

**Georgia's Imperative:
Implementing the Final Report of the President's
New Freedom Commission on Mental Health**



Ninth Annual Rosalynn Carter Georgia Mental Health Forum

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Welcome

Thomas H. Bornemann, Ed.D.
Director, Mental Health Program, The Carter Center

Welcome to the ninth annual Rosalynn Carter Georgia Mental Health Forum. This is a chance for those of us in Georgia to take a look at issues of compelling concern to our state. Like most states in the union, Georgia is challenged tremendously right now: challenged fiscally, challenged from a public policy perspective, and challenged to improve services and service delivery. That challenge is even tougher due to the economy and other factors. It is important for us to pull together as a total community and look at what we can do to move an agenda forward and overcome these challenges.

Today we are going to look at the President's New Freedom Commission on Mental Health as a framework from which to begin our work. As you read the report, you will see that it does not get into specifics. The details of how to implement the report's recommendations are for us to determine. Real change associated with the commission's report is going to happen here – at the state and local level. We have been looking forward to this forum and to rolling up our sleeves and seeing what can be done to improve mental health services here in Georgia.

Opening Remarks

Rosalynn Carter
Chair, The Carter Center Mental Health Task Force

Welcome to The Carter Center and to our Georgia Mental Health Forum. I am partial to Georgia. I got started here with my mental health work. That was a long time ago, and everything has changed since then. When Jimmy was governor, nobody talked about mental illnesses. No one would admit that there was a mentally ill person in the family.

I remember going to Central State Hospital in Milledgeville and seeing people tied in chairs, rocking. It was terrible. Back then, we began moving people out into the community into temporary centers until we could establish better facilities. I remember visiting one in Thomasville, Ga., on what had been an old Army post. What a change – it was such a wonderful contrast. People were able to walk outside. They had a store where they could choose their clothes, something they had not done in years. They went through a line in the cafeteria and chose their own food. Compared to what we are doing today, it doesn't seem like very much. Back then it was an amazing step forward from being shut up in an institution.

That day in Thomasville, I walked out onto the porch and saw two men who had been at Central State for years. They had recently been transferred to this facility. One man was smoking a cigarette. The other one wanted it and finally got up the courage to nudge the smoker and point to the cigarette. While the owner of the cigarette did not share then, the next time I went to Thomasville, I saw the two walking outside together, talking with each other. It was wonderful to see the change – from isolation to community.

Changes in mental health care are still going on. I recently received a survey report showing a reduction in stigma and an increase in people accessing the mental health system and obtaining treatment. That is improvement! Yet, the New Freedom Commission reports that in Georgia and states across the country, the mental health system is in shambles and needs to be transformed, not just reformed. It is sad that with all of the great advances in knowledge of the brain and in diagnosis and treatment of the illnesses, our system has not kept up with the progress and something this dramatic has to be done. We have tried many times in the past to improve the mental health system, sometimes by trial and error. We all know that there are programs that work. One of our forums focused on some of these here in our own state.

Over the past few years, there has been increased attention on mental health with the surgeon general's report and now with the President's New Freedom Commission report. What struck me when reading the report of the current commission was how many of the issues are the same as those of our commission 25 years ago. This is frustrating news. There is one striking exception, though, and that is recovery. With all the improvements in the ability to diagnose and treat mental illnesses effectively, we now know that recovery is possible. It is absolutely wonderful to see recovery as a focus of the report.

The commission has done its work. Now it's up to us, the mental health community and the general public, to complete the task of transforming our system of care and implementing the report's recommendations. And, if the general public is going to be of any help in our efforts, we have to educate them and get them involved.

Implementing these recommendations is going to be a huge task, and we must work together. No one group can do it alone. It will take all of us, everyone in the mental health field – policy-makers, advocates, professionals, researchers, consumers, and family members.

Today is an important time for us to come together. The mental health system in our state is struggling, as it is in states across the country. Programs are being cut. As a result, instead of moving forward with all our new knowledge and evidence-based practices, we are in danger of losing what we have. This is frightening.

Today we will look at the recommendations of the New Freedom Commission and see how we can best leverage and implement them. My hope is that we can agree on at least one recommendation from each of the six goal areas that can be incorporated into Georgia's mental health system. If we can do that, we will consider this day a success.



Keynote Address

James Stone, M.S.W., C.S.W.

Deputy Administrator, Substance Abuse and Mental Health Services Administration

The concept of mental health system transformation has been with us for years. While we all know that the delivery of services in the mental health system must change, we are still experiencing the very same problems that we had in the 1978 Carter commission report. That is the bad news.

The good news is that things really are changing now. We are focusing more on a science base, including research in brain functioning, understanding of trauma, and other factors in mental illness. The result is an understanding that mental illness is

Mental health is a public health issue because it affects the overall health of the community and our nation as well as that of an individual.

not a function of weak character or poor upbringing, but more complicated issues. We can only hope that soon the general public will equate mental health with physical health,

and as a consequence, we will see the stigma attached to people with mental illness go the way of the stigma that attended cancer in years gone by. In the past 25 years, there has been a tremendous change in the way mental health professions regard mental illness. At the time of the Carter commission report, we did not regard serious mental illness as treatable, and so we relied on institutional care. The word “recovery” was not in our vocabulary.

Our message to the public has to be that mental health is fundamental to physical health. That mental illness is real and is a physical illness with physical and chemical manifestations. That mental illness is treatable and recovery is possible. It is time,

therefore, to end the blame-and-shame attitude that people have and eradicate the stigma related to mental illness.

Good mental health needs to be part of our nation’s effort to promote good health in general. This concept is reflected in the surgeon general’s report on mental health. Just as a person can do much to promote and maintain overall health regardless of age, each person also can do much to promote and strengthen mental health at every stage. Therefore, it is important that we understand mental health care at every stage in the context of the public health model.

The public health model takes a community approach to preventing and treating illness. Its premise is that caring for the health of an individual protects the community, while caring for the health of the community protects the individual, with an overall benefit to society at large. Mental health is a public health issue because it affects the overall health of the community and our nation as well as that of an individual. The surgeon general’s report on mental health states that “from early childhood until death, mental health is a springboard of thinking and communication skills: learning, emotional growth, resilience, and self-esteem.” These are the ingredients of each individual’s successful contribution to community and society. Thus, not caring for the mental health of an individual denies that person a full life in the community and denies the community the benefits it could receive from that person’s sound mental health.



We can see the truth of this statement across the generations. Fifty percent of students with serious emotional disturbances drop out of high school. Only about one in three people with a mental illness is employed. The costs of mental illness in terms of health and lost productivity are staggering. The World Health Organization has identified mental illnesses as the leading cause of disability worldwide,

accounting for 25 percent of all disability in industrial countries. How we care for the mental health of the current child and adult generations will determine if mental health care will become a public health crisis for the next generation. About 5 to 9 percent of American children have a serious emotional disturbance that, left untreated, can lead to serious emotional illnesses and physical complications in adulthood.

By the year 2010, approximately 40 million Americans will be age 65 and older. More than one-fourth of older adults have mental health issues, including mental illnesses, alcohol use, depression, anxiety disorders, dementia (including Alzheimer's disease), and suicidal ideation. Their mental illnesses will significantly affect their health and functioning, with a compounding effect on the care they will need and its associated cost.

We have evidence that poor mental health can undermine physical well-being. We know that patients who experience a major depressive episode following a heart attack have an increased risk of early cardiac death. We know that emotions such as fear, anxiety, and depression can worsen the pain of cancer and other severe illnesses. Mental health and physical health are inseparable.

Scientific studies demonstrate that treating the mental health needs of adults benefits them both mentally and physically, even when they have a chronic illness. Treating the mental illnesses of dual-diagnosed patients can improve their interest and ability to care for themselves. It can engage them in following their primary care provider's directions and advice, particularly about taking medications. It can transform their hope in recovery or bolster their ability to cope with illnesses from which there is little chance of recovery. Science has substantially broadened our knowledge about the critical link between mental and physical health. Unfortunately, our society as a whole and our national health care system have been slow in making the benefits of this knowledge available to consumers at the clinical level.

Our current mental health system is characterized by services that are fragmented, disconnected, and often inadequate. Too often, today's system focuses only on managing the symptoms of mental illness and accepts long-term disability as a foregone conclusion. Recovery, not disability, should be the expected outcome for everybody. A recovery-focused system sees each individual as a unique human being and not just as a person with a categorical disability. A recovery-focused system focuses the dialogue about care to revolve around the comprehensive needs of

a person living in a community, such as finding a job and home and building fulfilling relationships with others.

Individuals with mental health disorders undergo unique experiences while being in recovery. They grow to accept having a chronic incurable disease that is a permanent part of them without guilt or shame, fault or blame. After time and focused help, they can avoid complications of the condition. They can participate in ongoing support systems as both recipient and provider. They can change many aspects of their lives, including their emotions, interpersonal relationships, and spirituality. They learn to accommodate their illness and grow through overcoming it. The most compelling element of recovery is the belief that people with mental illnesses can take charge of their own life and make choices.

However, our current mental health system is not focused on recovery. We cannot have a mental health care system that is driven by the needs of the consumers and their families without transforming the way we do business. What does it mean to transform a system? Let's look at a definition of transformation by retired Vice Admiral Cebrowski, special assistant for transformation in the Department of Defense, who studied this concept in depth. He views transformation as an ongoing process that demands profound changes at the core of a system, not at its margins. Transformation involves new ways of thinking, doing, and working together. Once the process of transformation begins, a profoundly different system will emerge, with changes in its structure, culture, policy, and programs.

In the final report by the President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, the commission

asks that we undergo a complete upheaval of what we know, what we do, and how we go about delivering mental health care from the federal to the clinical level. The commission envisions a national mental health system in which everyone with a mental illness at any stage of life will have access to effective treatment and supports. This system will actively facilitate recovery and helps those with mental illnesses build resilience to life's challenges. These words have particular meaning when we consider dual-diagnosis as one of life's greater challenges.

Achieving the Promise outlines six goals for a transformed mental health care system:

1. Americans will understand that mental health is essential to overall health.

The commission's two recommendations for achieving this goal are: (1) that we reduce the stigma of seeking care and (2) that we address mental health with the same urgency as we address physical health.

The stigma of seeking mental health care is so strong that nearly half of the nearly 15 million American adults who have serious mental illnesses will not seek treatment. Their failure to seek treatment has serious implications for long-term health. As many as half of the adults who have a diagnosable mental illness also will have a substance abuse disorder at some point in their lives. Research demonstrates that if only one disorder is treated, both usually get worse. In addition, failure to seek treatment for serious mental illnesses places adults at risk of other adverse affects, such as patient distress, impaired functioning, or heightened risk of death, pain, disability, and a loss of freedom.

As part of our efforts to eliminate stigma, SAMHSA has created the Center for Addressing Discrimination in Stigma (ADS

Center). The ADS Center is making information about recognizing and eliminating stigma available. This information is available at our Web address.

One manifestation of stigma is reflected in the disparity between insurance payments for primary care and mental health services.

Stigma is an antiquated byproduct of fear and ignorance that has no place in the 21st century.

Mental health care services have traditionally been more limited than other medical benefits. This situation affects state mental health care services in particular, since the states are increasingly relying on Medicaid programs to support their mental health care system. Medicaid is now the largest payer of mental health services in this country. SAMHSA is working with the Centers for Medicare and Medicaid Services (CMS) to investigate alternative financing models to align payment with what we know works in mental health care services. At the state level, you can advocate for better cooperation and collaboration between your state Medicaid office and state or local service providers.

The surgeon general's report on mental health found that the mental health field can help eliminate stigma by finding causes and effective treatments for mental disorders. This report states that, "When people understand that mental disorders are not the result of moral failings or limited willpower, but are legitimate illnesses that are responsive to specific treatment, much of the negative stereotyping may dissipate."

As mental health professionals, you can help eliminate stigma by focusing on the use of evidence-based practices and documenting their effectiveness by demonstrating to consumers and nonconsumers alike that recovery is a real possibility. Stigma is something that mental health professionals must fight aggressively. Stigma

is an antiquated byproduct of fear and ignorance that has no place in the 21st century. It is preventing people from receiving the treatment they need, denying adults their path to recovery, and undermining effective, integrated services for those with illnesses that are often disabling when left untreated.

2. Mental health care will be consumer- and family-driven.

A transformed mental health system will respond to an individual's diagnosis of serious mental illness with a highly individualized plan of care. This plan will recognize the individual in his or her entirety and will integrate the full range of an individual's needs to support recovery, such as housing and supported employment. To ensure that the needed resources are available, states should develop a comprehensive mental health plan outlining responsibility for coordinating and integrating programs.

I am pleased to say that these comprehensive state mental health plans are already moving from the commission's vision to reality. President Bush's 2005 fiscal year proposed budget contains \$44 million to help states begin to develop plans that can transform mental health care at the local level. When your state is debating the best elements of its comprehensive plan, make certain that representatives of your organization speak to what you believe will benefit the needs, desires, and demands of your consumers.

3. Disparities in mental health care are eliminated.

One disparity is the care available in rural areas. Another is racial and ethnic disparities. Minorities in the United States face many social and economic barriers to health care, including racism and discrimination,



violence, and poverty. Each of these conditions adversely affects both physical and mental health.

4. Early mental health screening, assessment, and referral to services are common practice.

In this goal, the commission emphasizes the need to treat dual-diagnosed disorders as primary illnesses. Integrated treatments can improve patient engagement, reduce substance abuse, improve mental health, and reduce relapses for all age groups. These

benefits apply not only to mental illnesses combined with substance abuse disorders but also to mental illnesses and other physical disorders.

One of the many factors that can affect the emotional health of young children is the mental health status of their parents. Therefore, treating the mental illness of adults becomes preventive treatment for children's disorders. The commission recommends that we initiate mental health screenings in all settings in which a high occurrence of behavioral disorders exists. Given the high incidence of substance use disorders among parents of children in the child welfare system, the commission suggests that these parents are screened for co-occurring disorders and linked as needed with appropriate treatment and supports.

Transformation of our mental health system requires that we change how we provide care, including building stronger partnerships among those with a stake in the mental health care of the community. The screenings recommended by the commission involve not only primary and mental health care providers but also the education, judicial, and child welfare systems, among others.

5. Excellent mental health care is delivered, and research is accelerated.

Accelerating research, and in particular shortening the lag between discovery of an effective form of treatment and the time when it becomes part of routine patient care, is essential for mental health system transformation.

SAMHSA is taking steps to more rapidly identify and disseminate evidence-based practices. One important and recent advance is the expansion of the National Registry of Effective Programs (NREP).

NREP conducts expert evaluations of programs to determine model evidence-based interventions and places these programs in a national registry. We expanded NREP last year by adapting its criteria to mental health and co-occurring disorder treatment programs. Now we are doing the same thing with mental health promotion and prevention programs.

This goal highlights another critical issue of mental health care in America: work force adequacy, both in terms of sufficient numbers and skills. Not only is there a shortage of providers, but many of the system's most experienced providers are not trained in cutting-edge, evidence-based practices.

For example, there is a serious need to crosstrain primary care providers to become knowledgeable participants in providing mental health care. Primary care providers now prescribe the majority of psychotropic drugs for both children and adults. Approximately 70 percent of the care for common mental disorders is delivered in general medical settings. I do not think that most people in primary care realize how much mental health service they actually provide.

State-level leadership and planning, financing, service delivery, and evaluation of consumer- and family-driven services will significantly advance the transformation agenda.

Another example is that the schools of social work in New York City are training students for jobs that no longer exist. They are still training people for the 50-minute clinical hour. Yet, social work does not happen in clinics anymore. We need to be working with people in their own environment. Therefore, we are working very hard to transform the way students are taught in schools of social work and psychology and in the psychiatric field. I would advise all of

you to look at how people are being trained as you look at your state system. Are they being trained for jobs that exist?

6. Technology is used to access mental health care and information.

The last goal states that we should use the technology that is available to us to access mental health care and information. For example, nearly 60 million people live in rural and frontier areas, each facing a range of life challenges, and deserve the same quality of mental health care as our urban citizens. But in areas without an adequate supply of mental health professionals, primary care physicians deliver most mental health care. Telehealth, for example, is rapidly emerging as our opportunity to cross-train and support primary care physicians to offer specialized care long distance and to integrate evidence-based practices at the local level.

I have just given you a brief overview of the New Freedom Commission's report and its vision of a transformed system. SAMHSA and other federal agencies are now taking the first tangible steps toward turning the commission's vision into a reality. We have created a Transformation Work Group, an executive team of 18 federal partners that have been meeting the past several months to analyze the commission's recommendations and determine how federal agencies can respond. The team has just recently completed a national mental health action agenda. This agenda is based on the conviction that mental health illnesses are treatable and recovery should be the expectation. The action agenda sets time-limited, realistic priorities for the first year of a planned five-year transformation. It defines the first steps of the federal role in the transformation. Federal agencies can act as leaders,

facilitating and promoting shared responsibility for change at the federal, state, and local levels.

However, the states will be at the very center of system transformation. State-level leadership and planning, financing, service

delivery, and evaluation of consumer- and family-driven services will significantly advance the transformation agenda.

When we create a mental health care system that supports every American in becoming all they can be, our nation will become all that it can be.

Questions and Answers

Q Please talk about the response from your federal partners at CMS regarding financing. I think a lot of people are willing to implement some of the creative solutions presented in the report but are unable to do so because of financing. For example, I know my primary care colleagues have a lot of trouble with reimbursement when they give a psychiatric diagnosis.

A Mr. Stone: I think that CMS is a lot more flexible than we give it credit for. Very often it does come down to a question of finance. I would suggest that you work very closely with your state Medicaid agency. Get to know those people, and I think that you will find a lot of opportunity for flexibility that you did not know existed. Part of the reason that it is not widely known that CMS is more flexible is that flexibility costs money, and frankly, there is no real advantage financially to the state to display that kind of flexibility. My underlying message is this is not about the lack of flexibility but about how much things cost. If you can showcase the value, you will find that CMS is a lot more flexible than you realize.

Q While it has taken awhile, we are beginning to see some trickling of funding to address co-occurring disorders. Can you share with us an overall picture of the agencies – including addiction treatment, mental health treatment, and prevention – to serve the complete client?

A Mr. Stone: I think the whole concept of co-occurring disorders is fairly recent. While consumers merged mental illness and substance abuse a long, long time ago, the field was very slow to pick up on it, and the bureaucracy was even slower.

We are the problem. The problem surrounding co-occurring disorders probably persists because we are comfortable working with our own little funding streams and our own little silos. This is doing a lot of damage to people in need of service. This is an idea whose time has come.

Coordination of care occurs at the local level, not at the state or federal level. Localities – counties and cities – have to figure out how to blend funds and how to encourage providers to provide those integrated services. The field is already there, and our consumer base is already aware. We have to figure it out.

Q What are you doing to get the parity bill that has been sitting at the federal government out of committee so it can be heard?

A Mr. Stone: It is very difficult for people in political life to take a position on mental health. Those in political life would like to pretend that mental illnesses do not exist. There is no real benefit for them. They are willing to get involved in substance abuse issues because that is visible and it gets them some

press. But mental illness and mental disability are generally scary to people in political life. I am not sure why. I think the continual education of those in political life by advocates is very important.

As for the parity bill, both the president and Secretary Thompson have expressed support for parity. Beyond that, the issue is languishing in Congress, probably because of other priorities. I think we can only continue to pressure our representatives to move it along. There has to be a will to do it, and I am not really seeing that will right now.

A Mrs. Carter: I want to add something to that. In the House, we have 268 representatives who are sponsors of the bill, more than half. In the Senate, we have 65 senators who are sponsors of the bill. We cannot get it out of committee because of the committee leadership. Since we have the votes in both the House and the Senate to pass it, we need to put pressure on the Republican leadership of those committees. Insurance companies are very powerful, so it is up to all of us and to everybody that we can influence to keep the pressure on, write local congress people or those who are running for office, to be sure that they support parity in insurance.

Q My question is related to housing. We often see people of all ages in long-term care settings who have mental health issues and who are in these settings solely because Medicaid will pay for the housing. Without affordable housing, we cannot transition them out of the nursing homes. Therefore, people end up in personal care home settings or boarding care settings because there is not affordable housing. I am wondering if you have any comments on what hope there might be for affordable housing.

A Mr. Stone: I think people do forget that housing is such an important issue. The Department of Housing and Urban Development (HUD) has essentially gone out of the business of providing subsidized housing for those with disabilities gradually over the past 10 years – all disabilities, not just mental health. It is becoming an increasing problem. What exacerbates it is that many of the programs that started out a long time ago with special funding from the federal government are decreasing their commitments to the housing providers. As a result, these providers are turning their housing into other kinds of housing.

Part of the issue is that we have to raise the amount of money that people obtain for disabilities – the income from Social Security, for example. People cannot reasonably afford decent housing on the SSI amount. Just raising SSI to a more reasonable level would do a lot to alleviate the housing problem. That is something else for which we should advocate.



Panel: Laying the Foundation

Cynthia Wainscott

Chair-elect, National Mental Health Association

Mr. Stone talked about transformation. We are a little overtransformed in Georgia right now, and we are leery of change because of what has happened here over the last 10 years. House bill 100 created 19 regions, which then became 13, which then became seven. Each one of those regional changes came with huge management upheavals. We now have geographic areas so large it is difficult to conduct local planning. In fact, much of the decision-making has been re-centralized. These changes were imposed upon us from outside the system, and it is interesting that consumers, families, and advocates opposed each of these changes. The uncovering of long-standing irregularities has damaged the public confidence in our system. Our internal strife – what my grandmother called “squabbling” – became very public sometimes.

As power shifts, people feel uncomfortable. Change is difficult. What we desperately need in Georgia is a coordinated voice. I think the New Freedom Commission’s report gives us an opportunity to do that.

One of the outcomes of what we have gone through is that our system is seriously underfunded. In fiscal year 1991, Mental Health, Developmental Disabilities, and Addictive Diseases (MHDDAD) services accounted for 5 percent of the state budget. In fiscal year 2002, it was 3 percent. Our population has increased by 31 percent during that same period, and the Consumer Price Index has gone up 36 percent. People who are a lot smarter with numbers than I am tell me that if the Department of Human Resources (DHR) had gotten its fair

share as the population and the Consumer Price Index went up, we would have an additional \$275 million.

As grim as those numbers are, they do not showcase the total problem, because significant Department of Community Health (DCH) dollars went into DHR and are administered now by DHR. This administrative change made DHR’s budget bigger but did not produce any service capacity enhancement. If you figure that administrative budget shift in the picture, we are even farther behind in our funding than the numbers indicate.

Another really serious problem we have is that our fiscal incentives absolutely do not encourage – in fact, they often discourage – planning between agencies. Our departments of Community Health, Juvenile Justice, Corrections, and Education operate independently of one another. There are huge mental health dollars spent by all of those other agencies.

We continue to miss an opportunity for early intervention in the schools. We need to expand, not contract, our understanding of and vision for prevention. We have gone from 13 prevention specialists to seven, and I currently believe we only have three. We are heading in the wrong direction on prevention.

Data is another serious deficit. We do not have a statewide data system with common data criteria to exchange information. We do not have a common definition for the population served. When you think about attempting to plan in a system that does not have a common language, you can begin to



see the handicap. The good news is that we are contracting for a gap analysis. With leadership by the Georgia Mental Health Planning and Advisory Council, a contract and request for information is on the street.

We have some real strengths, however. I think our major strength is the people here in this room today. I look around and see many colleagues who have committed untold hours of energy. We have an unrecognized power. We have

not held hands and marched together on common agendas very often. However, if we do unite in a common agenda, we can really transform our system, not just change it. Another strength we have is our national leadership position with recovery.

I am going to close by saying we have some deficits, we have some real strengths, and I think this is a remarkable opportunity for Georgia.

Goal One: Americans Understand That Mental Health Is Essential to Overall Health

Benjamin Druss, M.D., M.P.H., Rosalynn Carter Chair in Mental Health, Rollins School of Public Health, Emory University

“Mental health is essential to overall health” is the first goal of the President’s New Freedom Commission on Mental Health. I think the statement is self-evident for many of us here. It is like saying that you cannot make a coin with only one side. So why would the President’s New Freedom Commission make this their very first goal, and why should we be taking the time to talk about it today?

The reason is that too often mental health is not treated as essential to overall health, in the United States or here in Georgia. Mental health care in both the private and

Just as stigma perpetuates inequalities in mental health benefits and mental health care, the failure to recognize mental health as a part of overall health perpetuates stigma.

public sector is increasingly carved out or separated from other health services. Health and mental health benefits also are not equal. The difference in benefits packages reinforces the divisions between the treatment systems, endangers quality of care, and perpetuates the belief that mental health is not really a part of overall health. Finally, stigma is alive and well and drives this chasm wider, for just as stigma perpetuates inequalities in mental health benefits and mental health care, the failure to recognize mental health as a part of overall health perpetuates stigma.

The President’s New Freedom Commission described a fragmented and broken system and called for a major transformation. In today’s political environment, the states are the ones who need to take a lead in this process. We need to “think globally and act locally,” or think nationally and act in the

states. That is why this conference is so important. Within our state are a number of key constituencies, each of which has an important role to play in bringing about such a transformation in Georgia. Most of the stakeholder groups are represented here today: providers, purchasers, academicians, policy-makers, and consumers.

Providers

I know there are a number of providers in the room here today, both general medical and mental health. Primary care providers are the front line in the recognition and treatment of mental health in the United States. As we heard earlier, about 50 to 70 percent of mental health is delivered in primary care settings. You also heard the statistic that only half of mental disorders in primary care are correctly diagnosed and that only half of those that are diagnosed are appropriately treated. Primary care providers should know that these statistics are, for the most part, not their fault. We have a medical system that is ill-suited to provide population-based care and the follow-up required to improve these numbers. We must work together to improve that system.

Mental health providers must remember that our clients have bodies. We need to be aware of clients’ ongoing medical issues, keep a problem list, and make sure they have and are seeing a primary care provider regularly. We need to consider lifestyle issues such as tobacco use, diet, and exercise. Improving basic physical health is important for emotional and mental well-being.

Purchasers

Providers cannot do this alone. We need help from those of you who are purchasers, both in the private and public sectors. These efforts need to be conducted locally, using personal connections with employers as well as research evidence on cost and treatment efficacy. Currently, an Atlanta initiative is beginning to represent a joint effort of advocacy groups, providers, and corporate leaders to make Atlanta a national model for the provision of high-quality mental health care through the workplace.

We have heard about Medicaid. As the largest purchaser of public-health mental health benefits, Medicaid must be a critical partner in any efforts to transform mental health care, either nationally or in Georgia.

I know that these are not easy times for state Medicaid agencies. Costs and rolls are rising, states are strapped for cash, providers are frustrated, and constantly changing federal regulations are making it necessary to build new information systems. However, the very issues that make this such a challenging environment also make this a critical time to work on improving and streamlining the delivery of public health sector mental health services.

I am proud to say that Georgia has a forward-thinking Medicaid department, which has supported the first Medicaid-funded peer-to-peer counseling program in the United States. But just as we cannot transform Georgia's mental health care without the help of Medicaid, Medicaid needs our help in navigating through today's shark-infested political and economic waters in Georgia and other states.

Policy-makers

If mental health is part of overall health, what notion could be simpler and more logical than the idea of parity: that benefits should be the same for medical and mental health care? This legislation has been notoriously difficult to enact on a federal level. A limited federal parity law was enacted in 1996. It is set to expire at the end of this year, and it seems to be stuck in congressional committee. Most of the battles since 1996 for mental health parity have been fought and won in states. A total of 34 states now have some degree of mental health parity, with bills pending in many other state legislatures.

Many of you were probably involved in enacting Georgia's parity bill in April 1998, and it is one of the stronger state parity mandates. It is a considerable improvement on the federal legislation, but it also shows



how any parity bill, even a good one, has limits in ensuring equal treatment for mental disorders. For example, the law only applies to employers who carry mental health insurance. It does not preclude them from simply dropping mental health benefits altogether. Like most laws that focus on benefits, it does not ensure that clients are able to obtain access to the services listed on a benefits sheet. It also has only limited applicability to Medicaid and Medicare, which provide benefits to those individuals with the greatest disability. None of this is meant to undercut the great importance of parity; it is just to say that parity will be only one step – not an end point – in achieving true equality of mental health treatment.

Academicians

In Georgia, we have two psychiatry residency programs, four medical schools, four clinical psychology programs, seven schools of social work, and 34 nursing schools. These academic institutions have an enormous reach geographically, politically, and, of course, academically. We who belong to them need to work with front-line clinicians and policy-makers to make sure we are asking the sorts of questions and answers that are relevant to care in Georgia and that we share our results with those end users.

Academicians need not be afraid to climb down from the ivory tower, roll up our sleeves, and work as partners with other groups to improve day-to-day care. For example, the Medical College of Georgia is currently working with local consumer leaders to develop a recovery-based curriculum for medical students.

Finally, we have an obligation to develop a next generation of clinicians who understand that mental health is central to overall health. This includes not only mental health trainees but also other physicians and health care workers, encompassing the broader Georgia health care community.

Consumers

Consumers are the most important constituency of all, because they are the reason that the mental health system exists in the first place. This gives consumers and their families both a unique expertise and a moral legitimacy in arguing for improving and transforming care in Georgia.

The main lesson consumers must consider from goal one of the President's New Freedom Commission is that mental health advocacy is part of overall health advocacy. Most of what is currently broken in the mental health system is a microcosm of what is broken in the broader health system. Like the mental health system, the health system is not really a system at all but rather a hodgepodge of services poorly organized to serve the needs of consumers. Like mental health care, health care as a whole is gradually shearing into two systems – one for “haves” who benefit from new and exciting advances in medicine and one for “have-nots” treated in public settings whose caseloads are rising and resources are shrinking.

Given these parallels, it is important for mental health advocates to align with other health consumer advocacy groups to ensure that we are fixing the entire health system and that mental health is front and center in any broader efforts to fix that ailing health system.

While I have divided these stakeholders into providers, purchasers, policy-makers, academic leaders, and consumers, this division, like that between mental health and general medical care, is artificial. Nearly all of us are likely to fall into more than one of these groups. We should acknowledge and be at peace with the fact that we are likely to be wearing multiple hats and thus bear multiple responsibilities in improving mental health care in Georgia.

Finally, we must recognize that because mental health is part of overall health, mental health transformation must be a part of overall health transformation. We

are never going to be able to have an excellent mental health system if it is embedded in a dysfunctional health system. We are never going to be able to have an excellent health system if the mental health system remains broken. The two are inextricably intertwined. The prospect is at once daunting and liberating. It is daunting because transforming the health system is such an enormous task, and no one can accomplish it alone. It is liberating because it means that we, the mental health community, are part of a much larger group seeking to transform health care, and so we are not alone in our battle.

Goal Two: Mental Health Care Is Consumer- and Family-Driven

Larry Fricks, *Director, Office of Consumer Relations, Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases*

Goal two of the New Freedom Commission's report states, "Mental health care is consumer- and family-driven." I had an interesting window into the status of this the last two days while I was in Annapolis at a meeting of the Annapolis Coalition, a group working to develop a workforce in this country for behavioral health care. In the past, consumers have not been at these meetings. For this meeting, the coalition recognized that certified peer specialists were now part of this country's workforce. They officially recognized us and had us there. There was a lot of discussion about the report. Many of the presenters frequently used the word recovery during their presentations, but they quickly slipped back into the doctors and scientists being in charge and that the future of the system depended on their knowledge and expertise.

Finally, some of the groups represented there said, "Stop, remember goal number two? Going back to the old way of doing business will not promote recovery, because you cannot build a recovery system without the dramatic and powerful influence of people who have experienced recovery. You cannot build that system of recovery if you are allowing people to base what they are doing simply on what they are learning in academic settings."

These doctors and scientists were pretty honest about the disconnect between what is learned in school and what you do when you get out in the field. I am very excited about working with the Medical College of Georgia to design training for residents that helps them understand strength-based recovery.



An outgrowth of the 1999 surgeon general's report on mental health has been the realization of the value of peer-to-peer support in the acquisition of real recovery. Certified peer specialists (CPSs) provide hope and model the possibility of recovery to every consumer they serve. The role of the CPS is to transition ownership of recovery into the hands of the consumers. Our CPSs train other consumers to manage their illnesses and to promote their own recovery. This is one of the six evidence-based practices reported in the surgeon general's report.

Dr. Jim Saben, in his article about strengthening the consumer voice in managed care, published in the April 2003 edition of *Psychiatric Services*, says, "The primary responsibility of the certified peer specialist is to provide direct services designed to assist consumers in regaining control over their own lives and control over their recovery processes. Peer specialists

are expected to model competence in the possibility of recovery and to assist consumers in developing the perspective and skills that facilitate recovery." He goes on to say, "The aim of peer support is to provide an opportunity for consumers to direct their own recovery and advocacy process and to teach and support each other in the acquisition and exercise of skills needed for management of symptoms and the utilization of natural resources within the community."

The foundation of getting our CPS program off the ground in Georgia started with consumer-recovery values. The leadership came from the consumer movement, when the Georgia Mental Health Consumer Network wrote a grant to design the training and certification.

Next, we obtained the Medicaid rehabilitation option to finance certified peer specialists. There is a lot of flexibility in the rehabilitation option. When Substance

Abuse and Mental Health Service Administration (SAMHSA) administrator Charles Curie was at the 2003 Rosalynn Carter Symposium on Mental Health Policy, he said, "Folks, it is about relationships." Historically, in this country, the folks delivering the services – the state Office of

Peer support is 55 percent cheaper than other forms of day support services and more effective.

Mental Health, Developmental Disabilities and Addictive Diseases – and the Medicaid agency did not get along. There was a disconnect between those two agencies. If those two agencies, one funding the services and the other one delivering the services, cannot work together and are at odds, you cannot build a recovery system.

We developed a peer support institute so that consumers can know exactly what good peer support looks like. This gives consumers the power to tell the providers what they need.

We use technology to support our efforts. The certified peer specialists have their own Web site where they can go online and support each other, sharing information and best practices across the state.

We recently completed mediation recovery training by the University of South Florida. Peer specialists were trained on how to mediate toward recovery to help traditional staff understand the concept of recovery and how they can work together with consumers toward recovery. We offer continuing education every three months.

Peer support is 55 percent cheaper than other forms of day support services and more effective. Currently, we have 200 certified peer specialists who serve 2,500 consumers with this new Medicaid service. The billing this year for peer support will be \$5.5 million, and we have been doing this for three years. Preliminary outcome data of 500 patients, age 18 to 55 with schizophrenia and bipolar illness, found a 5 percent greater improvement for those serviced by peer supports than other day services in three areas: skills, functioning, and resources. South Carolina and Hawaii now have certified peer specialists. This represents goal two in action. It works.

Consumer leaders from New Zealand and the United Kingdom will be looking at three model consumer programs in this country, and ours is one of them. We are very honored by that.

Goal Three: Disparities in Mental Health Services Are Eliminated

Gail Mattox, M.D., *Chair, Department of Psychiatry and Behavioral Sciences, Morehouse School of Medicine*

It is a privilege to be part of this transformation team here in Georgia. What exactly do we mean by mental health disparities? There are three major areas in which we must focus: (1) Minorities have less access to and are less likely to receive care; (2) minorities in treatment typically receive poorer quality of care; and (3) minorities are underrepresented in mental health research.

There were two recommendations for goal three in the New Freedom Commission's report, which include improving access to culturally competent quality care and to quality care in rural areas.

I would like to step back for a moment to review some of the findings from the surgeon general's report specific to various ethnic

groups. We know from the available limited data that African-Americans receive mental health care at about half the rate of non-Hispanic whites. Sixty percent of older African-American adults are not receiving needed services: They are more likely to use emergency rooms and are more likely to try alternative therapies first. Older African-American adults are overrepresented in inpatient treatment and underrepresented in outpatient treatment. As for our African-American youth, we definitely do not see them very often in private psychiatric hospitals. They are more likely to be in long-term residential facilities or in the Department of Juvenile Justice.



African-Americans only make up about 2 percent of psychiatrists, 2 percent of psychologists, and 4 percent of social workers in the United States. For a variety of reasons, incorrect diagnosis is common, with schizophrenia overdiagnosed and affective disorders underdiagnosed. When somebody presents acute and psychotic, it is difficult to get a good history at that time. So frequently, the psychosis is determined to be possible schizophrenia versus a manic episode with psychotic features. Data also suggests that African-Americans may be receiving fewer SSRIs and less utilization of atypical antipsychotics, which means they are more likely to have severe side effects.

We know from the surgeon general's report that similar issues exist for the Latino-Hispanic population. For example, 37 percent are uninsured compared to 16 percent for all Americans. There are many barriers to care for the Hispanic population, such as language issues.

As for the American Indian and Alaska native populations, even though they only make up 1.5 percent of the population, they have the highest suicide rate, are suffering disproportionately from depression, and are overrepresented in inpatient care. They are only 25 percent as likely as whites to seek outpatient care, and when they do seek care, they may be diagnosed as "problem free."

When we look at mental health incidences over the past 30 days, the data suggests that the prevalence of mental health concerns was not that different among ethnic groups, according to the Kaiser Family Foundation. When surveys asked, "How often did you feel that your mental health was not good in the past 30 days," you see the percentages among different ethnic groups and averages for the entire U.S. population are very close. So



what does that mean if people are stating in answer to survey questions over the telephone that they have poor mental health, but they are not receiving services? This points out the disparities.

One in 10 children has some type of mental health issue, but fewer than one in five receives services. This is more pronounced with ethnic groups. For example, in the Kaiser Family Foundation survey, about 31 percent of white children were receiving needed mental health services compared to 22 percent of African-Americans and 14 percent of Hispanics.

Let's turn to the disparities in rural areas. Some of the major issues for rural consumers and residents are that they tend to be older and poorer, with more chronic health conditions. Rural residents under 65 are disproportionately uninsured, transportation is a major problem, isolation is a challenge, and there is limited access to mental health

specialists. If they are able to seek treatment, there are limited psychosocial rehabilitation services available in the rural areas once they have discharged.

Some of the recommendations specifically outlined in the president's commission report are:

- Tailor services for a diverse population
- Provide accessible and available care
- Provide culturally competent care
- Improve access to care, especially for rural areas
- Use technology such as telemedicine and video conferencing to reach remote areas
- Train general health care providers because they are often the front line for mental health services
- Train law enforcement
- Train emergency room staff

Some of Georgia's initiatives addressing the problem of disparities are:

- After-school and summer camp program for Latino youth
- Conversational English classes
- Bilingual staff
- Gender-specific treatment services
- Enhancement of the 24-hour help line
- Outreach to shelters and the homeless
- Wraparound services systems of care
- The five-year cultural competence initiative
- Improving transportation in rural areas

The National Alliance for the Mentally Ill (NAMI) has played a major role in Georgia with outreach initiatives to different ethnic groups, particularly the Family-to-Family program targeting the Latino and African-American communities. The National Mental Health Association of Georgia has played a major role with Project Hope, as one example. Over the last year or two, CHADD has been reaching out to look at the disparities in diagnosing ADHD in the African-American and other minority populations. I also would like to mention the Center of Excellence on Health Disparities, which is here in Atlanta at the National Center for Primary Care under the leadership of former Surgeon General Dr. David Satcher.

But with all of these initiatives and efforts, there are still major challenges facing us in Georgia. First of all, we know that there is still a high percentage of minority youth in the juvenile justice system. I served as a consultant to the Department of Juvenile Justice and had a chance to travel around the state. It was disheartening on intake day to see the large

number of minority youth and know that a high percentage of them have unmet mental health needs. We still have limited research around best practices for minority populations. We have a shortage of providers, particularly in the rural areas. The percentage of homeless and uninsured in Georgia is still a major issue, and the lack of availability of multiethnic staff is a problem.

Let me share some statistics. When we look at race and ethnicity in terms of poverty, poverty is higher among ethnic groups. More minorities are uninsured. The percentage of physicians who are African-American or Hispanic is small. Looking at Georgia's distribution of medical school graduates in 2002 and 2003, 263 were white, 52 black, and six were Hispanic.

I would like to conclude with Dr. Satcher's approach in the National Center for Primary Care. When looking at how to approach eliminating health disparities, he has always emphasized that it has to be a multidimensional effort. You have to look at environment, lifestyle, access to care, and biological genetic factors. You also have to account for basic science research, clinical research, and health sciences research, but most importantly, at community-based interventions and how can we work in partnership to address health disparities from a multidimensional perspective.

The New Freedom Commission report states, "In a transformed mental health system, all Americans will share equally in the best available services and outcomes regardless of race, gender, ethnicity, or geographic location." I am very encouraged and optimistic that together we can try to accomplish a transformed system here in Georgia.

Goal Four: Early Mental Health Screening, Assessment, and Referral Are Common Practice

Tricia Hernandez, M.S., Chair, Mental Health Services Coalition

Goal four is related to early mental health screening, assessment, and referral. We know clearly that screening is a preventive measure that can result in healthier outcomes. However, screening as a preventive measure generally falls to the bottom of the list when we talk about saving money or cutting funds in human services. That happened most recently in our budget cuts here in Georgia. For the current and next fiscal year, the majority of budget cuts came from prevention services.

I want to start with early screening. We were lucky enough at the Mental Health Services Coalition earlier this year to have Dr. Patrice Harris speak to us about her

The Quality Indicators Task Force recommended that the mental health status of children and adolescents should be assessed yearly, utilizing a method or measure appropriate for the child's age and development.

perspectives on early screening. She shared with us a resource from the American Psychiatric Association called *Quality Indicators: Defining and Measuring Quality in Psychiatric Care for Adults and Children*. I strongly recommend that as you are reviewing the New

Freedom Commission report recommendations on screening and assessment, you look at this book concurrently, because many of the recommendations are similar.

In 1999, the American Psychiatric Association established a task force for quality indicators for children. That task force looked at many recommendations that are similar to those outlined by the New Freedom Commission. The Quality Indicators Task Force recommended that the mental health status of children and adolescents should be assessed yearly, utilizing a method or measure appropriate

for the child's age and development. There was also a recommendation that children in higher risk groups, for example, those with parents having affective, anxiety, substance abuse disorders, or schizophrenia, be regularly assessed for evidence of impaired functioning. Children enrolled in special education programs, those in child welfare custody, and those with ongoing involvement in the juvenile justice system present a higher risk and should be monitored for earliest assessment of any developing problem. Recent studies show that children in the juvenile justice system experience mental illness and severe emotional disturbance at a rate of 85 percent or more.

In an effort to expand our acronym vocabulary here in Georgia, I come with a long string of letters called EPSDT. EPSDT is early and periodic screening, diagnosis, and treatment. The Mental Health Services Coalition brought this to the table as a potential platform to look at advocacy around early screening for children and adolescents. Congress passed EPSDT in 1967, so it has been around a long time. It requires any state providing Medicaid services to offer early and periodic screening, diagnosis, and treatment services to eligible individuals under the age of 21. EPSDT is a lengthy law, so I am only going to give some highlights.

There are two major components of EPSDT. One is assuring that health care resources are available and accessible to those in need and who are eligible through Medicaid. In addition, it requires that those Medicaid recipients receive assistance to effectively use these services. Toward this end, there needs to be a way for eligible



recipients to be informed that this is an available service to them and then be given help accessing the services. This is frequently done through case management.

Screening through EPSDT requires both a screening of general health – including mental health – and a developmental assessment. If an issue is identified during screening, there is a mandate under EPSDT that there be an immediate referral for further assessment. If further assessment indicates the need for treatment, there is a mandate that treatment be put into place immediately. Unfortunately, the first version of EPSDT in 1967 did not require states to pay for the treatment services required under the federal law. It was not until Congress passed an additional law in 1989 that Medicaid was then required to pay for the treatment services.

EPSDT covers both newly identified disorders through screening and assessment as well as those disorders that existed prior to the individual being eligible for Medicaid

benefits. Diagnosis and treatment services must include treatment for mental illnesses and conditions discovered through screening. The services that are found necessary through this screening, assessment, and treatment process must be provided, even if they are not already a part of the state's service provisioning through Medicaid. While EPSDT providers are not required to provide all EPSDT services, they are required to refer to other professionals who can provide those services. And finally, the state is required to report to the Department of Health and Human Services on a regular basis about how

many children, adolescents, and families are enrolled in the program and how many are getting screened, diagnosed, and treated.

Unfortunately, the Health Care Financing Administration does not aggressively enforce EPSDT, and the result has been low participation rates. In Georgia, EPSDT is managed in the Department of Community Health under the Office of Child and Maternal Health and is called Health Check. Each state, when implementing EPSDT, was expected to report to Health and Human Services their projected participation rate. Georgia's projected participation rate in 1995 was 80 percent. Georgia's actual participation rate has never exceeded 46 to 47 percent. Billing rates for EPSDT remain substantially low and have not been reassessed in the last 10 years. The reimbursement rate through Medicaid is \$55 for the entire screening.

This federal mandate does present a platform for us to start talking about how to put into place what already is required but is not being done. We could use 10- to 15-minute long general behavior checklists that are not difficult or challenging to complete and yet can make a tremendous difference in knowing how to take the next step if a child or adolescent needs further assessment. Many checklists exist for children, teens, and adults, such as depression symptom inventories and symptom indexes for depression, anxiety, and psychotic illnesses. The Connors Rating

Scales have both rating scales for parents and teachers so behaviors can be assessed across contexts.

While I have been talking primarily about assessments for children, it would be very dangerous to say that the screening assessment process stops at age 21. All of us are very familiar with the fact that illnesses and symptoms of mental illnesses become evident for many individuals in adulthood and often are misdiagnosed as other illnesses. These illnesses include schizophrenia, whose symptoms do not generally appear until adulthood, other psychotic

disorders, mood disorders such as major depression, and anxiety disorders. It also is important to consider the impact of environmental factors. There may be symptoms underlying many mental illnesses that do not become evident until environmental stressors make them more evident. Under the recommendations of the New Freedom Commission, and certainly by many other organizations, early detection leads to early intervention at any age.



Where does screening need to happen? Screening needs to happen where individuals are, particularly for children and adolescents. School settings are key, as are community living arrangements and primary health care settings.

Why have early screening? The New Freedom Commission report states that preventive interventions will keep problems from escalating. The American Psychiatric Association recommends indicated preventions that are targeted interventions for those individuals in high-risk groups already mentioned who currently display minimal symptoms. If we can catch people at the minimal symptom stage and provide appropriate and competent treatment, then we know that in later life, the individual will live a longer time in recovery. Early screening results that indicate some symptoms of mental illness should lead to more comprehensive mental health assessment. These assessments include intelligence testing, achievement testing, and personality testing to give a holistic review of where the individual is to ensure that the selected treatment is most appropriate for the individual.

How does referral to treatment play a role with early screening and assessment? If you have no early screening assessment, it would be impossible to figure out what kind of treatment setting an individual would need.

In Georgia, we have single points of entry across the state that can provide access to service delivery systems and to appropriate treatment for those who need mental health services, substance abuse services, co-occurring services, and culturally competent services.

As we look into creating some action steps here in Georgia, we must address the issue of parity – a healthy brain is part of a healthy body. It is already fundamentally evident across the nation that we give other illnesses the attention of early screening and assessment. We find this frequently in diabetes, in coronary disorders, and, most recently, in obesity. You see huge national campaigns about screening and early intervention and a lot of funding that goes into these campaigns. We do not see this as frequently with mental illness, and why not? From an advocacy perspective, we should certainly see that more.

A final important note is the importance of using a holistic approach, as those with other illnesses may present higher risk for the development of mental illnesses.

What is our role as advocates in early screening, assessment, and treatment? Using our voice to ensure federal law like EPSDT is followed, ensuring that laws in Georgia do not violate this federal law, and promoting parity among mental illnesses and other illnesses.

Goal Five: Excellent Mental Health Care Is Delivered and Research Is Accelerated

Peter Buckley, M.D., *Professor and Chair, Department of Psychiatry and Health Behavior, Medical College of Georgia*

Goal five is “excellent mental health care is delivered and research is accelerated.” This one sentence intertwines both care and

research. We first need to appreciate the context of goal five. Why were excellent care and research chosen as a goal for the

report? The report says, “Far too often, treatment and services based on rigorous clinical trials languish for years rather than being used effectively at the earliest opportunity.” The key point is that research does not get out into the field fast enough. Even when these discoveries become routinely

Unfortunately, these evidence-based and emerging best practices are patchy in their implementation, typically implemented in an inconsistent or watered-down fashion, which will adversely affect the outcome.

available at the community level, clinical practice too often is highly uneven and inconsistent, with deviations from the original treatment model.

As an example, we have some very good data specific to Georgia regarding schizophrenia with the schizophrenia Patient Outcomes Research Team (PORT) guidelines, rudimentary recommendations on how to treat people with schizophrenia. A survey published a couple of years ago by Dr. Anthony F. Lehman, director of the Center for Mental Health Services Research at the University of Maryland School of Medicine, and colleagues shows that while 90 percent of inpatients receive the proper amount of medication in conformance with the guidelines, only 40 percent of outpatients are receiving correct medication dosages. So even in the face of compelling data about medication protocols, there is a gap in service delivery.

Why are there such barriers in delivering science to service? We have already heard some of the issues that promote gaps, such as issues around reimbursement that do not fully support the services that we believe we should be able to give. We have heard about assessment issues, about disparities, and how our work force is not focused upon or given up-to-date training on best practices.

The recommendations for goal five are:

- Accelerate research to promote recovery and resilience
- Advance evidence-based practices using dissemination and demonstration projects and promoting public/private partnerships
- Improve and expand the work force, providing evidence-based mental health services and supports
- Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care

Just what is evidence-based practice? Evidence-based practice is defined as the integration of best research evidence and clinical experience with patient values. Emerging best practices are practices or treatments that are promising but do not quite yet have the evidence base needed to document and move into the full realm of evidence-based practices. Unfortunately, these evidence-based and emerging best practices are patchy in their implementation, typically implemented in an inconsistent or watered-down fashion, which will adversely affect the outcome. Data suggests that if you implement an evidence-based practice in a “quasi-fidelity,” or partial, manner, you lose the benefit of that practice.

Some examples of evidence-based practices include:

The Texas Medication Algorithm Project (TMAP). This was a true public/private partnership developed several years ago for best practices in medication treatment for both schizophrenia and mood disorders. TMAP started in Texas and has spread across several states, including Florida, Georgia, South Carolina, New York, and Pennsylvania.

One impact of TMAP is on cognitive improvements in people with schizophrenia. We know that if people with schizophrenia can improve their cognition, they will do far better in their recovery and in their capacity for employment than if we simply improve other symptoms like delusions or hallucinations. The individuals who got algorithm-based care as opposed to treatment-as-usual had significant improvements in their mental cognitive functioning. Not only do people experience cognitive improvements, but those people with algorithm-based care had lower overall use of mental health services as well as general medical and rehabilitation services. This effort demonstrated that this practice is feasible, delivering not only symptomatic improvements but also demonstrable service improvements.

Family Solutions Program. The University of Georgia implemented a family solutions jail diversion program for first-time juvenile offenders. In this 10-week program, children and their families commit to therapy. The children in this program had a re-offender rate of only 13 percent, as compared to a 21 percent re-offender rate for those who did not complete the program.

Recovery model in Ohio's state hospital. A study in the Ohio inpatient system compared treatment-as-usual to a recovery-based model. The recovery-based model was found to deliver hope, focusing on people's abilities rather than their disabilities. Individuals with recovery-based treatment planning did statistically better in terms of their overall functioning on global assessment of function.

Our future is in our current and future clinicians. We are concerned with how the academic environment will deliver core competencies in recovery-based practices. We simply cannot aspire to system transformation if we do not train our providers in recovery-based values and content. There currently is a large disconnect between what people are taught in colleges and universities and what they need to know when they get out into the field. We are hoping to engage in a planning process to look at this disconnect and shift the focus with our medical students early on. Medical students typically spend electives in laboratories or with researchers. Instead, it would be a helpful and relevant opportunity for our medical students to spend their electives with people in recovery and with peer support specialists. We also are interested in implementing recovery-based modules as part of residencies.

Available evidence-based resources include tool kits created by the SAMHSA for six topic areas:

- Illness management and recovery
- Medication management
- Assertive community treatment
- Family psychoeducation
- Supported employment
- Integrated dual-diagnosis treatment

These kits include information sheets for all stakeholders, introductory videos, practice demonstration videos, workbook manuals for practitioners, evaluation, and fidelity measurement.

What are some of the future opportunities for us? The New Freedom Commission report provides a fantastic opportunity for new alliances in advocacy to promote evidence-based practices. We have the

We simply cannot aspire to system transformation if we do not train our providers in recovery-based values and content.

opportunity to provide services and research efforts to integrate care. We have tremendous opportunities in early interventions, research, bridging science to clinical care, genetics, and other aspects of cognitive remediation. We have opportunities not

only for research and recovery but also for dissemination, promotion, and training on best practices. And finally, we have an opportunity to develop the knowledge base required for evidence-based practices.

Goal Six: Technology Is Used to Access Mental Health Care and Information

Rick Dunn, *Director of Evaluation, Decision Support Section, Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases*

I appreciate the opportunity to speak about the report by the President's New Freedom Commission on Mental Health and particularly how goal six can be achieved in Georgia. Some of the statements made by the president when he announced the formation of the New Freedom Commission helped me think about ways we can achieve the goals outlined by the

commission. The statement that struck me was, "Our fragmented mental health service delivery system is an obstacle to quality mental health care. Many years and lives are lost before help, if it is given at all, is given." I think the fragmented nature of the mental health service delivery system is an important framework for thinking about data.



The motivating principle behind these recommendations is to enable adults and children with serious mental illnesses or emotional disturbance to live, work, learn, and participate fully in their communities. It is important to remember this in the context of data and information, because we often think of data and information as primarily paperwork or busy work. The very fact that the commission identified a goal related to data and information forces us to keep in mind that ultimately, information and data are related to the concepts of recovery. If we are going to achieve recovery, community integration, and a high quality of life, information and data are critical.

Goal six states that our mental health system should capitalize on communications and information technology to improve the quality and effectiveness of care. I want to give a caveat: I am not an information technology person or a computer systems person. I am a data person. There are some specific recommendations in the report, such as the idea of an electronic medical record and telemedicine, that I unfortunately know very little about. Therefore, I am going to focus on the broader point, which is that quality information and data are important for achieving quality care.

Mental health systems should use information and knowledge to promote structures and influence processes in the most appropriate way to produce positive outcomes.

The larger point the commission was trying to make with goal six is that mental health systems need to make more decisions based on data and must develop the systems that will allow this type of decision-making to occur. The commission report stated that mental health systems should use information and knowledge to promote structures and influence processes in the most appropriate

way to produce positive outcomes. Again, quality care relies upon quality information. Additionally, we must improve access to information by consumers and their families. Informed choice by family and consumers requires quality information.

Achieving these information and data goals is certainly not going to be easy. Mental health has a long reputation for dramatically underinvesting in modern information systems. There also is a deserved reputation for lack of application of modern technology to mental health problems. That certainly makes things very difficult. Compounding these challenges is the fragmented nature of mental health service delivery systems. If we are going to get the information needed, some of this fragmentation of care will have to be coordinated and consolidated.

While we certainly have some barriers, there is good news. There has been a lot of work in recent years, sponsored by the Center for Mental Health Services, in developing common data standards. There has been a lot of work in developing common instruments that states could use as well as common ways to analyze and report results. These efforts lay an excellent foundation going forward to build upon the commission's recommendations.

I think it is fair to say that Georgia shares the commission's vision that quality care requires quality information. I wanted to share with you at least the goals and principles that guide our effort to build an information system that a mental health service delivery system deserves.

1. Data and information should be used to improve decisions. Clinical and administrative decisions made by consumers and family members, providers, payers, and managers will be enhanced by an

information system that provides all the data needed quickly, accurately, and efficiently.

2. Data and information should be used to improve services. An information system that makes available to stakeholders reliable information on a community's mental health needs, services, service users, costs, revenues, performance, and outcomes is critical to improving care.
3. Data and information should be used to improve accountability. To be the most beneficial, information on accountability needs to be readily available within the framework of continuous quality improvement.
4. Systems must improve communications. By communications, I do not necessarily mean communication between individuals or organizations, although that would be a nice principle to adopt as well. I am talking about communication between information systems. There is no single information system, and information cannot be shared across information systems or across service delivery systems. While we collect a wide variety of information – financial, serious incidence, encounter, enrollment, performance – the information cannot deliver value if it is isolated.

Based on these four principles, we need to develop what ideal or model information would look like. This is not something unique to Georgia. There has been a lot of foundation work done with SAMHSA and other states in terms of developing data standards, what type of information is needed to effectively manage a mental

health system, what type of information is needed by consumers and family members to make informed choices, etc.

The model information system would start with population characteristics and track all the way through outcomes. Some of the data components that the ideal information system would contain are:

- Population data is the demographic characteristics of our service area so we can understand the need for services within these areas.
- Encounter data is the information that characterizes the users of services, such as diagnostic information, functional status, symptoms, types of services used, and frequency of use.
- Financial data includes cost per unit of services, administrative costs, and revenues.
- Human resource data includes the characteristics of the providers of care and support staff.
- Organizational data includes information about the organizational structure and processes of providers.

Once that data is there, we must transform the data. The vision is a single information system that links together all of these different data components. Therefore, information about the population, enrollment, and outcomes must be linked to one another so you can view the results by consumer, provider, service area, or region – so the information is easy to understand and use and is relevant. Information systems should also be able to produce quality output, including performance indicators, report cards, and consumer outcomes. All of these elements are critical for management functions, quality improvement, and accountability. The system must be able to answer four key questions:



- What are we doing?
- What should we be doing?
- How well are we doing?
- How do we improve?

If we are able to answer those four questions, consumers, family members, providers, payers, and programs can better direct and manage mental health systems. It will have a large impact on the quality of care.

It is important to remember that this vision is the ideal. The problem with these types of visions is that they are pie in the sky. There are too many obstacles to implementation. What is important to note is that in Georgia we do not have to build a new information system from scratch. Many of the data elements described in the ideal information system are already being collected. We already have a lot of information now.

However, we certainly have some flaws. We do not have encounter data for non-Medicaid consumers, centralized financial

data, human resource data, or organizational data that we can readily utilize. We do not have the linkage between mental health and other service systems that may serve consumers, such as correction, labor, vital records, DFACS, education, etc.

While we do collect a lot of data, the value of that information is limited due to the fact that these databases or modules are not integrated. What information we have sits in silos. Each silo has its own gatekeeper, data definition, and identifiers. That is problematic when one wants to look at information to improve the quality of care. While we have outcome information and financial information, the two are not linked; therefore, we can't evaluate and improve.

A first real opportunity in Georgia to meeting goal six is to consolidate our existing data sets. We need to think of ways of using the information we already have more efficiently and more affordably.

Questions and Answers

Q When we talk to legislators about not cutting funding for medication, transportation, or mental health community services, we cannot show that Georgia spent more money as a result of making those cuts. If a legislator says we cannot afford to provide all these medications, then we need to be able to show that the outcome is a higher cost to the state: emergency room visitations, hospitalization, or unemployment. Without that data, we are challenged in our advocacy efforts and will continue to be challenged with very serious cuts to the mental health system.

A Mr. Dunn: We have a lot of information. That information is weak because we have a difficult time integrating it. If we were able to integrate a lot of our information, we would be able to provide the type of information that you need in your advocacy efforts. That is what is frustrating: The information exists, but it is limited in terms of its utility because we cannot associate it.



Work Groups – Charge and Recommendations

The President's New Freedom Commission on Mental Health was chartered to address the problems in the current mental health service delivery system. It comes 25 years after the Carter commission on mental health. Both were formed to assess the condition of the public mental health system and address the needs of people who have mental illnesses. This comprehensive review brought to light many problems facing our nation, including the availability and quality of services for people with mental illnesses as well as the lack of funding for mental health services. The findings were troubling, but a thorough appraisal was much needed. The report's findings and recommendations are useful for guiding the future of the public mental health system.

The Carter Center Mental Health Program was pleased to focus on the report

This comprehensive review brought to light many problems facing our nation, including the availability and quality of services for people with mental illnesses as well as the lack of funding for mental health services.

for the Ninth Annual Rosalynn Carter Georgia Mental Health Forum. It is extremely important that the entire Georgia mental health community take action on these findings. Panelists have reviewed the opportunities and challenges facing

Georgia in implementing these recommendations. After hearing from the experts in their respective fields, the participants at the forum broke into work groups to identify action steps that can be implemented to meet the goals outlined in the New Freedom Commission report. The forum concluded with participants offering

recommendations for implementing and taking action to start the transformation of the mental health system in Georgia.

Goal One

Goal one of the report is: Americans understand that mental health is essential to overall health. Specific recommendations to begin to meet this goal are:

1. Implement a school education pilot program. The pilots would engage a few schools across the state. Measures would look at how mental health education affects suicide rate, high school dropout rate, and delinquency rates.
2. Implement EPSDT training across state in school systems. It is not acceptable that EPSDT training is only 47 percent in this state. We must raise it to the national level by utilizing advocacy organizations to raise the issue within their own local school systems and follow through with implementation. A barrier we face is appropriate linkages for treatment. If a child is determined to be at risk for mental illness, we need to ensure the schools have a clear link to proper service delivery to that child and family.
3. Leverage the Atlanta Business Leaders' Initiative (ABLI). This group is the brainchild of three prominent CEOs who have come public with their mental illnesses – Tom Johnson, J.B. Fuqua, and Larry Gellerstedt. By educating other CEOs about the prevalence and cost of mental illnesses in their organizations, we can help drive parity in large organizations. If we can successfully implement this program

within the large employers in Georgia, it could become a model program for the country.

4. Statewide educational campaign. Implement an educational campaign, “Health Starts With the Head.” The campaign would target various populations – professionals, consumers, general public, and others. Alliances will be formed with mental health associations and DHR to create a task force to look at the possibility for implementing and funding a statewide campaign. To gauge effectiveness, we would conduct pre- and post-campaign surveys to assess attitudes and knowledge surrounding mental health issues.
5. Engage the media. Convene a small group of media leaders to brainstorm on the types of stories that would engage the media surrounding mental health issues and how mental health permeates other issues. Discuss with the media how the mental health community

could assist and the types of information that media require to craft stories that will address this goal.

Goal Two

Goal two of the report is: Mental health care is consumer- and family-driven. Recommendations of the work group to meet this goal are:

1. Fund existing mental health ombudsman bill. We need to work with legislators to move this bill forward with funding so the law goes into effect. The effectiveness of this legislation can be measured by looking at how many complaints came in, were received, and were resolved.
2. Allow consumers the ability to set their own recovery and treatment goals. A typical problem is that the consumer and their provider may both have completely different goals. For example, the consumer’s top priority may be to obtain gainful employment, while the provider’s priority might be to take medications and go to therapy. The consumer must be involved in setting goals.
3. Develop a unified language for recovery. We must use the same terminology so we have a common language across service delivery systems.

Goal Three

Goal three of the report is: Disparities in mental health services are eliminated. Recommendations of the work group to meet this goal are:



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1. Address how we categorize clients. Sometimes when working with diverse populations, we force people to check a box and categorize themselves in ways that may not reflect their culture or beliefs. We should allow for flexibility in how clients identify themselves. While the goal of checking boxes for identifying racial and ethnic background is to capture information for data analysis, we want to make sure we capture the right information.
 2. Address cultural competence. Cultural competence must be addressed at all levels. In order to improve access to quality care that is culturally competent, the state of Georgia must standardize, coordinate, and fully implement mental health cultural competence training for interpreters, providers, and all staff in accordance with federal laws and guidelines.
 3. Expand the mental health system in Georgia to encompass nontraditional services. The movement to decentralize the system in Georgia should continue and provide support for faith-based, community, and nontraditional services. Also affecting access are the hours of operation. Most intake and services are provided during traditional business hours only. We need after-hour and weekend services.
 4. Revitalize the “No Wrong Door” Project. The concept of the “No Wrong Door” Project was that no matter where someone shows up in the mental health system, that would never be a wrong door: Someone in that agency will be able to guide and provide something to this client. Providing a single point of entry so that clients are not forced to navigate a complex system alone is critical. A challenge is that sometimes

there is not a service to which to refer the client. However, we need to train people who are not working in the mental health field, such as primary care physicians, law enforcement, and emergency room personnel, to direct consumers appropriately. Some of this intelligent referral is going on, but it is fragmented and needs to be standardized. In order to accomplish this recommendation, there must be collaboration among all agencies.

5. Understand barriers preventing consumers from seeking services and treatment. We still do not fully understand how to address the consumers who are not seeking services and treatment. Are they showing up in their faith organizations or going to nontraditional sources? If so, we must provide education for those sources.

Goal Four

Goal four of the report is: Early mental health screening, assessment, and referral to services are common practice. The key recommendation of the work group to meet this goal was to link existing services to schools with an effective screening methodology. The first action step was to identify a screening methodology that is developmentally appropriate across the lifespan for use statewide by all agencies, as well as independent insurance agencies, to ensure consistency in information. We need the right tool with the right questions. We need a tool that is culturally competent, age appropriate, developmentally appropriate, valid, and reliable.

To get this first step accomplished we would need to:

- Build consensus for the idea.



- Identify what this screening tool would look like across the entire lifespan.
- Identify key points where this tool would be used.
- Identify how this screening tool would be developed.
- Identify how this screening tool would be disseminated across various systems to capture individuals at key points in their lifespan.
- Identify accountability for the use of the instrument.
- Identify service gaps so that when assessments uncover a problem, the individuals can be referred to appropriate services.

The responsible parties for implementing this recommendation would be a collaboration of different stakeholders, including insurance companies, medical associations, state agencies, university systems, licensing agencies, and advocacy agencies across the lifespan. Difficulties with how they would all talk to each other need to be addressed.

Goal Five

Goal five of the report is: Excellent mental health care is delivered and research is accelerated. The work group acknowledged

that we would like to see further work force development, the use of prevention strategies, a push toward more research, and more training on recovery principles. A key recommendation, however, is to conduct a gap analysis and use that information to plan further. We must first understand what level of implementation we really do have for best practices for adult mental health in Georgia. Using that information, we could then work in each of our regions with providers to identify a percentage of improvement we want to see. This would not mandate which evidence-based practice the provider must implement but help ensure responsibility for increasing the amount of evidence-based practice service provided. In this way, quality improvements can be made in a manner that best supports the needs of the local regions.

Goal Six

Goal six of the report is: Technology is used to access mental health care and information. The work group had two key recommendations. First, Georgia must facilitate a process that will result in a set of common data elements that will answer the questions: What are we doing, how well are we doing, what should we be doing, and how can we improve that? Second, a data warehouse needs to be established that would link multiple state agencies.

Both these action steps are massive areas that will improve mental health services tremendously by allowing the entire system to come together and speak the same language so that we can communicate and evaluate our efforts.

Closing Remarks

Rosalynn Carter
Chair, The Carter Center Mental Health Task Force

*I*t is unfortunate that presidential commissions are not provided the means for implementing their recommendations. The commissions do so much good work, and then it is left to others to act on their findings, and so often this does not happen. After the Carter commission, we formed a nongovernmental organization to work on this, and we did get the Mental Health Systems Act passed. The act didn't do much because it didn't last very long. But the recommendations did. They became a model for good programs around the country.

One of the striking differences in the 25 years since the Carter commission was that, back then, we never dreamed that people could recover from a mental illness. We were attempting to focus attention and efforts on what we could do at the federal level. Today we realize that the real responsibility and authority for service delivery rests at the state and local level. If real change and progress are going to occur, it will occur here. I am so impressed with the expertise and the innovative programs we have in our own state that can serve as models for the rest of the country. We can teach others a lot by what we are doing right here in Georgia.

It is our responsibility now to ensure that the issues identified as important to advance the recommendations of the New Freedom report stay in the forefront of policy-makers' and the general public's minds. It is up to all of us to make sure they are not forgotten but are acted on and integrated into all our organizations' activities. Government at all levels will be charged with the mechanics of transforming the system. Our responsibility is to help them where we can and make it happen.

We've explored today how we can contribute to this effort. And now, since we've come up with things we can do, we have another challenge: to follow through and get them done. We have to work together to accomplish our goals and improve the quality of care for all Georgians who have mental illnesses.

Rosalynn Carter

Biographies



Peter Buckley, M.D.

Dr. Peter Buckley is professor and chairman of the department of psychiatry and health behavior at Medical College of Georgia in Augusta. Prior to that, he was professor of psychiatry and vice chair in the department of psychiatry at Case Western Reserve University School of Medicine and medical director at Northcoast Behavioral Healthcare System. Dr. Buckley conducts research on the neurobiology and treatment of schizophrenia. He is author of a textbook on psychiatry and has authored/edited six other specialist books on schizophrenia. Dr. Buckley has published widely in major psychiatric journals, with over 200 publications as original articles, abstracts, and book chapters. He is a reviewer for federal and international grant agencies, is a reviewer for more than 25 medical and psychiatric journals, and serves on the editorial board of three journals. Dr. Buckley is a board member of several professional organizations. He is the recipient of several awards for his work, including an Exemplary Psychiatrist Award from the National Alliance for the Mentally Ill and the 2004 Administrative Psychiatry Award from the American Psychiatric Association.



Benjamin Druss, M.D., M.P.H.

As the first Rosalynn Carter Chair in Mental Health at Emory University's Rollins School of Public Health, Dr. Druss is working to build links between the mental health and broader public health and health policy communities. Prior to this position, he was on faculty in the departments of psychiatry and public health at Yale, where he was the director of Mental Health Policy Studies. Dr. Druss has published more than 50 peer-reviewed articles in medical and psychiatric journals largely focusing on the policy and systems issues on the interface between primary care and mental health. He has received several national awards for his work, including the 2000 American Psychiatric Association Early Career Health Services Research Award, the 2000 Academy Health Article-of-the-Year Award, and the Academy Health 2003 Alice S. Hersh New Investigator Award, presented to the top junior health services researcher in the country.



Rick Dunn

Rick Dunn is the director of the evaluation unit in the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases. He has extensive experience in statistical analysis, the techniques of policy analysis, and program evaluation. Prior to joining the state of Georgia, he taught public policy and research methods at the University of Georgia, Dickinson College, and the College of Charleston. Currently, he directs Georgia's Performance Measurement and Evaluation System (PERMES), data collection for numerous federal grants, and ongoing evaluations of particular services. He also currently serves as the co-principal investigator for Georgia's State Data Infrastructure Grant funded by the Substance Abuse and Mental Health Services Administration.



Larry Fricks

Larry Fricks currently serves as the director of the Office of Consumer Relations for the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network, Inc. that now has some 3,000 members, a founder of the Georgia Consumer Council, a founder of Georgia's Peer Specialist Training and Certification, and a founder of the Georgia Peer Support Institute. He also is on the national advisory council for the Center for Mental Health Services and the advisory board for The Carter Center Mental Health Journalism Fellowships.



Tricia Hernandez, M.S.

Tricia Hernandez has worked in both publicly funded and private, not-for-profit settings with adults and children diagnosed with mental illnesses and severe emotional disturbances as well as with juvenile sexual offenders. Her clinical experience includes completing comprehensive psychological assessments and providing individual and group therapy under supervision in community mental health centers, juvenile justice facilities, and in private practice. Most recently, she has worked as an operations manager in nonprofit organizations as well as co-developed a private, not-for-profit agency providing services related to foster care. She previously served as chair of the Juvenile Justice Committee of the Mental Health Services Coalition and currently serves as chair of the Mental Health Services Coalition, a collaboration of public and private individuals and organizations focused on advocating for meeting the mental health needs of Georgians.



Gail Mattox, M.D.

Dr. Gail Mattox currently serves as chairperson of the department of psychiatry and behavioral sciences at the Morehouse School of Medicine, where she also holds the rank of professor of clinical psychiatry. Dr. Mattox has more than 18 years of clinical experience as a community psychiatrist and served as the medical director for Fulton County Department of Mental Health, Developmental Disabilities and Addictive Diseases and as an associate medical director for Laurel Heights Hospital Residential Treatment Facility. She played a major role in the development of The CHAMPS Program in Fulton County, a system of care for youth with severe psychiatric disorders, and served as its first medical director. Dr. Mattox serves on the Mental Health Planning and Advisory Council for the state of Georgia and is active in numerous professional and community-based organizations.

Biographies



James Stone, M.S.W., C.S.W.

James Stone is deputy administrator of the Substance Abuse and Mental Health Services Administration, a division of the U.S. Department of Health and Human Services. He serves as chief operating officer for the agency, overseeing three centers: Center for Mental Health Services, Center for Substance Abuse Prevention, and Center for Substance Abuse Treatment, plus the Office of Applied Studies. His early career was spent in the juvenile justice field. He was deputy director of Detention Care for Onondaga County and then joined the New York State Division for Youth, where he served in a variety of positions, including director of Youth Homes in Rochester and superintendent of the Agricultural and Industrial School of Industry. He was appointed by Governor Patakas as commissioner of the New York State Office of Mental Health, overseeing state operations serving 6,000 inpatients in 27 hospitals and 20,000 outpatients.



Cynthia Wainscott

Cynthia Wainscott is chair-elect of the National Mental Health Association's board of directors and serves as the World Federation for Mental Health's vice president for North America and the Caribbean. From 1990-2002, she was executive director of the National Mental Health Association of Georgia. In the 1980s, she directed a National Institute for Mental Health pilot site for D/ART (Depression: Awareness, Recognition and Treatment), a groundbreaking public education campaign, and developed and trained model outreach programs nationwide. In Georgia, Ms. Wainscott is a member of the governor's Mental Health, Mental Retardation, and Substance Abuse Advisory Council, the state Medicaid agency's Drug Utilization Review Board, and the Mental Health Planning and Advisory Council. She is chair of the Georgia Parent Support Network and the Advisory Committee for Emory University's Fuqua Center for Late Life Depression as well as co-chair of the Governance Committee of the Mental Health Services Coalition. In 1995, she was named the most effective mental health association executive director in the United States.

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