



**THE GOVERNOR'S BEHAVIORAL HEALTH REFORM  
& INNOVATION COMMISSION (BHRIC) AND THE  
MEMBERS OF THE GEORGIA GENERAL ASSEMBLY  
ON BEHALF OF THE PEOPLE OF GEORGIA**

**Full Commission Meeting**

**November 2022  
Chairman Kevin Tanner**

# **Behavioral Health Reform and Innovation Commission**

**Paul D. Coverdell Legislative Office Building (CLOB 606)**

**18 Capitol Square SW Atlanta, GA 30034**

**November 16<sup>th</sup>, 2022**

**1:00pm – 5:00pm**

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## **AGENDA**

Meeting Convenes 1:00 PM

Opening Remarks 1:00 PM – 1:10 PM  
(Chairman Tanner)

## **Subcommittee Overview**

**Mental Health Courts and Corrections** 1:10 PM – 1:50 PM

- I. Opening Remarks  
*Subchair Chief Justice Michael Boggs*
- II. Familiar Faces project and recommendations  
*Marylyn Leake, Senior Policy Analyst, Behavioral Health Division, CSG Justice Center*
- III. Next Steps & Conclusion  
*Subchair Chief Justice Michael Boggs*

**Children and Adolescent Behavioral Health** 1:50 PM – 2:25 PM

- I. Opening Remarks  
*Subchair Dr. Eric Lewkowiez, M.D., M.S., DFAPA, DFAACAP, Medical College of Georgia -Augusta University*
- II. Presentation and Recommendations  
*Subchair Dr. Eric Lewkowiez, M.D., M.S., DFAPA, DFAACAP, Medical College of Georgia -Augusta University*
- IV. Next Steps & Conclusion  
*Subchair Dr. Eric Lewkowiez M.D., M.S., DFAPA, DFAACAP, Medical College of Georgia -Augusta University*

**Hospital and Short-Term Care Facilities** 2:25 PM – 3:05 PM

- I. Opening Remarks  
*Subchair Dr. Brenda Fitzgerald*
- II. Inverting the Burden: Supporting Patients with Complex Needs  
*Carrie Oliver, MPH Senior Innovation Manager & Aviva Berman, MPH Senior Innovation Manager, The Atlanta Regional Collaborative for Health Improvement (ARCHI)*
- III. Mental health provider networks: Paucity amidst scarcity  
*Jane Zhu, MD, MPP, MSHP, Assistant Professor of Medicine, Division of General Internal Medicine, Oregon Health and Sciences University (OHSU)*
- IV. IMD Waiver Requirements  
*Brian Dowd, Deputy Director, Medical Assistance Plans, GA Dept. of Community Health*
- V. Next Steps & Conclusion  
*Subchair Dr. Brenda Fitzgerald*

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## **Involuntary Commitment**

3:05 PM – 3:45 PM

- I. Opening Remarks/ Legislative Recommendations  
*Subchair Judge Brian Amero*
- II. Assisted Outpatient Treatment  
*Brian Stettin, Sr. Advisor for Severe Mental Illness, City of New York, NY*
- III. Data Sharing Between Criminal Justice and Behavioral Health  
*Stephanie Lopez- Howard, Statistical Analysis Center Director, Criminal Justice Coordinating Council*
- IV. Opening Doors to Recovery  
*Nora Lott Haynes, Involuntary Commitment Subcommittee Member*
- V. Competency Restoration  
*Dr. Karen Bailey, Involuntary Commitment Subcommittee Member*
- VI. Next Steps & Conclusion  
*Subchair Judge Brian Amero*

## **Workforce and System Development**

3:45 PM – 4:25 PM

- I. Opening Remarks  
*Subchair Representative Mary Margaret Oliver*
- II. Data Sharing in Georgia and future opportunities for improvement  
*Elizabeth Holcomb, Deputy Director and Legal Council, Georgia Office of Health Strategy and Coordination*
- III. Recommendations, Next Steps and Conclusion  
*Subchair Representative Mary Margaret Oliver*

## **Q & A**

4:25 PM – 4:35 PM

*(open to members and public)*

## **Next Steps and Closing Remarks**

4:35 PM – 5:00 PM

*(Chairman Tanner)*

## **Adjourn**

5:00 PM

**\*Agenda subject to change at the discretion of the Chairman.\***

## **Mental Health Courts and Corrections Subcommittee**

### ***Familiar Faces Advisory Committee***

Chief Justice Michael Boggs - **Chair**  
Judge Brian Amero  
Sheriff Andy Hester  
Chief Louis Dekmar  
Judge Brenda Weaver

Judge Kathleen Gosselin  
Stan Cooper  
Commissioner Timothy Ward  
Commissioner Michael Nail

### **Index of Presentations**

#### **I. Familiar Faces Advisory Committee Policy Recommendations**

*The Council of State Governments*



**Justice Center**

THE COUNCIL OF STATE GOVERNMENTS

# **Familiar Faces Advisory Committee**

Mental Health Courts and Corrections Subcommittee

Behavioral Health Reform and Innovation Commission

November 16, 2022

# Agenda

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- “Familiar Faces” and the Georgia Familiar Faces Advisory Committee
- Recommendations of the Mental Health Courts and Corrections Subcommittee
  - Priority Area 1: Bolster Capacity to Identify Familiar Faces
  - Priority Area 2: Improve Community Response to Familiar Faces
  - Priority Area 3: Expand Access to High-Quality Care and Supports
  - Priority Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in GA

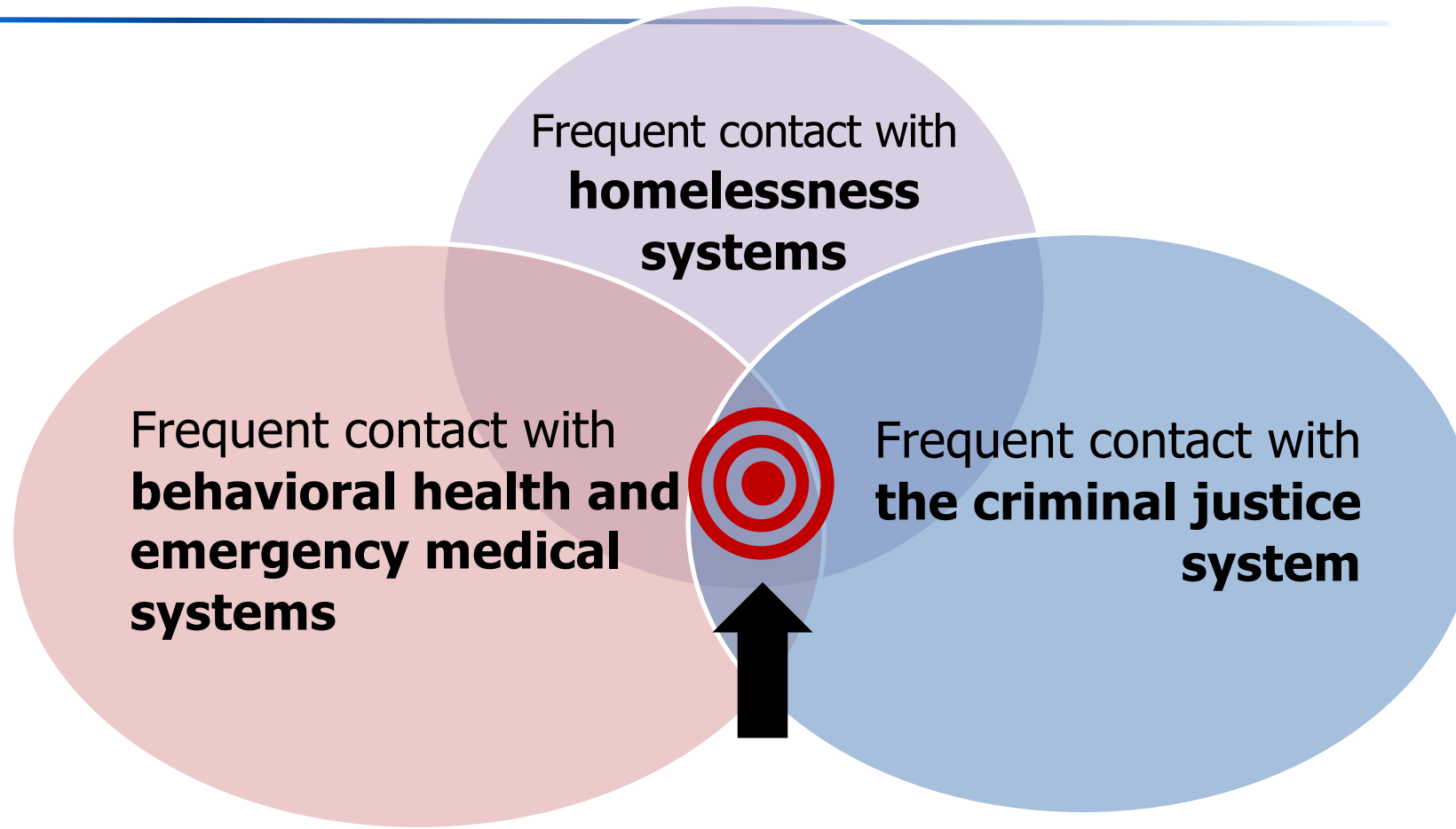
# Familiar Faces

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Very Small Population with a High Volume of Contact with Health and Justice Systems

# “Familiar Faces”

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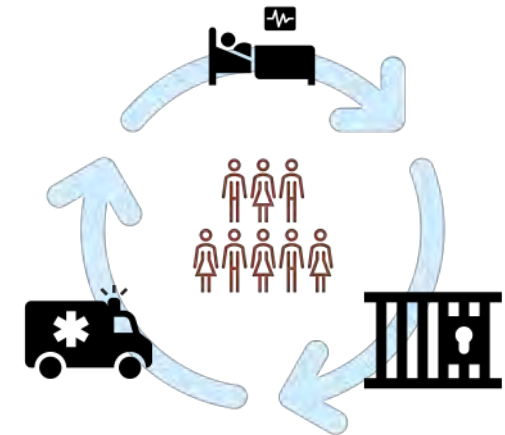
# People with mental illness incarcerated in Georgia jails

## 2020 Study of incarcerated people with mental illness in 9 Georgia jails, 2013-2018

Familiar Faces: **the top 1% of booking episode counts**

- Total Familiar Faces population = **2328**
- **Familiar Faces with mental illness = 649**

	Familiar Faces	Familiar Faces w MI
<b>Average # Arrests</b>	21	51
<b>Average Days Community Tenure</b>	394	172



John Speir, Sharon C. Johnson, Stefanie Lopez-Howard, Taylor Gann, Stephen Okala, Identifying Predictors of Mental Illness in County Jails (Atlanta: Criminal Justice Coordinating Council, 2022).

# Familiar Faces Advisory Committee

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Mental Health Courts and Corrections Subcommittee of the Behavioral Health Reform and Innovation Commission

# The Advisory Committee

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**Behavioral Health Reform and Innovation Commission**  
**Kevin Tanner, Chair**

**Mental Health Courts and Corrections Subcommittee**  
**Presiding Justice Michael J. Boggs, Chair**

**Familiar Faces Advisory Committee**

# Georgia Familiar Faces Advisory Committee

Judge Brian Amero	Chief Judge Henry County Superior Court	Henry County Superior Court
Chief Justice Michael Boggs *	Mental Health Courts and Corrections Subcommittee Chair	Georgia Supreme Court
Stan Cooper	Director, Probation Operations (Retired)	Georgia Department of Corrections
Chief Louis Dekmar	Chief of Police	LaGrange Police Dept
Kathlene Gosselin	Chief Judge	Northeast Circuit of Georgia
Andy Hester	Sheriff	Turner County
Chris Johnson	Interim Executive Director	Georgia Mental Health Consumer Network
Monica Johnson	Division Director, Behavioral Health Interim Commissioner	Georgia Department Behavioral Health and Developmental Disabilities
Kristyn Long	Deputy Chief Operating Officer, Deputy Executive Counsel	Office of GA Governor Brian P. Kemp
Stefanie Lopez-Howard	Statistical Analysis Center Director	Criminal Justice Coordinating Counsel
Evan Mills	Director of Development and Housing Programs	Advantage Behavioral Health Systems (Athens-Clarke)
Clint Mueller	Legislative Director	Association of County Commissioners of GA
Commissioner Michael Nail	Justice Courts Steering Committee Member	Georgia Department of Community Supervision
Kristin Stoycheff Schillig	Court Support Manager II, Justice and Mental Health Projects	Superior Court of Fulton County
Senator Brian Strickland	Georgia State Senator	Senate District 17
Kevin Tanner	Forsyth County Manager; Chair, Behavioral Health Innovation and Reform Commission	Forsyth County
Cordaryl Turner	Deputy Division Director	Georgia Department of Community Affairs
Judge Brenda Weaver	Chief Judge	Appalachian Circuit of Georgia

# County Teams

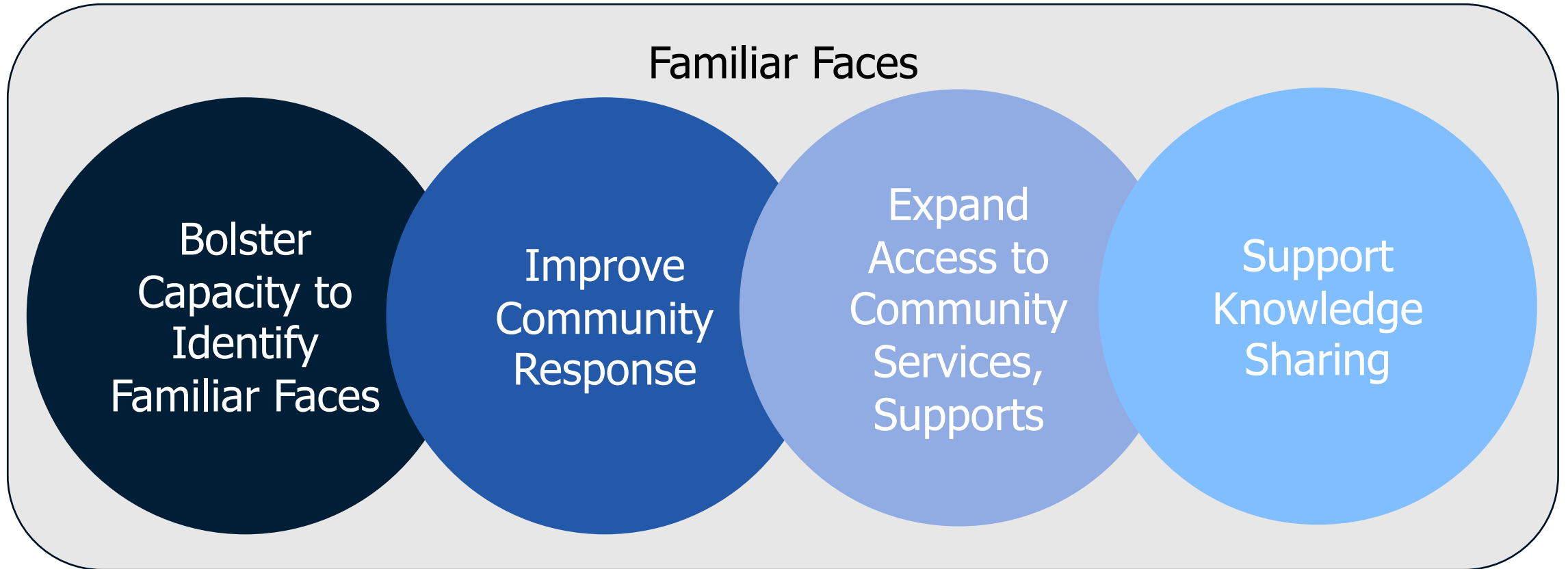


County	Familiar Faces	Stepping Up	JMHCP**
Athens-Clarke County		✓	✓
Chatham County		<b>Innovator</b>	✓
DeKalb County		✓	✓
Dougherty County		✓	
Forsyth County		✓	✓
Fulton County	✓	<b>Innovator</b>	✓
Newton County		✓	✓
Richmond County		✓	
Rockdale County		✓	✓
Troup County	✓		

\*\*Justice & Mental Health Collaboration Program

# Framework for Policy Ideas

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# Policy Area 1: Bolster Capacity to Identify Familiar Faces

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# Policy Area 1: Bolster Capacity to Identify Familiar Faces

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## **1.A. Develop state level guidance to standardize and streamline information-sharing that local system partners can opt to implement.**

- Standardized definitions across state agencies for serious mental illness and
- Fund a pilot to test and scale local implementation

## **1.B. Implement validated behavioral health screening in jails.**

- Provide pilot funding for jails to implement validated housing stability and behavioral health screening
- Support Georgia Sheriffs' Association and local sheriffs in expanding use of best practice behavioral health screening in jail credentialing and standards



# **Policy Area 2: Improve Community Response to Familiar Faces**

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# Policy Area 2: Improve Community Response to Familiar Faces

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## 2.A. Expand access to crisis and other resources

- Fund a small number of county-based, dedicated coordinator positions to build collaboration between criminal justice and behavioral health partners, and to work with co-responder protocol committees under SB 403.
- Support for DBHDD to conduct / contract for analysis of need for non-crisis beds for Familiar Faces: short-term housing/diversion options; Psychiatric Respite Centers, etc.

## 2.B. Reduce wait times for state hospital beds and competency evaluation/restoration services

- Empower a task force to address long wait times for competency evaluation and restoration services in Georgia.

# **Policy Area 3: Expand Access to High-Quality Care and Supports**

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# Policy Area 3: Expand Access to High-Quality Care and Supports

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## 3.A. Expand jail in-reach services in Georgia

- Build local capacity with competitive funding and technical assistance for a few diverse counties to create or expand collaborative jail in-reach and reentry programs
- Increase funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) case managers, pilot program in jails

# Policy Area 3: Expand Access to High-Quality Care and Supports

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## Recommendation 3.B. Increase housing access and availability for Familiar Faces

- Establish Tenant Selection Plans through DCA that do not create criminal record-related barriers to housing unrelated to fitness as a tenant, similar to North Carolina and Louisiana
- Assess feasibility of housing set-asides for the Familiar Faces population, inventory current DCA programs (e.g., HOME-ARP and the Housing Choice Voucher program)
- Increase supportive housing development for Familiar Faces by establishing incentives through DCS in the 2024 LIHTC Qualified Allocation Plan (QAP), such as implementation of a supportive housing set-aside.
- Seed a Landlord Incentive Fund with federal funding to be matched with private funds and allocated regionally, to recruit more landlords to serve this population (e.g., leasing incentive payments and risk mitigation funds)

# Policy Area 3: Expand Access to High-Quality Care and Supports

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## **3.C. Address behavioral health workforce shortages**

- Endorse the recommendations of the Workforce and Systems Development Subcommittee, including consistency in credentialing standards for managed care organizations in Georgia

## **3.D. Strengthen Georgia's Peer Support Specialist capacity.**

- Add peer members to Behavioral Health Innovation and Reform Commission and authorize it to lead a comprehensive, multi-year plan to further expand the number of forensic peer support specialists

# **Policy Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in Georgia**

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# Policy Area 4: Support Knowledge Sharing about Familiar Faces across Communities and Systems in GA

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## 4.A. Assist counties working with Familiar Faces

- Establish a statewide public-private partnership to be a clearinghouse for best practices, information, and resources that support developing and sustaining practices for Familiar Faces: data collection, use, and sharing; diversion; community-based services
- Draw on expertise and administrative capacity of a designated state agency, university system, and/or other entity



# Thank You!

Join our distribution list to receive updates and announcements:

<https://csgjusticecenter.org/resources/newsletters/>

For more information, please contact Marilyn Leake at [mleake@csg.org](mailto:mleake@csg.org) or Amy Button at [abutton@csg.org](mailto:abutton@csg.org)

*The presentation was developed by members of The Council of State Governments Justice Center staff. The statements made reflect the views of the authors, and should not be considered the official position of The Council of State Governments Justice Center, the members of The Council of State Governments, or the funding agency supporting the work.*

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# Appendix: Key Contributing Stakeholders

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Subject Matter Experts and Stakeholders Who Contributed to Development of Policy Recommendations

# Key Stakeholders: Policy Area 1- Bolster Capacity to Identify Familiar Faces

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- 10 county teams
- Association of County Commissioners of Georgia
- Department of Behavioral Health and Developmental Disabilities
- Georgia Sheriffs' Association
- Office of Georgia Governor Brian P. Kemp
- Chair, Workforce and Systems Development Subcommittee
- Strong support from the Familiar Faces Advisory Committee

# Key Stakeholders: Policy Area 2 Improving Community Response to Familiar Faces

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- 8 county teams
- Department of Behavioral Health and Developmental Disabilities
- Advisory committee/county coalition members with subject matter expertise

# Key Stakeholders: Policy Area 3 – Expanding Access to High-Quality Care and Supports

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- 10 county teams
- Atlanta Legal Aid
- Department of Behavioral Health and Developmental Disabilities
- Department of Community Affairs
- Dr. Sam Tsemberis, Pathways Housing First Institute
- Georgia Association of Community Service Boards
- Georgia Supportive Housing Association
- Peer listening session
- Workforce and Development Subcommittee
- Housing advocates

# Key Stakeholders: Policy Area 4 – Cross-Systems Knowledge Sharing in Georgia About Familiar Faces

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- 10 county teams
- Association of County Commissioners of Georgia
- Georgia Sheriffs' Association
- Georgia Association of Community Service Boards
- Advisory Committee subject matter experts

## **Children and Adolescent Behavioral Health Subcommittee**

Dr. Eric Lewkowicz - **Chair**

Dr. Garry McGiboney

Senator Donzella James

Gwen Skinner

Miriam Shook

Dr. Sarah Vinson

Commissioner Tyrone Oliver

### **Index of Presentations**

#### **I. Presenters to the Subcommittee in 2022**

*Subcommittee on Children and Adolescents*

#### **II. Identified Needs and Recommendations Presentation**

*Subcommittee on Children and Adolescents*

#### **III. Identified Needs and Recommendations Full Spreadsheet**

*Subcommittee on Children and Adolescents*

### **BHRIC Subcommittee on Children and Adolescents Members**

**Dr. Eric Lewkowiez (Chair), Miriam Shook, Dr. Sarah Vinson, Gwen Skinner,  
Commissioner Tyrone Oliver, Dr. Garry McGiboney**

### **Support to the BHRIC Subcommittee on Children and Adolescents**

**Ashley Dickson (United Way), Dr. Ann DiGirolamo (Georgia State University),  
Ann Marie Mukherjee (Georgia State University)**

### **Presenters to the BHRIC Subcommittee on Children and Adolescents 2022**

- **Dr. Paula Riggs**  
Professor of Psychiatry, University of Colorado School of Medicine  
Director, Division of Addiction Science, Prevention, and Treatment
- **Jill Mays**  
Director  
Office of Behavioral Health Prevention  
Georgia Department of Behavioral Health and Developmental Disabilities
- **Cassandra Price**  
Director  
Office of Addictive Disease  
Georgia Department of Behavioral Health and Developmental Disabilities
- **Honorable Judge Peggy Walker**  
Senior Judge
- **Dr. Emily Graybill**  
Clinical Associate Professor, Director of the Center for Leadership in Disability  
Principal Investigator for the Georgia Association for Infant Mental Health (GA-AIMH)
- **Dr. Terri McFadden, MD, FAAP**  
Pediatrician, Professor in the Department of Pediatrics of the Emory University School of Medicine  
Medical Director of Primary Care at the Hughes Spalding Campus of Children's Healthcare of Atlanta
- **Teresa Wright-Johnson**  
Parent Peer Support Specialist  
Founder of Zaria's Song
- **Laura Lucas**  
Infant and Early Childhood Mental Health Director  
Georgia Department of Early Care and Learning (DECAL)
- **Callan Wells**  
Senior Health Policy Manager,  
Georgia Early Education Alliance for Ready Students (GEEARS)  
Policy Advisor for the Georgia Association for Infant Mental Health (GA-AIMH)
- **Arianne Weldon**  
Strategic Innovation Manager  
Georgia Family Connection Partnership



- **John N. Constantino MD**  
Chief of Behavioral and Mental Health,  
Children's Healthcare of Atlanta  
Professor - Departments of Psychiatry and Pediatrics  
Emory University
- **Michael Ellis, MD**  
Psychiatrist  
St. Francis Hospital  
Columbus, Georgia
- **Synita Griswell, MPH**  
Autism and Developmental Disabilities Program Manager  
Children and Youth with Special Healthcare Needs  
Maternal and Child Health Section Division of Health Promotion  
Georgia Department of Public Health
- **Maliha Haider-Bardill**  
Autism Project Manager  
Georgia Department of Behavioral Health and Developmental Disabilities
- **Bhavini Solanki, MA**  
Director  
Behavioral Health  
Amerigroup
- **Caylee Noggle**  
Commissioner  
Georgia Department of Community Health
- **Lynnette Rhodes**  
Executive Director  
Medical Assistance Plans  
Georgia Department of Community Health
- **Ann DiGirolamo, PhD**  
Research Associate Professor  
Director-Behavioral Health, Georgia Health Policy Center  
Director-Center of Excellence for Children's Behavioral Health  
Georgia State University
- **Layla Fitzgerald, MS**  
Program Manager  
Office of Children, Young Adults and Families  
Georgia Department of Behavioral Health and Developmental Disabilities

**Presenters Scheduled for the BHRIC Subcommittee on Children and Adolescents for November 17, 2022 Meeting:**

- **Margaret Cawood**  
Deputy Commissioner of Support Services  
Georgia Department of Juvenile Justice

- **Christine Doyle, PhD**  
Director of the Office of Behavioral Health  
Georgia Department of Juvenile Justice
- **Melissa Haberlen DeWolf**  
Research & Policy Director  
Voices for Georgia's Children
- **John N. Constantino, MD**  
Chief, Behavioral & Mental Health  
Children's Healthcare of Atlanta
- **Darlene C. Lynch, Esq.**  
Head of External Relations  
The Center for Victims of Torture Georgia
- **Davielle Lakind, PhD**  
Assistant Professor  
Department of Clinical Psychology  
Mercer University
- **Amber McCorkle**  
Director of Education and Programs  
Clarkston Community Center

# **Behavioral Health Reform and Innovation Commission**

## **Subcommittee on Children and Adolescents**

Identified Needs/Recommendations as of  
October 24, 2022

# Mental Health and Substance Abuse - General

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse - General	Create an executive leadership position (i.e., Assistant Commissioner) at the Georgia Department of Behavioral Health and Developmental Disabilities that focuses on children and adolescent mental health and substance abuse.		X	X	

# Mental Health and Substance Abuse Treatment and Resources

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Treatment and Resources	Expand access to telehealth for mental health and substance abuse issues. Telehealth could offer access to direct patient care; clinician training, clinical consultation, and x-waiver training (outpatient use of buprenorphine for the treatment of opioid use disorder).	X	X		X
Mental Health and Substance Abuse Treatment and Resources	Increase the mental health and substance abuse treatment provider pay to bring more therapists into the service networks, which would build more community-based resources and improve access for rural areas and other underserved populations.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Expand the Certified Peer Support Specialist (Specialist) program and increase the compensation for the Specialists to exceed the minimum wage.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Close the gap of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, PeachState, and DBHDD by developing a coordinated plan of continuum of care.	X		X	

# Mental Health and Substance Abuse Treatment and Resources (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Treatment and Resources	Legislators and policy makers need to be cautious about expanding the legalization of cannabis due to the resulting negative impacts on adolescents. States that expanded the legal access to cannabis have seen increases in adolescent cannabis use and emergency room admissions.	X			
Mental Health and Substance Abuse Treatment and Resources	Expand evidence-based substance abuse and mental health treatment for co-occurring disorders with integrated treatment models, co-located treatment services, and coordinated care models so that community-based resources can provide the essential services.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Create and fund the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) with Children's Healthcare of Atlanta, Emory University, Georgia-AAP, and the Medical College of Georgia. The purpose of GaPPCAP and GMAP would be to support primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs. GaPPCAP would also provide education for core mental health competencies in pediatric behavioral health support.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Schools should explore the use of telehealth for medical and mental health services. The Georgia Department of Administrative Services has a statewide contract with approved telehealth providers.		X	X	X

# Mental Health and Substance Abuse Treatment and Resources (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Treatment and Resources	Schools and Regional Education Service Agencies (RESA) should work with local CSBs to develop coordinated mental health access for students (i.e., expand the APEX program).		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Crisis Stabilization Units to cover more regions of the state and provide information about the CSUs to CSBs, pediatricians, emergency room physicians and others.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Expand the availability of Child and Adolescent Substance Abuse Intensive Outpatient Program to more regions of the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Study the possibility of expanding the number of substance use disorder intensive residential treatment centers from the present two facilities to more locations in the state.		X	X	

# Mental Health and Substance Abuse Treatment and Resources (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Clubhouse Programs that provide continued care for adolescents recovering from substance use issues.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Only one facility offers transition aged youth services. Study the feasibility of expanding the program to more regions in the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand juvenile drug courts to more jurisdictions and link to community-based resources.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Operationalize the Georgia Student Health Survey data, for use by stakeholders, decisionmakers, and Georgia citizens by making it a queryable database (Georgia Tech's Center for Health Analytics and Informatics capable of creating and request sent to Acenture to consider as part of their community service/pro bono programs).		X	X	



# Mental Health and Substance Abuse Treatment and Resources (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Treatment and Resources	Continue funding for the Mental Health Training Initiative that provides mental health and trauma awareness training for educators.		X		X
Mental Health and Substance Abuse Treatment and Resources	Seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health - children from lower income families are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards, that increase the need for health care interventions.			X	
Mental Health and Substance Abuse Treatment and Resources	Public and private schools should consider establishing school-based plans and toolkits that help eligible students and family members enroll in health insurance that include mental health coverage.			X	X
Mental Health and Substance Abuse Treatment and Resources	Schools should partner with Federally Qualified Health Centers to offer integrated health services in schools.			X	X

# Mental Health and Substance Abuse Prevention

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Mental Health and Substance Abuse Prevention	Expand Prevention Clubhouses to add more regions of the state to broaden the reach of this successful program.		X	X	
Mental Health and Substance Abuse Prevention	Expand the Sources of Strength suicide prevention program that combines community work with school efforts to empower children and adolescent and to provide support for mental health and recognition of the importance of family support, access to services, spirituality, generosity, mentorship, and health activities.		X	X	X
Mental Health and Substance Abuse Prevention	Expand substance abuse prevention activities in schools and colleges and include community resources to aid the development of and expansion of prevention programs and activities, such as the Peer Assisted Student Transition program, College Prevention program, and Let's Be Clear program.		X	X	
Mental Health and Substance Abuse Prevention	Expand the Certified Student Peer Support Specialist program to include more schools and link to community-based resource programs.		X	X	

# Infant Mental Health Prevention, Intervention, and Support

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Infant Mental Health Prevention, Intervention, and Support	Enact policies that support infant and child caregivers who are experiencing stress related to housing and income support. Consider case management services.	X	X	X	
Infant Mental Health Prevention, Intervention, and Support	Support and expand high-quality early childhood programs that give children a safe, stable environment.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Create and fund the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) to support primary care professionals in identifying and treating mild to moderate behavioral health conditions in children and adolescents in primary care practices or school-based health centers. GaPPCAP would also provide education for core mental health competencies in pediatric care of children and adolescents.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Support evidence-based home visiting models that can provide information and support for parents.		X	X	

# Infant Mental Health Prevention, Intervention, and Support (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Infant Mental Health Prevention, Intervention, and Support	Provide funding for training on early childhood trauma to members of the child-serving workforce.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Develop and support strategies and implementation plans to expand the state's capacity to provide access to Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH (Georgia Association for Infant Mental Health) statewide to CSBs and other mental health providers.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Ensure Medicaid reimbursement for prevention and treatment for infant mental health and dyad treatment.			X	
Infant Mental Health Prevention, Intervention, and Support	Add Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH to workforce training programs.			X	X

# Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include coverage through health insurance to address social determinants of health (transportation, parking/lodging/meals costs, missed work pay, lack of child-sitting for siblings) to increase families' ability to engage in the care of their infants while in the NICU.	X	X	X	-
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources through private-public partnerships that support hospitals to provide on-site childcare facilities for siblings to help remove the barrier of securing and paying for sibling childcare while infant is in NICU.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand access to training and implementation of NICU Peer Recovery Coaching to reach families impacted by substance use and to improve coordination and monitoring of plans of safe care.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Support efforts like Reach Out and Read in the pediatric setting so families will continue to be encouraged and supported to read with their infants and throughout early childhood.		X		X

# Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand implementation of NICU peer-to-peer support provided by parents who have experienced having their infant in a NICU to those who currently have an infant in a NICU.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Provide resources for hospital systems to proactively develop innovative solutions that facilitate and support the family's presence in the NICU. These solutions could include providing a place for parents to stay and take care of their basic needs, such as eating, bathing, laundry, and sleep. Vouchers for lodging and meals would significantly reduce the financial burden of staying long periods in the NICU.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources so technology-based approaches can be implemented to supplement families' physical presence in the NICU, which may include text messaging updates, web-cam footage of infants, FaceTime and Skype updates, virtual visitation, and virtual rounding.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand support for NICUs by investing in the Regional Perinatal Center Neonatal Outreach Educators, coordinated by the Georgia Department of Public Health.		X	X	

# Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Develop and implement case and care management during and after the NICU stay to create a plan of safe care with families impacted by substance use.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include family-integrated approaches to care in the NICU as part of university and professional training for all types of practitioners who provide care in NICUs, including but not limited to nursing, medicine, social work, counseling, and allied health.				X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Embed practices in the NICU that encourage and support families to read aloud with their infants while in the NICU and promote private-public partnerships with hospitals to help with the cost of books.				X

# Autism Spectrum

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Autism Spectrum	There should be a re-evaluation of Medicaid reimbursement rates for ASD diagnosis and remove the restrictions on who is qualified to make a diagnosis, as also recommended by the American Academy of Pediatrics.	X	X	X	X
Autism Spectrum	Study how to create incentives to open more residential treatment facilities for acute ASD.		X	X	
Autism Spectrum	The state needs to give more resources to the Medicaid waiver program to get ASD patients off the waiting list.		X	X	
Autism Spectrum	Study how schools and universities could train more teachers and paraprofessionals on ASD awareness, interventions, and support.		X		X



# Autism Spectrum (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Autism Spectrum	Develop medical and psychosocial protocols as immediate follow-up after an ASD diagnosis, which should include respite care.				X
Autism Spectrum	Study how the state and school districts could provide more Board-Certified Behavior Analysts to work with teachers and ASD students.				X
Autism Spectrum	Provide case managers from Medicaid or commercial insurers to parents to help them find and best utilize services.		X	X	
Autism Spectrum	Insurance companies should be required to recognize a diagnosis of ASD from a PCP or child psychiatrist while waiting for the psychological evaluation which would allow immediate access to ABA treatment.	X		X	X

# Autism Spectrum (continued)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Autism Spectrum	Develop more acute autism crisis stabilization units funded by a combination of federal and state funds and reimbursements from Medicaid and insurance carriers.		X	X	
Autism Spectrum	Study the feasibility of school paraprofessionals receiving training as a Registered Behavioral Technicians.	X		X	X

# Psychologist Billing

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Psychologist Billing	The Department of Community Health (DCH) should study the feasibility of reimbursing psychologists for a 90791, a diagnostic evaluation.			X	X

# School-Based Mental Health (SBMH)

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
School-Based Mental Health (SBMH)	Explore funding opportunities/grants for prevention initiatives within the school setting, providing training and necessary infrastructure to support SBMH and SBMH coordination with other mental health providers and systems (i.e., CSBs, universities, private providers).		X	X	X
School-Based Mental Health (SBMH)	Expand youth-informed and youth-led mental health initiatives in more of Georgia's schools.		X	X	X
School-Based Mental Health (SBMH)	Explore more opportunities for licensing counselors and social workers within schools and agencies.		X	X	X
School-Based Mental Health (SBMH)	Consider the Certified Community Behavioral Health Clinic (CCBHC) Model to support SBMH programs.			X	X
School-Based Mental Health (SBMH)	Promote training programs to prepare students and therapists for working in the school setting.		X	X	X

# Medicaid & CMO Services for Child and Adolescent Mental Health

<u>Topic</u>	<u>Identified Need/Recommendation</u>	<u>Legislation Considerations</u>	<u>Budget/Grant Considerations</u>	<u>Administrative Considerations (State Agency)</u>	<u>Practice Considerations</u>
Medicaid & CMO Services for C&A Mental Health	Expand and promote funding sustainability for Certified Community Behavioral Health Centers (CCBHC), which are currently funded by a SAMHSA grant.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to sending children with severe and complex behavioral health issues out-of-state for inpatient treatment.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Explore reimbursement options for room and board when residential placement is necessary for children's behavioral health treatment.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to hoteling of foster care children for whom traditional placements are not an option.		X	X	X

**BHRIC Subcommittee on Children and Adolescents**  
**Identified Needs/Recommendations as of October 24, 2022**

<b><u>Topic</u></b>	<b><u>Identified Need/Recommendation</u></b>	<b><u>Legislation Considerations</u></b>	<b><u>Budget/Grant Considerations</u></b>	<b><u>Administrative Considerations (State Agency)</u></b>	<b><u>Practice Considerations</u></b>
Mental Health and Substance Abuse - General	Create an executive leadership position (i.e., Assistant Commissioner) at the Georgia Department of Behavioral Health and Developmental Disabilities that focuses on children and adolescent mental health and substance abuse.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand access to telehealth for mental health and substance abuse issues. Telehealth could offer access to direct patient care; clinician training, clinical consultation, and x-waiver training (outpatient use of buprenorphine for the treatment of opioid use disorder).	X	X		X
Mental Health and Substance Abuse Treatment and Resources	Increase the mental health and substance abuse treatment provider pay to bring more therapists into the service networks, which would build more community-based resources and improve access for rural areas and other underserved populations.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Expand the Certified Peer Support Specialist (Specialist) program and increase the compensation for the Specialists to exceed the minimum wage.	X	X		
Mental Health and Substance Abuse Treatment and Resources	Close the gap of mental health and substance abuse services and treatment that exists between Amerigroup, Georgia Families 360, CareSource, PeachState, and DBHDD by developing a coordinated plan of continuum of care.	X		X	
Mental Health and Substance Abuse Treatment and Resources	Legislators and policy makers need to be cautious about expanding the legalization of cannabis due to the resulting negative impacts on adolescents. States that expanded the legal access to cannabis have seen increases in adolescent cannabis use and emergency room admissions.	X			

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Mental Health and Substance Abuse Treatment and Resources	Expand evidence-based substance abuse and mental health treatment for co-occurring disorders with integrated treatment models, co-located treatment services, and coordinated care models so that community-based resources can provide the essential services.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Create and fund the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) and Georgia Mental Health Access in Pediatrics (GMAP) with Children's Healthcare of Atlanta, Emory University, Georgia-AAP, and the Medical College of Georgia. The purpose of GaPPCAP and GMAP would be to support primary care professionals in identifying and treating mild to moderate behavioral health conditions in children in primary care practices or school-based health programs. GaPPCAP would also provide education for core mental health competencies in pediatric behavioral health support.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Schools should explore the use of telehealth for medical and mental health services. The Georgia Department of Administrative Services has a statewide contract with approved telehealth providers.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Schools and Regional Education Service Agencies (RESA) should work with local CSBs to develop coordinated mental health access for students (i.e., expand the APEX program).		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Crisis Stabilization Units to cover more regions of the state and provide information about the CSUs to CSBs, pediatricians, emergency room physicians and others.		X	X	X
Mental Health and Substance Abuse Treatment and Resources	Expand the availability of Child and Adolescent Substance Abuse Intensive Outpatient Program to more regions of the state.		X	X	

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Mental Health and Substance Abuse Treatment and Resources	Study the possibility of expanding the number of substance use disorder intensive residential treatment centers from the present two facilities to more locations in the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand the number of Clubhouse Programs that provide continued care for adolescents recovering from substance use issues.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Only one facility offers transition aged youth services. Study the feasibility of expanding the program to more regions in the state.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Expand juvenile drug courts to more jurisdictions and link to community-based resources.		X	X	
Mental Health and Substance Abuse Treatment and Resources	Operationalize the Georgia Student Health Survey data, for use by stakeholders, decisionmakers, and Georgia citizens by making it a queryable database (Georgia Tech's Center for Health Analytics and Informatics capable of creating and request sent to Acenture to consider as part of their community service/pro bono programs).		X	X	
Mental Health and Substance Abuse Treatment and Resources	Continue funding for the Mental Health Training Initiative that provides mental health and trauma awareness training for educators.		X		X
Mental Health and Substance Abuse Treatment and Resources	Seek 1115 waiver to allow a portion of Medicaid funding to be used to address social determinants of health - children from lower income families are disproportionately exposed to a combination of health risks, such as poverty, violence, unsafe living conditions, and environmental health hazards, that increase the need for health care interventions.			X	
Mental Health and Substance Abuse Treatment and Resources	Public and private schools should consider establishing school-based plans and toolkits that help eligible students and family members enroll in health insurance that include mental health coverage.			X	X



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Mental Health and Substance Abuse Treatment and Resources	Schools should partner with Federally Qualified Health Centers to offer integrated health services in schools.			X	X
Mental Health and Substance Abuse Prevention	Expand Prevention Clubhouses to add more regions of the state to broaden the reach of this successful program.		X	X	
Mental Health and Substance Abuse Prevention	Expand the Sources of Strength suicide prevention program that combines community work with school efforts to empower children and adolescent and to provide support for mental health and recognition of the importance of family support, access to services, spirituality, generosity, mentorship, and health activities.		X	X	X
Mental Health and Substance Abuse Prevention	Expand substance abuse prevention activities in schools and colleges and include community resources to aid the development of and expansion of prevention programs and activities, such as the Peer Assisted Student Transition program, College Prevention program, and Let's Be Clear program.		X	X	
Mental Health and Substance Abuse Prevention	Expand the Certified Student Peer Support Specialist program to include more schools and link to community-based resource programs.		X	X	

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Infant Mental Health Prevention, Intervention, and Support	Enact policies that support infant and child caregivers who are experiencing stress related to housing and income support. Consider case management services.	X	X	X	
Infant Mental Health Prevention, Intervention, and Support	Support and expand high-quality early childhood programs that give children a safe, stable environment.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Create and fund the Georgia Pediatric Psychiatry Consultation and Access Program (GaPPCAP) to support primary care professionals in identifying and treating mild to moderate behavioral health conditions in children and adolescents in primary care practices or school-based health centers. GaPPCAP would also provide education for core mental health competencies in pediatric care of children and adolescents.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Support evidence-based home visiting models that can provide information and support for parents.		X	X	
Infant Mental Health Prevention, Intervention, and Support	Provide funding for training on early childhood trauma to members of the child-serving workforce.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Develop and support strategies and implementation plans to expand the state's capacity to provide access to Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH (Georgia Association for Infant Mental Health) statewide to CSBs and other mental health providers.		X	X	X
Infant Mental Health Prevention, Intervention, and Support	Ensure Medicaid reimbursement for prevention and treatment for infant mental health and dyad treatment.			X	
Infant Mental Health Prevention, Intervention, and Support	Add Child-Parent Psychotherapy (CPP) endorsed by GA-AIMH to workforce training programs.			X	X

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Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include coverage through health insurance to address social determinants of health (transportation, parking/lodging/meals costs, missed work pay, lack of child-sitting for siblings) to increase families' ability to engage in the care of their infants while in the NICU.	X	X	X	
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources through private-public partnerships that support hospitals to provide on-site childcare facilities for siblings to help remove the barrier of securing and paying for sibling childcare while infant is in NICU.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand access to training and implementation of NICU Peer Recovery Coaching to reach families impacted by substance use and to improve coordination and monitoring of plans of safe care.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Support efforts like Reach Out and Read in the pediatric setting so families will continue to be encouraged and supported to read with their infants and throughout early childhood.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand implementation of NICU peer-to-peer support provided by parents who have experienced having their infant in a NICU to those who currently have an infant in a NICU.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Provide resources for hospital systems to proactively develop innovative solutions that facilitate and support the family's presence in the NICU. These solutions could include providing a place for parents to stay and take care of their basic needs, such as eating, bathing, laundry, and sleep. Vouchers for lodging and meals would significantly reduce the financial burden of staying long periods in the NICU.		X		X

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Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Increase resources so technology-based approaches can be implemented to supplement families' physical presence in the NICU, which may include text messaging updates, web-cam footage of infants, FaceTime and Skype updates, virtual visitation, and virtual rounding.		X		X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Expand support for NICUs by investing in the Regional Perinatal Center Neonatal Outreach Educators, coordinated by the Georgia Department of Public Health.		X	X	
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Develop and implement case and care management during and after the NICU stay to create a plan of safe care with families impacted by substance use.		X	X	X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Include family-integrated approaches to care in the NICU as part of university and professional training for all types of practitioners who provide care in NICUs, including but not limited to nursing, medicine, social work, counseling, and allied health.				X
Infant Mental Health Prevention, Intervention, and Support in Neonatal Intensive Care Units	Embed practices in the NICU that encourage and support families to read aloud with their infants while in the NICU and promote private-public partnerships with hospitals to help with the cost of books.				X

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Autism Spectrum	There should be a re-evaluation of Medicaid reimbursement rates for ASD diagnosis and remove the restrictions on who is qualified to make a diagnosis, as also recommended by the American Academy of Pediatrics.	X	X	X	X
Autism Spectrum	Study how to create incentives to open more residential treatment facilities for acute ASD.		X	X	
Autism Spectrum	The state needs to give more resources to the Medicaid waiver program to get ASD patients off the waiting list.		X	X	
Autism Spectrum	Study how schools and universities could train more teachers and paraprofessionals on ASD awareness, interventions, and support.		X		X
Autism Spectrum	Develop medical and psychosocial protocols as immediate follow-up after an ASD diagnosis, which should include respite care.				X
Autism Spectrum	Study how the state and school districts could provide more Board-Certified Behavior Analysts to work with teachers and ASD students.				X
Autism Spectrum	Provide case managers from Medicaid or commercial insurers to parents to help them find and best utilize services.		X	X	
Autism Spectrum	Insurance companies should be required to recognize a diagnosis of ASD from a PCP or child psychiatrist while waiting for the psychological evaluation which would allow immediate access to ABA treatment.	X		X	X
Autism Spectrum	Develop more acute autism crisis stabilization units funded by a combination of federal and state funds and reimbursements from Medicaid and insurance carriers.		X	X	
Autism Spectrum	Study the feasibility of school paraprofessionals receiving training as a Registered Behavioral Technicians.	X		X	X

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Psychologist Billing	The Department of Community Health (DCH) should study the feasibility of reimbursing psychologists for a 90791, a diagnostic evaluation.			X	X
School-Based Mental Health (SBMH)	Explore funding opportunities/grants for prevention initiatives within the school setting, providing training and necessary infrastructure to support SBMH and SBMH coordination with other mental health providers and systems (i.e., CSBs, universities, private providers).		X	X	X
School-Based Mental Health (SBMH)	Expand youth-informed and youth-led mental health initiatives in more of Georgia's schools.		X	X	X
School-Based Mental Health (SBMH)	Explore more opportunities for licensing counselors and social workers within schools and agencies.		X	X	X
School-Based Mental Health (SBMH)	Consider the Certified Community Behavioral Health Clinic (CCBHC) Model to support SBMH programs.			X	X
School-Based Mental Health (SBMH)	Promote training programs to prepare students and therapists for working in the school setting.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Expand and promote funding sustainability for Certified Community Behavioral Health Centers (CCBHC), which are currently funded by a SAMHSA grant.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to sending children with severe and complex behavioral health issues out-of-state for inpatient treatment.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Explore reimbursement options for room and board when residential placement is necessary for children's behavioral health treatment.		X	X	X
Medicaid & CMO Services for C&A Mental Health	Determine alternatives to hoteling of foster care children for whom traditional placements are not an option.		X	X	X

## **Hospital and Short – Term Care Facilities Subcommittee**

Dr. Brenda Fitzgerald - **Chair**

Dr. Emily Anne Vall

Senator Brian Strickland

Dr. Lucky Jain

Commissioner Candice Broce

Dr. Mark Johnson

Jason Downey

Kim Jones

Donna Hyland

Commissioner Caylee Noggle

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**I. Inverting the Burden: Supporting Patients with Complex Needs**

*Subcommittee on Hospital and Short-Term Care Facilities*

**II. IMD Waiver Gap Analysis**

*Georgia Department of Community Health*

**III. Mental Health Access Challenges and The Role of Provider Networks**

*Jane Zhu, MD MPP*

# INVERTING THE BURDEN: SUPPORTING PATIENTS WITH COMPLEX NEEDS

11.14.22



# ARCHI CARE COORDINATION MEETING

ARCHI convenes the care coordination teams of the six metro Atlanta health systems on a bi-weekly basis

## Meeting Goals

- Discuss critical and emerging issues when trying to connect patients with community services and supports
- Meet with providers to improve the health systems' understanding of community services
- Establish connections and referral protocols between health systems and community services and supports



# THE ISSUE

Hospital Emergency Departments and Inpatient Units are being used for last resort housing for individuals with complex developmental or intellectual disabilities, and/or physical disabilities and/or behavioral health challenges

# THE IMPACT OF THE ISSUE

- **Multiple diagnoses can mean no system takes responsibility** for services leaving individuals hospitalized or as frequent visitors to the ER
- Highlight issues of navigation, assessments, eligibility criteria, and approvals that **extend the time an individual does not have access to services often forcing them to linger in difficult and unsafe conditions**
- The COVID pandemic has **exacerbated workforce issues and therefore the supply of services and supports across all healthcare settings**— hospitals as well as DD/BH facilities, treatment facilities and supportive housing environments
- Difficult for individuals and **extremely time intensive and costly for the health systems**
- Issue occurs with **enough frequency to threaten the health and safety of Georgians with disabilities**, that a structural solution is warranted



# THE ROOT OF THE ISSUE

Extended hospital stays for patients with complex BH/DD needs

Increase in administrative burden for hospital care coordination teams to resolve discharge challenges of complex patients from emergency departments

Limited support for complex patients to access community BH/DD services from hospital setting

Increase in patients with complex BH/DD needs and no medical necessity for hospital admission or stay

Increase in patients/families coming to hospital emergency departments due to inability to care or find support for frail or elderly patients with BH/DD needs



# CASE STUDY SUMMARY

## Northside Hospital

- Non-verbal patient with Down Syndrome admitted after found sitting next to deceased caregiver
  - *After an 80-day hospital stay, discharged to Emergency Guardian with help from GA Advocacy Office*

## Grady Hospital

- 18-year-old female patient with Fetal Alcohol Syndrome and low IQ left in ER by adoptive mother
  - *After 3-month hospital stay, receiving DBHDD assessments and legal aid support*

## Piedmont Health

- 22 year-old male patient in ER since October 14 is currently a risk to himself, patients and staff
  - *Medically stable but displaced since he was discharged from his group home and new placement refusing to take him*

## Emory Healthcare

- 34 year-old female frequent utilizer of Emory ERs; oftentimes mute, immobile and requiring help for ADLs
  - *Emory staff challenged with discharging her to a safe place with resources*

# CASE STUDY THEMES: CAPACITY & SYSTEM PROCESSES

**Lack of service availability requires extended and unnecessary hospitalization**, especially limited capacity of crisis beds, respite services and care, and transitional housing

**Lack of appropriate services/staff with appropriate skills and training leaves patient without support**

- Housing provider staff lack training in trauma and behavioral health disorders (i.e., housing providers unable to distinguish between violent acts and mental health disorders)
- Many complex patients need a support person/case manager to help them navigate the system and stay in services, not just after enrollment

**Intake procedures do not fit patient circumstances and delay care**

- Require guardians though patients in hospital care do not always have a guardian
- Multi-step processes are difficult to complete for individuals visiting ER even if doing so frequently

**Need stronger coordination with hospitals for waivers**, including waiver application process and easily knowing which patients are enrolled in a waiver program



# PROPOSED SOLUTIONS

## Short-Term

- **Increase the base salaries of employees working for DBHDD** to stabilize, grow and enhance workforce and contract rates to their core BH, ID and DD providers
- **Continue to backfill previously closed beds** designated for Developmental Disabilities and/or Skilled Nursing patients at Georgia Regional Hospital – Atlanta
- **Increase contract amounts to community core DD and ID providers** to account for salary increases.



# PROPOSED SOLUTIONS

## Medium and Long-Term

- **Creation of additional ACT or crisis support teams**, specifically within Fulton and DeKalb counties
- **Fund Fulton County Behavioral Health Crisis Center** (which includes crisis stabilization units)
- **Workforce study** to determine appropriate DBHDD staffing and service levels
- **An additional 150 crisis beds throughout the metro area in the 2023 budget**





# LOOKING AHEAD

Continue to convene our health systems and DBHDD leadership for greater collaboration and problem solving

Stay in touch:

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GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH

# IMD Waiver Gap Analysis



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Date: November 16, 2023



# Mission:

The mission of the Department of Community Health is to provide access to affordable, quality health care to Georgians through effective planning, purchasing, and oversight.



# IMD Waiver Background

# Background: SB 610

The senate bill directed DCH to submit an IMD waiver for private institutions only.



No later than December 31, 2022, the department shall submit a waiver request to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services to authorize private institutions for mental disease (IMDs) to qualify for Medicaid reimbursement for mental health and substance use disorder treatment. Upon approval of such waiver, the department shall take all necessary steps to provide for payment of such care at private IMDs with Medicaid funds.





# State Medicaid Director Letters

Additional guidance, including demonstration goals and milestone requirements for waiver demonstration, are highlighted in State Medicaid Director letters.

## Substance Use Disorder

- In July 2015, the CMS issued a state Medicaid director letter describing new service delivery opportunities for individuals with substance use disorder under Section 1115.
- In November 2017, the CMS issued a state Medicaid director letter revising the 2015 guidance.

## Serious Mental Health Conditions

- In November 2018, CMS issued new guidance allowing states to obtain Section 1115 waivers of the federal IMD payment exclusion for services for individuals with serious mental health conditions.



# SUD Demonstration Milestones

There are 6 categories with a total of 17 milestones that must be achieved for States wishing to participate in the SUD demonstration.



## Access to critical levels of care for OUD and other SUDs

- Coverage of a) outpatient, b) intensive outpatient services, c) medication assisted treatment d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management (*Within 12 to 24 months of demonstration approval*)



## Widespread use of evidence-based, SUD-specific patient placement criteria

- Assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines, e.g., ASAM Criteria (*Within 12 to 24 months of demonstration approval*)
- Utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care, b) interventions are appropriate for the diagnosis and level of care, and c) independent process for reviewing placement in residential treatment settings. (*Within 24 months of demonstration approval*)



## Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications

- Provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance should meet ASAM Criteria, or other nationally recognized, evidence-based SUD-specific program standards (*Within 12 to 24 months of demonstration approval*)
- State process for reviewing residential treatment providers to assure compliance with standards (*Within 24 months of demonstration approval*)
- Residential treatment facilities offer MAT on-site or facilitate access off-site (*Within 12 to 24 months of demonstration approval*)



## Sufficient provider capacity at each level of care

- Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT (*Within 12 months of demonstration approval*)



## Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

- Opioid prescribing guidelines along with other interventions to prevent opioid abuse (*Over the course of the demonstration*)
- Expanded coverage of, and access to, naloxone for overdose reversal (*Over the course of the demonstration*)
- Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs (*Over the course of the demonstration*)



## Improved care coordination and transitions between levels of care

- Policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities (*Within 12 to 24 months of demonstration approval*)



# SMI/SED (MH) Demonstration Milestones

There are 5 categories with a total of 19 milestones that must be achieved for States wishing to participate in the MH demonstration.



## Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

- Ensuring participating settings are accredited
- Establish oversight and auditing process
- Utilization review to ensure access to appropriate levels and types of care
- Participating settings meet federal program integrity requirements
- Implement state requirement that participating settings screen enrollees for co-morbid physical health conditions and SUDs



## Improving Care Coordination and Transitions to Community-Based Care

- Implement a process to provide intensive pre-discharge, care coordination services and community-based providers participate in transition efforts
- Implement process to assess housing situation for those transitioning from participating setting
- Protocol requirement to ensure contact is made by treatment setting with each discharged beneficiary within 72 hours of discharge and assess follow-up care
- Strategies to prevent or decrease LOS in EDs
- Strategies to develop and enhance interoperability and data sharing to increase care coordination



## Increasing Access to Continuum of Care Including Crisis Stabilization Services

- Annual Assessments of MH services availability, and updates on steps taken to increase availability
- Commitment to a financing plan approved by CMS to be implemented
- Strategies to improve state's capacity to track availability of inpatient and crisis stabilization beds
- Implement requirement that providers, plans, and the utilization review entities use an evidence-based, publicly available patient assessment tool to help determine appropriate level of care and LOS



## Earlier Identification and Engagement in Treatment Including Through Increased Integration

- Implement strategies for identifying and engaging individuals with SMI in treatment sooner including through supported employment and supported education programs
- Increasing integration of BH care in non-specialty care settings, including schools and primary care practices
- Establish specialized settings and services, including crisis stabilization services focused on needs of young people experiencing SMI or SED



## Other: Health IT Plan

- Leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals
- Address electronic plan sharing, care coordination, and behavioral health-physical health integration
- CMS will provide additional guidance







# IMD Waiver Gap Analysis Summary

# Summary

Milestone progress, level of effort to implement, and approximate cost estimates were assessed for FFS (MRO, PRTF, and other inpatient) and CMO covered services. Greater need to develop and expand services and policies were identified under FFS compared to CMOs.

- Highest cost gaps associated with system and infrastructure development and expansion of service provision centered milestones
  - Coverage of residential services and FFS inpatient settings
  - Health IT infrastructure
  - Expansion of MAT services
  - Utilization management and review processes
  - Care coordination and integration
- Limitations in gap analysis include:
  - Data gaps in cost and effort approximations for CMOs
  - Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation
  - Cost approximation only calculated for inpatient and medically supervised withdrawal services

	SUD		MH	
	FFS*	CMO	FFS*	CMO
<b>Milestones with Identified Gaps</b>				
<b>Confirmed gaps</b>	12	4	16	6
<b>Potential gaps</b>	1		3	7
<b>Totals</b>	13/17	4/17	19/19	13/19

	SUD		MH	
	FFS*	CMO	FFS*	CMO
<b>Level of Effort for Implementation</b>				
<b>High effort</b>	6	No data	9	No data
<b>Medium effort</b>	7		11	
<b>Low effort</b>	1		3	

	SUD		MH	
	FFS*	CMO	FFS*	CMO
<b>Approximate Cost</b>				
<b>Approx cost not estimated</b>	10	No data	14	No data
<b>&lt;5 Million (\$)</b>	1			
<b>5-10 Million (\$\$)</b>				
<b>&gt;10 Million (\$\$\$)</b>	6		5	

\*DBHDD is a co-administrator with DCH of the Medicaid Rehabilitation Option and PRTF, but not for other inpatient/outpatient BH services.



# Potential Costs for Inpatient and Residential MH/SUD Costs

A high-level model was developed using costs from a state with an approved 1115 Waiver based on an assumption that these costs represent a relatively mature program that sufficiently meets CMS milestones.

Inpatient MH/SUD Detailed Category of Service	Definition	CY2021 state PMPM	Annualized FFS high-level estimate <sup>1</sup>	Estimated State Share <sup>2</sup>
<b>Inpatient Mental Health</b>	A 24 hours per day hospital-based program which includes psychiatric, medical, nursing, and social services which are required for the assessment and or treatment of a person with a primary diagnosis of mental illness who cannot be adequately served in the community. Such programs may be offered by general hospitals, private hospitals for the mentally ill, and state operated psychiatric centers.	\$116	\$54,358,922	\$18,471,185
<b>Inpatient SUD Rehab certified Inpatient Substance Use Disorder Rehab</b>	These services may be provided by facilities certified by the state to provide Chemical Dependence Inpatient Rehabilitation and Treatment Services.	\$24	\$11,246,688	\$3,821,625
<b>Inpatient SUD Detox Medically Managed</b>	Inpatient SUD Detox – Medically Managed certified Inpatient Substance Use Disorder Detox – Medically Managed - Medically Managed Detoxification Services are provided by facilities certified by the state.	\$26	\$12,183,912	\$4,140,093
<b>Inpatient SUD Detox Medically Supervised</b>	Inpatient Detox – Medically Supervised certified Inpatient Detox – Medically Supervised - Medically Supervised Inpatient Detoxification Services are provided by facilities certified by the state.	\$26	\$12,183,912	\$4,140,093
<b>Residential Per Diem</b>	Reintegration, Rehabilitation, and Stabilization Service Per Diems	\$14	\$6,560,568	\$2,229,281
		<b>\$206</b>	<b>\$96,534,072</b>	<b>\$32,802,278</b>

## COST CONSIDERATIONS:

- Initial cost are likely to be less than other state's experience as GA will need to develop services and network that is not currently covered in FFS, i.e Residential and Inpatient treatment options
- Lower labor costs in GA as compared to other state may result in lower actual costs for GA.
- Cost model does not include the impact on cost for the Pathways population that has SMI.
- Cost model does not include cost of care coordination, administrative, and other IT related costs.



# Implementation Considerations

In addition to cost considerations, the gap analysis yielded considerations that may vary in level of effort to implement.



## **STATE PLAN SERVICES**

Meeting CMS milestone requirements will require the provision of services not currently covered in the state plan. i.e: residential and inpatient services.



## **INFRASTRUCTURE DEVELOPMENT**

New services will require developing adequate provider networks, utilization management protocols, and care management infrastructure to support the access to and the appropriate use of new services.



## **ABD POPULATION**

Gap analysis concludes greater gaps in FFS compared to CMOs to achieve milestones. The structure of the new system of care will depend on whether the state moves its ABD population into managed care. Even if the ABD population is moved to managed care, additional costs will need to be reflected in the capitation rates.



## **INTEGRATING SERVICES**

Integrating new services and improving the overall system of care for behavioral health services will require a significant investment of time and resources along with internal and external stakeholder input.



## **MANAGEMENT STAFF**

Additional staff will be needed to assist with planning, execution, and management of the IMD waiver in DCH and DBHDD.





# Appendix

# SUD: Preliminary Gap Analysis for FFS and CMO Services

An analysis of milestone progress identified the largest gap is the lack of coverage for inpatient and residential services.

Milestone	FFS				CMO		
Access to critical levels care for OUD and other SUDs							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
a) Coverage of outpatient	<ul style="list-style-type: none"><li>Covered in MRO</li></ul>	<ul style="list-style-type: none"><li>No gap identified: Network could be expanded</li></ul>			<ul style="list-style-type: none"><li>Covered by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
b) Coverage of intensive outpatient services	<ul style="list-style-type: none"><li>Covered in MRO with small provider network in Metro ATL</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Service needs expansion</li></ul>			<ul style="list-style-type: none"><li>Covered by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
c) Coverage of medication assisted treatment	<ul style="list-style-type: none"><li>Offered via a small provider network as a "bundled" authorization</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: Service needs expansion</li></ul>			<ul style="list-style-type: none"><li>Covered by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
d) Coverage of intensive levels of care in residential and inpatient settings	<ul style="list-style-type: none"><li>Not covered by DBHDD/DCH in the MRO</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Not covered by DBHDD</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>Covered by 2/3 CMOs</li></ul>	<ul style="list-style-type: none"><li>Gap identified: expansion to include additional residential settings and over 18 YO population</li></ul>	
e) Coverage of medically supervised withdrawal management	<ul style="list-style-type: none"><li>Not covered by DBHDD/DCH in the MRO</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Not covered by DBHDD</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>Covered by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	

Key: High Medium Low \$\$\$ - >10Mil \$\$ - 5 to 10Mil \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation



# SUD: Preliminary Gap Analysis for FFS and CMO Services

Comprehensive implementation of treatment and strategies to address opioid abuse and OUD yielded limited gaps.

Milestone	FFS				CMO		
Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress	Milestone Gap*	Approx Cost
Opioid prescribing guidelines along with other interventions to prevent opioid abuse	<ul style="list-style-type: none"><li>Prescribing guidelines and other interventions exist</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>			<ul style="list-style-type: none"><li>Performed by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
Expanded coverage of, and access to, naloxone for overdose reversal	<ul style="list-style-type: none"><li>DBHDD administers limited funds to expand access to naloxone (not comprehensive)</li><li>Medicaid moved to open access; No PA in place</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>			<ul style="list-style-type: none"><li>Covered by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs	<ul style="list-style-type: none"><li>Existing requirement for Medicaid providers to check PDMP</li></ul>	<ul style="list-style-type: none"><li>Gap identified: DCH does not have integration to monitor providers are checking PDMP</li></ul>			<ul style="list-style-type: none"><li>Existing requirements for Medicaid providers to check PDMP</li></ul>	<ul style="list-style-type: none"><li>Gap identified: all 3 CMOs do not have integration to monitor providers are checking PDMP</li></ul>	

Key: ■ High ■ Medium ■ Low \$\$\$ - >10Mil \$\$ - 5 to 10Mil \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# SUD: Preliminary Gap Analysis for FFS and CMO Services

Service gaps and lack of utilization management approach identified this milestone category as high cost and high level of effort to achieve.

Milestone	FFS				CMO		
Widespread use of evidence-based, SUD-specific patient placement criteria							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines, e.g., ASAM Criteria	Services under MRO: •Cross-walked against ASAM guidelines and criteria •Assessed using the ANSA tool	• Gap identified: Need to establish process for assessment			• All 3 CMOs use assessment tools	• No gaps identified	
a) Utilization Management approach such that: Beneficiaries have access to SUD services at the appropriate level of care	• Services under MRO are reviewed by an accredited ASO	• Gap identified: Service needs expansion to provide higher level of care. Process for UM needs to be developed		\$\$\$	• Completed by all 3 CMOs	• No gaps identified	
b) Utilization Management approach such that: Interventions are appropriate for the diagnosis and level of care	• Services under MRO are reviewed by an accredited ASO	• Gap identified: Service needs expansion to provide higher level of care. Process for UM needs to be developed		\$\$\$	• Completed by all 3 CMOs	• No gaps identified	
c) Utilization Management approach such that: Independent process for reviewing placement in residential treatment settings	• Not covered by DBHDD/DCH in MRO	• Gap identified: Not covered by DBHDD, UM approach does not exist		\$\$\$	• Completed by all 3 CMOs	• No gaps identified	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation



# SUD: Preliminary Gap Analysis for FFS and CMO Services

Processes, services, and assessments are limited due to lack of coverage for residential and MAT services.

Milestone	FFS				CMO		
Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance should meet ASAM Criteria, or other nationally recognized, evidence-based SUD-specific program standards	<ul style="list-style-type: none"><li>Providers under the MRO are required to have GA-DATEP license, and national accreditation for practice</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>			<ul style="list-style-type: none"><li>Performed by DCH</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
State process for reviewing residential treatment providers to assure compliance with standards	<ul style="list-style-type: none"><li>Not covered by DBHDD/DCH in the MRO</li></ul>	<ul style="list-style-type: none"><li>Gap identified: MRO does not cover SUD residential services, need to develop process</li></ul>		\$	<ul style="list-style-type: none"><li>Performed by DCH</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Residential treatment facilities offer MAT on-site or facilitate access off-site	<ul style="list-style-type: none"><li>Not covered by DBHDD/DCH in the MRO</li></ul>	<ul style="list-style-type: none"><li>Gap identified: MRO does not cover residential; MAT is not a stand-alone service in the State Plan; it is bundled with other outpatient services</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>1/3 CMOs provides facilitation to off-site MAT services</li></ul>	<ul style="list-style-type: none"><li>Gap identified: expansion of MAT services on site and facilitate off-site services</li></ul>	
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT	<ul style="list-style-type: none"><li>Not conducted by DBHDD/DCH for the MRO</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to develop assessment process</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs perform regular provider assessments through secret shopper calls and quarterly reviews.</li></ul>	<ul style="list-style-type: none"><li>Gap identified: expansion of MAT providers and contracts with all available GA Medicaid enrolled MAT providers</li></ul>	

Key: High Medium Low \$\$\$ - >10Mil \$\$ - 5 to 10Mil \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# SUD: Preliminary Gap Analysis for FFS and CMO Services

Gaps in policies exist due to lack of services for residential and inpatient facilities for FFS.

Milestone	FFS				CMO		
Improved care coordination and transitions between levels of care							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	<ul style="list-style-type: none"><li>Not covered by DBHDD/DCH in the Medicaid Rehab Option</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Not covered by MRO</li></ul>			<ul style="list-style-type: none"><li>Covered and performed by all 3 CMOs</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# MH: Preliminary Gap Analysis for FFS and CMO Services

Limited or lack of established Health IT infrastructure identified significant gaps in this milestone category.

Milestone					CMO		
Other: Health IT Plan							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals	<ul style="list-style-type: none"><li>Functionality within MRO does not exist</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Health IT infrastructure needs to be established</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>2/3 CMOs participate in GA HIN</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: may need to expand health IT infrastructure</li></ul>	
Address electronic plan sharing, care coordination, and behavioral health-physical health integration	<ul style="list-style-type: none"><li>Functionality within MRO does not exist</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to develop Health IT capabilities</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>2/3 CMOs have electronic data sharing system for coordinating care</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: 1 CMO may need to augment data sharing</li></ul>	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# MH: Preliminary Gap Analysis for FFS and CMO Services

Need for development of robust strategies and care coordination identified gaps in this milestone category.

Milestone	FFS				CMO		
Earlier Identification and Engagement in Treatment Including Through Increased Integration							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Implement strategies for identifying and engaging individuals with SMI in treatment sooner including through supported employment and supported education programs	<ul style="list-style-type: none"><li>DBHDD provides limited strategies; Supported Education pilot in one county only and Supported Employment is statewide but slot-limited</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Strategies need to be developed and implemented</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>1/3 CMOs has a strategy</li></ul>	<ul style="list-style-type: none"><li>Gap identified: 2/3 CMOs need to build a strategy</li></ul>	
Increasing integration of BH care in non-specialty care settings, including schools and primary care practices	<ul style="list-style-type: none"><li>DBHDD has BH integration models for schools</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to establish BH integration in primary care practice</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs have BH Integration</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: strategies to increase integration can be expanded</li></ul>	
Establish specialized settings and services, including crisis stabilization services focused on needs of young people experiencing SMI or SED	<ul style="list-style-type: none"><li>DBHDD covers services in CSUs</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Services need expansion outside of CSU settings</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs have established settings and services</li></ul>	<ul style="list-style-type: none"><li>Gap identified: 1 CMO needs to expand pilot</li></ul>	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# MH: Preliminary Gap Analysis for FFS and CMO Services

Lack of processes, protocols, and strategies have identified gaps.

Milestone	FFS				CMO		
Improving Care Coordination and Transitions to Community-Based Care							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress	Milestone Gap*	Approx Cost
Implement a process to provide intensive pre-discharge, care coordination services and requirements that community-based providers participate in transition efforts	<ul style="list-style-type: none"><li>DBHDD policies exist for discharge into the community from PRTFs and State-Owned Hospitals</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Process needs to be expanded</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs provide care coordination post discharge</li></ul>	<ul style="list-style-type: none"><li>Potential gap: requirement may need to be established for community-based providers</li></ul>	
Implement process to assess housing situation for those transitioning from participating setting	<ul style="list-style-type: none"><li>DBHDD policies exist for PRTFs and State-Owned Hospitals</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Process needs to be expanded</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs assess housing transitions</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	
Protocol requirement to ensure contact is made by treatment setting with each discharged beneficiary within 72 hours of discharge and assess follow-up care	<ul style="list-style-type: none"><li>DBHDD/DCH do not have policy for PRTFs</li></ul>	<ul style="list-style-type: none"><li>Gap Identified: Need to establish protocol requirements</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs have a protocol requirement</li></ul>	<ul style="list-style-type: none"><li>Potential gap: requirement may need to be updated to reflect 72-hour discharge</li></ul>	
Strategies to prevent or decrease LOS in EDs	<ul style="list-style-type: none"><li>DBHDD/DCH do not have joint policy on this type of strategy</li></ul>	<ul style="list-style-type: none"><li>Gap Identified: Need to develop joint DBHDD/DCH strategy</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs have clearly defined strategies</li></ul>	<ul style="list-style-type: none"><li>Potential gap: 1 CMO may not have clearly defined strategy</li></ul>	
Strategies to develop and enhance interoperability and data sharing to increase care coordination	<ul style="list-style-type: none"><li>DBHDD/DCH does not have robust strategies for this.</li></ul>	<ul style="list-style-type: none"><li>Gap Identified: Need to develop joint agency strategy</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>All 3 CMOs have strategies</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Key: <div>High</div> <div>Medium</div> <div>Low</div> <div>\$\$\$ - &gt;10Mil</div> <div>\$ - 5 to 10Mil</div> <div>\$ - &lt; 5Mil</div> *Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation							

Key: High Medium Low \$\$\$ - >10Mil \$\$ - 5 to 10Mil \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# MH: Preliminary Gap Analysis for FFS and CMO Services

Processes and requirements will need expansion to address gaps in this milestone category.

Milestone	FFS				CMO		
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Ensuring participating settings are accredited	<ul style="list-style-type: none"><li>DBHDD requires: HFR License, PRTF Accreditation, THC Accreditation, CMS Certified in State hospitals</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: For settings other than PRTFs and State-Owned Hospitals</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs ensure participating settings are accredited</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Establish oversight and auditing process	<ul style="list-style-type: none"><li>DBHDD/DCH have for MRO, but not for PRTF.</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to establish process for PRTF</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs have processes</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Utilization review to ensure access to appropriate levels and types of care	<ul style="list-style-type: none"><li>ASO provides utilization review for PRTFs</li></ul>	<ul style="list-style-type: none"><li>Gap identified: For settings other than PRTFs</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs conduct utilization review</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Participating settings meet federal program integrity requirements	<ul style="list-style-type: none"><li>PRTFs and State-Owned Hospitals have requirements built into licensure and accreditation</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: For settings other than PRTFs and State-Owned Hospitals</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs meet federal requirements</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	
Implement state requirement that participating settings screen enrollees for co-morbid physical health conditions and SUDs	<ul style="list-style-type: none"><li>Screening protocol implemented for PRTFs and included in State Policy for State-Owned Hospitals</li></ul>	<ul style="list-style-type: none"><li>Potential gap identified: For settings other than PRTFs and State Hospitals</li></ul>		\$\$\$	<ul style="list-style-type: none"><li>All 3 CMOs require screening at settings</li></ul>	<ul style="list-style-type: none"><li>No gap identified</li></ul>	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation

# MH: Preliminary Gap Analysis for FFS and CMO Services

Processes will need to be developed, largest gap is the CMOs inability to track availability of inpatient and crisis stabilization beds.

Milestone	FFS				CMO		
Increasing Access to Continuum of Care Including Crisis Stabilization Services							
	Milestone Progress	Milestone Gap	Level of Effort	Approx Cost	Milestone Progress*	Milestone Gap*	Approx Cost
Annual Assessments of MH services availability, and updates on steps taken to increase availability	<ul style="list-style-type: none"><li>DBHDD/DCH do not conduct annual assessments</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to develop process and implementation of annual assessment</li></ul>			<ul style="list-style-type: none"><li>2/3 CMOs perform assessment</li></ul>	<ul style="list-style-type: none"><li>Potential gap: 1 CMO may not have assessment</li></ul>	
Commitment to a financing plan approved by CMS to be implemented	<ul style="list-style-type: none"><li>DBHDD/DCH do not currently have financing plan</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Financing plan needs to be developed and approved</li></ul>			<ul style="list-style-type: none"><li>N/A</li></ul>	<ul style="list-style-type: none"><li>N/A</li></ul>	
Strategies to improve state’s capacity to track availability of inpatient and crisis stabilization beds	<ul style="list-style-type: none"><li>DBHDD has program to track availability for CSUs and DBHDD-contracted inpatient beds</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Needs to be expanded to include DCH inpatient beds</li></ul>			<ul style="list-style-type: none"><li>CMOs do not track availability</li></ul>	<ul style="list-style-type: none"><li>Gap identified: CMOs do not track availability</li></ul>	
Implement requirement that providers, plans, and the utilization review entities use an evidence-based, publicly available patient assessment tool to help determine appropriate level of care and LOS	<ul style="list-style-type: none"><li>DBHDD/DCH do not have this requirement for PRTFS</li></ul>	<ul style="list-style-type: none"><li>Gap identified: Need to implement a requirement and coordinate with CMOs</li></ul>			<ul style="list-style-type: none"><li>All 3 CMOs have requirements</li></ul>	<ul style="list-style-type: none"><li>No gaps identified</li></ul>	

Key: ■ High ■ Medium ■ Low    \$\$\$ - >10Mil    \$\$ - 5 to 10Mil    \$ - < 5Mil

\*Milestone progress and gaps were self-reported by CMOs and may require network adequacy validation



# Purpose:

Shaping the future of A Healthy Georgia by improving access and ensuring quality to strengthen the communities we serve.



# Mental health access challenges and the role of provider networks

Jane Zhu, MD MPP

Behavioral Health Reform & Innovation Commission

Georgia House of Representatives

November 16, 2022

## Today's Topics

Why are mental health networks inadequate?

What are existing network adequacy standards and challenges?

Considerations for monitoring and assessing network adequacy

Why are mental health provider networks  
inadequate?

# Access to Coverage Does Not Equal Access to Care



# Provider Networks Are a Key Link Between Coverage and Access

Provider networks are the sets of providers and facilities who deliver health services to plan enrollees

Key tool in managed care plans to manage costs

In-network and out-of-network providers subject to different cost-sharing

Narrower networks over time

Mental health networks included on average **~1 out of 11** available providers (Zhu et al 2017)

# Key Factors Driving Persistently Low Rates of Insurance Acceptance

Reimbursement disparities (Milliman 2019)

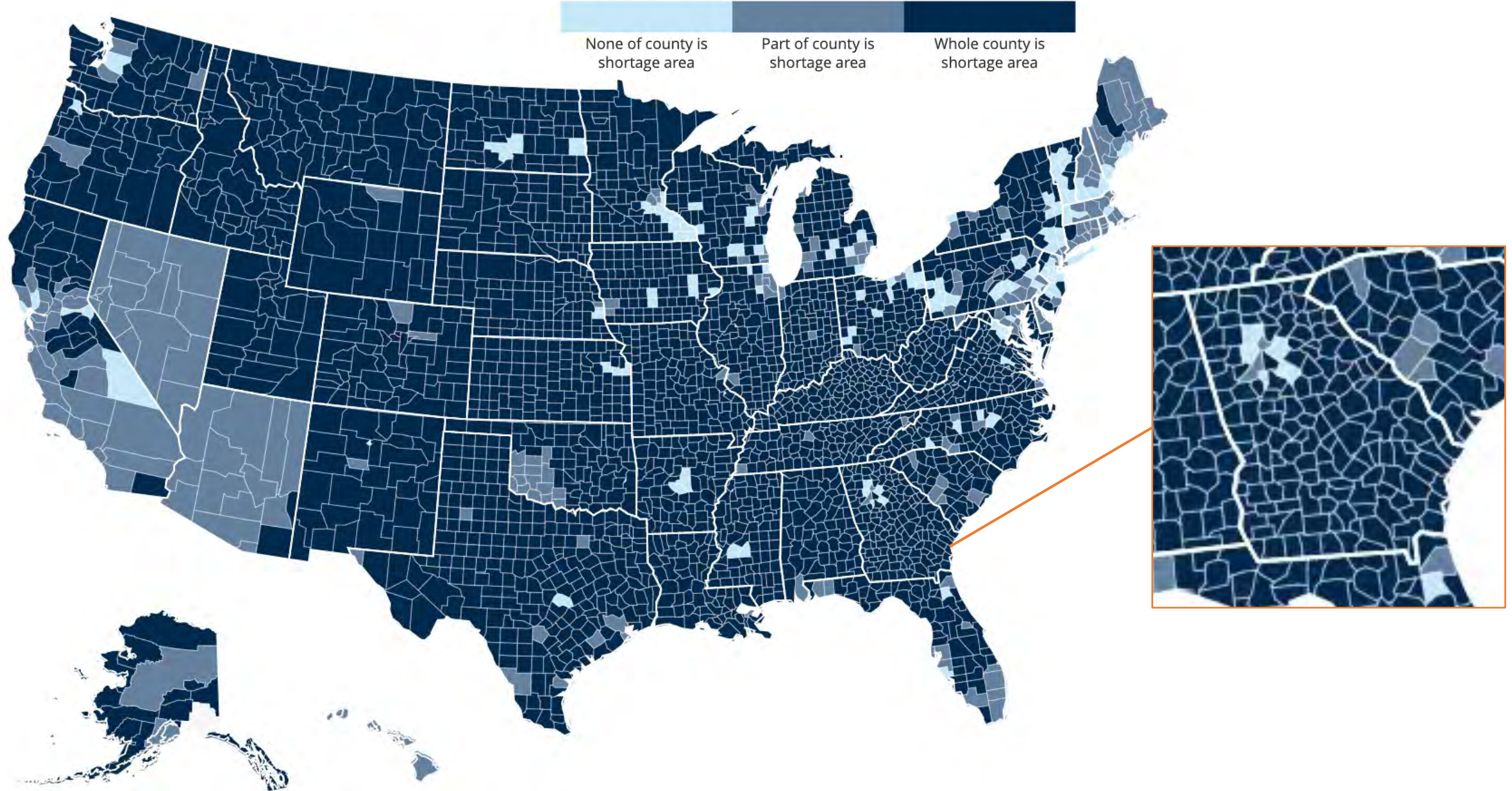
In Georgia, mental health professionals received **37% less** than other providers for the same billing codes

Billing delays (Dunn et al 2021); credentialing and administrative burdens (Bradley et al 2021)

Clinical complexity/acuity

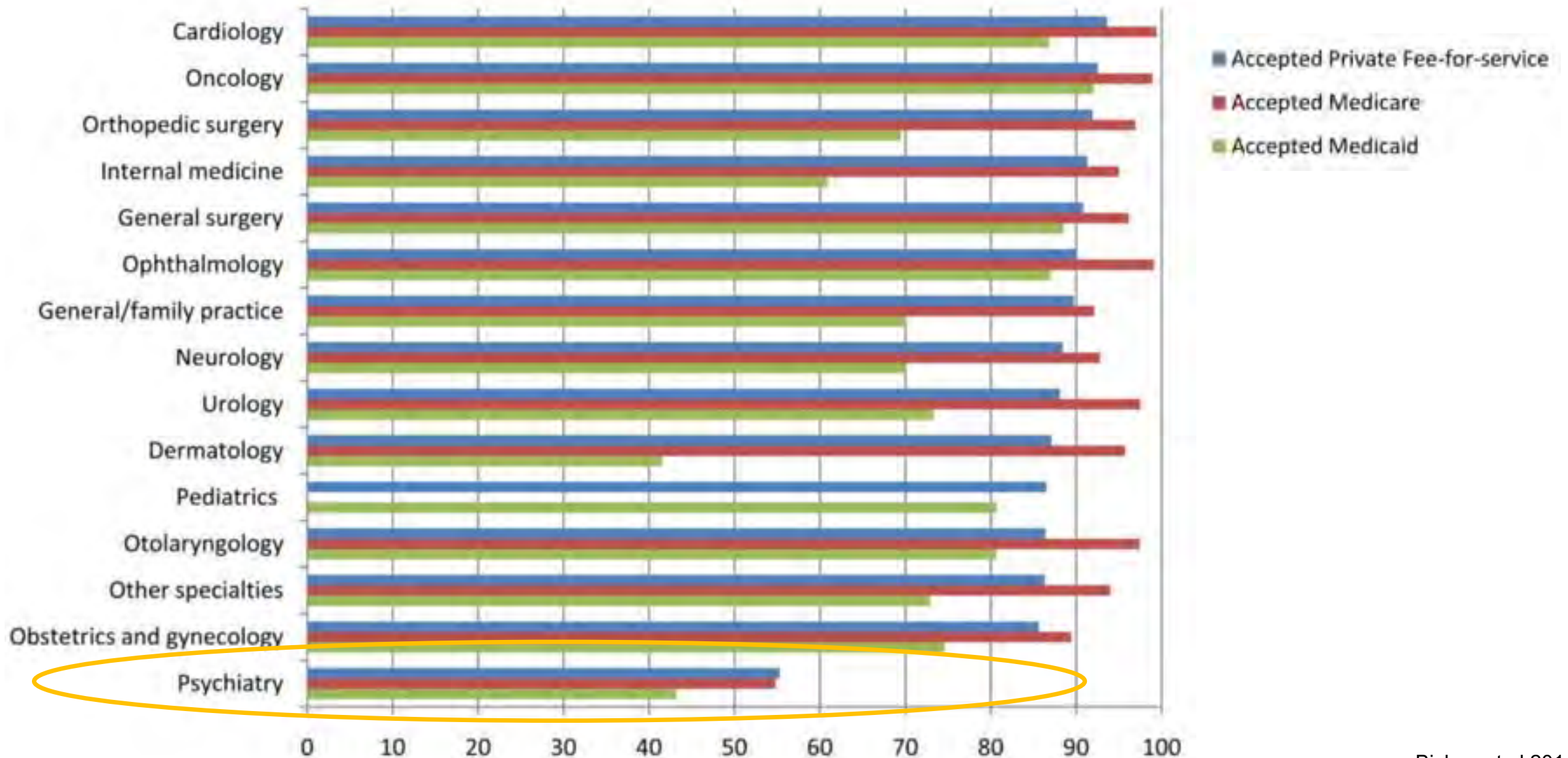
Psychiatrists accepting insurance see more serious mental illness, spend less time with patients (Busch et al 2020)

# Vast Majority of U.S. Counties have Mental Health Professional Shortages





# Small Shares of Psychiatrists Accept Any Insurance, 2016





## It Pays To Be Out-of-Network!

Private insurance paid an average **13-14% less** than did Medicare fee-for-service for psychotherapy and mental health office visits;

But paid **~40-50% more** than Medicare for these services when delivered out-of-network.

# Why Narrow Networks? Insurer Considerations

## Broader networks

- More provider choice and expanded access to providers
- “Any willing provider” laws may reduce insurers’ negotiating power

## Narrower networks

- Direct patients to high-value clinicians or hospitals
- Gives insurers bargaining power against providers → lower prices
- On average, better financial performance (McKinsey 2015)

## Effects of Narrow Networks on Health Care Spending

Narrow networks are a blunt instrument for reducing health care spending (Wallace 2019; Atwood and Lo Sasso 2016)

Generate “hassle” costs that reduce quantities of services

Associated with lower premiums (Polsky, Cidav, and Swanson 2016; Dafny et al 2017) → on the order of **6-16%** cheaper

## Effects of Narrow Networks on Patients

Higher **out of network use** and **out of pocket costs** (Bishop et al 2021, Milliman 2019)

Georgia: **9-10x** more likely to receive outpatient mental health care out of network vs. primary care

May limit access to high-quality providers (Yasaitis, Bekelman, Polsky 2017; Schleicher, Mullangi, Feeley 2016) and team-based care (Breslau et al 2021, Zhu et al 2021)

Reduced health care utilization (Atwood and Lo Sasso 2016)

Treatment delays (Bishop et al 2021)

## Provider Networks As A Tool Towards Parity

Health plans must offer BH coverage with financial requirements and treatment limits no more restrictive than those on medical and surgical benefits

2022 Mental Health Parity and Addiction Equity Act Report to Congress: health plans are failing to deliver parity for mental health and substance use disorder benefits

**Provider networks may contribute to this failure** → overlooked, difficult to regulate elements of insurance coverage

What are existing standards for network adequacy and challenges?

## Network Adequacy: Easy to Conceptualize, Difficult to Operationalize

*A health plan's ability to deliver **reasonable**, **timely** access to **sufficient** numbers and types of in-network providers*

# Standards Vary Significantly Across States and Coverage, but Coalesce Around Similar Considerations

*How far away are providers located?*

Travel time and distance

*How long are enrollees waiting to get appointments?*

Timely access/wait times

*How many providers can patients select from?*

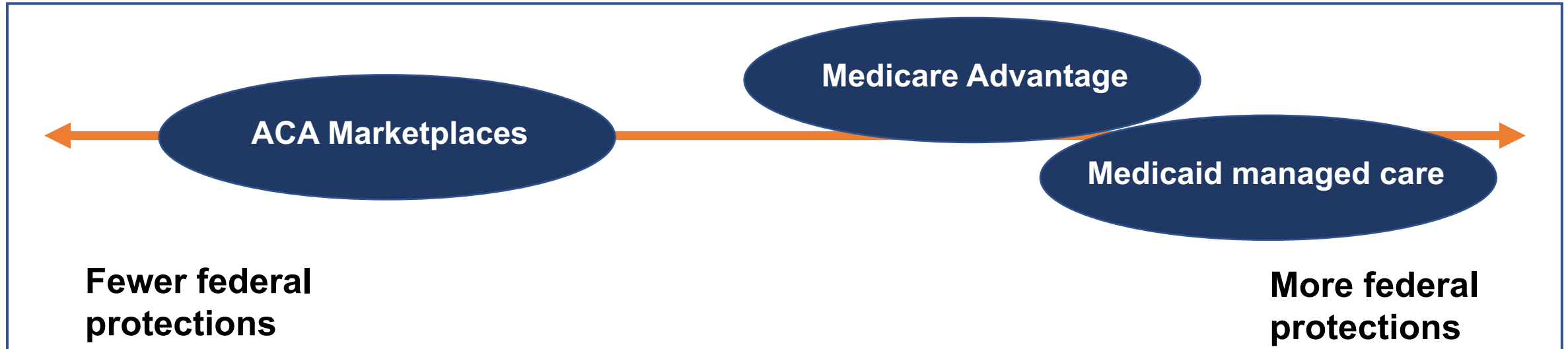
Provider choice

*Are there enough providers to serve enrollees' needs?*

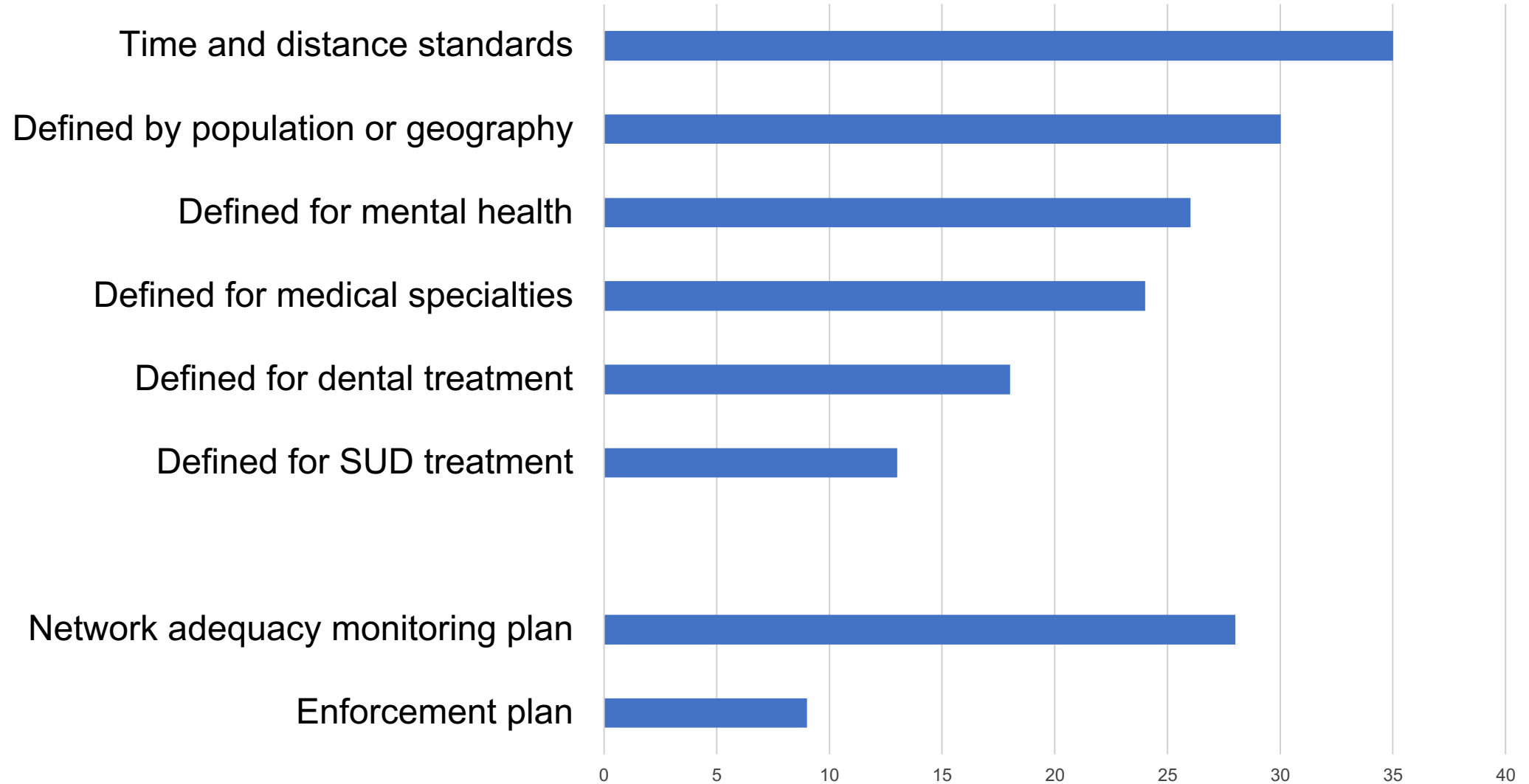
Provider-to-enrollee ratio/  
minimum number of providers



# Comparisons of Network Adequacy Standards Across Markets



# Variation in Network Adequacy Standards in Medicaid Managed Care (n=39 states)



# Challenges with Current Network Adequacy Standards

Provider directory inaccuracies

Providers contract with multiple plans – difficult to know who's available

Fragmented systems for gathering and collecting information

Uncertainty about how to incorporate new models of care delivery, including telemedicine and integrated behavioral health/primary care

Little to no enforcement

# Challenges with Current Network Adequacy Standards: Provider Directories

Basic information is inaccurate

~50%-70% records are inaccurate in provider location, specialty, insurance type, and acceptance of new patients (CMS 2018; Haeder et al 2016)

'Ghost' networks are prevalent

Up to 2/3 of psychiatrists listed in health plan directories see few or no Medicaid patients a year (Zhu et al 2022)

Care is highly concentrated

1/4 of Medicaid psychiatrists provide >80% of care (Ludomirsky et al 2022)

## Are Network Adequacy Standards Effective?

>90% of QHPs on ACA Marketplace meet network adequacy standards

No punitive enforcement; only corrective if and when enforcement exists

No changes in self-reported access among Medicaid enrollees in 5 states after implementation of network adequacy standards (Ndumele et al 2017)

## Considerations for monitoring and assessing network adequacy

# Examples of Network Adequacy Standards in Other States

Time and Distance				Provider-to-Enrollee Ratio		Appointment Wait Time	
		MCO	QHP	MCO	QHP	MCO	QHP
FL	PCP	✓	✓	✓		✓	✓
	OB/GYN	✓	✓	✓			✓
	MENTAL HEALTH	✓	✓	✓		✓	✓
GA	PCP	✓				✓	
	OB/GYN	✓				✓	
	MENTAL HEALTH	✓				✓	
	PCP	✓	✓	✓	✓	✓	✓
NM	OB/GYN	✓	✓				✓
	MENTAL HEALTH	✓	✓			✓	✓
PA	PCP	✓	✓	✓		✓	✓
	OB/GYN	✓	✓			✓	
	MENTAL HEALTH	✓	✓			✓	

## Case Studies

### New Mexico

Updated its ACA QHP regulations to align with those of Medicaid  
Imposed standards for inclusion of essential community providers beyond minimum federal requirements  
Established cultural competency requirements

### New Hampshire

Used all-payer claims data to measure share of all available providers that participate in a health plan  
Categorized providers based on claims for key covered services  
Developed public and interactive consumer-facing tool of network breadth

### Florida

In Medicaid, separate time and distance standards for adult and child psychiatrists; regional provider to enrollee ratios for 3 different mental health provider types and 6 different types of behavioral health facility types



# Landscape of Current and Proposed Standards

## Medicaid managed care

Mandated “readiness review” of MCOs prior to contracting & enforcement

Cultural and linguistic competencies

**Any quantitative standard →  
“Comprehensive Access  
Standard”**

## Medicare Advantage ACA QHPs

Mandated **time and distance standards**

Mandated **timely access standards**

Defined list of **provider and specialty types**

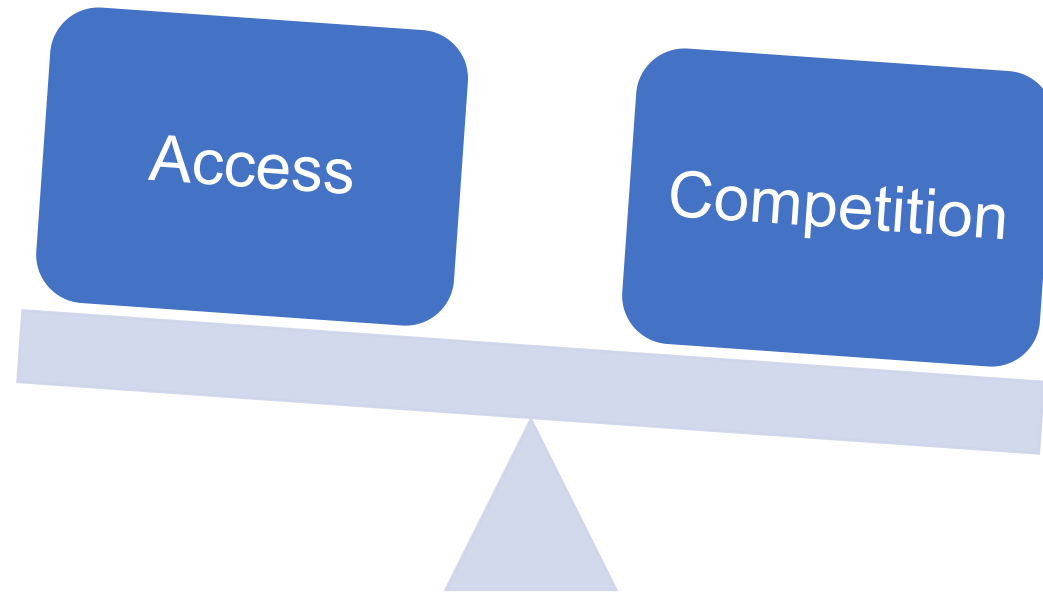
Geographic or rural/urban distinction

Measurement of telehealth availability

Requirements for inclusion of essential community providers

Greater oversight and enforcement of provider directory accuracy

## Legislative Considerations: How Narrow is “Too” Narrow?



Decisions on network breadth requires weighing the balance between ensuring access to care and allowing competition to keep prices and spending low

## Legislative Considerations: Looser vs. More Stringent Standards



Decisions on specific network adequacy standards require weighing the balance between ensuring flexibility to meet community needs and enforcing accountability to protect consumers

# Potential Levers to Improve Network Adequacy for Mental Health Services

## Data Collection and Transparency

- Standardize provider reporting and verification
- Strengthen capacity and systems for data collection
- More consumer-facing data transparency to aid decision-making

## Identify Access Issues and Standardize Measurement

- Incorporate multiple sources of information through claims, patient surveys, and provider directories
- Identify providers who see patients
- Consider access to different types of mental health providers
- Periodic audits of provider directory inaccuracies and access issues
- Facilitate a consumer complaint intake system

## Enforcement and Consumer Protections

- Oversight of provider networks before marketing to consumers
- Enforce accurate provider directories
- Align regulations across markets
- Corrective action and penalties
- Implement consumer protections to cover out of network care

Questions & comments  
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## **Involuntary Commitment Subcommittee**

Judge Brian Amero - **Chair**  
Judge Sarah Harris  
Judge Stephen Kelley  
Nora Haynes  
Representative Don Hogan

Chief Justice Michael Boggs  
Judge Bedelia Hargrove  
Dr. Karen Bailey  
Dr. DeJuan White

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*The Equitas Project*
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- VI. Identifying Prevalence of Inmates with Serious and Persistent Mental Illness in GA Jails**  
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- VIII. Analysis of Nine Jail Datasets for Representation of Mental Illness Among “Familiar Faces”**  
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- XI. 1013 Patients in Georgia Emergency Departments: Piedmont Healthcare’s Experience**  
*Piedmont Hospital*

## 1. Remove California Criteria for Admission into AOT program

On July 15, 2022, we received an AOT grant program implementation update from Carol Caraballo, the DBHDD Director of Adult Mental Health, at which time we were alerted to the fact that an Advisory Committee had been formed which included Senior Superior Court Judge David Sweat and our subcommittee member, Probate Court Judge Sarah Harris. While Ms. Caraballo didn't state that they needed any legislative assistance to implement the program as passed in 2021, she identified low enrollment as an AOT challenge. To aid in enrollment, we should consider the recommendations made by Brian Stettin from the Treatment Advocacy Center in the waning hours of last year's legislative session:

"There are three major ways in which [the AOT grant] ... criteria interfere with the optimal practice of AOT:

1. *These criteria do not allow AOT unless "the person's condition is substantially deteriorating." ([Line 953 of the current version of the bill as passed].)*

The right time to place a person under an AOT order is not when their "condition is substantially deteriorating." On the contrary, AOT has been designed as a discharge planning tool upon a person's release from a hospital, at a moment when they are doing (tenuously) *well*. It is precisely because the person is *not* substantially deteriorating that they are eligible for return to the community. By pairing their outpatient treatment plan with court oversight, we seek to ensure that they *remain* on a stable path. Imposing AOT at this juncture, at which the person is typically embracing the court's involvement, maximizes our chances of success. We take that precious opportunity away if the judge is required to deny AOT to a person who is presently in a psychiatrically stable condition. Fortunately, California has come to recognize this huge problem, and in 2021 amended their AOT criteria to remove current substantial deterioration as a requirement.

2. *These criteria do not allow AOT unless "the person has been offered an opportunity to participate in a treatment plan ... and such person continues to fail to engage in treatment." ([Lines 949-952 of the current version of the bill as passed].)*

As reasonable as this may seem on the surface, it has in practice led to an unfortunate approach to AOT in California (sometimes called “AOT Lite”) that should not be replicated in Georgia. It is of course appropriate for AOT eligibility to hinge on clear and convincing evidence that the person is unable to engage with treatment on a voluntary basis (as Georgia’s already do[es]). But in California, the “offered opportunity” criterion is generally interpreted to require not merely a history of *prior* unsuccessful voluntary opportunities offered, but an unsuccessful or refused offer *right before the filing of an AOT court petition*. This has led to nominal AOT programs in California in which the great majority of participants are not under court order or court supervision at all, with court orders reserved only for hardcore refusers of services and those who fare very poorly on the initial voluntary track.

It should not be surprising that most potential participants in California accept the initial offer [to participate in a treatment plan] to avoid a court proceeding. Even in programs elsewhere that go directly to court with those who meet the legal criteria, it is very common for respondents to stipulate to AOT rather than challenge the petition. But research tells us that those with stipulated court orders will have better outcomes in AOT, by virtue of experiencing the “black robe effect” imparted through the ritual of a court hearing and a personal connection with a caring judge. There is good reason to believe that AOT outcomes in California would be significantly better if programs were securing court-ordered treatment for all whose histories and condition indicate the need for it.

3. ***In requiring the person to have been hospitalized twice in the prior 36 months or to have committed violence in the past 48 months, these criteria ... exclude from consideration any period of hospitalization or incarceration “immediately preceding the filing of the petition.” ([Lines 942-943, 947-948 of the current version of the bill as passed].)***

Many states, like California, have AOT criteria requiring two hospitalizations in the last 36 months or a violent incident in the last 48 months as a specific history of failure in voluntary treatment. I have no problem with that. Where California goes weird here is in excluding from these “look-back” periods any hospitalization “immediately preceding the filing of the petition,” as well as any violent incident that occurred during such a hospitalization. In effect, if the person happens to be hospitalized on the date the petition is filed, the California law actually requires *three* hospitalizations in 36 months, or potentially *two* violent incidents in 48 months.



I have yet to hear a rational basis suggested for these exclusions. Why on earth should a hospitalization not count, just because it happened to “immediately precede” the filing of the petition? Same question for a violent incident that happened to occur during an immediately preceding hospitalization: Why not?? These seemingly random exclusions serve only to disqualify some individuals who clearly need AOT. Knowing the history of the California AOT law, I do not believe this was ever the legislative intent. They appear to be inadvertent consequences of re-phrasing New York’s AOT criteria, which very clearly exclude *the time period* of an immediately-preceding hospitalization – not the qualifying incidents -- from the retrospective review. (In other words, in New York, if the respondent has been hospitalized for the three months immediately preceding the filing of the petition, the 36-month look-back for a second qualifying hospitalization is extended to 39 months.) In any event, Georgia should not repeat this absurdity.”

Brian Stettin offers a solution to these problems:

“The solution here is very simple: delete [Lines 929 to 960 in the Bill as Passed] and replace with the following:

**(2) A description of the population the applicant proposes to serve through assisted outpatient treatment, including the number of patients anticipated to participate in the program over the course of each year of grant support;**

As someone deeply steeped in this area, I know that having these eligibility criteria imposed upon the grantees threatens the efficacy of the AOT grant program itself. A key to making AOT work is getting the people who need it most into the program. These extra criteria will make that exceedingly difficult.”

## **2. Fund Criminal Justice Coordinating Council research into data sharing between criminal justice and behavioral health.**

On July 15, 2022, Stefanie Lopez-Howard, the Statistical Analysis Center Director of the Criminal Justice Coordinating Council, recommended that we develop an overview of the magnitude of interaction among i) people with mental illness in treatment, ii) people with mental illness in jail, and iii) people with mental illness

in crisis in the community to see how many people are interacting with multiple systems at or about the same time. Additionally, Ms. Lopez-Howard recommended that we engage in a business process analysis and data map to match data across systems to see how people travel through multiple systems with an eye toward reducing arrests, hospitalization, and incarceration. Finally, she is recommending that we invest in the kind of business process and analysis and technology implementation that allows for on-going data sharing.

### **3. Fund Opening Doors to Recovery (ODR) state-wide.**

On August 25, 2022, Nora Lott Haynes, Bill Curruthers, and Dr. Michael Compton presented on the efficacy of the Opening Doors to Recovery initiative in DBHDD Region 5. Their work showed how participants coming out of local hospitals benefited from community navigators and how a partnership between the GCIC and program participants reduced participant arrests by almost two-thirds while at the same time improving their quality of life and connection to treatment. One of the key features of this program is that a participant consents to having their participation made part of the GCIC so that the police would be able to see an alert when they encountered a participant in crisis. Wouldn't it be fantastic if every person coming out of a state mental hospital or participating in an accountability court was included in this program and all of it was integrated into the co-responder model that is beginning to be rolled out! Imagine all of these folks having executed a psychiatric advanced directive as well. The outcomes would reduce arrest and give deference to the care that the participant wants to receive.

### **4. Recommend that competency restoration be limited to only the most serious offenses and that diversion “off ramps” be created during initial contacts with criminal justice and at every stage of the competency restoration process**

Dr. Karen Bailey, subcommittee member and a forensic psychologist with 30 years' experience in the field, presented to the subcommittee on September 28, 2022, and nationally renowned mental health/criminal justice reform leader Judge Steve Leifman presented to the committee on October 11, 2022. Both distinguished presenters agree that we should limit the use of what's known as competency restoration to only the most serious offenses.

Treating a person with mental illness simply to make it possible for them to stand trial, and for no additional purpose, is a shocking misuse of desperately needed resources. The funds saved by minimizing the practice could go instead to front-end, community-based prevention and treatment services.

[Locking People Up Is No Way to Treat Mental Illness](#), Norm Ornstein and Judge Steve Leifman, The Atlantic, May 30, 2022.

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial. Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder.

In Georgia, more than 870 persons are awaiting evaluations to determine their competency to stand trial on criminal charges. More than 350 persons are awaiting mental health competency restoration services so that they may then stand trial. The time spent waiting for evaluation or restoration services is measured in months.

These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.

There are, however, alternatives to the current scenario, and these alternative approaches often work better for the individual as well as the community and use limited resources and available dollars more wisely.

Because jails and courts struggle to effectively address serious mental illness (SMI), moving individuals in and out of these systems can make people with SMI worse.

Diverting people who experience mental health symptoms to a system where treatment can be addressed at the right level of need as something more akin to our physical health processes and facilities is a better option. Trained 911 dispatchers, mobile crisis units, co-responder models, CIT trained law enforcement who have access to psychiatric advanced directives and provider contact information through the GCIC, community navigators, and well-designed crisis stabilization facilities

that interact appropriately with criminal justice are likely more effective and humane alternatives.

These diversion opportunities also arise at each point in the competency process, and off-ramps from the criminal justice system to treatment and civil alternatives, including voluntary treatment, the use of Psychiatric Advance Directives, and even involuntary civil commitment when appropriate — such as the use of Assisted Outpatient Treatment (AOT) — should be considered at each of these points. Interventions should be tailored to the needs of the individual and the community at the evaluation stage, prior to restoration, upon return from restoration, and prior to and as a part of sentencing or other case disposition. Even individuals found incompetent to stand trial and unrestorable could take advantage of the right “offramp” opportunities for diversion and be linked to appropriate community services to reduce their risk of offending and returning to the competency system.

Source: [Leading Reform: Competence to Stand Trial Systems](#), a resource for state court systems authored by the National Judicial Task Force to Examine State Courts’ Response to Mental Illness

## **5. Develop Piedmont Healthcare Systems, Inc.’s Recommendations.**

On September 1, 2022, Fiona Hall, the Behavioral Health Service Line Executive Director of Piedmont Healthcare, Inc., stated plainly in her first slide that “Emergency Departments are the central intake point for patients who need transport to an Emergency Receiving Facility pursuant to a 1013 certificate. Due to lack of available beds for evaluation and treatment, patients are commonly held days or weeks in emergency rooms awaiting an appropriate placement. This result delays necessary care for those patients and impairs hospitals’ ability to care for other patients in need.” In 2021, Piedmont had 18,751 encounters with behavioral health patients resulting in \$18.7 million in uncompensated care and over \$3 million spent on contracts with private providers to care for these patients. They believe that the strain on local hospitals in this way is not sustainable. Dr. Dejuan White, psychiatrist and subcommittee member, indicated in a comment during the presentation that Piedmont’s experience appears to be not that different from his experience at Grady.

Ms. Hall presented the following recommendations: 1) increase in-patient bed availability; 2) improve the continuum and coordination of care; and 3) provide

alternate treatment or expanded acceptance criteria for medically compromised patients.

Perhaps we could consider partnering with the consortium of private healthcare providers that are meeting regularly in the Atlanta area to address these issues. Additionally, we could try and reach out to the state behavioral health institution in Tallahassee, Florida mentioned by Ms. Hall in her presentation which has been shown to reduce the medical clearance burdens that hospitals face here. In the end, we need to do a deep dive into these topics before we can make more specific recommendations.

#### **6. Research the extent to which local jurisdictions are experimenting with mental health diversion and create a state-wide data base for information sharing**

Anecdotally, there appears to be some diversion related experimentation on an ad hoc basis throughout the state at the intersection of mental health and criminal justice. One such example is the Misdemeanor Diversion Court founded in Henry County in 2018 by Senior State Court Judge Jim Chafin. This program diverts people with severe and persistent mental illness from traditional court processes to treatment, but it is not a mental health court and can result in the dismissal of the misdemeanor charge within 6 months of arrest. This program was created without funding through the cooperation of the local superior and state courts, the police and sheriff's departments, misdemeanor probation, the community service board and a nearby behavioral health crisis center (See attached Memorandum of Understanding for Diversion from Jail for Misdemeanor Offenders).

An effort should be undertaken to collect information from the courts regarding their diversion efforts with the goal of evaluating them and sharing best practices.

#### **7. Recommend a legal review of The Equitas Project and The CARES Act**

As part of his presentation to the subcommittee, Judge Steve Leifman shared the findings of the Equitas Project. The call to action of the Equitas Project was *Care, not Cuffs*. From May of 2019 to August of 2022, Judge Leifman led a blue-ribbon panel of experts from across the country who set out to disentangle mental health from criminal justice and create modern legal processes. Additionally, Judge Leifman introduced us to a framework the Equitas Project developed entitled

## Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society.

The work group aimed to produce legislative language that reflects cutting edge brain and behavior research, the civil liberties and patient's rights advocacy of consumers and families, as well as health provider and public safety innovations and efficiencies. The work group of nationally recognized experts in mental health law, psychiatry, and advocacy aspired to create model law which would set the gold standard for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety.

A legal review of this project should be done to consider whether and how to incorporate these proposed reforms into our body of law.

Furthermore, in 2022, the Community Assistance, Recovery and Empowerment Court Program (SB-1338) was enacted in the State of California as a form of Assisted Out-Patient Treatment. Legislative Counsel's summary of the bill in section 3 states as follows:

"Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which a defendant's mental competency is evaluated and by which the defendant receives treatment, with the goal of returning the defendant to competency. Existing law suspends a criminal action pending restoration to competency. This bill, for a misdemeanor defendant who has been determined to be incompetent to stand trial, would authorize the court to refer the defendant to the CARE process."

This particular diversion point should be considered as a possible off ramp from the criminal forensic side to treatment in Georgia.

- 8. Revise O.C.G.A. 17-7-130(c) to permit superior courts to exercise discretion to determine whether to transfer a violent offender to the department for in-patient restoration services or to outpatient restoration services pursuant to *Carr v. State*, 303 Ga. 853 (2018) and *McGouirk v. State*, 303 Ga. 881 (2018).**

Proposed Legislative Change to O.C.G.A. § 17-7-130(c):

“(c) If the court finds the accused is mentally incompetent to stand trial, the court may order a department physician or licensed psychologist to evaluate and diagnose the accused as to whether there is a substantial probability that the accused will attain mental competency to stand trial in the foreseeable future. The court shall retain jurisdiction over the accused and ~~shall~~ **may** transfer the accused to the physical custody of the department: **if, after a hearing, the court in its discretion determines the evaluation should be performed on the accused as an inpatient.** At its discretion, the court may allow the evaluation to be performed on the accused as an outpatient ~~if the accused is charged with a nonviolent offense.~~ Such evaluation shall be performed within 90 days after the department has received actual custody of an accused or, in the case of an outpatient, a court order requiring evaluation of an accused. If the accused is a child, the department shall be authorized to place such child in a secure facility designated by the department. If the evaluation shows: [SUBSECTIONS OF STATUTE OMITTED].”

#### Reasoning and Background:

O.C.G.A. § 17-7-130(c) permits the court to order a department physician or licensed psychologist to evaluate and diagnose as to whether there is a substantial probability a defendant will attain mental competency to stand trial in the foreseeable future, if the court finds at present that the defendant is mentally incompetent to stand trial. However, the current version of O.C.G.A. § 17-7-130(c) only allows the court to use its discretion to permit outpatient evaluation if the accused is charged with a nonviolent offense. Otherwise, “[t]he court shall retain jurisdiction over the accused and shall transfer the accused to the physical custody of the department.” O.C.G.A. § 17-7-130(c) (emphasis added). The Supreme Court of Georgia has found this automatic inpatient commitment provision to be unconstitutional. See *Carr v. State*, 303 Ga. 853 (2018); *McGouirk v. State*, 303 Ga. 881 (2018).

In *Carr*, the defendant was arrested and charged with rape, aggravated sexual battery, two counts of child molestation and a criminal attempt to commit a felony, which are considered violent offenses by the statute. See O.C.G.A. § 17-7-130(a)(11)(i)-(iv). He was released on bond, and a doctor from the department found the defendant to be not competent with a strong probability he could not be restored; nevertheless, the doctor concluded that restoration attempts should be



made and recommended that the restoration occur in an outpatient, community setting.

Similarly, in *McGouirk*, the defendant was arrested and charged with the offenses of aggravated child molestation, child molestation, cruelty to children, and arson in the first degree. 303 Ga. 881 (2018). These are also violent offenses as defined by the statute. O.C.G.A. § 17-7-130(a)(11)(A)(ii) and (ix) (sexual offense and arson in the first degree). He was released on bond. A doctor from the department performed a competency evaluation on the defendant and found him not competent at the time of her evaluation, but that she might be able to provide a better sense as to his restorability after providing restoration services. She found no indication the defendant was in need of inpatient care, and she recommended outpatient commitment.

Nevertheless, in both cases, the trial court automatically transferred custody of the defendants to the department for inpatient evaluation pursuant to the statute.

This automatic inpatient commitment solely on the basis of a defendant's mental incompetence and the nature of his charges impermissibly infringes upon a defendant's due process rights. See *Carr*, supra; *McGouirk*, supra. Although there is a "legitimate and important government interest" in accurately evaluating whether a defendant's competency can be restored for trial, *Carr*, 303 Ga. at 859, there must be a reasonable relation between this interest and the deprivation of the defendant's liberty. *Id.* at 860. The Supreme Court of Georgia held that the mere facts of a defendant's crimes, of which he must be presumed innocent, and his incompetency to stand trial were, alone, insufficient to deprive him of his liberty. *Id.* at 868. Further, depending on the defendant's needs, inpatient evaluations could work against the government's purpose of accurately evaluating whether the defendant's competency could be restored. *Id.* The Supreme Court of Georgia concluded that, absent any other lawful reason to be detained, the "automatic commitment for all those defendants [who are accused of a violent crime and found incompetent to stand trial] does not bear a reasonable relation to the State's purpose of accurately determining the restorability of individual defendants' competence to stand trial[.]" *Id.* at 869. Thus, "that aspect of O.C.G.A. § 17-7-130(c) violate[d] due process when applied to defendants who have been deprived of their liberty based solely on that statutory provision." *Id.*

The two cases provide a framework by which O.C.G.A. § 17-7-130(c) might be constitutionally applied. In *Carr*, the Supreme Court of Georgia counseled that



the court should consider all relevant evidence and make a finding as to whether the evaluation required by O.C.G.A. § 17-7-130(c) should be conducted on an inpatient or outpatient basis. A defendant who is not already lawfully detained should be committed to the department only if the court finds that such confinement is reasonably related to the purpose of accurately evaluating whether that particular defendant can attain competency. A hearing on this issue should be held at the same time or promptly after the court initially determines the defendant's competency to be tried. To the extent the prosecutor or the defendant wishes to present or contest evidence that speaks to the detention determination, that should be permitted.

*Id.* at 869-70. In *McGouirk*, relying on *Carr*, the Supreme Court of Georgia affirmed that “the court must exercise its discretion to make an individualized determination of whether [the defendant’s] confinement reasonably advances the government’s purpose of accurately determining whether there is a substantial probability that [the defendant] will attain mental competency to stand trial in the foreseeable future.” 303 Ga. at 883. In making such a determination, the court “should proceed as it does in determining how to evaluate mentally incompetent defendants accused of nonviolent offenses.” *Id.* at 883-84.

To: Judge Amero  
From: Danna  
Date: September 2, 2022  
Re: O.C.G.A. § 17-7-130(c) legislative change in light of *Carr v. State*, 303 Ga. 853 (decided June 18, 2018) and *McGouirk v. State*, 303 Ga. 881 (decided June 18, 2018)

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**Proposed Legislative Change to O.C.G.A. § 17-7-130(c):**

“(c) If the court finds the accused is mentally incompetent to stand trial, the court may order a department physician or licensed psychologist to evaluate and diagnose the accused as to whether there is a substantial probability that the accused will attain mental competency to stand trial in the foreseeable future. The court shall retain jurisdiction over the accused and ~~shall may~~ transfer the accused to the physical custody of the department- **if, after a hearing, the court in its discretion determines the evaluation should be performed on the accused as an inpatient.** At its discretion, the court may allow the evaluation to be performed on the accused as an outpatient ~~if the accused is charged with a nonviolent offense~~. Such evaluation shall be performed within 90 days after the department has received actual custody of an accused or, in the case of an outpatient, a court order requiring evaluation of an accused. If the accused is a child, the department shall be authorized to place such child in a secure facility designated by the department. If the evaluation shows: [SUBSECTIONS OF STATUTE OMITTED].”

**Reasoning and Background:**

O.C.G.A. § 17-7-130(c) permits the court to order a department physician or licensed psychologist to evaluate and diagnose as to whether there is a substantial probability a defendant will attain mental competency to stand trial in the foreseeable future, if the court finds at present that the defendant is mentally incompetent to stand trial. However, the current version of O.C.G.A. § 17-7-130(c) only allows the court to use its discretion to permit outpatient evaluation if the accused is charged with a nonviolent offense. Otherwise, “[t]he court shall retain jurisdiction over the accused and shall transfer the accused to the physical custody of the department.” O.C.G.A. § 17-7-130(c) (emphasis added). The Supreme Court of Georgia has found this automatic inpatient commitment provision to be unconstitutional. See *Carr v. State*, 303 Ga. 853 (2018); *McGouirk v. State*, 303 Ga. 881 (2018).

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The two cases provide a framework by which O.C.G.A. § 17-7-130(c) might be constitutionally applied. In *Carr*, the Supreme Court of Georgia counseled that

the court should consider all relevant evidence and make a finding as to whether the evaluation required by O.C.G.A. § 17-7-130(c) should be conducted on an inpatient or outpatient basis. A defendant who is not already lawfully detained should be committed to the department only if the court finds that such confinement is reasonably related to the purpose of accurately evaluating whether that particular defendant can attain competency. A hearing on this issue should be held at the same time or promptly after the court initially determines the defendant's competency to be tried. To the extent the prosecutor or the defendant wishes to present or contest evidence that speaks to the detention determination, that should be permitted.

*Id.* at 869-70. In *McGouirk*, relying on *Carr*, the Supreme Court of Georgia affirmed that “the court must exercise its discretion to make an individualized determination of whether [the defendant’s] confinement reasonably advances the government’s purpose of accurately determining whether there is a substantial probability that [the defendant] will attain mental competency to stand trial in the foreseeable future.” 303 Ga. at 883. In making such a determination, the court “should proceed as it does in determining how to evaluate mentally incompetent defendants accused of nonviolent offenses.” *Id.* at 883-84.



Model Legal Processes to Support Clinical Intervention  
for Persons with Serious Mental Illnesses  
and  
Pathways to Care: A Roadmap for Coordinating  
Criminal Justice, Mental Health Care, and Civil Court Systems  
to Meet the Needs of Individuals and Society

August 2022

## Preface

### Project History

The Equitas Project, Mental Health Colorado's national initiative to disentangle mental health and criminal justice, has been generously supported by The David and Laura Merage Foundation. Our call to action is *Care, Not Cuffs!*—we are advocating for a health care response to people's unmet health needs.

Mental Health Colorado is the state affiliate of Mental Health America. Since 1953, our mission has been to promote mental health, expand access to services, and transform systems of health care. To achieve healthier minds across the lifespan, we advocate for a strong start for all children; support for families; access to housing, health care, supports, and services; wellness in aging; reduced harm from drugs and alcohol; and the decriminalization of mental health.

A continuum of care, supports, and services throughout every stage of life enables human populations to thrive—and nowhere in this nation is such a continuum equitably available. The criminalization of people with unmet mental health and substance use care needs, and the impact of that criminalization on their families and communities, are costly to society and avoidable. Decriminalizing mental health and meeting people's needs for mental health and substance use care, supports, and services are top priorities for our advocacy work. *Care, not cuffs!*

In partnership with Equitas National Advisors, the Hon. Steven Leifman, J.D. and Ronald Honberg, J.D., we formed the Model Legal Processes Work Group in 2019 for the purpose of writing model civil and criminal mental health law that could be distributed and promoted for broad adoption across the country. The work group aimed to produce legislative language that reflects cutting edge brain and behavior research, the civil liberties and patient's rights advocacy of consumers and families, as well as health provider and public safety innovations and efficiencies. The work group of nationally recognized experts in mental health law, psychiatry, and advocacy aspired to create model law which would set the gold standard for least restrictive involuntary commitment (inpatient and outpatient), and for civil and criminal approaches to optimizing individual health outcomes, defending civil liberties, and preserving public safety.

From May 2019 through June 2022, The Equitas Project convened a series of work sessions to scope and fully execute the guidance documents presented here: *Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illness* and *Pathways to Care: A Roadmap for Coordinating Criminal Justice, Mental Health Care, and Civil Court Systems to Meet the Needs of Individuals and Society*.

### Project Purpose

As advocates informed by individuals with lived experience of the tragic flaws in our health care and criminal justice systems, we are sharing this guidance document for the purpose of stimulating more enlightened and urgent conversation among partners and allies nationwide about our mental

health and substance use crisis and the imperative of increasing access to housing, health care, supports, and services. Failure to thrive, homelessness, overdose, incarceration, suicide, and other premature death--the too prevalent consequences of Americans' unmet health care needs--must not be tolerated by those of us who aspire to build a stronger, better nation.

## **Advocacy Considerations and Priorities**

As consumer advocates, we appreciate and acknowledge that there are alternative pathways to well-being and understand that different approaches may be effective for some individuals. We also support cultural competence in providing equitable care, supports, and services for widely diverse individuals. We most urgently acknowledge that the present default pathway into jails and prisons, especially for underserved and vulnerable populations, yields terrible health outcomes and at great cost to individuals, families, and society. What we urgently need is an equitably accessible, reliably compassionate system of care, supports, and services that leaves no one's needs unmet.

Our purpose is to create surer, more equitable, more inclusive, pathways to care and well-being. To that desirable end, one of the most important stipulations in this guidance document is that:

*Having placement options and a continuum of appropriate related services is a key part of achieving successful outcomes. All three branches of government must collaborate to create and maintain such a system, and that collaboration likely requires coordination and communication at the state and local levels. Permanent interdisciplinary oversight structures – committees, task forces, commissions - are helpful in ensuring that collaboration and mutual accountability.*

The statutory language proposed in this document would create a more accessible legal pathway to involuntary care for the sake of an individual's health and well-being than is presently available in most states. Ensuring that "placement options and a continuum of appropriate related services" are available for the court's referral and, more importantly, that those services are available before someone gets to the point of needing crisis intervention and involuntary care must remain the focus for our collective advocacy.

Passing laws and changing practices within the justice system may be easier than creating an equitable continuity of housing, health care, supports, and services where there is little or none. In Colorado, Mental Health Colorado helped pass *SB19-222 Individuals at Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization* (see Appendix IV)—which was a triumph of bipartisan recognition that the state needs a safety net system to prevent vulnerable individuals with mental health and substance use need for care from becoming involved in the criminal justice system. But recognizing the need and passing the law is not like waving a magic wand. Implementation takes time and resources and collaborative commitment which must be continuously cultivated.

This guidance document wisely stipulates that involuntary commitment be contingent upon attempts made “to engage the person in receiving person-centered health care and a continuum of supports and services.” As consumer advocates we support and insist upon this. Again, mobilizing a system that is truly person-centered (inclusive, equitable, culturally competent) and that reliably makes such outreach and engagement attempts must be a focus for our collective advocacy.

This document also includes guidance for emergency intervention that our work group formulated at the very same time as Mental Health Colorado’s VP for Government Affairs, Lauren Snyder, was leading Colorado stakeholders in a year-long process which led to the passage of *HB22-1256 Modifications to Civil Involuntary Commitment statutes for persons with mental health disorders* (see Appendix V for summary and link). This law revises Colorado’s involuntary mental health treatment procedures for the first time since the 1970s and, among other things, establishes certain rights for persons being transported for evaluation and requires a discharging facility to establish continuity of care after discharge. We recommend that this new Colorado law be considered alongside the recommendations presented in this document.

## **Acknowledgements**

We are very grateful to The David and Laura Merage Foundation for their generous support of this project and our other efforts to disentangle mental health and criminal justice. We are deeply grateful to the members of the work group for their expertise, their passionate commitment to addressing egregious failures in our systems of health and justice, and for their generosity with their time and attention to this project over these past three years. We are particularly grateful to Judge Leifman for his suggestion that The Equitas Project support this work, for his leadership of the group, for his understanding and insight regarding the intersection of mental health and criminal justice, and for his warm heart, his joy, and his sense of humor.

Throughout the duration of the process, The Equitas Project provided staff support for the work of the group, and we gratefully acknowledge the skillful attention of Project Managers Gwendolyn West and Adam Goss, and Model Legal Processes Group Reporter Richard Schwermer (for whose outstanding services and expertise we contracted with the National Center for State Courts). We are also grateful to Ken Sonnenfeld and his associates at Ballard Spahr, Brittany Wilson and Erin Blasberg, for their legal expertise and research support. We have edited what follows for consistency and for inclusive, non-discriminatory language and we own and acknowledge all errors or deviations from what the work group authored which may have resulted from that editing process. We wholly credit the work group for all the valuable substance of this guidance.

Finally, we thank you, Readers, for your empathy, your caution, your wisdom, your gratitude for diversity, your respect for liberty, and your humanity.

Vincent Atchity, Ph.D.  
President & CEO, Mental Health Colorado



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# **Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses**

## **Introduction**

Most states' laws for the involuntary treatment of persons with mental illnesses in existence today were adopted in the 1970's. As part of an effort to deinstitutionalize the treatment of mental illness, this generation of statutes favored "dangerousness" standards and individual rights-oriented court processes for involuntary treatment over the need-for-treatment standards and informal procedures that existed before. As a result, in some states today, individuals with mental illnesses who do not clearly present an imminent risk of harm may not be able to benefit from pathways to well-being that may only be available through involuntary treatment. If there are no other pathways to treatment, these persons can be more likely to experience homelessness, poverty, serious health consequences, and involvement in the criminal justice system.

Modern mental health laws must be modified—and systems of health care, supports, and services enhanced—to improve access to timely, appropriate mental health care delivered in the least restrictive manner possible for those unwilling or unable to voluntarily accept that treatment. These laws also must appropriately take into account the person's right to self-determination. Statutory modifications should both ensure that persons with mental health and substance use care needs are able to access needed services voluntarily and provide for involuntary treatment not only for individuals who do meet traditional dangerousness criteria but also for those who are at significant risk of experiencing a crisis.

This guidance document is intended to provide policymakers with a template for revising all aspects of our current, often outdated and piecemeal, approach to mental health care. The proposed statutes and non-statutory guidance language lay out a more modern and cohesive model for effectively creating pathways to care for people with serious mental health and substance use care needs, consistent with today's scientific understanding of brain functioning.

## **Part I. Guidance for Court Ordered Mental Health Treatment**

This first section is proposed statutory language. Italicized text below is commentary intended to provide context and reasoning for the statutory language.

### **Statutory Language**

**1. "Person requiring court ordered treatment" means an individual who, as a result of mental illness and based on recent actions, omissions, or behaviors:**

- (a) presents a substantial risk of harm to self or others in the near future, which includes:**
  - (i) suicidal behavior or inflicting significant self-injury; or**
  - (ii) attempting, causing, or threatening to cause serious injury to others; or**

**(b) has demonstrated an inability to:**

**attend to basic physical needs such as medical care, food, clothing, or shelter; or  
protect the self from harm or victimization by others; or  
exercise sufficient behavioral control to avoid serious criminal justice involvement;  
or**

**(c) lacks the capacity to recognize that they are experiencing symptoms of a serious  
mental illness and therefore are unable to:**

**make a decision regarding treatment; or  
understand or retain information relevant to the treatment decision; or  
use, weigh or appreciate that information as part of the process of making the  
treatment decision; or  
communicate the decision; or  
appreciate the risks or benefits of treatment; and  
in the absence of treatment is likely to experience a relapse or deterioration of  
condition that would meet the criteria in (a) or (b).**

**2. The court shall order treatment of a person requiring court ordered treatment in an outpatient setting unless the court determines that outpatient treatment will not provide reasonable assurances for the safety of the individual or others or will not meet the person's treatment needs.**

*Court-ordered psychiatric treatment is reserved for individuals with a mental illness for which treatment is likely to be effective. Treatment must be provided in the least restrictive setting consistent with the needs of the individual and the interests of the public.*

*Court-ordered treatment is a significant event. By definition, it marks a diminution of the individual rights and freedoms of the person, so it is a legal step to be taken carefully. Taking account of current scientific understanding and legal precedent, the criteria for court-ordered treatment narrowly and objectively define the circumstances under which protecting a person's long-term well-being justifies overriding a person's freedom.*

*This definition intentionally refers to "court ordered treatment" as opposed to the term "commitment" as that term implies custodial treatment and confinement, whereas the type of treatment ordered and its setting should be the least restrictive that will be safe and effective. This least restrictive environment principle respects the rights of the individual, but it also is consistent with best medical practice and with the goal of using scarce treatment resources wisely.*

*Finally, the introductory provision of this definition requires a nexus between the person's mental illness and the need for court intervention. This does not, however, mean that it is necessary to find that mental illness is the sole cause of the person's dangerous behavior or incapacity. For example, a large percentage of individuals experiencing mental illnesses have co-occurring substance use and distinguishing between the two or trying to disentangle them is*

*not required. However, the finding of a mental illness will likely require the presentation of clinical assessment evidence that establishes one or more suggested diagnoses based on the latest version of the Diagnostic and Statistical Manual.*

*The court order must be based on evidence sufficient to meet one or more of the criteria specified in subsections (a), (b), or (c). Consistent with current case law, the existence of one or more of these provisions needs to be proven by the petitioner by clear and convincing evidence. This higher civil standard is required given the potential loss of liberty by the individual (see Addington v. Texas).*

*Subsection (a) is similar to many existing “dangerousness” provisions, but the risk of harm must be substantial, not merely speculative, and the harm anticipated must be proximate in time. Admittedly there is some element of prediction involved in these determinations, but established past conduct is relevant. The number of times harm has resulted in the past, the severity of that harm, how long-ago harmful conduct occurred, what treatment interventions, supports, and services may have intervened and could ameliorate repeat conduct –may all be relevant in establishing the nature and imminence of future conduct. The testimony of experts can also be particularly helpful in this assessment.*

*Subsection (b) considers a type of harm different from the type of harm in subsection (a). This second type of harm requires a finding of an inability to provide for basic life needs. The implication is that it requires a showing of more than poor life choices, or choices different than ones someone else might make, but rather substantial deficits in the ability to even make those choices. Again, these substantial deficits must be “as a result of a mental illness.” People are entitled to make poor choices, but if they lack the ability to make better choices as the result of unmet mental health or substance use care needs, and those choices relate to basic life necessities, then court intervention may be justified.*

*The alternative finding that the person has substantial deficits in the ability to protect the self from harm also requires a distinction between making choices with which some would disagree and that could result in harm (drinking alcohol, under- or over-eating, or riding a skateboard without a helmet) and a fundamental inability to weigh risks and make a choice. As with subsection (a), a prediction of serious harm based on a clear history or recent behavior would be required to justify court-ordered treatment.*

*Subsection (c) applies to individuals who do not meet the requirements of subsections (a) or (b), but who likely will meet one of those thresholds without treatment. Because of the nature of this standard, it requires an additional finding that the person lacks the capacity to recognize their symptoms of mental illness. This condition is a prerequisite for using this additional criterion. For example, a person might lack capacity to make a rational decision about the need for treatment if that person is regarded as unable to understand the information relevant to the decision due to mental illness. Alternatively, a person might be able to use information for some purposes but, due to their mental illness, still not be able to appreciate the way the information pertains to their own situation.*

*(c)(vi) requires a finding that this condition contributes to a likelihood that the person will, in the future, meet the criteria described in (a) or (b). This finding would be based on evidence of past deterioration or relapse episodes. No specific timeline for that predicted deterioration is included because of the individualized nature of relapse.*

*While the criteria found in subsections (a) and (b) are relatively standard provisions in state statutes, this alternative criterion for court-ordered treatment is advanced in response to the frequent complaint that under most existing laws a person must actually harm themselves or someone else in order to justify judicial intervention, no matter how clear, serious, or imminent the harm may be. The criterion is also intended to better comport with modern medical understanding of the symptoms of untreated serious mental illness.*

*If the court-ordered treatment involves medication, the court may authorize medication over objection if the court finds that the criteria in the Medication Over Objection provision in Part III are met.*

*Section 2 makes explicit the presumption for treatment in the least restrictive environment. It also directly reflects the requirement set forth in *Olmstead v. LC* that people with disabilities have a qualified right to receive state funded supports and services in the community rather than institutions.<sup>1</sup> This presumption should apply not only at the initial determination of capacity, but at each treatment placement decision and review opportunity.*

*Section 2 also obviates the need for a separate provision for Assisted Outpatient Treatment (AOT). Rather than having a distinct process for outpatient court-ordered treatment, the standard to invoke all non-emergency involuntary mental health treatment would be the same. Traditionally, after an order for treatment the court has no further role other than to review or terminate that order at some future time. However, a number of jurisdictions have added a more direct role for judicial oversight and encouragement of the person and their treatment. Adding a statutory provision directing that kind of oversight for appropriate persons is a worthwhile option for policymakers to consider. But we do not do so here.*

The following section sets out guidelines for the procedure to be followed in determining whether an individual meets the criteria for inpatient or outpatient treatment.

### **Proposed procedural processes**

1. Any adult over the age of 18 should be able to file a petition for court-ordered treatment of a person if the petitioner believes, in good faith, that the person has a mental illness and is in need of court ordered involuntary treatment consistent with the criteria of this statute.<sup>2</sup>

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<sup>1</sup> *Olmstead* provides that the community setting is required if a three-part test is met: the person's treatment professionals determine that community supports are appropriate; the person does not object to living in the community; and the provision of services in the community would be a reasonable accommodation when balanced with other similarly situated individuals with disabilities.

<sup>2</sup> For emergency interventions, see the separate Emergency Intervention Guidance that follows



2. A clinical certificate from an independent qualified mental health professional should be sufficient to hold a person in a treatment facility pending a hearing. Anecdotal reports suggest that many patients who are held pending a hearing are discharged prior to the hearing, sign in voluntarily, agree to services in the community, or stipulate to the entry of an order.
3. The individual should have the right to attend the hearing in person (although the hearing could be conducted remotely as long as the person can participate). If medication over objection is involved, ideally the process set forth in Part III of this document is included in this initial hearing rather than in a separate subsequent hearing.
4. If the court finds that the individual meets the statutory criteria, it should have authority to order placement of the individual in an inpatient or outpatient treatment setting, or a combination of both, depending on their assessed clinical need.

*Having placement options and a continuum of appropriate related services is a key part of achieving successful outcomes. All three branches of government must collaborate to create and maintain such a system, and that collaboration likely requires coordination and communication at the state and local levels. Permanent interdisciplinary oversight structures – committees, task forces, commissions - are helpful in ensuring that collaboration and mutual accountability.*

## **Part II. Guidance Language for Emergency Psychiatric Intervention**

In many cases, before the hearing described in Part I takes place, an emergency intervention is necessary.

This section is intended to provide guidance for an emergency intervention. Recommended standards and procedures cover the initial emergency assessment and subsequent assessments and processes short of a judicial determination of incapacity. The language may be adapted according to jurisdictional needs. The language contained in this section is not precise statutory language to be adopted verbatim. Italicized text serves as commentary for additional context and reasoning.

*Often the need for an emergency assessment arises because of a call for assistance, usually to 911. The better practice is the emerging initiative of 988 or other trained dispatch personnel who can make a more competent determination about the necessity of a law enforcement response. Better outcomes often occur when communities use co-responders or mobile crisis teams of clinically trained responders.*

*The standard for Emergency Intervention is by necessity lower than that for longer term court orders for treatment. Less information is available on which to make longer term decisions, and the presumption should be that a person's self-determination is limited only to the extent*



*necessary to assess the person's safety and prognosis. The initial detention for emergency assessment should be as brief as possible, and oriented to a treatment intervention as opposed to a criminal justice intervention, and a determination of the appropriateness of further detention.*

## **1. Purpose**

To provide a pathway to emergency psychiatric assessment and intervention that does not require an initial judicial process.

## **2. Definitions**

a. "Best Interest" means it can be reasonably established by an independent party that emergency mental health evaluation and intervention will be beneficial or that the person would otherwise consent to it if not incapacitated.

b. "Emergency Medical Technicians (EMTs)" are state certified emergency responders trained to provide emergency medical care to people who are seriously ill or injured. The responsibilities of EMTs include the transport of individuals to hospital emergency departments or other facilities responsible for providing emergency or crisis care.

c. "Legally empowered persons" include (1) physicians, nurse practitioners, advanced practice nurses, and physician assistants; (2) health care providers with expertise in diagnosing and treating mental illness, including but not limited to psychiatrists, advanced practice nurses with psychiatric expertise, psychiatric nurse practitioners, licensed clinical psychologists, licensed clinical social workers, and licensed professional counselors; (3) judges and other quasi-judicial officers such as a magistrate or magistrates; (4) law enforcement personnel and emergency medical personnel and (5) legal guardians of the individual subject to treatment under this provision.

d. "Mental illness" as utilized in this section includes any mental illness in the most recent Diagnostic and Statistical Manual (DSM) In addition, as utilized in this section, people with "mental illness" include people with substance-induced mental illness, co-occurring mental illness and substance use and/or substance use disorders, and/or cognitive disability, and/or other medical conditions or disabilities contributing to the symptoms or behaviors that are the reason that emergency psychiatric intervention may be needed.

e. "Qualified Mental Health Professionals" include psychiatrists, psychiatric nurse practitioners, advance practice nurses with psychiatric training, physicians and physician assistants with psychiatric training, psychologists, and others defined in state laws as qualified to conduct emergency psychiatric assessments.

f. "Paramedics" are advanced, state certified providers of emergency medical care, with more extensive training than EMTs in providing emergency assessments, transportation, and care.

g. "Telehealth" is the use of electronic information and telecommunications to support and promote long distance clinical health care, including mental health care.

### 3. Initial emergency psychiatric assessment

a. A legally empowered person may initiate the process of obtaining an emergency assessment of an individual if there is good cause to believe that, as a result of mental illness and based on the individual's recent actions, omission, or behaviors, the individual:

(1) poses a substantial risk of

- i. attempting suicide or inflicting serious self-injury;
- ii. causing or inflicting injury on others or engaging in threatening behavior or verbal threats that arouses fear of serious harm to self or others;
- iii. being unable to provide for immediate essential needs such as food, clothing, or shelter;
- iv. being unable to protect self from victimization by others; or
- v. being unable to exercise sufficient behavioral control to avoid criminal justice involvement, or

(2) is unable to recognize symptoms or appreciate the risks and benefits of treatment and, as a result, is unable or unwilling to adhere to treatment and attempts have been made to engage the person in receiving person-centered health care and a continuum of supports and services, placing them at substantial risk of a serious deterioration in their mental condition in the near future that would result in their meeting one or more of the criteria specified in (1).

*“Good cause” may be based on an examination of the individual, observation of the individual’s behavior, and information provided by third parties, including family members, associates, or others who have observed the person’s behavior. Laws preventing the use of this third-party information in determining whether an emergency evaluation is appropriate should be examined to determine applicability, and exceptions to their applicability may need to be created.*

b. To initiate the process of obtaining an emergency assessment, the legally empowered person may, if it is safe to do so, directly transport the person or may contact the authorized transport (described in section 4), and, if the latter, should provide to the transporting authority, in writing or orally, the reason for the finding.

c. Nothing in this section precludes a person, the person’s legal guardian, or other legally authorized representative from seeking a voluntary emergency psychiatric assessment.

### 4. Safe transportation

A person for whom transportation has been requested should be transported to a location designated for an emergency psychiatric assessment by EMTs, paramedics, mobile crisis personnel, or other trained peers or crisis responders. Law enforcement officers should provide transport only when no other means are available to protect the safety of the individual or those providing the transport. Unmarked vehicles should be used whenever possible. Handcuffs or physical restraints should be used only as a last resort and limited to those persons who have been identified as risks to self or others without the use of restraints.

*EMTs and paramedics responsible for routinely transporting individuals for emergency psychiatric assessments should complete Crisis Intervention Team (CIT) training or another certified training program in crisis de-escalation and the safe transportation of persons experiencing mental health crises.*

*When transported by law enforcement, handcuffs and other physical restraints should be considered only in emergency situations to immediately secure an out-of-control individual safely. However, even if used to get an individual under immediate control, the individual should then be transported as a medical emergency utilizing soft medical restraints if necessary and not in handcuffs.*

*One or more facilities or agencies within each region or mental health catchment area should be responsible for providing a safe, secure, welcoming space for conducting involuntary emergency psychiatric assessments. Such assessment sites should be within reasonable driving distances commensurate with access to emergency medical care, and qualified mental health professionals should be available to conduct emergency psychiatric assessments, based on projected levels of need.*

*These sites should be staffed by qualified mental health professionals. Additionally, they must have the capacity to provide basic medical screening and have relationships with emergency medical facilities for those individuals who require emergency medical interventions.*

*Local jails must not be used as an alternative to an appropriate assessment site, solely to detain persons who meet the criteria for emergency psychiatric assessment. The intent of these provisions is to prevent arrest as a mechanism to access care because there is no access to emergency psychiatric assessment.*

## **5. Emergency psychiatric assessment**

a. Emergency psychiatric assessments must be conducted by a qualified mental health professional to determine whether the person meets the criteria in 3(a) for continued emergency assessment and intervention and, if so, whether the person needs continued treatment, the best type of facility or other setting in which to provide that treatment, consistent with the principle of using the least restrictive environment, and whether the individual will accept such treatment voluntarily.

*This determination should consider not only the individual's appearance and behavior in the evaluation facility but also the individual's likely risks if discharged. The psychiatric assessment and determination of risk should also consider the contributions of co-occurring substance use, cognitive impairment, and medical issues that may exacerbate current or future risk. The evaluator should make every attempt to seek input from any care providers, family members, or others who have treated or observed the individual as part of the assessment, even absent the individual's explicit consent.*

b. Emergency psychiatric assessments may be provided either on site or through telehealth. Whether provided on site or virtually, emergency psychiatric assessments must include timely access to evaluations by qualified mental health professionals.

c. Emergency psychiatric assessments shall be initiated within 4 hours of arrival at an assessment site and shall be completed within 24 hours of arrival. Exceptions to these time requirements may be made only when medically necessary, and the facility must document that additional time is required in order to provide for safe transfer or discharge.

*Assessments should comport with clinical best practice standards for such assessments, in the same way we would expect for emergency medical assessments.*

## **6. Treatment during the emergency psychiatric assessment**

During the period of the emergency psychiatric assessment, access to consultation with an appropriate psychiatric care provider must be available, in person or via telehealth, and appropriate treatment provided.

*The designated site should provide or arrange for provision of treatment interventions to address the individual's immediate health needs and take all steps necessary to determine an appropriate disposition, including 24-hour observation of the individual and contacts with family members or others with knowledge of the facts who can be helpful in providing information pertinent to determining the level of risk, and recommended next steps. If emergency involuntary psychiatric medications are necessary, they are administered consistent with relevant rules and regulations governing such administration.*

If a person receiving emergency psychiatric assessment or the family or friends of this person presents a valid psychiatric advance directive (PAD), the facility and personnel responsible for conducting the assessment should honor the individual's preferences stated therein with respect to treatment and substitute decision makers, subject to limitations prescribed by state law.

## **7. Continuing Emergency Psychiatric Treatment**

a. If, after completion of the emergency psychiatric assessment and any emergency interventions deemed medically necessary the individual continues to meet emergency treatment criteria of 3(a) and requires continued involuntary emergency mental health evaluation and intervention, the individual may be held for up to an additional five calendar days in an appropriate facility or site.

*Persons subject to continuing emergency evaluations and intervention should continue to have access to a range of services, which may include medications (consistent with relevant state law), crisis intervention therapies, engagement with key caregivers and supporters, and provision of support by certified peer support specialists. As before, this facility or site should not be an emergency department of a hospital.*

*One value of a longer hold is that it may obviate further need for involuntary treatment because either the person signs in voluntarily or they improve to the point that they don't*

*require court ordered treatment. Five days is a balance between individual due process rights and effective opportunities for treatment.*

State law should designate inpatient facilities that can provide continuing emergency evaluation and intervention. Such facilities:

- i. may be situated at the same location as the designated facility for emergency psychiatric assessment, such as a psychiatric inpatient unit located at the same hospital where there is a psychiatric emergency assessment or crisis center, at another facility qualified or licensed by state regulation to provide involuntary emergency mental health evaluation and intervention, or in a community-based residential program qualified or licensed by state regulation to provide involuntary mental health evaluation and crisis intervention services, such as a secure locked 24/7 crisis stabilization program.
- ii. must, if not situated near the initial evaluation center, be established within reasonable driving distances, commensurate with access to emergency medical hospitalization, and must have the capacity to admit individuals for continuing involuntary emergency mental health evaluation and intervention based on projected levels of the individual's need.
- iii. should provide safe, secure, welcoming space for providing involuntary emergency and/or acute mental health evaluation and intervention, and must include the capacity to integrate attention to individuals who have co-occurring substance use conditions and cognitive disabilities, as well as accommodate individuals with common medical conditions and physical disabilities.
- iv. should have capacity to provide the same services to individuals who are admitted voluntarily, or who choose to convert to voluntary status after admission.
- v. should collectively have sufficient capacity to serve individuals with or without any type of insurance coverage.

b. Under no circumstances shall it be permissible to exclude persons from these services solely on the basis of having co-occurring substance use disorders, intellectual/ developmental disabilities (I/DD), physical disabilities, or medical conditions that do not require inpatient medical care.

c. If emergency involuntary psychiatric medications are necessary, they are to be administered in compliance with relevant state laws governing such administration.

d. If a person subject to a continuing emergency behavioral health evaluation and intervention or the family or friends of this person presents a valid psychiatric advance directive (PAD), the facility and personnel responsible for providing the evaluation and intervention shall

honor the individual's preferences stated therein with respect to treatment and substitute decision makers, subject to limitations imposed by state law.

*The use and contents of PADs vary greatly, as do laws recognizing their legal force. While they may contain provisions explicitly applicable to emergency evaluation settings, they are more commonly designed for non-emergency contexts. Nonetheless, information about de-escalation strategies and medication preferences may be particularly useful in an emergency assessment process as a matter of good clinical practice.*

## **8. Disposition after the continuing emergency hold is completed**

a. The period of involuntary mental health evaluation and intervention may continue up to, but no longer than 5 calendar days from the beginning of the assessment.

b. Upon completion of the evaluation and intervention, one of the following dispositions must occur, as determined by a qualified mental health professional, in consultation with the individual and the individual's caregivers and other mental health professionals who evaluated and treated the individual:

i. Discharge and referral for voluntary outpatient, home-based, or residential services in the community when the symptoms and behaviors that gave rise to the original emergency involuntary admission are no longer present and the individual's underlying condition has stabilized or improved to the degree that the individual is able to voluntarily, safely, and effectively receive continuing treatment at a less intensive level of care, and appropriate services are available to provide that continuing treatment at the lower level of care

ii. Continued hospitalization on a voluntary basis, as determined by the treatment team in consultation with the individual and the individual's caregivers, as available, when it is determined that the person still needs an inpatient level of care and has agreed to participate voluntarily. If a voluntary patient chooses to leave against medical advice, the staff of the facility shall evaluate the individual to determine whether he or she meets criteria for continued involuntary mental health evaluation and intervention and should document that evaluation.

iii. A petition for involuntary treatment for either inpatient or outpatient treatment when it is determined that the person meets the criteria for involuntary treatment (such as those set out in Part I of this document). The decision whether to seek involuntary treatment on an inpatient or outpatient basis shall be based on an assessment of the level of care and supervision required by the individual as well as the availability of resources to provide such care. If a petition for involuntary inpatient or outpatient mental health treatment for an individual is filed, the individual is entitled to a hearing as soon as practicable, but in no circumstance longer than 7 days, in order to determine whether the individual meets the criteria for civil commitment for involuntary mental health treatment. During this period, treatment under the conditions described in section 7 should



continue, and the individual should be regularly offered the opportunity to convert to voluntary status if clinically appropriate.

*Discharge planning and a seamless transition to the community are essential to achieving long term success. While an individual's medical privacy rights must be respected, it is important to at least attempt to gather information, support, and agreement from family members or other caregivers and the individual regarding that transition and what supports will be needed in the community.*

*If a person agrees to voluntary status, particular attention should be paid to providing timely access to community care and enhanced transition services. Collaboration between all health care and supervision partners is also essential for successful transitions to voluntary community care.*

### **Part III. Medication Over Objection**

#### **Principles for the Non-Emergency Administration of Psychiatric Medications Over Objection in Civil Matters**

##### **Introduction**

After formal commitment or emergency intervention (as described in Parts I and II), mental health professionals may determine that treatment with medication is necessary. This part sets out guidelines governing when such medication may be administered over objection in non-emergency situations. The fundamental right of individuals to consent to medical treatment, including mental health treatment, is well established in American law. However, this right is not absolute. As established in cases interpreting both the Constitution and common law, in the civil setting, whether a person is inpatient or outpatient, it is acceptable to administer psychiatric medication over a person's objections on a **non-emergency** basis when three conditions are met: **First**, it must be determined that the individual lacks capacity to make treatment decisions in the individual's own behalf. **Second**, the recommended treatment must be determined to be medically appropriate. **Third**, the treatment must further governmental interests that are sufficiently important to justify overriding the person's treatment refusal.

Key concepts are clarified in the following:

**Non-emergency:** All states have legal provisions for administering psychiatric medication over objection in situations in which there is documentation of immediate risk of harm to self or others. This document does not address those circumstances, nor make any recommendations that are intended to change the existing legal capacity for emergency medication administration. This document is only intended to address those situations in which there is no immediate emergency, but there are compelling reasons to provide psychiatric medications over objection in an ongoing manner in order to prevent future harm, as described in the following.

**Incapacity:** Persons have a recognized right to make their own decisions about medication, so the administration of medication over one's objection is only permissible if that person has

already been determined to lack decisional capacity, after due process. Involuntarily medicating an individual requires a finding of decisional incapacity *plus* a determination about the appropriateness of the medication. For purposes of these recommended principles, in the context of incapacity due to a mental illness, the procedure and standard for a determination of capacity is the same as described in Part I relative to defining a “person requiring court ordered treatment.” Note that while this proposed incapacity language intentionally goes beyond traditional “danger to self and others” and “gravely disabled” standards for incapacity, cases that have allowed medication over objection have only been based on these existing standards for incapacity, along with added requirements for assessments of best medical interests and findings of important governmental interests. “Danger to self or others” has been held to be an “important governmental interest,” but whether the proposed broadened definition of incapacity in Part I, particularly (1)(c) will also be sufficient to constitute an important governmental interest has yet to be determined.

**Best Medical Interests:** Courts have held that decisions about the best medical interests of an individual are ideally made by medical professionals, based on prevailing clinical standards. This determination should take into consideration factors such as the availability of less intrusive alternatives to involuntary psychotropic medications, the balancing of benefits and side effects and other potential negative effects of recommended medications, and the existence of previously documented expressions of treatment preferences by the individual who is being considered for involuntary medication through, for example, psychiatric advance directives.

**Furthering Governmental Interests:** Courts have recognized the existence of important governmental interests with respect to involuntary psychiatric treatment under two broad constitutional authorities: the state’s right to act to protect its citizens from harm (“police powers”) and its authority to act on behalf of individuals who are unable to help or protect themselves (“parens patriae”). In the civil context, assuming other requirements are met, the involuntary administration of non-emergency psychiatric medication may be authorized when necessary to prevent future harms to self or others, even when an emergency is not involved.

**Nexus with involuntary inpatient or assisted outpatient treatment (AOT):**

The principles below assume that medication over objection will be considered only for persons who have been court ordered to inpatient or outpatient treatment. Persons who do not meet criteria in a proceeding that meets due process requirements should not be subjected to medication over their objection.

In addition, even when a person meets criteria, voluntary participation in treatment is always preferable. Clinicians should work proactively with individuals to find the most preferable treatment options. The involuntary administration of medications should be a last resort when the three conditions above are met, and the person is unable (by virtue of incapacity) to identify a preferable medically appropriate treatment option that will effectively prevent future harm.

**Guardianships:** When a person who refuses medication has a guardian of the person, relevant state law should be consulted to determine if the guardian may authorize medication. Whether or not that is the case, the principles set forth below should guide decisions regarding medication over objection for persons under guardianships.



**Psychiatric Advance Directive (PAD):** An emerging tool for achieving the balance between self-determination and the need for involuntary treatment is the Psychiatric Advance Directive (PAD). The PAD allows those with recurring episodes of disabling mental illness, while in a stable phase, to explicitly provide anticipatory legal directives for consent to particular treatment or preferences relative to specific treatment components. In some circumstances these PADs also explain past treatment histories, successful and unsuccessful, with particular medications, approaches, and strategies.

## **Principles Applicable to Involuntary Medication**

1. Basis for Treatment: Administration of non-emergency involuntary psychiatric medication should only occur if there is clear and convincing evidence, in most instances based on the individual's history of prior treatment experiences and both successful and unsuccessful treatment responses, that:
  - a. Efforts to engage the person voluntarily in treatment have been tried but have not succeeded;
  - b. The medication is effective and medically appropriate (i.e., the benefits of the proposed treatment outweigh the risks, including the risks of the treatment and the risks of no treatment);
  - c. The medication is the least intrusive strategy for ameliorating the symptoms of mental illness that led to the person's court ordered treatment; and
  - d. The person lacks capacity to make an informed treatment decision. If the person has executed a psychiatric advance directive (PAD) or another legally valid document in which the person expresses his or her preferences regarding treatment, it should be consulted in determining the most desirable course of treatment.
2. Medication over Objection Treatment Hearing: The determination as to whether a person meets the criteria in section 1 should be made by a judge or by an administrative panel containing at least one medical professional who is not involved in the person's treatment.
  - a. The person who is the subject of the hearing is entitled to be present, represented by counsel, and afforded the opportunity to present evidence.
  - b. Whenever possible, the hearing should immediately follow the hearing on inpatient or outpatient court ordered treatment.
  - c. Involuntary treatment orders should be as specific as possible and should contain information including the medication(s) to be prescribed, how adherence to the medication(s) will be monitored, and the degree to which modifications to the medications can be made without returning to court.

*The reference to administrative panels is a recognition that in some states these panels, when appropriately constituted, are permissible and effective. Ideally, this court hearing is combined with the initial determination of decisional incapacity, rather than holding a separate, subsequent hearing.*

3. Continuation of Involuntary Treatment: Administration of psychiatric medications under this provision may be authorized for the duration of the inpatient or outpatient treatment order. Efforts should be undertaken throughout this period to engage the person in a voluntary treatment process. These efforts should include working with the person to improve the person's ability and capacity to make appropriate treatment decisions regarding mental illness, and to identify alternative treatment and medication options that may be preferable. The treatment team should document regular review of the order to administer medication(s) over objection to determine whether the specific medication(s) and dosages remain clinically appropriate and serve the best interests of the individual. Procedures should be in place by which medication over objection orders can be modified without a hearing, in consultation between clinicians and the individual, to ensure that the order is best meeting the person's needs.

4. Additional procedures for implementation of medication over objection under outpatient treatment: In states that require the court to monitor individuals subject to outpatient treatment orders including medication over objection, check-in with the court should be flexible, so as not to overburden either the individual or the judicial system. If a person who is not in a hospital setting does not adhere to the court order requiring medication over objection, and the treatment team determines that continued medication remains necessary, and the person's failure to adhere to medication has led to court ordered treatment in the past:

- a. In non-emergency situations, an ex-parte order may be obtained from the judge to have the person transported to a designated emergency facility to assess the need for involuntary medication(s) and to administer such medication(s).
- b. In emergency situations (as defined in Part II Section 3 of this guidance document), the treatment team may initiate the order to have the person transported to a designated emergency facility for administration of involuntary medication(s).
- c. States may facilitate this process further by granting the physician on the treatment team who is prescribing the medication the authority to initiate the order even on a non-emergency basis.

## **Part IV. Pathways to Care**

While the focus of this guidance document is on civil pathways to care, most contacts that people with unmet mental health and substance use care needs have with the justice system are in the criminal context, and far too many people who do contact the criminal justice system have poor outcomes. Part IV of this guidance document describes opportunities for diverting people from the criminal justice system, and ways in which procedures in criminal justice can be retooled to produce better outcomes – both for public safety and for people needing mental health and substance use care.

**Pathways to Care:**  
**A Roadmap for Coordinating Criminal Justice, Mental Health Care, and**  
**Civil Court Systems to Meet the Needs of Individuals and Society**

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## **Introduction**

Almost every year, the United States incarcerates more people per capita than any other nation,<sup>3</sup> at an annual cost of over \$1 trillion in direct and indirect costs.<sup>4</sup> Yet criminalization and incarceration reduce crime only marginally, and are linked to a range of harms to individual and community well-being.<sup>5</sup> In particular, incarcerated persons have a harder time finding work and housing, are more likely to experience ruptured relationships, and are more likely to suffer from mental and physical health concerns.<sup>6</sup> Recidivism rates reflect these negative effects, with over 80% of those exiting jails and prisons rearrested or reincarcerated within 9 years.<sup>7</sup>

Populations with the lowest incomes<sup>8</sup> and with the greatest share of trauma are the most likely to be incarcerated.<sup>9</sup> These high-risk populations also include a high prevalence of individuals with mental illnesses and/or substance use. By some estimates, over 70% of individuals in jail have at least one mental health or substance use care need, and up to one-third of those in jail have serious mental illnesses, much higher than the rate found in the general population.<sup>10</sup>

**Among incarcerated populations, mental illnesses and substance use disorders are the norm, not the exception.**

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<sup>3</sup> [https://www.prisonstudies.org/highest-to-lowest/prison\\_population\\_rate?field\\_region\\_taxonomy\\_tid=All](https://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=All)

<sup>4</sup> <https://joinnia.com/wp-content/uploads/2017/02/The-Economic-Burden-of-Incarceration-in-the-US-2016.pdf>

<sup>5</sup> <https://www.americanactionforum.org/research/the-economic-costs-of-the-u-s-criminal-justice-system/>

<sup>6</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration>

<sup>7</sup> <https://www.bjs.gov/content/pub/pdf/18upr9yfup0514.pdf>

<sup>8</sup> <https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/>

<sup>9</sup> <https://www.prisonpolicy.org/blog/2020/12/02/witnessing-prison-violence/#:~:text=Even%20before%20entering%20a%20prison,of%20the%20general%20male%20population>

<sup>10</sup> See: <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-screen-codjs.pdf>; pp. 1.

People with mental health and substance use care needs spend more time incarcerated than those without those needs for the same crime.<sup>11</sup> In many such cases, assessment and health care make more sense than criminalization and incarceration from both the government's and the individual's perspective; these individuals often have diminished responsibility for their violation of law, and access to quality inpatient or outpatient health care can better protect the public and help the individual than jail or prison, especially if little or no care is provided there. Many actors in the system—including judges, lawyers, law enforcement officers, and mental health evaluators—agree with this view but have no way of implementing it.

Housing these populations in jail costs far more taxpayer dollars than providing appropriate care, supports, and services for them in the community. Incarceration can also be much more harmful to people with mental illness than others.<sup>12</sup> Unfortunately, despite clear data on the high prevalence of mental health and/or substance use care needs in the criminal justice system, traditional criminal justice systems are designed and resourced as if mental health and substance use care needs were rare. For that reason, relatively few individuals with mental health and/or substance use care needs receive therapeutic interventions, usually through specialty court dockets with small numbers of participants, and the vast majority of individuals with mental health and/or substance use care needs are subjected to “traditional” criminal justice processes.

In our view, use of the traditional criminal justice system will often be inappropriate when a major contributor to the conduct is a serious mental health condition or substance use. Further, many individuals with relatively non-serious crimes, for which there may be little or no value ultimately in prosecution, are referred by the criminal court for “competency evaluation and potential restoration,” simply for want of any other perceived alternative for providing assessment and access to care. However, competency restoration is a costly process which may provide minimal health care and is primarily focused on returning the person to legal competence in preparation for prosecution, and therefore usually does little in the way of substantially addressing a defendant's long-term health care needs or criminogenic prognosis. Most states expend enormous resources on “competency restoration” processes, with little evidence of long-term effectiveness for either the individuals involved or for public safety. Further, if, after all the cost and effort invested in “competency restoration,” the person is ultimately returned for trial, they are often released with no continuity of care, or if incarcerated following trial, they may receive little assistance afterwards. Relative to the criminal justice system generally, according to SAMHSA, currently, “few specialized treatment programs exist in jails, prisons, or court and

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<sup>11</sup> <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>

<sup>12</sup> Lea Johnston, Vulnerability and Justice Desert: A Theory of Sentencing and Mental Illness, 103 J. Crime & Criminal. 147, 158-183 (2013) (describing negative effects of prison on people with mental illness).

community corrections settings.”<sup>13</sup> By contrast, research shows that public safety is enhanced, and recidivism is reduced when care interventions are matched to the needs of the individual.<sup>14</sup>

A range of initiatives has been designed to tackle small corners of this problem with specialized programs, but the broader criminal justice system continues to function inefficiently and ineffectively because it fails to routinely match best practice interventions to prevent recidivism to individual needs, for the majority of individuals who are experiencing MI and/or SUD. Taxpayers deserve to see their limited public funds targeted to create a systematic approach with better outcomes.

Our thesis in this “Roadmap” is that criminal justice systems that are appropriately designed and structured to promote wellness and recovery for the high-volume population with mental illness and substance use disorders would save money and produce better results. While transitioning from the current state to implementation of therapeutic interventions at scale may have relatively high initial costs, provision of effective intervention at the outset is a more sensible investment than repeated ineffective interventions. In fact, repeatedly cycling people with mental illnesses and substance use disorders through the traditional criminal justice system often makes things worse. It is harmful to them, fails to rehabilitate them, and often makes them more likely to return to jail. It is time our systems were redesigned to address more effectively the astonishing prevalence of people with mental health and substance use disorders within the system.

**Our Proposal:** The often-siloed relationships among the criminal justice system, the civil system, and the mental health treatment system - should be reimaged so that all work together as partners to use resources more efficiently, make the most effective services the norm, and thereby achieve the best outcomes for this population more routinely.

**Our Goal.** Our goal is to demonstrate how to reimagine and realign use of resources to ensure that they are precisely tailored to meet the therapeutic and other needs of the populations subject to the criminal justice system. Justice system dollars are ill-spent when the bulk of funding and resources are invested in traditional criminal justice processes which do not lead to good outcomes. Further, specialized therapeutic programs such as problem-solving courts, while they move in the right direction, are essentially costly system “workarounds”, often imposing restrictive eligibility requirements based on nature of offense, degree of disorder and other variables; thus, they affect only a small percentage of people in need and bring only marginal changes in community safety and overall recidivism rates.<sup>15</sup>

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<sup>13</sup> <https://www.equivant.com/on-the-rise-the-cost-of-mental-health-care/>

<sup>14</sup> Jennifer L. Skeem & Sarah M. Manchak, Does Specialty Mental Health Probation “Fight Crime and Save Money”? A Cost-Benefit Analysis, Presentation at the American Psychology-Law Society (AP-LS) Annual Conference, San Juan, Puerto Rico (Mar. 14-17, 2012)).

<sup>15</sup> See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, J Am Acad Psychiatry Law 49(4): 517-525, 2021 (DOI:10.29158/JAAPL.210076-21)

Taking therapeutic interventions to scale would allow courts to have routine processes in place, using existing resources more efficiently, to tailor interventions to the needs of the majority of individuals (those with MI and/or SUD), while at the same time focusing improved criminal justice interventions appropriately on those who pose significant risk to public safety, rather than unnecessarily providing low-risk and low-need individuals intensive services that they do not need, and that may make them worse. These reimagined criminal justice systems would be designed to recognize that everyone presents a combination of needs including varying therapeutic needs, housing and medical needs, and criminogenic risk-needs, and achieve better outcomes through more effectively matched interventions.

More specifically, a reimagined justice and community health system based on therapeutic interventions and risk need responsivity (RNR)<sup>16</sup> principles would prioritize, at minimum: use of incentives, procedural fairness principles, linkages to community services, collaboration among systems, community integration, therapies targeting criminogenic risk and needs, and individualized treatments and programming tailored according to the results of individual assessments. Note: While preventative childhood and other “upstream” resiliency building interventions exist for a wide array of populations, this Roadmap for reform specifically focuses on adults with mental illnesses and/or substance use disorders.

**A Purposeful Focus on People in the Criminal Justice System.** Every effort should be made to address disparities in access to mental health care outside of the criminal justice system. A more robust continuum of community behavioral health responses, also tailored to individual needs, could prevent unnecessary justice involvement for many with unmet mental health needs. However, improving access to mental health care alone will do little to prevent justice involvement for a significant share of incarcerated individuals with mental illnesses, in particular those who also score high on criminogenic risk-needs assessments. Systems must also be equipped to respond with a tailored mix of criminal court supervision or connections to civil responses according to individual needs. These pathways to care can be aligned according to the Sequential Intercept Model (SIM), which is a model for visualizing the criminal justice system split into six “intercepts” or points of engagement with defendants: Community Services, Law Enforcement, Initial Detention and Court Hearings, Jail or Court Supervision, Reentry, and Community Corrections. The SIM map is described in greater detail in Appendix I. While the SIM facilitates the design of a range of pathways out of the criminal justice system and into treatment, this Roadmap provides a more detailed model for building those pathways.

**Roadmap in Context.** Inter-system collaboration among justice system actors, mental health providers and administrators, housing providers, and other community agencies is an integral part of this Roadmap. Thus, this Roadmap is intended to be both a standalone document and one part of a larger document titled *Model Legal Processes to Support Clinical Intervention for Persons with Serious Mental Illnesses*. The *Model Legal Processes* document describes a system of access to both emergency involuntary mental health care and to a range of civil court processes outside the criminal justice system, for example Assisted Outpatient Treatment, that

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<sup>16</sup> <https://www.prainc.com/risk-need-responsivity/>



facilitate legally authorized treatment interventions for acute and repeatedly unaddressed mental health needs that today often go unaddressed or are difficult to access because of antiquated legal hurdles and gaps in the system of care. The “pathways to care” mentioned above and described below will link back to other sections in the *Model Legal Processes* document in order to redirect individuals into health care and away from a tragically criminogenic justice system.<sup>17</sup> At the same time, because all jurisdictions are unique, the language and resources included in this document are intended to be adapted to suit the needs of each jurisdiction.

**Terminology.** “Deflection,” “redirection,” and “diversion” are terms frequently used interchangeably when referring to alternative procedural approaches to public safety other than traditional pathways of arrest, charging and booking, detention and correction, and so on. Deflection and redirection both refer to early-stage interventions, although deflection can also occur ahead of any justice involvement. Diversion programs often originate from and are managed by prosecutors. Diversion can sometimes amount to holding a plea in abeyance, with post-plea variations sometimes referred to as “deferred prosecution” programs. Some of the procedures proposed below divert individuals from the criminal justice system, while others integrate a health approach into routine criminal justice processes. This Roadmap will describe an array of interventions similar to, but not identical with, “redirection,” “deflection,” and “diversion,” because rather than creating an array of specialized programs, this model is designed to reorient the entire criminal system, in alignment with parallel civil processes, to find the most appropriate intervention according to the needs of each person.

**Responsibilities for Health Care.** Communities should endeavor to build out a robust set of mental health and substance use services, effectively partner with the criminal justice system to create and support deflection and diversion pathways consistent with the SIM, and proactively deliver health care supports and services, including supportive housing, with a goal of preventing criminal justice involvement.

The outsized role of the criminal justice system—from police, to prosecutors, to prisons—in responding to population health, behavioral health, and other unmet needs better served by social and health systems is widely recognized. This project aims to promote recovery and reduce the populations with serious mental illnesses in jails, in prisons, and on the streets and urges greater “upstream” investment in health-focused crisis response alternatives. While the larger document includes a model emergency intervention process, vital resources and assistance should be made available even before that emergency intervention takes place, ideally obviating its need. This document endeavors to create alternative pathways for individuals needing mental health and substance use care. Following emergency intervention, well-designed court-ordered outpatient treatment, or Assisted Outpatient Treatment (AOT), has increasingly been proven to help stabilize and integrate individuals in need of care to avoid criminal justice involvement.

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<sup>17</sup> [https://ecommons.luc.edu/cgi/viewcontent.cgi?article=1027&context=criminaljustice\\_facpubs](https://ecommons.luc.edu/cgi/viewcontent.cgi?article=1027&context=criminaljustice_facpubs)



**Who Should Use This Roadmap?** This Roadmap is to be used by state and county-level policymakers and legislators, judges, leaders and stakeholders in mental health and substance use care, criminal justice system stakeholders, and advocates, to redesign their state and/or local criminal justice systems, step by step, to increasingly redirect justice-involved individuals with mental health and substance use care needs into the most appropriate pathway based on their criminogenic risks and needs and taking into account relevant responsivity and clinical considerations. Each of the following sections is labelled according to the stakeholder to which the section would be most applicable. Legislators and other policymakers should consider the entire document, as it represents a coordinated system of management promising long-term cost savings and improved public safety and health for the entire community.

**Whom This Roadmap Will Most Affect.** This Roadmap focuses on adults, particularly adults who have entered the criminal justice system but are not yet sentenced – that is, individuals with mental health and substance use care needs who are at any criminal justice intercept point from arrest up to incarceration. Note that similar considerations apply to juvenile justice systems, and in fact, many communities have already taken these approaches further to scale in juvenile justice. The following sections describe the role of this new Roadmap in context, then lays out the Roadmap itself, including descriptions of the pathways, a visual mapping tool, and a list of assessments. Finally, Appendix III applies hypothetical case studies to the Roadmap, describing types of individuals who might follow each pathway.

### **The Roadmap: Overview**

*The following sections are relevant to all stakeholders.*

This Roadmap is based on current scientific knowledge regarding the prevalence and treatment of individuals with mental health and substance use care needs throughout the criminal justice system. Systems and care plans should be designed to ask and answer the following questions:

What are the person’s criminogenic risks and needs? To what degree did those needs contribute to the crime?

What are the individual’s mental health needs? How acute and severe are they? Did they contribute to the crime? To what degree?

Does the individual have a substance use disorder? How active and severe? Did it contribute to the crime? To what degree?

Are there I/DD, brain injury, or neurodiversity issues present? How severe? What was their contribution to the crime?

What traumas has the individual experienced? How severe? What contribution to the crime is there?

How should these experiences affect the delivery of care and related services?

Is there a significant state interest in prosecution?

In order to answer these questions, screenings must take place as described in the “Procedures” section immediately below. Screening tools and procedures allow systems to more quickly identify and respond to an individual’s needs by directing them to designated pathways suited to address the clinical, criminogenic, and other needs of the individual. The pathways are described after the Procedures section. Finally, a variety of screening tools are described starting on page 31 below.

### **The Roadmap: Procedures**

The key to responding appropriately to individuals with mental health and substance use care needs is identifying those needs as soon as possible. Ideally, every person who comes in contact with the criminal justice system in a custodial context would initially receive a validated screen for mental health and substance use care needs, and for criminogenic risk. These screenings can be conducted in the field if a responding professional is trained to perform them, or upon booking in the jail.

However, even if an individual is not screened at one of these initial opportunities, any professional in the system thereafter should be empowered to initiate a screening process, and then an additional assessment if the screening instrument so indicates. Trauma screening tools, of which several are listed on page 31, have long been used to inform clinicians about individuals’ trauma histories in order to build responsive care plans. Care planning should also incorporate trauma responsiveness.

- Any peace officer, correctional officer, or other justice system/detention staff person should have the discretion and incentive to initiate a screening and assessment procedure at any appropriate point in the process.
- Once screening and assessment take place there need to be procedures designed to ensure that the results of the screening are communicated to the appropriate entities so that – when indicated – appropriate case redirection and care coordination can begin.
- Every individual screened and identified for therapeutic intervention through this process should be provided with appropriate case management services, including linkages to appropriate community care and support based on results of the screenings. These processes could be incorporated into existing functions, such as probation or pretrial services, and could be termed “community management services.”

### **Pathways and Eligibility Categories:**

Individuals screened as described above should then be directed into the following pathways. Tools to aid decision making are listed starting on page 42 below. The pathways are described in the “Pathway Descriptions” section starting on the next page and the decision-making process to reach those pathways is visually represented in the Decision Tree on page 41 below. Note that these pathways begin at the point of arrest, but that deflection and diversion practices that keep individuals from even entering the criminal justice system are enormously important to achieving better outcomes for those individuals and for public safety.

The following pathways are described in terms of the justice system interventions designed to meet individual needs. While eligibility for each pathway is described below, descriptions of who might be suitable for the pathway is by no means exhaustive and may depend on jurisdictional preferences and resources. In general, however, low-risk, lower-need individuals should be subject to minimal oversight and supported by case management and access to quality care, while higher-risk individuals with more significant needs should be redirected to proportionate levels of supervision and care, including, when appropriate, either civil court interventions such as Assisted Outpatient Treatment (AOT), or criminal court supervision in various therapeutic interventions. Additionally, while a range of support should be offered depending on the scores generated to inform placement in a given pathway, the precise mix of care, supports, and services tailored to each individual will also not be exhaustively described below. Therapeutic interventions should be selected and offered according to the principles described above, in order to successfully integrate individuals into the community after any of the interventions listed below.

Finally, another goal of this reimagined system is to be able to limit the use of competency restoration. Competency restoration should not be used simply because there is no other pathway for the person to receive needed care. Similarly, traditional criminal justice interventions should be more narrowly targeted to the minority of defendants with significant risk and little to no mental health or substance use contribution to their criminal behavior. Competency restoration should only be considered when the state's interest in prosecution is significant.<sup>18</sup> Although the role of competency restoration and traditional criminal justice responses are recognized in some of the following pathways, their use should be limited, as they are rarely the most effective response if the individual has significant mental health or substance use care needs.

### **Key Terms**

**Mental Illness:** “Mental illness” as utilized in this section includes any mental illness in the most recent Diagnostic and Statistical Manual (DSM) In addition, as utilized in this section, people with “mental illness” include people with substance-induced mental illness, co-occurring mental illness and substance use and/or substance use disorders, and/or cognitive disability, and/or other medical conditions or disabilities contributing to the symptoms or behaviors that are the reason that emergency psychiatric intervention may be needed.

**Mental Illness Contribution:** This term poses the question, “Would the crime likely have been committed in the absence of the individual’s mental illness(es)?” The crux of this metric is to determine whether the individual’s criminal behavior is better addressed through mental health care rather than incarceration or other punitive restrictions. Research suggests that mental illness in general is not a risk factor for criminal conduct. There are clear data about criminogenic risk factors, i.e., conditions that cause crime, and mental illness is not a criminogenic risk factor. However, there are clearly individual situations where active and untreated mental illness directly contributes to particular crimes. Further, mental illness is more commonly a responsivity factor, that is, a condition that must be taken into account and treated before other interventions, criminal

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<sup>18</sup> See [Leading Reform: Competence to Stand Trial Systems](#)

justice related or otherwise, can be expected to succeed. Mental illness contribution may include co-occurring substance use and/or cognitive impairment, and courts and clinicians should determine an approach suitable to treat all co-occurring conditions, no matter the pathway. Greater mental illness contribution may correspond to greater care needs.

**Needs:** This term refers to criminogenic needs and other needs, such as responsivity needs and maintenance needs. Criminogenic needs are “[r]isk factors for criminal recidivism that are potentially changeable or treatable.”<sup>19</sup> Responsivity needs are “[c]linical syndromes, impairments, or social service needs that usually do not cause crime but can interfere with rehabilitation.”<sup>20</sup> Finally, maintenance needs are “[c]linical syndromes, impairments, or social service needs that do not cause crime or interfere with rehabilitation efforts but can degrade rehabilitation gains.”<sup>21</sup> Criminogenic risk and needs screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk needs responsivity principle. Over time, changing levels of risk (and needs) according to these assessments can help systems monitor client progress and inform supervision and care decisions.<sup>22</sup>

**Risk:** Here, “risk” refers to criminogenic risk. Criminogenic risk means the likelihood of criminal recidivism, typically, the probability of being arrested for or convicted of any new crime or returned to custody for a technical violation.<sup>23</sup> Criminogenic risk screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk needs responsivity principle. Over time, changing levels of risk according to these screenings and assessments can help systems monitor client progress and inform supervision decisions.<sup>24 25</sup>

**Severity:** This term refers to the severity of the crime. While this Roadmap moves away from “misdemeanor” and “felony” categories, a misdemeanor would almost always be a low-severity crime as would many less serious felonies, and a high severity crime would be a serious felony.

**Substance Use Contribution:** This phrase poses the question, “Would the crime likely have been committed in the absence of the individual’s substance use?” The crux of this metric is to determine whether the root cause of the individual’s criminal behavior is better addressed through substance use care rather than only through interventions targeting the criminal behavior.

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<sup>19</sup> <https://www.prainc.com/risk-need-responsitivity/>

<sup>20</sup> Id.

<sup>21</sup> Id.

<sup>22</sup> <https://www.ndci.org/wp-content/uploads/Fact%20Sheet%20Risk%20Assessment.pdf>; see also: <https://ark.nadcp.org/>

<sup>23</sup> <https://www.prainc.com/risk-need-responsitivity/>

<sup>24</sup> <https://www.ndci.org/wp-content/uploads/Fact%20Sheet%20Risk%20Assessment.pdf>

<sup>25</sup> See also: <https://ark.nadcp.org/>

## **Pathway Descriptions**

*As noted above, these pathways assume that an arrest has been made and therefore that the criminal justice process has started. While this suggested model begins at that point, the importance of deflection (law enforcement discretion exercised to not make an arrest, and to instead direct the person to crisis services or community care and support) and diversion (withholding or deferring the initiation of criminal charges) cannot be overstated.<sup>26</sup> Pathway header colors indicate recommended process based on severity of mental health and substance use contribution and criminogenic risk-needs for the individual. Header colors correspond with pathway colors represented in the decision tree. See illustration on p.13.*

### **Pathway 1:**

### **Minimize Court Intervention and Connect to Care**

Individuals best suited for this pathway score as low risk, low need, and their risks of recidivism will be significantly reduced with mental health and/or substance use care. These individuals are likely to participate voluntarily in care, and a referral should be sufficient to redirect them to care. Although communities sometimes direct low-risk individuals to therapeutic dockets, low-risk individuals are poor candidates for criminal justice system supervision and are best supported with referrals to health care and minimal criminal justice oversight.<sup>27</sup> These individuals must have enough self-awareness to engage in care without oversight, or they are considered higher risk and/or need and are better suited to Pathway 2 or 3.

#### **Eligibility:**

High mental health and/or substance use contribution, low criminogenic risk and need, low severity crime, participation must be voluntary.

#### **Pathway:**

Complete transition to health care, supports, and services and no further criminal justice oversight.

May still require a future check-in with a judge to ensure ultimate compliance.

Charges dropped or held in abeyance, pending compliance and successful participation

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<sup>26</sup> See Vera Institute, Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses and Council of State Governments Justice Center, Behavioral Health Diversion Interventions: Moving from Individual Programs to a Systems-Wide Strategy

<sup>27</sup> Learn more about this research from Policy Research Associates (PRA) at their website: <https://www.prainc.com/risk-need-responsivity/>

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Low	Low	Low-Mod	Voluntary

**Pathway 2:** Connect to Civil System for Supervision and Treatment

Few criminal court systems regularly transition suitable candidates out of the criminal system to civil court proceedings. Doing so, as described in this pathway, would preserve resources and better meet the needs of individuals to receive tailored therapies and safely return to the community.

This pathway affords more judicial flexibility because it can be tailored according to the needs and risks of the individual. This pathway is not suitable for individuals found to be criminogenically high-risk or for those who have committed egregious crimes that would justify a significant state interest in prosecution. However, an individual with high health care needs would be suitable for the increased court oversight available in this pathway. When appropriate the individual should be transferred from the jail to an appropriate crisis stabilization or other care setting. Such individuals should not be retained in the criminal justice system (in contrast to cases described in Pathway 3). Instead, the criminal charges should be dismissed, and jurisdiction should be formally transferred to the civil court system, where care plan compliance can be monitored and enforced with non-criminal consequences. In some states, this approach may be implemented by applying customary civil criteria and procedures. In other states, however, it may be necessary to formulate modified criteria and procedures designed specifically for individuals formally diverted from the criminal justice system.<sup>28</sup>

Individuals best suited for this pathway would respond best to tailored levels of oversight by the civil court system and assisted outpatient treatment plans where participants are otherwise likely to discontinue engagement with care. These individuals are low-moderate risk, moderate-high need, and likely would not have been justice-involved but for a mental health, substance use, or co-occurring mental health and substance use issue. Typically, higher levels of oversight may be considered appropriate if the individual has higher needs for care, supports, and services and/or if the crime produced a victim.

**Eligibility:** High mental illness and/or substance use contribution, low-moderate risk, moderate-high needs, low-moderate severity crime. Participation may be voluntary or involuntary (court ordered treatment though often participation is “chosen” only because of the more coercive nature of the alternative.

<sup>28</sup> See Steven K. Hoge & Richard J. Bonnie, Expedited Diversion of Criminal Defendants to Court-Ordered Treatment, *J Am Acad Psychiatry Law* 49(4): 517-525, 2021 (DOI:10.29158/JAAPL.210076-21)

**Pathway:**

Immediately transfer to civil court with petition for AOT supervision, or other civil treatment hearings.

Civil Court should be engaged in ongoing oversight, with gradually diminishing involvement, and the option to increase court involvement or transfer to criminal court as a consequence of non-adherence.

Care plan to include therapeutic interventions responsive to criminogenic risk factors.

Charges dropped upon completion of the program.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Moderate	Moderate	Low-Mod	Voluntary or Involuntary

**Pathway 3:** Supervision and Care Managed by Criminal Courts; Step-Down to Civil

High-risk individuals respond best to intensive supervision in coordination with therapies tailored to their criminogenic needs. This pathway resembles a scaled-up behavioral health court docket in that this is a criminal court operating with treatment court principles.<sup>29</sup>

Jurisdictions may be more confident in a criminal oversight mechanism with possible court-imposed ramifications for non-adherence, but this pathway should be reserved for those who are high-risk, moderate-high need, and whose risks of recidivism will be significantly reduced with mental health and/or substance use care. If an individual otherwise suitable for Pathway 2 but whose crime the state has a minimal political interest in prosecuting, Pathway 3 may also be most suitable. Please note that the traditional criminal justice interventions described in Pathways 5 and 6 are still available should the state's interest in prosecution outweigh the potential benefits of this approach for the defendant.

**Eligibility:** High mental illness and/or substance use contribution, moderate-high risk, moderate-high needs, moderate severity crime. May also include high severity if jurisdiction deems appropriate. May be voluntary or involuntary participation.

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<sup>29</sup> See e.g. Adult Drug Court Best Practice Standards, National Association of Drug Court Professionals, <https://www.nadcp.org/standards/>



**Pathway:**

Maintain criminal justice supervision in a courtroom engaging in treatment court principles such as a mental or behavioral health court, or a court with a dedicated mental health docket.

Step down civil court ordered treatment as needed to either inpatient or assisted outpatient (AOT).

Care plan to include therapeutic interventions responsive to criminogenic risk factors.

Charges frequently dismissed when the person has adhered to the court ordered conditions and has shown improvement.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	High	High	Low-Mod	Voluntary or Involuntary

**Pathway 4:** “Traditional” Pathway with Ongoing Treatment

This pathway is reserved for those whose mental illnesses or substance use had little to do with their crime. Regardless of whether the individual’s mental illnesses or substance use contributed to the crime, individuals should be offered appropriate health care, supports, and services to address their needs. Where an individual has a mental illness and assesses as low-risk, diversion should be prioritized. Incarceration of people with mental illnesses should be an absolute last resort and where it is done, appropriate health care must be made available to them. Additionally, incarcerating low-risk people often does more harm than good.

**Eligibility:** Mental illness or substance use with little or no contribution to the crime, low-moderate risk, low-moderate needs, low-moderate severity crime. Participation in diversion should be voluntary.

**Pathway:**

Coordinate referrals to care in the community. Therapies must include those targeted to criminogenic risk.

Include ongoing care and provide resources to meet identified needs, including any criminogenic risk factors or other unmet needs.

Because the mental illness did not significantly contribute to the crime, it would be inappropriate to resume prosecution for a failure to comply with or otherwise participate in recommended health care.



MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Low-Mod	Low-Mod	Low-Mod	Voluntary Diversion

**Pathway 5:** “Traditional” Criminal Justice Pathway with Ongoing Treatment

Where an individual’s mental illness or substance use has not contributed to the crime, communities should first identify whether the individual can be diverted from the criminal justice system, as people with mental illness are more susceptible to the harmful effects of punitive interventions and jail than are people without mental illness. The individual may proceed through the “traditional” criminal justice procedures, but any court, detention facility, or other community supervision department should regularly provide these individuals with necessary health care, including, if applicable, cognitive behavioral therapy or other therapies designed to specifically address criminogenic risk factors.

**Eligibility:** Mental illness or substance use with little or no contribution to the crime (may have a co-morbid cognitive disorder), moderate-high risk and need, low-moderate severity crime.

OR: No mental illness or substance use present. No impairment preventing the individual from understanding the charges brought against him or her. Significant state interest in prosecuting and/or egregious charges with no opportunity for diversion to care.

**Pathway:**

Consider other deferred prosecution or diversion program eligibility. Diversion should be voluntary. This is unrelated to the individual’s mental illness or substance use.

Proceed with traditional court processes but order ongoing therapeutic interventions if incarcerated, including interventions specifically addressing criminogenic risk and needs.

Supervised probation and/or court monitoring recommended according to risk.

Incorporate ongoing risk/needs-responsive supports during incarceration and upon release, as applicable and needed.

Generally, criminogenic risk-needs should still be addressed.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Mod-High	Mod-High	Low-Mod or Significant State Interest	Voluntary or Involuntary

**Pathway 6:****Competency Restoration – Use Sparingly**

In instances where there is a significant state interest in prosecuting someone who is incompetent to stand trial, competency restoration<sup>30</sup> should be carefully considered. Competency restoration procedures often are not health care per se, frequently result in excessive jail stays while individuals wait for restoration services and impart little long term therapeutic benefit. Because of the minimal state interest in prosecuting misdemeanors and those assessed as low risk, competency restoration is rarely appropriate for those charged with a misdemeanor, and alternatives to criminal prosecution should be utilized.

**Eligibility:** Should be limited to those cases for which the state has a significant interest in prosecuting (particularly egregious crimes) and there is a significant ongoing impairment or inability to participate in court proceedings.

**Pathway:**

Proceed with competency evaluation, restoration, and trial, only as appropriate

There still may be an opportunity for civil interventions, and those should be considered

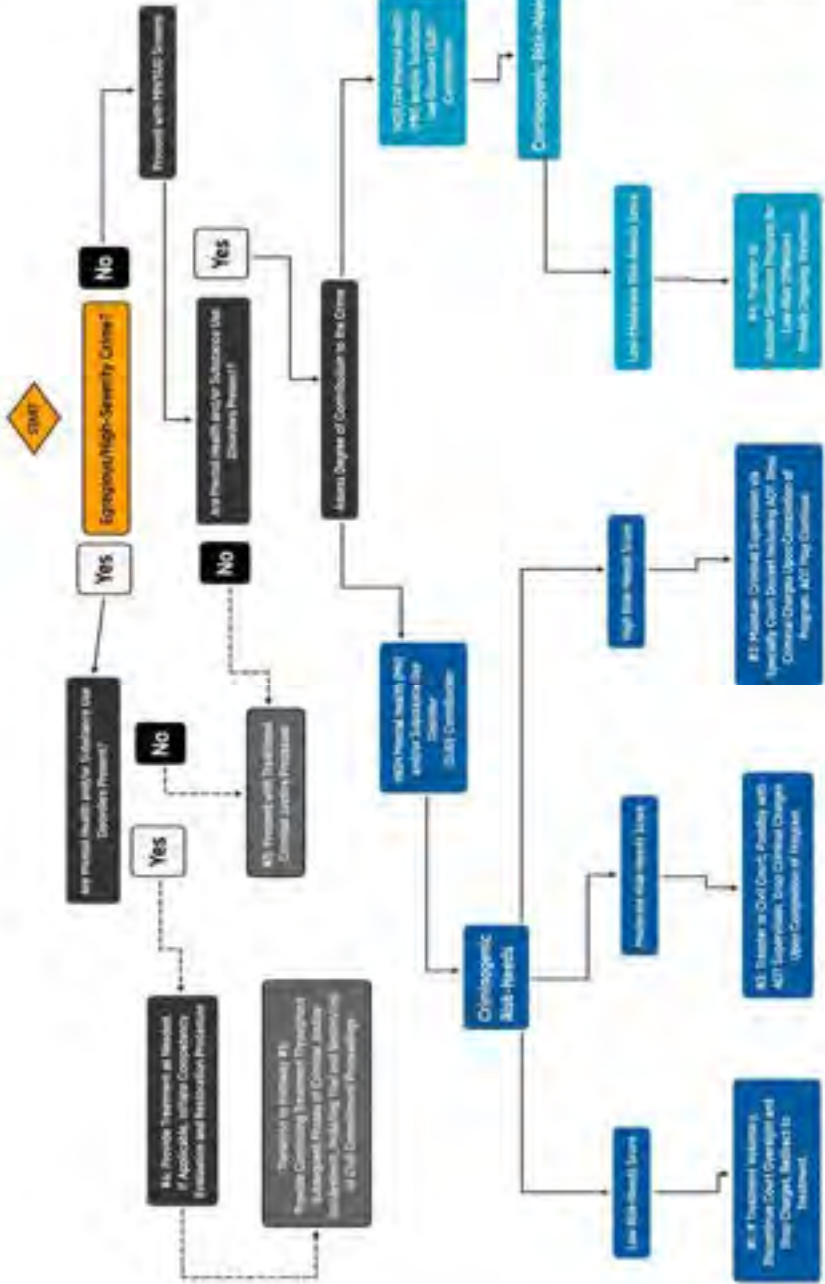
MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
MI/SUD Present	High	Any	High & Sig. State Interest	N/A

*See the Decision Tree on the next page for a visual representation of this decision-making process.*

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<sup>30</sup> For further discussion of competency restoration system issues, see <https://www.ncsc.org/behavioralhealth/task-force-publications-2/criminal-justice3/competence-to-stand-trial>

**Criminal Justice Redirection Framework  
Decision Tree**



## Screening Tools and Decision Making

*This section is most relevant to mental health providers and administrators.*

The following section includes model screening tools. Though these tools were identified by the partner jurisdictions that developed this guide, a given jurisdiction may find one or another tool more suitable to meet their unique needs.<sup>31</sup>

Screening and assessment results should be used to help make decisions about pathways into or away from court interventions at a number of points along the way. Screening results do not always align with intuitions. For example, the lowest-risk individuals, while politically safest to divert, are actually the least suitable for court supervision. Instead, communities should mandate court supervision only for moderate- to high-risk individuals. Ultimately, diversion decisions should be guided by these objective measures and each individual's needs, rather than allowing the criminal charge to be overly dispositive. Charges may be an indication of specific conduct at a specific moment in time, but the legal label for the crime often does not provide meaningful information about the defendant's suitability for a particular, tailored disposition. Instead, traits like those described below should inform the appropriateness of non-criminal options.

**Mental Health Screening.** Valid and reliable mental health screening instruments both out of custody and at jail intake can be used to help identify new health care needs (or initial health care needs) pending pre-trial release. Some screening and assessment information can also be provided directly to the court to facilitate more appropriate and tailored pre-trial orders, referral to an appropriate treatment court, and in-court responses to individuals.

Common mental health screens include:

Mental Health Screening Form-III (MHSF-III)

K6 and K10 Scales

The two most prevalent correctional or jail-specific mental health screens are:

Brief Jail Mental Health Screen

Correctional Mental Health Screen (CMHS)

*Note that there is a version for men and a version for women.*

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<sup>31</sup> For more on finding the right tool, see: Stepping Up Initiative, Implementing Mental Health Screening and Assessment; Center for Court Innovation, Digest of Evidence-based Assessment Tools; National Drug Court Institute, Selecting and Using Risk and Need Assessments.

The relative attributes of these two screens are discussed extensively in a National Institute of Justice publication: Mental Health Screens for Corrections.

**Criminogenic Risk Screening.** Criminogenic risk screening (and assessment if indicated by the screen) informs corrections, supervision, treatment, and court components of the system about how to engage with the arrestee/defendant, consistent with the risk need responsivity principle. Common risk and need screens and assessment instruments include:

The Level of Service Inventory–Revised (LSI-R)

Ohio Risk Assessment System (ORAS)

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)

Risk and Needs Triage (RANT)

**Substance Use Disorder Screening.** Substance use disorders (SUD) are associated with worse criminal justice outcomes and therefore require special and dynamic treatment strategies. Once in custody, validated and reliable screening tools should be used to identify substance use disorders to provide detention partners with an informed picture of treatment and custody needs. These tools typically include fewer than a dozen items, can be administered by non-clinicians, and are often freely available in the public domain. Many screening tools also now implicitly recognize the reality that mental health needs co-occur with substance use disorders.<sup>32</sup>

Examples of brief SUD screens include:

TCU (Texas Christian University) Drug Screen V

DAST (Drug Abuse Screening Tool)

SSI-SA (Simple Screening Instrument for Substance Abuse)

**Trauma Screening.** Trauma is a frequent responsivity factor that should be identified as early in the process as possible in order to identify appropriate treatment interventions and to avoid re-traumatizing the person while they are in treatment or custody. Widely validated and used tools include:

Trauma Screening Questionnaire (TSQ)

PTSD Checklist – Civilian Version (PCL-C)

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<sup>32</sup> An excellent treatise on why and how to effectively use screening and assessment in a justice context is SAMHSA's Screening and Assessment of Co-Occurring Disorders in the Justice System.

**Generally.** An excellent treatise on why and how to effectively use screening and assessment in a justice context is SAMHSA’s Screening and Assessment of Co-Occurring Disorders in the Justice System. This resource can further help jurisdictions identify the best tools available, according to their needs.

## **Planning for a Re-Envisioned System**

*This section is relevant to all stakeholders.*

To build the system described in this document, jurisdictions should have a change management plan including system and resource mapping<sup>33</sup>, data gathering regarding the availability of services, capacity of those services, and unmet needs, as well as project management capacity to review progress, adjust, and expand service availability as needed. Ideally a jurisdiction would have sufficient demographic and prevalence data to allow the jurisdiction to project the number of individuals likely to fall into each of the pathways. These projections can then be used to identify resource gaps and other system needs.

Ensuring cooperation among all justice system partners requires careful system planning at the outset. Leveraging iterative project development processes and data collection and analysis can ensure that processes work according to plan, partners are heard, and the project vision is achieved. Agency funding and staffing are in short supply in many jurisdictions across the country. Jurisdictions interested in long-term acute-care savings and improved outcomes for the whole community should consider the changes described in this document as a justice reinvestment opportunity. And given the central role of courts, dedicated resources should be designated to serve as points of contact and leaders in collaboration and coordination efforts.<sup>34</sup> The following steps describe recommended early planning and development steps in order to promote the adoption of best practices.

Numerous models have been developed to help jurisdictions manage systems change. The following are just some of the many available options:

The Stepping Up Initiative is a model to promote collaboration among county leadership through convening and planning to reduce the population of individuals with mental illnesses in jails.

National Center for State Courts (NCSC) offers a guide called Leading Change: Improving the Court and Community’s Response to Mental Health and Co-Occurring

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<sup>33</sup> For example, a Sequential Intercept Mapping

<sup>34</sup> See e.g. this National Judicial Task Force to Examine the State Courts’ Response to Mental Illness resource [https://www.ncsc.org/data/assets/pdf\\_file/0011/70013/BH-Recommended-Leadership-Positions.pdf](https://www.ncsc.org/data/assets/pdf_file/0011/70013/BH-Recommended-Leadership-Positions.pdf)

Disorders and a resource hub with additional information and resources at the intersection of mental health and criminal justice.

GAP Roadmap to the Ideal Crisis System, including a guide for overseeing, funding, and building a changed system. These principles can be applied to the process of building an ideal crisis system and can be adapted for building a health-oriented justice system, as described here.

Policy Research Associates Sequential Intercept Model Map and Mapping Resources can help with data gathering, identifying gaps, and planning to meet service needs.

Council of State Governments Justice Center offers a range of tools for leadership self-assessment, funding, reporting, and local policy information.

The Alliance for Community and Justice Innovation provides training and change management consultation and other resources to leaders in the criminal justice system.

#### **A. Purposeful System Planning and Assessment:**

**Oversight.** Early in the process of developing a model system to redirect justice-involved individuals needing care for mental health and problematic substance use into civil mental health care, a collaborative cross-system oversight body should be convened to plan, develop, and eventually oversee the system. This oversight body might include the following: judicial system leaders, police and sheriff leadership, local prosecutors' offices, the public defender's office, local mental health providers, hospitals, public health and social services departments, housing authorities, and other community partners. System planners should consider implementing trainings both for the oversight body itself and their staff to ensure all collaborators possess similar levels of familiarity with the guiding principles and mechanisms of the system.<sup>35</sup>

**A Shared Vision.** Long term goals should include building trust and collaboration, regularly assessing what resources currently exist and what gaps in those services need to be addressed; reduction or reallocation of spending on crisis-level criminal justice interventions; increased access and scope of health system responses; and enhanced public safety, including recidivism reduction. Data collection, data sharing, iterative problem-solving, and other regular communication strategies are also key.

**Staff.** Increased health care, supports, and services staff may well be needed over time, depending on the needs and resources of the community. These may include clinical

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<sup>35</sup> For training resources, visit Crisis Intervention Team (CIT) International here: <https://www.citinternational.org/> and the National Center for State Courts behavioral health website here: <https://mhbb.azurewebsites.net/>



staff, social workers to perform daily assessments, peer support service providers, case management and transition planning, and others.

Many jurisdictions lack adequate clinical staffing, but wherever possible, staff assignments or memoranda of understanding should be used to establish a point person with the authority to make real care plan recommendations for justice-involved individuals, with the cooperation of the courts and other justice system stakeholders.

Several jurisdictions have had success through designating coordinators or case managers specific to the intersection of mental health and criminal justice. Some use this resource as a boundary spanner, i.e., someone who can negotiate various court systems and legal issues in order to combine or defer pending cases in other jurisdictions, clear warrants, and perhaps consolidate prosecutions. Others designate coordinators to expedite assessments, referrals to service, and ancillary resources; and still others use the resource specifically to coordinate competency to stand trial issues – evaluations, transportation, and instigation to and transition from restoration services.

Peer support specialists are critical components of a well-functioning system intending to engage with individuals experiencing mental illnesses, as they help build trust and improve communication between individuals in the program and those managing and coordinating it.

## **Transition Planning: Public Safety and Courts**

*This section is most applicable to public safety and judicial stakeholders.*

After the above screenings are administered and results are gathered, a designated transition team such as a “community management services” team should be charged with transferring adults in custody into the most appropriate treatment setting. Preserving public safety is an integral goal of this process. Therefore, based on the treatment needs identified, the likelihood of compliance with court directives (based on the level of criminogenic risk), and the responsivity needs of the defendant (including mental illness and trauma history), the program team, including the prosecutors and other criminal justice professionals, should consider:

Dismissal of charges with referral to care

Pre-plea diversion or contingent dismissal, dependent on compliance with court ordered treatment and supervision conditions

Pre-plea diversion to a court-supervised civil option, such as Assisted Outpatient Treatment

Post-plea diversion or contingent dismissal, dependent on compliance with court ordered treatment and supervision conditions

Pre- or post-plea referral to an appropriate problem-solving court



## Transition Planning: Health Care

*This section is most appropriate for community mental health centers, Medicaid coordinating entities, state departments of mental and behavioral health, and similar entities.*

A well-coordinated collaborative system will delegate responsibilities at the highest levels, with practical changes affecting every level of staff involved. The following sample procedures are just a few of many that may be delegated to mental health care agencies via memoranda of understanding or other arrangements.

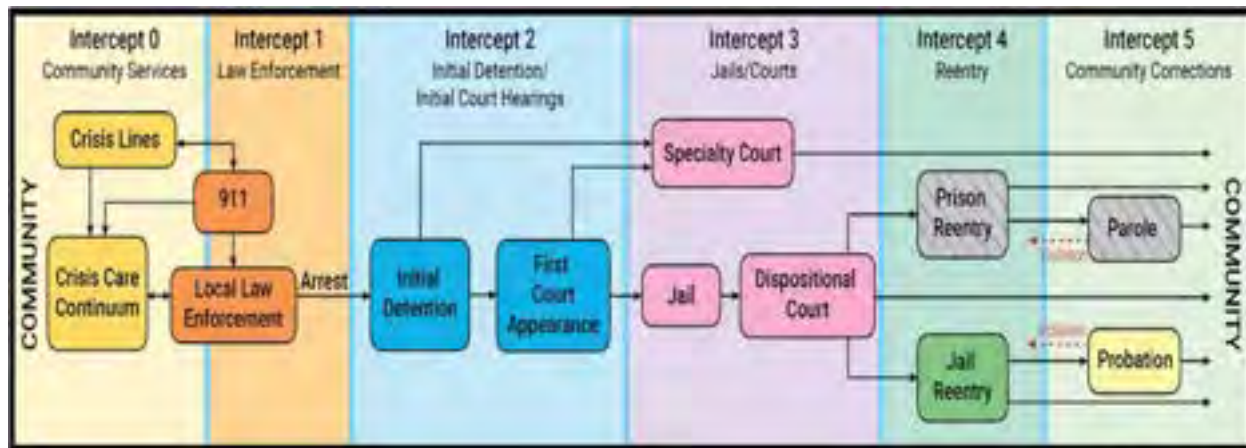
If approved for redirection to the civil system or supervised community integration:

1. All appropriate counselors and case workers will be assigned, will design the transition plan, and will obtain the individual's consent to treatment and to the release of records and other information. **See Appendix II below for the APIC transition planning model.**
2. Medical clearance is completed, and a supply of medication is provided.
3. A Peer Specialist will provide services upon release from jail including a "warm handoff" and ongoing support in the community.
4. Designated staff gather data to ensure compliance with the transition plan.

## Appendices

### Appendix I: The Sequential Intercept Model (SIM)

According to PRA, the creators of the SIM, “the Sequential Intercept Model was developed as a conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.” It provides a linear representation of the justice system with which communities may strategically plan to deflect, redirect, and divert individuals with mental illnesses and substance use disorders.



For more information on the Sequential Intercept Model, visit: <https://www.prainc.com/sim/>

### Appendix II: APIC Model

The *APIC Model* is a best-practice approach for transition planning for people meeting the criteria for redirection out of the justice system, wherever appropriate. The individuals suitable for the APIC Model plan are those with mental health and co-occurring substance use conditions, whose risks and needs must be incorporated into their intervention planning in order to most effectively promote health and preserve public safety.

APIC is not the only transition planning model, however. See SAMHSA’s website (<https://www.samhsa.gov/sbirt>) for more.

**The APIC Model provides a set of critical elements that are likely to improve outcomes for the target population. APIC is an acronym standing for: Assess, Plan, Identify, and Coordinate:**

**Assess** the clinical and social needs and public safety risks of the individual. Gather information, catalog needs, consider cultural issues, engage individual in self-assessment, and ensure access to and means to pay for services.

**Plan** for the treatment and services required to address the individual’s needs. Address critical period following release from jail, as well as long-term needs, seek family input, address housing needs, arrange integrated treatment for people with co-occurring disorders, and ensure access to medications as needed.

**Identify** programs responsible for services. Specify appropriate referrals in the treatment plan, forward treatment summaries to the provider, and ensure the treatment plan reflects the individual's level of disability, motivation for change, and availability of community resources.

**Coordinate** the transition plan to ensure implementation and to avoid gaps in care. Utilize case management services, make referral and placement decisions cooperatively, provide consumers with specific contact information for providers, and follow up with consumers who miss scheduled appointments.

### Appendix III:

**Case Examples:** These illustrations provide scenarios to which the diversion approaches that are outlined in this document can be applied. Each case below corresponds to the eight pathways in the order in which they appear above. How do the resources and culture in your jurisdiction accommodate opportunities to redirect individuals with cases like these away from criminal justice involvement and toward health supports?

#### Pathway/Category 1:

Alex normally managed his bipolar disorder well, but when stress at work became overwhelming, Alex became inconsistent with his medication and experienced a manic episode. Police were called when Alex was acting out of control, and during the encounter, Alex pushed a police officer. After being taken to jail, Alex was screened for criminogenic risk-needs and the presence of mental health and substance use issues. Alex was found to have low criminogenic risks or supervisory needs and could voluntarily participate in treatment. Even if Alex's charge would have been considered violent, Alex's risk-needs assessment indicated that Alex was not a risk to recidivate, and given Alex's low needs score and agreement to engage in community-based treatment, no further civil or criminal supervision is indicated.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Low	Low	Low-Mod	Voluntary

#### Pathway/Category 2:

Ben has a schizoaffective disorder. He had stable housing but had been previously convicted of low-level crimes. Ben was off his prescribed medication for the second time in a year. While in a psychotic state, Ben stole a cell phone from an electronics store. Ben was clearly psychotic at the time of the incident. The police were called, and because the high value of the phone made the offense a felony, he was arrested. A risk-needs assessment and a mental health and substance use evaluation were performed. Ben's moderate risk and moderate needs, combined with a property crime indicated that he was appropriate for pre-trial release and civil interventions, not criminal sanctions. Charges were deferred as a clinician at the community mental health center initiated the filing of a petition for a court hearing to determine what, if any, court oversight would be needed based on Ben's presentation. Meanwhile, Ben was connected with peer support and case navigation to ensure he would appear for his court date and access services in the community.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	Moderate	Moderate	Low-Mod	Voluntary or Involuntary

### **Pathway/Category 3:**

Connie, a young woman diagnosed with co-occurring substance use disorders, a bipolar disorder, and a with a history of very serious trauma had cycled in and out of jail and prison. Most recently, she was charged with aggravated assault (no weapons involved) while she was under the influence of stimulants. Whenever Connie was off her prescribed medications and using certain other substances, she lost control and became violent. To ensure that Connie would receive the appropriate level of support, a criminogenic assessment was conducted, confirming Connie's high risk-needs scores, and the presence of her serious mental illness and a co-occurring substance use disorder. The county's dedicated jail diversion program immediately began transition planning and referrals to treatment. Once stable, Connie needed to voluntarily agree to participate in the program in lieu of proceeding with criminal charges. The program included integrated MI/SUD treatment, a step-down court supervision process and drug screenings. Upon accepting the program, she was assigned a peer support specialist and a case manager who ensured that she stayed housed and stabilized while participating in the program. She also received treatment for her PTSD, and her treatment plan included strategies to account for her trauma. Upon successful completion of the program, charges were dropped, and Connie was connected to a community provider to continue treatment on an ongoing basis.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
High	High	High	Low-Mod	Voluntary or Involuntary

### **Pathway/Category 4:**

Don was a man in his mid-fifties with schizoaffective disorder. Several days after being evicted from his apartment, with no other housing options he broke into an unoccupied house and was arrested and charged with felony breaking and entering. He had no prior convictions, and because Don's screening indicated he had low to moderate criminogenic needs and because his illness did not directly cause him to commit his crime, he was not directed to a mental health docket or civil treatment but was instead ordered to a diversion program that provided cognitive behavioral therapy to address his criminal thinking, required periodic check-ins with probation staff, and provided housing support. Upon successful completion of the diversion program, the charges against Don were dismissed.

MI/ SUD Contribution	Criminogenic Risk	Needs	Severity	Participation
Low/ No MI or SUD	Low-Mod	Low-Mod	Low-Mod	Voluntary Diversion

### **Pathway/Category 5 – Traditional Criminal Justice Pathway:**

<b>MI/ SUD Contribution</b>	<b>Criminogenic Risk</b>	<b>Needs</b>	<b>Severity</b>	<b>Participation</b>
Low/ No MI or SUD	Mod-High	Mod-High	Low-Mod or Significant State Interest	Voluntary or Involuntary

### **Pathway/Category 6 – Competency Restoration:**

Hank was in his late 30s. He was homeless and suffered from serious, untreated schizophrenia. He believed he heard God's commands and assaulted and attempted to murder a young woman in broad daylight. Hank was taken into custody where the nature of his crime precluded him from undergoing any presumptive diversion procedures. The egregious nature of the crime necessitated pursuing prosecution and trial. The victim expressed an interest in Hank getting treatment as well. In custody, Hank received care from jail-based clinicians and was housed in a therapeutic environment in the jail while awaiting his first hearing. At the hearing, Hank's appointed attorney raised competency concerns, and Hank was then evaluated, adjudicated incompetent to stand trial, and referred to in-patient competency restoration. Once stabilized, Hank was found to have regained competency, went to trial, and the jury found him not guilty by reason of insanity, and he was then committed to the forensic wing of the state hospital for close supervision and treatment. The court takes the mental illness into consideration after the defendant enters a plea of guilty to a reduced charge and gives him credit for time served and orders that he follow the terms of the court-ordered treatment.

<b>MI/ SUD Contribution</b>	<b>Criminogenic Risk</b>	<b>Needs</b>	<b>Severity</b>	<b>Participation</b>
MI/SUD Present	High	Any	High & Sig. State Interest	N/A

### **Appendix IV:**

Colorado SB19-222 (Link to full text:  
[https://leg.colorado.gov/sites/default/files/2019a\\_222\\_signed.pdf](https://leg.colorado.gov/sites/default/files/2019a_222_signed.pdf))

### **Individuals At Risk of Institutionalization**

Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation.

### **Bill Summary**

**Medicaid - 1115 demonstration waiver - criminal or juvenile justice system prevention - mental health institute admission criteria - community behavioral health safety net system - appropriation.** The act requires the department of health care policy and

financing (state department) to develop measurable outcomes to monitor efforts to prevent Medicaid recipients from becoming involved in the criminal or juvenile justice system.

The act requires the state department to work collaboratively with managed care entities to create incentives for behavioral health providers to accept Medicaid recipients with severe behavioral health disorders. The act requires the state department to determine if seeking a 1115 demonstration waiver is the necessary response to ensure inpatient services are available to individuals with a serious mental illness. If the state department determines it is not appropriate, the state department shall submit a report to the general assembly with the state department's reasoning and an alternative plan and proposed timeline for the implementation of the alternative plan.

The act requires the state department to develop and implement admission criteria to the mental health institutes at Pueblo and Fort Logan.

The act creates a community behavioral health safety net system (safety net system) and requires the department of human services, in collaboration with the state department, to conduct the following activities:

- 1) Define what constitutes a high-intensity behavioral health treatment program (treatment program), determine what an adequate network of high-intensity behavioral health treatment services includes, and identify existing treatment programs;
- 2) Develop an implementation plan to increase the number of treatment programs in the state; Identify an advisory body to assist the department in creating a comprehensive proposal to strengthen and expand the safety net system;
- 3) Develop a comprehensive proposal to strengthen and expand the safety net system that provides behavioral health services for individuals with severe behavioral health disorders;
- 4) Implement the comprehensive proposal and the funding model no later than January 1, 2024; and Provide an annual report from January 1, 2022, until July 1, 2024, on the safety net system to the public through the annual SMART Act hearing.

## **Appendix V:**

Colorado HB22-1256 (link to full text:  
[https://leg.colorado.gov/sites/default/files/2022a\\_1256\\_signed.pdf](https://leg.colorado.gov/sites/default/files/2022a_1256_signed.pdf))

## **Modifications To Civil Involuntary Commitment**

Concerning modifications to civil involuntary commitment statutes for persons with mental health disorders, and, in connection therewith, making an appropriation.

## **Bill Summary**

Current law sets forth emergency procedures to transport a person for a screening and to detain a person for a 72-hour treatment and evaluation if the person appears to have a mental health disorder, and as a result of the mental health disorder, appears to be an imminent danger to



the person's self or others, or appears to be gravely disabled. Current law also sets forth procedures to certify a person for short-term or long-term care and treatment if the person has a mental health disorder, and as a result of the mental health disorder, is a danger to the person's self or others, or is gravely disabled. The bill modifies these procedures by:

- 1) Transferring duties of the executive director of the department of human services to the commissioner (commissioner) of the behavioral health administration (BHA);
- 2) Limiting who can take a person into protective custody and transport the person to an outpatient mental health facility, a facility designated by the commissioner of the BHA (designated facility), or an emergency medical services facility (EMS facility) if the person has probable cause to believe a person is experiencing a behavioral health crisis;
- 3) Requiring the facility where the person is transported to require an application, in writing, stating the circumstances and specific facts under which the person's condition was called to the attention of a certified peace officer or emergency medical services provider;
- 4) Requiring an intervening professional to screen the person immediately or within 8 hours after the person's arrival at the facility to determine if the person meets the criteria for an emergency mental health hold;
- 5) Establishing certain rights for a person being transported, which must be explained prior to transporting the person;

Effective July 1, 2023:

- 6) Subjecting a person who files a malicious or false petition for an evaluation of a respondent to criminal prosecution;
- 7) Authorizing a certified peace officer to transport a person to an emergency medical services facility (EMS facility) even if a warrant has been issued for the person's arrest, if the certified peace officer believes it is in the best interest of the person;
- 8) Authorizing an intervening professional or certified peace officer to initiate an emergency mental health hold at the time of screening the respondent;
- 9) Authorizing a secure transportation provider to take a respondent into custody and transport the person to an EMS facility or designated facility for an emergency mental health hold;
- 10) Expanding the list of professionals who may terminate the emergency mental health hold;
- 11) Requiring the evaluation to be completed using a standardized form approved by the commissioner;
- 12) Requiring an EMS facility to immediately notify the BHA if a person is evaluated and the evaluating professional determines that the person continues to meet the criteria for an emergency mental health hold and the *facility cannot locate appropriate placement*;
- 13) Requiring the BHA to support the EMS facility in locating an appropriate placement option. If an appropriate placement option cannot be located, the bill authorizes the EMS facility to place the person under a *subsequent* emergency mental health hold and requires the court to immediately appoint an attorney;
- 14) Authorizing a designated facility to place the person under a *subsequent* emergency mental health hold if the person has been recently transferred from an EMS facility to the designated facility and the designated facility is unable to complete the evaluation before the initial emergency mental health hold is set to expire;

15) Requiring the facility to provide the person with discharge *instructions* by facilitating a follow-up appointment within 7 calendar days after discharge, attempting to follow up with the person 48 hours after discharge, and encouraging the person to designate a family member, friend, or lay person to participate in the person's discharge planning.

Effective January 1, 2025:

16) Authorizing the BHA to delegate physical custody of the respondent to a designated facility;  
17) Requiring an extended certification to be filed with the court at least 30 days prior to the expiration of the original certification;  
18) Establishing requirements for a short-term or long-term certification on an outpatient basis;  
19) Requiring the outpatient treatment provider, in collaboration with the BHA, to develop a treatment plan for the respondent and requiring the BHA to create a one-step grievance process for the respondent related to the respondent's treatment plan or provider.

The bill establishes a right to an attorney for a person certified for short-term or long-term care and treatment, regardless of income.

The bill establishes certain rights for a person transported or detained for an emergency mental health hold or certified on an outpatient basis. The bill modifies current rights for a person certified for short-term or long-term care and treatment on an inpatient basis.

Beginning January 1, 2025, the bill requires the BHA to annually submit a report to the general assembly on the outcomes and effectiveness of the involuntary commitment system, disaggregated by region, including any recommendations to improve the system and outcomes for persons involuntarily committed or certified.



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For further discussion of competency restoration system issues, see <https://www.ncsc.org/behavioralhealth/task-force-publications-2/criminal-justice3/competence-to-stand-trial>

For a further discussion of competency restoration system issues, see *Competence to Stand Trial*, NAT'L CTR. FOR STATE CTS., <https://www.ncsc.org/behavioralhealth/task-force-publications-2/criminal-justice3/competence-to-stand-trial> (last visited June 28, 2022).

*See e.g.* this National Judicial Task Force to Examine the State Courts' Response to Mental Illness resource [https://www.ncsc.org/\\_\\_data/assets/pdf\\_file/0011/70013/BH-Recommended-Leadership-Positions.pdf](https://www.ncsc.org/__data/assets/pdf_file/0011/70013/BH-Recommended-Leadership-Positions.pdf)

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# Leading Reform: Competence to Stand Trial Systems

A Resource for State Courts<sup>1</sup>

August 2021 v2

## THE ISSUE

The majority of state hospitals maintain bed-wait lists of defendants who have been court-ordered for competency to stand trial evaluation or restoration services. A 2017 report found that in some states these waits are around 30 days, but three states reported forensic bed waiting lists of six months to a year. At any given time, there were at least 2,000 defendants waiting in jail for these beds.<sup>2</sup> During the pandemic these waits have skyrocketed, and in just three states combined, over 3,000 people were reported waiting in jail for a restoration bed. These are pre-trial defendants, sometimes charged only with misdemeanor offenses, all of whom are presumed innocent. And yet, many of them will spend far longer in jail or otherwise confined than they ever would have had they pled to or been convicted of the underlying offense.


## BACKGROUND

Of the countless ways in which mental illness and the justice system intersect, one of the most direct is when courts and judges are involved in an order for evaluation and ultimate determination of a defendant's competency to stand trial.<sup>3</sup> Any defendant, their counsel, the prosecutor, or the court can raise a concern that the defendant may be incompetent to stand trial in any criminal proceeding, from misdemeanors to capital murder. The United States Supreme Court in *Dusky v. U.S.* (1960) held that in order for a defendant to be found competent to stand trial, a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him."

If incompetence is raised, the defendant is evaluated by a mental health professional, and based on that evaluation (or evaluations) and other information, the court makes a determination of legal competency. If an individual is found incompetent, a process of restoration to competency generally commences.







During both the evaluation and restoration phases, defendants are often held involuntarily, or committed, either in jail or in a locked treatment facility. In *Jackson v. Indiana* (1972), the U.S. Supreme Court held that the nature and duration of an incompetent defendant's commitment must bear a relationship to the purpose for which they are committed. But for a variety of reasons people are often held for periods of time that bear no rational or proportionate relationship to the nature of the offense they are alleged to have committed, their level of risk to the community, or their clinical needs.

In the context of competency to stand trial, due process requires that accused persons understand the charges against them and be able to meaningfully assist in their defense. Due process also requires a limit on the restrictions on the accused's freedom during the evaluation and restoration process. These two seemingly simple propositions of due process are often interpreted and implemented in such inconsistent and ineffective ways that our systems frequently do more harm than good. In this area of the intersection of behavioral health and the justice system, the courts have an integral role and significant responsibility to identify and understand the issues and provide the leadership for change.

One of the first steps undertaken by the Task Force was the selection of eight trial judges from around the country who were asked to focus on

what they thought was working and what was not working relative to the competency processes. That two-day conversation set a solid path for identifying systemic problems and potential solutions to those problems.<sup>4</sup>

In an effort to understand all aspects of these issues, Task Force members and National Center for State Courts (NCSC) staff also engaged with other partner organizations and experts. Shortly after the NCSC focus group met, the Council for State Governments Justice Center (CSG), convened a remarkable group of experts from around the country to have a similar discussion, but from a broader perspective.<sup>5</sup> A result of that convening is the CSG product *Just and Well: Rethinking How States Approach Competency to Stand Trial*.<sup>6</sup>

This report builds on both the original interim recommendations to the Task Force and the *Just and Well* strategies to provide specific emphasis and implementation considerations from the perspective of the courts.

Many state courts are currently engaged in competency system and broader behavioral health system reform. Two regional Conference of Chief Justices and Conference of State Court Administrators summits were held in 2019, and the resulting technical assistance initiatives provided thereafter offered additional opportunities for discovery about what is and is not working, and how states are finding ways forward.<sup>7</sup>

Teams from Hawaii, North Dakota, Indiana, and Ohio, among others, identified the competency processes, and specifically the misdemeanor competency process, as area in need of reform.




State courts in each of these states initiated or participated in drafting legislation to reform the competence to stand trial systems in their states during the last year.

There have also been other efforts to gather data, identify and research best practices, and collaborate with experts on competency, including webinars, phone conferences, and joint resource development. The original focus group of trial judges reconvened in Los Angeles to observe the Los Angeles County misdemeanor and felony diversion program, housing resources,

and same-day competency evaluation process used in the Superior Court in Hollywood. They also recently met remotely to consider the impact of the pandemic on competency issues around the country, and several of these judges now serve as members of the Competency Subcommittee of the Task Force (the Subcommittee).<sup>8</sup> The Subcommittee examined and refined the original interim recommendations,<sup>9</sup> and their final recommendations were considered and approved by the Task Force in August, 2021.

## ■ RECOMMENDATIONS ■

### 1. Divert cases from the criminal justice system



The involvement of the criminal justice system with people with mental illness is all too often a result of "nowhere else to go." Unlike when someone suffers a physical health emergency, there frequently is no 24/7 emergency mental health response infrastructure. When a mental health emergency happens, the same 911 call is made, but instead of a ride in the back of an ambulance to the hospital, often the call results in a ride (with handcuffs) in the back of a police cruiser, to jail. From there, the involvement of the courts is almost inevitable. And once the courts are involved with someone who exhibits symptoms of a mental illness, legal competence is a natural issue to be raised, and an array of delays, incarceration, and other problems inevitably follow.

There are, however, alternatives to this scenario, and these alternative approaches often work better for the individual as well as the community and use limited resources and available dollars more wisely. Because jails and courts struggle to effectively address serious mental illness (SMI), moving individuals in and out of these systems can make people with SMI worse. Diverting people who experience mental health symptoms to a system where treatment can be addressed at the right level of need as something more akin to our physical health processes and facilities is a better option. Trained 911 dispatchers, mobile crisis units, co-responder models, CIT trained law enforcement, and well-designed crisis stabilization facilities are evidence-based, effective, and more humane alternatives.



These diversion opportunities also arise at each point in the competency process, and off-ramps from the criminal justice system to treatment and civil alternatives, including voluntary treatment, the use of Psychiatric Advance Directives, and even involuntary civil commitment when appropriate — such as the use of Assisted Outpatient Treatment (AOT) — should be considered at each of these points. Interventions should be tailored to the needs of the individual and the community at the evaluation stage, prior to restoration, upon return from restoration, and prior to and as a part of sentencing or other case disposition. Even individuals found incompetent to stand trial and unrestorable could take advantage of the right “off-ramp” opportunities for diversion and be linked to appropriate community services to reduce their risk of offending and returning to the competency system.





## 2. Restrict which cases are referred for competency evaluations

Even when the criminal justice system is invoked, there are still ways to divert people with mental illness from the competency road. The first potential point of diversion occurs when someone chooses to raise the issue of competency.



The constitutional standard for raising competence is quite low. The U.S. Supreme Court found in *Pate v. Robinson* that a hearing is required whenever there is a "bona fide doubt" about the defendant's competency. In recent years, the trend of raising competence has dropped steadily in some jurisdictions, yet skyrocketed in others, which suggests that local legal cultures, practical circumstances in specific jurisdictions, and individual discretion around legal strategy are driving the numbers rather than principled public policy choices. Legally, all defendants are presumed competent, and judges are under no obligation to order an examination unless there are sufficient grounds to do so.

Certainly, defense counsel have an obligation to explore all possible legal strategies on behalf of their clients, but it does not follow that competence should be raised every time there is a colorable argument. Newer defense lawyers, for example, may not have seen how the process really plays out as a practical matter and may not be aware of better alternatives to pursue for their clients.

In some circumstances, it may be appropriate to take competency off the table as a policy matter, by rule or by statute, and several jurisdictions currently prohibit the use of the restoration process for certain classes of pretrial detainees. There is a growing consensus that individuals charged with misdemeanors, for example, should rarely be subject to the competency process. They often end up incarcerated, waiting for an evaluation, then waiting for the report, then for a hearing, then for a restoration bed to open (most often in a state mental hospital), and then they begin a restoration process that on average takes several months. Next, if restored, they are frequently returned to jail to wait their turn for a final court hearing to formalize that status, and then they are able to restart the criminal trial process. By then, they have been in jail and confinement for far longer than they ever would have been had they been convicted and sentenced on day one. Often the result is that the case is now dismissed or pled to, with a sentence of "time served."

Of course there are exceptions to this scenario, and the fact that someone has been charged with only a misdemeanor tells us little to nothing about their criminogenic risks, needs, or danger to the community. But Jackson says and due process requires that the nature and duration of an incompetent defendant's commitment

**In some circumstances, it may be appropriate to take competency off the table as a policy matter, by rule or by statute, and several jurisdictions currently prohibit the use of the restoration process for certain classes of pretrial detainees.**



must bear a relationship to the purpose for which they are committed. The nature of most competency systems in our country are inherently disproportionately onerous and ponderous when applied to someone charged with a misdemeanor.

Even proposing the “bright line” of misdemeanors versus felonies as a way to presumptively cull cases from the competency system is potentially problematic, however. One risk is that defendants will be charged with felonies, when possible, in order to keep all disposition options on the table for the prosecution and the court. This dynamic is especially pronounced when there are only two options – competency evaluation or traditional prosecution. The better answer is to have a continuum of responses available to the prosecutor and court. A clinical and risk screening and assessment would suggest the appropriate level of treatment intervention and supervision required. This continuum could include:

- > A direct handoff to standard community-based treatment;
- > Diversion to a treatment program affiliated with the criminal justice system, potentially including some level of community supervision;
- > Referral to civil court options, such as civil commitment to a hospital or to Assisted Outpatient Treatment, if the defendant is treatment non-adherent<sup>11</sup> and is clinically appropriate; and
- > Other civil options such as guardianship.

Each of these options would ideally include appropriate supports, such as case management to ensure and coordinate rehabilitative or habilitative resources, such as housing, job training, public benefits, and the like.

If there are other effective options in which system players have confidence, the competency process will be used more sparingly and more appropriately. By diverting defendants to appropriate targeted interventions and services and reserving the competency to stand trial mechanism for fewer cases and for circumstances for which the process is more proportionate, resources would be better spent and the outcomes for everyone, including the defendants, would be better.



### 3. Develop alternative evaluation sites

Although some states have shifted competency evaluations to sites outside of state hospitals, they continue to take place in any number of locations — in the community, jails, courthouses, state hospitals, and in other designated secure facilities. Which of those options is used depends largely on what is available in that jurisdiction and what that jurisdiction has chosen to fund, not on what would be the most clinically appropriate. Generally, there is only one option in a jurisdiction.


Judges, when informed by appropriate screen and assessment results and by behavioral health professionals, are in the best position to make the determination



about which setting, among a range of options, is most appropriate for individual defendants. This decision should be in the context of a statute or rule that presumes that evaluations take place in the least restrictive setting appropriate for each individual's demonstrated criminogenic risk and clinical needs.

But judges cannot order evaluations in a setting that does not exist. Courts and judges have a role in advocating for these options, because if **more of the less expensive outpatient, community-based options for evaluation existed**, there would be less need to wait in jail for the evaluation, fewer transportation and other logistical issues, and perhaps better evaluations. Some of these other options are discussed in Recommendation 7.

#### 4. Develop alternative restoration sites



Similarly, there is usually only one option for restoration services in a jurisdiction, and that remains most commonly the **state hospital**. This likely leads to delays, jail time, and a **loss of liberty that is disproportionate to the purpose for which incompetent defendants are being restored**. Some states require, and others permit restoration in a psychiatric hospital. The result is that restoration services are provided only in an in-patient setting in the majority of states. Often this limit on restoration settings means there are a limited number of beds, which creates a bottleneck for the entire process and **increases jail time for these defendants as they wait for a restoration bed**. These realities point to the better options of diversion from the restoration process and to community treatment alternatives whenever possible<sup>12</sup>.

Treatment should generally be provided in the least restrictive setting that is appropriate, **so unless there is a safety to the community concern or other clinical issue, treatment should be in the community**. State statutes and rules should clearly presume less restrictive placements, and that presumption should only be overcome when the judge, again informed by objective assessment data and input from forensic professionals, finds that restoration services cannot safely or effectively be provided in the less restrictive community-based setting.

As community settings are developed and emphasized, care must be taken to maintain adherence to best practices and quality care. Decentralizing the provision of restoration services could potentially lead to inconsistent adherence to evidence-based practices, but that should not cause hesitance to move to a presumption in favor of community treatment. Instead, it should inform a system of accountability and appropriate oversight to ensure quality care. Uniform standards of care and consistent reliance on objective determinations of treatment placement eligibility are even more important as the number of restoration sites is increased and decentralized.

The advantages of decentralization outweigh the consistency concerns. The opportunities for integration of long-term community treatment and support with the short-term restoration episode are tremendous. Transitions from large restoration facilities to jail, and from jail to the community are frequently catalysts for a defendant's regression and decompensation. Changes in settings, medications, and therapeutic alliances are often problematic, and those changes can be minimized if appropriate, integrated, community settings are preferred.

Perhaps the most controversial experiment in competency restoration is jail-based restoration. Several states, under pressure to find alternatives to the long waits for restoration beds in state psychiatric facilities, have attempted to provide restoration services in jail. It should be acknowledged that this strategy does usually reduce the overall number of days the defendant is detained.

There are, however, a number of concerns about this approach. First, although jails are required to provide community-based standards of mental health services, often this is not the case. Moreover, the nature of a jail's mission for pretrial populations is to help detain defendants at risk of failing to appear and to protect public safety. As such a jail is not an appropriate setting if there is a significant need for behavioral health treatment. A recent *Journal of the American Academy of Psychiatry and the Law* review of best practices and recommendations for forensic evaluations in jails<sup>18</sup> agreed with the American Psychological Association's (APA) guidance that that competency evaluations should occur in environments that "provide adequate comfort, safety, and privacy" to ensure validity of assessments. Surely the same notion applies to restoration treatment as well.

Perhaps the natural result of this incongruity is that jail-based restoration efforts focus more on the other two components of restoration services — legal education, and medication. As discussed below, legal education has not been found to be particularly effective. Medication in jails can be critical, but may also implicate another set of problems when jail medication formularies are limited, especially with respect to certain medications that may have better results in maintaining stability of symptoms, such as long lasting injectable medications. Instead, given the transient populations within jails, they are often set up to prescribe daily dose medications, and there may be limited options of those that are readily available.

Daily dosing has its own problems with medication lines, refusals and compliance, but also with medication continuity once a person leaves the jail and hopefully transitions to more sustainable long term injectables.

**Transitions from large restoration facilities to jail and from jail to the community are frequently catalysts for regression and decompensation.**



Considering each of these factors, the recommendation is that community restoration should be the presumptive placement, and that jail-based restoration should only be considered when:

- > It is clear that the individual does not have a more acute clinical treatment need;
- > The only alternative is a wait of many months for a treatment bed that is not medically necessary;
- > The jail program is treatment focused and has appropriate medications available;
- > There are clear efforts at continuity between the restoration program and other settings where the person may be sent; and
- > Even then, because of the importance of addressing conditions of confinement in jails more broadly, funding separate jail restoration should be only a temporary option while other system reforms are in progress.

## 5. Revise restoration protocols

The seminal guide to best practices in competency evaluation and restoration is the *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*.<sup>14</sup>

### AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial

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#### Statement of Intent and Development Process

This document is intended as a guide to assist judges, attorneys, and mental health professionals in the evaluation and restoration of competency to stand trial. The guideline was developed through the participation of forensic psychiatrists, psychologists, and other mental health professionals, and was reviewed and approved by the American Academy of Psychiatry and the Law. The guideline is intended to be a guide to assist judges, attorneys, and mental health professionals in the evaluation and restoration of competency to stand trial. The guideline is intended to be a guide to assist judges, attorneys, and mental health professionals in the evaluation and restoration of competency to stand trial.

#### Guidelines

1. Assessment of competency to stand trial should be conducted by a qualified mental health professional. 2. The assessment should include a clinical history, a mental status examination, and a review of the defendant's legal rights. 3. The assessment should be conducted in a timely manner, and should be repeated if the defendant's condition changes. 4. The assessment should be conducted in a confidential setting, and should be documented in writing. 5. The assessment should be conducted in a setting that is appropriate for the defendant's needs. 6. The assessment should be conducted in a setting that is appropriate for the defendant's needs.

The authors evaluated the available research to determine best practices for, among other things, restoration approaches. While some states focus almost entirely on legal education in an effort to allow the defendant to demonstrate their ability to "consult with his lawyer with a reasonable degree of rational understanding," others prioritize treatment of the underlying mental illness.

This should not be an either/or approach, and there is some consensus that, given that most individuals found incompetent to stand trial have challenges stemming from symptoms of serious mental illness, medication is the most important catalyst for successful restoration. One meta-analysis of the research further concluded that "(t)he benefit of adding educational programs to medication protocols for competency restoration of non-developmentally disabled defendants

has not been clearly established."<sup>15</sup> There is an evolving recognition that there is value in all

three approaches — medication, individualized treatment, and legal education, to varying degrees depending on the individual defendant's overall needs. As such, given the value of restoration slots or beds, and given the potential for backlogs and delays to ripple through other parts of the system, care must be taken to prioritize getting defendants what they need when they need it rather than making restoration a one-size-fits-all strategy in one state hospital location.

The duration of time individuals spend in restoration programs is another important consideration. The rate of successful restoration for individuals with serious mental illness is relatively consistent across the various systems (80% to 90%), but the length of time defendants spend in restoration programs

around the country varies greatly. Some studies identified mean restoration periods of 60 days, while others documented mean times of a year or more.

One factor in the length of the process is the court's involvement in oversight and monitoring. When court involvement is too passive, the length of the restoration process can be longer, and the *Jackson* requirement for alacrity and proportionality lands at the court's doorstep. Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process. Court reviews of the process should occur early and often, and clinical discharge readiness decisions should be met with timely court consideration and authorization. When the courts control the back door of the restoration units, new individuals wait for admittance. Partnership with the treatment providers and trust in them to establish individual readiness for discharge from programs once clinically appropriate should be taken into account by judges.

While there is evidence that a court review of restoration status at 30 days is too soon, 45 days seems to be a potential sweet spot at which sufficient time has passed to allow medications to work and progress to be made. One of the AAPL reviewed studies found that almost half of the defendants in that sample were restored at the 45-day mark. While there is not sufficient research to recommend setting hard restoration timelines, this dynamic does have implications for case management, and perhaps initial status or review hearings should presumptively be set 45 days from the initiation of restoration services.

**Active court oversight of the restoration process and collaborative involvement with treatment professionals is more likely to produce energetic restoration efforts and a more timely, effective, and constitutionally compliant process.**



## 6. Develop and impose rational timelines

Beyond the *Jackson* directive to limit the length of pre-trial detention, there is no specific, uniform constitutional timeline for the various stages of the competency process. In *Oregon Advocacy Center v. Mink*,<sup>16</sup> the 9th Circuit, citing *Jackson*, found that Oregon violated a defendant's due process rights if the defendant was not transferred to the Oregon State Hospital within seven days of a court's commitment to the hospital for restoration. This is one of very few times a court has specified a required timeline, and that timeline only speaks to one part of the process. However, to the extent this fixed timeline poses significant logistic and resource challenges, it should serve as a catalyst for proactive collaboration among system partners to themselves develop workable and appropriate timelines rather than leave it to civil rights litigation.<sup>17</sup>



Delays can and do occur: (1) waiting for an evaluation after competence is raised, (2) waiting for the evaluation report and for a hearing on the findings of that report, (3) waiting for a judicial decision after that hearing, (4) waiting for a restoration slot after incompetence is determined, (5) waiting for restoration status reports and hearings on those reports, and finally, (6) waiting for a final legal determination of restoration. A separate issue arises when a defendant is deemed unrestorable. The length of detention and the resolution of those cases is another issue that states should review, including an examination of the processes for potentially transitioning to a civil commitment in those circumstances.

At each of these steps in the process there is an opportunity for delay, and also an opportunity for speed and efficiency. While there is no single time-standard answer for all jurisdictions, it is crucial that individual states address this timeliness issue and establish presumptive timelines through tailored statutes or rules as applicable. While some of the steps are largely controlled by case management decisions of the court discussed below, others are cross-jurisdictional and cross-branch issues that require the synchronization of several disparate parts. They, therefore, require collaborative consideration of each of the following timing issues:

- > The time from when doubt is raised to evaluation should be as brief as possible. Often defendants are incarcerated at this point, and frequently this is at a time shortly after arrest and perhaps a mental health crisis. A clinical response should be prioritized, and that response may inform the timing of an evaluation. In some circumstances it may be appropriate to wait for the defendant to stabilize, such as in the case of stimulant psychosis.
- > The time from the administration of the competency evaluation until a judicial determination of competence should also be brief. While largely a judicial scheduling issue, jurisdictions should ensure that evaluators, counsel, and the court all communicate about delays, and that scheduling these hearings be prioritized by each. There are also ways in which report templates and other aspects of evaluator training can facilitate quick turnaround times, and those are discussed in the next section.
- > Once a person is found incompetent, the *Jackson* considerations come into play, and the obligation to initiate restoration service promptly begins. While *Mink* finds that taking more than seven days to begin treatment violates the constitution, each jurisdiction (outside of the 9th Circuit) should carefully consider what timeline target makes legal and practical sense for them, while also considering that not all defendants need to go into a state hospital for restoration, and thus timely access should include access to alternative community-based restoration sites and models.
- > As discussed above, the first court review of the restoration process should occur quickly, as a significant portion of this population attains competence shortly after clinical stabilization, and often appropriate medication. Subsequent court reviews should also be frequent and meaningful, i.e., the court should ensure that the defendant is transported, that meaningful reports have been prepared and reviewed by all parties, and that treatment progress is maintained. Court liaisons or navigators can be particularly helpful in ensuring that these hearings are meaningful and productive, and that progress is maintained. Their role is discussed further below.



- > The maximum time a person can be maintained in a competency restoration program varies wildly from state to state. Often the possible duration is tied to maximum potential periods of incarceration, but those periods of time may be wholly incompatible with Jackson, and should be reviewed. There is also often confusion about the process to be followed when those time limits are reached — whose responsibility it is to file for a civil commitment, for example. These processes should be clear, and appropriately quick.

As difficult as that synchronization of disparate parts and interests may be, the payoffs could be huge. A recent effort to apply mathematical modeling to delays at each part of the competency process identified some remarkable opportunities:

The model validates that relatively small changes to specific variables that are determined or influenced by public policy could significantly reduce forensic bed waits. The following examples illustrate the outcomes projected by modeling data from the sample states:

- > Diverting two mentally ill offenders per month from the criminal justice system in Florida reduced the average forensic bed wait in the state by 75%. From an average wait of 12 days in early 2016, the average wait fell to three days.
- > Reducing the average length of stay for competency services by less than 2% in Texas — from 189 to 186 days — increased forensic bed capacity sufficiently to reduce bed waits from 61 to 14 days.
- > Increasing the number of forensic beds by 11% in Wisconsin — from 70 beds to 78 beds — reduced IST bed waits from 57 days to 14 days.<sup>18</sup>

These savings and improvements should be a strategic priority for all state courts and for our competency system partners.



## 7. Address operational inefficiencies

At each step of the process there are opportunities for refinement. Below are examples, but these are only some of the operational opportunities to improve the overall effectiveness of the competency system:

### **Evaluator training, availability, and speed**

In many states, the availability of qualified forensic examiners causes significant delays. One common cause of the lack of availability is funding for positions and compensation rates for the examiners, both of which should be addressed, but there are other operational strategies that have worked in some jurisdictions.

For example, in Massachusetts, every district and superior court has access to same day clinical competency evaluations conducted by state behavioral health staff or contracted providers of the state behavioral health system. Although thousands are done each

year, this allows for “screening” to take place so that only the most ill are referred for further evaluation as inpatients — where they likely clinically belong.

In Los Angeles, a small roster of psychiatrists is paid relatively well for conducting evaluations on a known schedule, for a set number of defendants, for a predetermined number of hours, at the same place each time. This predictability encourages engagement of the psychiatrists and consistency in their evaluations. Once a defendant is referred for evaluation and transported to the Hollywood court, they are evaluated in the morning, the disposition is in the afternoon, and transportation is immediately accomplished. Not every jurisdiction may be able to achieve this level of efficiency, but the principles that underly this success are replicable, and more of those principles are discussed below.

While in almost all cases the availability, qualifications, compensation, and training of forensic evaluators is not a responsibility of the judiciary, assuming control of all of those factors is an option. This would require strong clinical involvement to ensure clinical quality, but Arizona’s court system sets the qualification for evaluators, trains them, and directs payment to them. While this may be a unique circumstance, it should not be completely foreign to court systems, many of which directly employ mediators, custody evaluators, interpreters, and other direct service providers in instances where the performance of those services is integral to the operation of the courts.

Another useful strategy that endeavors to make the most efficient use of evaluator resources is the consolidation of evaluations. In some places this means bringing evaluators to the courthouse to do batched evaluations, in conjunction with a consolidated calendar to ensure sufficient volume to make it worth it. In other cases, it may mean regionalization of competency cases to bring the defendants from a number of smaller jurisdictions to one evaluation site.

Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations. As more jurisdictions are using teleservices for more purposes, often behavioral health related, there is more opportunity for assessment and evaluation of those strategies. The research results so far are quite encouraging. An initial randomized control trial conducted pre-pandemic and reported in the *Journal of the American Academy of Psychiatry and the Law* found that using a telemedicine evaluation produced assessment scores consistent with the in-person evaluations, that patients had no preference for in-person versus remote evaluations, and that the evaluators preferred the in-person option.<sup>78</sup> Given the rapid shift in the use of video technology for evaluations in the COVID-19 context, the preference of clinicians and courts may also evolve as more is learned about the values of more widespread use of this technology.

A 2018 review of that study and others that have followed, and the emerging legal findings, concludes that “[T]he use of (videoconferencing) can be a viable way to meet the demand for timely adjudicative

**Evaluator availability and efficiency can also be dramatically enhanced by the emerging option of video forensic evaluations.**



competence evaluations... [These] evaluations make the most sense when they improve the efficiency of services while maintaining the same standards of quality of traditional evaluations...<sup>20</sup> which they seem to have great potential to do.

To the extent that the obstacle to greater use of remote technology for evaluations (and other assessment and treatment) is attitudinal, recent events have likely increased everyone's level of comfort and proficiency with virtual options.

These strategies all support the model of evaluations taking place somewhere other than in a psychiatric hospital, though around the country that is still the most prevalent practice. The other emerging custodial approach is to conduct evaluations in jails, which is an option in at least nine states. While ironically this may in fact reduce the amount of time defendants spend in jail awaiting an evaluation, there are serious questions about the appropriateness of conducting forensic inquiries in jail. An entire 2019 *Journal of the American Academy of Psychiatry and the Law* article is devoted to the incongruity between the professional guidelines that specify such evaluations "should take place in quiet, private, and distraction-free environments," and the realities of a jail environment.<sup>21</sup> Some states have office space in courthouses devoted for evaluations even if the evaluatee is required to be detained in jails. However, in some jurisdictions evaluators navigate space within the jail where issues of privacy and noise can hamper quality of the assessments. More data and research on these options are needed.

**Translating behavioral health system processes and requirements to a criminal justice context, and vice versa, has shown to benefit all of the system players by saving resources and more effectively delivering behavioral health services and access to justice.**

### **Evaluation templates**

Regardless of how well trained an evaluator may be, different professional backgrounds, experiences, training, and preferences lead to different approaches to evaluation processes and reports. These differences can be helpful, such as the different perspectives of a psychologist and a psychiatrist. But when the reports themselves are dramatically different in content, style, and structure, delays and miscommunication may result. A number of states employ evaluation report templates, so that the readers — judges, lawyers and other clinicians — have a consistent experience in reviewing a report. This can ensure that all required statutory elements are addressed, factual background and detail are consistent, and conclusions and recommendations are legally sufficient. Different approaches and assessment tools can still be accommodated, but the presentation would be consistent. Whether a template is used or not, there should at least be specific drafting guidelines, and adherence to those guidelines ought to be required.<sup>22</sup>

## **Multiple opinion requirements**

The issue of how many evaluations and expert opinions are needed to make an informed decision about competency is largely an issue of local or state legal culture. Many jurisdictions are satisfied with one evaluation. Some allow for a second evaluation if an opponent disagrees with the initial results, and some jurisdictions begin with a requirement for two evaluations, and then an automatic “tie-breaker” if the opinions differ. There are some jurisdictions that allow even more than three forensic evaluations, though to what end is not clear. If more than one evaluation is required, one time-saving measure employed in some jurisdictions is to have the evaluators conduct the evaluation collaboratively, at the same single interview.

Various parties may push for multiple evaluations, including the litigants and the judge, each for various reasons. While legal customs (and the statutes and rules that enshrine them) are difficult to change, two things may gradually discourage this resource drain. First, if the timelines discussed above are imposed for the evaluation process for the time from referral to report, multiple evaluations may become impractical.

Second, below is a recommendation that competency teams be deployed — a team would consist of a judge, prosecutor, defense counsel, and a small cadre of neutral, objective evaluators. Some existing programs have found that the secret to efficient and fair processing of competency cases is trust, trust developed over time by frequent interactions, and enduring relationships. If the actors all had more experience with and trust in the evaluators, perhaps there would be less of an inclination to seek redundant evaluations, resources would be saved, and timeliness enhanced.

## **Case managers and court liaisons**

Several states have begun to use court connected or court employed personnel to provide case management-like functions for the court. Colorado calls them court liaisons, Washington calls them forensic navigators, other states refer to them as boundary spanners, but the function is essentially the same: bridge the behavioral health and criminal justice systems to more effectively manage individual defendants’ circumstances.

In a competency context, this case management role can facilitate the pairing of defendants and evaluators, identify services that would allow the evaluation and restoration process to occur in the community instead of a custodial facility, ensure appropriate attention is paid to timelines and resource coordination, and generally make sure that cases do not fall through the cracks. Translating behavioral health system processes and requirements to a criminal justice context, and vice versa, has shown to benefit all of the system players by saving resources and more effectively delivering behavioral health services and access to justice.

## **Court case management – centralized calendars, frequent reviews, and teams**

How an individual judge and a court system manage competency cases can make a dramatic difference in the process.



### > Centralized calendars

Calendar practices are another area of longstanding legal culture, and change can be difficult. Depending on the size of the jurisdiction, competency cases may be few and far between, or they may be an everyday occurrence. In either event, combining whatever cases there are and sending them to one judge (or more if the volume requires) will result in a more proficient judge. Law school, and most law practices, do not develop fluency in issues of psychotropic medication, therapeutic alliance, the DSM-5, and the myriad of other terms and issues that are the everyday concerns of competency to stand trial proceedings. But the nuances and context of these and other issues are central to getting it right in these cases. That fluency only develops with repetition and exposure to those issues. Court staff also benefits from repetition with these terms and processes.<sup>23</sup>

Another advantage of consolidation or centralization is that the ancillary resources implicated in competency cases are just that — ancillary, and they (forensic evaluators, treatment providers, hospital staff, community providers, public defender social workers, etc.) are rarely dedicated only to these cases. Bringing them together at a consistent time and place with familiar faces and predictable processes is more efficient for them and for the court.

### > Frequent reviews

Because of the huge impact that timeliness can have, frequent reviews at each stage can have an important effect. Cases — and people — can languish if the system players are not held accountable. The delays mentioned earlier, from referral for an evaluation to delivery of the report, from the order of commitment to restoration to transportation to a facility or to release to a community resource, and from status report to status report from a restoration services provider, all benefit from court oversight and accountability. Human nature is to procrastinate, and frequent brief but meaningful and productive court reviews provide deadlines that spur action and progress.

### > Teams

Centralized, coordinated calendars and frequent reviews are much easier if there is a competency team — judge, prosecutor, defense counsel, and evaluator(s). This team can also include whatever other resources are involved, such as a forensic navigator or case manager, state hospital representative, local mental health provider, etc. Some of the benefits to a team approach have been alluded to above, but essentially the advantage is proficiency. As with the judge, prosecutors and defense counsel learn about the mental health system and mental illness through experience,

**Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the adversarial process and focus on the operant ones.**

and with more experience comes the same more nuanced, contextualized understanding of competency law, psychiatry, and community behavioral health resources. That understanding allows them to be better advocates, and hopefully that leads to more just results.

A team approach also makes scheduling much easier for the court and for the other partners. Continuances and no-shows decrease if everyone has the same calendar and the same regular, predictable schedule.

But the most important benefit of the team approach is the efficiency that comes with predictability and trust among team members. Without abdicating their legal and ethical responsibilities, team members can nonetheless reduce the nonproductive steps in the adversarial process and focus on the operant ones. That predictability and trust can lubricate the otherwise clunky competency machine and make it run more smoothly.

## 8. Address training, recruitment and retention of staff

Many of the inefficiencies in the competency process have their roots in the lack of a sufficient behavioral health workforce. If there are too few qualified evaluators, for example, jurisdictions either lower the evaluator qualifications or they have waitlists for evaluations, or both. More forensic psychiatrists and psychologists are needed, and some systems have begun to actively incentivize that career track, but progress is slow. Communities have also expanded competency evaluations to other disciplines including social workers, and this can be another consideration. Again, with the use of video technology, more efficient access to an appropriate workforce may be facilitated.


Rural communities are particularly understaffed, and incentives to locate in those communities could be helpful. As noted, technology solutions are part of this issue, but likely cannot be the only answer. Attention to the racial and ethnic makeup of evaluators and others is also necessary, in order to promote trust and confidence in evaluators and the evaluation process.

The solutions are bigger than those that the judiciary alone can implement, but courts do have a stake in the outcome and a role in sounding the siren and focusing attention on the professional resource shortage problem.





## 9. Coordinate and use data




Some policymakers and funders respond most acutely to personal stories that illustrate a need, and others gravitate to data. The competency to stand trial problem certainly has no shortage of the former, but more and better data is also needed. The coordination of law enforcement, behavioral health, jail, and court data is difficult. There are disparate data elements, definitions, client identifiers, and technical systems.

Money is one motivator for good data collection and coordination, and some of the best data come from jurisdictions where a managed behavioral health care system demands it. Arizona has such a system, and the crisis care continuum there is gaining notoriety because of those data. They show that early intervention and diversion from the criminal justice system saves money, so investment in those strategies takes priority.

The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners. SAMHSA developed an “Essential Measures” guide for data collection across the SIM,<sup>25</sup> and the National Center for State Courts has a recently retooled behavioral health data elements guide as well.<sup>26</sup> However, it is not clear that there is a consensus about what competency process data should be collected or that there is any urgency about compiling those data.<sup>27</sup> This coordination and compilation can be a bit of a Sisyphean task, but one that state courts should nonetheless pursue to help drive system improvements.

**The courts have a significant role in identifying common data elements and coordinating data collection with law enforcement, jail, and treatment partners.**



## 10. Develop robust community-based treatment and supports for diversion and re-entry

The first recommendation above is to divert people with serious behavioral health issues and their cases from the criminal justice system, but a common refrain in the mental health context is, divert to what?<sup>28</sup> The simple answer is to divert to treatment, but the treatment system is often anemic at the pre-arrest community level, at the post-arrest correctional level, at the pre-trial and post-conviction level, and at the point of re-entry to the community. All system partners readily agree that the entire treatment continuum needs to be strengthened.



Concomitantly, there needs to be a continuum of legal avenues to access those services. Criminal court avenues exist, albeit imperfectly, and are often used out of necessity, but a range of civil legal options that can be used to access treatment are also essential. AOT, guardianships, conservatorships, psychiatric advance directives, and other less restrictive options that can be accessed at different stages of a person's diversion and re-entry path are essential to long-term success.

Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing. As much effort needs to be made to ensure a successful community reintegration as was made to intervene in the first place, or all of the resources spent to achieve stabilization and wellness are for naught.

As judges are increasingly expected to assume a problem-solving role rather than a strictly adjudicative one, the need for appropriate treatment options becomes more imperative. It is perhaps unfair to ask judges to manage defendants with mental illness and to hold them accountable for those outcomes without providing the courts the treatment tools and dispositional resources they need. This is one reason that courts and judges have such a substantial interest in leading change in this arena.

Treatment in this context is not just strictly mental health treatment, but also involves aspects of care related to substance use disorder treatment, supports for individuals with intellectual and developmental disabilities, and culturally competent services for veterans, as well as ancillary supports like case management, cognitive behavioral therapy related to criminogenic risks and needs, and wrap around services. Homelessness is also often a companion to mental illness and arrest, and judges and communities are always in need of housing options for defendants with mental illness who are entangled in the competency web — pre-trial, and upon community reentry. Robust treatment, supervision and support options throughout the process are essential if we are to expect better system outcomes and better outcomes for the individuals involved.

**Re-entry to the community from wherever the person exits the competency process needs to be coordinated, seamless, community focused, and with abundant supports, including transitional and supported housing.**

## ■ CONCLUSION ■

The competency to stand trial process is just one segment of the broader intersection of mental health and the criminal justice system, but it is one that is squarely within the judiciary's ambit. Significant system reform requires strong partnerships with local entities and with state entities in other branches of government.<sup>28</sup> For both institutionally necessary and for altruistic reasons, courts and judges should embrace the issues and actively pursue solutions.<sup>29</sup> **The complexity of the system and the siloed nature of the services cry out for collaboration and for leadership; and the judiciary is in a unique position to not only convene, but to lead.**

While the rules, statutes, resources, and processes related to competency to stand trial differ widely from state to state, there are common issues, and there is significant room for improvement in all states. This checklist provides a brief, task-oriented roadmap to assessing and reforming your competency system. It should be read in close conjunction with the companion Task Force product *Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts*, and the resources identified therein.

1. **Convene an interdisciplinary team to examine all aspects of the competency system and to make and advocate for recommended changes** This team should include legislators, executive branch representatives including the state mental health authority, local mental health providers, court administrators, prosecutors, defense counsel, jail administrators, state mental hospital representatives, competency evaluators, judges, and others as appropriate in your system.<sup>30</sup>
2. **Review *Leading Reform: Competence to Stand Trial Systems – A Resource for State Courts* and the materials referenced therein** Issues specific to statewide court systems are described, and the resources cited provide additional research, context, and insight helpful to court leaders and their partners. This may also be the time to consider the resources you have, and potentially to seek assistance from experts in the field, including technical assistance from the National Center for State Courts.
3. **Identify and gather data related to the competency process** Court filing and disposition information, jail data including screen and assessment results and relevant wait times, evaluation outcome and timeliness data, restoration outcome and timeliness data, and other overall timeliness and wait time or waitlist information.
4. **Review the crisis care and justice system diversion systems for opportunities to divert people with mental illness from the criminal justice system**<sup>31</sup>
5. **Identify opportunities to divert defendants from referral to the competency evaluation mechanism** This includes statutory or rule changes, and prosecutorial initiatives to link defendants directly to treatment rather than to an evaluation, either with a dismissal, a diversion agreement, or a referral to Assisted Outpatient Treatment, if appropriate.<sup>32</sup>
6. **Identify existing competency evaluation protocols, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based evaluators.



- 7. Identify existing competency restoration locations and processes, develop outpatient community options, and create a presumption to use those community sites unless unsafe or clinically inappropriate** This may require funding stream changes, and development and training of a new cohort of community-based restoration treatment providers.
- 8. Revise restoration protocols and timelines** Review best practices for restoration interventions and emphasize clinical treatment resources. Develop consensus about reasonable timelines for referral to and commencement of treatment, and about the reasonable duration of restoration services. Legislative change may be needed for some reforms.
- 9. Examine the qualifications, selection, and training of evaluators** Limit the number of automatic evaluations ordered, and then set the qualifications of evaluators as “high” as feasible given a potential reduction in the number of evaluations and set firm timelines for the completion of evaluations. Create a protocol for remote evaluations, particularly for rural areas. Develop a robust evaluator training curriculum, with a requirement for continuing education.
- 10. Collaboratively develop an evaluation template and require its use** Seek input from forensic psychiatrists, judges, prosecutors, and defense counsel to create a template that is consistent and meets legal and clinical needs.
- 11. Consider the creation (or expansion) of a court-connected case management role** Also called forensic navigators, boundary spanners, and court liaisons.
- 12. Centralize or consolidate competency calendars and implement a team approach** Refer cases in which competency is raised to one calendar, with the same judge, counsel, and added case management resources.
- 13. Establish a requirement for frequent, meaningful court reviews once a defendant is referred to restoration services**
- 14. Identify benchmarks for process improvement using reliable data** Regularly review those data to identify trends, impediments, and progress.
- 15. Identify gaps in the continuum of community treatment and supports for those transitioning out of the justice system, and advocate for additional services** Improvements in the rest of the process won’t be sustained if defendants cycle back through the system because of a lack of community support, so specific gaps in the continuum of services should be identified and solutions advocated for collaboratively.

## ENDNOTES

- 1 Prepared by Richard Schwjmer, National Center for State Courts consultant and retired Utah State Court Administrator under the auspices of the National Judicial Task Force to Examine State Courts' Response to Mental Illness (Task Force), established on March 30, 2020 by the Conference of Chief Justices and Conference of State Court Administrators. [This brief summary](#) includes a description of the Task Force membership and charge.
- 2 <https://www.mentalhealthpolicycenter.org/wp-content/uploads/2020/07/Prevalence-Numbers.pdf> These prevalence numbers have surely only increased as a result of the COVID-19 pandemic.
- 3 Different jurisdictions use different terms for these cases. Some call them Incompetent to Stand Trial (IST), some call them aid and assist cases, others refer to them as fitness to proceed, or by a procedural rule number or statutory reference. For purposes of this paper, we refer to them as Competency to Stand Trial (CST) cases. This frame recognizes that competency to stand trial relates to competency for criminal defendants and is distinct from competency to make personal or treatment decisions that might be heard in civil courts.
- 4 A summary of that focus group discussion can be found online [here](#).
- 5 Participants included forensic psychiatrists, researchers, state mental health directors, prosecutors, defender counsel, advocates for people with mental illness, legislators, judges, and others.
- 6 CSG drew from an extensive inter-branch and interdisciplinary advisory group to describe competency to stand trial nationally and provide ten strategies for state policymakers. The report reflects a partnership of NCSC, the National Association of State Mental Health Program Directors, and the National Conference of State Legislatures, in addition to the project conveners, the Council of State Governments Justice Center and the American Psychiatric Association Foundation through the work of the Judges and Psychiatrists Leadership Initiative. The group represents the three-branch nature of this issue, of which the courts are a critical component.
- 7 West and Midwest Region summits, focused on behavioral health issues in the courts, were conducted prior to the formation of the Task Force; the remaining regional summits are scheduled to be held in 2021 and 2022.
- 8 Subcommittee members include Judge James Bianco, Judge Matthew D'Ernie, Travis Finck, Sim Gill, Dr. Debra Pinals, Walter Thompson, and Judge Nan Waller. Additional liaison members are Lisa Callahan, Halie Fader Towe, and Bonnie Hoffman.
- 9 [Competency to Stand Trial](#) was published in 2020 as part of the Interim Report to the Task Force.
- 10 There is also a separate subcommittee of the Task Force focusing on diversion at all stages of the SIM, and those more comprehensive Diversion Subcommittee recommendations should be reviewed and adopted as well.
- 11 Some jurisdictions also require that the non-adherence to treatment has been demonstrated to contributed to re-hospitalizations and re-arrests.
- 12 Los Angeles County has an impressive community restoration program that utilizes dozens of neighborhood residential settings as locations for housing, treatment, and case management.
- 13 Distractions in Forensic Evaluations, <http://jpop.org/content/early/2019/05/16/JAAP.003842-19>
- 14 American Academy of Psychiatry and the Law, <https://www.aapl.org/sites/default/files/2020-05/2020%20Annual%20Treaty.pdf>
- 15 <https://www.wa.gov/ReportFiled/2017/06/01/StandTrial-Recommendations-Treatment-to-Restore-Sound-Mental-Health-Treatment-Options-and-Strategies-Associated-Long-Term-Effects-Full-Report.pdf>
- 16 Oregon Advocacy Center v. Mink, 322 F.3d 1101 (9th Cir. 2003).
- 17 Unreasonable delays in the evaluation and restoration processes have been the impetus for lawsuits in at least a dozen states, and most if not all of them have resulted in findings of unlawful delay.
- 18 <https://www.mentalhealthpolicycenter.org/wp-content/uploads/2020/07/Prevalence-Numbers.pdf>
- 19 <http://jpop.org/content/early/2019/05/16/JAAP.003842-19>
- 20 Luxton and Lexcen (2018), Professional Psychology: Research and Practice Vol. 49, No. 2, 124-131, accessed at [https://www.researchgate.net/publication/324485311\\_Forensic\\_Competence\\_Evaluations\\_and\\_Rehabilitation\\_A\\_Review\\_and\\_Best\\_Practice\\_Recommendations](https://www.researchgate.net/publication/324485311_Forensic_Competence_Evaluations_and_Rehabilitation_A_Review_and_Best_Practice_Recommendations)
- 21 Distractions in Forensic Evaluations, <http://jpop.org/content/early/2019/05/16/JAAP.003842-19>



- 22 See e.g., [Massachusetts Competency to Stand Trial Report Guidelines](#).
- 23 Some courts use existing Mental Health Court teams to manage competency cases.
- 24 <http://www.bazelon.org/wp-content/uploads/2019/09/Bazelon-Division-to-What-Essential-Services-Publication-September-2019.pdf>
- 25 <https://store.samhsa.gov/product/data-collection-across-the-sequential-intercept-model-sim-essential-measures/PEP19-SIM-DATA>
- 26 [https://www.ncsc.org/\\_data/assets/pdf\\_file/0019/38026/State\\_Court\\_Behavioral\\_Health\\_Data\\_Elements\\_Intern\\_Guide\\_Final.pdf](https://www.ncsc.org/_data/assets/pdf_file/0019/38026/State_Court_Behavioral_Health_Data_Elements_Intern_Guide_Final.pdf)
- 27 GAINS/PRA workbook elements
- 28 Task Force resources for leading this reform at the state and local levels, respectively, include [Leading Change Guide for State Courts](#) and [Leading Change: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders](#).
- 29 Appendix A is a checklist for court leaders to use as a framework for beginning that pursuit.
- 30 The Task Force resource, [Leading Change for State Court Leaders](#) provides an outline for leading broader behavioral health system change, and may be relevant for this narrower purpose as well.
- 31 Helpful resources include [Cross-Services: Meeting Needs, Saving Lives](#) and [Roadmap to the Ideal Crisis System](#).
- 32 See [Implementing Assisted Outpatient Treatment: Essential Elements, Building Blocks and Tips for Maximizing Results](#).

[www.ncsc.org/behavioralhealth](http://www.ncsc.org/behavioralhealth)





# Opening Doors to Recovery (ODR)







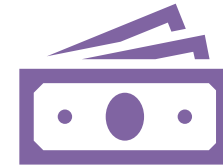
# RESPONSE TO THE CRISIS



2004: GBI and NAMI GA  
began CIT program



2009: Region 5 identified  
MH Gap and Barriers



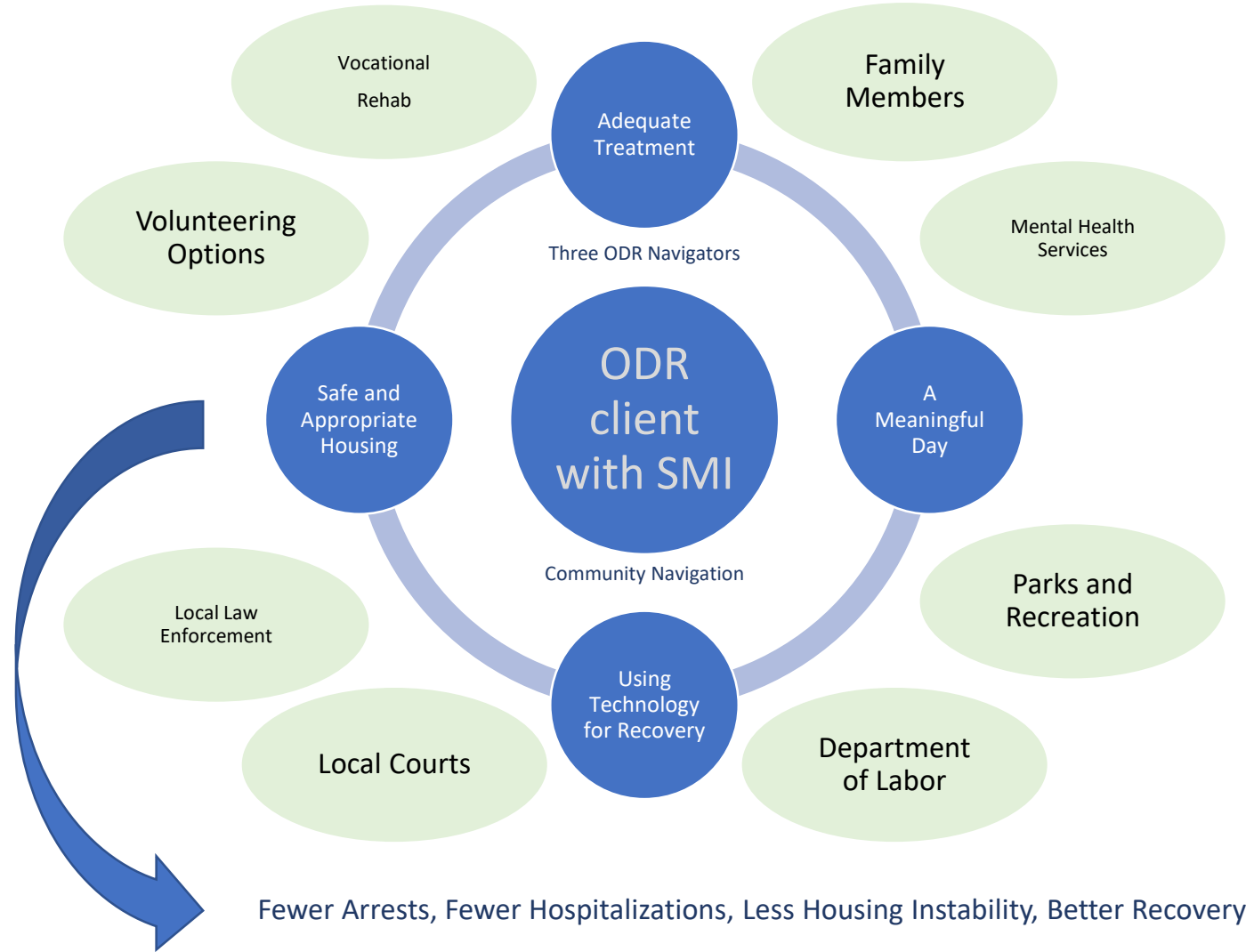
2010: Funds for Opening  
Doors to Recovery

# Opening Doors to Recovery

- Team of 3 Community Navigation Specialists (Navigators)
  - Professional CNS
  - Family CNS
  - Peer CNS
- Focus on two chief goals
  - Reducing institutional recidivism
  - Promoting recovery

# Opening Doors to Recovery

- Promoting recovery by
  - Ensuring adequate treatment
  - Securing safe and stable housing
  - Helping clients develop a meaningful day
  - Using technology to promote recovery
- Other components of the ODR model
  - “Blue Ribbon” meetings of diverse partners (collaborative fusion)
  - A GBI GCIC-supported linkage between the police and the CNSs





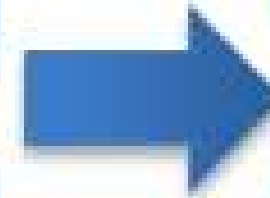


Fragmented, Inaccessible Community Services

Unengaged Local Stakeholders

Frequent Police Contacts

Limited Support for Recovery



Institutional  
Recidivism

Lack of Personal  
Recovery



*Georgia Regional Hospital at Savannah*



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	Community Support Teams	Opening Doors to Recovery	Intensive Case Management	Assertive Community Treatment
Level of service intensity	++	+++	+++	++++
Staffing composition	≥3.5 team members: 1 licensed clinician, 1 (or 2 .5 FTE) CPS, 1 (or .5 FTE) RN, 1 paraprofessional (preferably a CAC)	A team of 3 “Community Navigation Specialists”: 1 Professional CNS, 1 Peer Family Member CNS, 1 Peer Specialist CNS	9 team members: 1 licensed clinician, 4 masters-level clinicians, 2 bachelors-level clinicians, 2 paraprofessionals	1 psychiatrist, 1 RN, 1 team leader (licensed), 1 licensed clinician, 2 paraprofessional mental health workers, 1 substance abuse clinician, 1 CPS
Case load per team	30–60	25–40	200 (rural)–300 (urban)	100
Clients per staff member	9–17	8–13	22–33	~13
Clients served	Persons with SMI and: significant functional impairments and continuous high-service needs (i.e., greater than 8 hours of service per month). A lower level of service/support has been tried.	Persons with SMI with an established history of inpatient or criminal justice recidivism, defined as ≥2 institutional stays of ≥2 nights over the past 6 months.	Persons with SMI with repeated hospitalizations, ER visits, incarceration, and homelessness, or at-risk for these.	Persons with SMI with significant impairments/high acuity and history of unsuccessful treatment in outpatient settings, with repeated hospitalizations, ER visits, and/or incarcerations. Serious impairment; persistent recurrent, severe, or major symptoms (e.g., psychosis); or who are experiencing suicidal/homicidal or high-risk tendencies OR person needs 24/7 supports.
Primarily a treatment service	✓		✓	✓
Primarily a navigation service		✓		

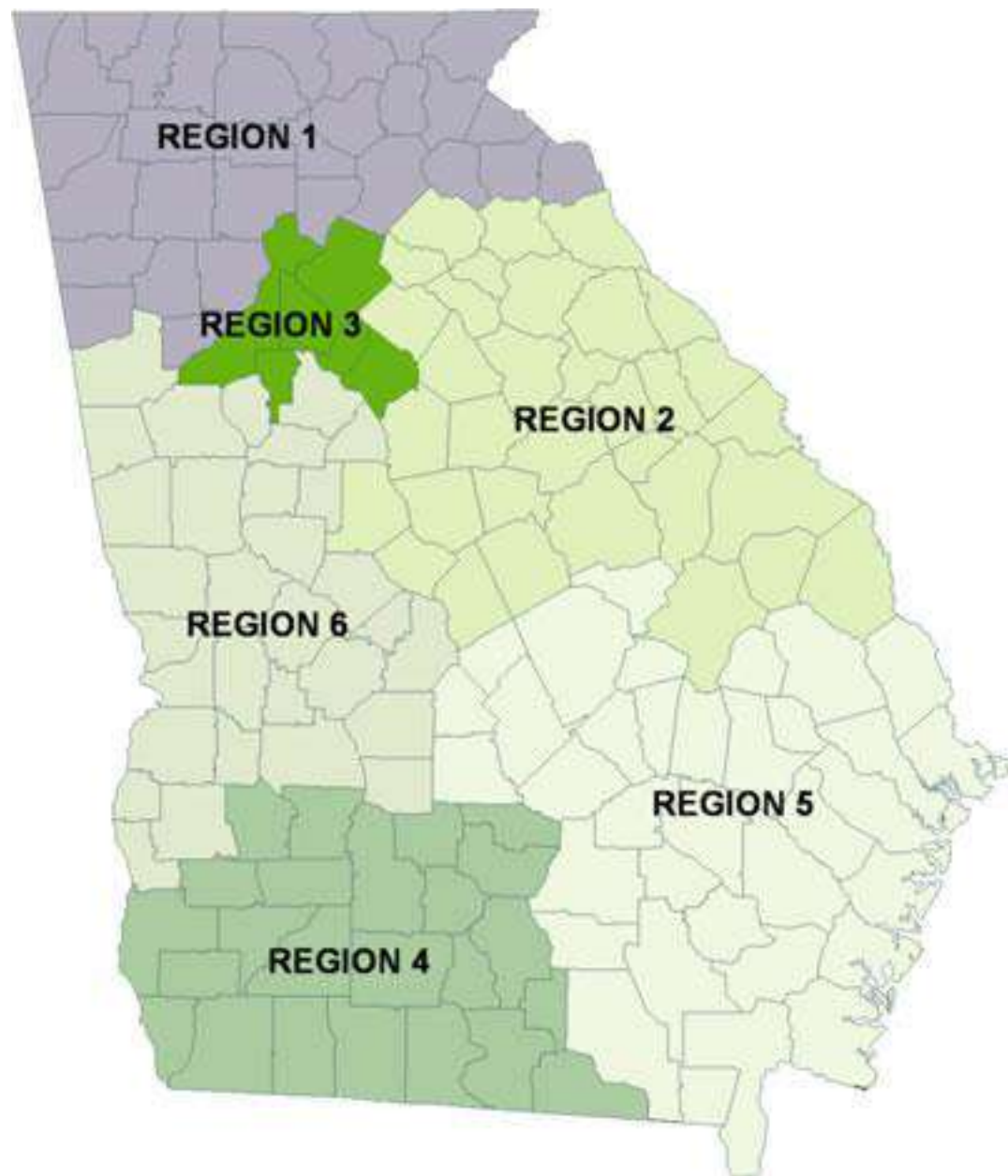


	Community Support Teams	Opening Doors to Recovery	Intensive Case Management	Assertive Community Treatment
<b>Overarching focus</b>	Improving adherence (i.e., decrease hospitalizations, incarcerations, ER visits, and crisis episodes; increase community tenure/independent functioning; increase time working or with social contacts; increase personal satisfaction and autonomy).	Reducing inpatient and criminal justice recidivism; promoting recovery by focusing on: ensuring adequate treatment, identifying safe housing, helping participants develop a meaningful day, and using technology to facilitate recovery. Engaging and utilizing local community resources.	Identifying service needs; minimizing symptoms that interfere with daily living skills, independent functioning and personal development; assisting consumers to increase social support skills and self-manage rehabilitative services. Partner in the development of an individual recovery plan; implement the recovery plan; referral, coordination, and related activities; monitoring.	Staff work as a team 24/7 to provide community-based interventions that are rehabilitative, intensive, and integrated in the community.
<b>Where/when developed</b>	Unknown	Georgia, 2008–2013	Evolved from ACT and traditional case management	Wisconsin, early 1970s
<b>SAMHSA evidence-based practice (KIT available)</b>	No	No	No	Yes: SAMHSA SMA08-4344
<b>Established fidelity process</b>	None known	Yes	None known	Yes



# Opening Doors to Recovery

- Development of the model was led by NAMI-Georgia in conjunction with multiple public, private, governmental, and academic partners.
- Implementation and testing was initially funded by the Bristol-Myers Squibb Foundation.
- Target population: Individuals with psychotic or mood disorders with a history of recidivism ( $\geq 2$  stays at the local State Hospital or other inpatient units in the past 6 months)
- 100 participants in the initial demonstration
- 34-county region of southeast Georgia (Region 5)





# 1. The initial article describing the ODR model

# Opening Doors to Recovery: A Novel Community Navigation Service for People With Serious Mental Illnesses

Michael T. Compton, M.D., M.P.H.  
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Beth Broussard, M.P.H., C.H.E.S.  
Benjamin G. Druss, M.D., M.P.H.  
Nora Haynes, Ed.S.

Pat Strode  
Catharine Grimes, M.B.A.  
Charles Li, M.D.  
June A. DiPolito, M.Ed.  
Glyn V. Thomas, Ph.D.

This column describes Opening Doors to Recovery in Southeast Georgia, a partnership between public agencies, a private corporation, a not-for-profit organization, and an academic institution. Teams of community navigation specialists that include a licensed mental health professional, a family member of an individual with a serious mental illness, and a peer with lived experience in recovery seek to enhance participants' community integration, support them

in developing a meaningful day, ensure access to adequate treatment, and facilitate stable housing, improved relationships, and desired vocational, volunteer, or educational activities. (*Psychiatric Services* 62:1270–1272, 2011)

In recent decades, the organization of mental health services for individuals with serious mental illnesses has changed dramatically, partly driven by shifts from institution- to community-based treatment. As a result of the restructuring of health care services

ly recent innovation in community-based services. In Georgia, a certified peer specialist program combines consumer-provided services and consumer advocacy and has resulted in consumer influence on policy (2). Certified peer specialists help consumers direct their own recovery and make use of resources in the community, while providing colleagues with personal insights into serious mental illnesses and factors that facilitate recovery.

Informed by ACT and the peer support movement, Opening Doors to Recovery in Southeast Georgia (ODR) is

- published in *Psychiatric Services*, 2011
- partnerships that created ODR saw the need for such a program during a unique mix of successes and crises within the state
- creation of ODR was informed by Assertive Community Treatment (ACT), Georgia's certified peer specialist program and the peer support movement, Georgia's Crisis Intervention Team (CIT) program, and the recovery paradigm
- ODR seeks to reduce the number of days spent in inpatient units, or detention facilities, or days homeless
- The collaborative spirit of ODR is exemplified by grass-roots efforts to engage local legislators, mayors, chiefs of police, sheriffs, judges, faith-based communities, mental health care providers, emergency departments, and higher educational institutions in the 34-county region of Southeast Georgia. Such relationships are crucial to ODR's work, which partly consists of mapping all accessible and reliable resources in the region to facilitate recovery.



## 2. Aim A: Developing and Evaluating the CNS Training



# Development, Implementation, and Preliminary Evaluation of a Recovery-Based Curriculum for Community Navigation Specialists Working with Individuals with Serious Mental Illnesses and Repeated Hospitalizations

Michael T. Compton · Thomas Reed ·  
Beth Broussard · Ike Powell · Glyn V. Thomas ·  
Alicia Moore · Kelly Cito · Nora Haynes

Received: 17 January 2012 / Accepted: 15 January 2013 / Published online: 19 March 2013  
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**Abstract** A recovery-oriented curriculum for training the Community Navigation Specialists (CNSs) of the new *Opening Doors to Recovery in Southeast Georgia* program was developed, implemented, and preliminarily evaluated. This new mental health program provides mobile, community-based support services to individuals with serious mental illnesses and a history of psychiatric inpatient recidivism (and commonly past incarcerations and homelessness). Teams of CNSs include a licensed social worker, a family member of an individual with a serious mental illness, and a peer specialist with lived experience. In two courses held in February and June of 2011, 14 newly hired CNSs participated in the new training. A pre-training/post-training evaluation demonstrated statistically significant improvements in pertinent knowledge and self-efficacy for working in a community navigation role. As the recovery paradigm continues to be implemented in diverse

real-world mental health treatment settings, recovery-based training curricula should be carefully constructed and evaluated.

**Keywords** Community mental health · Recovery · Serious mental illnesses

## Introduction

The concept of *recovery* has been discussed extensively in recent years in relation to serious mental illnesses such as schizophrenia, bipolar disorder, and severe major depressive disorder, as well as alcohol and drug dependence. A central theme of the recovery paradigm pertains to shared decision-making within therapeutic relationships, as opposed to more traditional stances of physician paternal-

- published in *Community Mental Health Journal*, 2014
- 6 newly hired CNSs in February 2011, 8 additional CNSs in June 2011
- 14 CNSs demonstrated statistically significant improvements in pertinent knowledge based on a paired sample *t* test (possible range 0–24; observed range 8–19; pre-training mean:  $11.5 \pm 2.8$ ; post-training mean:  $15.0 \pm 2.4$ ;  $t = 5.75$ ,  $df = 13$ ,  $p < .001$ )
- They also had significant increases in self-efficacy for working in a community navigation role with individuals with serious mental illnesses (possible range 28–112; observed range 81–112; pre-training mean:  $98.3 \pm 9.5$ , post-training mean  $104.5 \pm 7.6$ ;  $t = 3.64$ ,  $df = 13$ ,  $p = .003$ )
- summary: a recovery-focused curriculum was designed, implemented, and preliminarily evaluated, with positive results



### 3. Aim B: Program Evaluation



# Community Navigation to Reduce Institutional Recidivism and Promote Recovery: Initial Evaluation of Opening Doors to Recovery in Southeast Georgia

Thomas A. Reed • Beth Broussard • Alicia Moore • Kelly J. Smith •  
Michael T. Compton

Published online: 21 June 2013

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**Abstract** New approaches for preventing repeated inpatient psychiatric stays, detention in jails and prisons, and homelessness among individuals with serious mental illnesses with established histories of such recidivism, while promoting recovery, are direly needed. We present findings from an initial program evaluation of a new community-based, recovery-oriented “community navigation” program in southeast Georgia, called *Opening Doors to Recovery*. Twenty-three in-depth interviews were conducted with key stakeholders, program participants, community navigation specialist team members, and referring mental health professionals to identify hopes and strengths, challenges and weaknesses, and recommendations pertaining to the new program. Cited strengths included teamwork and pooling of resources from various partners, as well as the novel recovery-based, community navigation team approach. An initial lack of fidelity processes across teams and an ongoing scarcity of safe and affordable housing were identified as weaknesses, with the latter seen as a liability of the overall mental health and social service systems rather than the program itself. Findings from this evaluation highlight strengths and opportunities of this new community navigation approach, including those related to the involvement of certified peer specialists and multiple community partners.

- published in *Psychiatric Quarterly*, 2014

**Table 1** Hopes and strengths described by study participants

Commonly described hopes for ODR	Commonly described strengths of ODR
<p>To decrease recidivism</p> <p>To help consumers actively pursue recovery for themselves</p> <p>To identify and close gaps in the system (reduce fragmentation and better link resources)</p> <p>To ensure sustainability of the program</p> <p>To move toward disseminating the program</p> <p>To educate the community and reduce stigma</p>	<p><i>The overall ODR program</i></p> <p>Partnerships among multiple stakeholders with a common goal</p> <p>Pooling of resources from various agencies</p> <p>Close relationship with community partners</p> <p><i>Community navigation service</i></p> <p>Team-based approach involving three types of navigators</p> <p>“Whatever it takes” mentality</p> <p>Mobile, 24/7 availability</p>



**Table 2** Challenges/weaknesses and recommendations given by study participants

Commonly reported challenges and/ weaknesses	Commonly given recommendations for ODR
Slow pace of implementation of technological supports	<i>Recommendations from participants in general</i>
Insufficient housing resources (limited availability and excessive restrictions)	Create fidelity measures to standardize procedures
Lack of fidelity across different teams	Establish a mechanism to bill Medicaid for navigators' services
Peer navigators may feel devalued compared to professional counterparts	Develop linked information systems for seamless, real-time sharing of information
	Set clear expectations for consumers, navigators, and family members in terms of roles, responsibilities, and boundaries
	Further recognize the value of the peer navigator
	<i>Recommendations from navigators</i>
	Combine overlapping resources from different organizations and partners
	<i>Recommendations from referrers</i>
	Add a nursing component, a psychiatric component, and more navigators
	<i>Recommendations from consumers</i>
	Make safe housing more readily available





## 4. Main Findings from the Initial ODR Implementation

# Opening Doors to Recovery: Recidivism and Recovery Among Persons With Serious Mental Illnesses and Repeated Hospitalizations

Michael T. Compton, M.D., M.P.H., Mary E. Kelley, Ph.D., Alicia Pope, M.Ed., Kelly Smith, M.A., Beth Broussard, M.P.H., C.H.E.S., Thomas A. Reed, June A. DiPolito, M.Ed., Benjamin G. Druss, M.D., M.P.H., Charles Li, M.D., Nora Lott Haynes, Ed.S.

**Objective:** Repeated hospitalizations and arrests or incarcerations diminish the ability of individuals with serious mental illnesses to pursue recovery. Community mental health systems need new models to address recidivism as well as service fragmentation, lack of engagement by local stakeholders, and poor communication between mental health providers and the police. This study examined the initial effects on institutional recidivism and measures of recovery among persons enrolled in Opening Doors to Recovery, an intensive, team-based community support program for persons with mental illness and a history of inpatient psychiatric recidivism. A randomized controlled trial of the model is underway.

**Methods:** The number of hospitalizations, days hospitalized, and arrests (all from state administrative sources) in the year before enrollment and during the first 12 months of enrollment in the program were compared. Longitudinal trajectories of recovery—using three self-report and five

clinician-rated measures—were examined. Analyses accounted for baseline symptom severity and intensity of involvement in the program.

**Results:** One hundred participants were enrolled, and 72 were included in the analyses. Hospitalizations decreased, from  $1.9 \pm 1.6$  to  $.6 \pm .9$  ( $p < .001$ ), as did hospital days, from  $27.6 \pm 36.4$  to  $14.9 \pm 41.3$  ( $p < .001$ ), although number of arrests (which are rare events) did not. Significant linear trends were observed for recovery measures, and trajectories of improvement were apparent across the entire follow-up period.

**Conclusions:** Opening Doors to Recovery holds promise as a new service approach for reducing hospital recidivism and promoting recovery in community mental health systems and is deserving of further controlled testing.

*Psychiatric Services* 2016; 67:169–175; doi: 10.1176/appi.ps.201300482

- published in *Psychiatric Services*, 2016

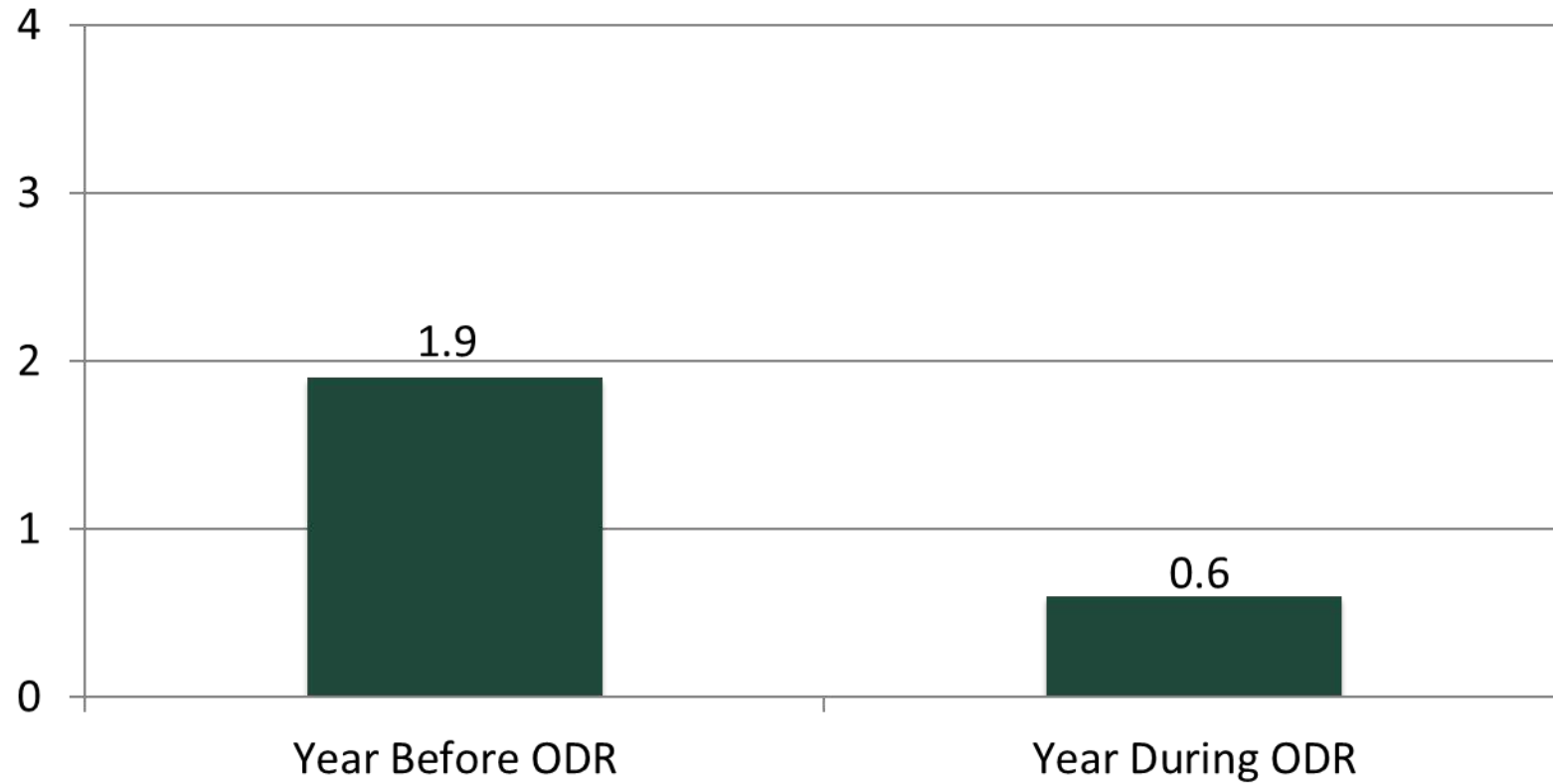
COMPTON ET AL.

**TABLE 2. Hospitalizations and arrests of 72 study participants in the year before and during the year of enrollment in Opening Doors to Recovery (ODR)**

Outcome	Before enrollment		During enrollment		p		
	M	SD	M	SD	Pre-post	Symptom severity	Intensity of involvement
Hospitalizations	1.86	1.60	.56	.87	<.001	.136	.011
Hospital days	27.6	36.4	14.9	41.3	<.001	.196	.061
Arrests	.49	1.06	.44	.98	.900	.282	.541
Arrest rate <sup>a</sup>	.00139	.00301	.00127	.00280	.977	.266	.598

<sup>a</sup> Arrests per nonhospitalized day

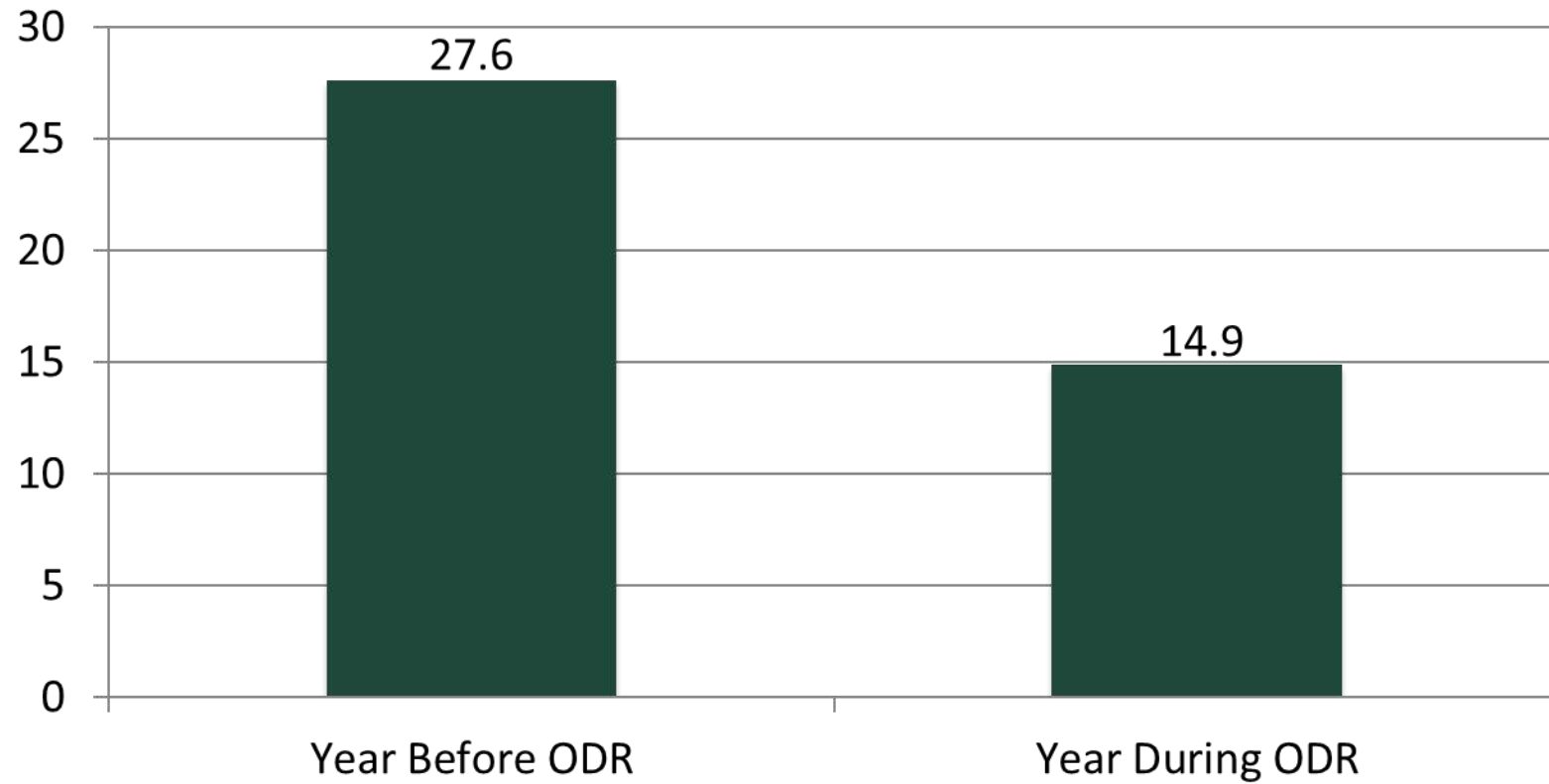
**Number of Hospitalizations in  
Georgia State Hospitals (DBHDD Data)**  
*n=72*



$p<0.0005$

**Number of Days Hospitalized in  
Georgia State Hospitals (DBHDD Data)**

***n=72***



*p*<0.0005



**TABLE 3. Trajectories of primary recovery outcomes and symptom severity one year after enrollment in Opening Doors to Recovery (ODR)**

Measure											p			
	Baseline		4 months		8 months		12 months		Baseline vs. 4 months	Baseline vs. 8 months	Baseline vs. 12 months	Linear trend	Symptom severity	Intensity of involvement
	M	SD	M	SD	M	SD	M	SD						
Primary outcome														
MCAS-P <sup>a</sup>	74.6	11.6	78.9	13.6	78.8	12.8	81.1	13.4	.017	.008	<.001	.001	.230	.159
MHRM <sup>b</sup>	79.8	17.5	83.5	16.9	83.1	15.8	85.5	19.4	.059	.215	.020	.056	.299	.362
QOLI <sup>c</sup>	21.3	31.5	27.2	27.7	29.1	27.1	31.6	27.6	.166	.177	.010	.019	.816	.477
PANSS <sup>d</sup>	81.1	16.4	75.7	15.3	74.0	15.9	70.6	13.8	.007	<.001	<.001	<.001	<.001	.097

<sup>a</sup> Multnomah Community Ability Scale–Patient Version. Possible scores range from 22 to 110, with higher scores indicating better community adjustment.

<sup>b</sup> Mental Health Recovery Measure. Possible scores range from 0 to 120, with higher scores indicating better mental health recovery.

<sup>c</sup> Quality of Life Inventory. Possible scores range from –96 to 96, with higher scores indicating better quality of life.

<sup>d</sup> Scores range from 30 to 210, with higher scores indicating greater symptom severity.



**TABLE 4. Trajectories of secondary recovery outcomes one year after enrollment in Opening Doors to Recovery (ODR)**

Measure	4 months		8 months		12 months		p			
	M	SD	M	SD	M	SD	4 vs. 8 months	4 vs. 12 months	Symptom severity	Intensity of involvement
Daily Living Activities Scale <sup>a</sup>	89.8	24.4	96.5	26.5	99.7	22.5	.205	.032	.248	.290
Adequate treatment <sup>b</sup>	2.7	1.0	3.1	1.2	3.4	1.1	.306	.009	.723	.355
Meaningful day <sup>b</sup>	2.6	1.2	2.7	1.2	2.9	1.1	.600	.087	.858	.240
Safe housing <sup>b</sup>	3.3	1.1	3.7	1.2	4.0	1.0	.292	.013	.968	.322
Use of technology <sup>b</sup>	2.7	1.0	3.0	1.3	2.9	1.4	.124	.350	.615	.942

<sup>a</sup> Possible scores range from 20 to 140, with higher scores indicating better daily living skills.

<sup>b</sup> Possible scores range from 1 to 5, with higher scores indicating more independence of functioning.



## 5. An Examination of the Family CNS Role on the ODR Team

# A Potential Role for Family Members in Mental Health Care Delivery: The Family Community Navigation Specialist

Neely Anne Laurenzo Myers, Ph.D., Yazeed Alolayan, M.B.B.S., Kelly Smith, M.A., Susan Alicia Pope, M.Ed., Beth Broussard, M.P.H., Nora Haynes, Ed.S., Michael T. Compton, M.D., M.P.H.

**Objective:** Opening Doors to Recovery (ODR) in southeast Georgia included a family community navigation specialist (F-CNS) in addition to a peer specialist and a mental health professional. This qualitative study assessed the usefulness of the F-CNS role.

**Methods:** Semistructured interviews were conducted with 30 respondents (ten ODR participants with serious mental illnesses; ten family members; and ten ODR leaders and team members, including two F-CNSs). Interviews were recorded and transcribed for qualitative analysis.

**Results:** Many respondents found the F-CNS to be helpful, providing psychosocial support, serving as a communi-

cation liaison, and being a team member dedicated to the family. Aspects that might require improvement include insufficient description of the F-CNS role to participants and the limited experience and training of the F-CNSs.

**Conclusions:** The F-CNS represents an unexplored role for family members of persons with serious mental illnesses that may complement the roles of other service providers and strengthen recovery-oriented teams.

*Psychiatric Services* 2015; 66:653–655; doi: 10.1176/appi.ps.201300569



## 6. An Examination of the “Meaningful Day” Concept of ODR



# A Mixed-Methods Study of the Recovery Concept, “A Meaningful Day,” in Community Mental Health Services for Individuals with Serious Mental Illnesses

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Received: 2 March 2015 / Accepted: 13 November 2015 / Published online: 9 December 2015  
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**Abstract** The recovery concept encompasses overcoming or managing one’s illness, being physically and emotionally healthy, and finding meaningful purpose through work, school, or volunteering, which connects one to others in mutually fulfilling ways. Using a mixed-methods approach, we studied the emphasis on “a meaningful day” in the new Opening Doors to Recovery (ODR) program in southeast Georgia. Among 100 participants, we measured the meaningful day construct using three quantitative items at baseline (hospital discharge) and at 4-, 8-, and 12-month follow-up, finding statistically significant linear trends over time for all three measures. Complementary qualitative interviews with 30 individuals (ODR participants, family members, and ODR’s Community Navigation Specialists and program leaders) revealed themes pertaining to companionship, productivity, achieving stability, and autonomy, as well as the concern about insufficient resources.

The concept of “a meaningful day” can be a focus of clinical attention and measured as a person-centered outcome for clients served by recovery-oriented community mental health services.

**Keywords** Community mental health · Meaningful day · Recovery · Serious mental illness

## Introduction

Events surrounding the onset and ongoing management of a serious mental illness can preclude many individuals living with these conditions from believing that they can attain the kind of life they had hoped to live (Crosse 2003). Persons with serious mental illnesses often fear that they will be unable to achieve societal expectations, such as

- published in *Community Mental Health Journal*, 2016
- data on “meaningful day” from the 100 participants over time
- 30 qualitative interviews: 10 participants, 10 family members, 2 Professional CNSs, 2 Family CNSs, 2 Peer CNSs, 4 mental health administrators involved in ODR’s implementation

**Table 4** Trajectories of meaningful day measures across 1 year after enrolling in ODR

Measure	Mean scores (standard deviations)				Statistical test significance		
	Baseline	4 months	8 months	12 months	Baseline to 4 months	Baseline to 8 months	Baseline to 12 months
Meaningful day thermometer	57.0 (28.7)	64.4 (27.0)	69.9 (26.7)	71.5 (26.1)	0.021	0.001	<0.0005
Meaningful days in the past 30 days	17.7 (8.7)	18.9 (8.6)	19.7 (8.5)	20.9 (8.6)	0.228	0.110	0.021
CNS rating of meaningful day	–	2.6 (1.2)	2.6 (1.3)	2.9 (1.1)	–	0.380	0.047



## *Theme 2: Productivity*

Many ODR participants, family members, and staff and mental health administrators felt that a meaningful day is a day in which one is accomplishing something, or working towards a goal. The Recovery Passport, which was a notebook given to each ODR participant to help with goal setting, was seen by many as a tool that was helpful in planning a meaningful day. Being productive was viewed as synonymous with having a purpose. An ODR participant stated, “I would define ‘meaningful day’ as productivity and quality of the day; I guess how much you get accomplished, how you spend your time.” Another ODR participant said, “A meaningful day is contributing to society...working, going to your regular scheduled appointments, taking your medicine. Like I said, it just sums up being productive.” Yet another ODR participant noted, “A meaningful day is getting something accomplished, possibly going to a job, working a successful day,





these 6 published articles, along with numerous conference presentations, paved the way for a National Institute of Mental Health (NIMH) grant proposal for a formal, experimental, “randomized, controlled trial”

# “Randomized, Controlled Trial”

- A well-blinded RCT is considered the ***gold standard*** for clinical trials, yielding the highest level of scientific evidence. Blinded RCTs are commonly used to test the efficacy of medical interventions and provide compelling evidence that the study treatment causes an effect on the health outcome of interest (or not).
- Study participants are ***randomized***... Study participants differ from one another in known and unknown ways that can influence study outcomes, and randomization enables statistical control over these influences. In effect, randomization “washes away” all other possible causes of the observed outcome so that just the comparison of two treatments is being tested.

**Randomized, Controlled Trial**  
**3 referral sites (2 in Savannah, 1 in Brunswick)**  
**n=240, ODR v. ICM**  
**Follow-up at 4, 8, 12 months**

**Aim A. Test the impact of ODR on hospital recidivism.**  
(days in inpatient psychiatric settings, using State administrative data)

**Aim B. Test the impact of ODR on arrests.**  
(number of arrests, using State administrative data)

**Aim C. Test the impact of ODR on housing outcomes.**  
(homelessness, housing instability, and housing satisfaction)

**Aim D. Test the impact of ODR on recovery.**  
(7 scales of community adjustment, mental health recovery, community navigation competencies, meaningful day activities, hope, and empowerment)



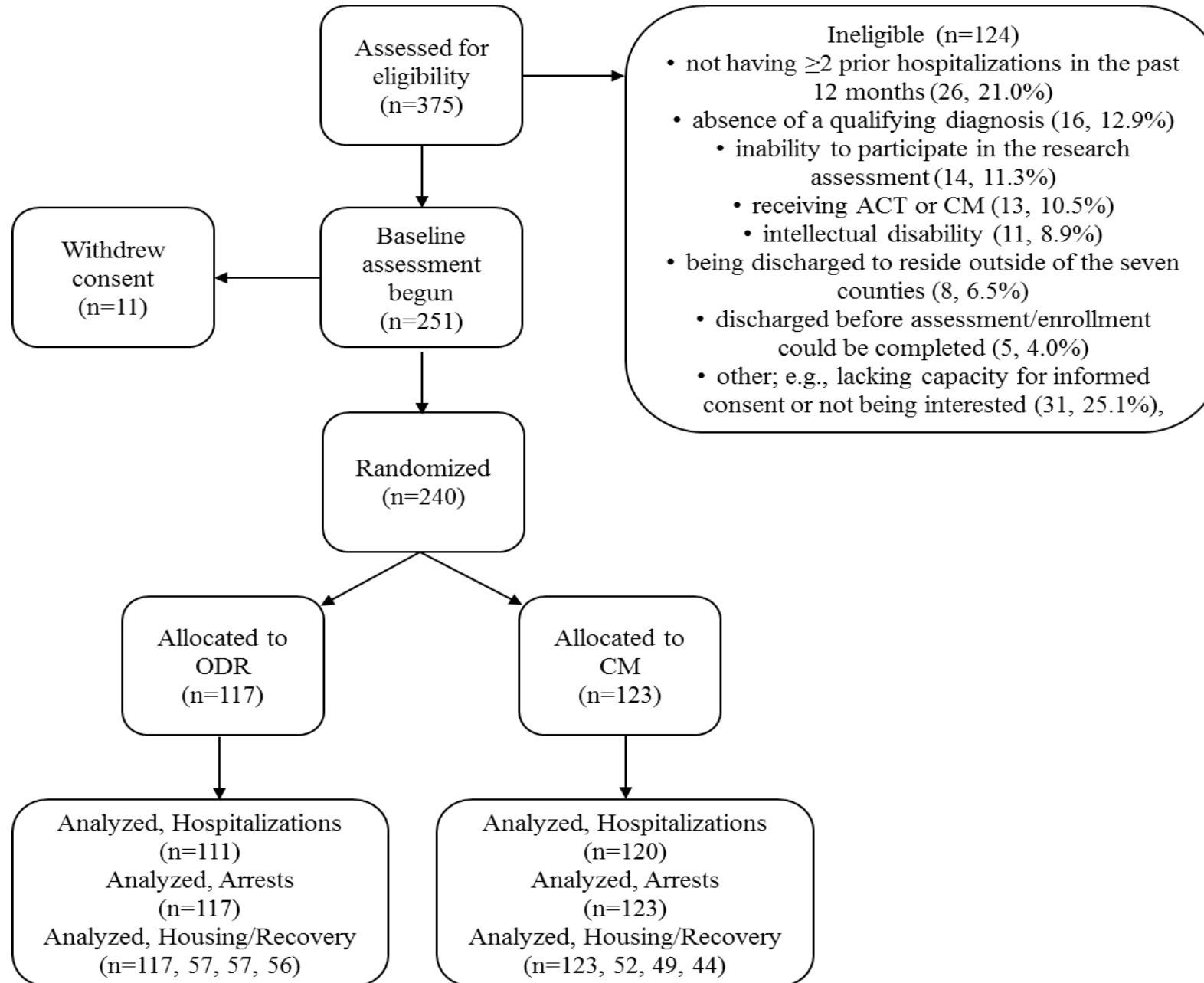






# Opening Doors to Recovery: A Randomized, Controlled Trial of a Recovery-Oriented Community Navigation Service for Individuals with Serious Mental Illnesses and Repeated Hospitalizations

Michael T. Compton, M.D., M.P.H.<sup>a,b,\*</sup>, Mary E. Kelley, Ph.D.<sup>c</sup>, Simone Anderson, M.Ed.<sup>d</sup>,  
Samantha Ellis<sup>d</sup>, JaShala Graves, M.A.<sup>d</sup>, Beth Broussard, M.P.H., C.H.E.S.<sup>e</sup>,  
Luca Pauselli, M.D.<sup>f</sup>, Adria Zern, M.P.H.<sup>a</sup>, Leah Pope, Ph.D.<sup>a,b</sup>,  
Mark Johnson, M.D.<sup>d</sup>, Nora Lott Haynes, Ed.S.<sup>g</sup>



	<b>Overall n=240</b>		<b>ODR n=117</b>		<b>CM n=123</b>	
	mean / n	SD / %	mean / n	SD / %	mean / n	SD / %
Age, years (mean±SD)	35.9	11.6	35.8	11.8	36.0	11.4
Sex, male	155	64.6	81	69.2	74	60.2
Ethnicity, Non-Hispanic	228	95.0	112	95.7	116	94.3
Race						
<i>Black / African American</i>	114	47.5	56	47.9	58	47.2
<i>White / Caucasian</i>	116	48.3	55	47.0	61	49.6
<i>Other</i>	10	4.2	6	5.1	4	3.3
Marital Status						
<i>Single and never married</i>	148	61.7	65	55.6	83	67.5
<i>Divorced, separated, or widowed</i>	78	32.5	45	38.4	33	26.8
<i>Married or living with a partner</i>	14	5.8	7	6.0	7	5.7
Years of School Completed (mean±SD)	11.0	2.7	10.8	2.6	11.2	2.9
Living Situation						
<i>With parents, siblings, or other family members</i>	83	34.6	38	32.5	45	36.6
<i>Homeless, or staying in a homeless shelter</i>	69	28.8	38	32.5	31	25.2
<i>With friends, boyfriend/girlfriend, or spouse/partner</i>	43	17.9	21	17.9	22	17.9
<i>Alone</i>	31	12.9	14	12.0	17	13.8
<i>Other</i>	14	5.8	6	5.1	8	6.5
Has Children (n=239)	122	51.0	65	56.0	57	46.3
Currently Unemployed (n=239)	208	87.0	103	88.0	105	85.4
Monthly Income, Including Those with No Income, USD (mean±SD)	450.5 <sup>a</sup>	653.0	380.2	543.8	517.3	738.3
Monthly Income, among Those with an Income, USD (mean±SD) (n=153) <sup>b</sup>	706.6 <sup>c</sup>	698.9	593.1	579.3	815.7	785.5
Doesn't have Health Insurance (n=239)	176	73.6	90	76.9	86	70.5

	<i>Overall n=240</i>		<i>ODR n=117</i>		<i>CM n=123</i>	
DSM-5 SCID Psychotic and Mood Disorder Diagnoses						
<i>Psychotic Disorder</i>	155	64.6	70	59.8	85	69.1
<i>Bipolar Disorder</i>	51	21.3	30	25.6	21	17.1
<i>Depressive Disorder</i>	34	14.2	17	14.5	17	13.8
Admission Legal Status, Involuntary	161	67.1	75	64.1	86	69.9
Length of Stay (mean±SD), n=236	13.1	11.5	12.9	9.8	13.3	13.0

**Table 2. Outcomes at 12 Months by Domain**

<i>Domain</i>	<i>Measure</i>	<i>Overall n=240</i>	<i>ODR n=117</i>	<i>CM n=123</i>	<i>ODR vs. CM Effect size<sup>a</sup></i>	<i>statistic</i>	<i>p-value</i>
<b>Endpoint Measures / Primary Outcomes</b>		<b>Mean (SD) or N (%)</b>				<b>Wald <math>\chi^2</math></b>	
<b>Hospitalizations</b>	12-month incidence rate	111 (48.1)	53 (47.8)	58 (48.3)	OR=.96	-.15	.884
	Number of hospitalizations <sup>b</sup>	2.2 (1.7)	1.9 (1.5)	2.3 (1.8)	RR=.79	-1.77	.077
	Number of days hospitalized <sup>b</sup>	19.4 (22.1)	18.0 (15.1)	20.7 (27.0)	RR=.86	-3.40	.001
<b>Arrests</b>	12-month incidence rate	73 (30.4)	24 (20.5)	49 (39.8)	OR=.35	-3.50	<.0005
	Number of arrests <sup>b</sup>	2.0 (1.3)	1.7 (1.1)	2.0 (1.3)	RR=.74	-1.59	.113
	Time to arrest (months)	9.8 (5.3)	11.0 (4.7)	8.9 (5.5)	HR=0.42	-3.46	.001
<b>Repeated Measures / Secondary Outcomes<sup>c</sup></b>		<b>Mean (SD)</b>	<b>Mean <math>\Delta</math> (SE)</b>		<b>Cohen's d</b>	<b>t</b>	
<b>Housing</b>	Housing Satisfaction Scale (1–5)	2.44 (.78)	-.88 (.09)	-.52 (.10)	.45	-2.59	.010
	Housing Instability Index (0–10)	2.57 (2.47)	-2.97 (.27)	-2.48 (.30)	.20	-1.21	.228
<b>Recovery</b>	Recovery Summary Score (average Z-score)	-.04 (.79)	.56 (.08)	.30 (.09)	.33	2.10	.037
	Multnomah Community Ability Scale (1–5)	3.49 (.65)	.47 (.07)	.32 (.08)	.23	1.34	.182
	Maryland Assessment of Recovery Scale (1–5)	4.05 (.76)	.22 (.08)	.05 (.09)	.22	1.43	.152
	Herth Hope Scale (1–5)	2.18 (.52)	.24 (.06)	.14 (.06)	.19	1.22	.225
	Empowerment Scale (1–4)	2.89 (.31)	.11 (.03)	.00 (.03)	.32	2.18	.030
	Community Navigation Abilities Scale (1–7)	4.63 (1.16)	1.15 (.13)	.75 (0.14)	.35	2.15	.033

<sup>a</sup> All effect sizes adjusted for age, gender, and non-white race for valid missing at random (MAR) assumption.

<sup>b</sup> Conditional means in those with a hospitalization or arrest.



Table 2. Outcomes at 12 Months by Domain							
Domain	Measure	Overall n=240	ODR n=117	CM n=123	ODR vs. CM Effect size <sup>a</sup>	statistic	p-value
Endpoint Measures / Primary Outcomes		Mean (SD) or N (%)				Wald $\chi^2$	
Hospitalizations	12-month incidence rate	111 (48.1)	53 (47.8)	58 (48.3)	OR=.96	-.15	.884
	Number of hospitalizations <sup>b</sup>	2.2 (1.7)	1.9 (1.5)	2.3 (1.8)	RR=.79	-1.77	.077
	Number of days hospitalized <sup>b</sup>	19.4 (22.1)	18.0 (15.1)	20.7 (27.0)	RR=.86	-3.40	.001
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	Number of arrests <sup>b</sup>	2.0 (1.3)	1.7 (1.1)	2.0 (1.3)	RR=.74	-1.59	.113
	Time to arrest (months)	9.8 (5.3)	11.0 (4.7)	8.9 (5.5)	HR=0.42	-3.46	.001
Repeated Measures / Secondary Outcomes <sup>c</sup>		Mean (SD)	Mean $\Delta$ (SE)		Cohen's d	t	
Housing	Housing Satisfaction Scale (1–5)	2.44 (.78)	-.88 (.09)	-.52 (.10)	.45	-2.59	.010
	Housing Instability Index (0–10)	2.57 (2.47)	-2.97 (.27)	-2.48 (.30)	.20	-1.21	.228
Recovery	Recovery Summary Score (average Z-score)	-.04 (.79)	.56 (.08)	.30 (.09)	.33	2.10	.037
	Multnomah Community Ability Scale (1–5)	3.49 (.65)	.47 (.07)	.32 (.08)	.23	1.34	.182
	Maryland Assessment of Recovery Scale (1–5)	4.05 (.76)	.22 (.08)	.05 (.09)	.22	1.43	.152
	Herth Hope Scale (1–5)	2.18 (.52)	.24 (.06)	.14 (.06)	.19	1.22	.225
	Empowerment Scale (1–4)	2.89 (.31)	.11 (.03)	.00 (.03)	.32	2.18	.030
	Community Navigation Abilities Scale (1–7)	4.63 (1.16)	1.15 (.13)	.75 (0.14)	.35	2.15	.033

<sup>a</sup> All effect sizes adjusted for age, gender, and non-white race for valid missing at random (MAR) assumption.

<sup>b</sup> Conditional means in those with a hospitalization or arrest.



Table 2. Outcomes at 12 Months by Domain							
Domain	Measure	Overall n=240	ODR n=117	CM n=123	ODR vs. CM Effect size <sup>a</sup>	statistic	p-value
Endpoint Measures / Primary Outcomes		Mean (SD) or N (%)				Wald $\chi^2$	
Hospitalizations	12-month incidence rate	111 (48.1)	53 (47.8)	58 (48.3)	OR=.96	-.15	.884
	Number of hospitalizations <sup>b</sup>	2.2 (1.7)	1.9 (1.5)	2.3 (1.8)	RR=.79	-1.77	.077
	Number of days hospitalized <sup>b</sup>	19.4 (22.1)	18.0 (15.1)	20.7 (27.0)	RR=.86	-3.40	.001
Arrests	12-month incidence rate	73 (30.4)	24 (20.5)	49 (39.8)	OR=.35	-3.50	<.0005
	Number of arrests <sup>b</sup>	2.0 (1.3)	1.7 (1.1)	2.0 (1.3)	RR=.74	-1.59	.113
	Time to arrest (months)	9.8 (5.3)	11.0 (4.7)	8.9 (5.5)	HR=0.42	-3.46	.001
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<sup>b</sup> Conditional means in those with a hospitalization or arrest.

# What do our patients get arrested for?

240 patients with SMI coming out of an inpatient stay and participating in the larger study of ODR v. (Intensive) Case Management

Consented to giving us access to their  
record of arrests and prosecution (rap) sheets

## Ranking of the 15 Most Common Charges among Individuals with Serious Mental Illnesses Who Had Ever Been Arrested in Georgia, 171 of 240 (71%)

	<b>Charges (n=708; average of 12.6 charges across average of 8.6 arrests)</b>	n	%
1	Criminal trespass (M)	52	7
2	Willful obstruction of law enforcement officers (M)	48	7
3	Disorderly conduct (M)	42	6
4	Theft by shoplifting (1 F, 23 M, 15 X)	39	6
5	Probation violation (20 F, 14 M)	34	5
6	Driving under the influence of alcohol (M)	34	5
7	Marijuana – possession of less than 1 oz. (M)	33	5
8	Driving while license suspended or revoked (M)	29	4
9	Simple battery (M)	27	4
10	Failure to appear to court (7 F, 15 M)	22	3
11	Theft by taking (5 F, 5 M, 11 X)	21	3
12	Burglary (F)	19	3
13	Purchase, possession, distribution, or sale of marijuana (14 F, 1 M)	15	2
14	Aggravated assault (F)	13	2
15	Terroristic threats and acts (11 F, 1 M)	12	2

**Ranking of the Most Common Charges from the Earliest Two Arrests and the Most Recent Two Arrests among Individuals with Serious Mental Illnesses Who Had Been Arrested at Least Four Times in Georgia, n=99**

<b>Earliest Two Arrests (n=266 charges) average of 20 and 21 years old</b>		<b>n</b>	<b>%</b>	<b>Most Recent Two Arrests (n=294 charges) average of 33 and 35 years old</b>	<b>n</b>	<b>%</b>
<b>1</b>	Marijuana – possession of less than 1 oz. (M)	22	8	Probation violation (18 F, 9 M)	27	9
<b>2</b>	Driving under the influence of alcohol (M)	19	7	Disorderly conduct (M)	26	9
<b>3</b>	Theft by shoplifting (4 M, 12 X)	16	6	Willful obstruction of law enforcement (M)	23	8
<b>4</b>	Burglary (F)	16	6	Criminal trespass (M)	20	7
<b>5</b>	Criminal trespass (M)	15	6	Failure to appear to court (4 F, 12 M)	16	5
<b>6</b>	Willful obstruction of law enforcement (M)	15	6	Theft by shoplifting (1 F, 11 M, 2 X)	14	5
<b>7</b>	Theft by taking (1 F, 2 M, 11 X)	14	5	Driving while license suspended/revoked (M)	13	4
<b>8</b>	Purchase, possession, manufacture, distribution, or sale of marijuana (12 F, 1 M)	13	5	Giving false name/address/birthdate to officer (M)	9	3
<b>9</b>	Simple battery (M)	10	4	Willful obstruction of officers with threats (F)	8	3
<b>10</b>	Driving while license suspended/revoked (M)	10	4	Marijuana – possession of less than 1 oz. (M)	7	2
<b>11</b>	Disorderly conduct (M)	8	3	Simple battery (M)	6	2
<b>12</b>	Aggravated assault (F)	6	2	Probation violation (prob terms altered) (X)	6	2



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12	Aggravated assault (F)	6	2	<b>Probation violation</b> (prob terms altered) (X)	6	2

# What do our patients get arrested for?

Mostly minor misdemeanors in which  
arresting officers have a lot of discretion

The types of charges and processing of charges  
change over time based on formal and  
informal policies within the criminal legal system,  
and likely based on evolving life circumstances  
and illness characteristics of our patients

Table 1. Hospitalization Costs, by ODR and Control Group

	ODR	Control		
		ICM	CM	Control Total
CSU days	663	471	234	705
Total CSU costs	\$457,456	\$325,566	\$159,392	\$484,958
State Hospital days	291	460	38	498
Total State Hospital costs	\$212,957	\$339,331	\$27,627	\$366,958
Total Days (CSU + State Hospital days)	954	931	272	1,203
Total Costs (CSU + State Hospital costs)	\$670,413	\$664,897	\$187,019	\$851,916
Average per client <sup>a</sup>	\$5,730	\$6,999	\$6,679	\$6,926

Note: Hospitalization costs in Georgia: \$729/day (CSU) and \$782/day (State Hospital), per the Georgia Department of Behavioral Health and Developmental Disabilities (personal communication, October 6, 2020). Costs were inflation-adjusted to the year in which they were incurred (2015–2019), per the Bureau of Labor Statistics Inflation Calculator [https://www.bls.gov/data/inflation\\_calculator.htm](https://www.bls.gov/data/inflation_calculator.htm)

<sup>a</sup>Total cost divided by number of clients in each group (ODR=117; ICM=95; CM=28; Total Control=123)

Crime Category	Total Crime Costs	ODR Group		Control Group					
		ODR Total Arrests	ODR Total Costs	ICM Total Arrests	ICM Total Costs	CM Total Arrests	CM Total Costs	Control Grp Total Arrests	Control Grp Total Costs
Assault <sup>c</sup>	40,330	5	202,077	6	241,655	1	40,330	7	281,985
Intimate partner violence	28,251	1	29,084	0	0	0	0	0	0
Burglary and other low-level felonies <sup>d</sup>	3,356	1	3356	2	6598	2	6598	4	13,196
Arson	80,191	0	0	0	0	1	78,182	1	78,182
Impaired driving	24,694	1	25,883	1	25,422	2	49,388	3	74,810
Stolen property	9,422	1	9,422	0	0	0	0	0	0
Fraud	2,053	1	2,053	1	2,053	0	0	1	2,053
Vandalism/ trespass	1,349	4	5,327	12	16,326	4	5,305	16	21,631
Drug possession	15,742	2	30,823	8	127,525	6	92,736	14	220,261
Disorderly conduct	1,819	3	5,519	5	9,152	1	1,773	6	10,925
Larceny/theft	3,343	6	19,806	9	29,973	5	16,487	14	46,460
Other <sup>e</sup>	501	14	7,019	31	15,706	11	5,484	42	21,190
Total		39	340,369	75	474,410	33	296,283	108	770,693
Average CJ cost per client			2,909						6,266





# Rockdale County Implementation Fulton County Grant Proposal

# Identifying Prevalence of Inmates with Serious and Persistent Mental Illness in GA Jails

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Criminal Justice Coordinating Council



This project was supported by Grant No. 2017-BJ-CX-K023 awarded by the Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the US Department of Justice.



## About CJCC

Created by the Georgia General Assembly in 1981 as an Executive Branch agency, the Criminal Justice Coordinating Council (CJCC) represents the culmination of many efforts to establish a statewide body that would build consensus and unity among the State's diverse and interdependent, criminal justice system components. CJCC is legislatively charged with eleven areas of criminal justice coordination. Among those responsibilities is to serve as the statewide clearinghouse for criminal justice information and research.

## About the Georgia Statistical Analysis Center

Federally recognized by the Bureau of Justice Statistics as the state statistical coordinating entity, the 10-person division of the CJCC supports all the data collection and analysis for the grant-making divisions of the organization, in addition to conducting independent research and evaluation to help the state make data-driven policy decisions about criminal justice and victim services issues.

## About Applied Research Services



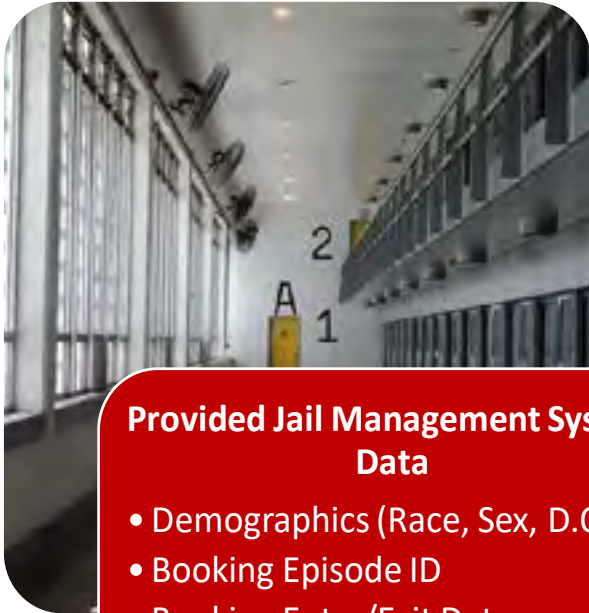
Applied Research Services is a national consulting firm based in Atlanta, Georgia, which conducts complex research design and analysis to support public policy, programming, and legislative decisions. ARS has partnered with the GASAC on high impact research using computerized criminal history (CCH) data since 2000 and receives quarterly updates to the Georgia Crime Information Center (GCIC), the state criminal history repository. ARS also has access to 40 years of Georgia prison inmate data, as well as probation and parole supervision data, which has mental health screening and diagnosis for persons who have a felony conviction history. Their expertise in Georgia criminal justice administrative datasets is unparalleled.

# Study Background



- Started with a question from Deputy Commissioner at Department of Community Health about how many people with serious and persistent mental illness who might qualify for SSDI/SSI/Medicaid are in county jail
- Study uses only **criminal justice data** sources: jail, computerized criminal history (CCH), Department of Community Supervision, and Department of Corrections data
- Checking measures derived from jail data and CCH with Department of Community Supervision and Department of Corrections data
- **Goal 1:** Provide jail intake staff with a screening tool they can use to identify people within their jails who might qualify for SSI/SSDI/Medicaid because of their mental illness, using jail data to which they have access – proxy measures
- **Goal 2:** Estimate the percentage of the county jail population in GA with serious and persistent mental illness

# Data Analysis Methodology



## Provided Jail Management System Data

- Demographics (Race, Sex, D.O.B.)
- Booking Episode ID
- Booking Entry/Exit Date
- JMS System Inmate ID
- Booking Charges
- Cell Movement Data



## Imports/Cleans Booking Data for CCH Merge

- Creates gibberish hashkey to de-identify data later, but preserve unique ID for inmates
- Creates length-of-stay variable
- Creates Booking Episode Count variable
- Create variables for number of cell movements per booking episode
- Standardize fields and columns across all datasets
- Create variable for number of days between booking episodes



## Conduct CCH, DCS, GDC Match and Analysis

- Receives identified file for CCH match
- Conducts CCH match and analysis including:
  - Analysis of charge history and inter-county movement and offending
  - Arrest history and length of time between arrests
- Match to DCS to identify MH Flag for offenders with felony history
- Advanced statistical analysis to compare offenders with misdemeanor offense history to felony
- Logistic Regression to assess potential screener indicators

# Participating Jail Characteristics



Active Population 2018

101,493

Percent of Georgia Population  
Covered: 30%

Active Population of Participant Jails  
represented 23% of Total state Jail  
Population in 2018

9 Jail Participants

3 Urban Jails  
3 Suburban Jails  
3 Rural Jails

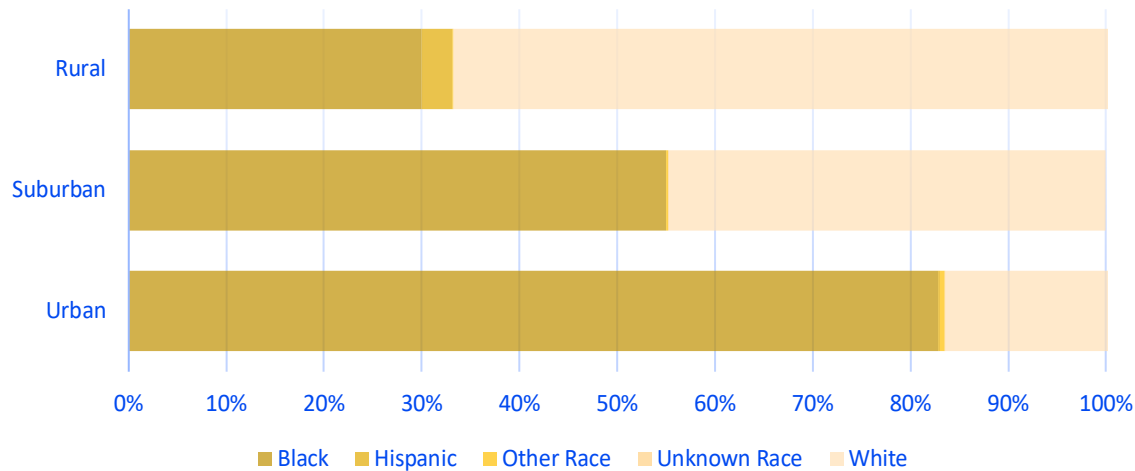
Urban Jails: 55% of Inmates  
Suburban Jails: 39% of Inmates  
Rural Jails: 6% of Inmates



# Overall Jail Population Characteristics

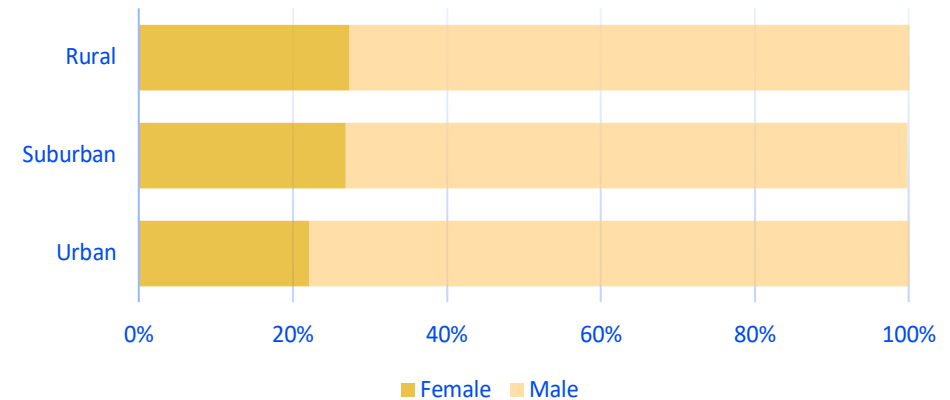


## RACIAL BREAKDOWN FOR MATCHED DATASET



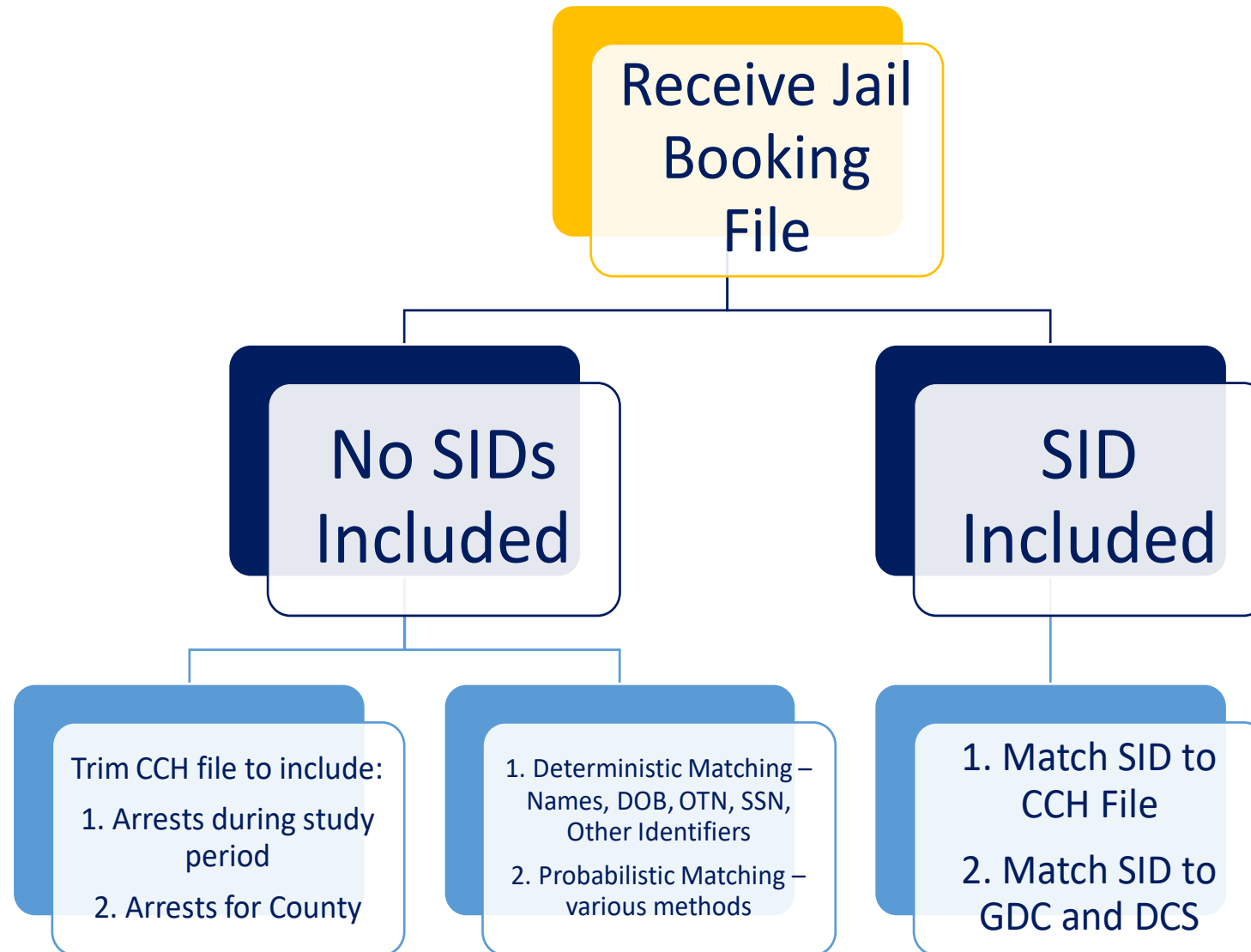
- In Rural Jails, the percent of inmates who were white was 2x the percent African American.
- Hispanic Ethnicity was not uniformly captured in the jail datasets.

## GENDER BREAKDOWN FOR MATCHED DATASET



- Across all jails, inmates averaged 1.7 booking episodes regardless of mental health status during the study period
- The gender breakdown among inmates was consistent across all jail types – Roughly 75% male, 25% Female

# Matching Records Process



# Matching Results



## Person Records Provided

Total Person Records Provided:

369K+

Percent Person Records Matched to CCH:

71%

## Booking Episode Records Provided

Total Booking Episode Records Provided:

611K+

Total Booking Episode Records Matched:

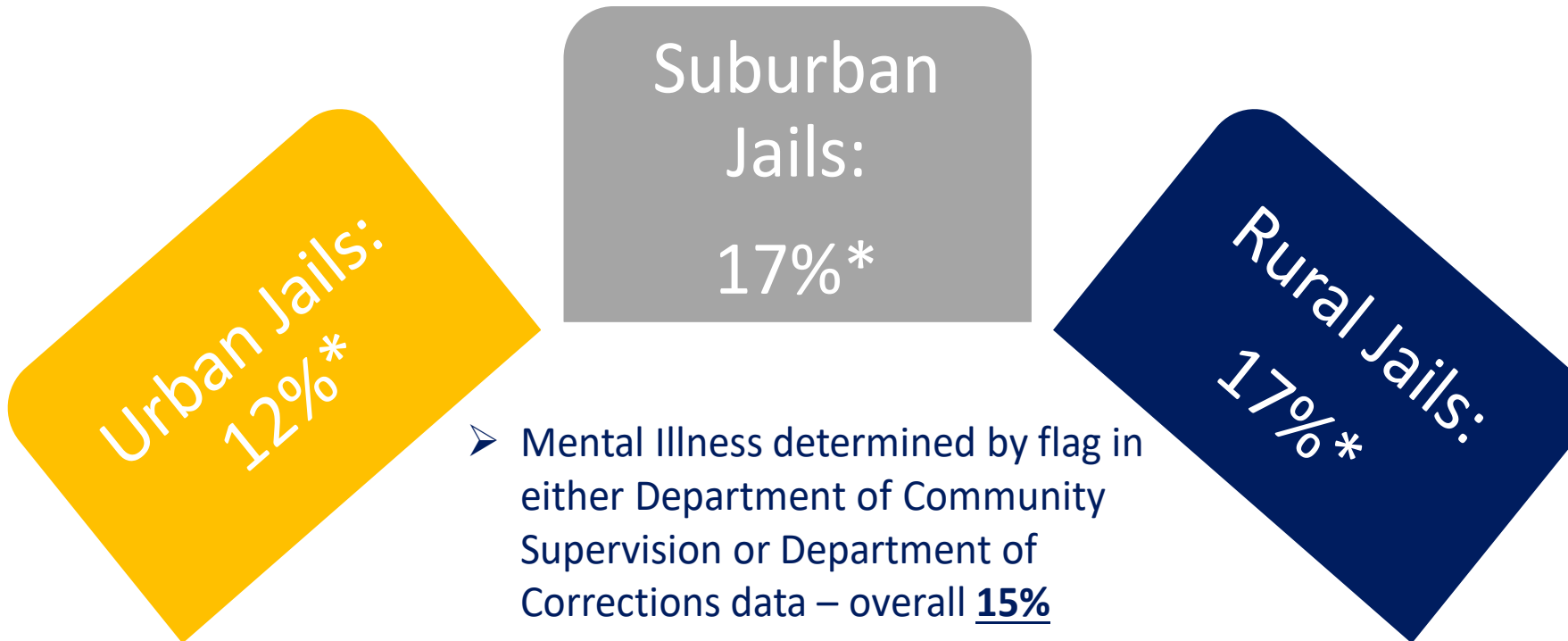
69%

## Cell Movement Records

6 of 9 Jails provided Data

Percent of Matched Booking Episodes Covered: 50%

# Estimated Prevalence of Mental Illness Findings



\* Percent of Booking Episodes

# Felony Arrest History Explained



Booking Episodes  
with no Felony  
History

- 162,615
- 39% of matched booking episodes

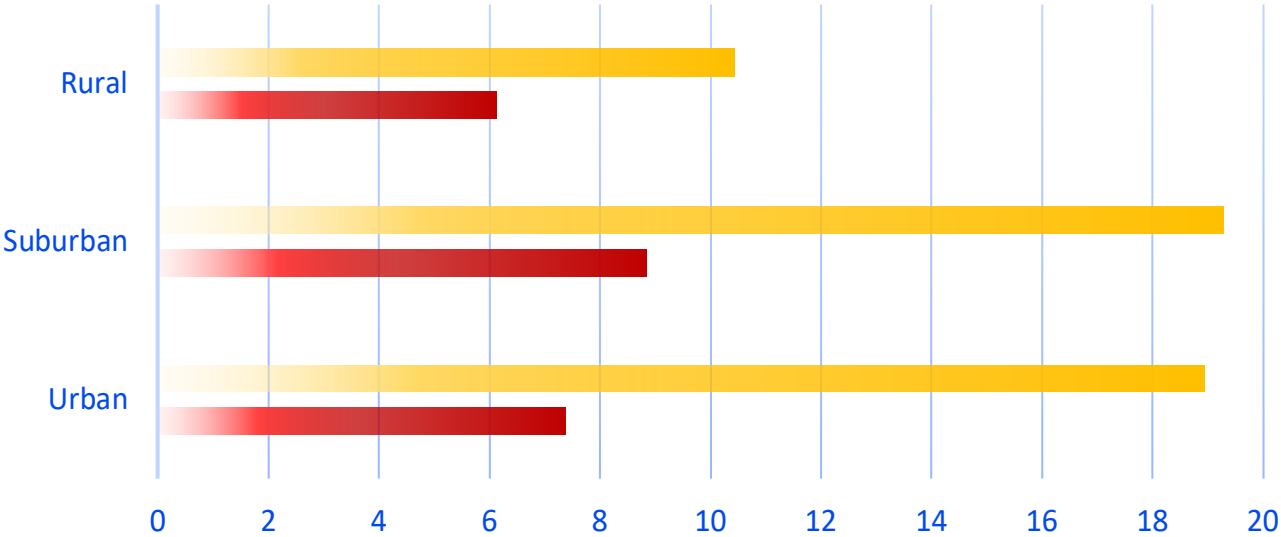
Persons booked with  
No Felony Arrest  
History

- 98,022
- 49% of persons booked

# Arrest History of Jail Population with Mental Illness



**AVERAGE NUMBER OF ARRESTS BY  
MENTAL HEALTH STATUS**



	Urban	Suburban	Rural
MH	18.93	19.28	10.44
No MH	7.37	8.83	6.12

AVERAGE NUMBER OF ARRESTS

**Key Takeaway:**

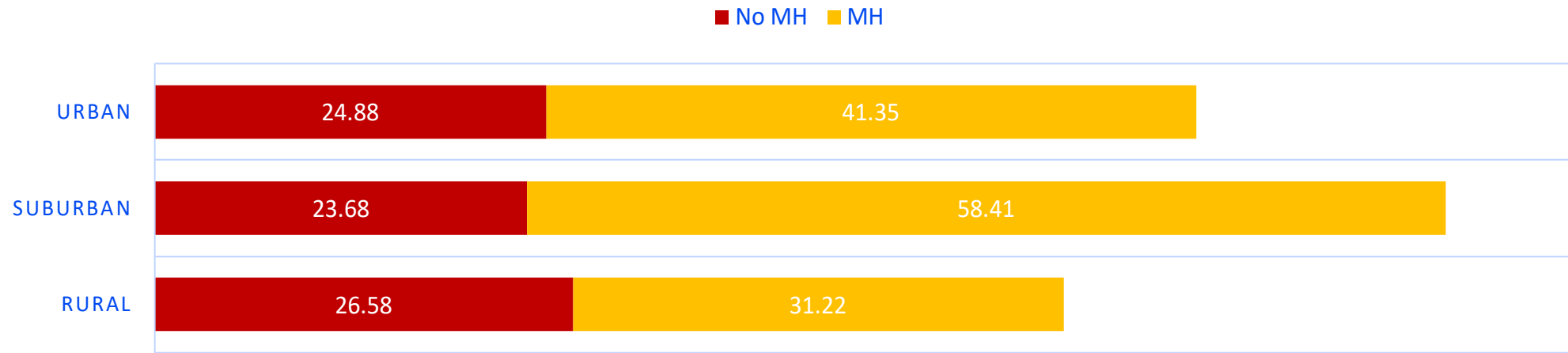
Persons with mental illness booked into jails have over 2x as many arrests on average as those without mental illness.



# Length of Stay Among Those with Mental Illness



## AVERAGE LENGTH OF STAY - IN DAYS - FOR THOSE WITH AND WITHOUT MENTAL ILLNESS

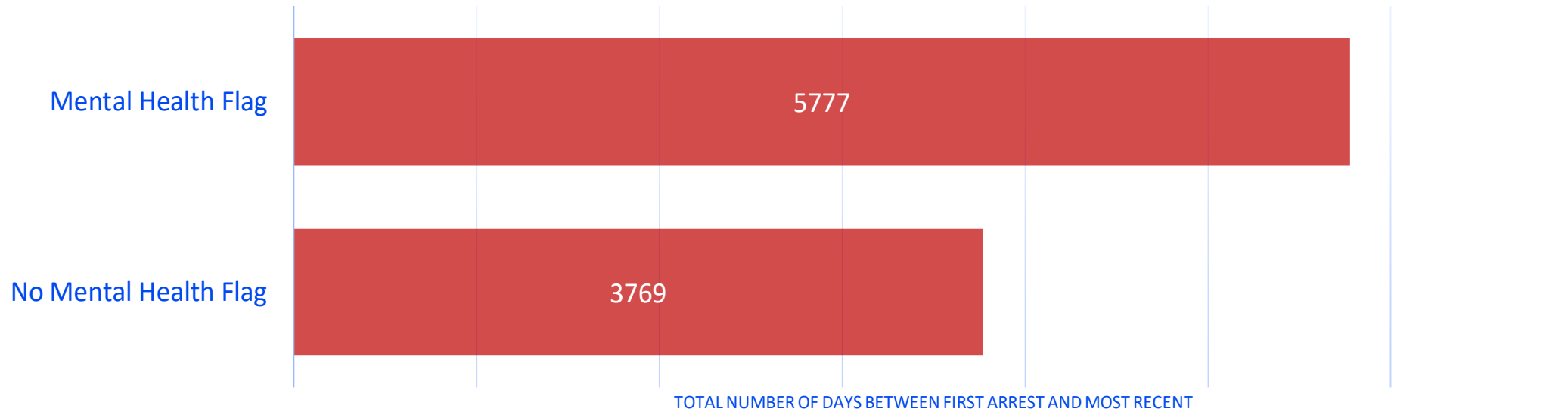


- In suburban jails, those with MI stayed on average 2.5x as long as those without.
- On average those in suburban and urban jails, inmates with a MH Flag stayed incarcerated roughly 1.5-2.5xs longer than those without the mental health flag. Those with mental illness in rural jails stayed almost the same amount of time as those without.
- Overall, inmates with mental illness stayed on average **54** days and those without **26** days.

# Criminal Career Length by Mental Health Status



## "CRIMINAL CAREER LENGTH" - FROM FIRST ARREST TO MOST RECENT

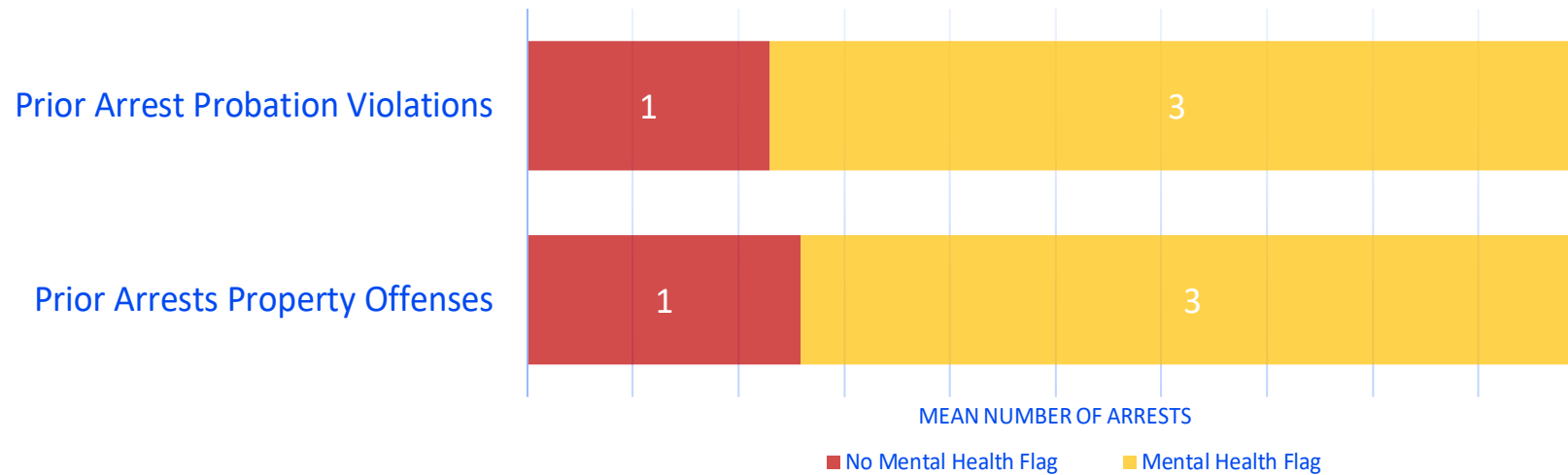


- Those with mental illness had been “active” criminally for almost twice as long as those without mental illness

# Property and Probation Violation Arrest History



## MEAN NUMBER OF PRIOR PROBATION VIOLATION AND PROPERTY ARRESTS

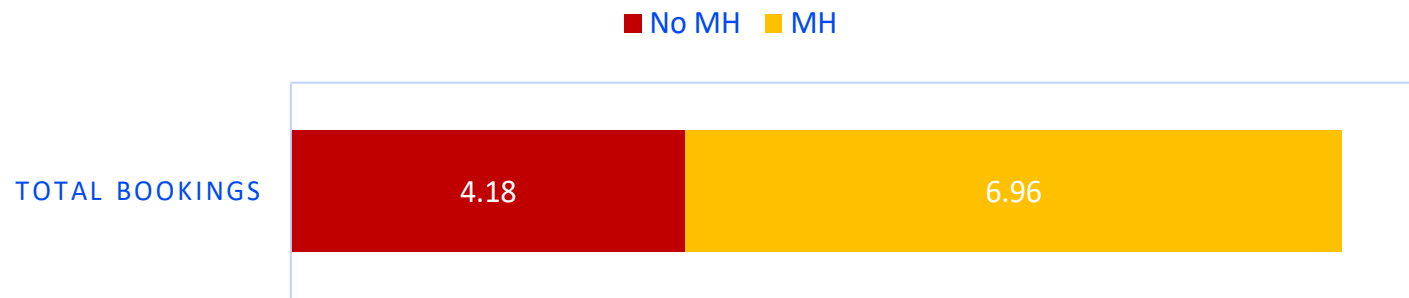


- Those with mental illness have twice as many prior property and probation violation arrests as those without

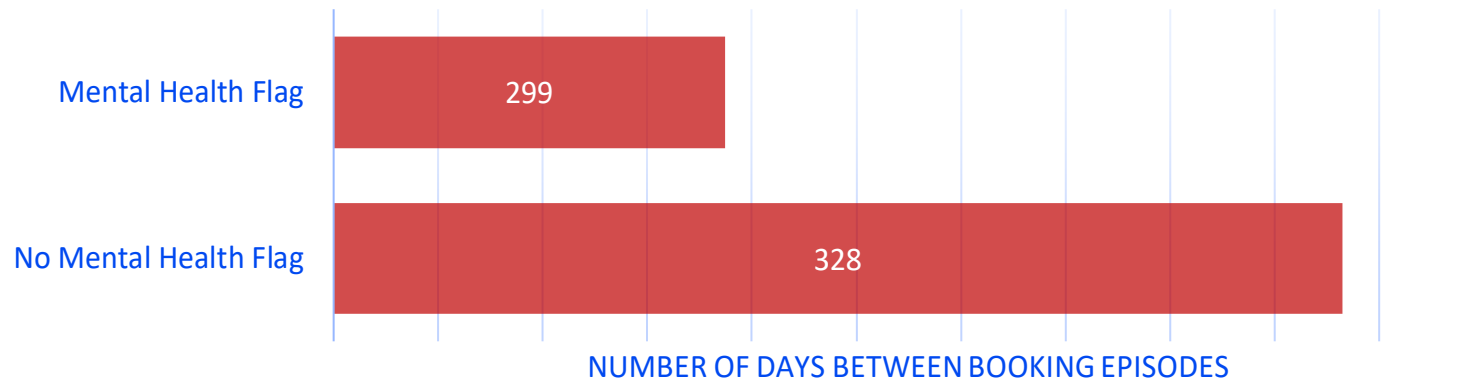
# Jail Recidivism for those with Mental Illness



## AVERAGE NUMBER OF BOOKING EPISODES BY MENTAL HEALTH STATUS



## MEAN NUMBER OF DAYS BETWEEN BOOKING EPISODES



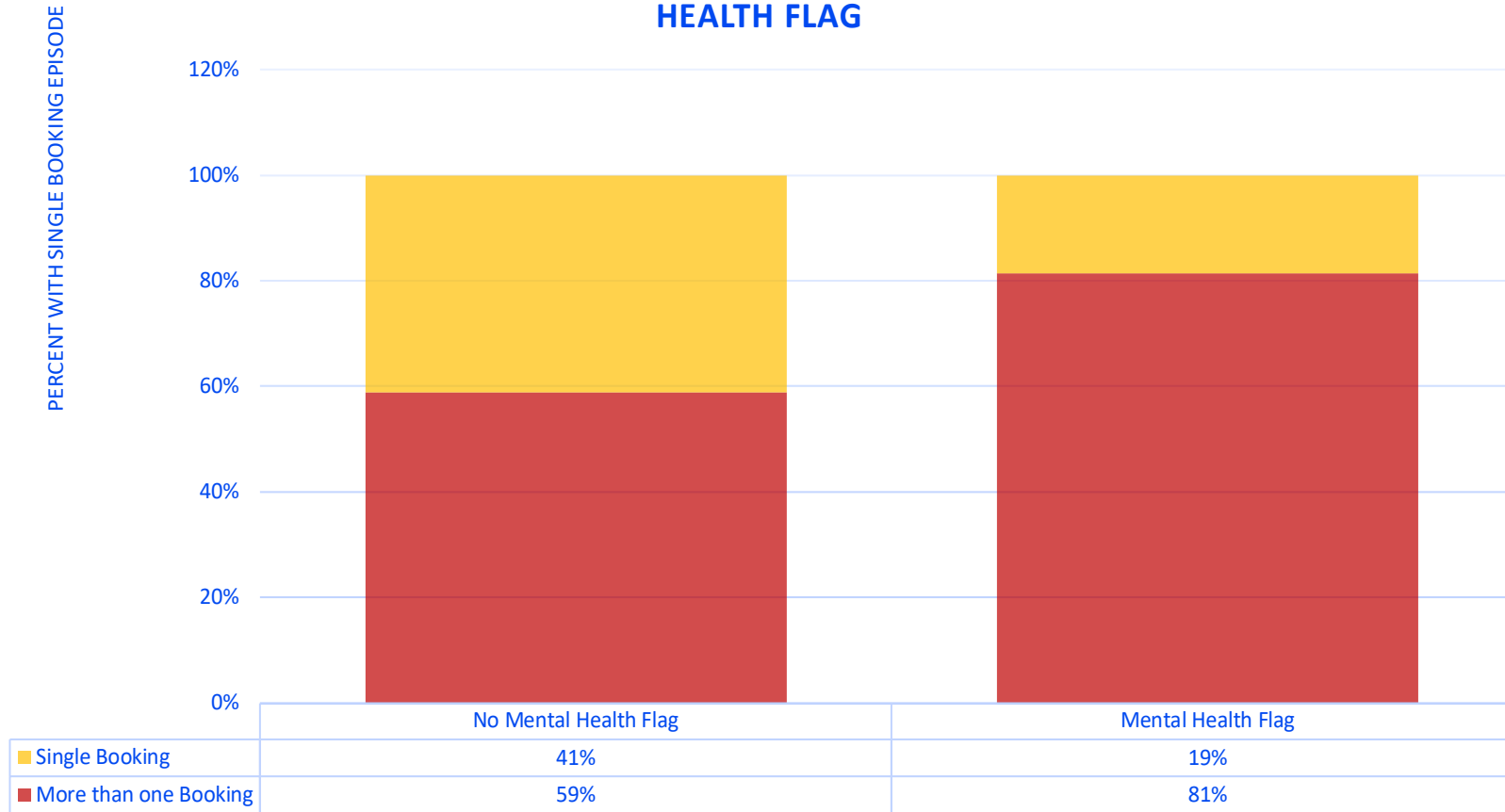
### Key Takeaways:

- Those with mental illness are booked 1.5x as often as those without – on average
- On average, those with mental illness spent on average 29 fewer days in the community between booking episodes
- Both are booked more than once per year on average

# Multiple Booking Episode Risk



PERCENT OF SAMPLE WITH MORE THAN ONE BOOKING EPISODE BY MENTAL HEALTH FLAG



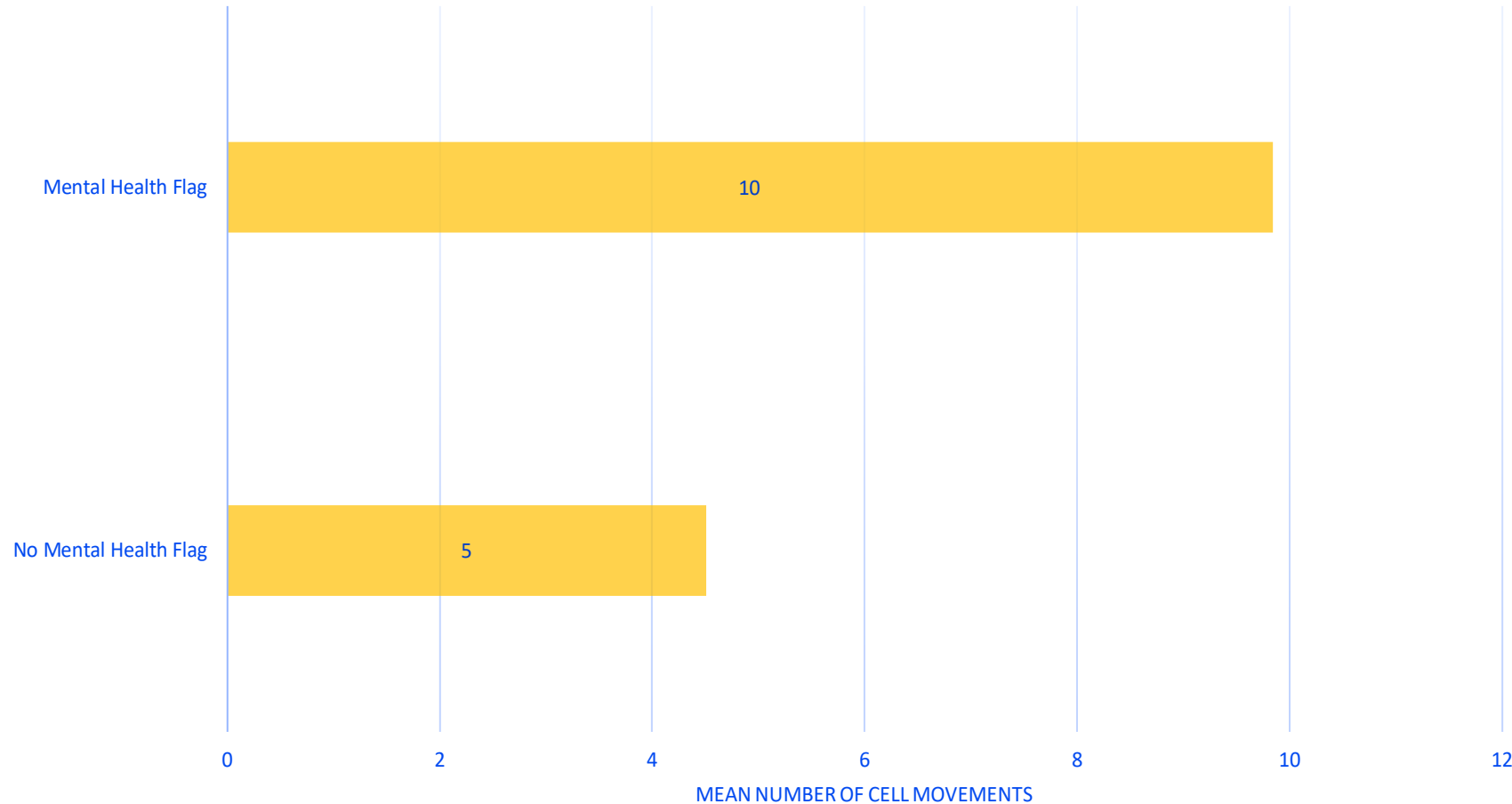
## Key Takeaway:

- Those without mental illness are **2x** more likely to have had a single booking episode during the study period as often as those without mental illness

# Average Number of Cell Movements by Mental Health Status



MEAN NUMBER OF CELL MOVEMENTS PER BOOKING EPISODE



## Key Takeaway:

- Those with MI are moved **twice** as many times *per booking episode* between cells as those without MI.





# A Familiar Faces\* Analysis of the Study Dataset

## Key Takeaways:

1. Familiar Faces are 3x more likely than the overall study sample to be flagged for mental illness.
2. Those with mental illness use a disproportionate share of jail resources – they were 9% of the sample but used over one quarter of total jail bed days.
3. Familiar faces with mental illness spend 40% fewer days in the community than *even those* with mental illness who are not familiar faces.

## 199,959 People Booked over 413,478 Booking Episodes

6,934,241  
Total jail Bed Days

74,904  
People with more than 1 booking episode

394 Days in the community between booking episodes

**Familiar Faces**  
2,328 People in Top 1% of Booking Episodes

**Familiar Faces**  
34,789 Cumulative Booking Episodes

**Familiar Faces**  
378,742 (6%) Total Jail Bed Days

## 17,538 People booked had Mental Health Flag (8.8% of people booked)

1,959,828 (28%) total jail bed days

People with MH spent 379 days in the community between bookings

60,108 Cumulative Booking Episodes (15% total bookings)

**Familiar Faces**  
28% have a Mental Health Flag

## 649 "Familiar Faces" Have A Mental Health Flag (0.3% of people booked)

129,792 (2%) Cumulative Jail Bed Days

172 days in the community on average

9,615 Cumulative Booking Episodes (2% of total booking episodes overall)

\* **Familiar Faces** = Persons who are booked so many times that the number of times they were booked over the study period was in the 99<sup>th</sup> percentile.

# Performance of Indicators As Proxy Measures



Urban Jails Logistic Regression		Predicted		
		Mental Health Flag		
Mental Health Flag	Observed	No	Yes	Percentage Correct
	No	163,734	2,317	98.6%
	Yes	19,315	2,588	<b>11.8%</b>
Overall Percentage				88.5%

Variables in the Equation and Odds Ratios			
Variable Name	B	Sig.	Odds Ratio
Age At Booking	-0.047	0.00	0.954
Total Bookings	0.021	0.00	1.022
Criminal Career Days	0	0.00	1
# Prior Property Arrests	0.069	0.00	1.071
# Prior Probation/Parole Violation Arrests	0.252	0.00	1.287
Male	0.506	0.00	1.659
Constant	-1.968	0.00	0.14
*Significance at the 0.0 level indicates p<0.01, or the 99th Percentile			

Suburban Jail Logistic Regression Output		Predicted		
		Mental Health Flag		
Mental Health Flag	Observed	No	Yes	Percentage Correct
	No	85,352	2,928	96.7%
	Yes	24,183	4,174	<b>14.7%</b>
Overall Percentage				76.8%

Variables in the Equation and Odds Ratios			
Variable Name	B	Sig.*	Exp(B)
Age At Booking	-0.027	0	0.973
Cell Movement Count	0.025	0	1.025
Total Bookings	0.004	0	1.004
Criminal Career Days	0	0	1
# Prior Property Arrests	0.066	0	1.069
# Prior Probation/Parole Violation Arrests	0.118	0	1.125
Male	-0.137	0	0.872
Constant	-0.928	0	0.395
*Significance at the 0.0 level indicates p<0.01, or the 99th Percentile			

# Limitations and Next Steps



## Limitations

- Mental Health flag depends on felony history
- No SID matches for almost 1/3 of provided records
- Missing data on cell movement for various jails
- Missing release dates and other key information

## Next Steps

- Work with 4 Jails to Compare Proxy Indicators to validated screener
- Assess percentage of people with no felony history who screen positive for mental illness

# Want data help? Contact Us!



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# IDENTIFYING PREDICTORS OF MENTAL ILLNESS IN COUNTY JAIL DATA



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John Speir, Ph.D. - Principal

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## Criminal Justice Coordinating Council

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# Acknowledgements

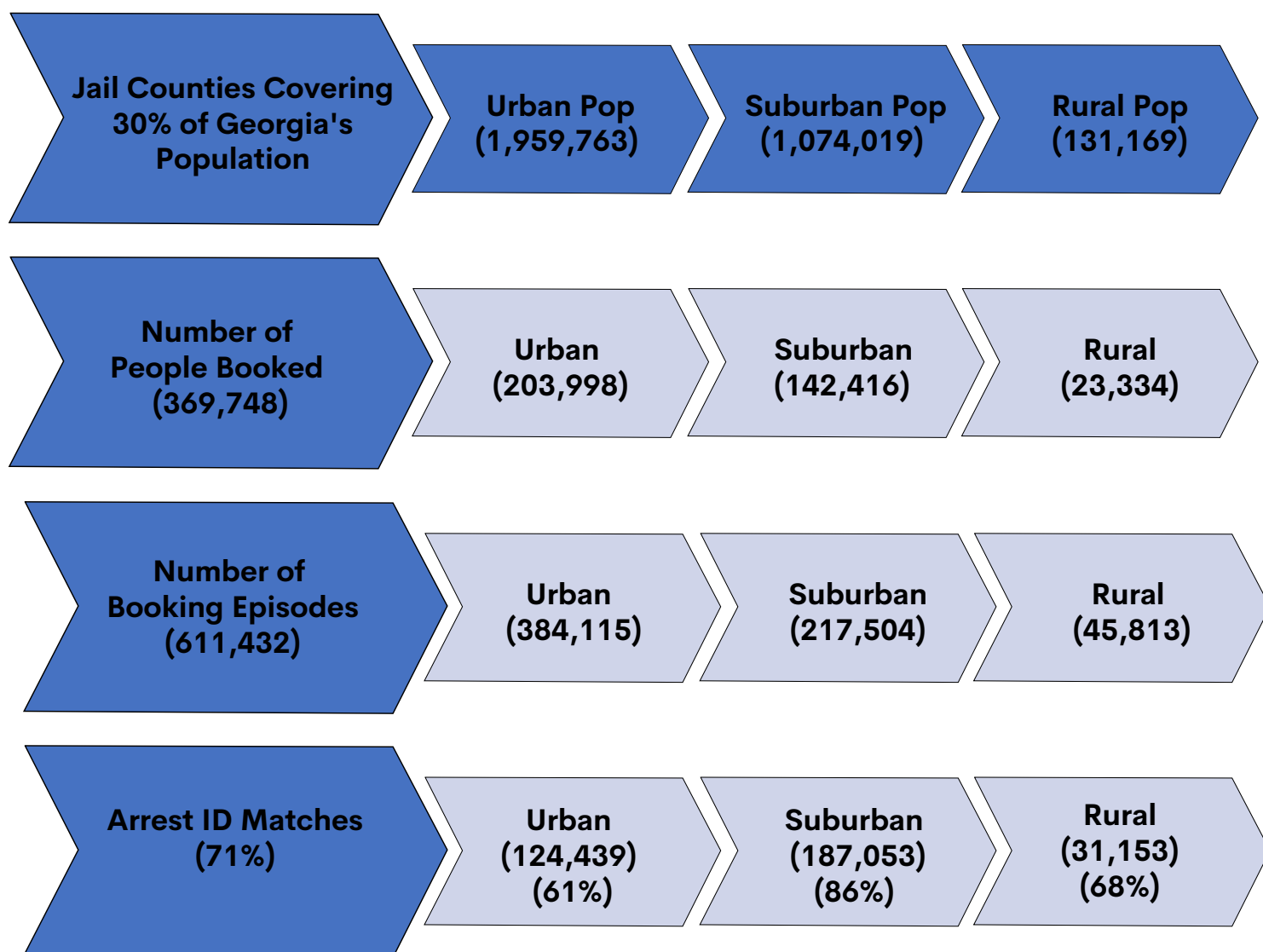
Research-to-practice is not possible without trust and partnership from practitioners. Applied Research Services and the Georgia Statistical Analysis Center thank the Georgia Sheriff's Association – Executive Director Terry Norris, former Training Director Tonya Welch, Administration Director Christie Luman, and current Training Director Brent Loeffler – for helping us kick this project off and giving us the opportunity to present our findings at their conference. Having their stamp of approval in our initial communication with the selected jails helped us obtain buy-in for initial interviews and data acquisition.

We thank each of the nine county jails and the Sheriffs from those counties for their generosity of time and data. This project would not have been possible without their willingness to speak with us candidly about their booking process, send us data (sometimes in multiple, and iterative batches), and helping us connect to new and different staff when our contacts moved on from their positions. We are very grateful for their willingness to participate in the research process.

Finally, thank you to Mr. Joe Hood, former Deputy Commissioner of the Department of Community Health, for asking the question in the first place. His need to know an estimate of the prevalence of mental illness within our county jails is the foundational research question for this study.

# Estimating Prevalence of Mental Illness Among Persons Booked into Georgia Jails (2013-2018 Study Period)

*Data from Nine Georgia County Jails, Computerized Criminal History,  
Department of Corrections, and Department of Community Supervision  
3 Urban, 3 Suburban, 3 Rural Jails Participating*



# Conservative Estimate of Prevalence of Mental Illness Among Persons booked in County Jails

Bookings Involving Mental Illness (59,998)	# People with Mental Illness Booked (17,538)	14% Booking Episodes Involve Mental Illness	9% of Persons Booked Have Mental Illness
--	---	---	--

## Risk Factors Associated with Mental Illness and Impact on Jails

Mental Illness	No Mental Illness
Average Length of Stay: <b>54 Days</b>	Average Length of Stay: <b>26 Days</b>
Average Days Between Bookings: <b>299</b>	Average Days Between Bookings: <b>328</b>
Average Number of Cell Movements Per Booking : <b>10</b>	Average Number of Cell Movements Per Booking : <b>5</b>
Average Number of Days from First Arrest to Most Recent: <b>5,777</b>	Average Number of Days from First Arrest to Most Recent: <b>3,769</b>



### 2x More Likely to Have Mental Illness

- Homeless Persons
- Persons with at least 1 quality of life arrest



### 1.5x More Likely to Have Mental Illness

- Men
- Persons booked within the same year
- Persons with more than one booking episode in the study period

# Background and Literature

In 2018 legislative session, the Senate passed bill 407 which struck the previous prohibitions in Georgia code that precluded inmates in prison or jails from being assessed for eligibility for Medicaid. Additionally, the bill allowed use of Medicaid funds to pay for services rendered at eligible medical institutions for prison or jail inmates. While the removal of this restriction represents a boon and potential cost savings for county jails and the state prison system, the Georgia Department of Community Health, which administers the Medicaid program, needed to ascertain how many county jail inmates may qualify for Medicaid under current eligibility criteria. The federal Social Security Administration (SSA) has established data exchanges with the county jail management system vendors to identify persons arrested and booked so that benefits could be suspended until the person is released. SSA shares these data with the Department of Community Health so that Medicaid benefits may also be suspended, and not cancelled, as they had historically been.

A recent BJS published issue brief using jail and prison inmate self-report found that more than a quarter of jail inmates had experienced symptoms of serious psychological distress in the 30 days prior to the survey. More alarming, 44% of BJS jail survey respondents asserted that a health professional had diagnosed them with a mental disorder <sup>i</sup>. A recent Government Accountability Office study <sup>ii</sup> of states that did and did not expand Medicaid under the Affordable Care Act found that in non-expansion states, approximately 2% of the prison population would qualify for Medicaid. Jail inmates were not considered in the study. Criteria in non-expansion states for Medicaid eligibility includes income thresholds and medical diagnosis that indicates disability for those younger than 65.

Recent studies have found certain indicators common to persons with serious mental illness (SMI) which serve as proxy indicators to estimate the number of inmates in county jail with mental illness, who might qualify for social security and thus Medicaid. These factors include <sup>iii</sup>:

- Length of Jail stay
- Likely to be detained pre-trial
- Likelihood to make bail
- Number of Booking Episodes

# Background and Literature Cont

Recidivism among persons with serious and persistent mental illness is also a concern for Georgia's current Governor, Brian Kemp. During the 2019-2020 legislative session, the General Assembly passed HB 514, which created the Georgia Behavioral Health Reform and Innovation Commission. Among the issues the Commission will examine over four years is "the impact behavioral health issues have on the court system and correctional system, ... the need for aftercare for persons exiting the criminal justice system." Given the concerns surrounding recidivism, and that roughly more than a quarter of jail inmates experience symptoms of serious psychological distress,<sup>iv</sup> understanding the scope of issues underlying mental health service utilization is of growing interest to policy makers. Studies in both urban and rural settings have consistently found that substance abuse disorders<sup>v</sup> and co-occurring disorders are drivers of jail readmission<sup>vi</sup>. Other studies have found that individuals with serious mental illness return to prison in about half the time as those without.<sup>vii</sup>

Although service provision affects both mental health outcomes<sup>viii</sup> and recidivism rates<sup>ix</sup>, inmates appear to experience more difficulty in obtaining health insurance that could assist in accessing these services upon release. Moreover, a recent study suggests that jail inmates are denied Medicaid coverage at higher rates than both prison inmates and psychiatric patients<sup>x</sup>.

Barriers to Medicaid coverage for inmates are a critical concern for service utilization considering more than 70 percent of inmates use health care services within the first 10 months of release<sup>xi</sup>. To circumvent low coverage approval rates, the Substance Abuse and Mental Health Services Administration (SAMHSA) funds a national technical assistance program dedicated to increasing Medicaid approval across the U.S. The SSI/SSDI Outreach, Access, and Recovery (SOAR) method uses in-depth medical and personal summaries of disability to facilitate in the SSI application process. Based on data from SAMSHA's SOAR technical assistance website, criminal justice best practice sites had completed 407 SSI/SSDI applications for persons in either prisons or jails. Of those, 73% were approved in an average of 85 days. This is compared to the average approval rate of 29% for eligible applications. Further, the increases in acceptance for Medicaid coverage have led to upward of five million dollars in reimbursements in some cases<sup>xii</sup>.

Identifying the prevalence of mental illness among county jail inmates is a challenge because of the heterogeneity of jail management systems, and the way data are collected. Jails tend not to focus on data collection for research or reporting, further compounding the difficulty of using jail management system data for systematic analysis<sup>xiii</sup>. The present analysis creates a standardized dataset using data from nine county jails in Georgia so those records can be matched to computerized criminal history and other state criminal justice administrative data. Once matched, we assessed the predictive value of proxy indicators within the county jail datasets on inmate mental illness. We also use the administrative data to estimate the prevalence of persons with mental illness in county jails.



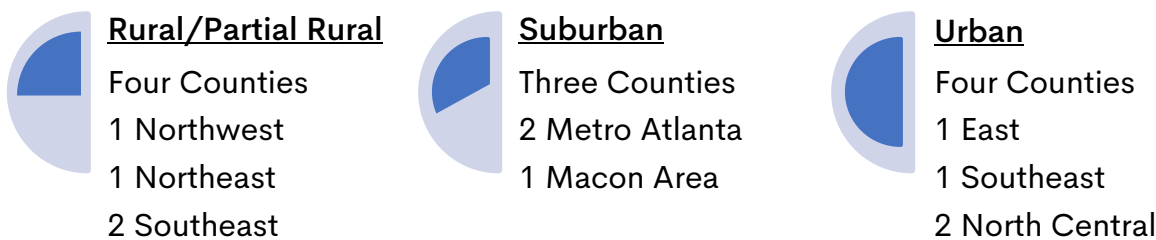
# Methodology

The present study consisted of secondary data analysis of county jail, Georgia Bureau of Investigations' computerized criminal history (CCH), Department of Corrections (GDC), and Department of Community Supervision (DCS) data. Work was divided between the Georgia Statistical Analysis Center (GASAC), a division of the Criminal Justice Coordinating Council; and Applied Research Services (ARS). Where one agency or the other was primarily responsible for a portion of the work, we use that entity's acronym. Otherwise, the first-person plural "we" is used.

Prior to obtaining data from the jails, we conducted semi-structured interviews with jail intake staff, medical staff, and jail commanders.

## Jail Selection

ARS stratified county jails in Georgia using jail census, demographic, and county urban/rural designations from the Census and the Health Resources and Services Administration. Any counties that were part of Metropolitan Statistical Areas, but not the locus of the city around which the MSA is built, were designated suburban. We initially identified 11 counties of interest.

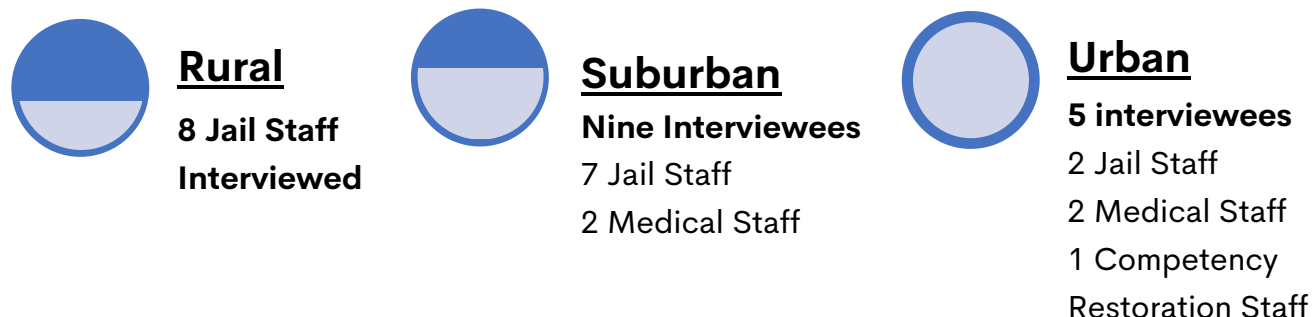


*GASAC received data from nine counties. Below is a breakdown of the final county participation count.*

- |                     |   |  |
|---------------------|---|--|
| <b>Rural (3)</b>    | { | <ul style="list-style-type: none"><li>• 1 Declined</li><li>• 1 Dropped for Non-Cooperation</li><li>• 1 Non-Selected County Volunteered</li></ul> |
| <b>Suburban (3)</b> | { | <ul style="list-style-type: none"><li>• 1 Total Participation – No Counties Declined or Dropped Out</li></ul>                                    |
| <b>Urban (3)</b>    | { | <ul style="list-style-type: none"><li>• 1 Declined</li><li>• 3 Accepted Participation</li></ul>  |

# Interviews and Standardized Dataset

The interviews probed on the data collected throughout the intake process and the purpose for which data are collected. In total, we interviewed 21 jail intake, command, or medical staff.



All but one agency used a commercially available jail management systems. The one agency on a legacy, mainframe system was transitioning to a commercial system shortly after delivering the data to GASAC. All but one agency had data available from January 1, 2013 to December 31, 2018. The common data elements we identified from the interviews included:

Person Data	Booking Episode Data	Additional Data
<ul style="list-style-type: none"><li>• System identifier</li><li>• State Identification</li><li>• Number</li><li>• First name</li><li>• Last name</li><li>• Race</li><li>• Sex</li><li>• Gender</li><li>• DOB</li><li>• Address</li></ul>	<ul style="list-style-type: none"><li>• Booking Date</li><li>• Release Date</li><li>• Booking Episode ID</li><li>• Charges Booked</li><li>• Bond Information</li></ul>	<ul style="list-style-type: none"><li>• Cell Movement Data</li><li>• Charge Disposition</li><li>• Arresting Officer and Agency</li><li>• Alerts/Notes about an Inmate</li></ul>

No jails maintained any information about a booked person's medical history. All jails had contract medical providers with their own electronic medical record systems. None of the jails maintained any information in their jail management systems about discharge planning. Indeed, discharge planning was not part of standard jail operations. Often people cycled through the jail too quickly to adequately plan for discharge.

Prior to requesting data, we scheduled virtual meetings with each jail to walk through the data entry screens in their jail management systems. We completed these walk-throughs with four of the jails. We received screenshots of data entry screens from the JMS vendor for 2 other jails. We were not able to schedule walk throughs with the remaining three jails.

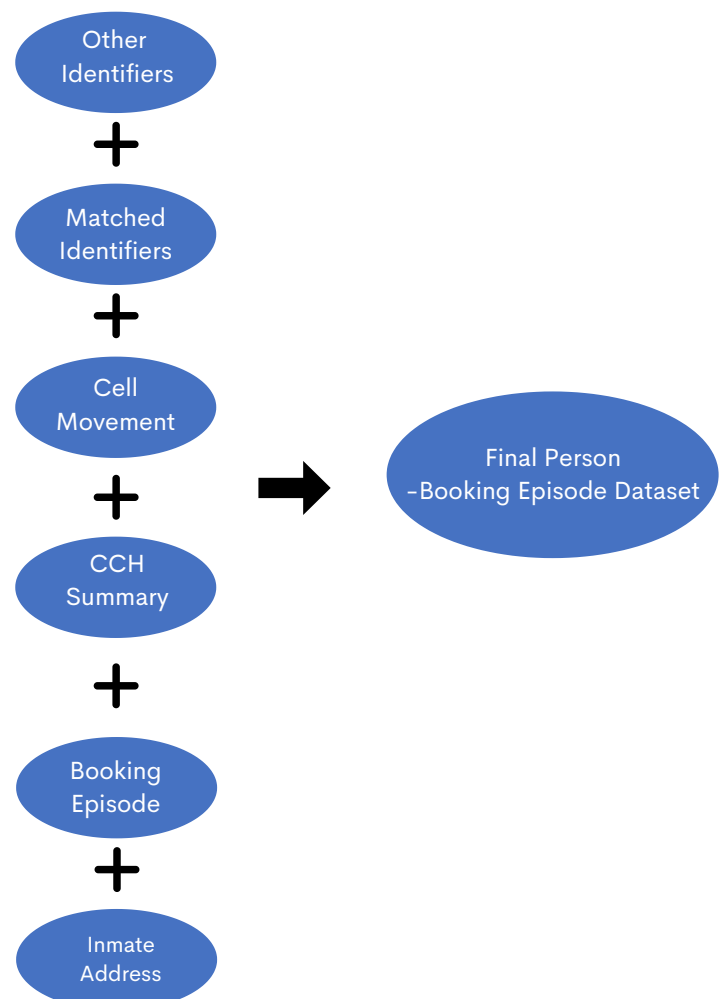
# Data Harmonization and Transformation

Upon receipt of each jail dataset, GASAC isolated the person identifiers to create a unique hashkey for each inmate. These included:

Identifier	Number of Jails Providing
First Name	8
Last Name	8
Address	7
Race	9
Sex	9
Date of Birth	9
Native JMS Person Identifier	9
State Identification Number	3

Once GASAC assigned the hashkey, data were sent to ARS to match with computerized criminal history, Department of Community Supervision, and Georgia Department of Corrections data. The latter two datasets contributed information about whether a person had a mental illness – based on a mental health level of 2 or greater in GDC data, or an elevated score on DCS' 11-point mental health screener.

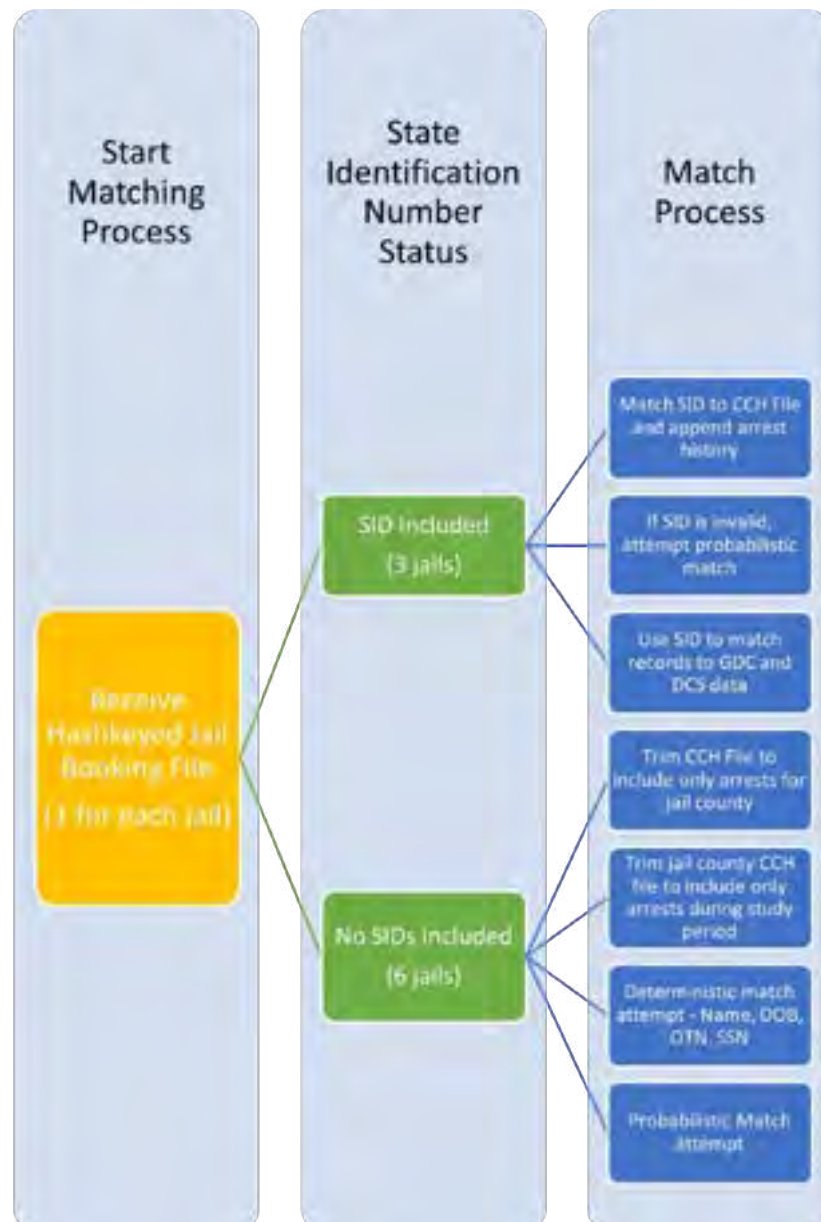
The remaining variables were divided into tables to create the final datasets. The final dataset contained 58 variables and was structured at the person-booking episode level – meaning that each person may be listed multiple times for different booking episodes. The dataset was derived from individual databases created for each jail. The databases consisted of 6 tables.



# Administrative Dataset Matching

ARS maintains the CCH research database for the Georgia Bureau of Investigations. Because the firm designed and validated the actuarial risk assessment for the Georgia Department of Corrections, and the Department of Community Supervision, ARS also has ready access to research datasets for those two state agencies. Without these three datasets, we would be unable to estimate mental illness within the county jail population using solely administrative data. The graphic below provides an overview of the matching process ARS uses with computerized criminal history. ARS uses CDC's LinkPlus registry program to combine CCH data to other administrative datasets using both deterministic and probabilistic matching.

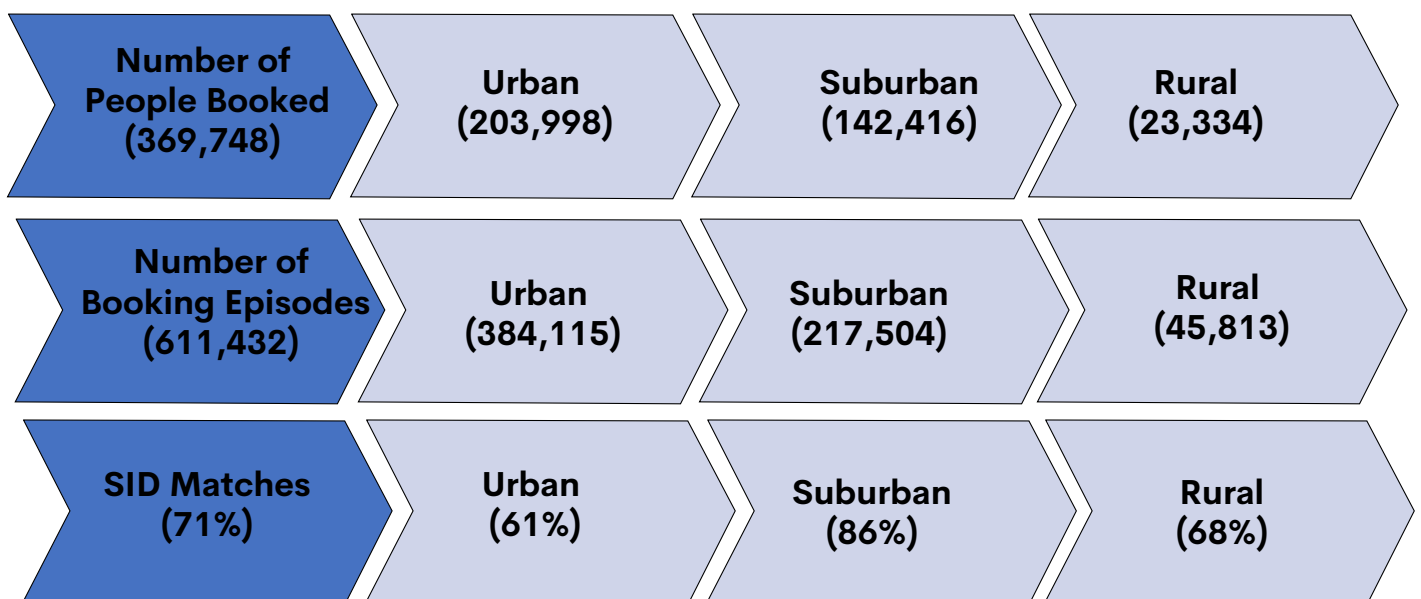
Once ARS matches the person to a valid SID, they can pair the person's entire arrest history within the state of Georgia. The offenses in that history are scored and translated into categories and flagged. Where a jail had some missing data on race or sex information about someone, ARS could use the CCH race and sex to populate those fields.



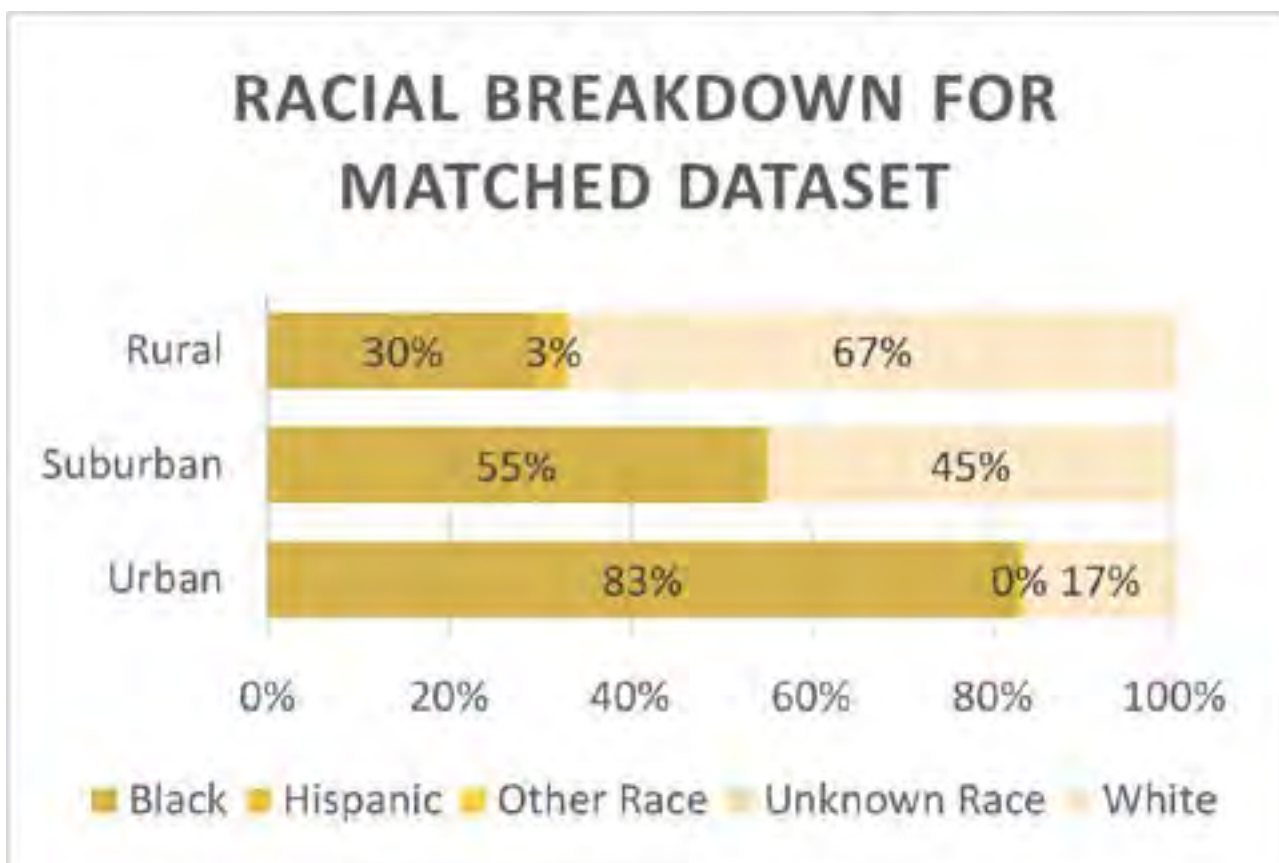
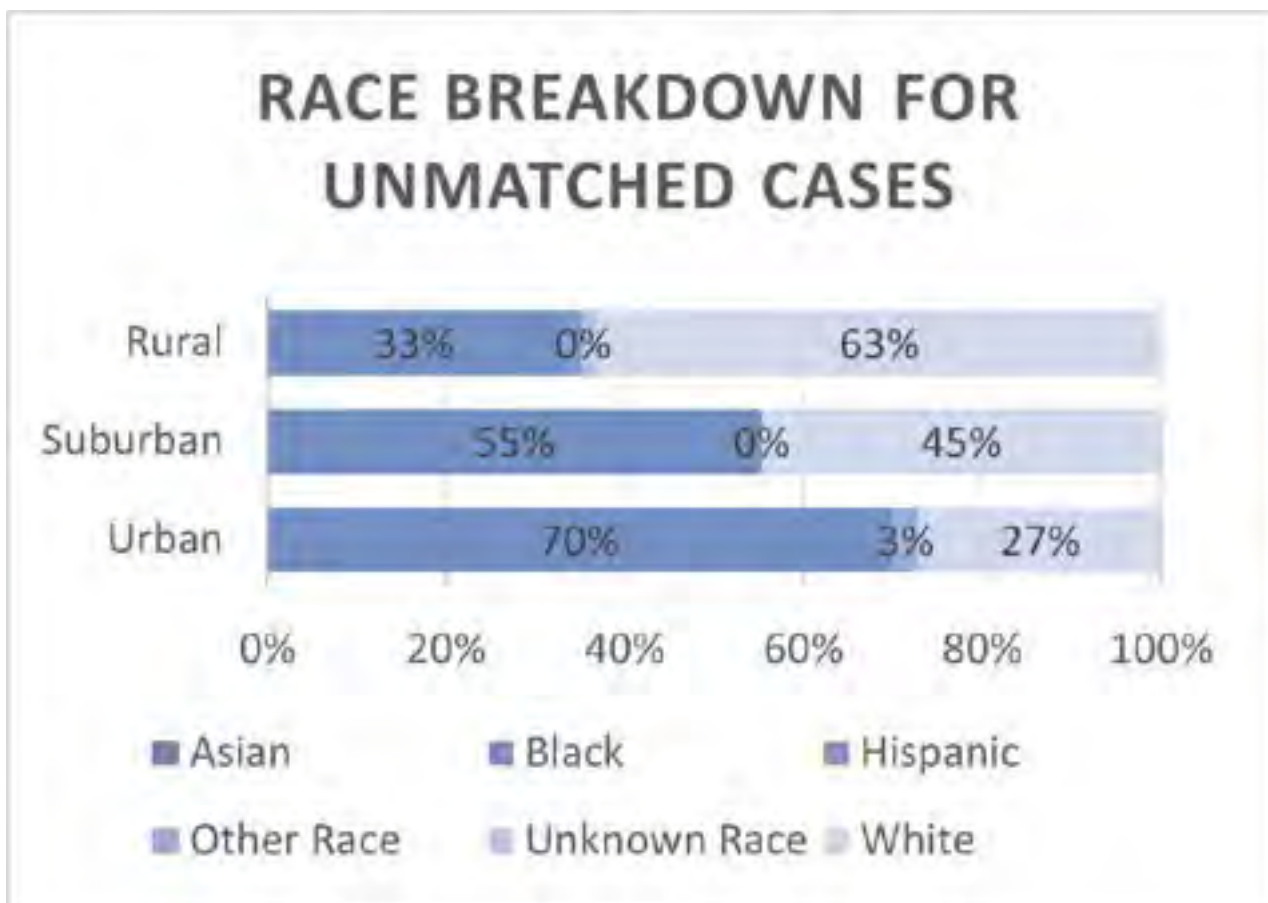
The SID from CCH can be used to match records to both GDC and DCS data. Those datasets supplied information on whether any booked person **with a felony offense history** had been in a mental health program or scored highly on a mental health screener.

Only one jail provided clean SIDs. The match rate for that jail was upwards of 90% of booking episodes. The other two jails that provided SID information did so in an open text field with multiple SID, and SID-like numbers in the field. Those had to be parsed, cleaned, and each number was tried against the CCH database for a match.

Below is a summary of the number of persons and booking episodes in the dataset. Overall, ARS was able to find SID's for 71% of the people in the dataset representing 69% of the booking episodes in the dataset.

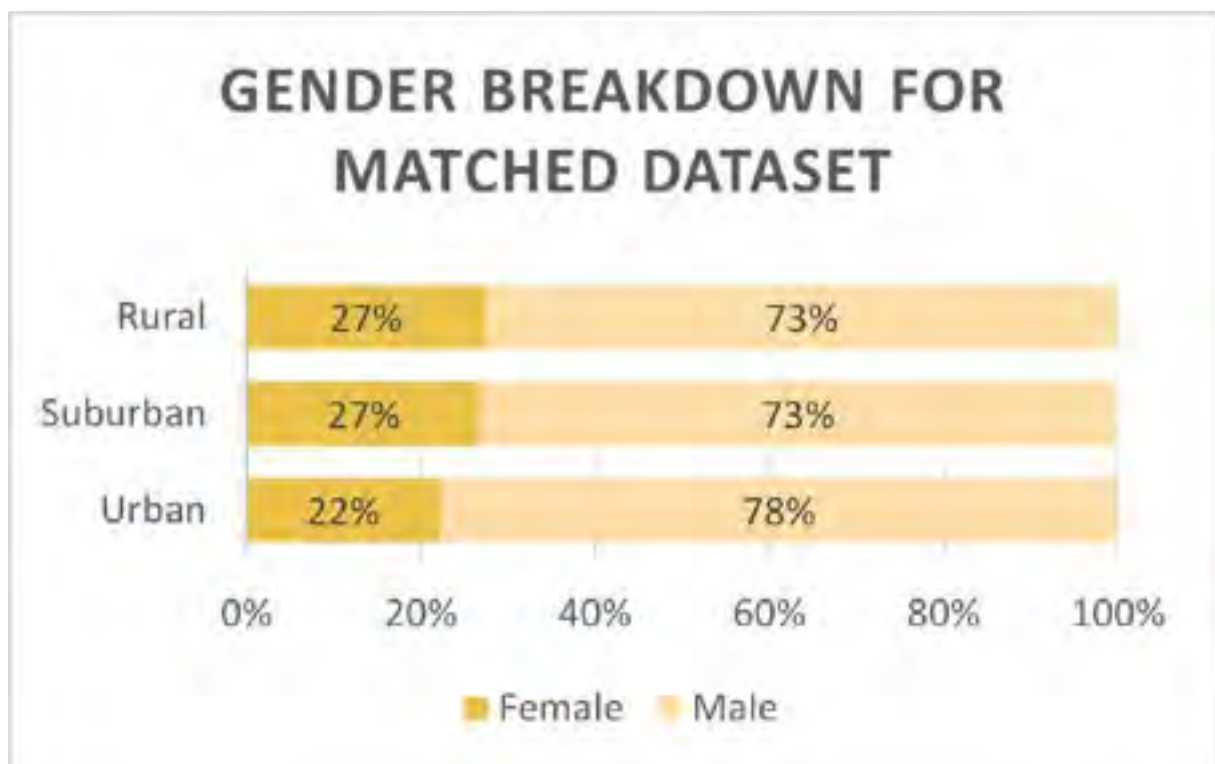
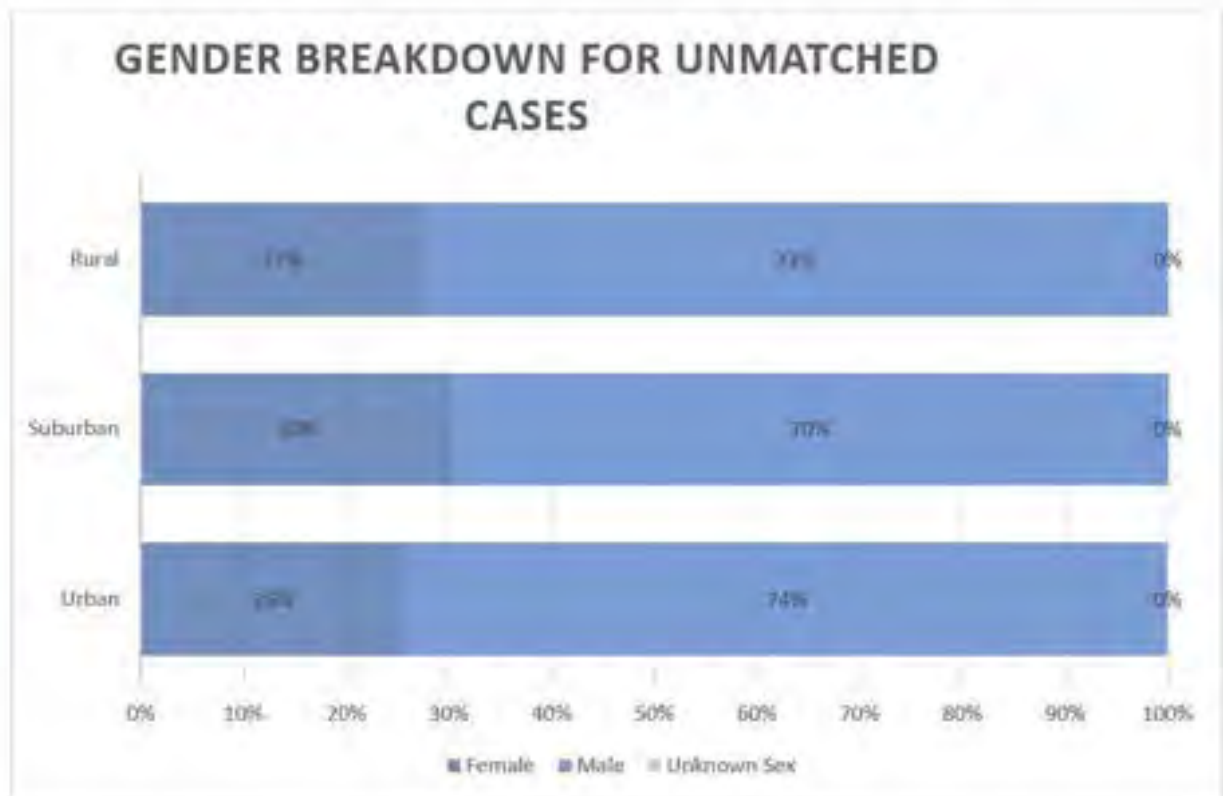


The charts below demonstrate that the demographic breakdown for the matched dataset versus the full dataset.





As compared to urban and suburban jails, the population in rural jails was substantially whiter. With respect to gender breakdown, almost three quarters of the overall and matched samples for all jails were male.



Finally, with respect to age, the overall population was 35 on average. The matched sample was 34 on average and the non-matched sample was between 36 and 34.

Whether someone's record successfully matched CCH did not seem to be dependent on booking frequency either. Across the three jail types, the average number of bookings per person was 1.7 for those with and without a Valid SID.



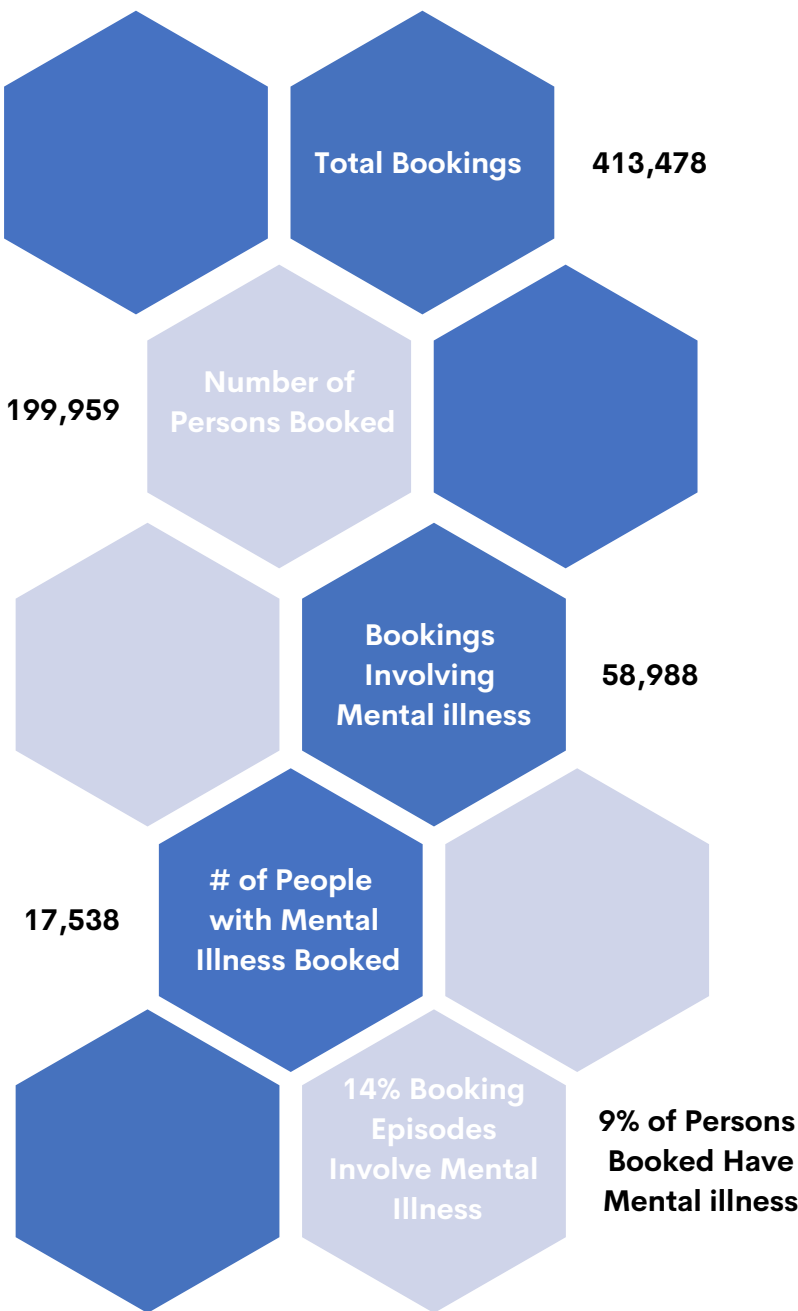
Given the basic demographic breakdowns of the matched and non-matched data, and that we were able more than two-thirds of the people in the original datasets, we are confident that the missing records from non-matches are not likely to bias our findings.

# Findings

## Conservative Estimate of Prevalence of Mental Illness in County Jails

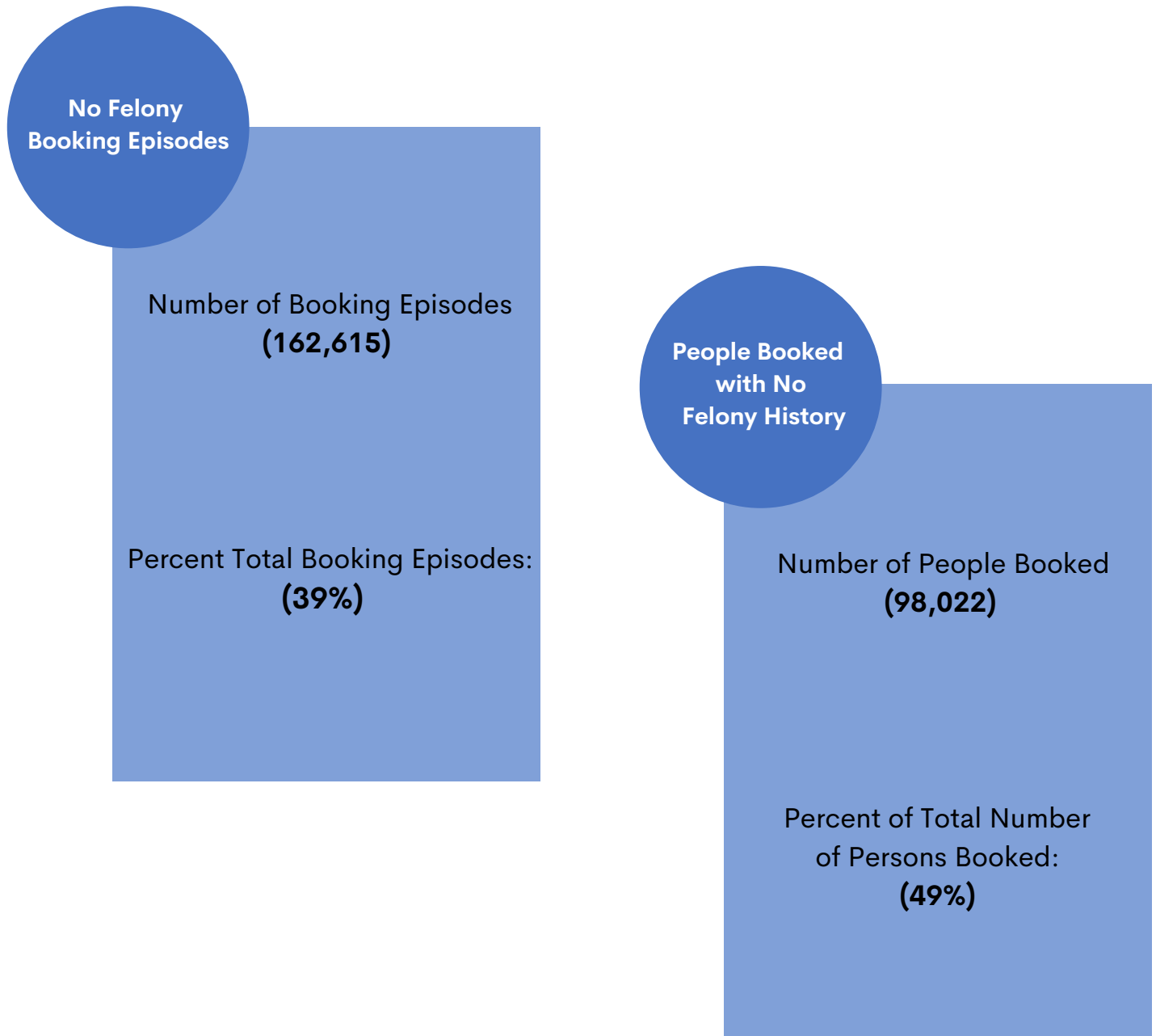
The indicator for mental illness in our dataset is derived from an 11-point mental health screener that DCS conducts, and GDC’s mental health classification for inmates.

A person in our dataset must have a felony conviction history to be found in either GDC or DCS datasets. Therefore, the estimate below is **conservative** and likely **understates** the percent of people who have mental illness, and by extension total bookings involving mental illness.



These prevalence estimates are conservative because a substantial portion of our matched sample had no felony conviction history, and thus their mental health status is completely unknown, since jails did not give us these data. These prevalence estimates are based on known mental health flags as denoted in DCS and GDC data.

Nevertheless, even with these conservative estimates persons with mental illness are represented in county jails at twice the rate that they are in the general population. According to the National Institutes of Mental Health, 5.6% of the U.S. population has serious mental illness.<sup>xiv</sup>

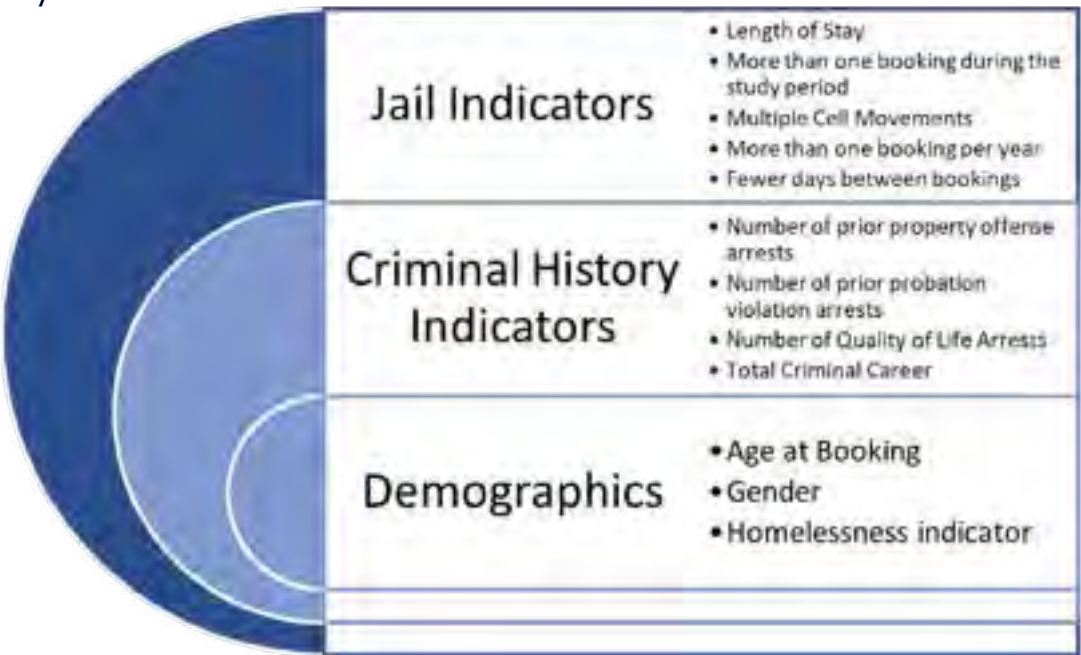


Almost half of all people booked into the jails in our sample during the study period had no felony conviction history. That means they would never had gotten screened at either DCS or GDC for mental illness, and thus their mental health status is effectively unknown in the administrative datasets at our disposal. This fact presents a substantial limitation to the current study and to our prevalence estimate.

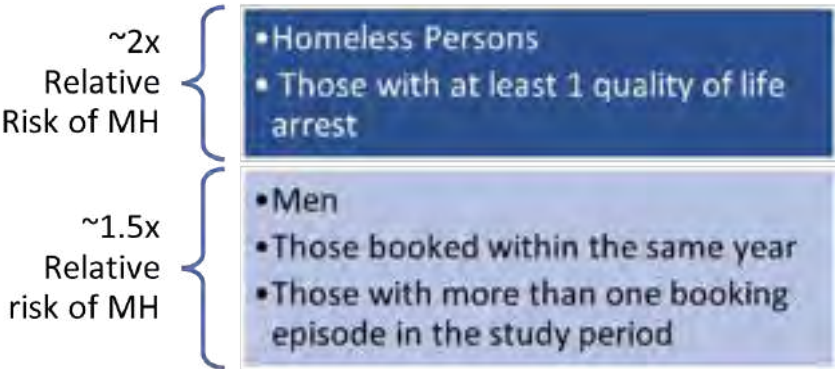
# Significant Difference on Multiple Jail Episode Indicators between Persons with Mental Illness and those Without

The second focus of the present study is to identify proxy indicators within jail management system and criminal history data that may predict mental illness. While there are at least two validated xv, short-form screening tools for mental illness available to jails, identifying predictors that can be calculated on, and potentially programmed into, jail management systems would be a time-savings for intake officers. As stated previously, persons with mental illness tend to differ in their jail experiences from those without mental illness on such factors as length of stay and number of times booked to the same (or different) jails.

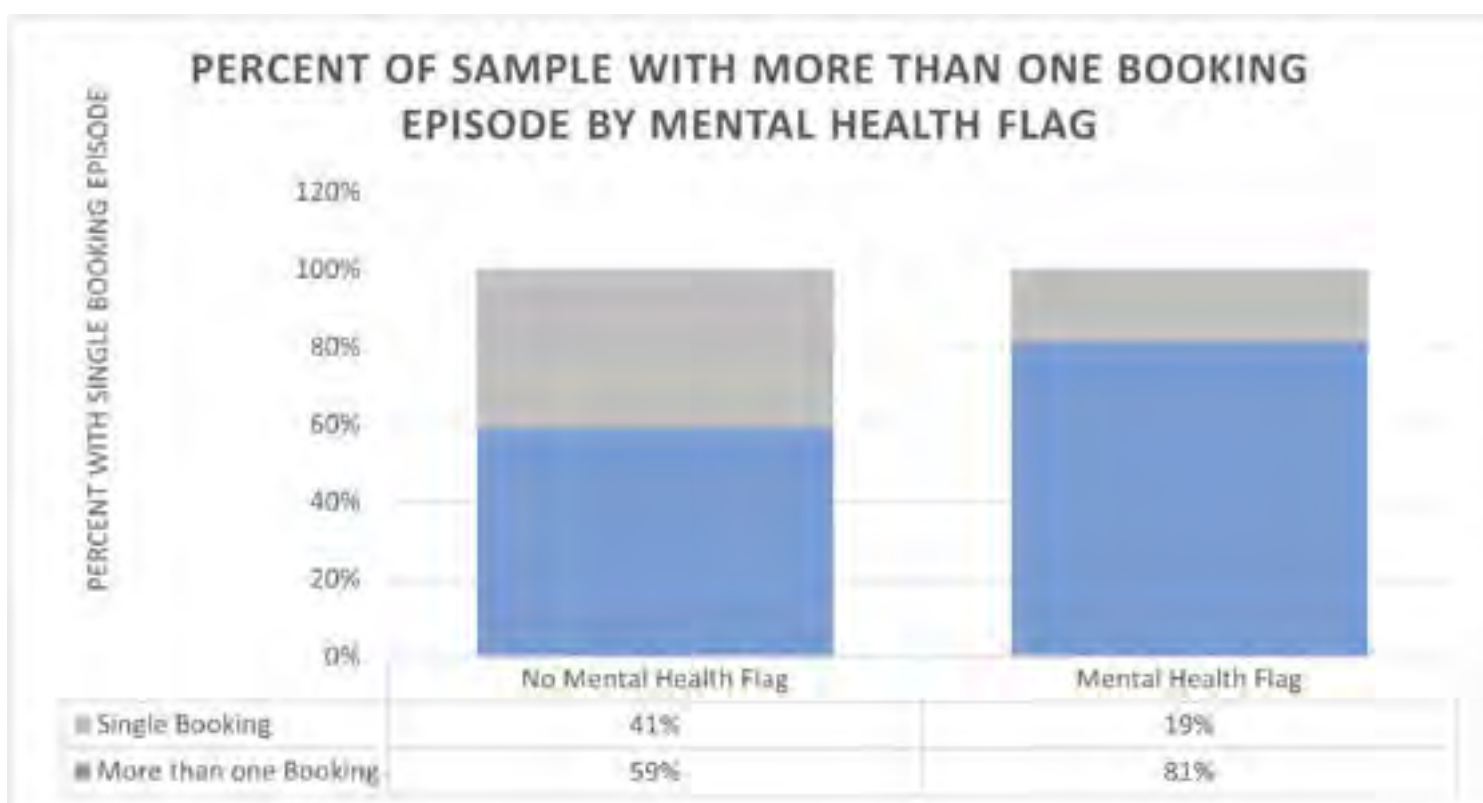
We used t-tests and chi-square analysis to determine whether mental illness was significantly associated with:



In brief, we find significant relationships between our mental illness flag and the following indicators:

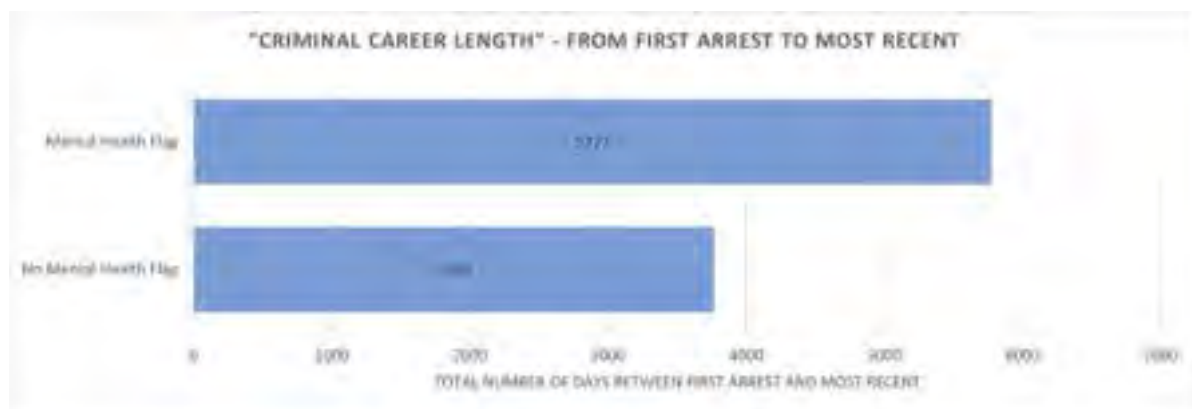
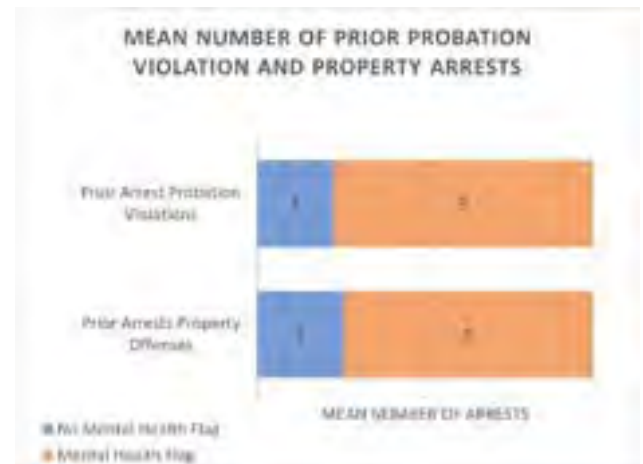
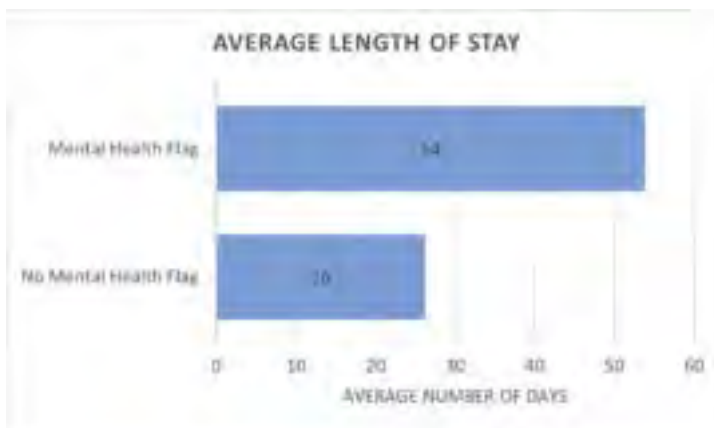
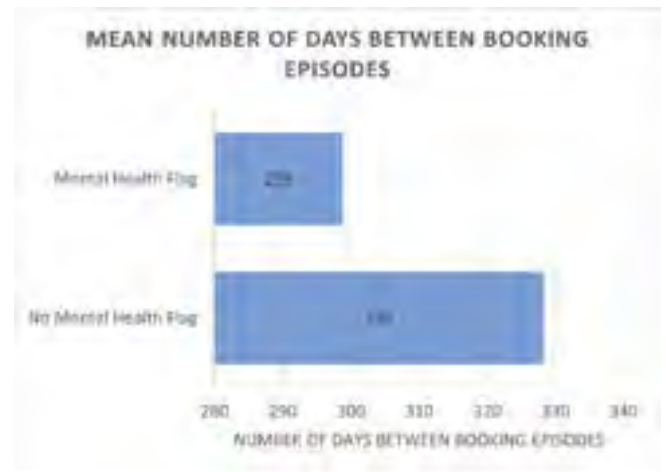
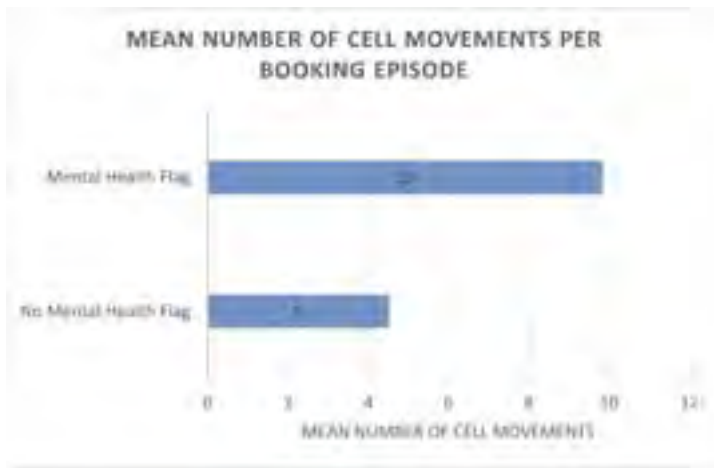


Indeed, while those with no mental health involvement were just slightly more likely to have more than one booking episode during the study period, only 20% of those with a mental health flag had a single booking episode in the five-year study period.



We have similar findings on our t-tests for differences in means for our quantitative indicators. On every single quantitative indicator of interest, persons with mental illness had an average double or triple of that for those without mental illness. These differences are all statistically significant at the  $p < 0.05$  level and below.





Those with mental illness had been "active" criminally for almost twice as long as those without mental illness. When they were booked into our study jails, they stayed twice as long as those without mental illness. While they were booked, they moved around within the jail twice as many times as those without mental illness. They had three times as many arrests for property offenses and probation or parole violations. The only indicator on which persons with mental illness seemed to have some parity as those without is on number of days between booking episodes. Those without mental illness stayed out of jail approximately 30 days longer on average than those with mental illness.

# Assessing Proxy Indicators for Mental Illness

We conducted two types of inferential analysis to determine whether we could derive a set of predictive factors for mental illness from jail management system data. First, we conducted k-means cluster analysis to assess whether having a mental illness substantially differentiated those without such that we could estimate the proportion of those without a felony history who might have a mental illness, based on which cluster they fell into.

Next, we incorporated the indicators we found to have a significant relationship to mental illness on bivariate analysis into a logistic regression model to predict mental health involvement. The findings for both are reported below.

## Grouping Those With and Without Mental Illness into Separate Groups

We conducted two types of inferential analysis to determine whether we could derive a set of predictive factors for mental illness from jail management system data. First, we conducted k-means cluster analysis to assess whether having a mental illness substantially differentiated those without such that we could estimate the proportion of those without a felony history who might have a mental illness, based on which cluster they fell into.

Next, we incorporated the indicators we found to have a significant relationship to mental illness on bivariate analysis into a logistic regression model to predict mental health involvement. The findings for both are reported below.

### Urban



- ☐ Number of Dsys B/W Episodes
- ☐ Age at Booking
- ☐ Total Booking Episodes
- ☐ Criminal Career Days
- ☐ # Prior Property Arrests
- ☐ # Prior Probation Violation Arrests
- ☐ Length of Stay

### Suburban/Rural



- ☐ Number of Dsys B/W Episodes
- ☐ Age at Booking
- ☐ Cell Movement Count
- ☐ Total Bookings
- ☐ Criminal Career Days
- ☐ # Prior Property Arrests
- ☐ # Prior Probation/Parole Violation Arrests

As the figure above indicates, we excluded length of stay from the Suburban/Rural cluster because one of the largest jails in that grouping did not provide release dates. On the Urban clusters, we only received cell movement from a single jail, so we could not use those data. The tables below provide a summary of the final cluster centers.

Urban Jail Cluster Centers		
Variable	Cluster Number	
	1	2
Number of Days b/w Bookings	339	281
Age At Booking	31	42
Total Bookings	3	4
Criminal Career Days	1920	8509
# Prior Property Arrests	1	4
# Prior Probation/Parole Violation Arrests	1	2
Length of Stay	21	28
Number of Cases in each Cluster		
Cluster	1	144,458
	2	55,511
Valid	199,969	
Missing	0.000	

Suburban/Rural Jail Cluster Centers		
	Cluster Number	
	1	2
Number of Days b/w Bookings	327	300
Age At Booking	29	40
Cell Movement Count	6	5
Total Bookings	4	10
Criminal Career Days	2176	9047
# Prior Property Arrests	1	3
# Prior Probation/Parole Violation Arrests	1	3
Number of Cases in each Cluster		
Cluster	1	142,556
	2	70,953
Valid	213,509	
Missing	0.000	

Chi-square tests revealed a significant relationship between cluster membership and mental health flag status.

Urban Jails Mental Health Flag by Cluster Number		Cluster 1	Cluster 2	Total
No Mental Health Flag	Count	127,033.00	39,021.00	166,054.00
	Expected Count	122,882.70	43,171.30	166,054.00
	% Within MH_flag	76.50%	23.50%	100.00%
Mental Health Flag	Count	12,082.00	9,853.00	21,935.00
	Expected Count	16,232.30	5,702.70	21,935.00
	% Within MH_flag	55.10%	44.90%	100.00%
Total	Count	139,115	48,874	187,989
	Value	df	Asymptotic Significance (2-sided)	
Pearson Chi-Square	4620.728a	1	0.000	
N of Valid Cases	187,989.00			

Those with mental illness were almost evenly split between the clusters, but they were almost twice as likely to be in Cluster 2 as those without mental illness. Looking at the Expected versus Observed counts in the table above (cells highlighted in gray), there are almost 75% more persons with mental illness in Cluster 2 than what is expected. Assessing the center of the means for Cluster 2 reveals why – the center for the Number of Days indicator is roughly thirty days lower than for cluster 1; criminal career days is almost 7 times larger than Cluster 1; and the ratio for number of prior property and probation violations is maintained in Cluster 2.

The same pattern holds true in suburban/rural jails.

Suburban/Rural Jails Mental Health Flag by Cluster Number		Cluster1	Cluster 2	Total
No Mental Health Flag	Count	122,979	53,477	176,456
	Expected Count	117,816	58,640	176,456
	% Within MH_Flag	69.69%	30.31%	82.60%
Mental Health Flag	Count	19,577	17,476	37,053
	Expected Count	24,740	12,313	37,053
	% Within MH_Flag	52.84%	47.16%	17.40%
Total	Count	142,556	70,953	213,509
	Value	df	Asymptotic Significance (2-sided)	
Pearson Chi-Square	3922.560a	1	0	
N of Valid Cases	213,509.00			

There are 42% more people with mental illness in cluster 2 than what would be expected by random chance. Those with mental illness are 1.5 times as likely as those without to be in cluster 2. With the exception of Cell Movement counts, the centers for cluster 2 are substantially higher than those for Cluster 1, so this pattern makes sense. Those without mental illness are more likely to be in Cluster 1. This makes the k-means clustering too imprecise a tool to use for estimating the percentage of the population without a felony history, for whom we have no mental health indicator in the administrative data.



## Testing Predictors of Mental Illness in a Logistic Regression Model

We then broke the jails into three groups – Rural, Urban, and Suburban to run logistic regression models assessing the degree to which the variables for which we found significant relationships to mental illness might be predictive of illness. Below we report only the predicted versus observed classification table and the odds ratio table. The predictive value for the variables that seem promising on bivariate analysis falls apart when inserted in a model.

Urban Jails Logistic Regression		Predicted		
		Mental Health Flag		
	Observed	No	Yes	Percentage Correct
Mental Health Flag	No	163,734	2,317	98.6%
	Yes	19,315	2,588	11.8%
Overall Percentage				88.5%

Variables in the Equation and Odds Ratios			
Variable Name	B	Sig.	Odds Ratio
Age At Booking	-0.047	0.000	0.954
Total Bookings	0.021	0.000	1.022
Criminal Career Days	0	0.000	1
# Prior Property Arrests	0.069	0.000	1.071
# Prior Probation/Parole Violation Arrests	0.252	0.000	1.287
Male	0.506	0.000	1.659
Constant	-1.968	0.000	0.14
*Significance at the 0.0 level indicates p<0.01, or the 99th Percentile			



The model predicted only 12% of the mental health flags in the urban jail dataset correctly. The remaining 88% were incorrectly classified. A look at the Odds Ratios tells us why. While those with mental illness have almost twice as many booking episodes, a criminal career that is twice as long, the odds ratios for those with or without mental illness is equal. The only variables in this model that predict greater odds of having a mental illness are being male and having a prior arrest for probation violations.

The models for suburban and rural jails performed only marginally better. The predictive power of the individual variables was not great, but they were slightly better at accurately classifying cases with mental illness. This model for suburban jails correctly predicted 15% of mental health cases.

Suburban Jail Logistic Regression Output		Predicted		Percentage Correct
		Mental Health Flag		
	Observed	No	Yes	
Mental Health Flag	No	85,352	2,928	96.7%
	Yes	24,183	4,174	14.7%
Overall Percentage				76.8%

Variables in the Equation and Odds Ratios			
Variable Name	B	Sig. *	Exp(B)
Age At Booking	-0.027	0.00	0.973
Cell Movement Count	0.025	0.00	1.025
Total Bookings	0.004	0.00	1.004
Criminal Career Days	0	0.00	1
# Prior Property Arrests	0.066	0.00	1.069
# Prior Probation/Parole Violation Arrests	0.118	0.00	1.125
Male	-0.137	0.00	0.872
Constant	-0.928	0.00	0.395
*Significance at the 0.0 level indicates $p < 0.01$ , or the 99 <sup>th</sup> Percentile			

Again, the odds ratios do not clearly distinguish between those with mental illness and those without. Of note, being male is a significant predictor of mental illness in the Urban jails, but in suburban and rural jails, being female is a significant predictor of mental illness. Males are 87% as likely as females to have mental illness.

The model performed best on the rural jail sample – but only marginally so. Here, the variables correctly classified 17% of mental health flags.

Rural Jail Logistic Regression Output		Predicted		Percentage Correct
	Observed	Mental Health Flag		
		No	Yes	
Mental Health Flag	No	14,088	406	97.2%
	Yes	2,475	513	17.2%
Overall Percentage				83.5%

Variable Name	B	Sig. *	Exp(B)
Age At Booking	-0.044	0.00	0.957
Cell Movement Count	0.02	0.00	1.02
Total Bookings	0.025	0.00	1.025
Criminal Career Days	0	0.00	1
# Prior Property Arrests	0.118	0.00	1.125
# Prior Probation/Parole Violation Arrests	0.362	0.00	1.437
Male	-0.714	0.00	0.49
Constant	-0.892	0.00	0.41
*Significance at the 0.0 level indicates p<0.01, or the 99th Percentile			

Three variables here have some viable predictive power. Males in rural jails are *half* as likely as women to have a mental illness. Those with prior arrests for probation or parole violations are 1.5 times as likely to have mental illness. And those with prior property arrests are slightly more likely to have mental illness. While these odds are better for crafting a probability-based screener, they still do not provide sufficient accuracy given how many booking episodes the model classified correctly.

# Discussions and Limitations

## We set out to do three things:

1. Estimate the prevalence of people with mental illness in county jails;
2. Identify proxy indicators for mental illness in jail management system data;
3. Assess the degree to which those indicators could be used to predict mental illness.

Our findings are promising on all fronts, but precise on two. We have a conservative estimate of the proportion of jail booking episodes, and the percentage of those booked, who have mental illness. Such an analysis using criminal justice administrative data had never been done in Georgia. Moreover, the fact that we have 142 jails with almost as many different jail management systems presents a unique challenge at obtaining statewide data. However, the selection of 9 jails from which we obtained data demonstrate that the data jails collect is consistent and provides a good foundation for assessing the degree to which persons with mental illness interface with the criminal justice system.

We have identified promising proxy indicators for mental illness, but we could not achieve robust predictability once those were put into a logistic regression model. Data missingness meant that we could not use all variables we collected information on in all models, nor could we assess how viable they are for predicting mental illness. While the need for differing models for rural, urban, and suburban jails is evident given our preliminary findings, we cannot ascertain which factors should be included in which models.

One of our more promising indicators seemed to be the homeless flag, but only 992 out of over 400,000 booking episodes could be identified as involving someone who is homeless. This is because we did not receive a reliable flag from the jails for homelessness and were thus relying upon text analysis of address fields. Moreover, we received address information for the active population (not booked) for two of the jails, so those data were incomplete.

There is also the problem of whether mental illness predicts many of the items we are trying to use to predict mental illness. The issue of simultaneity is a difficult one to control for in a limited dataset and with incomplete data.

## Next Steps

Our journey does not end here. We have partnered with four of the 9 jails in this study to further assess the proxy measures we have identified. We plan to use a pen and paper screening tool to collect information about all people booked into our partner jails for a short period. The screener tool will give us information about persons without a felony conviction who would never have been assessed for mental illness by either DCS or GDC. These screener results can be compared with jail administrative data, DCS, and GDC data to more accurately classify all persons booked. We can then assess the performance of our identified indicators against the screener to develop a tool based on administrative data.

# Endnotes

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- [iv] Ibid.
- [v] Kopak, A.M, Guston, K., Maness, L., & Hoffman, N.G. (2019). A prospective study of behavioral health indicators and repeat jail admissions among rural inmates. *Health and Justice* 7(5), <https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-019-0087-8>.
- [vi] Wilson, A.B., Draine, J., Hadley, T., Metraux, S., Evans, A (2011). Examining the Impact of Mental Illness and Substance Use on Recidivism in a County Jail. *International Journal of Law and Psychiatry*, 34(4), 264–268. <https://doi.org/10.1016/j.ijlp.2011.07.004>
- [vii] Cloyes, K. G., Wong, B., Latimer, S., & Abarca, J. (2010). Time to Prison Return for Offenders With Serious Mental Illness Released From Prison: A Survival Analysis. *Criminal Justice and Behavior*, 37(2), 175–187. <https://doi.org/10.1177/0093854809354370>.
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- [ix] Morrissey, J. P., Cuddeback, G. S., Cuellar, A. E., & Steadman, H. J. (2007). The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. *Psychiatric Services*, 58(6), 794–801.
- [x] Cuddeback, G. S., Morrissey, J. P., & Domino, M. E. (2016). Enrollment and service use patterns among persons with severe mental illness receiving expedited Medicaid on release from state prisons, county jails, and psychiatric hospitals. *Psychiatric Services*, 67(8), 835–841.
- [xi] Regenstein, M., & Christie-Maples, J. (2012). Medicaid coverage for individuals in jail pending disposition: Opportunities for improved health and health care at lower costs.
- [xii] Substance Abuse and Mental Health Services Administration (2019). "SOAR Works for Individuals Involved in the Criminal Justice System." Available at: <https://soarworks.samhsa.gov/sites/soarworks.prainc.com/files/CJ%20Best%20Practices%20infographic.pdf>
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# ANALYSIS OF NINE JAIL DATASETS FOR REPRESENTATION OF MENTAL ILLNESS AMONG “FAMILIAR FACES”

(*Familiar face* = person booked so many times that the number of times booked over the 5-year period is in the 99th percentile)

**199,959 People Booked over 413, 478 Booking Episodes**

6,934,241 Total Jail Bed Days

74,904 People with More than 1 Booking Episode

394 Days in the Community Between Booking Episodes

**Familiar Faces: 2,328** People in the Top 1% of Booking Episode Count

**Familiar Faces: 34,789** Cumulative Booking Episodes

**Familiar Faces: 34,743 (6%)** Total Jail Bed Days

**17, 538 People Booked Had Mental Health Flag (8.8% of people booked)**

1,959,828 (28%) Total Jail Bed Days

People with Mental Health Spent **379** Days in the Community Between Bookings

**60, 108** Cumulative Booking Episodes (15% Total Bookings)

**Familiar Faces: 28%** Have a Mental Health Flag

**649 "Familiar Faces" Have a Mental Health Flag (0.3% of People Booked)**

**129,792 (2%)** Cumulative Jail Bed Days

**172** Days in the Community on Average

**9,615 Cumulative Booking Episodes** (2% of Total Booking Episodes Overall)

**Key Takeaway: Familiar faces are 3x more likely to have a mental health flag than the overall sample.**



Data analyzed are from the dataset including nine county jails – 3 urban, 3 suburban, 3 rural. Data span all jail bookings for the years 2013-2018. Full analysis of this dataset is available at: <https://cjcc.georgia.gov/document/document/cjcc-identifying-predictors-mental-illness-county-jail-data-report-1pdf/download>.



A collaborative effort  
between:

State Court Misdemeanor  
Diversion Program

The State Court Judges

**Target Population:**

Adults who are facing non-  
violent misdemeanor charges  
and have a suspected mental  
illness whether diagnosed or  
not.

Pam Betts, Solicitor General

Probation Services

Henry County Sheriff

Defense Attorneys

Counseling Providers

Jennifer Starr

Program Coordinator

One Judicial Center, Ste 340

44 John Frank Ward Blvd

McDonough, GA 30253

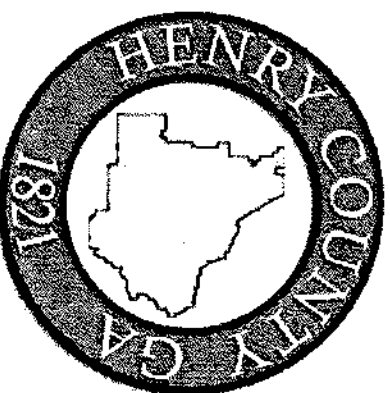
770-288-7367

State Court of Henry  
County

Misdemeanor  
Diversion Court

*Established November*

*2018*



**Mental illness is not a  
crime.**



## **Mission Statement**

### **The Henry County**

#### **Misdemeanor Diversion**

Court's mission is to provide treatment for individuals charged with a misdemeanor and dealing with mental health issues. The Court combines increased supervision and accountability with effective and intensive treatment, thereby reducing recidivism.

## **Participants**

### **The Henry County**

#### **Misdemeanor Diversion**

Court is a treatment program for those who have signs of some form of mental illness and received a non-violent misdemeanor charge wherein their mental illness or impairment may

have impacted their

behavior during the police encounter.

### **The Court**

The Misdemeanor Diversion

Court is a division of the

State Court of Henry County.

The Judges are aware of the significant impact of mental illness on the court system, the lives of participants and their families. Participants meet with the Presiding Judge once a month and non-compliance is sanctioned.

Cases can be transferred from City, Magistrate and State Court if the Judge feels the person would qualify for the Misdemeanor Diversion Court. Admission is

subject to the Solicitor's recommendation and concurrence. This is a voluntary normal six (6) month program, which may be extended if necessary.

Violent offenders will not be permitted. Extensive criminal histories will not be permitted unless it becomes evident it is the same non-violent crime or similar crimes which occurred because of dealing with mental illness.

# **MEMORANDUM OF UNDERSTANDING FOR DIVERSION FROM JAIL FOR MISDEMEANOR OFFENDERS**

## **1.**

This Memorandum of Understanding (MOU) outlines policies, procedures, goals and expectations among and between the Henry County Superior Court, the State Court of Henry County, the Henry County Sheriff's Department, the Henry County Police Department, Henry County Sentence Enforcement, CorrectHealth and the Pine Woods Behavioral Health Crisis Center under the McIntosh Trail Community Service Board.

**WHEREAS:** The Parties to this MOU recognize that approximately fifty percent of the inmates in the Henry County Jail are being treated for some form of mental illness; and,

**WHEREAS:** The Parties to this MOU recognize that for some non-violent misdemeanor Offenders with mental illness, diversion from Jail to treatment is appropriate; and,

**WHEREAS:** The Parties to this MOU desire to reduce the number of mentally ill individuals being jailed in Henry County; and,

**WHEREAS:** The Parties to this MOU desire to connect people with mental illness to appropriate treatment; and,

**WHEREAS:** The Parties to this MOU desire to reduce the recidivism rate for the mentally ill; and,

**THEREFORE:** The Parties hereto commit to the following:

## **2.**

Each party to the MOU shall comply with their own internal policies and procedures and will notify other participants as soon as practicable of any conflicts in their participation under the MOU.

3.

Each party to the MOU understands that their participation in the MOU does not relieve them from any legal obligation or responsibility they may have.

4.

Each party to the MOU will designate a primary contact for co-ordination of this MOU and an emergency contact.

5.

Henry County Police Officers will be exercising significant discretion in determining the best protocol to follow in dealing with subjects encountered that are committing criminal activity while exhibiting possible signs of mental illness or other mental impairment.

6.

Upon a Henry County Police Officer having probable cause to believe that a person,

- a) Has or is committing a penal offense; and,
- b) That the individual is mentally ill and needs involuntary treatment; and, or,
- c) The person is in need of sub-acute detoxification services; then,
- d) The Officer will make an initial determination as to whether the suspected offense is a misdemeanor or a felony; then,
- e) If the offense is a felony, the Officer after arresting the suspected Offender will transport the individual to the Henry County Jail per standard operating procedures; or,
- f) If the offense is a misdemeanor that can be charged as:
  - 1) Disorderly conduct; or,
  - 2) Simple Battery; or,

- 3) Shoplifting; or
- 4) Criminal trespass; or,
- 5) Marijuana possession less than an ounce; or,
- 6) Public drunk; or,
- 7) Obstruction not involving serious physical contact; then,
- g) The Officer will issue a citation for the offense to the Offender with the court date notated as "To Be Notified" (TBN) before the Henry County State Court and also notate on the Citation, "Released to Pine Woods"; then,
- h) The Officer will transport the Offender to Pine Woods Behavioral Health Crisis Center at 1209 Greenbelt Drive, Griffin, GA 30223 (or an equivalent medical facility) for evaluation and release on citation; and if,
- i) The Officer is unable for any reason to transport the Offender to a medical facility for evaluation, then the Offender may be transported to the Henry County Jail, where the Offender will be booked in and the Henry County Jail will set a bond at \$999.00.<sup>1</sup> The Jail will at the earliest available time notify the State Court Caseworker of the arrest and status of the Offender's incarceration or being released on bond.

7.

Upon admission to Pine Woods, the intake person at Pine Woods will ask the Offender to voluntarily sign HIPAA Waivers supplied by the State Court Caseworker. There will be a specific waiver to use if the Offender is taken to Pine Woods and a different waiver to be used if the Offender is taken to Jail. If a HIPAA waiver is obtained from the suspected Offender, a copy will be provided to Pine Woods or the Henry County Jail, and the State Court Caseworker.

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<sup>1</sup> This bond being appropriate for a misdemeanor and will be used to identify the cases for the special State Court docket.

8.

Upon arriving at Pine Woods the Officer will relinquish custody of the suspected Offender to the Pine Woods Staff for evaluation. If the Officer transports the Offender to another medical facility or the jail, the Officer will follow standard Departmental policy.

9.

The Officer will as soon as practicable transmit a copy of the Citation and report as required by O.C.G.A. 37-3-42(a), to the State Court Caseworker.

10.

Pine Woods personnel will make their best efforts to release the Police Officer within twenty (20) minutes of arrival unless the Officer is requested for safety assistance.

11.

Pine Woods will conduct an evaluation, attempt stabilization and determine the most appropriate and least restrictive treatment setting consistent with the suspected Offender's needs. Pine Woods will release the Offender in accordance with the Offender's health condition and Pine Woods' policies.

12.

Pine Woods will notify by email the State Court Caseworker of the Offender's status and release.

13.

The State Court Caseworker will monitor the misdemeanor cases identified as having mental health issues for scheduling, tracking and status. The State Court Caseworker will advise the Solicitor General's office and the State Court Clerk's office of these cases.

14.

The State Court Caseworker will advise the Sentence Enforcement Office of the scheduled court dates, and a Representative of Sentence Enforcement will attend Court to take responsibility for tracking/supervising the Offender's compliance with his/her treatment plan, medication and no future criminal activity.

15.

The State Court Caseworker will advise the State Court's contract indigent defense counsel of the scheduled court dates, and to have an attorney on-call, in the event an Offender requests an attorney.

16.

Upon the Court date of the cited Offenders, the State Court will handle as appropriate for the criminal charge and mental health considerations with an emphasis on treatment options.

17.

Some of the signatories to this MOU are covered entities under HIPAA. All signatories to this MOU agree to share health care information on Offenders as necessary for the law enforcement and judicial purposes to carry out this MOU. All signatories agree and will protect and safeguard the confidentiality of the health information of the Offenders and not disseminate health care information to any other person or entity not a signatory to this MOU, except as provided by law.



MEMORANDUM OF UNDERSTANDING 11/06/18

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**Execution on Following Page**

MEMORANDUM OF UNDERSTANDING 11/06/18

Agreed to and Executed by:

Superior Court of Henry County

By: [Signature]

Date: 11/19/18

Position: Superior Court Judge

State Court of Henry County

By: [Signature]

Date: 11/8/18

Position: Chief Judge

Henry County Sheriff's Department

By: Kate McBrayer

Date: 11/8/18

Position: Sheriff

Henry County Police Department

By: [Signature]

Date: 11/8/2018

Position: Chief of Police

Henry County Sentence Enforcement

By: V. Carl Brown

Date: 11-8-2018

Position: Director

McIntosh Trail Community Service Board

By: [Signature]

Date: 11/8/18

Position: CEO

CorrectHealth

By: \_\_\_\_\_

Date: \_\_\_\_\_

Position: \_\_\_\_\_

# 1013 Patients in Georgia Emergency Departments: Piedmont Healthcare's Experience

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Executive Director, Behavioral Health Service Line  
Piedmont Healthcare, Inc.

Deborah Moses, JD  
Vice President, Risk & Insurance Services  
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September 1, 2022



*Real change lives here*



Emergency Departments are the central intake point for patients who need transport to an Emergency Receiving Facility pursuant to a 1013 certificate. Due to lack of available beds for evaluation and treatment, patients are commonly held days or weeks in EDs awaiting an appropriate placement. This result delays necessary care for those patients and impairs hospitals' ability to care for other patients in need.





Behavioral Health patients are brought to Piedmont Emergency Departments by the following:

- EMS, Law enforcement, Mobile crisis units
- Family and Friends
- State and private mental health facilities

Patients are brought to Emergency Departments due to:

- Medical clearance needed for Behavioral Health placement
- Inability to find placement at psychiatric facility
- Transporting at risk patient to the closest facility for psychiatric assessment
- Patient not responding to treatment at local Mental Health facilities

Barriers to placement of mental health patients from Emergency Departments:

- Difficulty in assessing for inpatient admission due to patient inability to participate in care
- Medical exclusionary criteria rendering patient ineligible for inpatient admission
- Patient refusing medications or treatment, causing high acuity
- Inpatient facilities at capacity for admission
- Patient denied due to inability to treat patient condition
- Lack of insurance

### Piedmont ED Behavioral Health Encounters - 2021

Athens	2,738
Atlanta	1,205
Columbus	2,051
Cartersville	986
Eastside	1,876
Fayette	1,156
Henry	1,678
Macon	2,346
Mountainside	709
Newnan	1,138
Newton	952
Rockdale	993
Walton	923

# Clinical Environment for Behavioral Health Patients Holding in Emergency Departments

**Hospital EDs do not provide a suitable environment for holding 1013 patients for extended time periods**

## **Behavioral Health Pods:**

- Emergency Rooms across the country have begun to implement Safe Space for BH patients within the ED
- Designed to keep patients safe with removal of unnecessary objects that can be used to harm self or others
- Special attention is given to reduce the amount of ligature risk within this space

## **Safety Pods were developed for short stays with priority on keeping patients safe**

- There is no access to the outside for patients
- Bathrooms are shared and not easily accessed for patients without staff assistance
- Limited activities for patients within the ED
- This environment is non-therapeutic for patients staying multiple days

## **Limited Piedmont facilities have ability to create BH Pods within their established space**

- Currently not all Piedmont EDs have a safety pod for BH patients
- Staffing shortages and high acuity and medical crisis patients create resource issues

**Even where Safety Pods have been developed, there are often not enough for daily patient population**

# Patient Experience by Payor Status

Patient payor status is a significant root cause in inability to transfer patients for necessary care and evaluation

Average length of stay for patients with commercial insurance: **3 to 5 hours**

Average length of stay for patients with traditional Medicaid or no insurance: **2 or more days in ED**

Patients in rural areas experience significantly longer length of stay due to limited available beds and services

Length of stay is growing for uninsured patients

# Impact on Hospitals

Emergency Departments struggle to provide adequate safeguards for at-risk patients due to the nature of the environment and acuity of other patients in the department

Holding patients for days or weeks awaiting transport, presents challenges in caring for acute care patients who present for treatment

There is little to no reimbursement for the hospitals for the patients with the longest hold times

Hospitals often incur expense of placement for patients who will not otherwise be accepted for necessary care

BH patients are increasingly violent against staff, resulting in injury and retention issues

## Financial Impact to Hospital Systems



Hospitals incur millions each year due to large numbers of BH patients holding in Emergency Room beds.

- GCAL board process is lengthy and delays ability to claim beds for patients within the day needed, resulting in longer holds
- Length of stay is significantly longer than other patients due to inability to find placement
- Patients with higher acuity or frequent trips to the ED for Behavioral Health can remain in EDs or an unnecessary medical bed for 30 to 100+ days
- Inpatient psychiatric facilities pick patients for acceptance into their facilities, leaving the EDs to handle mentally ill patients that remain



Private facility contract bed placement fee:

- Due to the high demand of BH patients and slow movement for placement many health system have set up private contracts with inpatient behavioral health centers.
- Piedmont contracts with private healthcare system for \$4,200 per patient to accept patients with no insurance or patients that facilities can't bill the insurance
- These costs are directly attributable to bed capacity and availability issues

In the last 3 years, Piedmont Healthcare has experienced an annual average of **\$18.7M in uncompensated care** related to BH patients.

In addition, Piedmont spent over **\$3M** in 2021 to place BH patients who were unable to be timely placed in a private or state facility.

## Continuum and Coordination of Care is Needed

Behavioral Health patient care is widely distributed to different facilities with numerous treatment plans and discharge options:

- Patients entering the system can be sent to multiple facilities for inpatient, outpatient, aftercare etc. throughout their journey, commonly with no one managing the patient's care
- Outpatient psychiatric services are challenged to provide consistent and stable care, with discharge planners often sending patients to primary care after discharge. Medications and treatment can be altered by outside treatment team causing re admission to inpatient within a few weeks.
- Patients often name multiple treatment teams they have encountered in a few short months, each changing or altering medications or interventions for the patient.
- Medical units discharging patients with Behavioral Health needs do not have in depth training to help find correct placements, services etc.
- There are some wonderful treatment programs that are not being accessed as most providers are unaware of and patients are not referred



# Recommendations to Facilitate Timely Access to Necessary Care

## **Increase inpatient bed availability**

- Patients have little to no options when choosing Behavioral Health facilities if they are not commercially insured
- Most patients are transferred to whatever facility has accepted them regardless of facility's ability to meet the patient's needs
- Private facilities rarely are at capacity, but are unwilling to accept patients due to payer issues

## **Provide alternative treatment or larger acceptance criteria for medically compromised patients**

- Easily maintained medical issues (i.e. oxygen, catheters, pregnancy) are automatically excluded from most mental health facilities
- Behavioral Health patients are rarely treated at level of need after developing routine medical conditions
- Most acute care hospitals do not have access to psychiatric services for ongoing treatment of medical patients

# Recommendations to Facilitate Timely Access to Necessary Care

## Psychiatric EDs or Emergency Receiving Facilities across the state with ability for medical clearance

- Therapeutic treatment focused centers for Behavioral Health patients to present or be dropped off by EMS or law enforcement, where patients feel safe and can be appropriately case managed to meet their needs
- Medical clearance can be obtained at facility to allow patients admission to inpatient care with reduced stress
- Support expansion of DBHDD Behavioral Health Crisis Centers, Crisis Service Centers to provide alternatives to hospital placement

## **Workforce and System Development Subcommittee**

Rep. Mary Margaret Oliver- **Chair**  
Renee Johnson  
Dr. Nicoleta Serban  
Wayne Senfeld

Cindy Levi  
Michael Polacek  
Polly McKinney  
Sallie Coke

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*Workforce and Systems Development Subcommittee*



## **Recommendations to the BHRIC Workforce Committee - Workforce and Systems Development Subcommittee Addressing Barriers to Licensure**

The following recommendations identify and address barriers to licensing of Marriage and Family Therapists (LMFTs) and Associate Marriage and Family Therapists (AMFTs) by the Georgia Secretary of State's Composite Board of Professional Counselors, Social Workers, and Marriage Therapists.

### **Background**

In the Official Code of Georgia Annotated Chapter 10A of Title 43, Marriage and Family Therapy is defined as the specialty that evaluates, diagnoses, and treats emotional and mental conditions, whether cognitive, affective, or behavioral; resolves intrapersonal and interpersonal conflicts; and changes perception, attitudes, and behavior; all within the context of marital and family systems. The definition goes on to state that marriage and family therapy requires an applied understanding of the dynamics of marital and family systems, including individual psychodynamic; the use of assessment instruments that evaluate marital and family functioning; designing and recommending a course of treatment; and the use of psychotherapy and counseling. Licensed Marriage and Family Therapists (LMFTs) can diagnose and treat mental illness; work in various units including individuals, couples, and families; and see patients in a wide age range.

To be licensed as a Marriage and Family Therapist in the state of Georgia, one must have earned a master's or doctorate degree in a Marriage and Family Therapy program or an allied field with coursework in Marriage and Family Therapy along with having passed a national licensing exam and completed 2,500 hours of directed and supervised clinical experience for master's degree earners, or 1,500 hours for doctorate degree recipients. To achieve the required experience to be licensed as a Marriage and Family Therapist, new therapists are encouraged to pursue pre-licensed credentialing as an Associate Marriage and Family Therapist (AMFT), which eases the path toward later licensure. The requirements for an Associate Marriage and Family Therapist are similar to those for full licensure but require verification of an internship/practicum of 500 hours of direct clinical experience with 100 hours of supervision, all of which will be applied to their overall licensure requirements.

Currently, there are 123 Marriage and Family Therapy programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) nationally; three of these programs are physically located within Georgia. Mercer University and Valdosta State

University have master's degree programs in Marriage and Family Therapy on their respective campuses. The University of Georgia has a PhD Marriage and Family Therapy Program at its Athens campus. Currently, there are 1,176 LMFTs and 116 AMFTs in Georgia.

## Recommendations

### 1. Problem

Statutory requirements for LMFT licensure are outdated and in need of revision due to COAMFTE's accreditation requirements having changed in 2021. Post graduate clinical experience required in OCGA 43-10A-13 is out of line with other states, making it difficult for out of state licensees/MFT graduates to receive licensure in Georgia. GAMFT has introduced HB 1599 during the 2022 legislative session, which revises OCGA 43-10A-13 to update training requirements and clinical hours needed for licensure in Georgia. The Georgia Occupational Regulation Review Council (GORRC) reviewed proposed changes offered in this bill in September and October 2022, unanimously approving all of them. They recommended passage as submitted for legislative approval during the 2023 legislative session.

#### **Recommendation: Pass HB 1599 (2022) to Update Licensure Requirements for MFTs**

- a. Support passage of changes to MFT licensure requirements proposed in HB 1599 LC 33 9142 (2022).
  - o HB 1599 was introduced in 2022 by Chairman Alan Powell. It went through review by the Georgia Occupational Regulation Review Council in the summer and autumn of 2022 and was approved unanimously without changes in October 2022. The final Report and Recommendation of the GORRC may be found [here](#).
  - o The GORRC Report found as follows at p. 4: "Amending the requirements for marriage and family therapists would have a positive economic impact to the state. Amending licensure requirements would put Georgia in line with national requirements and surrounding states. **These changes will help attract and retain qualified individuals in the state. As a result, the citizens of Georgia would see an increase in the number of licensed therapists, increasing access to mental health services.**" (emphasis added)
  - o HB 1599 would revise subsection (a) of Code Section 43-10A-13, relating to requirements for licensure in marriage and family therapy by updating coursework and practicum hours required in order to conform to those required by the national accrediting agency for AMFTs effective in 2022, and reducing the direct clinical experience for licensure as an LMFT to bring Georgia in line with the requirements of other states in this region.

### 2. Problem

The volume of applications to the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists has increased by approximately 65% since 2017 with no commensurate increase in staffing. There are currently five staff members supporting multiple separate licensure boards. The shortage of staff causes delays in the processing of applications.

In addition, the burden on Board members charged with reviewing applications has also grown tremendously. Increasing the representation of Board members sitting on the Composite Board, while retaining an equal number of Board representatives for each profession, would allow for increased speed in reviewing license applications. **Recommendations: Increase**

**Staffing and Board Capacity to Review License Applications**

- a. Provide increased funding within the state budget for the Secretary of State Professional Licensing Division for additional staff support.
- b. Increase representation on the Composite Board by one person for each of the three professions governed by the Board. Minimal impact in budget related to per diem costs, etc. This addition will require statutory changes to OCGA 43-10A regarding Board representation. This would also require modifications in the statutory requirements for review and majority approval of licenses by Board members.

**3. Problem**

The applications for AMFTs and LMFTs are out of date, unnecessarily complex, and often redundant. Additionally, the applications are at a minimum 17 pages long and must be printed and completed by hand unless the applicant owns special software. The complexity and handwritten nature of these applications are frequent contributors to mistakes or incomplete applications, issues that not only increase the burden on the Board staff, but also invariably delay application approval and the timely entrance of new professionals into the workforce.

**Recommendations: Shorten Simplify, and Computerize License Applications**

*Note that these changes would not require legislative action. The Board is working on addressing these issues.*

- a. Shorten and simplify the application for AMFTs and LMFTs.
- b. Create an online application that can be completed electronically and can log and store applicant information throughout the applicants' training and application process.
- c. Replace snail mail communications regarding applications with email communications in most instances, unless unavailable to the applicant.
- d. Create a direct online process for applicants to check their application status in order to easily identify errors and reduce the time staff uses to respond to applicant inquiries.
- e. Increase telephone and email access to Board staff to respond to questions from applicants.
- f. Provide for automatic approval of an applicant's educational and internship/practicum experiences for applicants who completed COAMFTE programs with a simplified and standardized method for Board staff to verify a program's COAMFTE accreditation based on information available on the COAMFTE website. Now each applicant has to confirm this same fact.
- g. Improve the ease of access to information and strengthen FAQs for applicants.
- h. Integrate the participation of professional associations, such as GAMFT, when improving application.



#### **4. Problem**

Georgia currently limits Medicaid eligibility for behavioral health providers who are MFTs, LPCs, LCSWs to serve patients only to children ages 0-21. This change was made by an amendment to the state plan in January 2022. Legislative action was not required. However, these behavioral health professionals are not authorized to bill Medicaid for providing services to adults.

#### **Recommendation: Medicaid Eligibility for Behavioral Health Providers**

- a. Expand eligibility for LMFTs, LPCs, and LCSWs to provide services to Medicaid eligible adults in order to increase access to mental health care for this population.

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Impact of Salary Increase in State Hospitals  
Behavioral Health Reform and Innovation Commission  
Workforce and Systems Development Subcommittee  
November 14, 2022

DBHDD workforce overview:

- 4,568 – Total DBHDD workforce (includes contracted agency staff)
- 3,670 – Total hospital employees
- 1,138 - Filled clinical positions
  - Clinical positions include: nurses, psychologists, physicians, psychiatrists, therapists, social workers, etc...
- 1,404 – Total vacancies in hospitals – More than 500 of these are clinical:
  - 390 nurses
  - 37 physicians
  - 30 psychologists
  - 35 social workers

The FY 2023 budget provided additional money to the state hospital system to support higher salaries in critical positions. The appropriation was in response to historic turnover rates in the state's five psychiatric state hospitals operated by DBHDD. Since the beginning of 2020, and through June 2022, DBHDD experienced a net loss of 1,238 employees, which represents a 32% reduction of DBHDD hospital workforce. This unprecedented reduction in workforce had a significant impact on the agency's ability to serve its target populations; on any given day, as much as 10 to 20 percent of bed capacity was "offline" due to the inability to the lack of staff. The ripples of these bed closures can be felt in jails and emergency departments across the state.

The General Assembly specifically funded salary increases for the system's highest turnover positions and provided more flexible funding to support bringing beds back online. The pay package has had a positive impact on non-clinical positions, but clinical positions continue to present a challenge. As requested, below is a chart of the pay package:

Role (Varies by Level in Certain Cases)	Pre-COLA	Current Market Adjusted	% Increase
Forensic Psychiatrists (Board Certified)	\$195,000	\$225,000	15.4%
Psychiatrists (Board Certified)	\$185,000	\$215,000	16.2%
Physician Extenders	\$90,000	\$107,281	19.2%
Registered Nurses (Level "3")	\$56,072	\$76,666	36.7%
Licensed Practical Nurses (Level "3")	\$31,695	\$44,512	40.4%
Non-Clinical Direct Care (HSTs/FSTs/CNAs/CSWs) (Level "1")	\$24,322	\$31,200	28.3%
Psychologists (Level "3")	\$80,784	\$94,975	17.6%
Licensed Social Workers (Level "3")	\$38,760	\$60,957	57.3%
Food Service Workers (Level "1")	\$16,239	\$25,622	57.8%
Housekeeping (Level "1")	\$16,807	\$23,270	38.5%

Since the implementation of the pay package, DBHDD has achieved a 264-net employee gain since 6/1/22, comprised primarily of:

- 192 non-clinical direct care employees

- 23 nurses (RN's/LPN's)
- 22 food service
- 20 housekeeping

Approximately 25 percent of hires in these key roles are rehires of former DBHDD employees resulting from increased rates of pay. While DBHDD is gaining traction around the hospital system in hiring key roles in non-clinical direct care, food services, and housekeeping, the Department still faces tremendous challenges in hiring clinical positions, such as nurses, psychologists, and physicians.



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09/01/2022



## OFFICE OF HEALTH STRATEGY AND COORDINATION

### MEMORANDUM

**To:** Chairman Tanner and Representative Oliver

**From:** Elizabeth Holcomb, OHSC Legal Counsel

**Date:** July 21, 2022

**Subject:** Compilation of Data Sharing Issues and Research

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Over the last year, the Office of Health Strategy and Coordination (OHSC) has examined various issues related to the practice of data sharing in state government and approaches taken by other states to optimize interagency data sharing in Georgia. The practice of data sharing, whether in the public or private sector, is governed by federal and state laws that depend on the entities seeking to transmit, receive, or exchange the data, the type of data to be shared, and the intended purpose for which the data will be used.<sup>1</sup> While some agencies may not have a need to share or receive data from another agency, there is an undeniable benefit and need for state agencies with shared clients spanning multiple programs and delivery systems to be able to share data. This is especially the case for the state's health agencies that are organized in silos that allow for specialization in different areas of health care but are considered separate entities for data sharing purposes. Outlined below is a summary of our findings on other states' approaches worth considering as models for Georgia, an overview of the statute creating the Georgia Data Analytic Center (GDAC), recent legislation to address data sharing in Georgia, and a brief discussion of the legal barriers to sharing personally identifiable health information.

#### I. Other States

Several states have recognized the important role data can play in enhancing delivery of services and improving overall efficiencies by establishing frameworks for statewide or interagency data sharing. The use of the term "interagency data sharing" refers to any exchange of data between or among two or more agencies and the practice of "statewide data sharing" refers to a state's overarching system and policies for data sharing between agencies.

States' approaches to data vary in governance structure and operation – some utilize a central data repository or integrated data system as a conduit for the receipt, maintenance,

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<sup>1</sup> Milam, Sallie. (2019, April 11). Privacy Officers and Data Sharing: A Q&A with Network Attorney Sallie Milam. *Network for Public Health Law*. <https://www.networkforphl.org/news-insights/privacy-officers-and-data-sharing-a-qa-with-network-attorney-sallie-milam/>.



and transmittal of the data from one agency to another, while others designate an entity or state data officer to oversee the coordination of data sharing between agencies. States with established systems for statewide or interagency data sharing utilize a combination of the following approaches:

- Executive order.
- Legislation.
- Task forces, committees, and commissions.
- Formal data sharing documents such as memoranda of understanding (MOU) and data use agreements (DUAs).

Most states designate an agency as responsible for overseeing the exchange of data, but the designated agency is not necessarily responsible for housing the data or establishing an integrated data system. State trends include increased use of formal data sharing agreements in combination with a statewide data governance structure created by executive or legislative branch action.

#### Summary of Other States' Approaches:

- **Standardized Data Use Agreement (Illinois)**
  - In 2016, Illinois facilitated an enterprise memorandum of understanding (eMOU) among 13 state agencies which standardized data sharing practices and encouraged interagency data sharing to improve state services. The resulting effect was for Illinois to embrace a comprehensive effort to share data among agencies and state partners.
  - In addition to the eMOU, additional specific approvals for a particular dataset may be sought depending on the specific use case.
  - Indiana had implemented a new inter-agency data sharing model that, at the time of study, was found to be too time-consuming.<sup>2</sup> Illinois ultimately relied on Virginia's enterprise sharing agreement approach as a model platform to build out its current eMOU.
  - Key Features:
    - Contemplates, but does not require, a technological platform across which the data would be shared.
    - Establishes common agreement to framework and terms.
    - Employs active management through the Operational Committee.
    - Establishes a FOIA-like process for requesting data from departments. A department can deny the request for a valid reason, then the state CIO can overturn the denial if there is not a valid legal reason for not providing the data.
- **Cloud Platform and Presumption of Data Sharing (Ohio)**
  - A 2020 Executive Order creating its InnovateOhio Platform included a presumption of data sharing unless prohibited by law. The EO set forth a review process for determining whether federal law prohibits sharing and provided that data sharing pursuant to the order is a lawful use of data, trumping any state law provision to the contrary: "Notwithstanding any other provision of the Revised Code, a State agency's provision of data under the program is considered a

permitted use of the data under the Revised Code and the State agency is not in violation of any contrary provision of the Revised Code by providing the data[.]”

- **Management Performance Hub and Partnership (Indiana)**
  - Indiana law, IC 4-3-26 et seq., P.L.269-2017, created the Indiana Management Performance Hub (MPH) to establish and maintain a program to support data collection, analysis, and exchange among executive state agencies and to provide access to – and release of – government data by executive state agencies to local government, educational institutions, researchers, nongovernmental organizations, and the general public, as permitted by confidentiality and disclosure laws.
  - In practice, the MPH is responsible for implementing policies and mechanisms that remove legal or technical reasons to decline data-sharing requests. Through the MPH and its programs, Indiana state government has undergone a cultural transformation where agencies that were once risk averse and inclined to refuse requests for data citing federal privacy laws now embrace enterprise data sharing practices.
  - [Indiana Data Partnership \(IDP\)](#): The IDP is an enhancement of the MPH through a formed partnership with Indiana University to create a secure, replicable, and sustainable framework that helps organizations successfully partner to maximize holistic solutions and minimize duplication of efforts through sharing and viewing common data.
  - [Use Case Example](#): One example of the partnership in action focuses on Employ Indy, Central Indiana’s Workforce Investment Board. Youth Employment Services, an Employ Indy program, needed to identify the best areas to evaluate for program expansion locations. Assessment of existing organizations (community centers), key demographic indicators of youth disconnected from education/work opportunities, and connectedness to other education and workforce resources allowed Employ Indy to identify which locations provide the highest impact.
- **Integrated Client Database (Washington State)**
  - The Washington State Department of Social and Health Services Research and Data Analysis (RDA) Division maintains an Integrated Client Database with data from 10 state agencies, 40 separate data systems, and millions of individuals. RDA’s integrated data environment has been used by the state’s Health Home Program to generate tens of millions of dollars in performance payments from the U.S. Centers for Medicare and Medicaid Services, as a result of improved care management for persons dually enrolled in Medicare and Medicaid.
  - [Agencies involved](#): Health Care Authority (Medicaid Agency) and Department of Social and Health Services (Long-Term Services and Supports, Developmental Disability Services, Economic Services, Vocational Rehabilitation, Behavioral Health Institutions, and Forensic Mental Health).
- **Four Document Approach Led by Attorney General (Connecticut)**
  - The Connecticut Office of Policy and Management (OPM) and its Chief Data Officer have been working to make data sharing more efficient, uniform, and safe as the demand for interagency data has increased. A [2020 report](#) describes progress by state agencies and the Office of the Attorney General to provide for a flexible, durable data sharing process for the state, while also providing for participating agencies to have proper oversight over their data and to reduce the

effort needed to share data for legitimate state purposes. The Office of the Attorney General and OPM have been working to draft template agreements, based on a four-document approach, which brings together concepts recognized in the previous state examples:

- 1. Letter of intent or policy agreement of the participating agency leaders to achieve an integrated data sharing process.
  - 2. Enterprise Memorandum of Understanding (eMOU). This type of MOU, similar to Indiana, sets forth the “nuts and bolts” of how data is shared for all participating state agencies in Connecticut, regardless of whether the data is identifiable or de-identified. The eMOU avoids the need to negotiate and draft a new contract every time data needs to be shared, in turn saving the state time and money. The United States Commission on Evidence-Based Policymaking recommended the Enterprise Memorandum of Understanding as a “best practice” method for data sharing.
  - 3. Data Sharing Agreements (DSA). Documents that are signed by the provider of data for the purposes of sharing the data with a particular party or parties. It provides the legitimate governmental purpose for the data sharing, the legal basis for what is shared, and who can have access to the data.
  - 4. A Data Use License (DUL). This is a document that is signed by the receiver of data and sets forth the security provisions for the data, who will have access to the data, the use of the data, and how the data will be returned to the provider or destroyed after the legitimate purpose is completed.
- **Original Trust Agreement Framework and Data Trust (Virginia)**
    - In 2012, Virginia became a trendsetter by establishing a trust agreement framework and governance model to support data sharing between agencies which includes an enhanced Memorandum of Understanding that has been adopted and revised by multiple states including Indiana, Illinois, and Arizona. This model was supported by a Secretarial Committee on Data Sharing formed in September 2011 by the Secretaries of Technology and Health and Human Resources to explore opportunities and constraints for an enterprise data-sharing agreement for state agencies.
    - In 2020, a Virginia [executive order](#) established data governance bodies to improve data sharing between state agencies and localities. The Executive Order implements the recommendations from the 2019 publication: [Data Sharing and Analytics Governance Structure for the Commonwealth of Virginia Report](#). This report proposed establishing a Commonwealth Data Trust to create a safe, secure, and legally compliant information sharing environment.
    - The intent of the trust is to ensure the privacy and security of sensitive personally identifiable information (PII, PHI, and SBU) through the development of a common de-identification algorithm deployed to all agencies that share data in the secure information sharing environment. This anonymization will allow the de-identified record level data to be shared amongst member parties through a multi-tiered security model without violating federal or state laws, regulations, or policies.
    - In 2021, Virginia also passed legislation ([SB 1365](#)) creating an Office of Data Governance and Analytics within the state’s Office of the Secretary of

Administration that is overseen by an existing Chief Data Officer. Virginia’s law authorizes the disclosure of PHI by defining its intended purpose as necessary for activities that are HIPAA permitted disclosures or exceptions.

## II. Georgia

In Georgia, there is not a uniform statewide process or system by which interagency data sharing occurs. In terms of process, this means that there is no statewide protocol for agencies to submit requests for data from another agency. Although agencies share data and have executed data sharing agreements that are in place, there is not a standard template or drafting process; each agreement is written and negotiated through agency legal teams to support specific use cases. In terms of a system, agencies share data between one another in accordance with security and privacy standards set by the Georgia Technology Authority (GTA) but do not currently default to sharing through an integrated data system or to and from a central data repository. However, the Georgia Data Analytic Center (GDAC) created by [HB 197](#) in 2019 has established an integrated data system with the authority to seek out data from state agencies to further research and inform policy decisions to support the health, safety, and security of Georgia citizens. However, the procedures set forth under the GDAC statute do not expressly contemplate utilizing GDAC as a coordinating entity for the exchange of data from one state agency to another state agency, in contrast to some of the states described above.

### Georgia Data Analytic Center (O.C.G.A. §§ 45-12-150 – 45-12-155)

The GDAC statute establishes a framework to utilize GDAC as an “integrated data system” and “central data repository” without directly mentioning these terms. Still, it is clear that GDAC was intended to represent both of these concepts. OPB is required to procure “hardware, software, and a data base system capable of performing analytics at scale and capable of evaluating all data to the extent required to carry out the purposes of [GDAC],” describing the technical requirements of an integrated data system.

Its enabling statute directs GDAC to seek to receive and maintain individually identifiable data but transmit de-identified data wherever possible, with certain limitations.<sup>3</sup> Specifically, GDAC must only receive, maintain, and transmit individually identifiable information if permitted under the Code Section creating GDAC and other applicable law, and if the information is in a secure format that prevents disclosure of individually identifiable information.<sup>4</sup> The manner in which GDAC receives, maintains, and transmits data must be approved by OPB and the state agency or department whose data elements are requested.<sup>5</sup> Such approval process includes the identification of data to be shared, review and approval of the appropriateness of GDAC receiving the data, including whether the transmitting agency has authority to collect the data which GDAC seeks to receive, whether the collection of the data furthers GDAC’s purpose of improving public health and safety, security, and well-being of Georgia residents, and whether reasonable efforts have been made to ensure GDAC will receive only the appropriate data needed to accomplish its purpose.<sup>6</sup>

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<sup>3</sup> O.C.G.A. § 45-12-151(c).

<sup>4</sup> *Id.*

<sup>5</sup> O.C.G.A. § 45-12-152.

<sup>6</sup> *Id.*

#### Summary Points:

- **State Agencies are directed to cooperate with GDAC in submitting data.** State agencies are directed to cooperate with GDAC for the receipt of or access to publicly supported, fiscal, or health data; however, a state agency is not required to transmit or provide access to data if there is a finding by the applicable agency or the Attorney General that such transmission or access would violate state or federal law. The Attorney General's review must include consideration of an analysis from the state agency or department whose data are being requested.
- **Generally, GDAC can release data in aggregate, de-identified form to the public so long as it is approved by OPB and the state agency from which GDAC received the data.** The GDAC statute makes clear that identifiable information should not be disclosed by an agency or by GDAC in violation of state or federal law, including HIPAA. There are exceptions under HIPAA for research purposes and criteria that must be met by Institutional Review Boards (IRBs) and as discussed above, these requirements are baked into the GDAC statute.
- **GDAC's Purpose is Narrowly Tailored to Research and Aligns with HIPAA's Exception for Research Purposes.** GDAC's role and authority to collect, house, and share data is narrowly tailored around research purposes, namely those that support the improvement of public health and the safety, security, and well-being of Georgia residents. OPB/GDAC is responsible for setting policies and procedures that meet certain requirements in statute. Such requirements make clear that the creation of GDAC is to establish a process by which policy concerns of agencies can be studied in an integrated information environment to inform policy decisions.
- **The GDAC statute recognizes that limitations to data sharing exist under federal and state law, stating that data should not be shared to the contrary but indicates that there are exceptions.** The requirements for business associate agreements and IRB approval for research purposes indicate that there are exceptions to these limitations and such requirements were included with the intention to help GDAC fall within the HIPAA exceptions for research purposes.
- **The GDAC statute specifically requires a data use agreement or business associate agreement to be in place prior to the receipt or transmission of PHI by GDAC with any person or entity from which or to which information is to be shared.** Such agreements are to ensure compliance with all applicable privacy and security standards including but not limited to HIPAA.

#### Recent Legislation to Address Data Sharing in Georgia - [SB 374](#)

Senate Bill 374 was introduced in 2022 by Senator Blake Tillery and, if passed, would have caused GDAC to be considered an agent of all executive branch state agencies for sharing government information and an authorized receiver of government information. For HIPAA covered entities, this would have allowed agencies to share information with GDAC without it being considered a disclosure that must be permitted and documented under HIPAA rules. Under the bill, any government information accessed, received, or obtained by GDAC that is protected by any form of confidentiality or privilege would still not be subject to further disclosure by GDAC. In addition, GDAC would still be bound by its statutory requirements to receive and maintain individually identifiable data but transmit de-identified data wherever possible.

### **III. Legal Framework and Barriers**

The legal framework of information sharing is an important piece of responsible data sharing as state and federal laws must be considered regardless of whether a data use agreement or MOU is utilized. The states that have made great strides in creating systems to support interagency data sharing are still faced with limitations surrounding the exchange of PHI; however, the determination that limitations exist in statute or rule is usually the result of agencies weeding out perceived barriers and effecting a cultural shift in attitudes around interagency data sharing.

All of the state health agencies collect and house data meeting the definition of protected health information (PHI) under [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#), Public Law 104-19, and are considered covered entities subject to federal policies. However, HIPAA is a permissive statute that allows PHI to be disclosed for certain purposes. Georgia's health agencies have demonstrated a willingness to enter into data sharing agreements to support treatment, payment, and health care operations, all of which are "health care activities" recognized under the HIPAA Privacy Rule for which covered entities can use and disclose PHI. However, the definitions for these health care activities, described in more detail below, provide limited guidance to covered entities that seek explicit authorization for a disclosure rather than determining whether a disclosure falls within a permitted exception. An agency's perceived barrier to sharing data is usually tied to discomfort over the absence of an explicit authorization or varied interpretations of an undefined term, such as "coordination of care" under HIPAA. For these reasons, it is important that agencies have a forum to discuss data sharing opportunities, share concerns, and interpret together whether a disclosure is permissible absent direct guidance or explicit permission granted in state or federal to share the data.

Outlined below are recognized permitted disclosures under HIPAA for health care activities, including coordination of care, and arguments to help maximize data sharing between agencies.

#### HIPAA Privacy Rule and Permitted Disclosures for Health Care Activities

The HIPAA Privacy Rule permits a covered entity<sup>7</sup> to use and disclose PHI, with certain limits and protections, for three core health care activities: (1) treatment, (2) payment, and (3) health care operations activities. These activities are defined under 45 CFR 164.501 as follows:

- **"Treatment"** generally means the provision, coordination, or management of health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.
- **"Payment"** encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their coverage responsibilities and provide benefits under the plan, and to

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<sup>7</sup> "Covered entity" is defined in HIPAA as 1. a health plan; 2. a health-care clearinghouse; 3. a health-care provider who transmits any health information in electronic form in connection with a covered transaction [relating to health claim report, status, payment, etc.]. Mental health treatment providers, either in the community or as a unit in a jail, will ordinarily be covered entities. An organization that is a covered entity is subject to HIPAA's minimum level of restrictions for sharing protected health information (PHI). A covered entity is subject to HIPAA for all communications, regardless of whether the information is transmitted electronically in a given case.



obtain or provide reimbursement for the provision of health care. In addition to the general definition, the Privacy Rule provides examples of common payment activities which include, but are not limited to:

- Determining eligibility or coverage under a plan and adjudicating claims;
  - Risk adjustments;
  - Billing and collection activities;
  - Reviewing health care services for medical necessity, coverage, justification of charges, and the like;
  - Utilization review activities; and
  - Disclosures to consumer reporting agencies (limited to specified identifying information about the individual, his or her payment history, and identifying information about the covered entity).
- **“Health care operations”** are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment. These activities, which are limited to the activities listed in the definition of “health care operations” at 45 CFR 164.501, include:
    - Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination;
    - Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities;
    - Underwriting and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims
    - Conducting or arranging for medical review, legal, and auditing services, including fraud and abuse detection and compliance programs;
    - Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity; and
    - Business management and general administrative activities, including those related to implementing and complying with the Privacy Rule and other Administrative Simplification Rules, customer service, resolution of internal grievances, sale or transfer of assets, creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity. General Provisions at 45 CFR 164.506.

In addition, HIPAA recognizes permitted uses and disclosures for agencies conducting “health oversight activities”:

- ***Health Oversight Activities*** – Under HIPAA, a covered entity (or a business associate acting on its behalf) may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health care system, government benefit programs where health

information is relevant to eligibility, or regulatory or civil rights law compliance where health information is necessary for determining such compliance.

Coordination of care is recognized within the definition of “health care operations” under HIPAA and emphasized in guidance released by OCR in 2019.

Although HIPAA does not clearly define the scope of care coordination, it does mention it as part of the definition of “health care operations” under 45 CFR 164.501. In addition, the Office of Civil Rights (OCR), the regulatory entity responsible for enforcing HIPAA rules, issued guidance in 2019 to clarify that care coordination is a reason to support the sharing of PHI between covered entities in certain scenarios.

Such guidance sought to clarify that, in limited circumstances, a covered entity may disclose PHI to another covered entity for its own health care operations purposes or for the health care operations of the recipient covered entity. The HIPAA Privacy Rule recognizes that such limited circumstances exist when (1) each entity either has or had a relationship with the individual who is the subject of the PHI being requested, (2) the PHI pertains to that relationship, and (3) the disclosure is for a health care operation specific to case management and care coordination under 45 CFR 164.501. According to the example provided by OCR in its guidance of this permitted disclosure, if an individual enrolled in a health plan of Covered Entity A and then switched to a health plan provided by Covered Entity B, Covered Entity A can disclose PHI to Covered Entity B for Covered Entity B to coordinate the individual’s care, without the individual’s authorization.<sup>8</sup> Still, the disclosures made pursuant to this exception are also subject to the minimum necessary standard even if the disclosure is made between covered entities.

The requirement that covered entities must currently or previously have had a relationship with the individual who is the subject of the PHI could likely easily be met by state health agencies providing Medicaid services. In addition, O.C.G.A. § 33-21A-2, relating to the state Medicaid program and care management organizations, defines “coordination of care” to mean “early identification of members who have or may have special needs; assessment of a member’s risk factors; development of a plan of care; referrals and assistance to ensure timely access to providers; actively linking the member to providers, medical services, and residential, social, and other support services where needed; monitoring; continuity of care; and follow-up and documentation, all as further described pursuant to the terms of the contracts between the Department of Community Health and the care management organizations.”

There could be an opportunity to increase the awareness among the agencies of the federal guidance on disclosures for health care operations involving the coordination of care. In addition, it is significant that HIPAA rules do not specifically define “coordination of care” but acknowledge it within the definition of health care operations. While it would be ideal if HIPAA rules gave explicit permission to covered entities and related business associates to use and disclose PHI to social service agencies and community-based support programs, no such direction exists at this time. In the meantime, the meaning of “coordination of care” is

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<sup>8</sup> See HIPAA and Health Plans – Uses and Disclosures for Care Coordination and Continuity of Care, HHS.gov, <https://www.hhs.gov/hipaa/for-professionals/faq/3014/uses-and-disclosures-for-care-coordination-and-continuity-of-care/index.html>.

open to interpretation, and federal guidance regards it as a significant activity permitting disclosure of PHI from one covered entity to another covered entity under federal guidance.

Data classified as PHI can be shared in de-identified or limited data set form without being subject to HIPAA.

Simply because a database houses data containing PHI does not mean that the data cannot be shared in another format.

De-identifying the data or creating a limited data set are options that should be explored where PHI/PII cannot otherwise be shared in typical identified form. According to the Privacy Rule, a limited data set, in which specific identifiers have been removed, may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set. Limited data set files contain patient-level health information and are considered identifiable files, but they do not contain specific direct identifiers that constitute PHI under the HIPAA Privacy Rule.

Although there are exceptions to HIPAA that allow one covered entity to share PHI with another covered entity for treatment, payment, and health care operations, there may be instances where the purpose for which the data to be shared does not fall within one of these exceptions. In these cases, or when the minimum necessary standard<sup>9</sup> adds another layer of limitation, the option of sharing a limited data set should be explored before concluding that data cannot be shared at all.

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<sup>9</sup> The “minimum necessary” rule states that covered entities may only access, transmit, or handle the minimum amount of PHI that is necessary to perform a given task.



# Governor's Office of Health Strategy and Coordination

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## ***Compilation of Data Sharing Issues and Research***

Elizabeth Holcomb, JD, MPH  
Deputy Director & Legal Counsel

Behavioral Health Innovation and Reform Commission  
November 16, 2022



# Creation of OHSC, Powers and Duties

- The Office of Health Strategy and Coordination (OHSC) was established after passage of House Bill 186 (2019 Session).
- Governor Kemp appointed a Director, Mr. Grant Thomas, in June 2021.
- OHSC now consists of four full time staff and operates as a division of the Governor's Office of Planning and Budget.

**Mission:** to break down the silos between government agencies, health care providers, and health care consumers and to promote health care policies that increase access and quality.

**Statutory Powers and Duties:**

*"Strengthen and support the health care infrastructure of the state through interconnecting health functions and sharing resources across multiple state agencies and overcoming barriers to the coordination of health functions."*

*"Facilitate collaboration and coordination between state agencies, coordinating state health functions and programs, serving as a forum for identifying Georgia's specific health issues of greatest concern, and promoting cooperation from both public and private agencies to test new and innovative ideas."*



# Interagency Data Sharing, States' Approaches

OHSC has examined the practice of data sharing and approaches taken by other states to optimize interagency data sharing in Georgia:

- “Interagency data sharing” = any exchange of data between or among two or more agencies.
- “Statewide data sharing” = a state’s overarching system and policies for data sharing between agencies.
- State trends include increased use of formal data sharing agreements in combination with a statewide data governance structure created by executive or legislative branch action.

## States’ approaches to data sharing vary in governance structure and operation:

- Utilize a central data repository or integrated data system as a conduit for the receipt, maintenance, and transmittal of the data from one agency to another
- Designate an entity or state data officer to oversee the coordination of data sharing between agencies – may or may not house the data or serve as an integrated data system or repository
- Standardized formal data sharing agreements; enterprise agreements or templates
- Cultural shift where agencies lean more toward sharing versus not sharing data





# Legal Framework and Considerations

- The practice of data sharing, whether in the public or private sector, is governed by federal and state laws that depend on:
  - the entities seeking to transmit, receive, or exchange the data,
  - the type of data to be shared, and
  - the intended purpose for which the data will be used.
- The legal framework of information sharing is an important piece of responsible data sharing as state and federal laws must be considered regardless of whether a data use agreement or MOU is utilized.
- Limitations: HIPAA (Protected Health Information), 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records)



# Balancing Privacy Laws with Data Exchange

- States have had success in balancing privacy laws and optimizing data exchanges, effecting a cultural shift in attitudes around interagency data sharing:
  - Illinois
  - Ohio
  - Indiana
  - Washington State
  - Connecticut
  - Virginia

## ***Overcoming barriers to sharing identifiable information:***

- *HIPAA Privacy Rule permits covered entities to use and disclose PHI for three core health care activities: (1) treatment, (2) payment, and (3) health care operations activities.*
- *Minimum necessary standard option of sharing a limited data set for research, health care operations and public health purposes.*
  - *Patient-level health information without specific direct identifiers considered PHI.*
- *Last resort of de-identifying the data.*



# Georgia's Data Sharing Framework

- State agencies currently share data between one another in accordance with security and privacy standards set by the Georgia Technology Authority (GTA).
- The Georgia Data Analytic Center (GDAC) created by HB 197 in 2019 has established an integrated data system with the authority to seek out data from state agencies to further research and inform policy decisions to support the health, safety, and security of Georgia citizens.
- Lack of a standardized system, state-wide approach to data sharing:
  - Agencies do not default to sharing or required to share data through an integrated data system or from a central data repository.
  - There is not a uniform, statewide protocol for agencies to submit requests for data from another agency.
  - Although agencies share data and have executed data sharing agreements in place, there is not a standard template or drafting process; each MOU or DUA agreement is written and negotiated through agency legal teams to support specific use cases.



# Policy Considerations for Georgia

- Create a **uniform statewide process or system** by which interagency data sharing occurs in Georgia.
- Coordinate the development and use of a **Standardized DUA or Enterprise MOU** by all state Agencies.
- Designate an **oversight entity** to coordinate data transfers from one state agency to another.
- Determine whether the designated entity responsible for facilitating and overseeing data sharing between state agencies should also serve as a **central data repository** for the state from which data can be released to requesting agencies.
- **Empower the role of GDAC** to receive and disclose data from state agencies by reviving legislation introduced in the 2022 session.
  - **Senate Bill 374**, sponsored by Sen. Tillery during the 2022 Legislative Session, would have made GDAC an agent of all executive state agencies.



# Questions/Comments

Thank you!

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## Data Sharing Executive Summary

### **BACKGROUND:**

Several states have recognized the important role data can play in enhancing delivery of services and improving overall efficiencies by establishing frameworks for statewide or interagency data sharing. With such frameworks in place, a state is better positioned to overcome barriers to data sharing and the use of the term “interagency data sharing” refers to any exchange of data between or among two or more agencies and the practice of “statewide data sharing” refers to a state’s overarching system and policies for data sharing between agencies.

States’ approaches to data vary in governance structure and operation – some utilize a central data repository or integrated data system as a conduit for the receipt, maintenance, and transmittal of the data from one agency to another, while others designate an entity or state data officer to oversee the coordination of data sharing between agencies. States with established systems for statewide or interagency data sharing utilize a combination of the following approaches:

- Executive order.
- Legislation.
- Task forces, committees, and commissions.
- Formal data sharing documents such as memoranda of understanding (MOU) and data use agreements (DUAs).

The Georgia Data Analytic Center (GDAC) created by HB 197 in 2019 has established an integrated data system with the authority to seek out data from state agencies to further research and inform policy decisions to support the health, safety, and security of Georgia citizens. However, the procedures set forth under the GDAC statute do not expressly contemplate utilizing it as a coordinating entity for the exchange of data from one state agency to another state agency.

### **SYNOPSIS:**

There are various policy and legislative changes that could be pursued to optimize data sharing across state agencies. These potential options include:

- **Create a uniform statewide process or system by which interagency data sharing occurs in Georgia.**
  - There is no statewide protocol for agencies to submit requests for data from another agency.
- **Coordinate the Development and Use of a Standardized DUA or Enterprise MOU by All State Agencies**
  - Although agencies share data and have executed data sharing agreements in place, there is not a standard template or drafting process; each agreement is written and negotiated through agency legal teams to support specific use cases.
  - The development of such agreements in other states has served to standardize data sharing practices, encourage interagency data sharing to improve state services, and create a cultural shift in attitudes around data sharing.



- **Coordinate interagency data sharing through a designated entity that oversees data sharing for the state and facilitates data transfers from one agency to another.**
- **Determine whether the designated entity responsible for facilitating and overseeing data sharing between state agencies should also serve as a central data repository for the state from which data can be released to requesting agencies.**
  - In terms of system, Georgia's agencies currently share data between one another in accordance with security and privacy standards set by the Georgia Technology Authority (GTA) but do not default to sharing through an integrated data system or from a central data repository.
- **Establish in state law or policy a presumption of data sharing across all state agencies.**
  - Ohio established this policy by Executive Order which effectively overrides any state law provision to the contrary and sets forth a review process for determining whether federal law prohibits sharing.
- **Empower the role of the Georgia Data Analytics Center (GDAC) to receive and disclose data from state agencies by reviving legislation introduced in the 2022 session deeming GDAC an agent of all executive state agencies more easily.**
  - [SB 374](#) was introduced in 2022 by Senator Blake Tillery. If passed, the legislation would have caused GDAC to be considered an agent of all executive state agencies for sharing government information and an authorized receiver of government information. For HIPAA covered entities, this would have allowed agencies to share information with GDAC without it being considered a disclosure that must be permitted and documented under HIPAA rules. Under the bill, any government information accessed, received, or obtained by GDAC that is protected by any form of confidentiality or privilege would still not be subject to further disclosure by GDAC. In addition, GDAC would still be bound by its statutory requirements to seek, receive, and maintain individually identifiable data but transmit de-identified data wherever possible. This portion of the GDAC statute could be reviewed in any attempt to revive SB 374.
  - GDAC's establishing statute does not expressly contemplate utilizing GDAC as a coordinating entity for the exchange of data from one state agency to another state agency. This designation could be added to GDAC's role in legislation that builds upon SB 374 from this last year.
  - **If language in SB 374 is revived, additional language could be added to the current draft bill designating GDAC as the entity responsible for facilitating and overseeing data sharing between state agencies and assigning GDAC as the central data repository for the state from which data can be released to requesting agencies.**

*Commentary:*

The legal framework of information sharing is an important piece of responsible data sharing as state and federal laws must be considered regardless of whether a data use agreement or MOU is utilized. The states that have made great strides in creating systems to support interagency data are still faced with limitations surrounding the exchange of personally identifiable information; however, the determination that limitations exist in statute or rule is usually the result of weeding out perceived barriers and effecting a cultural shift in attitudes around interagency data sharing.

## **WORKFORCE AND SYSTEMS DEVELOP SUBCOMMITTEE REPORT BEHAVIORAL HEALTH REFORM AND INNOVATION COMMISSION**

### **Summary of 2022 Activities**

#### **I. July 7, 2022 - Student Cancellable Loans and Behavioral Health Data Surveys by Professionals**

- a. *Polly McKinney*, Advocacy Director, Voices for Georgia's Children
- b. *Chet Bhasin*, FACHE, Executive Director, Georgia Healthcare Workforce Board

The agenda and witnesses at the July 7, 2022, focused on Section 2-2 of HB 1013 relating to the creation of a Behavioral Care Workforce Data Base for the purpose of collection and analyzing minimum data set survey of the behavioral health care professionals, and Section 2-1 that creates additional types of service cancelable educational loans.

Witnesses for the Subcommittee agenda spoke to the data surveys, namely Polly McKinney from Voices for Georgia's Children, and Chet Bhasin, the newly appointed Executive Director of the Georgia Board of Health Care Workforce. Director Bhasin described his initial contacts with the licensing boards directed to collect data from behavioral health care provides, and his timetable for compliance with HB 1013. The specific types of survey information required to be collected and the purposes were discussed.

For Section 2-1 of HB 1013 creating new cancelable education loans, there have been discussions and questions ongoing on when the loans administered by the Georgia Student Finance Commission might be granted for eligible students and how to define underserved or geographic areas under 20-3-374(b)(3). These questions require clarification.

#### **II. September 15, 2022 - Data Sharing Among State Agencies, Data Sharing Platforms, and SB 374**

- a. *Elizabeth Holcomb*, Legal Counsel for the Office of Health Strategy and Coordination (OHSC)
- b. *Kanti Chalasani*, Director of Georgia Data Analytic Center (GDAC)

The Subcommittee heard from Dr. Kanti Chalasani, Director of the Georgia Data Analytic Center (GDAC) and Elizabeth Holcomb, Legal Counsel for the Office of Health Strategy and Coordination, and her research paper on Compilation of Data Sharing Issues and Research. Ms. Holcomb's paper surveyed the efforts of other states to share data by either legislation, Executive Order, or Memoranda of Understanding (MOUs).

In addition, the Subcommittee reviewed SB 374, legislation introduced and passed in the Georgia Senate in 2022, but not passed by both Chambers, that incorporated some of the ideas to enforce data sharing described in Ms. Holcomb's paper. The subcommittee Chair has talked with the Senate sponsor of SB 374, Senator Blake Tillery, about the specific elements of his legislation, and also conferred with Ms. Holcomb on our anticipated proposal to reintroduce data sharing legislation in the 2023 General Assembly Session.

**III. October 27, 2022 - Issues of Licensure, Credentialing, and Certification that Create Unnecessary Obstacles**

- a. *Melissa Haberlen-DeWolf*, Research and Policy Director, Voices for Georgia's Children
- b. *Lesley Kelley*, Senior Policy Analyst, Voices for Georgia's Children
- c. *Belisa M. Urbina*, Executive Director, Ser Familia
- d. *Carol Caraballo*, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)
- e. *Judge David Sweat*
- f. *Leslie Austin*, Provider Enrollment Manager, Georgia Department of Community Health (DCH)
- g. *Brig Zimmerman*, Executive Director, Georgia Composite Board of Professional Social Workers and Marriage & Family Therapists, Secretary of State's Office
- h. *Anita Brown*, Georgia Psychological Association
- i. *Dr. Shannon Mullins*, Georgia Psychological Association
- j. *Dr. Stephen Livingston*, Association of Marriage and Family Therapists
- k. *Gail Macke*, Executive Director, Georgia Licensed Professional Counselors

The Subcommittee solicited from a variety of behavioral Health professional recommendations for changes to the Secretary of State office of Georgia Composite Board of Professional Counselors. A specific review of SB 403 relating to co-responder programs was discussed to determine whether any amendments are necessary to facilitate or clarify the status of mental health providers who are part of a co-responder team.

**Recommendations**

1. Loan Repayment Assistance Program for MH/SU Professionals - HB 1013 called for the creation of a service cancelable loan program for students enrolled in any degree program for mental health and substance use professionals, which will be administered by the Georgia Student Finance Commission. This program creates an incentive for students to enter degree programs to become mental health and substance use professionals by awarding loans to students which can later be repaid through service once they are licensed and practicing in the field. We have reviewed other states' programs and related workforce data and believe it would be worthwhile for Georgia to incentivize its current workforce to practice in mental health professional shortage areas through a loan repayment assistance program for individuals who are no longer students but actively practicing in the workforce as a licensed mental health or substance use professional. Participants in the program would receive loan repayment assistance that is conditioned on five consecutive years of service in a facility with a Health Professional Shortage Area (HPSA) designation that serves the Medicaid and PeachCare for Kids population. This loan repayment program would be administered of the Georgia Board of Healthcare Workforce. This concept has been discussed previously with HB 1013, but new language is necessary to ensure such loan assistance can be offered to licensed professionals in addition to the service cancelable loan program available to eligible students.

2. Data Sharing - Several states have recognized the important role data can play in enhancing delivery of services and improving overall efficiencies by establishing frameworks for an overarching system and policies for data sharing between agencies and “interagency data sharing” – any exchange of data between or among two or more state agencies. The legal framework of information sharing is an important piece of responsible data sharing that sometimes translates into barriers, but other states have had success in balancing privacy laws and optimizing data exchanges, effecting a cultural shift in attitudes around interagency data sharing. In Georgia, there is no uniform statewide process or system by which interagency data sharing occurs, nor is there a statewide protocol for agencies to submit requests for data from another agency or coordinating entity. However, the Georgia Data Analytic Center (GDAC) created by HB 197 in 2019 has established an integrated data system with the authority to seek out data from state agencies to further research and inform policy decisions to support the health, safety, and security of Georgia citizens. There was legislation introduced by Senator Tillery in 2022, SB 374, which would have removed some barriers to data sharing by making GDAC an agent of all executive state agencies for sharing government information and an authorized receiver of government information. The Commission recommends revisiting SB 374 this session with enhancements that serve to further empower GDAC by designating it as the entity responsible for facilitating and overseeing data sharing between state agencies, and the central data repository for the state from which data can be released to requesting agencies.
3. Increase Psychiatric Residency Programs – This will make a direct response to the mental health workforce shortage. Usually, the low number of psychiatrists per 100,000 persons is the reason Georgia shows up as 49-51st on mental health access (despite the huge increases in resources during the settlement agreement and last year following the Commission recommendations.) I’d love to have this start up included in the Workforce task force ask for the 2023 Session.
4. Behavioral Health Workforce Study – Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complete a study on current wages of behavioral health providers at all levels, including recommendations on how to increase wages for providers. HB 1013 required a study of reimbursement rates for mental health services. This workforce wages study would be a next step to ensuring behavioral health practitioners in the state are compensated fairly.
5. Reimbursement Rate Study – Department of Community Health (DCH) complete - When the reimbursement study conducted by DCH is completed, we reserve the right to comment further. We believe reimbursement rates for intensive psychiatric beds for children is inadequate, and in general, behavioral health services for children are inadequately paid.
6. Enhancing Opportunities for Foreign Trained Behavioral Health Professionals -- The state of Georgia is continuing to increase in ethnic and racial diversity, which also increases the need for culturally competent and equitable health services/providers. Furthermore, Georgia’s population has shown an exponential increase in foreign-born people who now reside in the state, contributing to 10% of Georgia’s population. In addition to facing a behavioral health

workforce shortage, fewer minority and foreign-born behavioral health providers are accessible and readily available to serve these communities. There is a need for Foreign Trained Behavioral Health Professionals, however, there are barriers that may impede this process. Other states have reduced these barriers through temporary licensure, the creation of task force, and pathways for Foreign Trained Behavioral Health Professionals for making licensure easier to navigate, obtain, and use. Other activities that may support this work include establishing culturally competent divisions within state agencies such as DBHDD, creating incentive programs, implementing National CLAS Standards, improving coordination between agencies and programs, and culturally-responsive crisis services.

7. Examine Issues of Internships, Practicum Requirements, and Supervision for Service Providers – There are several challenges to granting behavioral health licensure in Georgia. First, there has been approximately an 80% increase in applications from 2017 to 2022; however, the number of Board members to review applications has not increased to meet this growing demand. There are three members from each licensing association on the Georgia Composite Board of Professional Social Workers and Marriage & Family Therapists who review applications, and two of the three members are required to review and approve each application. Board membership is a volunteer position, and members are spending approximately 10-12 hours per week reviewing applications and complaints. Additionally, Georgia's application requirements are generally more stringent than those of other states. Adjusting these requirements would streamline the application and approval processes.

For example, there are unique challenges to obtaining a Marriage and Family Therapist (MFT) license in Georgia. The application process is complicated and has not been updated in over 25 years. The application is over 17 pages and needs to be completed on paper. The Association of Marriage and Family Therapists has recommended that the application be shortened and simplified and transitioned to an online process. Additionally, as noted above, there are currently too few staff reviewing applications – more reviewers are needed to accommodate a growing workforce. Moreover, there are currently greater direct clinical and supervision hour requirements to obtain MFT licensure in Georgia relative to neighboring states.