral health services.

Resources

- Directed Payments in Medicaid Managed Care Issue Brief. MACPAC. June 2023.
- Medicaid Administrative Claiming (MAC) Explainer Video. Public Works Alliance.

DeKalb County

Medicaid Administrative Claiming

Background

Medicaid Administrative Claiming (MAC) reimburses for the linking, educating and planning related to services covered by medicaid: medicaid outreach, referral, coordination and monitoring, medicaid eligibility intake and arranging transportation. State agencies need to put up an unmatched state dollar, called a Certified Public Expenditure (CPE), to draw down a federal match, called the Federal Financial Participation (FFP). This can be done in two ways: by amending contracts with providers (direct charge), and/or by tracking staff's reimbursable time (time-tracking).

Opportunity

Obtain federal matching dollars by doing Medicaid Administrative Claiming (MAC) DeKalb County, Georgia's fourth most populous county, does not currently participate in MAC. Given the investment DeKalb makes in public health, including youth violence prevention, there is a real opportunity here for a multi-million-dollar annual return through MAC. DeKalb County could institute the time-tracking themself, or there are several third-party claiming consultants that handle the administrative burden in return for a percent of reimbursement.

Example

- New Mexico increased annual revenue for its state Children, Youth and Families Department (CYFD) by more than $4million annually by tracking and claiming for reimbursable Medicaid administrative activities.

Resource

- Medicaid Administrative Claiming (MAC) Explainer Video Public Works Alliance.

Governor's Office & State Legislature

Create a Health Care Tax on CMOs to generate state share of Medicaid expenditures

Background

Under the Medicaid statute, states may generate their share of Medicaid expenditures through multiple sources, including health care-related taxes, sometimes referred to as provider taxes, fees, or assessments. In the last fifteen years, health care-related taxes have become a more common funding source for state Medicaid programs, with 49 states and DC having some sort of tax in place - on providers, hospitals and/or CMOs. These funds can then be used as the non-federal share to claim the federal matching funds.

Opportunity

Create a Health Care Tax on CMOs to generate state share of Medicaid expenditures. Georgia already taxes hospitals at a rate of 1.45% on their net profits and uses the funds to draw down federal Medicaid funds. To similarly create a tax on CMOs, Georgia must seek a waiver from CMS. This would have no impact on taxpayers as the taxes are reimbursed by the state and CMS.

Examples

- In Fiscal Year 2023, 18 states have have a CMO tax in place (AK, CA, DC, GA, IL, KS, LA, MD, MI, NH, NJ, OH, OR, PA, RI, TX, WA, WV) - (though Georgia's is referred to as a provider tax).

- New York Tax Waiver Application that if approved, will bring in net revenues of approximately $1.4 billion per year for New York State.

Resources

- "Health Care-Related Taxes in Medicaid." MACPAC. May 2021.

- "The Medicaid MCO Tax Strategy." Fiscal Policy Institute. March 2024.

Federally Qualified Health Centers (FQHCs)

Add Associates and Interns

Background

Under the federal Health Resources and Services Administration (HRSA), FQHCs are usually restricted in which providers are eligible under PPS rates, usually to licensed providers. During the COVID-19 pandemic, the Federal government allowed pre-licensed staff that are still acquiring their service hours, such as Associate Marriage and Family Therapists (AMFTs), Associate Social Workers, (ASWs), and Marriage and Family Therapist Interns (MFTIs) to be added to the list of providers eligible for PPS rates. Since the pandemic, some states have submitted State Plan Amendments (SPAs) to extend that flexibility permanently. Associates and interns are still overseen by licensed providers and because the claim is still submitted by a supervising billable provider, a Change in Scope of Service Request (CSOSR) is not required to begin billing for AMFTs, ASWs, and MFTIs.

Opportunity

Submit State Plan Amendments (SPAs) to Add AMFTs, ASWs, and MFTIs as billable provider types under PPS rates. FQHCs are rooted in community and often the safety net for the most vulnerable populations. Expanding who is eligible to provide services under PPS rates not only sustains the operations of the FQHC, but also incentivizes pre-licensed providers to stay at these critical community hubs instead of leaving for private practices once obtaining licensure.

Examples

- Georgia just had a State Plan Amendment approved to allow licensed professional counselors, licensed marriage and family therapists, and certified peer specialists to deliver services and be reimbursed by FQHCs.

- California approved a State Plan Amendment to add Associate Clinical Social Worker (ASW) and Associate Marriage and Family Therapist (AMFT) as billable provider types in 2023.

Resource

- CA Department of Health Care Services. Associate Clinical Social Worker and Associate Marriage and Family Therapist Services for Federally Qualified Health Centers and Rural Health Clinics, May 2020.

Philanthropy

Bring together funding and community support that improve public systems

Background

Philanthropic organizations large and small have been investing in child and adolescent mental health in Georgia for many years through grants and relationships with nonprofits. The Mental Health Funders Collaborative (MHFC) was formed in 2016 to bring these funders together in a coordinated effort to learn and work alongside nonprofits, public agencies, and other partners. By pooling resources, MHFC supports efforts that help children and adolescents, especially those facing the biggest challenges, get better mental health care. Today, MHFC is a group of over 40 funders, from family foundations to corporate and community foundations, all working in lockstep to improve Georgia's mental health system and give every child a fair shot at wellbeing. While philanthropic funding is essential, it remains modest compared to the scale of public systems and Medicaid. Therefore, philanthropy must strategically leverage both financial and social capital to help drive transformative change within public systems.

Opportunities

1. **Uplift the wisdom, experience, and agency of young people.** Fund and work with local organizations like YouthMove, Partnership for Southern Equity and Amplify Pledge that are already rooted in communities and have relationships with youth. Support could look like funding their existing efforts, funding and collaborating on outreach and advocacy campaigns, and using social and relational capital to connect these organizations to decision-makers.

2. **Capacity Building for Paneling & Credentialing at DCH.** DCH has expressed a desire to reexamine and streamline its paneling and credentialing process for providers, which will require external consultant support. Philanthropy can support this capacity building.

3. **Capacity Building for Data & Accountability at DCH.** Considering the recent re-procurement of CMO contracts, many of Georgia's public institutions and politicians are calling for data, accountability and monitoring. The Governor's budget includes 20 oversight positions for CMO contracts at DCH. Philanthropy fund and work with local institutions \to develop a data dashboard that tracks which youth are receiving what services in which settings and fund the onboarding and training of the new DCH oversight positions.

4. **Funding FQHC initial adoption of Associations and Interns.** If FQHCs submit state plan amendments to add AMFTs, ASWs, and MFTIs as billable provider types, it will take at least one year for these costs to be offset by the new PPS rates. Philanthropy

can provide one-time funds to cover these gaps which will incentivize FQHCs to submit the state plan amendment and ultimately result in a sustainable revenue flow.

5. **Support CMO Benefit Design for High-Need Youth.** Use relational capital to push for this benefit design. DCH, DBHDD, and the governor's office are all zeroed in on high-need youth as a critical group that needs its support reimagined. Philanthropy can use its relational capital to hone these public systems in on a CMO benefit that includes wraparound services, transitional housing in-lieu-of benefit, tiered care coordination benefit. Additionally, philanthropy could fund the initial year cost of wraparound services before administrative claiming dollars kick in.

6. **Support education/outreach to providers to learn about and how to bill for child-parent psychotherapy and dyadic models**. Georgia has done incredible work to codify child-parent psychotherapy, but many providers are still not aware of this work, or do not have the administrative capacity to implement this work. Philanthropy could support GEEARS with its outreach effort and/or fund the administrative support to providers to establish this practice.

7. **Explore S-CHIP Health Service Initiative (HSI) for early childhood**. Through the Children's Health Insurance Program (CHIP), states can develop Health Services Initiatives (HSIs) to improve the health of low-income children and youth- specifically, children under age 19 who are eligible for CHIP and/or Medicaid. HSIs are funded using a portion of a state's existing CHIP administrative dollars - up to a 10% cap of the total CHIP allocation. The federal share of the HSI project cost is funded at the state's CHIP match rate upon approval by the Centers for Medicare & Medicaid Services (CMS) of a state plan amendment (SPA). 24 states have HSIs, with some states having multiple HSIs, and these include programs around poison control, school health services, lead poisoning, maternal care, child nutrition, reproductive health and behavioral health. Philanthropy could use its relational capital to urge public systems to not only develop an HSI, but to utilize it for early childhood efforts such as the implementation of child-parent psychotherapy and dyadic models.

8. **Build a network for providers to be able to do administrative claiming.** Many providers do not participate in Medicaid Administrative Claiming (MAC) because the cost of tracking data and submitting claims does not offset the reimbursement received. There are two ways philanthropy could support here: First, there are several third-party claiming consultants that handle the administrative burden in return for a percent of reimbursement. Philanthropy could procure these third-party organizations and cover their cost. At a larger scale, philanthropy could build and fund a network that providers could join through which the third-party consultant handles the administrative claiming.

Pediatric Providers

Utilize child-parent psychotherapy CPT codes for parents of children ages 0-3

Background

Research demonstrates that early prevention and treatment for children birth to 5 years old is more beneficial and cost-effective than attempting to treat emotional difficulties and their effects on learning and health after they become more serious, and evidence-based child trauma treatments return $3.64 per dollar of cost. In August 2024, the US Surgeon General released an advisory on the mental health and well-being of parents emphasizing the unique stressors parents and caregivers face and stating that the leading cause of pregnancy-related deaths in the US is mental health conditions. Additionally, parents visit the doctor most frequently and regularly in the first three years of their child's life for well-child visits thus providing a unique opportunity for physicians to have access to new parents.

Opportunity

Pediatric Providers: Utilize child-parent psychotherapy CPT codes for parents of children ages 0-3. Child-parent psychotherapy is an evidence-based practice that treats the child and the caregiver(s) together, improving positive parenting skills through observation, coaching, and treatment through assessment, traditional therapeutic services, and rehabilitative services. Georgia's Infant and Early Childhood Mental Health Taskforce's Policy and Finance Working Group, convened by the Georgia Department of Early Care and Learning, has done incredible work to codify child-parent psychotherapy, and the Georgia Association for Infant Mental Health (GA-AIMH) has trained over 100 mental health clinicians across the state in Child-Parent Psychotherapy, but many providers are still not aware of this work, or do not have the administrative capacity to implement this work.

Resources

- "The Basics of Infant and Early Childhood Mental Health: A Briefing Paper." Zero to Three. 2017.

- "Parents Under Pressure." The U.S. Surgeon General's Advisory on the Mental Health & Well-Being of Parents. 2024.

School-Based Providers

Provide Community Health Worker (CHW) Telehealth for APEX and School-Based Health

Background

With 75% of Georgia's counties being rural, teens in these areas face higher rates of behavioral health issues, anxiety, and depression than those in urban areas. Yet, 65 rural Georgia counties lack even a single pediatrician. To increase access to care, expanding telehealth services and broadening the roles of providers, like community health workers (CHWs), are key solutions for rural Georgia.

Opportunity

School-Based Health Providers: Deliver Community Health Worker (CHW) Telehealth for APEX. Furthermore, Telehealth organizations are often set up to more easily submit claims. Submitting claims via a common statewide system could be built into the telehealth contracts.

Care Providers & CMOs

Use GaHIN to exchange health information and electronic clinical and social care referrals

Background

GaHIN, the Georgia Health Information Network, connects providers with electronic health information. GaHIN holds both clinical data and also DFCS information such as youth that are currently in residential facilities or foster care. Therefore, they have the infrastructure to be able to connect the dots between providers and facilities - a gap identified by providers.

Opportunity

Use GaHIN to exchange health information and electronic clinical and social care referrals. In particular, CMOs must incentivize providers to use GaHIN. Georgia Unify, GaHIN's social care referral platform, facilitates referrals and coordination of services to close the referral loop for patients.

Resource

- "Aetna Provides Grant to Georgia Health Information Network for SDOH Referral Pilot Project." Sep 2023.

Community Providers

Training for pre-psychosis signs and symptoms (aka "first break work")

Background

The initial phase of psychosis, known as early psychosis or first episode psychosis (FEP), marks a critical time in the lives of those experiencing these symptoms. Early identification and access to proven, effective care is essential. With timely treatment, both short- and long-term outcomes can improve significantly, offering hope for a healthy, fulfilling life.

Opportunity

Training for pre-psychosis signs and symptoms (aka "first break work"). When the first signs of psychosis are carefully screened and managed—or if early symptoms (called prodromal symptoms) are identified—the onset of schizophrenia can be prevented or lessened. Timing is critical. Training community providers to recognize these early symptoms within the first year is essential for effective intervention.

Examples

- **Texas**: Coordinated Specialty Care for First Episode Psychosis (CSC-FEP) program provides outpatient mental health treatment to persons experiencing an early onset of psychosis. Services are provided to empower the person's ability to lead a self-directed life within the community.

- **Illinois**: FIRST.IL is a specialized treatment approach that helps individuals who are between the ages of 14 to 40 and who have had a treated or untreated psychotic illness for no more than 18 months.

- **California:** Early Psychosis Intervention (EPI) programs like Coordinated Specialty Care (CSC) provide evidence-based care for individuals experiencing psychosis and their families.

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Georgia Health Information Network
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Georgia Health Policy Center at GSU
Georgia Mental Health Consumers Network
Georgia Recovery Council of Georgia
Georgia State Legislature
Georgia Watch
Georgians for a Healthy Future
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Voices for Georgia's Children

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Mental Health Funders Collaborative
Enhancing the Wellbeing of Georgia's Youth

GEORGIA'S USE OF TELEHEALTH IN SCHOOL-BASED MENTAL HEALTH

October 2025

Increasing rates of anxiety, depression, and behavioral health disorders in youth directly impact their social development, overall well-being, and academic performance.[1] The implementation of school-based mental health (SBMH), whereby services are delivered and received in a school setting, is critical to helping students have greater access to mental and behavioral health services. Successful SBMH programs often use an effective service-delivery ecosystem that leverages the Multi-tiered System of Supports (MTSS). This system comprises three tiers: (1) Universal Prevention, (2) Early Intervention, and (3) Intensive Intervention. To best serve students and families across all three tiers, many different modes of delivery are used. Beyond traditional in-person services, alternative modes of care such as telehealth have become increasingly important in alleviating common barriers to care like transportation challenges and behavioral health workforce shortages.

School-based Mental Health Workforce Challenges

Research supports the following recommended national ratios for the SBMH workforce:[2]

- 250-to-1 for school counselors; and
- 500-to-1 for school psychologists.

In the 2023-2024 school year, the state of Georgia fell below the student-to-school psychologist recommendation with a ratio of 2,018-to-1.[3] Schools nationally have reported that they are unable to meet these recommended ratios,[2] especially in rural communities.[4] Georgia, among several other southern states, has one of the largest mental health workforce shortages in the United States.[5] Out of the 159 Georgia counties, 151 have a mental health workforce shortage. Most counties that suffer from this shortage are rural, with only two Atlanta metro counties identified as having partial shortages.[6] This suggests that SBMH programs in Georgia's rural areas are critically understaffed. School-based clinicians are also challenged by providing services within the limited hours of a school day.[7] This often translates into having less flexibility when scheduling appointments and serving students and families, especially during the summer months when caseloads, students' needs, and access to families can vary widely. Related workforce barriers include navigating differences in lengths of work contracts, such as academic school year versus year-round.[8]

Telehealth and the Georgia Apex Program: An Expansion of the Model

Within SBMH programs, telehealth has been used to address some of these workforce challenges by improving access to mental health services and filling equity gaps that were intensified during the COVID-19 pandemic.[9] Services delivered using telehealth can include psychiatric evaluations, crisis intervention, and individualized therapy.[10] Within MTSS, these are considered Tier 2 and Tier 3 services.

The Georgia Apex Program (Apex) is an SBMH program grounded in the MTSS framework. With funding by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Children, Young Adults & Families, the program recently completed its 10th year of implementation. Through partnerships with local community behavioral health agencies, Apex currently provides mental health services in more than 800 schools across 135 school districts with 256 clinicians. The program provides services in rural, suburban, and urban areas throughout the state of Georgia in K–12 public schools.

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DBHDD

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strengthening pathways for resilient communities and lifelong wellness

Georgia Health Policy Center

Monthly programmatic reports completed by Apex providers demonstrate that telehealth has become a vital resource in SBMH delivery in Georgia. Program data compiled to analyze the prevalence of telehealth services delivered throughout the state indicates that in Year 8 and Year 9 of program implementation, 91% of Apex providers used telehealth to deliver SBMH services. The number of services delivered increased from more than 35,000 in Year 8 to more than 37,000 in Year 9. This, combined with Apex data collected during Years 6 and 7 (i.e., during the COVID-19 pandemic), suggests a steady increase in the adoption of telehealth, alongside expansion in the number of SBMH services delivered and schools served across the state.[9,11,12] Apex data offers a snapshot of telehealth's growing role in improving access and bridging service gaps, particularly for students and families in Georgia who experience barriers to receiving in-person care.

Telehealth for the Apex School-Based Mental Health Services in Year 10

In Year 10 of Apex (2024-2025 school year), more than 36,000 Tier 2 and Tier 3 mental health services were provided through telehealth. Further analysis of data reveals that Tier 3 services (targeting students with identified mental health diagnoses) accounted for most of the telehealth care delivered (Figure 1). Tier 2 services often included behavioral health assessments, classroom observations, and other moderate supports, while Tier 3 services included more intensive interventions such as individualized outpatient therapy, case and medication management, behavioral health assessments (such as the *Child and Adolescent Needs and Strengths*), community support individual services, family outpatient services, diagnostic assessments, and psychiatric treatment. Telehealth services were especially important in areas where in-person services were limited. It is important to note that the most recent Apex data demonstrates equal use of telehealth services in both rural (51%) and urban (49%) areas of the state (Figure 2). This finding suggests access to telehealth might help mitigate barriers to mental health services based on location alone.

- A total of 4,119 Tier 2 services were delivered via telehealth during Year 10.
- In contrast, 32,178 Tier 3 telehealth services were provided the same year.

Figure 1. Trends in telehealth service utilization across Tier 2 and Tier 3 Georgia Apex school-based mental health services in Year 10 (2024-2025)

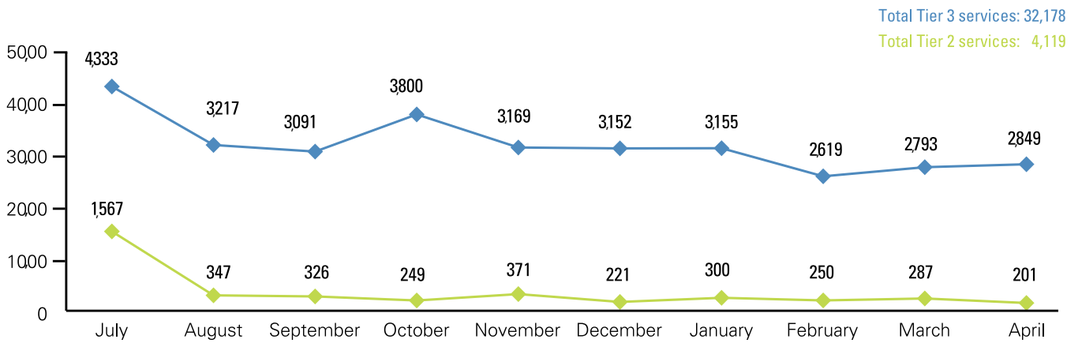
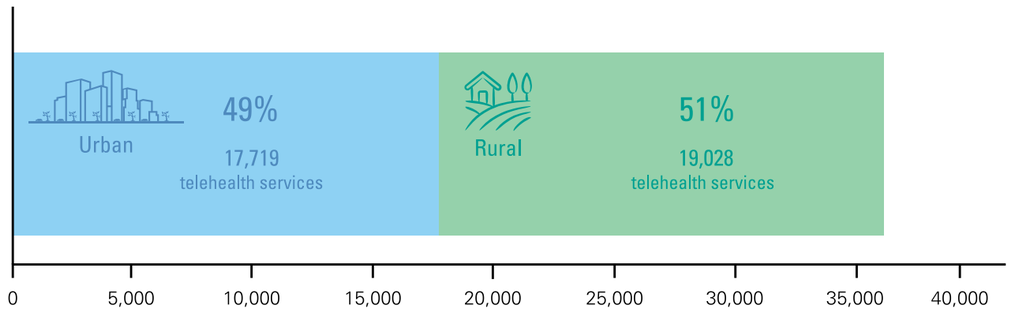


Figure 2. Telehealth service utilization by location in Year 10 of the Georgia Apex Program



The Regional Map with Apex Service Areas displays the percentage of schools in each region of Georgia that are Apex schools.

Among all telehealth services reported, the top five services were:

- Behavioral health assessment (Tier 3) — 7,144 encounters;
- Individual outpatient services (Tier 3) — 3,046 encounters;
- Community support individual services (Tier 3) — 2,947 encounters;
- Medication management (Tier 3) — 1,749 encounters; and
- Response to intervention assessment and referral services (Tier 3) — 1,741 encounters.

Combined, these services made up 57% of all Year 10 telehealth activity, highlighting the critical role telehealth plays in meeting the clinical needs of students requiring a higher level of care or ongoing support.

Data from Year 10 (2024) shows that telehealth utilization was higher during the summer months in comparison to any other time of the year. In July 2024, 5,900 total telehealth encounters were reported, while January 2025 had 3,455 total telehealth encounters. This trend suggests that telehealth is a vital tool in providing a continuity of care in the summer when school-based services are less accessible (see Figure 1). These data were extrapolated from a subset of data for the fiscal year and does not represent a full year of data.

Georgia Apex Program Laying Inroads for a Local Telehealth Pilot

In 2025, DBHDD received a $1 million appropriation to expand the reach of the Georgia Apex SBMH program through a telehealth pilot program. This pilot seeks to meet the growing behavioral health needs of youth and families in Georgia's rural areas despite workforce shortage across the state. DBHDD's Office of Children, Young Adults & Families is currently working with three approved Georgia Department of Administrative Services providers to conduct the pilot. Additionally, collaboration with the Georgia Department of Education Regional Education Service Agencies will help inform pilot outcomes.

Considerations and Recommendations

To enhance the implementation of telehealth in SBMH programs, which helps alleviate workforce shortages and supports a continuum of youth mental health services, the following recommendations should be considered:

1. Emphasize the utilization and impact of telehealth as a solution to SBMH challenges (e.g., SMBH workforce shortages and continuum of care service delivery).
2. Prioritize utilizing or creating funds for telehealth infrastructure, which may include costs for technology, training, secure internet connection, and broadband infrastructure in rural areas, among other things.
3. Telehealth providers, schools, and school districts should work collaboratively to implement telehealth, help educate communities, and reduce concerns and misconceptions about telehealth safety, treatment fidelity, and confidentiality.
4. In high-need schools and communities, providers and schools may choose to partner with telehealth platforms to expand the delivery of Tier 2 and 3 services.
5. Monitor telehealth utilization data trends across the state (e.g., seasonal spikes, service types) to inform ongoing implementation strategies that support continuous, appropriate service delivery to students, especially during out-of-school times.
6. Advocate for remote client monitoring to be included in Medicaid reimbursement for telehealth.
7. Integrate contracted, out-of-state, licensed mental health professionals into Georgia SBMH service delivery through the Professional Counselors Licensure Compact Act (HB 395)[13] and other means.[14]

Conclusion

Implementing telehealth has not only helped behavioral health providers overcome geographical limitations in service delivery but has also expanded access to mental health services for a broader range of students facing barriers, particularly those in rural communities of Georgia. National and local data demonstrate that telehealth offers an effective solution to the behavioral health workforce shortage. Locally, the Georgia Apex Program data show that telehealth facilitates not only increased access to services during summer months but also

helps meet the clinical needs of students requiring ongoing support or higher levels of care. This highlights the program's strength in supporting a continuity of care for students and families throughout the full calendar year. Implementing telehealth service delivery and incorporating it within SBMH programs can expand reach and address challenges to accessing quality mental health services faced by many youths and families across Georgia.

References

1. Sappenfield, O., Alberto, C., Minnaert, J., et al. (2024, October). Adolescent mental and behavioral health, 2023. In: *National Survey of Children's Health Data Briefs* [Internet]. Rockville, MD: Health Resources and Services Administration. https://www.ncbi.nlm.nih.gov/books/NBK608531/
2. Panchal, N., Cox, C., & Rudowitz, R. (2022, September 6). The landscape of school-based mental health services. *KFF*. https://www.kff.org/mental-health/issue-brief/the-landscape-of-school-based-mental-health-services/
3. National Association of School Psychologists. State shortages data dashboard. nasponline.org/about-school-psychology/state-shortages-data-dashboard
4. National Center for Health Workforce Analysis. (2024, November). *State of the behavioral health workforce, 2024*. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf
5. Peake, J. (2025, March 24). Cities with the largest shortage of mental health workers. *Addiction-REP*. https://addiction-rep.com/resources/cities-with-the-largest-shortage-of-mental-health-workers/
6. Eldridge, E. (2024, January 5). UGA student on 'digital divide' in mental health care and high speed internet study. *GPB News*. https://www.gpb.org/news/2024/01/05/uga-student-on-digital-divide-in-mental-health-care-and-high-speed-internet-study. thecurrentga.org+9gpb.org+9gpb.org+9
7. Gencarella, L. (2023, September 29). *Private practice vs. school based therapy: What's the difference*. https://speakingsensory.com/private-practice-vs-school-based-therapy-whats-the-difference/
8. Georgia Appleseed Center for Law & Justice. (2023, January). *Establishing a school based behavioral health program*. https://gaappleseed.org/wp-content/uploads/2023/01/GAA-SBBH-Handbook.pdf
9. Georgia Apex Program. (2021). *Georgia Apex Program: Service delivery during the COVID-19 pandemic*. Georgia Health Policy Center. https://ghpc.gsu.edu/download/georgia-apex-program-service-delivery-during-the-covid-19-pandemic/
10. County Health Rankings & Roadmaps. (2024). *Telemental health services*. University of Wisconsin Population Health Institute. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/telemental-health-services
11. Georgia Apex Program. (2023). *Georgia Apex Program: Year 8 evaluation slide deck*. Georgia Health Policy Center. https://ghpc.gsu.edu/download/apex-year-8-evaluation-slide-deck/
12. Georgia Apex Program. (2024). *Georgia Apex Program: Year 9 evaluation slide deck*. Georgia Health Policy Center. https://ghpc.gsu.edu/download/apex-year-9-evaluation-slide-deck/
13. Georgia General Assembly. (2021). *House Bill 520* (2021-2022 Regular Session). https://www.legis.ga.gov/api/legislation/document/20212022/197345
14. McCullough, T. (2025, April 28). Trends in state strategies to improve the behavioral health workforce. *National Academy for State Health Policy*. nashp.org/trends-in-state-strategies-to-improve-the-behavioral-

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Current GMAP Program Overview

The Georgia Mental Health Access in Pediatrics (GMAP) Program is a HRSA-funded initiative that increases access to pediatric behavioral health care statewide. Launched in 2021, GMAP equips pediatric primary care providers with the knowledge and support needed to assess, treat, and refer children with behavioral health needs.

Current program components:

1. Teleconsultation – Two phone-based consultation lines
    - CHOA behavioral health specialists
    - Augusta University child psychiatrists
2. Provider Training & Education
    - Through Project ECHO telementoring
        1. CHOA and GA-AAP facilitate implementation of Behavioral Health ECHOs
3. Care Coordination Resources
    - County-based behavioral health provider directory

GMAP is implemented through a partnership between:

- DBHDD Office of Children Young Adults and Families (lead)
- Children's Healthcare of Atlanta
- Georgia AAP → in collaboration with Augusta University / MCG + Children's Hospital of Georgia
- Georgia State University Center of Excellence for Behavioral Health & Wellbeing

Current annual cost: ~$1M (baseline infrastructure and service operation)

Why Expansion Is Needed

To move from regional coverage to true statewide reach, GMAP requires:

- Unified teleconsultation platform and centralized call line
- Increased psychiatry support capacity (residents + supervising faculty)
- Engagement of perinatal psychiatry (PEACE for MOMS) and school-based systems (e.g., GA APEX)
- Coordinated triage to appropriate networks, beyond CHOA-only providers

This will allow us to:

- Serve more rural and underserved pediatric populations
- Expand consultation availability and hours
- Improve warm handoffs and referral outcomes
- Connect maternal mental health and pediatric behavioral health access
- Expand capacity of workforce by engaging psychiatry residents in medical programs

Alignment Opportunities with State Priorities

- Perinatal mental health integration (PEACE for Moms & moms-to-babies continuum) -- model similar to Texas
- School-based system coordination (GA APEX)
- System of Care goals under BHCC
- Behavioral health workforce development

Potential academic/clinical partners:

- Emory School of Medicine
- Augusta University / MCG
- Morehouse School of Medicine
- Mercer University (previously engaged; expansion stalled due to no funding in the initial HRSA proposal)
- Philadelphia College of Osteopathic Medicine (PCOM) Georgia (osteopathic psychiatry pipeline)

Cost Model

Current model delivers:

- Consultation *(telepsychiatry guidance to PCPs)*
- Referrals
- Training and workforce development

To scale statewide and include new partners, ensure 40–60 hrs/wk consultation coverage, perinatal linkages, and a central triage line:

Estimated expansion cost:

$2M–$2.5M annually for infrastructure & consultation. These additional funds support program expansion, as well as funding for resident involvement.

This is not direct care — this is the infrastructure and expert support system enabling PCPs to care for children and families.

Our Ask

We are seeking funding and strategic guidance from state leadership/BHCC to:

1. Establish a centralized state teleconsultation call line
    - Statewide triage -- appropriate partner networks
2. Expand psychiatric consultation workforce
    - Fund residency involvement across four medical schools
3. Integrate perinatal & pediatric access
    - Align with PEACE for Moms and APEX schools
4. Pilot new regional consultation hubs
    - Build toward universal access for all counties

Summary

1. What we do now: Provide pediatric BH consultation, training, and care navigation statewide (~$1M)
2. What we want to do: Expand to fully statewide, coordinated maternal-child BH access
3. What we need: ~$2–$2.5M & partnerships across Georgia's medical education system and existing BH infrastructure

2024

SEPTEMBER

GEORGIA MENTAL HEALTH ACCESS IN PEDIATRICS

IMPACT REPORT

Program Partners

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN
Georgia Chapter

AUGUSTA UNIVERSITY
MEDICAL COLLEGE OF GEORGIA

Children's
Healthcare of Atlanta

CENTER OF EXCELLENCE FOR CHILDREN'S BEHAVIORAL HEALTH
integrating research, policy, and practice

D·B·H·D·D
Georgia Department of Behavioral Health and Developmental Disabilities

What is the Georgia Mental Health Access in Pediatrics (GMAP) Program?

GMAP helps pediatric providers take better care of children and adolescents with behavioral health concerns through provider education and improved access to behavioral health experts.

How Does GMAP Work?

Georgia Mental Health Access in Pediatrics

GMAP increases pediatric providers' comfort to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice through:

Provider Education

Project ECHO®

Project ECHO® is a collaborative model for behavioral health knowledge sharing and care management that helps clinicians and community providers better serve their patients through advanced curriculum and training, along with discussions on current case studies.

Behavioral Health Teleconsultation

Children's Healthcare of Atlanta & Georgia Chapter, American Academy of Pediatrics Advice Lines

Behavioral health specialists provide HIPAA compliant guidance on treatment and management of pediatric behavioral health conditions through telephonic consultation to providers.

Referral Network

Georgia-Specific Resource Directory

Care coordination services are available for the families that providers serve through a directory of behavioral health specialists, organized by county.

Because of the challenges to access behavioral health services, families often turn to their pediatric primary care providers first for behavioral health needs, yet many primary care providers do not have the necessary resources or knowledge to treat behavioral health conditions.

In May 2021, the GA-AAP surveyed its **1,414 members** about pediatric mental and behavioral health consultation needs. **54% to 82%** of responding pediatricians recommended the following: knowledge of behavioral and mental health resources; help identifying those resources; and training on coding, screening, integrated behavioral health, and medication management.

The GA-AAP survey also highlighted exacerbated mental health needs of youth during the COVID-19 pandemic. **96%** of pediatricians reported an increase in anxiety and depression, **70%** reported an increase in suicidal ideation, and nearly half reported an increase in mood disorders since the pandemic.

GMAP supports providers by offering a community of practice around the current behavioral health concerns facing youth in Georgia, behavioral health specialists close to where families reside, and an advice line where providers can ask de-identified behavioral health-related patient care questions.

Why GMAP?

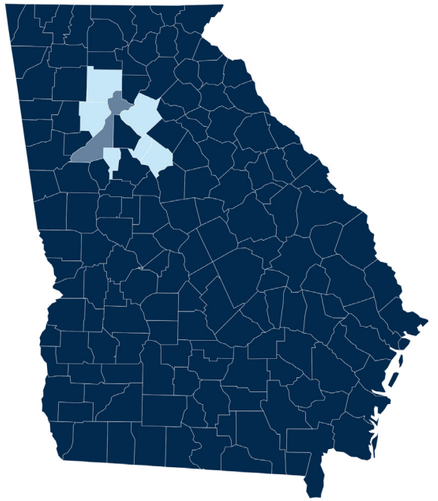
Georgia children, adolescents, and their families, especially those living in rural areas, face a number of challenges to receiving behavioral health services, including a shortage of mental health providers, barriers to access care, and a lack of access to specialty providers.

Nearly **1 in 6 U.S. youth ages 6 to 17 experience a mental health disorder each year**.[1] In Georgia, 10.4% of children ages 3 to 17 reported anxiety or depression in 2020.[2]

24% of children in Georgia have one or more emotional, behavioral, or developmental conditions.[3]

72% of Georgia's counties have been identified as mental health professional shortage areas by the National Alliance on Mental Illness-Georgia, which ranks Georgia 48th among all states on access to mental health care.

Health Professional Shortage Areas: Mental Health, by County, July 2024[4]



None of county is shortage area | Part of county is shortage area | Whole county is shortage area

Source: Rural Health Information Hub. *Health Professional Shortage Areas: Mental Health, by County, July 2024 - Georgia*. Retrieved from https://www.ruralhealthinfo.org/charts/7?state=GA

History of GMAP

October 2021
The Health Resources and Services Administration (HRSA) awarded Georgia a five-year $445,000 Pediatric Mental Health Care Access (PMHCA) grant. The Georgia PMHCA program was created to increase pediatric providers' expertise in treating mild to moderate behavioral health concerns in children ages 0 to 21.

April 2022
The Georgia PMHCA program officially became the Georgia Mental Health Access in Pediatrics program or GMAP.

September 2022
The HRSA Maternal and Child Health Bureau awarded GMAP a supplemental award of $300,000 to expand program efforts. The supplemental award was used to facilitate trainings on suicide prevention and Culturally and Linguistically Appropriate Services. The trainings were open to all child- and family-serving stakeholders in Georgia.

December 2021
The teleconsultation line housed within Children's Healthcare of Atlanta (Children's) increased from 10 to 20 hours a week.

July 2022
Mindworks Georgia, GMAP's Advisory Board, held a formal stakeholder meeting.

Note: Mindworks Georgia was formerly known as the Interagency Directors' Team

August 2023
GMAP expanded its teleconsultation reach. GA-AAP launched a new advice line, operated by a child & adolescent psychiatrist, specifically targeting south and southeast Georgia.

Year 1 by the Numbers
September 2021-September 2022

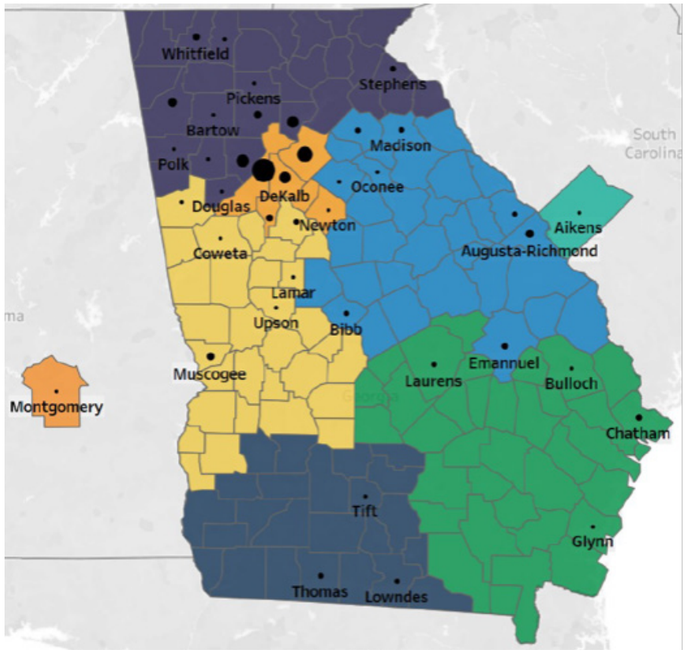
286 consultations and referrals
5 Project ECHO cohorts
93 providers trained
11 newly enrolled pediatric providers

Year 2 by the Numbers
September 2022-September 2023

296 consultations and referrals
9 Project ECHO cohorts
129 providers trained
103 newly enrolled pediatric providers

Program Findings and Outcomes

County of Practice of GMAP Enrolled Provider from Year 1 to Year 3



Between year 1 to year 3, 171 providers enrolled in GMAP. Amongst the 171, 139 providers are reflected in the map, 32 are not included due to missing geographic data. The map is organized by the six DBHDD regions in Georgia.

22

ECHO cohorts thus far. Topics include:

- Adverse childhood experiences
- Attention deficit and hyperactivity disorder (ADHD) and oppositional and disruptive behaviors
- Anxiety
- Anxiety and depression: 2 cohorts (Year 1) 2 cohorts (Year 3)
- Building resilience
- Communication disorders
- Coordination between medical and education systems
- Eating disorders
- Early childhood mental health (2 cohorts)
- Essential topics in early childhood mental health (2 cohorts)
- Learning disabilities
- Managing anxiety & depression (3 cohorts)
- Managing ADHD in pediatric setting
- Pediatric obsessive compulsive disorder
- Substance and addictive disorders

Provider Specialties

From September 2023–August 2024, 157 separate and individual providers interacted with GMAP.

	Total unique providers* Y3
Doctor of Medicine	118
Nurse Practitioner	16
Registered Nurse	8
Physician Assistant	5
Doctor of Osteopathic Medicine	5
Certified Pediatric Nurse Practitioner	3
Licensed Mental Health Counselor	1
Pediatric Nurse Practitioner	1
Total	**157**

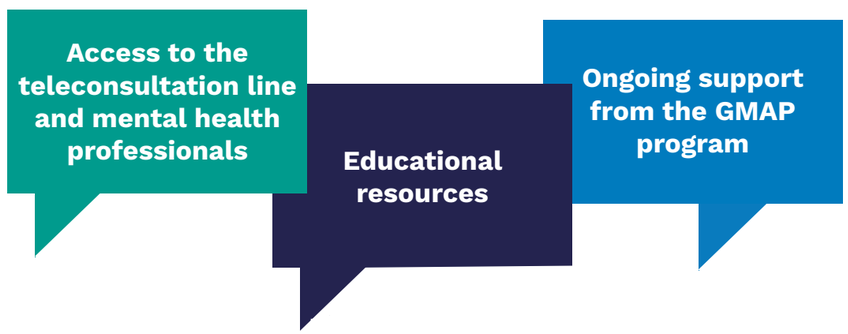
* “Unique providers” refers to the total number of individuals who participated in a Project ECHO cohort or called the advice line, with all duplicate calls removed.

	# of consultations and/ or referrals per year	Cumulative consultations and/or referrals	%
Year 1 September 2021-2022	286	286	38%
Year 2 September 2022-2023	296	582	40%
Year 3 Concludes September 2024	163	745	22%

Top Reasons Clinicians Contact the Consultation Line

- Anxiety
- ADHD
- Depression
- Autism
- Disruptive Impulse-Control, Conduct Disorder/Behavioral Disturbance

Enrolled providers shared what they liked most about the GMAP program:



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> **What I like most about the GMAP program is hearing the views of experts and the clinicians concerning treatment.**
> **-GMAP enrolled provider**

4 out of 5 enrolled providers would recommend the GMAP program to their colleagues.

100%

of providers who called the teleconsultation line stated their reason for the call was answered by a mental health professional.

96%

of providers stated that their ability to impact the lives and health of youth with behavioral health conditions had increased since their involvement in the GMAP program.

81%

of all teleconsultation calls in year one were for medication management.

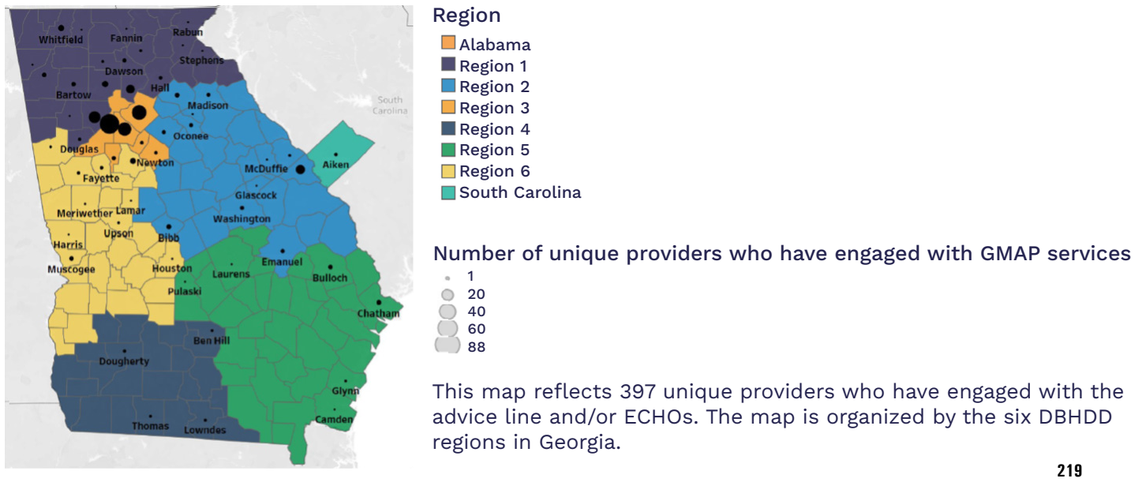
72%

of all teleconsultation calls in year two were for medication management.

78%

of all teleconsultation calls in year three were for medication management.

County of Practice of Provider Who Has Engaged with the Advice Line and/or ECHO Cohort to Date



This map reflects 397 unique providers who have engaged with the advice line and/or ECHOs. The map is organized by the six DBHDD regions in Georgia.

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What's Next for GMAP?

GMAP will develop a strategic roadmap to ensure the program's long-term sustainability. Areas in the roadmap will include:

Program Expansion
- Expand the ECHO training topics to include more specific behavioral health topics and concerns.
- Include more health provider specialties that focus on pediatric health.
- Partner with FQHCs (federally qualified health centers) and organizations with providers outside of pediatrics but aligned with our target audience.
- Create a centralized teleconsultation line where all Georgia regions can connect to GMAP providers.
- Enhance the resource directory to ensure all regions have access to behavioral health resources.

Measuring Program Impact and Successes
- Accurately quantify the program's cost-effectiveness, showing that participation in GMAP not only supports prevention and early intervention but also yields tangible benefits.
- Create and disseminate yearly impact reports to showcase the program's successes.

Additional Funding Opportunities
- Establish collaborative partnerships with community organizations, new partners, and state and national-based associations.
- Support primary care physician implementation of integrated care.
- Utilize opportunities to incorporate Culturally and Linguistically Appropriate Services (CLAS) within GMAP's work.

Sources

1. Whitney, D., Peterson, M. (2019). U.S. National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. *JAMA Pediatrics*, 173(4), 389-391. https://doi:10.1001/jamapediatrics.2018.5399
2. The Annie E. Casey Foundation. (2022, August 8). 2022 *Kids Count Data Book*. https://www.aecf.org/resources/2022-kids-count-data-book
3. The Annie E. Casey Foundation. (2023 May). *Children Who Have One or More Emotional, Behavioral, or Developmental Conditions in Georgia*. https://datacenter.aecf.org/data/tables/10668-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=12&loct=2#detailed/2/12/false/2043,1769,1696,1648/any/20457,20456
4. Rural Health Information Hub

Georgia Mental Health Access in Pediatrics

Integrating behavioral health into primary care practice

Nearly **1 in 5**[1] U.S. school-age children has a mental health need, yet half are not receiving treatment.

In Georgia, nearly **1 in 4**[2] Georgia youth ages 3 to 17 years have one or more emotional, behavioral, or developmental conditions.

In 2019, **30%** of Georgia high school students[3] reported feeling sad or depressed every day for two or more weeks.

By enrolling in the GMAP program, primary care providers can help fill this gap by increasing their behavioral health knowledge or skillset.

[1]Whitney, D.G. & Peterson, M.D. (2019). U.S. national and state-level prevalence of mental health disorders and disparities of mental health care use in children. JAMA Pediatrics, 173(4): 389-91.

[2]https://datacenter.kidscount.org/data/line/10668-children-who-have-one-or-more-emotional-behavioral-or-developmental-conditions?loc=12&loct=2#2/12/false/1696,1648/asc/any/20456

[3]Centers for Disease Control and Prevention. 1991-2019 High School Youth Risk Behavior Survey Data. Available at http://yrbs-explorer.services.cdc.gov/

GMAP supports pediatric primary care providers in meeting children and adolescents' behavioral health needs.

Pediatric primary care providers participating in GMAP gain access to behavioral health needs.

Education with continuing medical education and nursing credits available

Guidance on cases through the phone advice line staffed by psychiatric providers

Directory of behavioral health providers by Georgia county

GMAP increases pediatric providers' skills to treat and manage mild-to-moderate behavioral health concerns in day-to-day practice.

GMAP's goal is to build the knowledge base of primary care providers and provide helpful resources to increase their confidence in behavioral health care delivery.

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DEDICATED TO THE HEALTH OF ALL CHILDREN
Georgia Chapter

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integrating research, policy, and practice

Children's
Healthcare of Atlanta

Georgia Department of Behavioral Health & Developmental Disabilities
D·B·H·D·D

For more information visit
gacoeonline.gsu.edu/gmap
or email us at GMAP@gsu.edu

U.S. Department of Health and Human Services (HHS) as part of an award totaling $2.09 million with 20% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS or the U.S. government.

HB 612/SB 131 and Section 1557 PCDST Rule

On January 1, 2026, a new federal rule will put Georgia's parity non-enforcement in black and white. Under Section 1557's PCDST rule (45 C.F.R. § 92.210), every denial that relies in whole or in part on a decision tool (InterQual, MCG Health) must name the tool, explain how it was applied, and give enough detail to understand the decision. If Georgia's MCOs and health insurers comply with the denial notice requirements, each mental-health denial from and after January 1, 2026, will carry its own parity violation receipts.

More than three and a half years after the unanimously passed Mental Health Parity Act, Georgia still allows Medicaid MCOs and health insurers to substitute the use of proprietary tools for the Parity Act's binding standards—requiring tools that are evidence-based, generally recognized by practicing mental health clinicians, and independent. The consequence is predictable: unlawful denials, shrinking access, and fiscal exposure.

HB 612/SB 131 is the practical fix. It establishes an independent parity review panel to verify compliance with the Parity Act, order corrective action, and, when violations persist, recommend withholds, sanctions, or capitation recoupment. It also makes outcomes visible with public metrics on access and denials.

This is not a new parity benefit. It is enforcement of existing law to protect families and taxpayers. The General Assembly should pass HB 612/SB 131 this session and stand the panel up by Q2 2026, so that the evidence appearing in denial letters from and after January 1, 2026, leads to accountability—not care denials.

The PEACE for Moms program is a Psychiatric Access Program that provides psychiatric referrals, clinical support, and education, with the goal of uniting stakeholders (e.g., prescribers, therapists, and birth support personnel). PEACE for Moms clinical services include medication recommendations, diagnostic clarification, care plan development, telehealth consultations, and skills group referrals (which is direct patient interfacing). The PEACE for Moms consult process starts with the primary provider gathering information from the patient, and then the provider calls the consult line. A mental health specialist calls the provider back same-day or the next day and provides recommendations and resources. Importantly, the patient consents to PEACE for Moms to reach out to them.

PEACE for Moms also provides Mothers and Babies training, which is a program developed by Northwestern that uses a cognitive-behavioral based therapy approach to teach caregivers stress management, mindfulness, and communication skills. It is less intensive than group therapy and requires meeting virtually for 6-9 weeks for 1 hour at a time. PEACE for Moms is attempting to expand the program to other sites across the state and is offering training for other organizations who want to implement Mothers and Babies (e.g., labor and delivery units, CSBs, peer support programs, etc.). The program does not have to be 16 of 36 BHRIC Subcommittee on Children and Adolescents implemented by a clinician; it can be run by anyone who understands maternal mental health (e.g., peer educators or nurse navigators) and can be provided one-on-one or in group settings.

To prepare a consult for PEACE for Moms, a clinician (or someone who works with the clinician) just needs to provide the clinician's name, cell number, and email address, as well as the patient's name, date of birth, date of delivery or estimated date of gestation, cell number, email, zip code, and consent for contact. The PEACE for Moms team includes Toby Goldsmith, MD, Whitney Adams, PhD, Arica Washington, Jill Mast, Mekia Blackmon, Michaela Kitchens, and Kathryn Black.

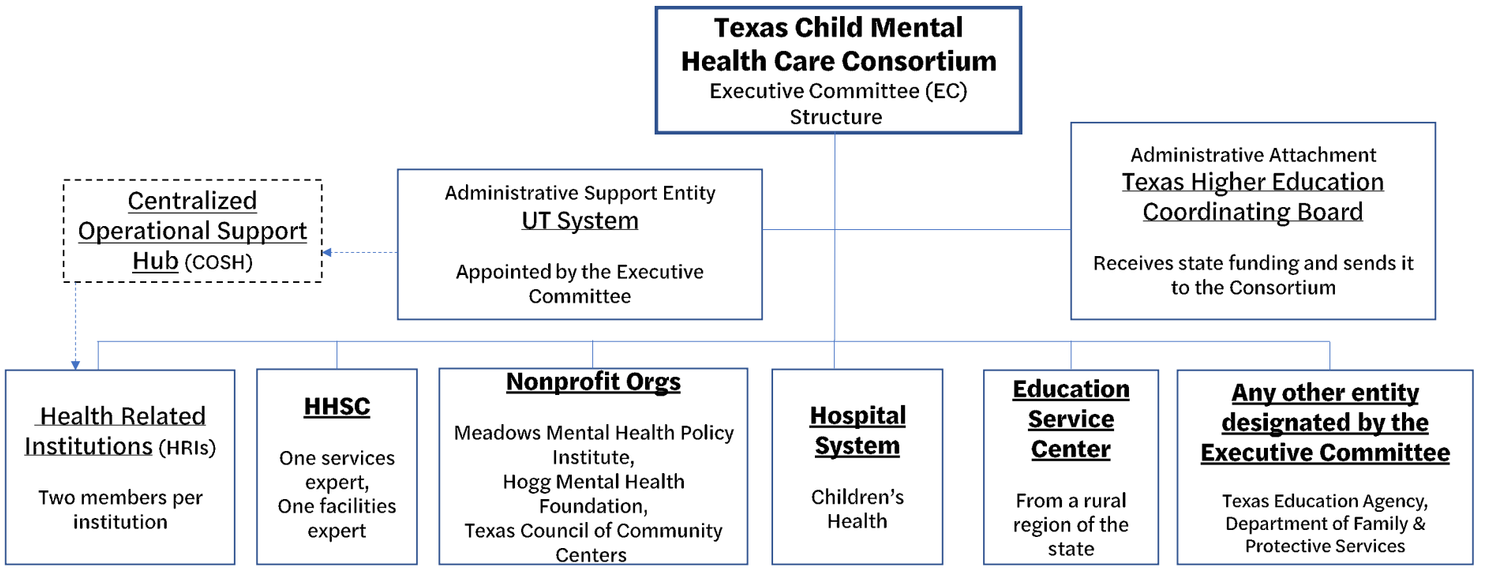
Texas Child Mental Health Care Consortium

tcmhcc Texas Child Mental Health Care Consortium | CPAN Child Psychiatry Access Network | PeriPAN Perinatal Psychiatry Access Network

The Texas Child Mental Health Care Consortium (TCMHCC) was created in 2019 by the Texas Legislature to leverage the expertise and capacity of Texas medical schools and other health-related institutions of higher education to address urgent mental health challenges and improve the mental health care system for children and adolescents.

What is the Texas Child Mental Health Care Consortium (TCMHCC)?

- Established through Senate Bill 11 of the 86th Legislative Session
- Mission: To advance mental health care quality and access for all Texas children and adolescents through inter-institutional collaboration, leveraging the expertise of the state's health-related institutions of higher education, local and state government agencies, and local and state mental health organizations.
- Vision: All Texas children and adolescents will have the best mental health outcomes possible.



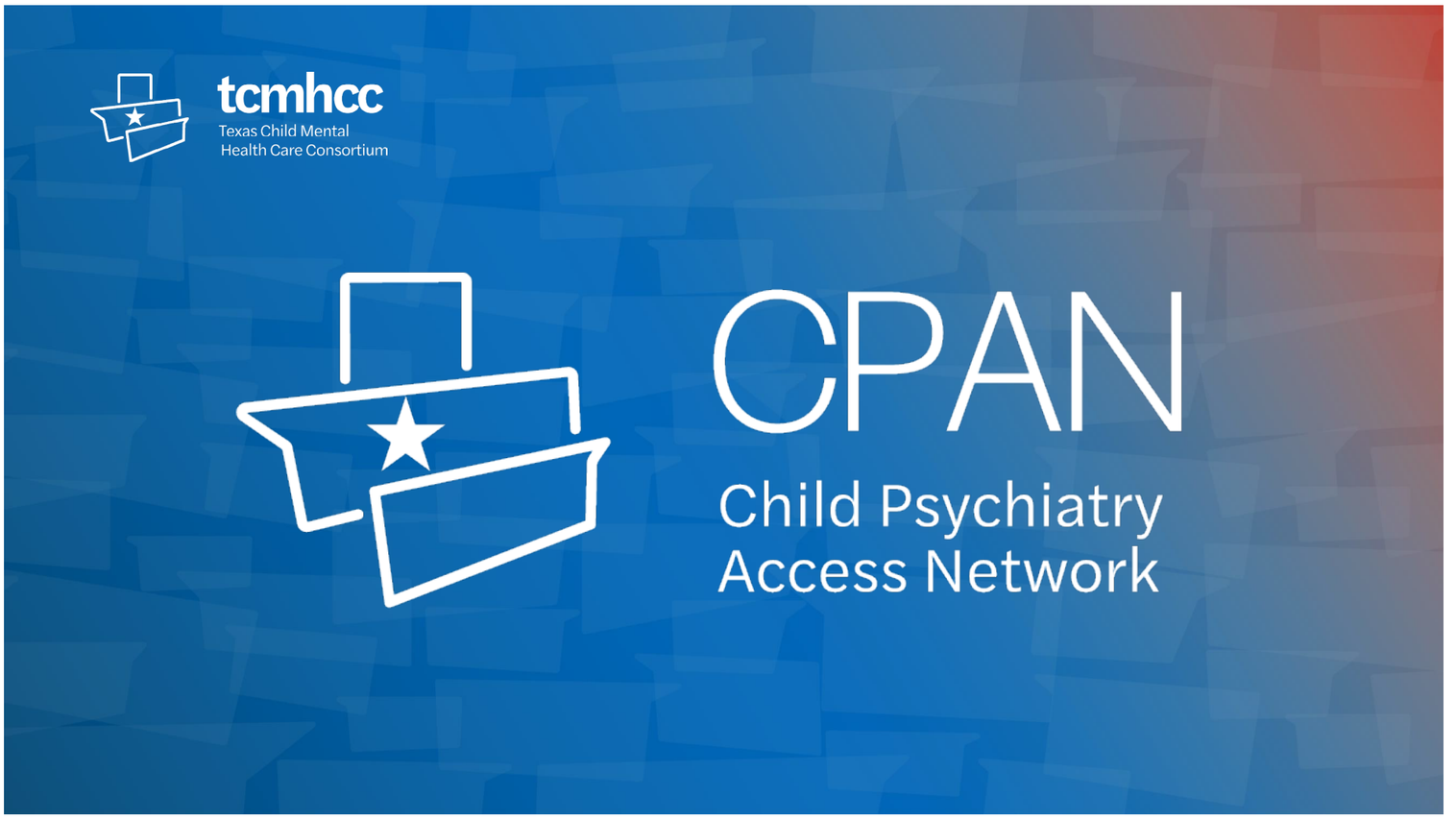
Texas Child Mental Health Care Consortium Initiatives

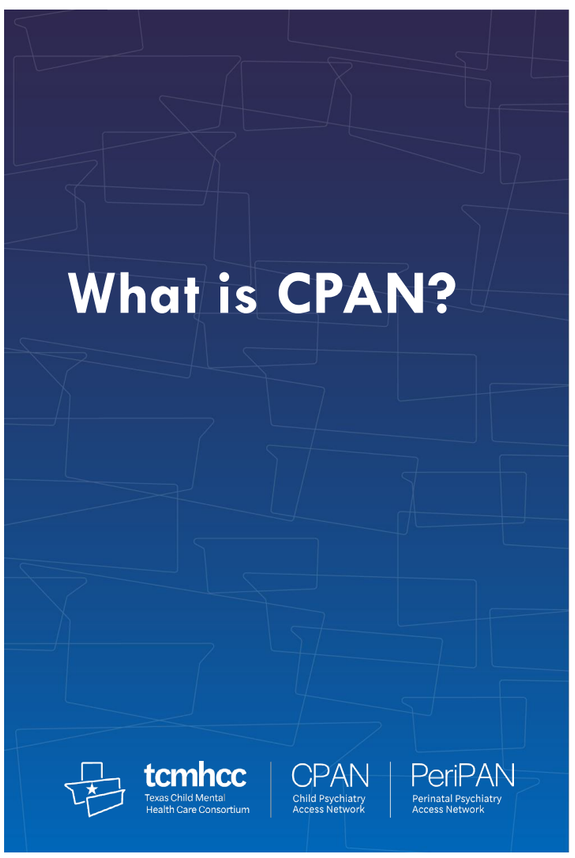
Strengthening systems and increasing access to care through interconnected programs

Learn more:
www.tcmhcc.utsystem.edu/

tcmhcc
Texas Child Mental Health Care Consortium

- Child Psychiatry Access Network (CPAN)
- Perinatal Psychiatry Access Network (PeriPAN)
- Texas Child Health Access Through Telemedicine (TCHATT)
- Child and Adolescent Psychiatry (CAP) Fellowships & Community Psychiatry Workforce Expansion (CPWE)
- Children's Mental Health Research





Rapid clinician-to-clinician **consults** with a psychiatrist or other mental health clinician.

Convenient and quick access by **phone or text.**

Free evidence-based support. No insurance needed. Consults may be billable.

Timely, one-time direct **patient-psychiatrist consults.**

Vetted, individualized patient **referrals & resources** for clinicians who want to learn about a certain topic.

Free and frequent virtual **CMEs** on pediatric & perinatal mental health topics & ethics.

How Does CPAN Work?

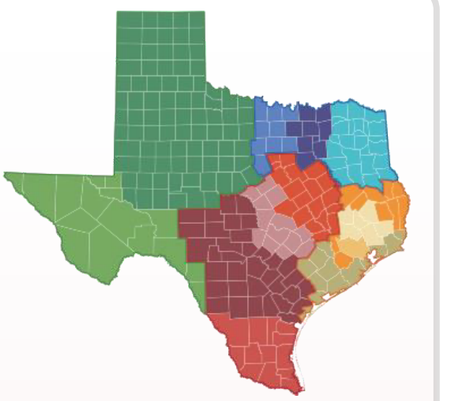
PCP or Pediatrician Seeks Advice

Call **888-901-CPAN** Or Text Your Local Hub

A knowledgeable behavioral health specialist is standing by to assist.

Possible Outcomes:

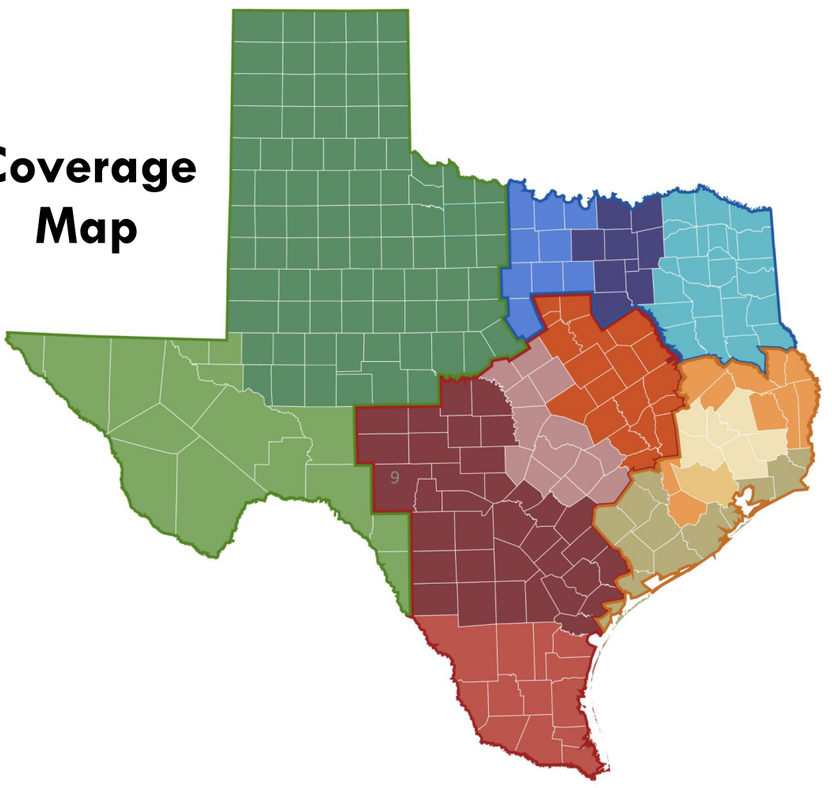
- Psychiatrist consult
- Guidance to PCP to assess or treat patient
- Local, vetted referrals or resources
- Direct patient consult may be recommended



To ensure a rapid, expert response, CPAN can draw upon its **12 program hubs**

tcmhcc Texas Child Mental Health Care Consortium | CPAN Child Psychiatry Access Network | PeriPAN Perinatal Psychiatry Access Network

Coverage Map



Dial 1 North and Northeast Regions

1. The University of North Texas Health Science Center at Fort Worth
2. The University of Texas Southwestern Medical Center
3. The University of Texas at Tyler Health Science Center

Dial 2 South and Southeast Regions

1. Baylor College of Medicine
2. The University of Texas Health Science Center at Houston
3. The University of Texas Medical Branch at Galveston

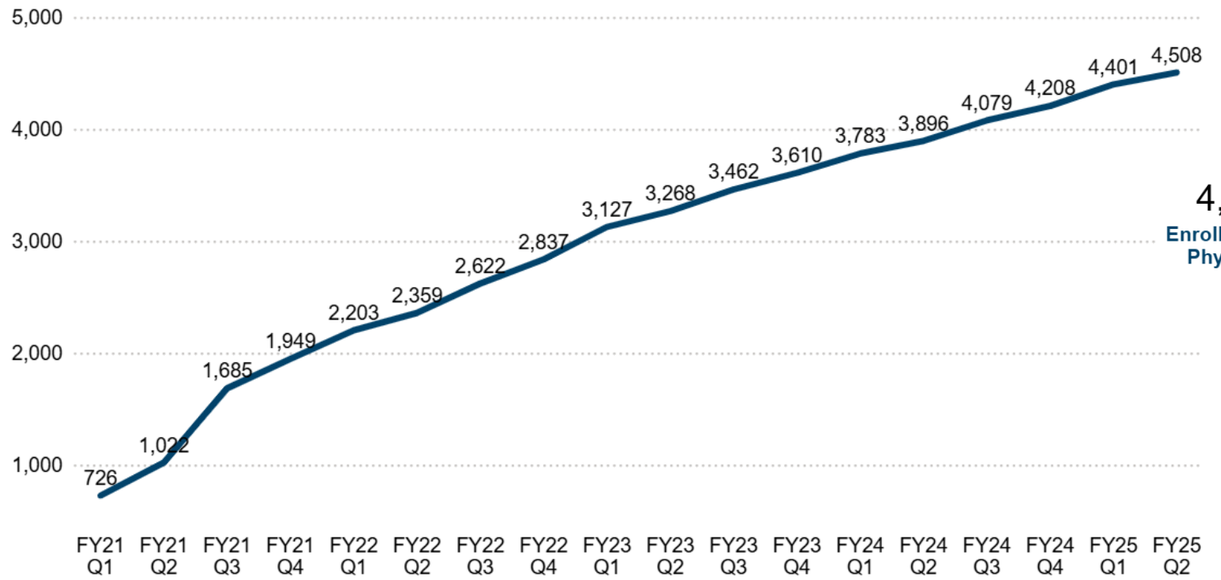
Dial 3 Valley and Central Regions

1. Dell Medical School at The University of Texas at Austin
2. The University of Texas Health Science Center at San Antonio
3. The University of Texas Rio Grande Valley School of Medicine
4. Texas A&M University System Health Science Center

Dial 4 West Region

1. Texas Tech University Health Sciences Center
2. Texas Tech Health El Paso

Growth in Enrolled CPAN Pediatricians & General/Family Physicians



4,506
Enrolled CPAN Physicians

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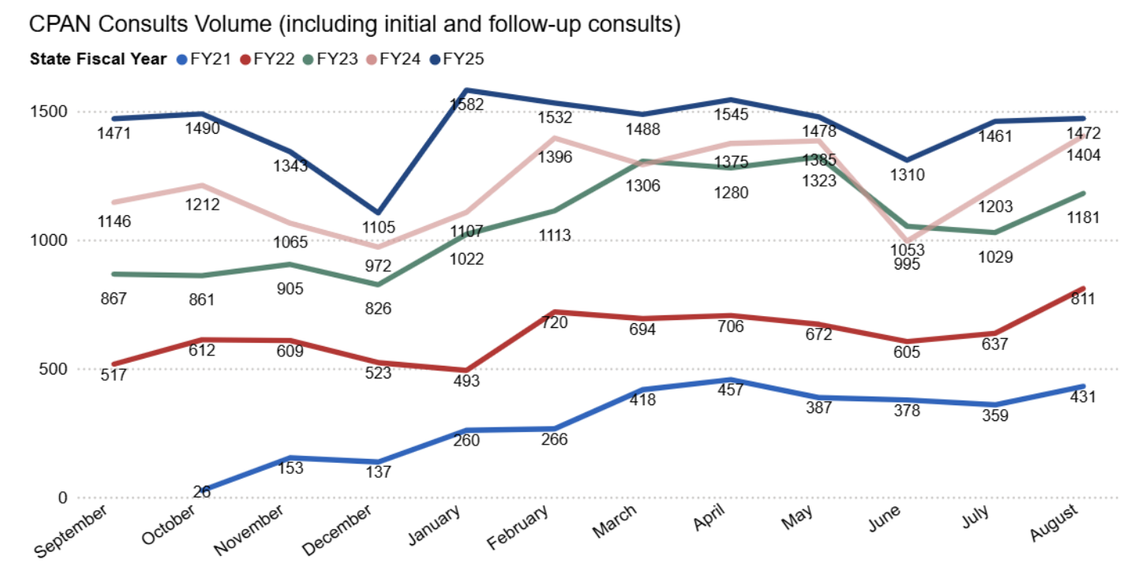
CPAN Monthly Provider Consultations - Annual Trends

October 2020 – August 2025

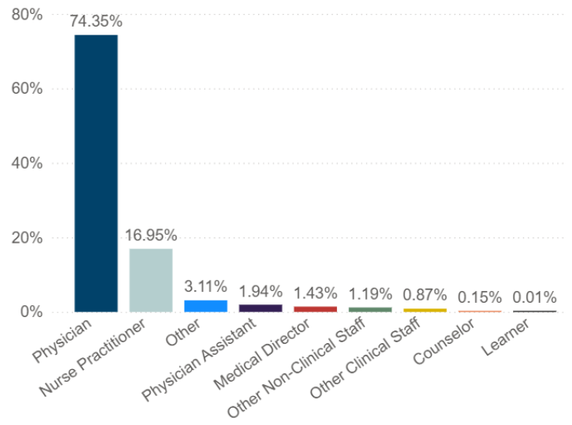
55,466
Total Provider Consults



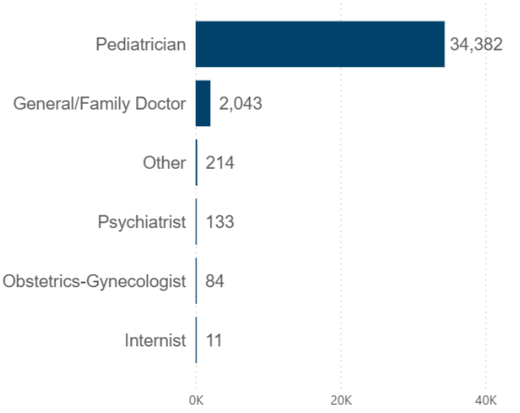
CPAN Consultation Callers

as of August 31, 2025

CPAN Consults by Health Care Provider Role



CPAN Consults by Physician Type



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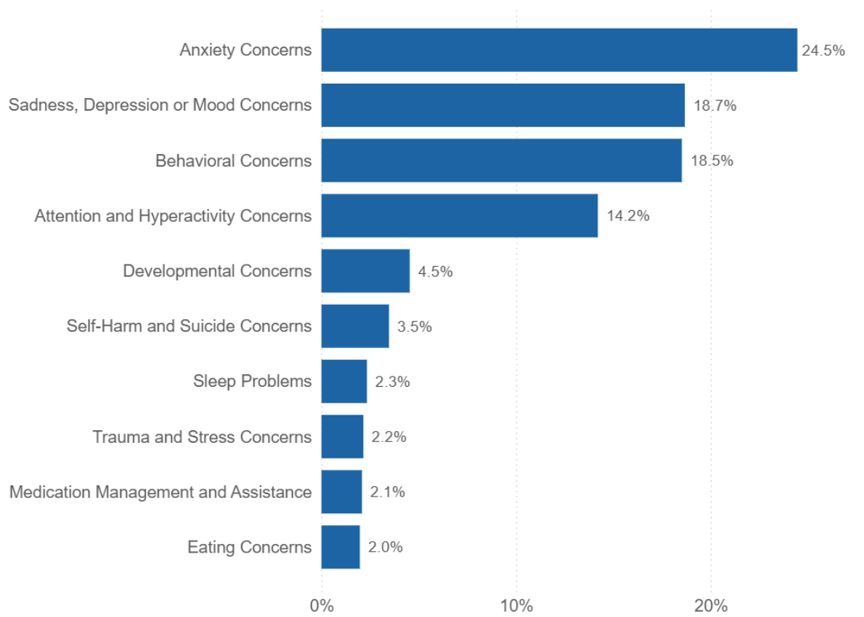
Top 10 Patient Areas of Concern Reported in Consultations

as of August 31, 2025



52,792

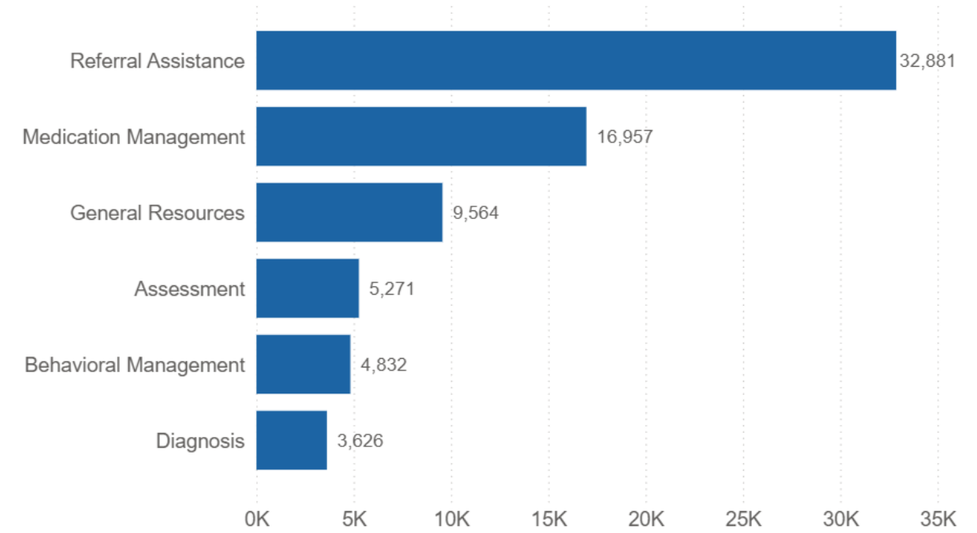
Patient-Specific CPAN Consults

Notes:

1. The complaints displayed in this dashboard are reported by the caller about the patient.
2. The complaints shown are for patient specific consults, not all consults are patient-specific.
3. A single consult may contribute to multiple complaints, as providers can report multiple complaints. Counts or totals may be higher than the number of distinct consults.
4. The "Complaints" field is a text field, and for reporting purposes, responses have been mapped into specific categories based on key terms. Please note, some values may not have been mapped due to formatting inconsistencies or misspellings.

Reasons for CPAN Consultation Call

as of August 31, 2025



31%

Medication-Related CPAN Consults

Note: Callers can identify more than one purpose for each consult.

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One-Time Direct Patient Consultations

Our experts may suggest a direct patient consult, a service that includes:

- A one-time, child / adolescent psychiatrist telehealth visit for the patient and family.
- Support for the primary provider.
- Assessment results or follow-up care recommendations sent to referring physician, clarifying diagnosis or treatment options.
- Scheduling and coordination by our team.

CPAN does not provide ongoing patient care but can continue to provide guidance and support to the primary care team.

No charge to the clinic or patient/family, no insurance needed.

tcmhcc Texas Child Mental Health Care Consortium | CPAN Child Psychiatry Access Network | PeriPAN Perinatal Psychiatry Access Network

Referrals Provided Through CPAN Consultations

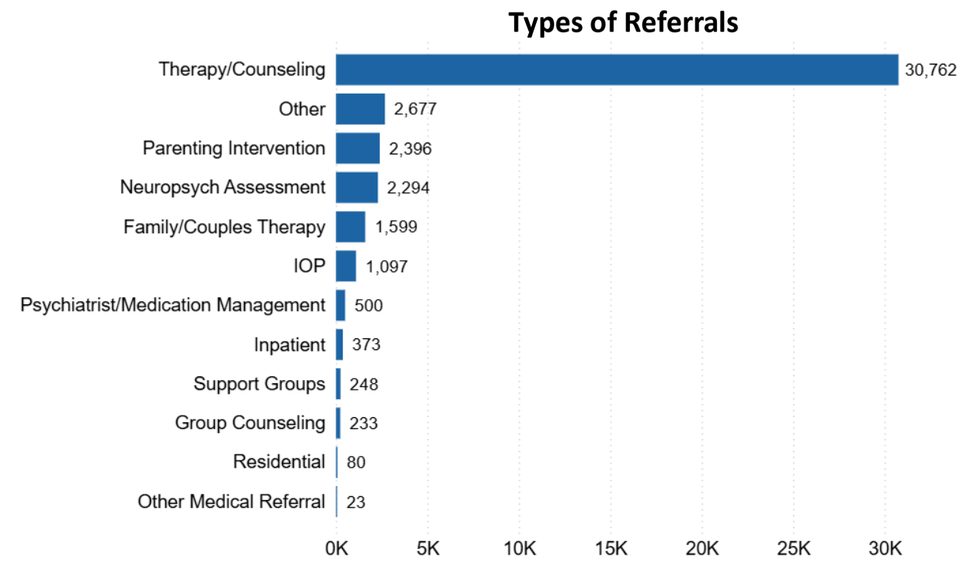
as of 8/31/2025

39,116
Total Referral Requests

72%
Total Referral Request All Consults

99%
Patient-Specific Referral Requests

1%
General Referral Requests



Note: Providers calling CPAN can request more than one type of referral.

CPAN Provider Survey

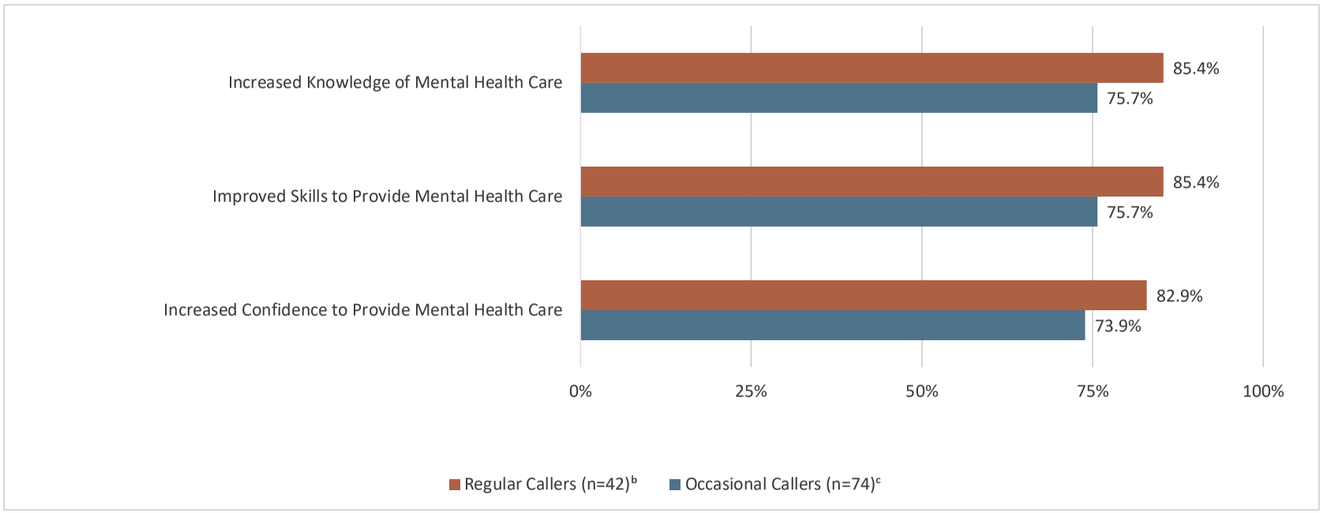
Survey Sample & Responses

- Surveyed enrolled providers who have used CPAN in the past 12 months
- Sample: Identified a diverse sample of providers across HRIs based on social vulnerability and population density (n=428 providers)
- 124 providers responded (29% response rate)

Recommendations and Future Use

- **98%** would **recommend** CPAN to other providers
- **96%** intend to **continue using** CPAN in the next 6 months
- **80%** of providers who attended training found it very/extremely helpful

Benefits to CPAN Users



Percentages show providers reporting "Moderately/Very Much" improvement

tcmhcc
Texas Child Mental Health Care Consortium
PeriPAN
Perinatal Psychiatry Access Network

PeriPAN
Perinatal Psychiatry Access Network

Texas Perinatal Psychiatry Access Network (PeriPAN)

tcmhcc Texas Child Mental Health Care Consortium | CPAN Child Psychiatry Access Network | PeriPAN Perinatal Psychiatry Access Network

PeriPAN works exactly like CPAN and is focused on the mental health needs of prenatal, pregnant, and postpartum women.

- Access to **reproductive psychiatrists** and other mental health experts for consultation, guidance on screening and care, resources, and referrals.
- Free mental health CMEs and collaborative ECHOs on **maternal mental health** topics.
- For **all clinicians who see perinatal women**, including OB/GYNs, family doctors, pediatricians, midwives, PAs, NPs, and residents.

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tcmhcc Texas Child Mental Health Care Consortium | PeriPAN Perinatal Psychiatry Access Network

PeriPAN Enrollment

As of August 31, 2025

- 1,071 OB/GYNs
- 273 OB clinics
- 70 Women's or Maternal Health clinics
- 30 Midwifery practices

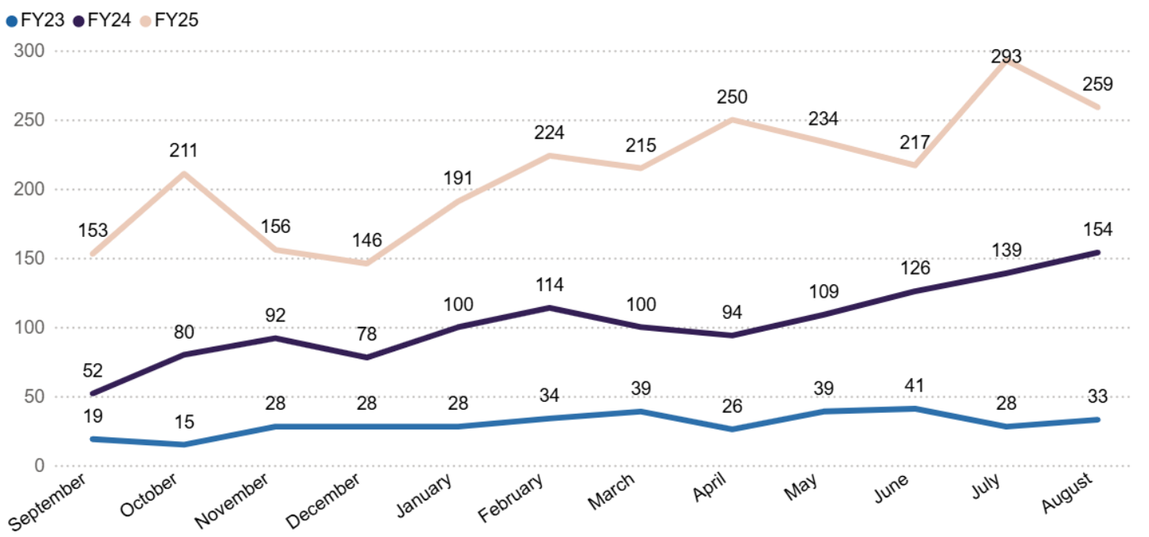
**This data is preliminary and subject to change*

21

PeriPAN Monthly Consultations - Annual Trends

As of August 31, 2025

4,152
Total PeriPAN Consults

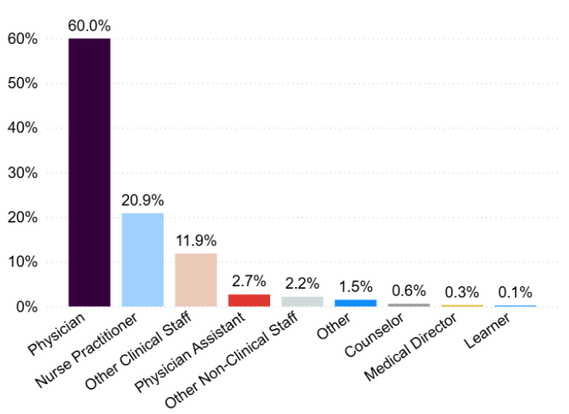


22

PeriPAN Consultation Callers

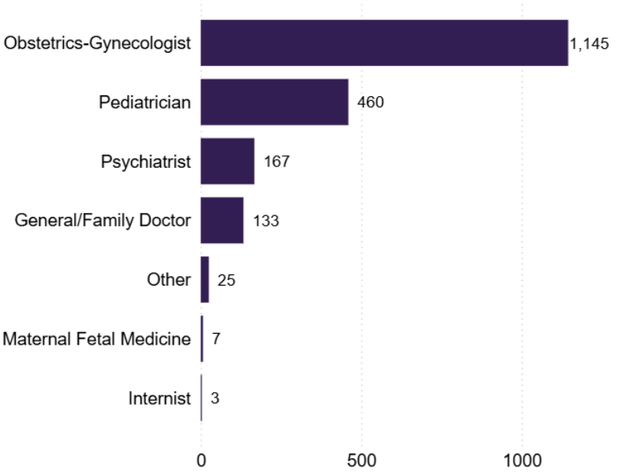
as of August 31, 2025

PeriPAN Consults by Health Care Provider Role



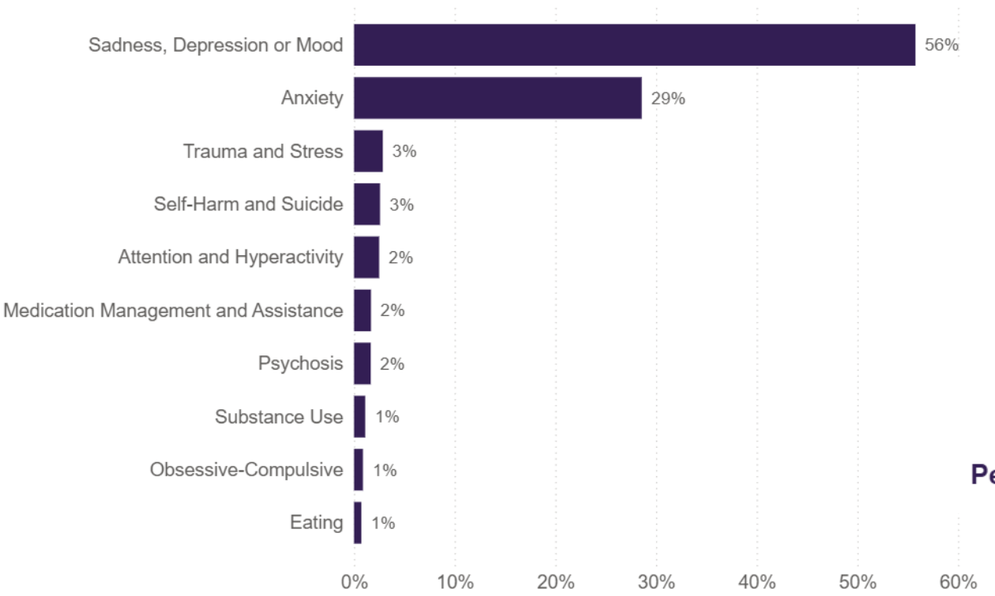
Note: When a provider has multiple consults, they are counted based on the total number of consults rather than the distinct type of provider.

PeriPAN Consults by Physician Type



Top 10 Patient Areas of Concern Reported in Consultations

as of August 31, 2025

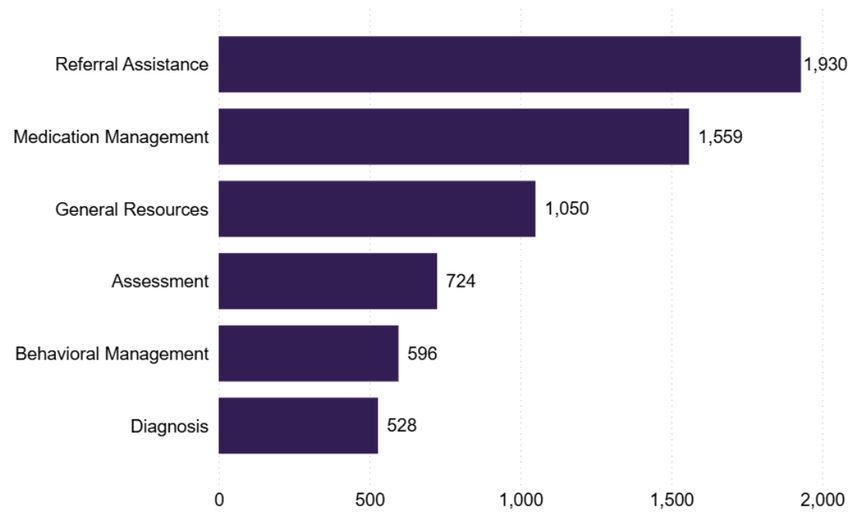


3,432
Patient-Specific PeriPAN Consults

89%
Patient-Specific PeriPAN Consults (%)

Reasons for PeriPAN Consultation Call

as of August 31, 2025



41%
Medication-Related PeriPAN Consults

Note: Callers can identify more than one purpose for each consult.

tcmhcc Texas Child Mental Health Care Consortium | PeriPAN Perinatal Psychiatry Access Network

What is TCHATT?

- Focused mental health support & care for students in pre-K to 12th grade.
- Free, no insurance needed.
- Parent/guardian consent required.
- Virtual care (computer or smartphone).
  - Most appointments occur at school.
- Services may include therapy, psychiatry, case management support.
  - TCHATT is not a crisis service.
- Our licensed, local clinicians assess and address a student's mental health needs.
- We offer a limited number of sessions.
  - If a student needs more care, we help the family connect to community services.
- TCHATT is not a school program.
  - TCHATT is a separate, confidential mental health program for students.
- We can help students reduce anxiety, manage emotions, and cope with challenges to be more confident and successful in school.

TCHATT

MOU

- MOUs are signed with the school district for provision of services to schools in their district
- District lead provides school contacts for onboarding purposes

School Onboarding

- School liaisons are identified
- Technology for telehealth services provided
- TCHATT school liaisons are trained to submit referrals via the Trayt portal

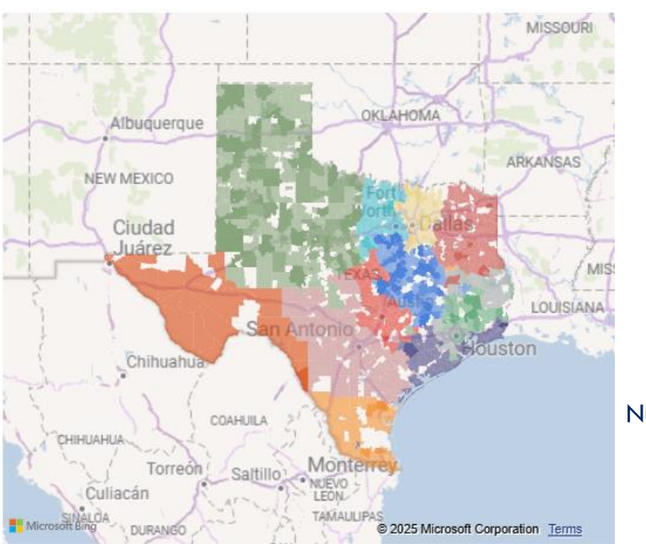
Service Provision

- School liaison identifies a student who may benefit from TCHATT and submit a referral into Trayt after verbal parental consent is obtained
- HRI staff contact families and parents/guardians complete consent paperwork
- Student is enrolled to receive telehealth sessions, then connected with care in the community as needed

Active TCHATT Campuses

as of August 31, 2025

HRI
- BCM
- TAMUHSC
- TTUHSC
- TTUHSC EP
- UNTHSC
- UT AUS DELL
- UTHSCH
- UTHSCSA
- UTMB
- UTRGV
- UTSW
- UTTHSC



944
Number of School Districts Enrolled in TCHATT

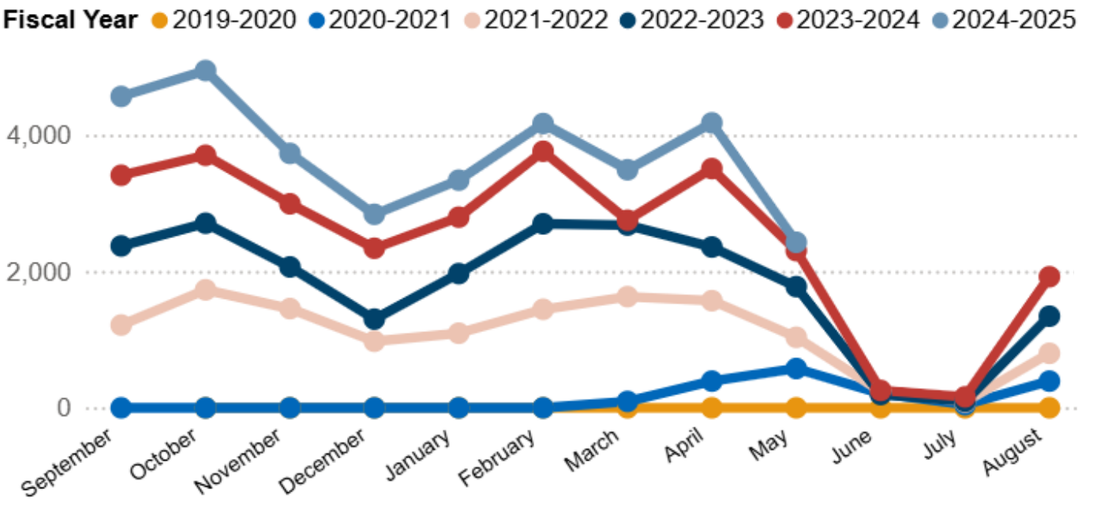
7,260
Number of School Campuses Enrolled in TCHATT

4,485,932
Number of Students Able to Access TCHATT

81%
Student Coverage

TCHATT Referrals By Month, FY2021–2025

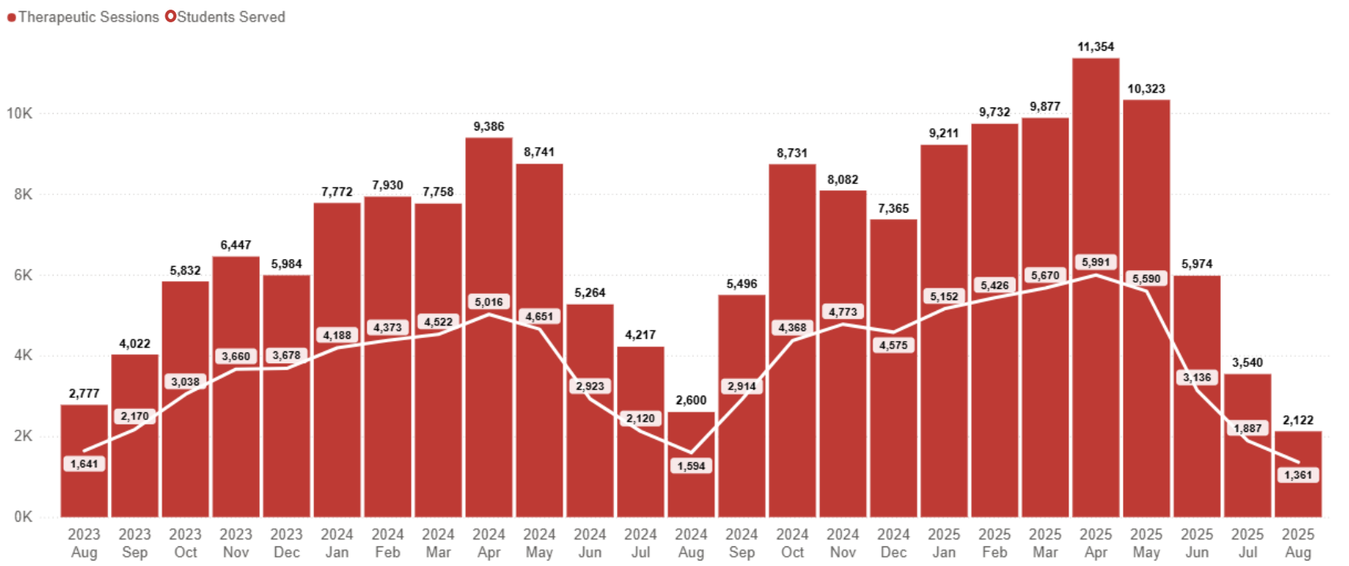
as of August 31, 2025



100,224
Students Referred

TCHATT Sessions and Students Served

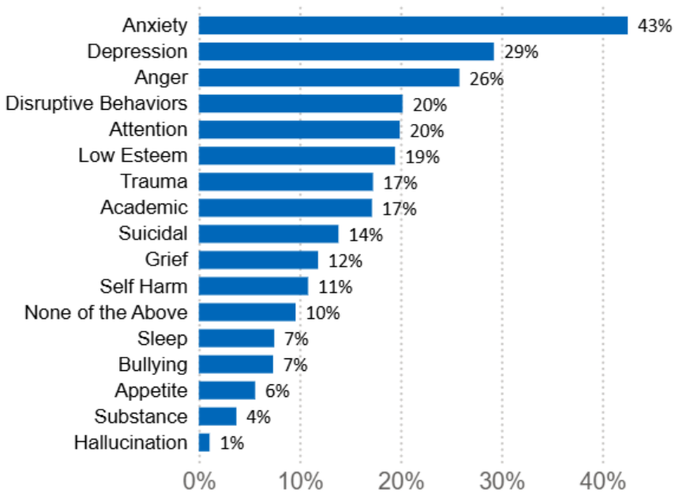
as of August 31, 2025



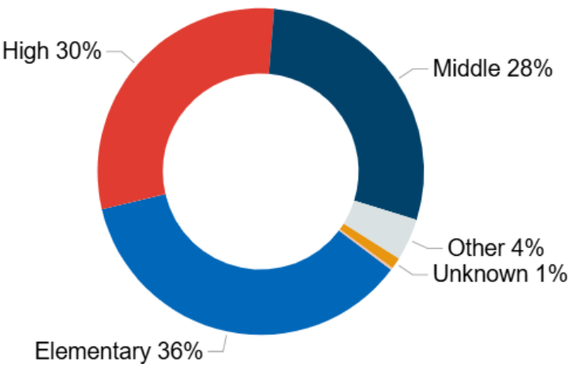
Reasons for Referral and Referrals by School Level

as of August 31, 2025

Reasons for Referral



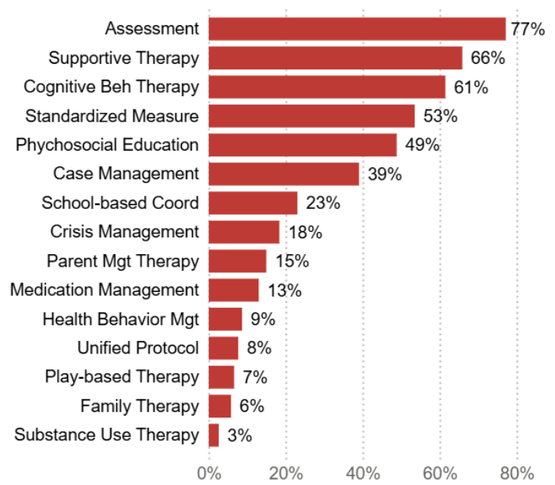
Referrals by School Level



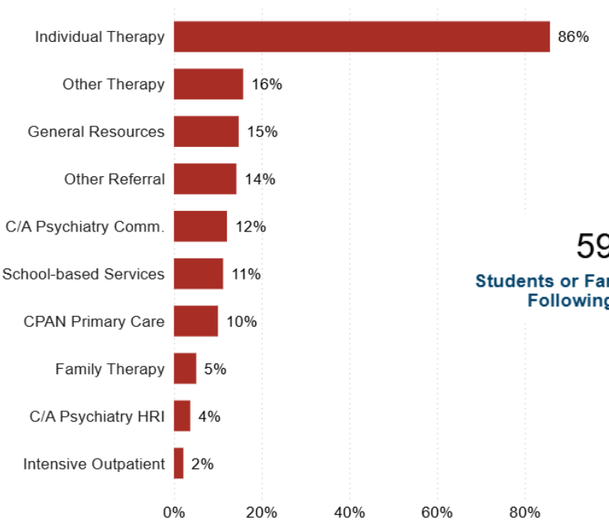
Types of Supports and Referrals Families Received Through TCHATT

as of August 31, 2025

Proportion of Students/Families Receiving Different Types of Services/Supports



Referrals Following TCHATT Care



59%

Students or Families Referred Following TCHATT

TCHATT School Staff Survey

Survey Sample & Responses

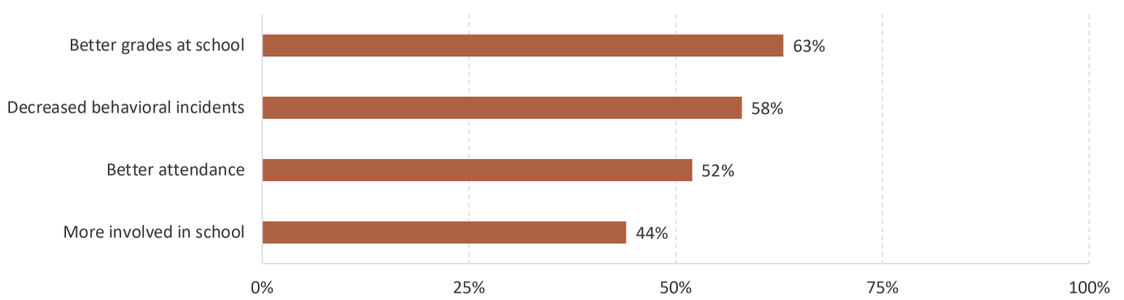
- Surveyed TCHATT program implementers (one per campus)
- Identified a diverse sample of enrolled campuses across HRIs based on rural/urban/charter classification, economic disadvantage, and district size (n=483 campuses)
- 226 school staff responded (49% response rate)

Recommendations and Future Use

- **89%** would **recommend** TCHATT to other schools
- **93%** intend to **continue using** TCHATT in the next 6 months

TCHATT Perceived Outcomes

Student Improvements Reported by Staff



Impact on School Staff Capacity

91%

of school staff reported increased capacity to meet students' non-educational needs

90% Parents **satisfied** with TCHATT.

83% Parents report child/family is better after TCHATT.

as of June 30, 2025

"I am so grateful for this program. My daughter was in a really rough place and this program was like a shining light to her. It sparked amazing conversation between my daughter and me.
She has some tools in her belt to handle situations she can't control in the future.

Thank you! Thank you! Thank you!

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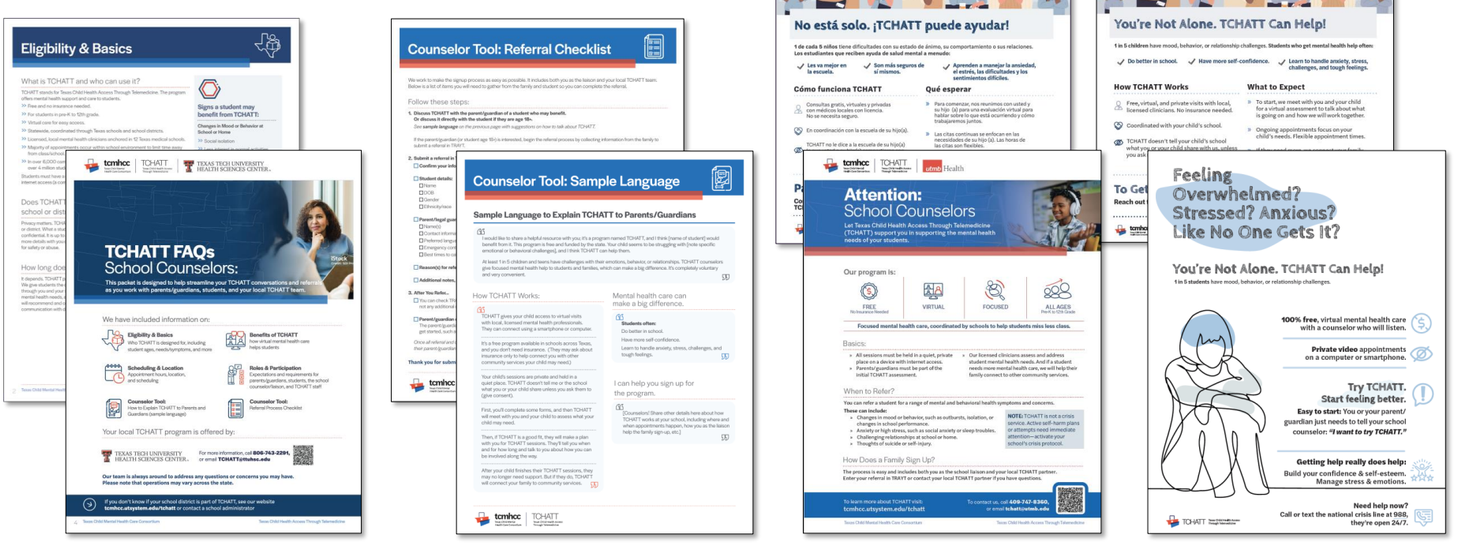
TCHATT Resources for Schools

Flyers for students, parents, school counselors
FAQ packet & tools for school counselors



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Texas Child Mental Health Care Consortium

Workforce Development Initiatives

Community Psychiatric Workforce Expansion
Child and Adolescent Psychiatry Fellowships
Other workforce initiatives

Community Psychiatry Workforce Expansion (CPWE)

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Texas Child Mental Health Care Consortium

- Funds full-time academic psychiatrists as academic medical directors and new psychiatric resident rotation positions at facilities operated by community mental health providers.
- As of June 30, 2024, partnering with 20 out of 39 LMHAs/LBHAs and 6 other Community Mental Health Providers
- 475 residents have participated in the CPWE program since September 2020
- CPWE residents have completed 17,940 encounters with Texas patients in FY24

> *"I appreciated working within community mental health setting and the wealth of integrated care it provided for our patients…the private clinics we worked at did not have such access to counseling, case management, substance use treatment, etc." – CPWE Resident*

Child and Adolescent Psychiatry (CAP) Fellowships

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Texas Child Mental Health Care Consortium

CAP Fellowships increase the number of medical professionals in Texas who specialize in the diagnosis and treatment of psychiatric and associated behavioral health issues affecting children and adolescents to:

- Increase the ratio of child and adolescent psychiatrists to the child population;
- Reduce the number of designated mental health professional shortage areas; and
- Reduce wait times to see a child and adolescent psychiatrist.

CAP Fellowship: Growth in Filled Positions

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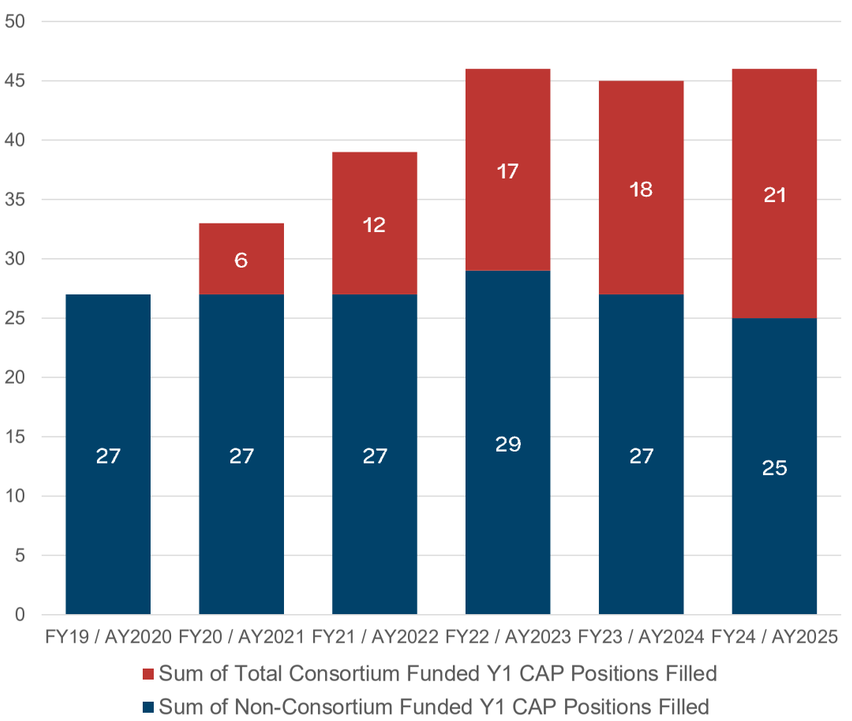
Texas Child Mental Health Care Consortium



Other Workforce Expansion

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Texas Child Mental Health Care Consortium

Additional ARPA-funded workforce expansion initiatives focus on increasing the number of trained professionals in mental health care.

- Advanced Practice Providers
- Psychologists
- Licensed Professional Counselors
- Licensed Clinical Social Workers
- Licensed Marriage and Family Therapists
- Issue Specialization Programs
- Blended Training Programs

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Research Initiatives: *Learning Healthcare System*

Youth Depression and Suicide Research Network
Childhood Trauma Research Network
New and Emerging Child Mental Health Researchers

The Core Failure: Parity Without Enforcement

Why do Georgia's regulators protect the payers rather than the children and families the Georgia Mental Health Parity Act was meant to serve? Why do they ignore the plain words of a statute passed without a single dissenting vote? This failure of enforcement is not peripheral—it is the **root of Georgia's mental health crisis.**

More than three and a half years after passage of the Parity Act, regulators who should be holding health insurers and Medicaid managed care organizations (MCOs) accountable instead allow them to rewrite medical necessity and deny care with impunity.

Narrowed Definitions, Unlawful Denials

Georgia's Parity Act (HB 1013, 2022) fixes binding statutory definitions of "medically necessary" care and "generally accepted standards of MH/SUD care": criteria must be evidence-based, recognized by practicing clinicians, and independent of payer influence. In comparative analyses filed with DCH and OCI, Georgia's Medicaid MCOs and insurers admit they instead rely on proprietary tools like InterQual and MCG—vendor criteria that are payer-financed, nontransparent, and therefore do not satisfy the statute. Under Medicaid rules and state contracts, plans must apply governing law (see 42 C.F.R. §§ 438.3, 438.66); using proprietary substitutes is not discretion, it's noncompliance.

This unlawful narrowing drives illegal denials: redefining "medical necessity" to require imminent risk where the statute supports earlier intervention, dismissing chronic suicidality as "baseline," or denying dialectical behavior therapy (DBT) when it's the evidence-based standard. Each denial issued under noncompliant criteria is a violation of state law, a contract breach, and—where capitation is certified—false certification exposure and federal financial participation (FFP) risk.

Beginning January 1, 2026, Section 1557's PCDST rule (45 C.F.R. § 92.210) will force MCOs and health insurers to name the tool and its application in denial letters, converting these practices into written admissions. Regulators should respond with corrective action plans, withholds/sanctions, recoupment, and referral to OCR, and require replacement of proprietary MH/SUD criteria with statutorily compliant standards.

Georgia's $12+ Billion Contingent Liability

It makes no sense for Georgia not to enforce the Parity Act. Enforcement protects children and families **and** taxpayers. Under Medicaid law, federal matching funds are available only for expenditures made "in accordance with" the approved State plan (42 U.S.C. § 1396b(a)). If DCH pays capitation to MCOs that deny care using noncompliant definitions of medical

necessity or generally accepted standards, those payments are unallowable—and CMS can **recoup FFP from the State**, despite the fact the violations were the result of the MCOs' failure to comply with the Parity Act (see 42 C.F.R. §§ 438.3, 438.66).

Since Parity took effect on July 1, 2022, Georgia has drawn more than **$12 billion in FFP** tied to MCO contracts—funds **at risk** if DCH continues to countenance failure of the MCOs to use the statutory definitions and the unlawful use of InterQual and MCH Health utilization management criteria. CMS doesn't have to chase the plans; it can demand repayment from Georgia.

The rational course is plain: enforce parity, impose CAPs/withholds/sanctions, and recoup capitation from noncompliant MCOs (including rate-certification adjustments), both to vindicate Georgians' rights and to mitigate federal clawbacks. In short: CMS will collect—the only question is **from whom**.

Network (In)Adequacy: Narrow Networks Limit Care

Plans and Medicaid MCOs cite a clinician "shortage" to mask **inadequate networks**. The real gap isn't demand vs. supply; it's **available clinicians vs. in-network clinicians**. In many areas, provider networks include **well under half** of active providers.

CHOA Real-Time Parity Compliance System

Children's Healthcare of Atlanta built an EHR-based system to track mental health care gaps in real time—showing whether parity is met. By following ED discharges, starts of recommended services, and denial/wait-time choke points, CHOA pinpoints where "coverage" exists only on paper.

Initial findings:

- Community capacity meets **<50%** of mental health care need for youth in crisis.
- **60%** of youth remain unconnected to medically necessary mental health care services **30–75 days** post-ED discharge.
- **12%** of youth return to the ED for another behavioral crisis; **1 in 5** of those having received **no** outpatient MH care.

These repeats aren't random—they're the predictable result of failing to connect youth to ongoing care.

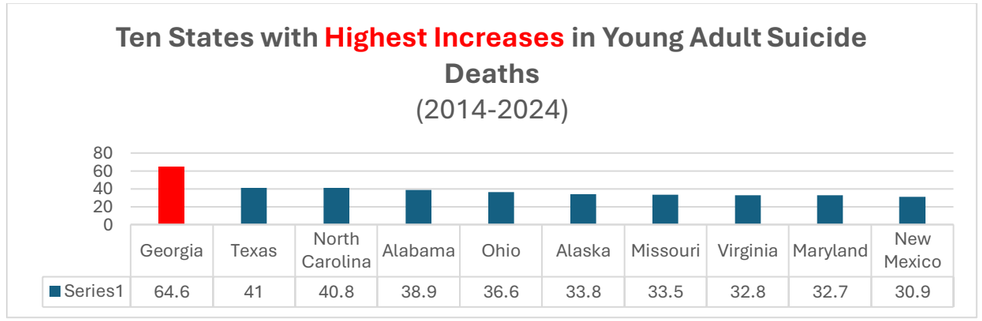
No Evidence-Based Care for Georgia's Suicidal Children

From June–December 2024, Children's Healthcare of Atlanta—handling ~25% of Georgia's adolescent behavioral-crisis ED visits—**could not find a single in-network outpatient dialectical behavior therapy (DBT) provider** for discharged patients under any of the state's three Medicaid MCOs. "Coverage" without network capacity is no coverage.

DBT is an evidence-based cognitive-behavioral therapy validated by multiple randomized control trials designed for borderline personality disorder, chronic suicidality, depression, PTSD, eating disorders, and substance use.

In the 2024 Georgia Student Health Survey, **more than 73,000** middle and high school students admitted seriously considering suicide at least once in the prior 12 months. **More than 38,000** admitted to attempting suicide during that period.

Research from 2014 to 2024 shows that the suicide deaths among young adults in Georgia (age 18-27) **increased by 65%**, the largest increase of any state in the country.



Many Georgia MCOs and health insurers invoke a bogus **"suicide baseline"** concept to deny or down-tier care—claiming chronic suicidality is a patient's "normal" and not an indication for higher-level treatment. This has **no clinical basis**, contradicts standard risk assessment (recurrent/escalating suicidality = higher risk), **violates parity** by redefining medical necessity downward, and **normalizes danger**.

Enforcing Parity Has Only a Minimal Impact on Premiums and Capitation

Parity enforcement doesn't add new benefits—it **enforces benefits plans already price and certify**. Medicaid capitation assumes legal compliance (including parity), and commercial premiums already reflect covered behavioral care and expected use. Post-MHPAEA studies found **~1–2% average premium effects**, mostly early and not structural. In short, enforcement redirects already-priced dollars to compliant care, not unfunded mandates.

Done well, parity trends cost-neutral or cost-reducing: brief shifts toward outpatient/collaborative care are offset by **fewer ED visits, readmissions, and delayed-care hospitalizations** within 6–18 months. Cleaning up ghost networks, opaque prior

authorization standards, and non-evidence-based criteria cuts denial/appeal rework and out-of-network spend. Regulators should test carrier claims via MLR trends, out-of-network rates, time-to-appointment, and parity comparative analyses—and **deny rate hikes tied to past noncompliance.**

Reinvesting Recoveries in Behavioral Health

When regulators recover funds from insurers and Medicaid MCOs for parity violations, **where the dollars go matters** as much as the fines. Georgia's OCI recently announced **$20+ million** in penalties, yet recoveries are typically swept into the **general fund**, providing **no direct benefit** to communities harmed by unlawful denials and thin networks.

Georgia should create a **Behavioral Health Reinvestment Fund** to statutorily dedicate these dollars to closing access gaps: expand crisis services; grow the child/adolescent workforce (training, loan repayment, DBT capacity); strengthen school-based care; and build parity-enforcement infrastructure (audits, public dashboards, independent medical review). The fund should have **clear oversight**—annual public reports, measurable targets, community input—and be **shielded from diversion**.

Using parity fines to fund parity solutions honors families who bore the costs, reduces future violations, and limits federal clawback risk. Without reinvestment, Georgia faces a paradox: **penalties balance the budget, not behavioral health access** for children and families.

What Makes Georgia's Parity Act Unique

Statutory Clarity, Clinical Integrity

It hard-codes the key definitions into statute.
Most states rely on regulators or plan documents to flesh out terms like "medically necessary" or "generally accepted standards of care." Georgia put detailed definitions directly in the law. For mental health and substance-use treatment, coverage criteria must be evidence-based, generally recognized by practicing clinicians, and independent of payer influence. That's rare; it leaves far less room for insurers to "reinterpret" standards.

It speaks to the tools, not just the outcomes.
Georgia's definitions effectively reach utilization-management tools (e.g., proprietary guidelines). If a tool isn't evidence-based, clinician-recognized, and independent, it doesn't meet Georgia's standard—regardless of how common its use is elsewhere.

It binds both commercial plans and Medicaid managed care.
Many state parity laws focus on commercial insurance. Georgia's framework also flows through Medicaid MCO contracts, making parity requirements enforceable where a large share of children—more than 70% of Georgia's Medicaid enrollees are children—and low-income families get care.

It was written to withstand "deference" games.
By spelling out standards in the statute itself, Georgia reduces reliance on shifting regulatory interpretations. The Parity Act anticipated the outcome of a 2024 Supreme Court decision, and its length results in courts and regulators being directed back to the statutory text.

It pairs clinical integrity with enforcement hooks.
Because the definitions are statutory, deviations aren't just "policy disagreements"—they're violations of state law and contract (for MCOs), opening the door to corrective action, withholds, and recoupment.

It aligns neatly with new federal transparency.
Starting January 1, 2026, Section 1557's PCDST rule requires denial letters to name the decision tool and explain how it was applied. Georgia's uniquely specific standards make those disclosures immediately actionable for enforcement.

Bottom line: Georgia didn't just say "treat mental health like medical." It wrote **how** to decide medical necessity for MH/SUD into the law—evidence-based, clinician-recognized, independent—and made those rules binding on insurers and Medicaid MCOs. That precision is what makes Georgia's parity statute unusual and, if enforced, powerful.

APPENDIX D: SUBCOMMITTEE ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Intellectual and Developmental Disabilities

2025 Annual Report

Chair

Carol Britton Laws, Ph.D.

Members

Cindy Levi

Sen. Sally Harrell

Dr. Harry Hamm

Gwen Skinner

Deanna Julian

Ron Wakefield

November 2025

Report prepared with assistance from the Georgia Health Policy Center and the Center of Excellence for Behavioral Health & Wellbeing at Georgia State University

Table of Contents

Introduction

House Bill 514 (from the 2019 General Assembly session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees to review these focus areas, including the Subcommittee on Intellectual and Developmental Diseases, chaired by Dr. Carol Britton Laws.

In 2025, the Subcommittee on Intellectual and Developmental Disabilities held four public meetings. The following topics were covered: current work of the IDD Workgroup, direct service professionals (DSPs) workforce interventions, and employment for individuals with IDD, statewide comprehensive needs assessments, topics of concern for people with disabilities and families in Georgia, and out-of-state placements of people with IDD. This report includes a summary of the subcommittee's public meetings and its 2025 recommendations.

List of Presenters to the BHRIC Subcommittee on Intellectual and Developmental Disabilities

BHRIC Subcommittee on Intellectual Developmental Disabilites

Dr. Carol Britton Laws, Chair
Cindy Levi, Sen. Sally Harrell, Dr. Harry Hamm, Gwen Skinner, Deanna Julian

Support to the BHRIC Subcommittee on Intellectual Developmental Disabilities

Ashlie Oliver and Courtnee King, Georgia Health Policy Center (GHPC)

Presenters to the BHRIC Subcommittee on Intellectual Developmental Disabilities		
Date	**Topic**	**Presenter**
Aug. 20, 2025	DBHDD Intellectual and Developmental Disabilities Workgroup Progress	**Ron Wakefield** Director, Intellectual and Developmental Disabilities Services, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) **Rita Young** Chair, Assessment Tool Subcommittee **Bruce Lindemann** Chair, Planning List Subcommittee **Diane Wilush** Chair, New Waiver Subcommittee
Sept. 10, 2025	Direct Service Professionals Workforce Interventions	**Ashleigh Caseman** Director, Office of Medicaid Coordination and Health Systems Innovation, DBHDD **Dr. Sandra Pettingell** Research Associate, Institute on Community Integration, University of Minnesota
Sept. 24, 2025	Employment Opportunities for Individuals with Intellectual and Developmental Disabilities	**Ben Dell** Coordinator for Intellectual and Developmental Disability and Project SEARCH, Georgia Vocational Rehabilitation Agency **Doug Crandell** Advancing Employment
Oct. 22, 2025	Statewide Comprehensive Needs Assessment; Topics of Concern for People with Disabilities and Families in GA; Out of State Placement	**Dr. Hamida Jinnah** Associate Research Faculty; Director, Research and Evaluation; Institute on Human Development and Disability, University of Georgia (UGA) **Katie Bailey, LCSW** Director of Project and Operational Strategy; and Sheila Jeffrey, Project Assistant, Sangha Unity Network. **Ashlie Oliver, MPA** Senior Research Associate, Center of Excellence for Behavioral Health & Wellbeing, GHPC **Ana Laboy, Ph.D.** Senior Research Associate, Center of Excellence for Behavioral Health & Wellbeing, GHPC **Courtnee King, MPP** Research Associate I, Center of Excellence for Behavioral Health & Wellbeing, GHPC

Summary of Presentations to Subcommittee

DBHDD Intellectual and Developmental Disabilities Workgroup Progress

Presentations from Ron Wakefield, Director, IDD Services, DBHDD; Rita Young, Chair, Assessment Tool Subcommittee; Bruce Lindemann, Chair, Planning List Subcommittee; and Diane Wilush, Chair, New Waiver Subcommittee

Commissioner Tanner provided background on BHRIC, which was created during the 2019 legislative session to make improvements to behavioral health services in Georgia. During the 2025 legislative session, it was codified that the commission would sunset at the end of 2026. The legislation added two new subcommittees, Intellectual and Developmental Disabilities (IDD) and Addictive Diseases. The subcommittees will hold several meetings and make recommendations that will be included in the annual report.

Dr. Carol Britton Laws, the chair of the IDD subcommittee, is a clinical professor at the University of Georgia (UGA) and a national expert in IDD. She has a background in social

work and works with the Institute of Human Development and Disability. She has been working in this field for over 20 years. She hopes to use her experience to bring perspective to the IDD subcommittee. Dr. Laws shared that a lot of work has been happening, so the group is not starting from scratch. The goal is to discuss the next steps and how the group can help move them forward.

Ron Wakefield shared that the Senate Study Committee on Individuals with IDD and Waiver Plan Access created recommendations in 2022 to create the commission and to refine the waiver planning list. From September 2023 to February 2024, the IDD workgroup convened. There was a cross section of stakeholders engaged in the work. The workgroup recommended a longer-term planning project to better examine challenges to the IDD planning list, identify priority recommendations, and develop specific business cases to support decisions and implementation, considerations for new waiver requests, and criteria for IDD planning list subpopulations.

DBHDD contracted with Guidehouse Inc. to evaluate DBHDD's current approach to managing the planning list for the NOW and COMP waivers and provide recommendations to optimize the process for allocating funding for waiver services. The work included a current state assessment, an environmental scan, a five-year service forecast, community and partner engagement, and a final report. The final recommendations include enhancing the prioritization of waiver offers via an urgency screening tool or updates to the Determination of Need Revised (DON-R) assessment tool, implementing a multilist model, creating an additional 1915(c) waiver for developmental disabilities (DD), and enhancing data analysis and reporting.

The IDD Workgroup was reconvened in March 2025 in partnership with the Division of IDD to develop strategies, action steps, and timelines for implementing recommendations from the Guidehouse report. The work is being conducted through three subcommittees including Assessment/Screening Tool, Planning List, and New Waiver.

Assessment Tool Subcommittee
The DBHDD IDD workgroup Assessment Tool subcommittee is chaired by Rita Young, with the Participant Directed Advocates of Georgia. The subcommittee meets bimonthly and will continue to through the end of 2025. Their work to date includes the following:

- Reviewed the Guidehouse report and recommendations;
- Reviewed Georgia's current assessment instrument (DON) and urgency criteria — Georgia revised the instrument by adding medical and behavioral health assessments, resulting in changing the name to the DON-R;
- Reviewed the Guidehouse-recommended assessment — the Prioritization of Urgency of Need for Services (PUNS) and the Screening for Urgency of Need (SUN);
- Met with Pennsylvania support coordinators who have utilized the PUNS for years to learn from their experience;
- Contacted Louisiana officials regarding their experience with the SUN;

- Engaged in a demonstration of the administration of the DON-R; and
- Reviewed a crosswalk of the three instruments.

The subcommittee found that all the tools have their strengths and weaknesses. There is not one tool that is better than the others. Considerations for the benefits and challenges of each tool can be found in the full notes for this meeting, which can be made available upon request.

Assessment Tool Subcommittee Recommendations
The Assessment Tool subcommittee recommendations to date include:

- Face to face, in-home interviews are preferable for establishing rapport and assessing the living situation. Consider a hybrid approach based on family preference and DBHDD workload issues.
- Use best elements from DON-R, PUNS, and SUN.
- Contract with the Ralston Institute at UGA to conduct a validation study of new instrument.
- Consider a tiered approach to reassessment of individuals on planning list.
- Utilize the urgency criteria created by the subcommittee.

Next steps for the workgroup include the following:

- Create new assessment tool.
- Conduct a focus group including members from underrepresented populations to provide critical feedback regarding the new tool.
- Assist in the design of training and education for DBHDD navigators and other staff members.
- Assist in the design of a communication plan for individuals and families, providers, and community partners and stakeholders.

Planning List Subcommittee
The Planning List Subcommittee is chaired by Bruce Lindemann with the Developmental Disabilities Advisory Council. Its work to date includes the following:

- Reviewed the Guidehouse report and recommendations.
- Reviewed the current planning list.
    - As of March 31, 2025, there were 7,833 individuals on the Planning list. The age range was from two2 to 89 years.
    - DON-R scores are listed, with 644 individuals have score of "0."
    - Urgent indicator captured. Over 1,300 people said urgent care was needed, 6,000 said no, and 400 did not answer.

- Reviewed urgency criteria used in PUNS in Pennsylvania.
- Reviewed DBHDD process maps for applying for services.

Planning List Subcommittee Recommendations
Recommendations to date include to:

- Utilize the three-tier structure, as recommended by Guidehouse, but with a revision to the original time frames —
    - Immediate list — individuals need services within the current fiscal year.
    - Planning list — individuals will need services within the next one to five fiscal years.
    - Forecasting list — individuals will need services in the next six-plus fiscal years.
- Require that all data elements included on the planning lists be completed — no blank data fields allowed.
- Add data fields to better track movement of individual through the process, such as —
    - Date assigned to navigator for assessment.
    - Date assessment is completed.
- Improve communication and data sharing with the Department of Education and the Division of Family and Children Services — data from DFCS and DOE should be used to help populate the forecasting list.
- Consider establishing a minimum age at which an individual or his or her family should submit a waiver application.
- Develop an individual/family portal in the new electronic system to allow individuals and families to track progress.

Next steps for the workgroup include the following:

- Design the three-tiered list model based on the chosen assessment instrument.
- Assist in the design of communications to individuals, families, providers, and stakeholders.
- Assist in the design of training and education for DBHDD staff members, providers, and stakeholders.

New Waiver Subcommittee
The New Waiver subcommittee is chaired by Diane Wilush with United Cerebral Palsy.

The subcommittee's work to date includes:

- Review of Guidehouse report and recommendations;

- Reviewed the waiver eligibility criteria federally and in the Southeast states;
- Requested and reviewed data including the number of individuals receiving family support services in fiscal years (FYs) 2023 and 2024, what they are receiving and are they on the current planning list and how many individuals receiving family support services are ineligible for waiver services, and cost of services;
- Reviewed family support services policy and procedures including family support services, direct and brokered goods, and services list and protocols; and
- Reviewed each service and determined whether it should be included in new waiver services.

New Waiver Subcommittee Recommendations
Recommendations to date:

- Set aside an amount of state dollars to continue capacity to serve individuals who do not meet waiver eligibility criteria.

Next steps for the workgroup include the following:

- Determine eligibility criteria for new waiver;
- Categorize services into broader service definitions;
- Consider service funding caps per service; and
- Assist in the design of a communication plan for individuals and families, providers, and community partners.

Ron Wakefield thanked the members of the subcommittees for volunteering their time. The commissioner charged the group with completing the work by the end of this year, but some of the work will go beyond this year.

Ron Wakefield shared some of the future work that the department is engaged in. One issue is provider shortages following the pandemic. There is a group of people trying to tackle the workforce issue, including by providing incentives, improving credentialing, and other activities. The group discovered that the people with the most complex needs do not have providers able to serve them at the level of need that is required. Trying to find the reasoning for this is a focus of the department. Three new service lines were introduced, including intensive Community-Based Residential Alternatives (CRA), behavior-focused CRA, and specialized transitional CRA. Person-centered development is a critical component of each.

Following the last rate study, DBHDD introduced the Georgia DBHDD Provider Transformation Proposal, which is a project to encourage providers to work more toward community integration. One area includes working on increasing intensive technical assistance for providers, families, and individuals. There is more to come with this.

Direct Support Professionals Workforce Interventions

Presentations from Ashleigh Caseman, Director, Office of Medicaid Coordination and Health Systems Innovation, DBHDD; Dr. Sandra Pettingell, Research Associate, Institute on Community Integration, University of Minnesota

Ashleigh Caseman shared that the IDD network has a workforce shortage that was exacerbated by the public health emergency. DBHDD has been focused on solutions including an IDD rate study, pilots, and employee resource network.

2021 National Core Indicator data showed that the turnover ratio for direct service professionals (DSPs) is 44.3% within the first six months of employment. The full-time vacancy rate is 18.1%, while the part-time vacancy rate is 24.3%. In Georgia, among DSPs who were employed as of Dec. 31, 2021, 16.7% were employed less than six months, and 14.5% were employed between six and 12 months. These numbers are due to low wages and the demanding characteristics of the job. Compared to the national average, Georgia is below the average in several arenas, including wages, paid time off, health insurance, and other fringe benefits.

The bipartisan Senate Study Committee on People with IDD and Waiver Plan Access was authorized by Senate Resolution 770 during the 2022 legislative session. The committee was tasked with examining home and community support structures provided to individuals with IDD and recommending a plan for how to adequately serve individuals with IDD. Beginning in 2022, the DBHDD Division of DD established a workforce development workgroup as part of the American Rescue Plan Act (ARPA) initiative. The focus of the workgroup is on low wages and benefits, insufficient competency-based training and supervisory and mentoring supports, lack of career ladders or advancement opportunities and professional growth, lack of a pipeline generating a new engaged DSP workforce, high turnover rates, and overall high demand of being a DSP.

In 2023, DBHDD updated rate recommendations for services provided through the NOW and COMP waivers. A rate review is now required every four years per legislation. The FY 2024 state budget approved the rate study recommendations, which was a $107 million provider rate increase for NOW and COMP providers. DSP wages increased from $15.18 an hour to $16.70 an hour.

Updated 2023 NCI data shows a significant decrease in employee turnover, with a 15 percentage-point decrease over four years and historic wage increases.

DBHDD has three pilot programs for DSPs to earn a competency-based certification that recognizes their knowledge and skill in supporting people with IDD in community-based settings. These pilots are funded by ARPA. Each pathway includes approximately 50 hours of competency-based online instruction through Relias or the College of Direct Support and an assessment that will lead to a DSP entry-level credential (DSP-I). Certification is based

on the CMS core competencies for DSPs. There was no cost to the DSP to participate, but they did receive a one-time stipend for completing the certification.

Competencies that are built into the workforce-development strategies can improve workforce recruitment and retention. The workforce must have the knowledge, skills, and ethical compass to perform a wide array of tasks that support people with IDD to be healthy, safe, valued, and engaged members of their communities. The CMS core competencies set includes communication, person-centered practices, evaluation and observation, crisis prevention and intervention, safety, professionalism and ethics, empowerment and advocacy, health and wellness, community living skills and support, community inclusion and networking, cultural competency and education, training, and self-development. A certification program tests the knowledge and skills required to perform the job. It also introduces a career ladder to promote tenure.

The National Alliance of Direct Support Professionals (NADSP) E-Badge Academy program is administered by United Cerebral Palsy. DSPs must complete 50 hours of online learning through Relias or the College of Direct Support and apply the learning in practice. The E-Badge Academy sought to support 200 DSPs, 20 DSPs at 10 provider organizations from February of 2024 to the extension through 2025.

The E-Badge Academy is designed to encourage participating DSPs to complete NADSP-Accredited trainings and to use the information gained through training in their work. There are two major badge categories. The first is an Accredited Education badge focused on knowledge. To claim this badge, a user must upload training records documenting the completion of NADSP-accredited training. The second is a Core Competency badge focused on skills and values. To claim the badge a user must upload a testimonial describing an example of their work that meets the requirements for the badge.

Each of the Core Competency badges is associated with one skill statement from the CMS Core Competencies. For example, earning the Respectful Communication badge indicates that the participant has demonstrated that they communicate with the individual and his or her family in a respectful and culturally appropriate way. In writing the testimonial, the learner addresses the following prompts: describe an example in which your use of respectful communication had a positive impact on a person you support; explain how your use of respectful communication aligns with the NADSP Code of Ethics.

Each submission of a testimonial is evaluated by NADSP staff who are trained to assess the quality of the testimony provided. The process involves evaluating if the testimonial demonstrates the skill statement associated with the badge, if the testimonial addresses the first prompt for this badge, if the testimonial addresses the second prompt for this badge, and if the work described in the testimonial is in line with the NADSP Code of Ethics.

To earn the DSP-I certification level requires at least 15 badges, which must include the Code of Ethics Commitment badge, the 50 hours of accredited education badge, and at least one Core Competency badge from crisis prevention and intervention, safety, person-centered practices, or health and wellness.

The pilot took place between February 2024 and September 2025. As of June 2025, there were 351 certificates awarded, including 177 participants who earned the DSP-I, 107 who earned the DSP-II, and 67 who earned the DSP-III, the highest level. There are several additional certificates to be awarded this month.

The Department of Labor (DOL) Certified DSP Apprenticeship program is administered by River Edge Behavioral Health. Every apprentice completes 159 virtual training hours through Relias. An assigned mentor will be coupled with the apprentice at each provider agency. The pilot was started in February 2024 and will sunset in September 2025.

Registered apprenticeships are industry-vetted and approved and validated by the U.S. DOL. Some key elements of all registered apprenticeship programs include that it is a paid job, there is structured on-the-job learning and mentorship, they receive supplemental education, the programs are diverse, there are quality and safety protections, and apprentices receive credentials.

The benefits of the program to provider organizations include recruiting and developing a highly skilled workforce that can help grow their business; improving productivity, profitability, and an employer's bottom line; creating flexible training options; minimizing liability costs through appropriate training; and increasing the retention of workers, during and following the apprenticeship program. The provider organization has several responsibilities, including registering through an application with the DOL and DBHDD to participate, providing a mentor for apprentices that enroll in the program, and paying the apprentice a minimum of $10 per hour. Once the pilot ends, the plan is to be able to increase provider rates based on staff credentials through the rate study. Additionally, there are several benefits for the staff going through the program, including earning a paycheck, mentoring provided by a seasoned employee, rewards for being productive, credit for prior learning and experience, taking pride in accomplishments, being considered a valued employee, and opportunities for advancement.

A total of 245 apprentices achieved DSP-III, with a possibility of 10 more completing soon. 26 provider agencies participated in the pilot, 176 apprentices completed the initial pilot, and an additional 86 participants participated in pilot extensions. There was an 82% completion rate, with the possibility of going up to 86% by the end of the pilot extension. Additionally, 18 mentors enrolled to receive credentialling after they completed work with the apprentice. One hundred percent have completed the coursework.

The DSP Training and Assessment Program (TAP) was created through ARPA funds. The program is led by the Institute on Human Development and Disability at UGA. The online credentialing option is open to learners who are already employed by support providers, those in self-direction, and those who are interested in working with adults with IDD. There is a self-paced online competency-based training component and an online exam that is proctored remotely. Learners enrolled in online courses in spring and fall 2024. The DSP-I exam was delivered in August 24 and January 25. DSP-II courses were offered in spring 2025, and the exam was administered in June 2025.

This pilot was informed by the Institute on Credentialing Excellence, which is a leading developer of standards for both certification and certificate programs and is both a provider of and a clearinghouse for information on trends in certification, and test development and delivery. The purpose of the DSP TAP is to prepare potential DSPs for the job and recognize the competency of DSPs who are currently working in the field.

Learners completed a self-paced online competency-based training offered over the course of one spring or fall semester. There was a standardized exam that measures DSP knowledge and skill. The exam was developed to meet Institute for Credentialing Excellence National Commission for Certifying Agencies accreditation standards. The exam can be delivered to anyone regardless of employment setting, and it is replicable and scalable to meet state needs. The DSP TAP includes staff of people in participant/self-directed programs.

The learner takes courses through the College of Direct Support and engages in a series of lessons in the DSP-I, entry-level curriculum and a DSP-II, emerging-level curriculum. The curriculum is developed by the Research and Training Center on Community Living at the University of Minnesota. National advisory and editorial boards comprising leading subject matter experts ensure the content follows best practices.

To support learners, there were monthly technical assistance meetings held on Zoom, a learner handbook was developed, and the learner could print transcripts for all modules completed.

After completing the DSP-I entry-level curriculum, learners could sit for the DSP-I Credentialing Exam, which is designed to measure the knowledge and skills identified by the CMS Core Competencies for beginners in the direct support field. Certified DSP-Is could then complete the DSP-II curriculum and exam. The exam is written to be accessible to learners with low literacy and for those who do not speak English as their first language. The exam is also designed to meet the NCCA accreditation standards.

To develop the exam, subject matter experts were consulted, including DSPs, provider organizations, people with disabilities, front-line supervisors, researchers, the DSP advisory council, and Uniting for Change. Subject matter experts were used at all levels of development. The job description for entry-level DSPs was also looked at, including the CMS core competencies, DSP credentialing toolkit, and subject matter experts.

For spring and fall 2024 DSP-I cohorts, there were 559 registrants in the College of Direct Support, and 490 completed the coursework. Four hundred forty learners registered to take the exam, and 426 passed the exam. The DSP-II spring 2025 cohort had 320 registrants and 277 who completed the coursework. Of the 272 registered to take the exam, 260 passed.

An independent evaluation of the DSP pilots was conducted by the Institute on Community Integration at the University of Minnesota. The evaluation has two components, including a

formative evaluation that tracks and reports on the pilot implementation and a summative evaluation that examines the expected outcomes. In collaboration with the pilot leads and DBHDD, an evaluation was developed and was consistent across all three pilots.

There were five questions that guided the evaluation:

- Are the pilots being implemented as intended?
- Are the expected number of staff enrolling in the pilots?
- Did the expected number of staff receive certifications?
- Are staff (and other stakeholders) satisfied with their certification experience and effort required?
- Are staff (and other stakeholders) satisfied with the impact of the certification?

Evaluation methods included tracking and documentation of implementation approach and progress, tracking completed certifications, surveying participating staff and organizations, and conducting focus groups of participating staff. Individual evaluation reports will be completed for each pilot, as well as a summary cross-pilot evaluation report, and will include recommendations for sustainability.

Employment Opportunities for People with Disabilities

Presentations from Ben Dell, Intellectual and Developmental Disability and Project SEARCH Coordinator, GVRA; and Doug Crandell, Institute on Human Development and Disability

Ben Dell, from the Georgia Vocational Rehabilitation Agency (GVRA), shared that GVRA's mission is to serve Georgians with disabilities to empower them to live independently. GVRA is a client-focused agency that partners with the community to expand opportunities for Georgians with disabilities. There are five divisions of GVRA, including vocational rehabilitation, the Roosevelt Warm Springs/Cave Spring Center, Disability Adjudication Services, the Business Enterprise Program, and the Georgia Industries for the Blind. GVRA serves 40,000-plus individuals, and 20,000-plus students and adjudicated 90,000-plus claims annually. GVRA's employee turnover rate has decreased from 30% in FY 2023 to 22% in FY 2024 and has remained at 22% in FY 2025. There are three levels of counselors, with different levels of training and experience. There are currently 178 counselors and 15 vacancies around the state.

Individuals can apply for GVRA services through the local education agency, through GVRA, or through DBHDD's supported employment collaboration. An individual is eligible for services if they have a physical or mental impairment, want to work, and require services.

In a vocational rehabilitation case, documentation is important to not slow down an individual's case flow. A vocational rehabilitation case is "Closed-Rehabilitated" when the individual has received services under a plan for employment to achieve the desired

employment outcome, the employment is in the most integrated setting possible, employment is compensated at or above minimum wage, employment has been stably maintained for 90 days, the individual and GVRA determine employment to be satisfactory, and the individual is informed of the availability of post-employment services.

There are instances where the vocational rehabilitation case is "Closed-Other than Rehabilitated" in the case of a criminal offender or current incarceration, death of individual, extended services not available, health/medical, no longer eligible, no longer interested in receiving services, transferred to another agency, unable to locate or contact, and "all other reasons."

Intellectual disability has an overall general population prevalence of approximately 1%. About 6.5 million people in the United States have an IDD. Only 19.1% of people in that population are employed, compared to the employment rate of people without disabilities, which is 61.8%.

Georgia has a disability prevalence rate of about 13%. "Cognitive difficulty" makes up approximately 5% of overall population, with more than half being considered "working age adults."

A large number of case closures in FY 2023 were cases that were not actively receiving services due to individuals not participating. Many case closures are due to individuals no longer being interested in receiving services or because they were unable to be contacted or located after multiple attempts. IDD cases were closed-rehabilitated about 10% more often. Supportive employment services are a big reason why cases are closing successfully. Of the 1,026 successful closures since 2023, the average wage is $11.56, and the average hours worked is 24 hours per week.

There is a large amount of IDD cases in urban population areas in Georgia, which could be due to a higher overall population in those areas but also could be that in some of the more rural areas there is less information about these services and unknowns around how it would impact Social Security or other public health benefits. To address this disparity, there is a need to provide information and education early around the state.

GVRA's Pre-Employment Transition Services (PRE-ETS) represents the earliest set of services available for students with disabilities. They are individualized and based on the student's interest and transition goals. These services are short-term and are designed to help students identify career interests. The five PRE-ETS are job exploration counseling, workplace readiness training, work-based learning experiences, postsecondary education counseling, and instruction in self-advocacy.

PRE-ETS is a large part of what GVRA is doing. They are mandated that 15% of their budget is dedicated to PRE-ETS.

Common transition services include community work adjustment training, assistive work technology, on-the-job training, specific vocational training, job coaching, supported employment, and customized supported employment.

There are three types of supported employment, including traditional supported employment, individual placement and supports supported employment, and customized supported employment, which is a new supported self-employment.

Doug Crandell then shared that the work of Advancing Employment is supported by the Georgia Council on Developmental Disabilities (GCDD) through the Advancing Employment Community of Practice. Each year, the Community of Practice votes on the policy imperatives on which to focus. Advancing Employment blends policy work with assistance and training, along with partners such as GCDD; they prioritize bringing state as model employer to Georgia. This month is the first time in Georgia that state agencies must report on how well they are recruiting and maintaining workers with disabilities. Georgia's challenge is fragmentation, but that is improving. Georgia became the 20th state to phase out subminimum wages in the state for workers with disabilities.

Disabilities Benefits (DB) 101 is a federal grant that has allowed Georgia to tailor a disability benefits 101 to Georgians specifically. Individuals can put in their information such as their job, and their hours and can see how that will affect their benefits.

Self-employment policy changes have been implemented over the last six years. Georgia is now one of three states that have supported self-employment policies.

A current policy operative is implementing job coaching with natural supports.
There are two new initiatives related to employment, including Rotary International, which has an inclusive employment hiring partnership, which happens in Canada. They are trying to expand to the United States. The second program is Putting Faith to Work, which utilizes faith networks to help people find work.

During the Q-and-A, several questions and concerns arose related to the number of individuals categorized as "no longer interested in services." It was suggested that exit interviews or other feedback mechanisms be implemented to gather more information. Other questions were raised about the accessibility of services for rural parts of Georgia, including service provision and barriers to access such as transportation. Ben Dell shared that GVRA can provide some assistance, but they are not able to provide transportation for the life of the job, but try to empower the individual to have a plan of transporting to and from work.

DeAnna Julian commented that coming from Albany and trying to serve the more rural areas, it is exceedingly difficult to get counselors down there; it is worth it for the committee to look at. Looping back to people being disinterested in services, DB 101 can really be great to give a clear sense of what it can look like for people if they are unsure about going to work for their benefits. Transportation is a huge barrier for those without public transportation and who can't rely on natural supports.

Ben Dell clarified that the exclusionary criteria for criminal behavior refers to someone who has been incarcerated or tied up in the criminal justice system. Threats against GVRA staff are also an exclusionary behavior. Also is if an individual is actively participating in illegal drug use. Part of our eligibility is that an individual is able to benefit from services, and people using drugs are less able to benefit.

Ben Dell shared that the goal is that an individual would be assigned to the same counselor throughout their process. He also shared that intake is based on the individual completing the referral. It is similar to any way to sign up for services — the intake interviewer speaks with the person about their goals, and then they are connected to a counselor. After initial online or paper sign-up, they have the opportunity to do the rest of the process in person. Where the client is seen is dependent on where the counselor is located. There are currently 178 counselors and 15 vacancies. So, there are 193 counselors "fully staffed" across the state.

Counselor level 1s have a 30-day training period before they are expected to manage a caseload. The training includes learning modules and training and mentorships with counselor level 3s in their office. Or, they receive training on supported employment services.

Following a question about DB 101, Ben Dell shared that lack of awareness is an obstacle. One of the challenges is exploring how to pilot trainings from parent to parent and GVRA counselors getting this out there. They need to figure out how to pilot, gather data, and improve.

Following a question about barriers for the deaf population, Ben Dell shared that they have a deaf and hard of hearing unit at GVRA to serve that population, and it is supported by sign language interpreters as needed.

Statewide Comprehensive Needs Assessment; Topics of Concern for People with Disabilities and Families in GA; Out of State Placement

Presentations from Dr. Hamida Jinnah, Associate Research Faculty; Director, Research and Evaluation Unit; IHDD UGA; Katie Bailey, LCSW, Director of Project and Operational Strategy, Sangha Unity Network; Sheila Jeffrey, Project Assistant, Sangha Unity Network; Ashlie Oliver, MPA, Senior Research Associate, Center of Excellence for Behavioral Health & Wellbeing, GHPC; Ana Laboy, Ph.D., Senior Research Associate, Center of Excellence for Behavioral Health & Wellbeing, GHPC; and Courtnee King, MPP, Research Associate I, Center of Excellence for Behavioral Health & Wellbeing, GHPC

Hamida Jinnah presented on two needs assessments completed around employment for people with IDD. The first is the 2023 Georgia Statewide Needs Assessment, State Rehabilitation Council (SRC) at GVRA. The methodology is based on the Rehabilitation Services Administration's (RSA's) recommended process for all states to complete every

three years. Georgia had not completed this process for over a decade. This is the second iteration of the needs assessment. Online and paper surveys were administered with accommodations where needed as well as interviews and focus groups. There were 350 surveys completed by IDD, 426 by key stakeholders, 112 by employment service providers, and 21 by employers.

Key findings include that the top three barriers to employment for people with disabilities include access to dependable transportation, misconceptions and low expectations among professionals, and fear of losing benefits. Additional barriers identified include lack of long-term services and ongoing job coaching, employers' concerns about risks associated with hiring individuals with disabilities, poor job performance, and a lack of job preparation. The populations identified as most likely to be underserved or unserved include individuals with significant or complex disabilities, individuals with IDD, and individuals with psychiatric disabilities/mental illness. Identified barriers to employment for racial and ethnic minority populations include lack of long-term services and ongoing job coaching, employers' concerns about risks associated with hiring individuals with disabilities, poor job performance, and lack of job preparation, skills, or education needed for the job.

A large focus of GVRA is on youth. Identified barriers to employment for youth and students with disabilities and transition-age youth include access to dependable transportation, lack of awareness about vocational rehabilitation services, and limited work experience. Key services needed for youth and students with disabilities related to transition include:

- Job skills training and transportation assistance;
- Long-term job services and on-the-job support;
- Transition services to prepare to move from education to employment;
- Starting transition and career planning as early as middle school;
- Educating and informing parents earlier about the available services for students with disabilities both through GVRA and other provider agencies; and
- Standardizing the PRE-ETS curriculum and delivery of services.

Providers agreed on the need to improve and expand existing community resource providers (CRPs) in Georgia, including increasing their capacity to offer training and support services, customized employment services, and transportation assistance. CRPs should develop expertise in serving specific populations, including deaf and hard of hearing individuals, people with visual impairments, transition-age youth, racial and ethnic minorities, and individuals with significant disabilities.

Factors identified that keep businesses from hiring, retaining, or promoting individuals with disabilities include concerns about liability and workers' compensation; uncertainty about how to provide disability-related accommodations; limited understanding of

disabilities; lack of necessary skills, credentials, education, or job preparation among applicants; budget restrictions or hiring freezes; safety concerns; challenges with job retention; cost of accommodations; lack of dependable transportation; poor job performance; and disability-related factors.

The second needs assessment was the 2023 Georgia Employment Needs Assessment from the Georgia Council on Developmental Disabilities (GCDD). This was a combination of online and paper surveys, interviews, and focus groups. One hundred eighty-eight surveys were completed, which included 92 individuals with disabilities, 40 family and caregivers, and 56 key informants. Eighty-eight individuals provided input through interviews or focus groups, including 56 individuals with disabilities, five family members or caregivers, and 27 key informants.

Themes arose around barriers to getting or seeking a job. Individuals with disabilities noted barriers such as access to dependable transportation, concerns about accommodations, and misconceptions and low expectations among professionals. Key informants identified barriers including access to dependable transportation, fear of losing SSI or SSDI benefits, and employer concerns about risks of hiring individuals with disabilities. Family/caregivers identified barriers including employer concerns about risks of hiring individuals with disabilities, misconceptions and low expectations among professionals, and access to dependable transportation.

Another theme was helpful in obtaining meaningful employment. Individuals with disabilities identified on-the-job supports, job placement, and postsecondary education as helpful services. Key informants identified transition services, job development and placement, and on-the-job supports as helpful services. Family members and caregivers identified supported employment with extended follow-up, on-the-job supports, and job development and placement as helpful services.

In terms of aspects that have positively impacted the ability to obtain and maintain employment, individuals indicated more understanding employers about their specific needs, job skills training, and on-the-job supports. Key informants identified job skills training, better knowledge of how employment would impact benefits, and more understanding employers about their specific needs. Family members and caregivers identified more understanding employers about their specific needs, on-the-job supports, and customized work requirements as positive impacts.

Katie Bailey then shared that since 2018, the Sangha Unity Network has had a grant from the GCDD to support the growth and expansion of a statewide grassroots network of self-advocates, which became Uniting for Change. Uniting for Change envisions a community where all people belong and are heard. A place where people are involved speak out and

make their own choices and are seen and treated as equal and true to their destiny. This network is led by a group of committed self-advocate leaders.

Adults with disabilities indicated that what they wanted and what they wished was different. Some quotes from people with disabilities were “tear the roof off my sheltered life,” “go where I want, make new friends, rights to vote, go where I want, the right to open my own mail,” and “learn how to work a computer.” These quotes were from seven years ago, but Uniting for Change is hearing much of the same wants. Uniting for Change has been teaching the Home- and Community-based Services Settings Rule to self-advocates and to providers. Some of the things that would help and support people with the things they indicated they wanted in 2018 are full access and integration into their communities, individual initiative, autonomy and independence, individual rights including privacy, dignity, respect and freedom from coercion and restraint, and person-centeredness.

An online survey was launched and 209 self-advocates responded. Sixty-five people indicated that they use a NOW waiver, 74 identified that they use a COMP waiver, 24 indicated that they had state-funded services, 12 indicated that they were on a planning list, four indicated that they privately pay for support services, and 30 indicated that they did not have a waiver nor were they on a planning list.

One survey question asked what was most important to self-advocates in Georgia. The top 10 responses were being heard and respected, relationships, support when requested, helping others, work/being employed, respect, valued social roles, real choice and autonomy, education and learning, and activities of their choice.

From the 209 responses, several themes emerged. The first theme was transportation. Key issues identified include a lack of reliable public transportation or paratransit, few options in rural areas, inaccessible infrastructure, and a desire for personal transportation. The next theme was related to housing and independent living. Key issues identified include affordable, accessible housing scarcity; desire to live with friends, partners, or alone; being stuck in unwanted group home placements; and a lack of flexible living supports. The third theme was access and opportunity. Key issues identified include loneliness, a desire for meaningful friendships and the need to make real connections, limited real options, lack of transportation and inaccessible environments, and communication getting misunderstood or ignored. The next theme was work and economic access. Key issues identified include the need for real job opportunities, not just token positions, low wages and a lack of benefits, the need for skill development and career support, and financial limits on independence. The last theme related to respect and voice. Key issues identified include being ignored, spoken over or not believed, decisions being made without consent or input, and a lack of inclusion in conversations and planning.

Dr. Laws shared that a recent survey was sent out to a participant-directed listserve and Uniting for Change membership and received 49 responses. The questions asked the respondent to indicate what they would like the IDD Subcommittee to focus on and why. Key words that emerged were community, service, housing, family, support, transportation, and needs. Topics most frequently cited were housing, including long-term affordable options, standardized room and board policies for providers, options for medically complex support needs, training to families and providers to de-escalate before crisis to keep people out of jails and hospitals, hiring staff, aging parents, community engagement including transportation and job coaching, and medical, including behavioral health and suicide prevention, audiology services, and dental.

GHPC shared that there are currently eight adults with IDD that are placed out of state. The longest placement was made in September 2019. They were served through the Georgia IDD Crisis System prior to being referred to intensive services and rehabilitation programming out of state due to the acuity of their needs resulting in health and safety concerns for themselves and/or others. Individuals had multiple service disruptions in Georgia due to significant and repeated property damages causing unsafe environments and/or repeated physical aggression events to self and/or others.

In FY 2024, there were 22,045 students with a significant developmental delay and 16,472 students with an intellectual disability (ID) in Georgia. Comparatively, in FY 2020 there were 19,815 students with a significant DD and 16,710 students with an ID in Georgia.

During the Q-and-A, Hamida Jinnah shared that for the two reports, online surveys were posted on their website, and partners across Georgia helped circulate those surveys. They did rigorous outreach and made sure that rural and urban counties were represented. Katie Bailey shared that they used a similar outreach effort. They have over 8,000 people on a mailing list, many of which include the DBHDD providers, and all self-advocates who have participated in anything before. They also offered a $50 gift card as a drawing.

Following a question about lower functionality people potentially being left out of the surveys, Katie Bailey shared that the majority of the people who answered probably live in more independent areas or with families. They asked providers and support coordinators when they were conducting their visits to try to support someone to answer. Dr. Laws shared that for her survey, some of it was completed with assistance. So, there were supporters who entered the information after asking a service recipient the question and then getting their response, and they typed it for them or there was some facilitation. Hamida Jinnah shared that in both surveys, the first question was, are you the individual with disability or someone else? And then if it’s someone else they have the data on who completed it for them.

Regarding a question related to children placed out of state, it was clarified that there are some children that are out of state but were placed by different agencies. DBHDD does not have that information. One of the difficulties is that some of the children, especially in relation to autism, can also be diagnosed with another behavioral health diagnosis and so they may be captured in some of the numbers that are out of state under a different diagnosis.

Recommendation Priorities

The Intellectual and Developmental Disabilities Subcommittee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action:

1. Utilize the urgency criteria created by the DBHDD Intellectual and Developmental Disabilities Subcommittee on Assessment and conduct a validation study of the new assessment instrument.
2. Utilize the three-tier structure, as recommended by Guidehouse, but with a revision to the original time frames —
    a. Immediate list — individuals need services within the current fiscal year.
    b. Planning list — individuals will need services within the next one to five fiscal years.
    c. Forecasting list — individuals will need services in the next six-plus fiscal years.
3. Develop an individual/family portal in the new electronic planning list system to allow individuals and families to track progress.
4. Develop a communication strategy with families on the waitlist. Work with the Department of Education on identifying children who may be waiver eligible and how to prepare for applying. Provide funding for transition coordinators to do this.
5. Set aside an amount of state dollars to continue capacity to serve individuals who do not need as intensive services as NOW/COMP waiver.
6. Look at how to sustain the direct support professional (DSP) certification pilots via the Medicaid rate by including them in the next rate study.
7. Increase the number of participants enrolled in the DSP Certification programs who are self-directed.
8. Create an awareness campaign around disability benefits 101.
9. Increase GVRA presence in schools and collaboration with staff. Provide funding for Department of Education transition coordinators.
10. Improve communication between GVRA, schools, and providers and strengthen GVRA partnerships with Department of Education, DBHDD, and Workforce Development.

11. Train counselors to align individuals' strengths and talents with market trends for person-centered employment.
12. Recognize counselors as GVRA's greatest asset and address turnover, hire more counselors, raise pay, and manage caseloads effectively.
13. Address geographic disparities in service quality and availability, recognizing that CRCs in rural areas are needed. Increase outreach to underserved and rural populations.
14. Collect feedback from GVRA's consumers and stakeholders for improvement.
15. Rebuild trust of GVRA through better communication and transparency.
16. Simplify GVRA applications, reduce paperwork, and shorten timelines.
17. Expand evidence-based models like Individual Placement and Support.
18. Build a coalition that is comprised of key stakeholders in Georgia working on employment issues for people with disabilities.
19. Ensure that the rates from GVRA and DBHDD are sufficient to support the person.
20. Overhaul the disability payment system by increasing payments for supported employment and understanding and addressing gaps in funding.

APPENDIX E: SUBCOMMITTEE ON MENTAL HEALTH COURTS AND CORRECTIONS

Georgia Behavioral Health Reform and Innovation Commission

Subcommittee on Mental Health Courts and Corrections

2025 Annual Report

Chair

Justice Verda Colvin

Members

Judge Sarah Harris

Judge Stephen Kelley

Judge Kathy Gosselin

Judge Jason Deal

Dr. Karen Bailey, Ph.D.

Stan Cooper

Nora Lott Haynes

DCS Commissioner Michael Nail, MPA

November 2025

This report was prepared with assistance from the Georgia Health Policy Center's Center of Excellence for Behavioral Health & Wellbeing at Georgia State University

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Introduction

House Bill 514 (from the 2019 General Assembly session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to the treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, including the Subcommittee on Mental Health Courts and Corrections, chaired by Justice Verda M. Colvin (2024-2025).

Since the appointment of Justice Colvin in April 2025, after the departure of Chief Justice Micheal Boggs, the subcommittee has met virtually every month. They have discussed ways to ensure that those who have mental health issues obtain the assistance needed with noninvasive measures. In this regard, they have had speakers inform the subcommittee about the effectiveness of the pilot Co-Response Teams. This information led the chair to address the Georgia Sheriffs' Association to challenge all departments to implement a Co-Response Team.

They also had speakers to discuss the pilot program Open Doors of Recovery (ODR), which "walks" with persons who suffer with mental health illness who voluntarily submit themselves to the program. ODR fosters success in their daily lives by ensuring they have housing, medication, and daily work, whether paid or voluntary. This program lasts for a year. As part of ODR, the subcommittee also learned about an alert system that could be transformational in helping Georgian's law enforcement, providers, and those who suffer with mental health issues.

List of Presenters to the BHRIC Subcommittee on Mental Health Courts and Corrections 2025

BHRIC Subcommittee on Mental Health Courts and Corrections 2025

Justice Verda Colvin, Chair
Judge Sarah Harris, Judge Stephen Kelley, Judge Kathy Gosselin, Judge Brenda Weaver, Karen Bailey, Ph.D., Stan Cooper, and Department of Community Supervision Commissioner Michael Nail, MPA

Support to the BHRIC Subcommittee on Mental Health Courts and Corrections 2025

Elyse Phillips, Jayne-Anne Ahmann, Susan McLaren, and Ashlie Oliver, Center of Excellence for Behavioral Health & Wellbeing, GHPC

Presenters to the BHRIC Subcommittee on Mental Health Courts and Corrections 2025

Date	Topic	Presenter
June 20, 2025	Georgia Co-Responder Programs	**Kevin Tanner** Commissioner, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) **Judge David Sweat** Senior Judge, Georgia Superior Courts
Oct. 24, 2025	Opening Doors to Recovery	**Chad Jones** View Point Health **Dr. Micheal T. Compton** Professor of Psychiatry, Columbia University; Research Psychiatrist at the New York State Psychiatric Institute

Summary of Presentations to Subcommittee

June 20, 2025: Georgia Co-Responder Programs

Presentations from Kevin Tanner, Commissioner of the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and Judge David Sweat, Senior Judge, Georgia Superior Courts

Commissioner Tanner presented on the enhancement of co-responder programs across Georgia. The co-responder programs pair mental health professionals with law enforcement to respond to behavioral health crises. These programs aim to divert individuals from jail or emergency rooms toward treatment and support services. In 2022, House Bill 1013, known as the Georgia Mental Health Parity Act, passed and emphasized the need for parity and access as well as better crisis response across the state of Georgia. During that same legislative session, Senate Bill 403 formalized the co-responder framework that BHRIC helped develop. Commissioner Tanner shared that DBHDD, which is administering the Co-Responder Pilot program, is required to provide information each year to the general assembly about these programs; the most recent program data is gathered into the 2024 Co-Responder Report.

Commissioner Tanner presented highlights of the report, including outcomes and main takeaways. He began with the challenges and limitations to the program. The biggest challenges to the program are funding gaps, as full funding was not allocated for this program. They needed $333,000 to fully staff a team of three professionals for the pilot programs, but were allotted only $89,000 per site, which was not enough for the full team. Workforce shortages, especially of providers, have limited the ability to expand services to rural areas. The BHRIC Workforce Subcommittee found that reimbursement rates in Georgia were the second-lowest in the country and recommended a rate study be conducted. The work study, which was completed in 2023, found that Georgia was 40% below other comparable states. The rate study recommended an increase in rates, and with that increase Commissioner Tanner reported that Georgia now is up near the top of the country for reimbursement.

Commissioner Tanner highlighted another effort to improve the workforce, Ralston Institute at the University of Georgia. The Ralson Institute will be merged with the Institute on Human Development and Disability, also at the University of Georgia. At the time of the presentation, the Ralston Institute was searching for key staffing roles. It is planned to be a center for best practices that this committee talked about. Another challenge was consistent training, and there is still a need for standardized, cross-disciplined training. Carol McVey and her team have worked on standardization.

Since its inception in July 2023, the co-responder program has had several key performance indicators, including 1,936 total co-response events since funding inception,

34% events initiated by 911 calls, and 553 events involving repeat callers (29% of co-response events). There are typically one to two response types per co-response, 38% of co-response activities for follow-up, 30% of co-response types for crisis calls, and 12% of co-responses initiated by law enforcement for a behavioral health consult.

Outcomes of co-response calls included these: only 2% of encounters resulting in arrest, with 41 total arrests; six months of the program had zero arrests reported; 39% of encounters resulting in referrals; 25% of encounters resolved on-scene. Results show that the co-responder model is working and creating a safer environment in the community.

The main takeaways of the pilot programs included these: 25% of crisis cases were resolved at the scene; 55% were voluntary transports; one-third began through 911 calls; 39% encounters led to community referrals; and 24% were directly referred by officers. Commissioner Tanner noted that these officer referrals show that the force recognizes the value of the co-responder team and that they are recognizing when they need to bring that team into a case.

Other accomplishments of the program included having new partners approach DBHDD to learn about the co-responders program and how it could be implemented in their communities. The department also had co-responder day at the Capitol where the House and Senate recognized the program with resolutions, and there is going to be a national co-responder conference (Atlanta was chosen to host), with over 1,200 individuals in attendance. On June 5, the Gwinnett County Board of Commissioners unanimously approved to keep funding their behavioral health unit for another year. Morgan County is also going to be funding a co-responder and jail in reach program with a $375,000 grant over four years.

Next, Commissioner Tanner shared that they are preparing to launch the G-PACT statewide training initiatives, which will be teaching strategies and techniques to first responders and law enforcement to navigate crisis events effectively and divert people from the criminal justice system. The first class will be held at the Behavioral Health and Law Conference in September 2025. The department will also be exploring local funding for sustainability. States are not realistically able to fund these programs in every community across the state, so there is a need to show the benefits and cost-benefit analysis of these programs to the local governments. The department is hoping that counties will see there is a high return on investment in these programs. There is also a need to focus on data collection and evaluation, as the data does not currently tell the complete story. All current data is in aggregate, so they are hoping for more individual stories on how the program affected people, and how it changed outcomes in the long term. Our goal is to continue to work on creating a better evaluation process, to identify those that are working well across communities, and to pinpoint areas that need improvement or additional support. Preliminary data from one county showed a huge return on investment based on decreased

days in crisis beds, jail, and emergency departments and decreased days facing homelessness.

During the Q-and-A session, Justice Colvin asked the status of the pilot programs. Commissioner Tanner explained that, first, there are other programs we work with that are not part of these pilot programs that are funded just by the local government, and they partner with DBHDD. Hall County is a jail in-reach program, and Morgan County is starting soon. The pilot programs stood up are Advantage, Loganville/Monroe; Clayton Center, Clayton County; Georgia Pines, Mitchell, and Colquitt counties; Highland Rivers, Floyd County; McIntosh Trail, Stockbridge; Middle Flint, Perry; New Horizons, Harris County; Pineland, Bulloch County; and Unison, Ware County. Jackson County is also interested in starting a program. These programs are through sheriff's offices, and all of these have unique aspects to them. Some of them have the clinician riding alongside law enforcement, some are dispatch models where a clinician is dispatched out to a call, some teams in rural areas utilize more of a virtual telehealth model, and some teams are multijurisdictional. If any sheriffs reach out about this program, they can be directed to me. One of our goals is to help new programs get stood up using a tiered approach, where we might start funding at 75% of the need, and the local government comes in with 25%, and then tiering down until they are self-sustaining.

One of the biggest challenges for these programs is getting buy-in from law enforcement, and this curriculum has not been put in their basic mandate courses. However, there was some legislation that requires a course on crisis-type mental health training during police academy. Not just for law enforcement, but also community providers, fire EMS, and local hospitals. It was asked whether the data on these programs has been shared around to places that have not started these programs to try to sell them on it. Commissioner Tanner explained that this has not happened yet, and it is going to probably require sheriffs who have had positive experience with the programs to talk to other sheriffs in order to convince them to take up the program. We are hoping to work with partners to start sharing back information.

Judge David R. Sweat was asked to present on the co-responder protocol committee, which is a way to get law enforcement agencies involved in the process since there can be tension between law enforcement and those with behavioral health personnel. Judge Sweat shared that it is great to get law enforcement and behavioral health teams together, since they serve the same individuals. Currently there are 62 teams across the state; 10 are statewide, and most are Community Service Board teams. There are many different models, including jail in-reach, school-based co-responders, etc., and there has been a lot of success.

Gwinnett County, which has 17 teams, responded to 5,000 calls last year and estimated that they are saving about $80,000 a month in service time when a co-responder team takes over calls. They also divert people away from jail and toward appropriate community

resources. Only 15% become 1013 (involuntary evaluation). Additionally, they are diverting people away from emergency departments.

Judge Sweat noted that there were changes to the 1013 protocols, specifically the 1013 consult. This provision of the code allows law enforcement to be in touch with a clinician, who can have a video encounter with an officer or individual and can authorize the individual to be taken to a mental health crisis center. This change allows officers to get direction and improve outcomes. While this is a great resource, there is still hesitancy in law enforcement concerning the telehealth consult. DBHDD's legal team is looking at updating the 1013 forms to include telehealth consultants to help with the hesitancy. There is also the opportunity to partner with 988, which can be a much quicker and more appropriate response to local crisis teams. If we can knit together 988 to connect someone to the same ZIP code who could respond much faster and with knowledge of local resources, it could benefit individuals in crisis and law enforcement officers who would be standing by with those individuals who need care.

Judge Sweat shared that the biggest challenge right now is funding. He suggested that it may be possible in some counties to move maximum reimbursement limit funds from Community Service Boards toward these programs.

During the Q-and-A, Justice Colvin asked what the subcommittee could do to move this forward and get the word out about these programs. Judge Sweat responded that our judges could have a role in convening, get involved in the correspondent protocol committee, or have it at the courthouse so it's in a familiar environment for law enforcement and judges to learn about what's going on and to support these programs. He also mentioned the need for uniform data collection, to have specific numbers on what we're doing and what the outcomes are. Firsthand accounts of success stories also need to be shared. There is an annual report that contains some of those narrative stories that can be shared.

October 24, 2025: Opening Doors to Recovery

Presentations from Chad Jones, from View Point Health, and Dr. Micheal T. Compton, Professor of Psychiatry at Columbia University and Research Psychiatrist at the New York State Psychiatric Institute

Chad Jones presented on a program called Opening Doors to Recovery (ODR). Georgia Behavioral Health is parsed out into 22 Community Service Boards, and View Point Health primarily serves Gwinnett County, Rockdale County, and Newton County. There are 12 different programs, and View Point Health has done some projects with Judge Hargrove and they are part of the NICK project in DeKalb County. Additionally, they do about 12 different programs in DeKalb, Fulton, and Clayton counties, and one program that is more statewide. The ODR program, a fidelity-based model, is housed in Rockdale County and was

founded by Nora Haynes, working alongside Dr. Compton. View Point Health does a lot of work around judicial reform law; for example, they have 17 co-responder teams, the most in the state, which includes a law enforcement peace officer and an assigned mental health clinician. The team goes out for calls. Rockdale also has12 different accountability courts, which do a lot of reentry work. Rockdale County also has the Rockdale Reentry Intervention Prevention Program (RRIPP).

ODR fills the gaps in continual care. The program engages individuals who are incarcerated that meet a certain criterion. The program also looks for underlying causes for recidivism, and if recidivism has anything to do with behavioral health. Staff at ODR are not case managers but are referred to as navigators, as they help participants navigate the system. Two main keys to navigators: First, it's a peer-led program. Navigators have been incarcerated, "been there, done that," and can show that there is a better way. They act as peer coaches, and are on call, so any time a client wants to call outside of normal business hours they can. ODR is the first in the nation to get peer support through a Medicaid plan. The second key piece of the program is that a clinician is part of the care team. While Georgia has a lot of places for case management, when there is a crisis beyond the skills of a peer, such as the need for medication, most managers must call someone outside their program for clinical assistance. In ODR the clinical component is baked into the program; the team lead is a licensed clinical professional that the participants are free to call.

With those two components of the peer to guide them, and the clinical component, ODR takes the individual from jail and walks with them through the key elements of stabilization. The number-one element is housing, and links to housing programs. ODR has housing grants, term housing, and traditional housing, linked either through View Point Health or other providers. Once they have stable housing, participants focus on job readiness. No one gets a free ride, so even if someone is not job-ready, they can volunteer to give back to the community in some way. Next, they look at food insecurity and other issues. Once individuals are oriented, ODR continues to coach them for up to one year. If there is a clinical need, they can do a continuing stay authorization, which can extend the year. This team serves 30 people at a time, so at any given year with transition, they may serve up to 40 people in a year.

Another crucial component of the program is the link to law enforcement. If something happens and law enforcement has to respond to an individual who is in ODR, the individual is flagged and law enforcement can call ODR to become a first responder. In many cases ODR can help prevent that person from being incarcerated again. The ODR client also has a "passport" of the care plan; the client signs a release for the ODR staff and others, so everyone is working off the same plan. The navigators coach clients in job skills, e.g., how to interview and how to dress properly for interviews. ODR also helps with job placements that will help in their recovery. For substance use issues, they try to plug individuals into some other treatment provider (AA, NA, etc.) over the course of the year so that the person

has help after the program. After the year, ODR does “soft touches” driven by the client that can reach back out to the program.

Dr. Micheal T. Compton also presented on the ODR program. ODR began in 2004 with Georgia’s implementation of the Crisis Intervention Team. The GBI and NAMI Georgia began the CIT program to understand the mental health gaps and barriers in case management. In 2009 Region 5 identified the fact that there’s insufficient community-based case management going on. NAMI Mommies saw their sons and daughters coming in and out of jail and in and out of the psychiatric unit because they were not getting the outpatient support that they needed (especially for serious mental illnesses like schizophrenia, bipolar, etc.), assembled a large group of stakeholders who met multiple times, and created a new approach to case management: ODR.

The navigator team in ODR consists of three navigators, the licensed mental health professionals like a social worker, a peer navigator, and a family navigator, which is a family member of someone with a serious mental illness. Focus is on two chief goals: reducing institutional recidivism (preventing arrests, hospitalizations, and homelessness) and promoting recovery. Recovery means you are able to live with your mental illness but still be a productive person with hope for the future. Promoting recovery by ensuring adequate treatment, securing safe and stable housing, helping clients develop a meaningful day, and using technology to promote recovery. They do not necessarily provide the treatments themselves but ensure their client gets into those services. Other components of the ODR model: “blue ribbon” meetings of diverse partners (collaborative fusion), and a GBI Georgia Crime Information Center (GCIC)-supported linkage between the police and the CNSs. In blue ribbon meetings, ODR brings together multiple stakeholders to make sure that in the local community, everyone is on board and understands what ODR recovery is. The goals of the model of ODR are fewer arrests among clients, fewer hospitalizations, and less homelessness. ODR helps participants really embrace recovery.

A large group of stakeholders helped to create the ODR model, and they were able to present this model over time to the Carter Center in 2010, and then to Gov. Purdue, and a few years later to Gov. Deal. This helped build a strong network in Southeast Georgia where the model was then tested with funds from the Bristol Myers Squibb Foundation. The pilot demonstration had 100 participants and targeted individuals with psychotic or mood disorders and a history of recidivism from the 34-county region of southwest Georgia (Region 5). The pilot included four navigator teams, each assigned to follow 25 patients for a one-year period. At the conclusion of the granting period, the stakeholder group focused on writing peer-reviewed articles to gain national recognition of the model. The papers published focused on the evaluation of the curriculum for the navigator training and included in-depth interviews with providers and recipients of the program and statistical analysis of patient outcomes to present the effectiveness of the program.

Dr. Compton then went on to receive funding from the National Institutes of Health to conduct a randomized controlled trial to test the effectiveness of the program further. The findings from the randomized control trial showed that the ODR program reduced the number of arrests and hospitalizations. Additionally, individuals in the program reported greater satisfaction with their housing, higher levels of empowerment, community navigation skills, and skills needed for recovery. Overall, the program showed a decrease in cost for providing services to individuals with mental health challenges and criminal justice involvement.

Q: Justice Colvin: In light of the statistics you’ve given, the data you’ve collected illustrates how Georgia should invest in these programs since they save money. Has there been any talk about pushing legislation with this kind of data that you’ve been able to put together to put these throughout the state of Georgia?

A: Dr. Compton: I’m just a researcher, and my job is to generate new knowledge and prove things one way or another. Clearly ODR outperforms traditional case management, but that’s where my job stops.

A: Chad Jones: I did have one conversation with a legislator and then one with a different committee around ODR, but it doesn’t get brought up a lot because Intensive Case Management (ICM) is in the Medicaid plan already. Typically, they focus on what services are already billable in that plan. ICM is comprised of a program called Assertive Community Treatment Act, which is a fidelity-based treatment model. What I pitch to them is that a lot of clients will sit in an Assertive Community Treatment, and at some point, they will step down to ICM. The reason I have pitched that ODR may be a better area in the middle is because when you get to ICM, there is not the peer component and there’s not the clinical component. So ODR would be a nice step from level 3 to 2, then to 1, ICM. They’re completely different programs, but there’s not been a lot of communication around that because people focus on what’s already in the state Medicaid plan.

A: Nora Haynes: Before we did House Bill 1013, it was in that bill, but it did not get funded [the case management part for ODR].

Q: Justice Colvin: ODR is voluntary, so there is no court order that participants go into the program. How do you get law enforcement to have ODR in their system?

A: Dr. Compton: There’s never been anything like this before in the country. What happens is when you’re pulled over, the officer puts your driver’s license into several databases at GCIC. Working with Vernon Keenan, the director of GBI at the time, we created a new database at GCIC where all ODR participants are included, so when a law enforcement officer in Georgia does a query, that query also taps our database to see if there is a match. If there is, the law enforcement officer gets a special notice that says this person is in

mental health treatment, please call this number. The officer can then call the number, and it goes to the navigator because the client has signed a HIPAA release for the officer to talk to the patient's clinician. We received another big grant from NIH and did another randomized controlled trial just about this linkage system. We are about to analyze the results to see if the linkage system itself reduces the risk of arrest by giving the officer information and support that he otherwise would not get.

Q: Justice Colvin: Would you be able to share this with us? (Yes)

A: Chad Jones: We got information just this morning that co-responders put their notes into the police system with GCIC even though they're View Point Health employees, and we've been able to link the two databases for CAD and ODR. So, when GCIC flags and you call ODR, ODR then for any additional support they need or vice versa, if the co-responder needs additional support and pulls up in CAD, they're all View Point Health–connected. Our rearrest rate this year is only 2% now because we've been able to connect all these databases into one system and connect people together.

Q: Harris: When we were doing HB 1013 we did use some of this data to try to get the AOT program and a distinction in funding. I'd like to understand better how this is paid for. Are some of the services covered under Medicaid?

A: Chad Jones: We did the funding in three ways. First, we can bill for some of those services like counseling and case management through Medicaid. For the services in ODR that are not billable, Rockdale County actually has a contract to pay for the program. The third part is Certified Community Behavioral Health Clinics, of which there are about 13 of these in Georgia, and ODR is in one of them. So we are in a planning grant to use CCBHC dollars because ODR work aligns with the mission of CCBHC.

A: Dr. Compton: It's a braided funding. Medicaid is not enough since ODR does more than just clinical billable services. In Southeast Georgia, the salaries of navigators were entirely paid for by the grants like the Bristol Myers Squibb grant and NIH grants. So we weren't really concerned about billing or how to pay for ODR during the research because we just wanted to prove the model and the grants were able to fund those services. Obviously the grants go away and that's the problem with funding things with grants.

Q: Harris: Other than funding, what have been some of the other challenges? I would assume staffing is always a challenge as well.

A: Chad Jones: Staffing is always a challenge. Not as much as getting team members, as we had the same team the entire time. The challenge is sometimes peers themselves need support as well since they are dealing with their things, so challenges around the coaching of the peers piece, and monitoring that. The CIT training has prompted a lot of law

enforcement officers to accept and honor the program; however, it is still a challenge with law enforcement from time to time.

A: Nora Haynes: I have another challenge: When you first start ODR in a community, you need relationships to get buy-in with stakeholders. I do think stigma is decreasing, but it was really hard to get people to do business in a different way and to realize that they do have a role in this person's recovery. It's hard to go into a new community and teach them how to be involved.

Q: Justice Colvin: Even when people leave ODR or other treatment, what can we do as a society to have some semblance of a check-in so people don't go off the radar and somehow relapse and start the cycle back over again? Because at some point ODR participants have to move on to the next phase. Do the check-ins last forever or is there some point where participants move forward?

A: Chad Jones: Soft check does last forever, but it is participant-driven. So once you graduate ODR, you can check in, but we have had situations where participants didn't check in, but co-responder responded and pulled them up in CAD and saw that they were part of ODR, and will call ODR with the former participant. You really have to have that continued care, but we have had at least two co-responders check in together with individuals.

Colvin: How do we set up something where once people are done with the system, someone would still check in and see if an individual is still doing what they need to do? We have to have funding to do it, but a system that would identify a person that's having these issues so they could come back into getting what they need to be stabilized.

A: Chad Jones: Whenever folks are done with their legal thing, the constitution applies to them, and they are free to stop checking in. The connection that happens depends on the continuum of care of programs that fill the gaps in care and connect them back into services when they fall out. Georgia Health Information Exchange the information network, and Georgia Directory could connect someone to services, you have jail in-reach, accountability court, ODR, etc. Georgia has a lot of these programs that are already perfectly aligned to fill these gaps in the continuum, you connect them through Georgia Connect, so when someone shows up at the hospital because they didn't take their medication, it's automatically in the system and someone can then come and check in to get them into more services again. Sometimes you can't force it, but the idea is to create a network so everyone can get information exchanged. It requires building up and using technology to increase that continuum of care.

Q: Nora Haynes: I have an idea about that. When someone is committed to assisted outpatient treatment, which is not the criminal justice system, is there a certain amount of time you can be part of that?

A: Harris: No, you can be in it for up to a year, and there is a mechanism to extend it further, but generally it will end when they graduate from the program. They can come back into the program, but there is not continual care because you want them set up for success. If they start to fall off that and they're not going to their provider, their provider could then file another petition to get them back into the system, but there's not an easy way to do it.

Q: Nora Haynes: Is there a database of who has ever been in AOT?

A: Harris: If you were in one of the pilot programs, yes; otherwise, no. I talked about trying to get that linkage like you did with ODR, but we haven't gotten to that point yet.

A: Justice Colvin: I think this is something we should work on in our committee, developing this linkage, because we have to do funding to set up more ODRs, and of course that's legislative, but the linkage should be something that could be obtainable. We should let them know we really want to work on that.

A: Harris: If we keep it narrow in scope, it could help. When we were working on HB 1013 the idea of databases was too much for people. Wouldn't necessarily need the legislature to do this either. Are there Community Service Boards or someone to be a driver of this somewhere? How can we set this up in other areas? Is there a training or a manual that says how we put this program together to help the communities to be able to do this?

A: Chad Jones: There is a conference training, and training manuals that go through two weeks of training. CCBHC's really need to drive this more than Community Service Boards. This program follows their model more closely.

Q: Judge Deal: Seems like law enforcement are one of the first groups that know when something is wrong. Seems like a small thing we could do is try to get law enforcement notice (via databases maybe), as if given the choice if they called the mental health folks instead of arresting this person, they would have chosen to call the mental health people. It would be helpful to provide law enforcement notice of what issues a person has and who to call, via GCIC or a database. They could potentially call a probation officer or have a co-responder go with them instead of only having the option to take the individual to jail or not.

A: Justice Colvin: That was exactly my point. I think that is something we can put in our report, that we want to work toward implementing a linkage system, not database, whereby people will know when they interface with certain people that this is the person to call to see if we can get them help versus taking them to jail.

A: Chad Jones: As you mentioned about co-response, you all know about Maddie's Call ASD. We have used that in our jurisdictions in co-response to piggyback on that; they go into CAD and flag individuals who have been touched by us in mental health. They will then call and dispatch a co-responder and a clinician will come out. So we already piggyback on existing laws and you could do the same.

Recommendations

The recommendations from the subcommittee are as follows:

1. Expand and support Co-Response Teams
    a. Conduct a survey among the Georgia Sheriffs' Association to determine how programs are organized, funded, and locally supported, and explore what the deterrents are to starting a team.
2. Continue to work with Superior Court judges and district attorneys to ensure there is a clear understanding of OCGA 17-7-130 to work toward expeditiously shortening the time to complete competency evaluations.
3. Explore the possibility of creating an alert system or data linkage that will link systems so that when someone encounters a person who chronically suffers from mental health issues, electronic systems would identify such persons. This would then allow the person who encounters them to alert the noted therapist and/or health care facility who could then intervene.
4. Enhance post-program support for individuals who have completed accountability court by implementing regular follow-up.

APPENDIX F: FORENSIC COMPETENCY ADVISORY COMMITTEE

Georgia Behavioral Health Reform and Innovation Commission

Advisory Subcommittee on Forensic Competency

2025 Annual Report

Chair

Judge Lindsay Burton

Members

Dr. Julie Oliver

Judge Lindsay Burton

Judge Penny Freesemann

Chelsee Nabritt

Judge Kathlene Gosselin

Fraser Kline

Dr. Christian Hildreth

Brandon Bullard

Judge Eric Brewton

Dr. Emilie Risby

Judge Sarah Harris

Herb Cranford

Nikia Smith Sellers

November 2025

Report prepared with assistance from the Center of Excellence for Behavioral Health & Wellbeing at the Georgia Health Policy Center, Georgia State University.

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Introduction

House Bill 514 (from the 2019 General Assembly session) created the Georgia Behavioral Health Reform and Innovation Commission. The commission, chaired by former Rep. Kevin Tanner from House District 9, was formed to conduct a comprehensive review of the behavioral health system of care in Georgia. The commission is responsible for reviewing several key areas: behavioral health services and facilities available in Georgia; identification of behavioral health issues in children, adolescents, and adults; the role of the education system in the identification and treatment of behavioral health issues; the impact that behavioral health issues have on the court and correctional systems; legal and systemic barriers to treatment of mental illnesses; workforce shortages that impact the delivery of care; access to behavioral health services and supports and the role of payers in such access; how untreated behavioral illness can impact children into adulthood; aftercare for persons exiting the criminal justice system; and the impact of behavioral health on the state's homeless population.

The commission created five subcommittees in order to review these focus areas, including the Advisory Subcommittee on Forensic Competency chaired by Judge Lindsay Burton (2024-2025).

During 2025, the Advisory Subcommittee on Forensic Competency held one public meeting relating to the areas of improvement for individuals who are charged with crimes and are developmentally disabled with no co-occurring mental health condition. Much of the conversation centered around the need to address jail diversion for individuals with an intellectual disability who otherwise languish in jail. Additional conversation centered on individuals with intellectual disabilities who are deemed nonrestorable in the justice system and do not have opportunities for release.

List of Presenters to the BHRIC Advisory Subcommittee on Forensic Competency

BHRIC Subcommittee on Forensic Competency

Judge Lindsay Burton, Chair
Dr. Julie Oliver, Judge Penny Freesemann, Chelsee Nabritt, Judge Kathlene Gosselin, Fraser Kline, Dr. Christian Hildreth, Brandon Bullard, Judge Eric Brewton, Dr. Emilie Risby, Judge Sarah Harris, Herb Cranford, Nikia Smith Sellers

Support to the BHRIC Subcommittee on Forensic Competency

Ana LaBoy, Ashlie Oliver, Susan McLaren, Elyse Phillips, and Jayne-Anne Ahmann, all from the Center of Excellence for Behavioral Health & Wellbeing at the Georgia Health Policy Center.

Presenters to the BHRIC Subcommittee on Forensic Competency 2025

Date	Topic	Presenter
July 21, 2025	Open discussion of potential legislative changes or areas of improvement for individuals who are charged with crimes and are developmentally disabled.	Dr. Julie Oliver, Judge Penny Freesemann, Judge Kathlene Gosselin, Judge Eric Brewton, Judge Sarah Harris, Herb Cranford, and Nikia Smith Sellers
Oct. 31, 2025	Open discussion of potential legislative changes or areas of improvement for individuals charged with crimes who are noncompetent and languishing in jail.	Judge Lindsay Burton, Fraser Kline, Dr. Christian Hildreth, Brandon Bullard, Judge Eric Brewton, Herb Cranford, Nikia Smith, Judge Roxanne Formey, Judge Sarah Harris, and Rhonda Moree

Summary of Subcommittee Discussions

Individuals Charged with Crimes Who Are Developmentally Disabled

Discussion participants included Dr. Julie Oliver, Judge Penny Freesemann, Judge Kathlene Gosselin, Judge Eric Brewton, Judge Sarah Harris, Herb Cranford, and Nikia Smith Sellers

Judge Burton led a discussion on the focus of the subcommittee, as well as challenges that individuals face when dealing with competency and intellectual disabilities. The focus of the subcommittee will be on potential legislative changes or areas of improvement for individuals who have intellectual and developmental disabilities and are charged with crimes. The options for what happens to noncompetent individuals with intellectual and developmental disabilities (IDD) are unclear, notably with felony cases. The places for them to receive care are unclear, as civil commitment is reserved for individuals with mental health conditions.

Considering these gaps, the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is attempting to ensure that they are aware of whether an individual has a waiver or qualifies for one at the time of their evaluation. They are working on a system that will flag individuals who are eligible for a waiver at the time of their evaluation to successfully divert them, but the system is not currently functional and requires a person's eligibility to be checked manually. They are working on only making recommendations for waivers if it is confirmed that the individual is eligible, as well as determining what is occurring with a person's clinical state at the time of the evaluation. DBHDD is also working with jails, as they are willing, to have physicians complete paperwork that will make an individual eligible for a nursing home and can refer them directly from jail to avoid a hospital waiting list, but this can be complicated and time-consuming. As Dr. Julie Oliver noted, nursing homes may not be willing to accept forensic individuals, especially with a violent or sexual charge.

Fraser Kline observed that for individuals charged with serious crimes, those who are nonrestorable currently languish in jails for several years, which is an issue that needs to be addressed, especially for those individuals who can potentially be released into the community but require a release date and need a place to go before a release date can be given, perpetuating a cycle that leaves the individual in jail despite being found nonrestorable.

There is an additional need to investigate who the legal spokesman is for individuals who are not competent, as presently, there is no one aside from the judge who is able to legally make a decision for them, but the next step, and how the court may oversee it, is unclear. Families need advocates, as they often cannot advocate for themselves. It may be necessary to bring in the Georgia Department of Human Services (DHS), as they are the guardians of

last resort in the state. At times, a bond is given so the individual may remain in the community. An annual review is done under these bond conditions. Herb Cranford stated that the manner in which Georgia currently handles this is not ideal, and it is suggested that it become more systematic and involve state agencies. Outpatient civil commitment has an additional layer of DBHDD oversight, but this is not a possibility for individuals without a mental health condition.

As part of the greater picture, it may be prudent to survey other states to gather information about what they are doing with nonrestorable, noncompetent individuals in jail. Additionally, it may be beneficial to connect with the IDD subcommittee to find out what they are looking at and researching in their subcommittee. There is a need to look at community supports for these individuals. There is a law for an individualized plan for individuals with IDD that Community Service Boards and the DHS become involved in, which makes options available. This will be more complicated with serious charges.

For individuals who cannot live on their own, there are private institutions available that are worth exploring, but at this point, the only option appears to be placing individuals on bond. An issue this presents is that the court becomes the monitor, which creates safety issues. Furthermore, because of the lack of oversight when an individual is on bond, there may be new issues faced by the individual that the court may not be made aware of. Waivers potentially present the best option for nonrestorable individuals with IDD. To achieve this, a representative from DHS may be present in the court to confirm they do qualify for a waiver, or that additional time is needed, because that gives individuals the option of a facility as opposed to languishing in jail. At the initial hearing, to see if there is a competency evaluation required, if waiver information is available, it can guide the judge's decision-making process. There is work needed on this topic.

There are additional challenges to receiving a waiver in Juvenile Court. To receive waivers in Juvenile Court, oftentimes information is needed from the school system to demonstrate that an individual has had issues prior to arrest. It may be beneficial to have a representative to obtain information from the school system. However, for individuals who are transient, the court may not be able to find out where they were in school. The waivers are particularly challenging to be approved in Juvenile Court if the individual was not diagnosed before the age of 18. Additional information on this subject is needed.

Furthermore, the subcommittee agrees that more information is needed on the subjects of providing the court with more options to plan for nonrestorable individuals to be released on bond, the waiver system, how to get DHS involved after an individual is found noncompetent and nonrestorable, especially for different areas depending on the level of offense, the different options for individuals with IDD versus dementia or Alzheimer's disease, and how evaluations can be done to assess an individual's ability to be treated for their condition.

For the next meeting, the subcommittee would benefit from a representative from DHS presenting on the waiver system, and the options or services available for individuals with IDD, as well as drafting a plan for the future. Additionally, the topic of individuals charged with misdemeanors and low-level felonies who are cycling in and out of jail should be addressed. This is a good opportunity to tie in DHS services for reentry. What other states are doing in regard to individuals who are not competent but do not have a mental health condition, but have an IDD or a condition like dementia or Alzheimer's, should be discussed.

Recommendation Priorities

The Forensic Competency Advisory Committee identified the following recommendations from the testimony heard over the past 12 months as priorities for immediate action:

1. Provide early intervention and ongoing support for individuals with IDD who become involved in the justice system and their families. Look to the ARC Pathway to Justice initiative as a best practice.
2. Create a pilot project where individuals who are charged with criminal offenses and who have been found not competent, not restorable, and not meeting criteria for civil commitment are reviewed by a panel of participants including DBHDD, DHS, probate court, state/Superior Court, prosecutor, and defense counsel. The pilot would involve monthly interagency meetings to improve coordination of services and give each participant the opportunity to offer resources that may safely resolve the case.

Georgia Health Policy Center

Georgia State University | Andrew Young School of Policy Studies

Intellectual Developmental Disability Jail Diversion

Behavioral Health Reform and Innovation Commission
Forensic Competency Advisory Committee
August 2025

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EXECUTIVE SUMMARY

This report was commissioned by the Behavioral Health Reform and Innovation Commission's Forensic Competency Advisory Committee and prepared by the Georgia Health Policy Center. It investigates existing best practices and policies for individuals with intellectual and developmental disabilities (I/DD) or a cognitive-diminishing disorder without co-occurring mental illness who have been found incompetent to stand trial and nonrestorable.

Intellectual Developmental Disability: Rights and Policies in the Competency Process

Individuals with I/DD have long faced barriers in the competency process, especially when they do not have co-occurring with mental illness. Under the *Olmstead* decision and *U.S. v. Georgia,* states are legally obligated to provide services in the least restrictive setting, meaning individuals who meet criteria for I/DD should have access to community-based support when found incompetent. The state response to *U.S. vs. Georgia 1o-cv-249* is provided, including the joint filing evaluating the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD's) response to the settlement. State laws for defined competency treatment periods are provided, differentiating by the type of crime committed.

U.S. vs. Georgia 1o-cv-249, a Civil Rights Division complaint against the state of Georgia, addressed the state's failure to be of service to individuals with I/DD and mental health conditions in integrated care settings appropriate to individual needs. A joint filing outlined DBHDD's response to the requirements of the settlement, resulting in the organization of five subcommittees and discrete projects implemented in six counties.

Georgia's settlement response included strategic initiatives such as housing pilots and monitoring tools, yet systemic gaps remain.

Research indicates that most individuals who can be restored to competency typically achieve it within six months of treatment. Reflecting this research, 20 states set their maximum treatment periods at one year or less. Other states determine the allowable treatment duration based on different factors, such as the maximum potential sentence for the charged offense. Georgia law allows for a maximum of one year for competency restoration.

Cognitive-Diminishing Disorders in the Justice System

The report also examines the challenges faced by individuals with cognitive-diminishing disorders in the justice system, which are often similar to those with I/DD. Restoration is often not possible due to the progressive nature of conditions like dementia, and courts, jails, and care facilities are often unprepared to accommodate this population. Recommendations from the American Bar Association Commission on Law and Aging call for specialized long-term care units in prisons, changes to Medicaid policies, expanded use of release options, and development of "dementia-friendly" environments. Additional experts recommend increased training, early diversion, and stronger support systems both in custody and post-release.

<u>Examples of Best Practices</u>
Connecticut — 60 West

- Private skilled nursing facility for justice-involved individuals with complex medical, psychiatric, or behavioral needs.
- Cares for individuals transitioning from state care or who may be difficult to place in traditional nursing homes.

Massachusetts and Vermont — MissionCare

- Modeled after 60 West, operated by iCare Health Network.
- Offers long-term, community-integrated nursing care for individuals who are difficult to place in standard care facilities.

Tennessee — TN START Assessment and Stabilization Program

- Statewide crisis response and stabilization system for individuals with I/DD and behavioral or mental health needs.
- Offers 24/7 on-site or remote response, prevention-focused planning, clinical consultation, and the establishment of community partnerships.

North Carolina — Individualized Reentry Plans

- Supports justice-involved individuals with I/DD or traumatic brain injuries in housing, employment, benefits, and behavioral health services.
- Plans start prerelease and continue post-release, with peer specialists guiding reintegration.

New York — Intellectual and Developmental Disability Alternative to Incarceration Program

- Diverts eligible individuals with I/DD from traditional court processes into a treatment-focused program.
- Emphasizes behavioral regulation, skill-building, and long-term individualized support.

<u>Recommendations from Experts</u>
Georgia-specific recommendations from legal and advocacy experts include:

- Expanding access to Medicaid waivers, including reducing the 7,000-person waitlist, improving eligibility pathways, and allowing DBHDD to conduct its own assessments;

- Improving nonjail placements, including expansion of crisis beds, incentivizing providers, and deploying rapid-response teams;
- Enhancing communication across systems, especially between DBHDD divisions and public defenders;
- Addressing placement barriers for those with behavioral challenges and I/DD and reconsidering the use of guardianship in favor of more responsive supports; and
- Embedding prevention efforts, such as investing in childhood supports, assessing the root causes of justice involvement, and ensuring environments are safe and appropriate.

In sum, individuals with I/DD or cognitive-diminishing disorders who are found incompetent and nonrestorable require coordinated, community-based responses, not prolonged incarceration. Critical gaps remain in placement options, waiver access, and cross-system coordination. Adopting proven best practices from other states and expanding diversion efforts will be essential to ensuring this population receives humane, legally compliant care.

INTELLECTUAL DEVELOPMENTAL DISABILITY: RIGHTS AND POLICIES IN THE COMPETENCY PROCESS

Context for Individuals With I/DD Who Are Found Incompetent and Nonrestorable

The Behavioral Health Reform and Innovation Commission's Forensic Competency Advisory Committee asked researchers at the Georgia Health Policy Center (GHPC) to conduct an environmental scan of how other states are addressing individuals with intellectual and developmental disabilities (I/DD) without co-occurring mental illness in the competency process. The advisory committee is particularly interested in best practices for these individuals once they are found incompetent to stand trial. The following report outlines legislation and policies for this population during the competency process, and any best practices or recommendations from current experts on areas or strategies for improvement, to limit the amount of time that people with an I/DD or cognitive-diminishing medical condition (Alzheimer's disease, dementia, and the like) spend in jail.

Olmstead Decision

The Supreme Court's 1999 *Olmstead* decision was based on the Americans with Disabilities Act. It held that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than institutions when the following three-part test is met:

1. The person's treatment professionals determine that community supports are appropriate;
2. The person does not object to living in the community; and
3. The provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities."[1]

[1] https://www.olmsteadrights.org/about-olmstead/

Since the decision in 1999, the courts have set the standard that *Olmstead* applies not only to psychiatric hospitals, but also to all state and Medicaid-funded institutions, including nursing facilities. Courts have also found that it applies to individuals living in the community who are at risk of institutionalization. In Georgia, *Olmstead* was part of a settlement that included individuals in forensic hospitals who had been found incompetent to stand trial or not guilty by reason of insanity. Therefore, individuals with I/DD who have been found incompetent should qualify for community supports and services under the precedents set by the *Olmstead* decision.

U.S. vs. Georgia 1o-cv-249

The Georgia settlement (*U.S. vs. Georgia 1o-cv-249*)[2] included a notice of the joint filing of the report on the independent review of the Georgia Department of Behavioral Health and Developmental Disabilities' (DBHDD's) efforts to comply with the requirements of the 2010 settlement.[3] Five subcommittees were organized and staffed within DBHDD, responsible for housing support and case management strategic planning, fidelity monitoring and tool implementation, program evaluation, supported housing staff inventory and analysis, and data and IT analysis, to fulfill the obligations of *Olmstead*. The report addressed discrete projects, including a pilot program with Pathways/Step Up to be implemented in six counties. This program provides housing outreach, stabilization, and support services to promote community integration, and implementation of the DBHDD Supported Housing Fidelity Monitoring Tool. The risks of individuals with developmental disabilities are also addressed by implementing a health risk screening, among other measures.

State Policies for Competency Restoration Treatment Periods

States have varying policies about how long an individual may be held by the state during competency treatment, with some denoting time limits depending on the type of crime committed (misdemeanor vs. felony, violent vs. nonviolent). This report by the Justice Policy Institute summarizes the "Maximum Defined Competency Treatment Periods" of each state.[4] Research shows that people are likely to be restored to competency within six months of receiving treatment, and in keeping with the research, 20 states have a maximum treatment period of one year or less. Other states base their maximum treatment period on other factors, such as the maximum possible sentence for the alleged offense.

Georgia

Georgia's maximum defined competency treatment period is one year. In cases where evaluation finds the accused is incompetent to stand trial and there is a substantial probability the accused

[2] https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/examples/Olmstead/gaolmsteadagreefs.pdf
[3] The settlement documents can be found here. Please note the link opens as a download on your browser.
[4] https://justicepolicy.org/wp-content/uploads/2022/02/jpi_when_treatment_is_punishment_national_factsheet.pdf

can attain competency in the foreseeable future, DBHDD will provide restorative treatment, which can include placement in an inpatient facility or a jail-based competency restoration program. The department and the court must then periodically reevaluate the accused to determine progress toward competency restoration.

If, after a defined restoration period, the accused does not attain competency and it is determined that there is no substantial probability of restoration in the foreseeable future, the court must proceed with civil commitment proceedings or release, as appropriate. DBHDD has discretion regarding treatment options, including outpatient or jail-based programs, especially for those charged with nonviolent offenses. The statute also permits court-ordered re-evaluations and reports to inform ongoing judicial determinations regarding the accused's competency and placement.

COGNITIVE-DIMINISHING DISORDERS IN THE JUSTICE SYSTEM

Individuals With a Cognitive-Diminishing Disorder Who Are Incompetent and Nonrestorable

The Forensic Competency Advisory Committee was also interested in how other states are addressing individuals with a cognitive-diminishing disorder, such as dementia or Alzheimer's disease, without co-occurring mental illness in the criminal justice system and the courts. The following section outlines legislation and policies for this population during the competency process, and any best practices or recommendations from current experts on areas or strategies for improvement.

Cognitive-Diminishing Medical Conditions in the Courts

Cognitive disorders are defined as "any disorder that significantly impairs the cognitive functions of an individual to the point where normal functioning in society is impossible without treatment," falling into the broad category of neurocognitive disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.[5] Because these conditions are permanent, restoration is often less likely than for individuals without this impairment, akin to individuals with an I/DD. These individuals face a range of issues in the legal system similar to those with an I/DD, including a lack of necessary resources to re-enter society, the inappropriateness of psychiatric hospitals for treatment, and hesitation of nursing homes to allow for individuals with a criminal history.[6]

Recommendations From the American Bar Association Commission on Law and Aging

In a report published by the American Bar Association Commission on Law and Aging, a mixed-methods, cross-collaborative research effort was completed to fill the gap regarding the lack of data and information on justice-involved adults with dementia.[7] The research effort collected survey data and interviewed correctional health and legal field stakeholders to gather information relating to their experiences with people diagnosed with dementia in the criminal legal system. The following are recommendations from the commission's report that may help divert individuals with dementia from prosecution or improve their well-being during incarceration.

Corrections

- Dementia care facilities must balance residents' care needs with public safety.
- Models of dementia care for people with a history of or a propensity for violence should be studied, best practices should be developed, and compliant facilities should be funded and implemented.
- Laws and policies that prohibit placement in otherwise appropriate care settings need to be changed. For example:
    - Medicaid regulations for intermediate care facilities for individuals with intellectual disabilities require residents to need "active treatment." Individuals who can live with less support or whose needs are not "intensive" enough are sometimes denied access to services of intermediate care facilities for individuals with intellectual disabilities, even if such a setting could provide appropriate care and community for them. Such policies can inadvertently prohibit placement in otherwise appropriate group-based living settings.[8] A civil path for diversion or release as outlined above needs to be developed. Care facilities need to be developed, ideally through public-private partnerships, and funded to care for people with dementia who are perceived to present a threat to public safety.
    - https://www.60-west.com/ (discussed below)
- Standards and processes for medical release, conditional release, and compassionate release should expressly include dementia as a qualifying condition.

Correctional Health Care

- When release is not possible, state prison systems and large jails should consider designating specialized long-term care nursing units with facilities that can house and care for aging inmates with complex health needs.
- Establish a facility-based geriatric care team (larger facilities) or identify and train a key facility person who can provide legal advocacy and manage the care of inmates with dementia.

[5] https://www.ncbi.nlm.nih.gov/books/NBK559052/
[6] https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1157&context=jj_etds
[7] https://nri-inc.org/media/0h0fbcju/2022-dementia-crim-just-rpt.pdf
[8] https://medicaid.ncdhhs.gov/8e-intermediate-care-facilities-individuals-intellectual-disabilities/download?attachment

- Institute “dementia-friendly” environmental design elements that are relatively quick and inexpensive, such as adding more and clear signage, improving lighting, installing handrails and different paint colors, and moving dementia patients to lower bunks.

Research Recommendations

- Research is needed on the diversion models used by courts to assess their effectiveness in identifying, assessing, and promoting appropriate dispositions of criminal cases involving arrestees with dementia.
- All stakeholder entities should collaborate on funding and implementing public and public-private research and demonstration projects to establish and test the use of memory-care and other long-term care facilities and supportive services for the optimal care of people with dementia diverted or released from the criminal legal system, including those with hard-to-manage behaviors.
- Correctional health care professionals and other professional groups should collaborate on developing consensus methods and tools for screening and assessing people with dementia who interact with the criminal legal system.

Other Recommendations from the Literature

The authors of this article published in the *American Journal of Law and Medicine* conducted qualitative semistructured interviews with legal practitioners to gain an understanding regarding their experience and professional opinions on policy, ethical, and logistical challenges of persons living with dementia (PLWD).[9]

Recommendations:

- Training and education on dementia for all of those involved in the justice system, including law enforcement, judges, and prosecutors.
- Increased social services and placement options for PLWD within the legal system and community.
- Increased number of psychological examiners who receive specialty training for safe placement for PLWD who have been arrested and are awaiting trial.
    - Placement issues may be resolved by assigning social workers to PLWD with a pending trial to provide assistance with housing, specifically age-specific facilities that are appropriate for PLWD.
- Community resources that prevent incidences within the criminal justice system, and alternatives to pretrial holds and sentences.
- Improved community resources, training, science-based practice guidelines for PLWD, and support for attorneys and public defenders.
- Reformed treatments designed for rehabilitation, as dementia is irreversible.

This report by the Wilson Center for Science and Justice outlines best practices for care and release of the aging prison population and dementia.[10] Recommendations include topics such as the lack of study of dementia in carceral settings, limitations of medical release mechanisms, reentry and release planning for release-eligible individuals living with dementia, and improvements to dementia care in carceral settings.

Examples of Best Practices

Connecticut

The state of Connecticut partners with a private care facility, 60 West, which cares for individuals transitioning from state care or who may be difficult to place in traditional nursing homes.

Massachusetts and Vermont

MissionCare, operated by the iCare Health Network (the same company behind 60 West), has facilities in Holyoke, Mass., and Bennington, Vt. These facilities follow the same care model as 60 West, offering long-term skilled nursing care to people who are difficult to place, including those with histories of justice involvement or challenging psychiatric, behavioral, or medical profiles.

Prioritizing Diversion and Decarceration of People With Dementia

Some researchers recommend community-based crisis services as an alternative to arrest and recommend the utilization of treatment courts rather than criminal courts as possible “upstream solutions” to prevent individuals with dementia from becoming incarcerated.[11] These types of diversion services are available for those with serious mental illness and have been shown to reduce the amount of jail time these individuals serve.[12] These programs typically fall into two main categories: prebooking, when an individual is not charged with a criminal offense and is diverted into mental health treatment, and post-booking, where diversion occurs after an individual has been arrested and booked into jail or charged with a criminal offense. However, diversion programs for those with dementia would require the availability of appropriate facilities, such as the 60 West nursing home in Connecticut, as psychiatric facilities and traditional nursing homes would not be able to accommodate these individuals.

[9] https://www.cambridge.org/core/journals/american-journal-of-law-and-medicine/article/crime-incarceration-and-dementia-an-aging-criminal-system/B18ED9316CA4069C543B575D2FD3C431

[10] https://wcsj.law.duke.edu/wp-content/uploads/2024/05/The-Aging-Prison-Population-and-Dementia.pdf

[11] https://journalofethics.ama-assn.org/article/prioritizing-diversion-and-decarceration-people-dementia/2023-10

[12] https://www.researchgate.net/profile/Frank-Sirotich/publication/40696359_The_Criminal_Justice_Outcomes_of_Jail_Diversion_Programs_for_Persons_With_Mental_Illness_A_Review_of_the_Evidence/links/54dfc2650cf2953c22b42dfe/The-Criminal-Justice-Outcomes-of-Jail-Diversion-Programs-for-Persons-With-Mental-Illness-A-Review-of-the-Evidence.pdf

RECOMMENDATIONS FROM EXPERTS

GHPC reached out to several experts in the state of Georgia who work with individuals with I/DD or severe mental illness who have become involved in the criminal justice system. These experts included individuals from advocacy agencies, lawyers, law professors from Georgia State University, and an expert in health policy and behavioral sciences. GHPC received responses that included references to literature, which we have incorporated throughout this report. Below are the discussions and recommendations on this topic that we gathered from experts either through informal interviews or email.

Susan Goico, Atlanta Legal Aid

GHPC spoke with Susan Goico, director of the Atlanta Legal Aid Society's Disability Integration Project, and she provided insights on areas of improvement in several aspects of the legal process for individuals with I/DD. She brought up several concerns with the current system, including a lack of adequate treatment or care for individuals with I/DD, even when they were under the support and supervision of the state. For example, she has experience with individuals who have been arrested directly from their group homes, where they are expected to receive proper support. She also emphasized that individuals with I/DD have a right to community-based services under the *Olmstead* decision, and there needs to be more urgency around connecting people to services and getting them out of jail. Another major concern is that the Medicaid waivers are considered an "optional Medicaid service" and that much-needed funding could be cut for these programs.

Recommendations Around the Medicaid Waver

Goico has several recommendations around expanding access to the Medicaid waiver:

- Currently 7,000 people are on the waiting list for the waiver, so there is a need to increase funding to help move people through the process faster. Individuals are moved off the list when they are "most in need," which can overlook individuals with I/DD. There should be clearer protocols to move people with disabilities off the list faster to prevent them from living in jail.
- The eligibility criteria for individuals with I/DD can be challenging, especially when historical information about an individual is not readily available. It is recommended that DBHDD have the ability to do its own evaluation for eligibility for the waiver when records are unavailable.
- Goico recommends stronger communication and workflow between the different branches of DBHDD. If someone has gone through the competency evaluation and was found incompetent by the forensic side, that should be enough to qualify them for a waiver and should alert the necessary teams that an individual is in that situation.

Recommendations for Nonjail Placements for Individuals With I/DD

Goico has several recommendations for preventing jail time for individuals with I/DD and finding placements for them:

- Jail diversion strategies should be emphasized early. Public defenders can sometimes put together a plan before their client must go through the competency process when they know that person has an I/DD. They should be able to call DBHDD immediately to get a plan together.

For people who already have a waiver, public defenders can get them out of jail; however, they need a place to go:

- DBHDD needs a rapid-response team to get people out of jail and have a crisis home for people to go to until they can be connected to a longer-term provider.
- There is a need to recruit and incentivize providers to work with this population, as people with I/DD need support from a wider provider base to get their needs taken care of.
- There is a need for more crisis beds to be made available. Currently, the system is at a crisis point, as there are crisis homes, but those homes are being used by people who are living in them long term.

Best Practices Example: The Nick Project

The Nick Project is a multisector status review of individuals with mental illness in the jails. Started in 2012, the project's mission is to connect people with mental illness in the DeKalb County Jail to the publicly funded mental health supports and housing they need to prevent recidivism and build a meaningful life. They work with partners, including DBHDD, and area community mental health providers, including View Point Health, Grady, Community Friendship, and the Georgia Resilience and Opportunity Fund. They facilitate monthly meetings where stakeholders come together to discuss particular clients comprising individuals currently in the DeKalb Jail or Georgia Regional Hospital for competency evaluations, and individuals who have been released from jail and are living in the community with services. They share any client successes or victories, and mental health providers, social workers, and lawyers at the public defender's office identify which clients have issues that need to be addressed, and their cases are discussed. Since 2012, they have been able to connect almost 300 individuals to services.

Georgia Advocacy Office

The Georgia Advocacy Office (GAO) discussed the challenges with individuals with I/DD finding placements outside of jails. They stated it is difficult to access services when Medicaid waivers are siloed between what is an individual's primary condition, I/DD, or a mental illness. In addition, people with I/DD are not meant to be in nursing facilities because of Pre-Admission Screening and Resident Review, which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness or I/DD. Intermediate care facilities may be an option for some people with I/DD, but Georgia has only one

state-run intermediate care facility organization with campuses in Augusta and Gracewood, although private facilities also exist across the state.[13]

Concerns and Recommendations for Medicaid Waivers

On the topic of Medicaid waivers, the experts from GAO commented that obtaining a waiver for individuals with an I/DD was the most effective way to get them services and community supports. However, there is a disconnect between the number of people who need waivers and the number of waivers that are funded each year. Additionally, eligibility requirements for waivers can be difficult for some individuals, including those who do not have historical records from before they were 18 years old. Provider capacity presents an additional challenge with the services available to those with Medicaid waivers. There are shortages in both the number of providers and providers with the specific skill sets and expertise necessary to care for individuals with more challenging behaviors.

Guardianships

The experts at GAO did not feel that guardianships were appropriate when dealing with individuals with I/DD in the justice system. The experts believe that guardians could create additional barriers to getting them the care and support they need. Guardians may see their ward only once per year, and they would still need to find that individual appropriate supports and work to connect them to the Medicaid waiver or services. An advocate can do that work without going through the process of finding a guardian first. DBHDD also has support teams that can be more effective than a guardian.

General Recommendations

- When a person is already connected to services and commits a crime or goes to the hospital, there should be a review of the service provider to find out why that person ended up in that situation. There should be an evaluation of the environment that the individual was living in, and an expert or training should be provided to that location to help prevent future events.
- Jails should be provided with someone they can call when they are unsure of how to support an inmate with I/DD. There should also be standards of mental health care and I/DD resources provided in jails. People stay in crisis in jails for extended periods of time because the jails cannot provide adequate support but are also reluctant to initiate involuntary mental health evaluations (DBHDD Form 1013) for individuals even if it might be necessary.
- The Georgia Crisis Access Line needs to be more reachable during crises.
- Competency evaluations should happen rapidly to prevent extended time in jail.

[13] ResCare Community Living, Pruitt Health

- Instead of placing responsibility on the individual, a wider focus and deeper investment in supports are needed for people to live life safely and prevent crime. Factors such as household environment or food access could be keeping individuals in a cycle of behavior. Judges and state agencies are advised to consider what supports are needed to prevent people from offending or to keep them from reoffending.
- Services should be tied to the needs of the individual and not simply based on their diagnosis or disability.
- Services and supports should be started in childhood, and with consistent supports early, people will offend less in adulthood.

Best Practices Example: Tennessee START

The experts at GAO held up Tennessee's TN START Assessment and Stabilization program as a current best practice for supporting crisis response and community supports for individuals with I/DD. The program is a statewide resource for individuals with I/DD who have complex behavioral or mental health needs.[14] It is currently available only to individuals with a Medicaid waiver, but they are looking to expand services to all individuals with I/DD in the state. Its hyperlocal approach (five teams across five regions of the state) provides the following services:

- 24/7 on-site or remote crisis response and consultation;
- Ongoing cross-systems crisis stabilization planning to include prevention and intervention for eligible individuals;
- Clinical consultation, education, and training;
- Establishing and maintaining formalized community partnerships and systems linkages;
- Comprehensive assessment and evaluation of support needs, existing services, and available resources;
- Assessment and facilitation of therapeutic resource center admissions; and
- Systemic analysis, consultation, and support.

Cortney Lollar — Professor at Georgia State University College of Law

Cortney Lollar, professor at Georgia State University College of Law, discussed the specific language of the policy surrounding individuals with I/DD when they are found incompetent to stand trial and unlikely to be restored. The law that governs this issue is Georgia Code Section 17-7-130. Subsection (c)(3)(B), and then section (e), describes when someone has been deemed incompetent and not likely to regain competency. According to this statute, once a person has been deemed incompetent and not likely to regain competency, they can either be placed in the

[14] https://www.tn.gov/disability-and-aging/about-us/divisions/clinical-services/tn-start.html

physical custody of the sheriff in that jurisdiction, or they can be detained until their case is dismissed or civil commitment is sought.

In the case of *Carr vs. State,* 303 GA. 853 (2018), while the Georgia Supreme Court does not explicitly address subsection (e) of the statute, the court found that automatic detention in the context of (c) was not appropriate and was, in fact, unconstitutional. The court also addresses the issue of lengthy detention under the statute: "We agree that indefinite or even unreasonably extended detention under OCGA § 17-7-130 (c) would be unconstitutional. … [W]e construe OCGA § 17-7-130 (c) as limiting the detention it authorizes to the reasonable time needed to fulfill its purpose." In other words, the court found that the statute did not authorize indefinite or unreasonably extended detention, and that once a determination has been made about a person's competence and the unlikelihood of it being restored, the trial court must "within 45 days … consider a nolle prosequi of the pending charges and release the defendant or seek his civil commitment and commit or release him based on the outcome of the civil commitment trial." As such, this case likely provides some court precedent for legally challenging longer detention times for the people who fall under subsection (e).

For people who have been deemed incompetent but for whom there is still a question as to whether their competency can be restored, in Fulton County, the sheriff's office has contracted with Emory University to provide competency restoration services. According to an order from a recent federal case, *Georgia Advocacy Office v. Jackson,* the judge found, however, that "the sole roles that the Fulton County Sheriff's Office play in the competency restoration program are providing a housing pod for the custody and general care of 16 or more program participants within the jail, providing security for Emory personnel, and administering medications to the inmates as prescribed. The Fulton County Sheriff's deputies and/or detention officers play no part in providing the competency restoration treatment itself." Unlike the Fulton County Sheriff's Office, many sheriff's offices in Georgia do not have access to resources and facilities like Emory University nearby to assist in this process. Consequently, when the statute indicates that people should be returned to a sheriff's office after being deemed incompetent and not likely to be restored to competency, the likelihood is, according to Lollar, there is not much being done to facilitate helping people with I/DD who are deemed not appropriate for civil commitment but also not likely to have competency restored get out of a carceral setting. Nevertheless, by statute, no matter where the placement is, a person should have a determination made about their future within 45 days of this placement.

From the Literature: States' Examples and Resources to Support Individuals With I/DD

Complying With Title II of the Americans with Disabilities Act

On this site, the U.S. Department of Justice, Civil Rights Division, provides information to support criminal justice entities to comply with Title II of the Americans with Disabilities Act (ADA), highlighting central responsibilities of state and local government with examples of the effective implementation strategies by state and local leaders in the United States. It also outlines the requirements of state and local governments to comply with Title II.

Some of the key topics included are training; special considerations for law enforcement agencies; analysis of policies, practices, procedures, and standing orders; and collaboration with other entities. Additional resources include examples of policies and practices compliant with the ADA throughout the United States. Finally, case findings and remedies are provided in categories such as law enforcement, corrections and juvenile detention facilities, and community-based services.

Individualized Reentry Plan

The Alliance of Disability Advocates in North Carolina currently offers an individualized reentry plan (IRP) to individuals with I/DD or traumatic brain injuries. The program is funded by the Department of Health and Human Services and specifically dedicates IRP services to individuals with either of these diagnoses. The primary services provided by the reentry team include "housing, employment, benefits, mental health and substance abuse resources, travel training, independent living skills, vital records, and driver's license restoration resources."

The Alliance of Disability Advocates' reentry program works closely with the Department of Adult Corrections to facilitate successful reentry for all consumers prereleased and subsequently works with family members and probation and parole to support post-release. The IRP also includes certified peer specialists, who hold space for the concerns of IRP participants and gather information about their goals regarding housing, employment, education, social service applications, and mental health and substance use resources post-release.[15]

Intellectual and Development Alternative to Incarceration Program

In Rockland County, N.Y., the Office of the District Attorney offers a diversion program exclusive to individuals with I/DD charged with a crime. Licensed mental health professionals, psychologists, or psychiatrists evaluate an individual's eligibility for the program through a referral process and an examination of their history, with consideration that the target population has an impairment that cannot be resolved with treatment. Co-occurring disorders are also identified and addressed. While the requirements of the Intellectual and Development Alternative to Incarceration Program are unique to each participating individual, the overarching goals remain the same. The aims of the program are to gain an understanding of the behavior that led to the arrest of the individual and to promote behavioral regulation, skill development, and environmental support. To complete the program, the district attorney's office, the court, and the case management team evaluate adherence to the program guidelines.[16,17]

[15] https://adanc.org/reentry/
[16] https://www.rocklandda.org/iddati
[17] https://vimeo.com/481501734

Other Resources

Dismissals as Justice
Anna Roberts, a former public defender, wrote an article discussing judges exercising their power to dismiss *de minimis* prosecutions. It argues that this power can be used in individual cases to push back against overcriminalization and overincarceration.[18]

When Individuals With Developmental Disabilities Become Involved in the Criminal Justice System: A Guide for Attorneys
The Arc of New Jersey created a guide for attorneys that features information regarding individuals with developmental disabilities in the court system. The guide includes background information on the issue of the I/DD population in the justice system, working with clients diagnosed with developmental disabilities, common terminology, common offenses, legal defense preparation, relevant laws, and central support services.[19]

The Arc, Pathway to Justice
The Arc's National Center on Criminal Justice and Disability provides an in-person training for law enforcement, victim services providers, and legal professionals covering topics such as how to identify, interact with, and accommodate persons with I/DD and other disabilities.[20]

Designing Jails for Individuals With Cognitive-Diminishing Disorders
Fishkill Regional Medical Center in New York, and the Federal Medical Center, Devens in Massachusetts created facilities in the prison system specifically designed for individuals with dementia.[21,22]

CONCLUSION

The *Olmstead* decision set forth the precedent that individuals with I/DD have a right to community supports and services. However, within the criminal justice system, it is challenging to divert individuals with I/DD and those with a cognitive-diminishing disorder who may qualify for these supports out of the prison system after they are declared incompetent to stand trial and nonrestorable. Civil commitment or release are some of the few options available, but putting these individuals into an environment where they will receive the supports and services they need is difficult in Georgia. Common recommendations from people working with these individuals include increasing the number of Medicaid waivers available, changing restrictions on eligibility to cover more individuals, and fixing the lack of facilities, bed spaces, and staff available who are specifically trained to work with I/DD individuals. Other recommendations focused on prevention of I/DD individuals from engaging in criminal behaviors, including providing support services earlier, addressing environmental factors contributing to negative outcomes, and ensuring home environments or living situations meet an individual's unique needs.

[18] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://law.ua.edu/wp-content/uploads/2017/12/Dismissals-as-Justice.pdf
[19] https://thearcofnova.org/wp-content/uploads/sites/6/2018/08/Justice-System-Guide-for-Attorneys-April-2021.pdf
[20] https://thearc.org/our-initiatives/criminal-justice/pathway-justice/
[21] https://correctionalnews.com/2009/12/04/spotlight-julyaugust-2008-prison-gray/
[22] https://www.prnewswire.com/news-releases/first-of-its-kind-memory-disorder-prison-unit-federal-inmates-certified-as-certified-nursing-assistants-federal-correctional-staff-certified-with-specialized-certification-300964099.html

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