



Georgia Department of Audits and Accounts

Performance Audit Operations

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Why we did this review

The purpose of this review was to answer specific questions requested by the House and Senate Appropriations Committees. In their request, the committee chairs asked specific questions about three topics in regard to Child and Adolescent Mental Health: 1) the impact of the Fee-for-Service policy initiated April 2007; 2) the effectiveness of DHR's needs assessment process and changes to availability of children's mental health services over time; and 3) the utilization of relevant appropriated funds. This report answers questions two and three. The first question will be addressed in a companion report, 08-37A, to be released in February 2009.

Who we are

The Performance Audit Operations Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of these reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; and assess compliance with laws and regulations.

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Limited Review of DHR's Child and Adolescent Mental Health Program

What we found

The Department of Human Resources' Child and Adolescent Mental Health (CAMH) Program provides mental health services to youth under the age of 18 who are either uninsured or eligible for Medicaid because of a disability or placement in foster care, as well as to youth eligible for low-income Medicaid but not yet enrolled in a Care Management Organization (CMO). CAMH services are provided in a variety of settings, including homes, schools, clinics, residential programs, and hospitals. Based on the questions that prompted our review, most of our findings focus on community-based (non-hospital) services.

We found that DHR lacks a systematic process for determining the most critical needs for the child and adolescent population. While the agency does undertake activities that would help identify needs, neither the process nor the results are documented. Without these documents, it is not possible to determine if CAMH services result from a consideration of all significant child and adolescent needs, including the geographic areas where these needs exist. Instead of a document listing and prioritizing child and adolescent mental health needs, we identified more than 20 stated priorities in multiple documents, without an indication of the relative importance of these priorities. The lack of a transparent process exists despite legislation requiring DHR to report such information to the General Assembly on a biennial basis.

In response to our question and based on the list of priorities included in agency documents, CAMH officials did identify the top five priorities that are intended to address child and adolescent needs – providing core and specialty services statewide, developing systems of care, providing crisis services, serving youth in the welfare system, and increasing family-oriented treatment practices. Two of these priorities had no identified performance measures for their related activities.

CAMH met its own goals for two of the other three priorities. We found that CAMH served approximately 10,000 uninsured children and adolescents in fiscal year 2008 and that about 6,000 uninsured youth estimated to be in need were not served by CAMH. The service penetration rate for the state was 65% but varied considerably across counties.

Our review found weaknesses regarding the quality and use of regional plans. According to state law, regional plans should be a significant source of information in CAMH's assessment of child and adolescent needs, which should drive the allocation of available funds. However, we found plans that provided little data to support stated needs, that were based on out-dated information provided by DHR, and that were inconsistent from one region to the next. DHR officials did not appear to give regional plans any significant attention during the planning process, despite legislation requiring that the plans be the basis of appropriation requests. We could not determine if the limited attention devoted to the plans by DHR was a result of the quality of the plans or a cause of the poor quality.

Regarding CAMH spending, we found that the Program's reported expenditures (and therefore, the fund balances) are not indicative of all DHR funds spent on mental health care for the child and adolescent population. The reported expenditures of \$84 million (\$74.2 million in state funds) do not include all costs incurred for this purpose and likely include costs that should be charged to other programs. For example, the Adult Mental Health Program paid a large portion of the state share of Medicaid costs for non-CMO children and adolescents receiving mental health services in the community, artificially lowering CAMH expenditures and inflating Adult MH expenditures. The expenditures are also impacted by re-rates, or manual journal entries, that moved expenditures from one program to another. Three of the four re-rates we reviewed lacked adequate documentation to support either the reason or the amount of the transaction.

Approximately 70% of the reported expenditures during fiscal year 2008 were for services associated with agency-identified critical child and adolescent needs. The \$35 million remaining in the CAMH budget as of June 1, 2008, was used, with only a \$1 million surplus. \$17.2 million (47.7%) was spent on core and specialty services, \$2.1 million (5.8%) was expended on other services associated with critical needs, and \$7.5 million (20.8%) was transferred out of the Program. Administrative costs, including a re-rate, totaled \$3.8 million (11%) and approved reserve requests for core and specialty services totaled \$1.8 million (5.1%). Remaining expenditures were for other items not tied to a critical need.

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Purpose of the Special Examination

The purpose of this review was to answer specific questions requested by the House and Senate Appropriations Committees. In their request, the committee chairs asked questions about three basic topics in regard to Child and Adolescent Mental Health: 1) the impact of the Fee-for-Service policy initiated April 2007; 2) the effectiveness of DHR's needs assessment process and changes to availability of children's mental health services over time; and 3) the utilization of relevant appropriated funds. This report answers questions two and three. The first question will be addressed in a companion report, 08-37A, expected to be released in February 2009. The complete list of questions from the committees, as well as the details about our objectives, scope, and methodology are included in **Appendix A**.

This report has been discussed with appropriate personnel with the Department of Human Resources' Division of Mental Health, Developmental Disabilities, and Addictive Disorders (MHDDAD or "Division"). A draft copy was provided for their review, and they were invited to provide a written response, including any areas in which they plan to take corrective action. Their responses are included at the end of each finding.

Background

MHDDAD Organization

The Child and Adolescent Mental Health Program (CAMH) is located within MHDDAD. The Program consists of three subprograms: Community Services, State Hospital Services, and Outdoor Therapeutic Program. Due to the nature of the audit request, this report primarily discusses community-based services.

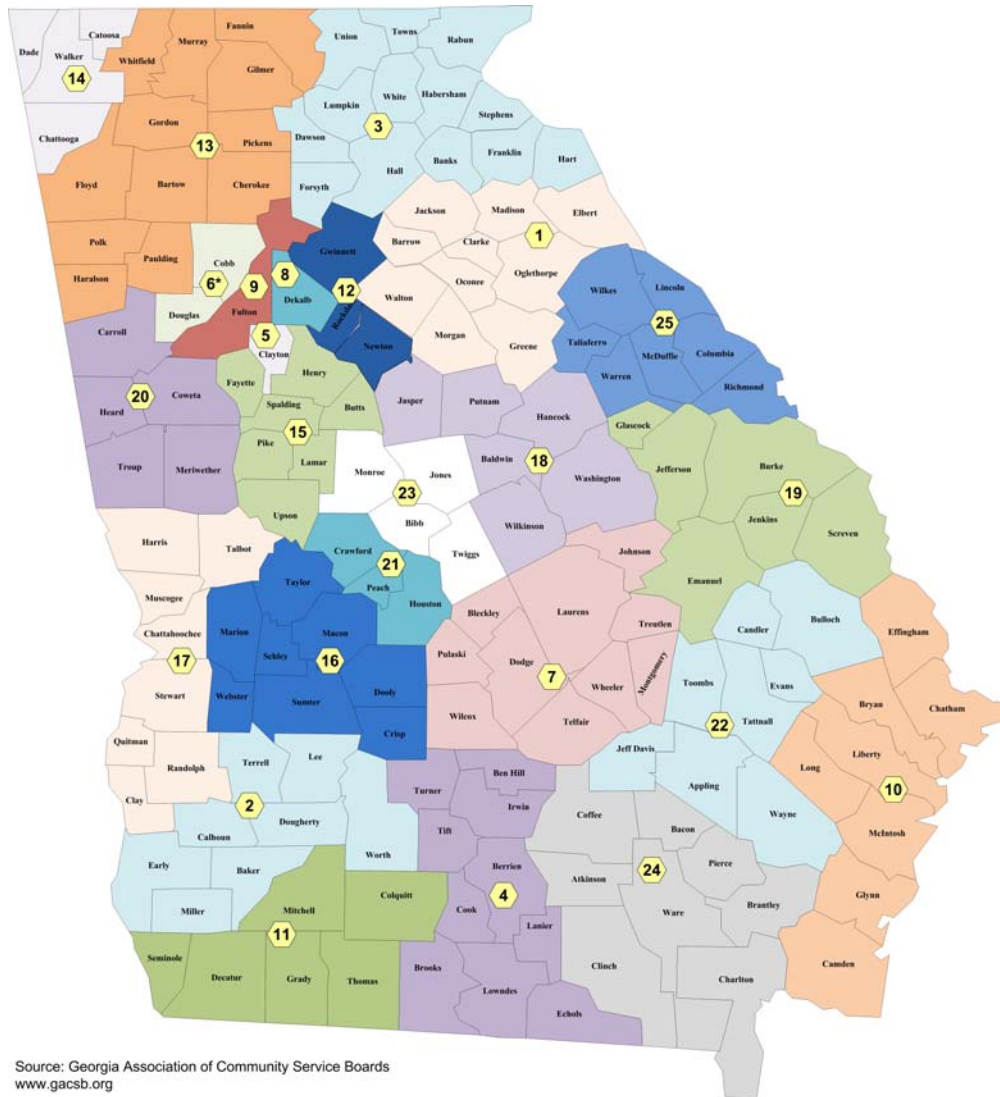
MHDDAD has five regional offices that serve as the primary contacts for service providers within their respective regions. O.C.G.A. 37-2-4.1, which requires the regional offices, also mandates associated regional planning boards. The boards are responsible for "coordinated and comprehensive planning" for the region under standards and procedures set by MHDDAD. The boards' role is limited to planning, while the Division is responsible for the procurement of needed services.

Community Mental Health Providers

MHDDAD contracts with approximately 150 providers of community mental health services for children and adolescents. The providers include all of the state's 25 quasi-governmental community service boards (CSBs), which were created by the General Assembly in 1993 with House Bill 100. CSBs are public corporations created "for nonprofit and public purposes to exercise essential governmental functions." Each CSB has a service area¹ consisting of specific counties (**Exhibit 1**). County governing authorities appoint most CSB board members.

¹ As of 2006, CSBs can go beyond their service areas to treat individuals from other parts of the state.

Exhibit 1 Georgia's Community Service Boards



- | | |
|--|--|
| 1 Advantage Behavioral Health Systems | 14 Lookout Mountain Community Services |
| 2 Albany Area CSB | 15 McIntosh Trail CSB |
| 3 Avita Community Partners | 16 Middle Flint Behavioral HealthCare |
| 4 Behavioral Health Systems of South Georgia | 17 New Horizons CSB |
| 5 Clayton Center Behavioral Health Services | 18 Oconee Center |
| 6 Cobb CSB/ Douglas CSB* | 19 Ogeechee Behavioral Health Services |
| 7 Community MH Center of Middle Georgia | 20 Pathways Center |
| 8 DeKalb CSB | 21 Phoenix Center Behavioral Health Services |
| 9 Fulton County Department of MHDDAD | 22 Pineland MH/DD/AD |
| 10 Gateway Behavioral Health Services | 23 River Edge CSB |
| 11 Georgia Pines CSB | 24 Satilla Community Services |
| 12 GRN CSB | 25 Serenity Behavioral Health Systems |
| 13 Highland Rivers CSB | * Cobb and Douglas have separate boards, but share administrative staff. |

While CSBs have traditionally been MHDDAD's primary community provider of mental health, developmental disability, and addictive disease services, in recent years, MHDDAD's use of non-CSB providers has increased significantly. More than 100 new providers have been contracted since 2007. These providers are either non-profit or for-profit entities and may have been providing services to clients outside the MHDDAD system in prior years.

Most of the mental health services provided by MHDDAD contractors are categorized as either core or specialty services. Examples of core services include psychological testing; nursing assessment and care; and individual, family, or group outpatient services. Examples of specialized services include intensive family intervention; behavioral assistance; and structured residential treatment. The availability of these services varies by region.

Child & Adolescent Mental Health Population

MHDDAD serves children and adolescents (C&A) with serious emotional disturbance (SED). The SED population is defined as "persons from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities." Nationally, the Center for Mental Health Services (CMHS) estimates 8% of the child and adolescent population has a SED. Using the CMHS estimate, approximately 202,500 Georgia children and adolescents would have a SED.

The payer of service for the C&A population has been in a state of flux in recent years. Currently, the MHDDAD system serves and is the payer for four SED populations with different eligibility standards. They include the following:

- **Uninsured** – C&A in parental custody who are not covered by either private or public insurance. Their services are paid for by MHDDAD.
- **Medicaid: Disabled** – C&A in parental custody but eligible for Medicaid because of a disability. Their services are paid for by federal Medicaid funds and state matching funds. The state share is paid by MHDDAD.
- **Medicaid: Foster Care** – C&A in the custody of the Division of Family and Children Services, making them eligible for Medicaid. Their services are also paid for by federal Medicaid funds and state matching funds. The state share is paid by MHDDAD.
- **Medicaid: Low Income, Transitional** – C&A in parental custody who are eligible for membership in a Medicaid Care Management Organization but whose coverage has not started. This transitional period can be as long as 60 days from the date eligibility is determined. During that time, any services provided are paid for by MHDDAD.

Once a child has been identified as eligible for services, a comprehensive evaluation is performed to determine whether the child requires a) early intervention and crisis stabilization or b) ongoing support and treatment. This decision affects the range of services that will be provided and the timeframe for which they are authorized. Early intervention and crisis services are generally offered for 90 days or less.

Authorization for ongoing support and treatment can be as long as 180 days before another evaluation is required.

Recent Changes to C&A Mental Health System

Prior to June 2006, MHDDAD primarily served uninsured children and those on Medicaid who were not in foster care. However, several events have occurred in the state's C&A mental health system in the past three years that have significantly impacted the mental health delivery system. These changes have included changes in MHDDAD's data collection, payment methods, populations served, and provider network. The C&A populations have experienced transitions among the various government programs/payers for their provision of mental health services, changing the entities responsible for child and adolescent mental health services in Georgia.

- Beginning June 2006, the Department of Community Health (DCH) placed Medicaid-eligible low-income youth in parental custody, along with members of PeachCare for Kids, into Care Management Organizations (CMOs). This shift to CMOs was intended, at least in part, to expand the role of potential providers of service to the C&A population. The CMOs became responsible for coordinating and paying for the care of those populations.
- In July 2006, the MHDDAD data collection system moved from capturing enrollments to service encounters. Enrollments measured individuals who were eligible for services within a given period whether or not they actually received services. The new data collection system provided DHR with a mechanism to track the number of persons actually receiving services.
- In April 2007, MHDDAD moved from Grant-in-Aid (GIA) funding to Fee-for-Service (FFS) for most C&A community mental health services. Prior to the funding change, providers received a fixed monthly payment rather than funding in accordance with the individual services delivered. This change in reimbursement was intended to ensure that providers are only paid for services provided and to expand the provider pool.
- In July 2007, a federal mandate from the Center for Medicare and Medicaid Services (CMS) required that DHR unbundle services provided to C&A in its Levels of Care program. (Levels of Care paid a flat daily rate for residential services of a specific intensity.) In response to this mandate, MHDDAD now provides mental health services to youth in DFCS custody while "Room, Board, and Watchful Oversight" charges are paid by DFCS.
- In January 2009, MHDDAD transitioned C&A residential mental health services from GIA to FFS. Residential services, which are a specialized, community-based service, were not included in the original shift to FFS.

Activity Data

Exhibit 2 contains information on the number of individuals enrolled in CAMH services from 2004 to 2006 and individuals served in fiscal years 2007 and 2008. The drop between fiscal years 2006 and 2007 can be explained by two previously-discussed events: 1) Enrollment figures included children and adolescents approved

to receive services from the provider, not necessarily individuals that actually received services during the reported year, so enrollment numbers do not reflect the actual number served;² and 2) Enrollment figures also contained the Medicaid C&A population that, in 2007, began to receive services by CMO-contracted providers; therefore, DHR no longer captures the number of individuals in this population that have received mental health services. The increase in individuals served in 2008 is partly attributed to the transition to documenting encounters, which may have produced a slight undercount in 2007.

Exhibit 2					
Activity Data – State Fiscal Years 2004-2008					
	Individuals Enrolled			Individuals Served	
	2004	2005	2006	2007	2008
C&A MH Community Services	41,004	40,064	40,543	17,197	25,240
Source: Governor's Office of Planning and Budget, APS Healthcare KnowledgeBase					

Financial Information

As shown in Exhibit 3, state funds accounted for 89% of the Program's total revenue. At the subprogram level, state funds accounted for 76% of the Outdoor Therapeutic Program (OTP) subprogram, 88% of the Community Services subprogram, and 95% of the State Hospital Services subprogram. Federal and other fund sources combined provided the remainder of each subprogram's revenue.

Exhibit 3								
CAMH Fiscal Year 2008 Revenue and Expenditures by Subprogram								
Revenue	OTP		Community		Hospital		Total	
State Funds	\$3,961,154	76%	\$66,789,950	88%	\$6,309,909	95%	\$77,061,013	89%
Federal Funds	143,138	3%	8,967,513	11%	0	0%	8,687,149	10%
<u>Other Funds</u>	<u>1,119,251</u>	<u>21%</u>	<u>471,321</u>	<u>1%</u>	<u>360,020</u>	<u>5%</u>	<u>1,315,461</u>	<u>1%</u>
Total Funds	\$5,223,543	100%	\$76,228,784	100%	\$6,669,929	100%	\$87,063,624	100%
Expenditures								
Personal Services	\$4,038,894	81.8%	\$4,508,454	6.4%	\$6,298,129	69.8%	\$14,845,476	17.7%
Regular Operating	783,334	15.9%	320,935	0.5%	2,497,709	27.7%	3,601,978	4.3%
Motor Vehicle	21,128	0.4%	14,213	0.0%	-	0.0%	35,341	0.0%
Equipment	12,000	0.2%	-	0.0%	-	0.0%	12,000	0.0%
Computer Charges	18,386	0.4%	3,872	0.0%	6,440	0.1%	28,698	0.0%
Real Estate Rentals	-	0.0%	66,693	0.1%	-	0.0%	66,693	0.1%
Telecommunications	23,917	0.5%	29,335	0.0%	25,448	0.3%	78,701	0.1%
Contracts	37,394	0.8%	65,031,620	92.9%	160,695	1.8%	65,229,708	77.7%
<u>Grants and Benefits</u>	<u>2,214</u>	<u>0.0%</u>	<u>2,120</u>	<u>0.0%</u>	<u>30,804</u>	<u>0.3%</u>	<u>35,138</u>	<u>0.0%</u>
Total Expenditures⁽¹⁾	\$4,937,267	100%	\$69,977,242	100%	\$9,019,225	100%	\$83,933,734	100%
(1) Total expenditures are understated by \$534 when compared to the program expenditures reported by the State Accounting Office.								
Source: FY08 DHR PeopleSoft 998 Subprogram Level Report								

² For example, an individual is added to the enrollment list in May 2005, has one appointment in June 2005, and remains on the list during the following fiscal year – resulting in an inflated FY06 count.

Program and subprogram expenditures are shown at the object class level. Community Services expenditures totaled 84% of the Program's expenditures; State Hospital Services and OTP combined for the remaining 16%. Within the Community Services subprogram, contracts accounted for more than 90% of expenditures. These contracts totaled more than three-fourths of the entire Program expenditures. The other two subprograms spent a majority of their funds on personal services.

Related Audits and Studies

In 2004 and 2005, the Healthcare Audits Division (HAD) of the Department of Audits and Accounts released two reports on CSBs at the request of the Governor. Among other things, the reports found that GIA funds were not distributed according to need and that the state should consider a FFS model to ensure greater accountability. The report noted, however, that DHR did not have adequate financial information to determine the appropriate fee amounts for successfully implementing FFS.

In response to HAD's first audit, the Governor created the Community Care for Behavioral Health and Developmental Disabilities Task Force as part of the Commission for a New Georgia. The Task Force was to "determine the current state of Georgia's public behavioral health and developmental disabilities delivery system and to develop a comprehensive implementable plan for improvement." In its July 2005 report, the Task Force recommended that MHDDAD adopt a FFS reimbursement model. (To date, the FFS model has only been applied to the CAMH program. CSBs continue to receive GIA funding for Adult Mental Health.)

Georgia's Mental Health Planning and Advisory Council (MHPAC) requested a gap analysis in 2004 to provide a comprehensive assessment of the state's mental health delivery system. The MHPAC is a federally mandated committee whose primary purpose is to provide oversight and guidance to MHDDAD through advocacy and its annual review and recommendation of the Division's federal Mental Health Block Grant application. The State of Georgia contracted with APS Healthcare to conduct the Georgia Mental Health Gap Analysis, which was completed in 2005. The Gap Analysis noted several mental health service gaps and recommended that Georgia continue with ongoing gap analyses to measure changes.

In 2007, MHDDAD contracted with the Human Service Collaborative to provide an analysis of state spending on behavioral health services for Georgia children and adolescents and their families across funding streams and child-serving systems. While the report did not provide an analysis of the entire child and adolescent mental health service delivery system in Georgia, it did consider the impact of multiple environmental changes, such as implementation of CMOs, the conversion to Fee-for-Service, and changes to Levels of Care. The report made dozens of recommendations to improve C&A mental health services in Georgia.

In 2007, renewed concerns surrounding Georgia's mental health system prompted the Governor to create a Mental Health Service Delivery Commission. This Commission was tasked with completing a comprehensive study of the conditions, needs, and issues within the state's mental health system. Its final report to the Governor had not been released by the time this report was published in January 2009.

Findings and Requested Information

Availability of Child and Adolescent Mental Health Services

The Division does not systematically identify CAMH needs and link these needs to mental health priorities.

Division administrators stated that their understanding of the child and adolescent population's needs is informed by regular meetings with Division staff, other state agencies, DHR leadership, and executive officers of regional planning boards. In addition, they are informed by reports, created by Division staff and others, that describe items such as MHDDAD activities and the environment in which they are offered. While these meetings and documents may help identify needs, the Division lacks a systematic process for identifying and documenting needs for child and adolescent mental health. The methods described by Division personnel are not part of a documented, systematic process, and there is no resulting document that links CAMH activities to a list of identified, prioritized needs. Without a comprehensive needs assessment document, it is not possible to determine if CAMH services result from a consideration of all significant C&A needs, including the geographic areas where these needs exist.

To identify needs assessment best practices, we obtained guidance published by the federal Substance Abuse and Mental Health Services Administration and reviewed needs assessments from a number of state and local entities.³ We determined that typical elements of a mental health needs assessment include analyses of local, state, and national data, surveys of target populations, input from mental health providers and key decision-makers from other government entities, and information gathered in community forums (see Exhibit 4). Examples of needs identified by other states during this process include enhancing services for youth transitioning into adult service systems, providing integrated treatment for persons with co-occurring mental health and substance use disorders, ensuring earlier intervention and screening, and providing cultural and linguistic services.

A comprehensive needs assessment is necessary as the basis for a mental health plan, which sets funding priorities and guides mental health activities. Federal guidance on conducting needs assessments indicate that the end result should be an "accurate appraisal of the current situation that you seek to change." State-level needs assessments required by federal Mental Health Transformation grants repeatedly describe the results of their needs assessment as a basis for their comprehensive state mental health plans. However, other than the Mental Health Gap Analysis published in 2005, we found no evidence of a comprehensive needs assessment informing MHDDAD priorities. Requested by Georgia's Mental Health Planning and Advisory Council, a federally-mandated advisory group, the Gap Analysis was performed by external contractors using federal grant funds.

Regional Assessments

Mental health needs can vary across communities or geographic areas; therefore, an evaluation of needs at a local level must be conducted, even when setting state priorities. Region plans, which are a product of Regional Planning Boards and

³These entities are listed in Appendix A, Objectives, Scope, and Methodology.

MHDDAD Regional Offices, contain some elements of a needs assessment. However, we found that they are not conducted in a consistent enough manner to be used for state-level planning and that regional plans are not given more than cursory review by Division staff.

Exhibit 4 Needs Assessment Best Practices		
Elements	Examples	Purposes
Analysis of Existing Data – Gather and compare national, state, and local information.	Agency data that provides state/local demographics, the number of consumers served, mental health funding, distribution of services and the types of services provided. National statistical data detailing the prevalence of SED within demographic subgroups, epidemiological statistics, and established treatment best practices. Comparison data reporting performance measurements related to treatment outcomes or hospital readmission rates.	Document how many have been served compared to those in need, where money has been spent and on what services. Determine if subpopulations obtain equitable access, how state compares to others. Document performance and gaps from performance goals.
Surveys of Target Population – Gather information from a representative sample of the target population.	Personal interviews and telephone surveys providing feedback about what is and is not working with mental health service delivery.	Identify perceived needs or barriers and other relevant experiences of mental health consumers and their families.
Input from Key Informants – Meet with community leaders and decision makers knowledgeable about the community who can accurately identify priority needs and concerns.	Providers such as clinicians, hospitals, and other deliverers of mental health treatment services from within the current mental health system. Stakeholders from local and state government, education, medical/health, juvenile justice and youth organizations.	Identify needs and barriers as experienced by local mental health providers and other governmental agencies.
Community Forums – Hold public meeting(s) that allow stakeholders to discuss the community needs, identify the priority needs, and propose plans for these needs.	Public hearings, listening sessions, and group discussions devoted to receiving feedback from community stakeholders.	Identify needs and barriers as perceived by community members and mental health advocates. Get buy-in for plans.
Source: SAMSHA guidelines and auditor review of other state and local needs assessments		

It should be noted that the Georgia General Assembly has shown support for regional and local input in the planning process and clearly stated links between local needs and spending priorities. O.C.G.A. §37-2-7 requires the Division to formulate a biennial⁴ state plan for disability services that includes input from regional offices and community providers, proposed annual budgets, and analysis of the effectiveness of previous activities. The Legislature’s interest in local and regional planning is also evidenced in its requirements for Regional Planning Boards and MHDDAD Regional Offices, as discussed in the next finding.

⁴ The Division has not submitted a plan since mid-2007, which included a plan for state fiscal years 2006 and 2007.

State-Level Assessments

The documents we reviewed included priorities that had been established based on needs identified by agency leadership, state leadership, or federal grant requirements. While the identified needs may be valid, evidence did not exist that they were identified after considering all needs that may exist for the child and adolescent population. Because the documents resulted from less than comprehensive reviews, each document includes a different set of priorities.

Without a clear connection between C&A mental health needs identification and program activities, there is no assurance that the most critical mental health needs have been identified and will be acted upon. The lack of planning based on demonstrated need has been noted before. A 2004 audit of the Division's community-based services performed by the Department of Audits stated that, "while it seems logical that funding decisions, both at the state level and CSB level, be made based upon a planning process that incorporates analyses of the population of consumers who are not being served that are potentially eligible to receive services, such is not the case." Current Division leadership indicates that its efforts in the past four years have been geared toward known deficiencies in the child and adolescent system: ensuring a basic level of core mental health services across the state, developing a statewide crisis and access line, and developing C&A crisis treatment capacity. No document we reviewed stated these as the Division's underlying priorities.

MHDDAD should create a process for regularly assessing need for its services and clearly linking these needs to its program activities. Because of the extensive nature of a comprehensive needs assessment, the Division could consider a multi-year process. Key informant interviews and consumer surveys could be conducted in alternating years, but regional needs assessments and data analyses could be done annually. Improvements required in regional needs assessments are discussed more fully in the finding that follows.

DHR Response: DHR noted that "MHDDAD has ongoing processes that identify child and adolescent mental health needs and links these needs to mental health priorities. We agree that these processes are dispersed and have not resulted in a singular document identifying and prioritizing the needs of the child and adolescent mental health population. Current planning processes are associated with specific activities, fund source requirements, commissions and/or external advisory bodies. Examples include the Child and Adolescent Subcommittee of the Mental Health Planning and Advisory Council (MHPAC), Commission for a New Georgia, the cross-agency C&A State Incentive Grant Advisory Board, the Child and Adolescent Purchasing Plan, and the Regional Board planning process.

"Current planning processes do not follow the model prescribed in the draft review largely due to the program's complex external environment with multiple and overlapping funding sources, legal requirements, and oversight bodies. Lack of a singular list of program needs, however, does not equate to a lack of strategic direction within the program. The review itself finds that 70 percent of community expenditures were directed to address critical needs. In addition, changes to the child and adolescent mental health program were implemented to meet the strategic objectives of ensuring:

- *allocated child and adolescent dollars are used to serve youth*
- *a basic package of mental health services are available statewide*
- *families have community-based alternatives to hospitalization"*

MHDDAD Regional Plans do not appear to significantly influence state-level decision-making, and the current regional planning process lacks adequate structure to ensure value in local needs assessments.

We found little evidence that regional planning efforts get significant consideration from MHDDAD or DHR when priorities are established and funding decisions are made at the agency level. Our review of regional plans indicated that each region has repeatedly identified specific needs from one year to the next. (One 2010 regional plan stated that “Nearly all of the issues cited in previous ...plans still prevail so this year’s report will be mercifully brief.”) In addition, our survey of CSB executives found that just 7 of 13 of those familiar with regional plans were able to draw connections between the plans and Division service offerings. However, we also found that, in their current form, regional plans are not particularly useful for informing state-level decisions regarding mental health services to be offered.

State law clearly intends for local needs to inform decisions regarding MHDDAD spending. For example, O.C.G.A §37-2-4.1, which was updated in 2002, instructs the Division on the role of regional offices and regional MHDDAD Planning Boards. Regional offices are required to prepare an annual plan for the funding and provision of all MHDDAD services in the region. In addition, “Each board shall provide and facilitate coordinated and comprehensive planning for its region in conformity with minimum standards and procedures established by the Division.” Each board’s plan is submitted to the Division “so as to ensure that the plan is a basis for the annual appropriations request.” As discussed in the previous finding, we were unable to identify the role the plans make in appropriations requests.

However, we noted inconsistencies in the regional planning process and in the resulting contents of the plans⁵ that make their value in the planning process questionable in their current form. The current regional planning process lacks adequate structure to ensure that regional plans provide more useful local needs assessments in the future. As discussed below, the current process should include more specific policies and procedures for assessing need, a formal feedback process to ensure quality of the reports, increased dissemination and use of activity, spending and population data, and creation of sub-regions or districts to facilitate board effectiveness:

- **Policies and procedures** – Current guidance on regional planning comes in the form of published MHDDAD policies. Our review of the annually updated policies from calendar years 2005-2007⁶ found that they are not stringent enough to ensure that input is garnered consistently across the state. In fact, the policies have become significantly less prescriptive over this period. Fewer requirements are provided regarding specific inputs to the needs assessment process, and guidance on report content has diminished. The result of these policies is that the regions vary in their approaches to gathering information. Some evaluate data, conduct surveys and hold public hearings, while others have much less formal processes. Inconsistencies are therefore evident in the resulting plans.

⁵ These weaknesses were discussed in a Department of Audits’ report on CSB business practices published in 2005.

⁶ Because of a lag between regional and state planning processes, these policies would have guided the regional plans submitted for state fiscal years 2008, 2009, and 2010.

- **Feedback and enforcement** – Inconsistencies also result from a lack of enforcement of current policies. For example, despite a policy to segregate priorities by target population, two regions repeatedly report mental health goals without distinguishing between needs of adults and needs of children and adolescents. Staff reported to us that in the past Division workers spent time reviewing the reports and soliciting more information or corrections, but that this practice no longer exists. Without feedback and resulting corrections, inconsistencies among regional plans make it difficult to determine how widespread identified needs and priorities really are.
- **Data dissemination and use** – One element severely lacking in regional planning efforts is the use of data to support the assertion of need. For example, a plan may state a need for increased access to care, but supply no statistics to illustrate the extent of the need. This lack of supportive data is a result of years of documented inadequacies in Division information systems. However, recent improvements in data quality and quantity should enable the Division to share useful information with regional boards and offices in a more timely fashion.
- **Region configuration** – The number of MHDDAD regions has decreased from 13 in 1999 to seven in 2004 to five in 2005, resulting in areas too large for effective local needs assessment. One board in particular has noted that its resulting 44-county region is “entirely too large, 20,000+ sq miles, to be effectively served by one Planning Board.” By law, Boards are required to meet not less than once every two months. Because of the travel time required for meetings, the size of the regions has also been linked to problems with retaining and recruiting board members. Although only one board has consistently mentioned this issue, of the four regions that reported board membership statistics for planning year 2010, vacancy rates ranged from 29% to 50%.

In its annual application for federal mental health funding, the Division notes that to “ensure the perspectives of the local communities are a driving force, each region is required by law to have a planning board made up of at least 50% consumers and family members responsible for service system planning and local needs assessment.” In order to be certain that local needs are truly driving state-level funding decisions, and that local needs are met over time, the regional planning process requires additional structure and support from the state. MHDDAD should improve its policies and procedures, provide effective feedback on regional plans, disseminate better quality data, and ensure planning boards maintain adequate membership. With the improved quality of local needs assessments, the Division should be required to demonstrate the influence of these assessments on funding decisions.

It should be noted that the change to five regions was in part an effort to facilitate interagency coordination by making the MHDDAD regional structure consistent with that of the Department of Juvenile Justice (DJJ). However, DJJ divides its regions into two to three districts each. With few exceptions, these districts mirror the makeup of DFCS regions. To make the regional planning process more feasible (and to continue to facilitate interagency coordination), the Division should consider subdividing its regions and regional planning boards into working groups that cover smaller territories.

DHR Response: In its written response, DHR noted that “Regional Planning Boards meet regularly and efforts have been made via telephonic conferencing, video-conferencing, and meeting in smaller sub-groups to conduct business. Achieving a quorum at these meetings has been challenging since the governing authority of the positions was removed [in 2002 as a result of House Bill 498]. A State-wide Leadership Council is also in place which is comprised of Board Chairpersons from each of the five Regional Planning Boards; this also provides another opportunity to provide input into the planning process. This group meets with the Division Director each month. Every effort has been made to provide each county with a voice in the planning process. In fact, MHDDAD has worked with the Regional Planning Boards to reach out to individual county governments to ensure that they are represented on the Planning Boards. However, given the limited human and material resources of the Boards, we are not confident that the steps recommended on pages [10-11] of the draft review will do more to ensure more useful local needs assessments from the boards. A careful review of legislation, which will be necessary to effect the transition of Mental Health and Addictive Diseases into a new Department of Behavioral Health, should include a thorough study of the role of the Regional Planning Boards.”

“Regional Planning Boards and the Leadership Council are sources of citizen input among many other advocacy and stakeholder groups in our state. Regional Plans are utilized to provide local thinking. However, priorities selected for funding and implementation are ultimately selected through a more comprehensive process that includes this local input.”

MHDDAD has established numerous priorities for child and adolescent mental health, making it difficult to determine which of the associated needs are “most critical.” For those selected “most critical” in response to our question, MHDDAD does not consistently meet its internal goals.

As noted previously, no single document identifies child and adolescent mental health needs in Georgia. For that reason, we could not easily identify the most critical needs as determined by MHDDAD. In the absence of a comprehensive needs assessment, we reviewed multiple planning documents and, along with assistance from MHDDAD officials, identified 20 priorities. Division staff then identified those priorities that it considered critical (see Appendix B). It should be noted that the identified critical needs were not the most often cited within planning documents. Once the critical priorities were identified, we confirmed the “need” that the priority was intended to address.

According to Division staff, the most critical needs are being addressed by various activities and spending decisions. We have reported Division activities and performance indicators associated with the critical needs identified by the Division, as well as two additional needs, which are frequently cited in planning documents, selected by the audit team. We were unable to determine whether targets for these measures are appropriately set by the Division because comparative statistics for internal goals, such as providing crisis services, are not available. Where available, we report national averages to provide context to the Division’s performance. A table of reported performance measures is included in Exhibit 5. Spending decisions related to each of these priorities is the topic of a later finding on page 28.

Exhibit 5: Performance Measures Related to Division Priorities												
Need/Priority	SFY2005	FFY05	SFY2006	FFY06	SFY2007	SFY2008						
Provide Core and Specialty Services Statewide												
Improved Functioning: Children and adolescents with serious emotional disturbance (SED) in hospital or community-based treatment, will gain improved functioning (e.g. improved community participation and home-life).	Target: 64% Actual: 62%		Target: 65% Actual: 71%		Target: 75% Actual: 46%	Estimate: 55% Actual: 47%						
Develop and Implement a Systems of Care Approach												
None reported.												
Provide Crisis Services												
Mobile Crisis Teams: Children and adolescents will have improved access to mobile crisis services.					Actual: 217	Target: 434 Actual: 564						
Provide Services to Youth in Child Welfare System												
DJJ and DFCS Served: The number of Department of Juvenile Justice and Department of Family and Child Services children and adolescents with serious emotional disturbance and/or addictive diseases referred to MHDDAD and entered into service will increase.					DFCS and DJJ Target: 7,500 Actual: 5,201	DFCS Target: 3,912 Actual: 5,201						
Increase Family-Oriented Treatment Practices												
None reported.												
Reduce Admission/ Readmissions to Hospitals												
Hospital Admissions: The use of hospitals for treatment of children and adolescents will be reduced as shown by a reduction in the number of C&A admissions to state hospitals.					Target: 1,600/yr or less Actual: 1,556	Target: 1,320/yr or less Actual: 1,379						
Hospital Bed Use: The average use of state hospital beds for child and adolescent mental health services will remain within designated system capacity.	Target: 70 or less Actual: 64.1		Target: 56 or less Actual: 42.4		Target: 50.4 or less Actual: 40.2							
Readmissions (30 days): Children and adolescents (ages 0-17) readmitted to state hospitals within 30 days of discharge.		GA: 10% National Average: 7%		GA: 8% National Average: 6%								
Readmissions (180 days): Children and adolescents (ages 0-17) readmitted to state hospitals within 180 days of discharge.		GA: 21% National Average: 15%		GA: 17% National Average: 14%								
Utilize Evidence-Based Practices												
Best Practice Services: Children and adolescents with serious emotional disturbance will have improved access to best practice treatment and support services. It should be noted that the numbers reported here are only for utilization of Intensive Family Intervention (IFI) Services, which is not an evidence-based practice.			Target: 42% Actual: 40%		Target: 28% Avg/Qtr Actual: 30%	Target: 3,780 Actual: 3,667						
Key:												
<table border="0"> <tr> <td style="background-color: #d9ead3; width: 20px; display: inline-block;"></td> <td>Priorities Identified by Division</td> </tr> <tr> <td style="background-color: #d9ead3; width: 20px; display: inline-block;"></td> <td>Priorities Identified by Audit Team</td> </tr> <tr> <td style="background-color: #f4cccc; width: 20px; display: inline-block;"></td> <td>Division Performance Did Not Meet Target</td> </tr> </table>								Priorities Identified by Division		Priorities Identified by Audit Team		Division Performance Did Not Meet Target
	Priorities Identified by Division											
	Priorities Identified by Audit Team											
	Division Performance Did Not Meet Target											
Source: DHR Board Reports and Georgia Reports from the U.S. Center for Medicare and Medicaid												

- Provide core and specialty services statewide – Core services are basic mental health services such as Psychiatric Treatment, Individual and Group Counseling, and Crisis Intervention. Specialty services are generally more intensive and include residential and in-home treatments like Intensive Family Intervention and Structured Residential Services. (For a description of all core and specialty services, see Appendix C.) In fiscal year 2008, core services were provided to individuals from every county in Georgia. Specialty services were less available,

with 20 counties having no residents served. We were unable to determine if any residents of those 20 counties were in need of a specialty service.

All Division services are intended to improve a youth's daily functioning in school, in and with their families, and in their communities. In order to be eligible for services, children and adolescents are assessed using a measure of functional impairment. Reduction in these scores during the time in treatment is considered a measurement of improved functioning. Between fiscal years 2006 and 2008, the Division reported decreases in the percentage of youth who experienced a positive change in functioning. In addition, family members of consumers reported lower levels of satisfaction with outcomes of Division services than the national average. The most recent satisfaction surveys available for child and adolescent mental health services (compiled in a fiscal year 2005 report) showed the percent of family members reporting positively about outcomes (46%) was well below the national average (73%).

- **Develop and implement a “Systems of Care” approach** – MHDDAD officials identified a need for more comprehensive services, requiring additional coordination among agencies serving the youth in its system. A Systems of Care approach is one in which child-serving agencies link services and provide resource coordination for a child across their respective agencies. (Individualized, comprehensive services offered through a system of care may be referred to as “wraparound services”.) MHDDAD officials identified two initiatives directly related to this approach:
 - *KidsNet Sites* – Three pilot community locations provide wraparound services and serve as the location of care for children: Metro Atlanta, Savannah, and Northwest Georgia. These sites are provided grants to offer screening and referral services in local DFCS offices, juvenile courts, and other community-based locations, to provide case management/coordination services and to support families in advocating for their needs and navigating service systems.
 - *Local Interagency Planning Teams* – The Division has also redeveloped local multi-agency teams for children as Local Interagency Planning Teams whose function is to coordinate service delivery for children with intensive service needs in 110 communities statewide. Teams are comprised of DFCS, DJJ, MHDDAD, school system, mental health provider, public health department, and Department of Labor Vocational Rehabilitation representatives.

While MHDDAD has undertaken initiatives to implement Systems of Care, these efforts are not integrated with the service delivery system. Providers are required to support service and resource coordination efforts, but these services are not reimbursable through fee-for-service or Medicaid. One CSB explained: “The youth we serve are most often involved with several agencies or the court systems and to provide a ‘seamless system of care’, which has repeatedly been promoted by the DHR/Division, many collaborative meetings/staffings have to occur. These are needed services but are an unfunded mandate.” Just under half (9 of 19) of the CSBs who responded to our survey specifically noted the need to reimburse costs associated with case management and resource coordination.

- **Provide crisis services** – Crisis services are intended to prevent hospitalizations through the use of immediate and intensive community services. The Division offers four community-based crisis services: Crisis Intervention, Intensive Family Intervention (IFI), Crisis Stabilization, and Community-Based Inpatient. (See **Appendix C** for descriptions of these services.) In fiscal year 2008, 3,930 children and adolescents received at least one crisis service, amounting to 17% of youth served.

Regional Planning Boards and providers often cite limited availability of crisis services as a concern. In our survey of CSBs, respondents cited concerns with the capacity for crisis situations and the limited availability of crisis units and mobile response teams. Crisis Intervention is the only crisis service available statewide. Mobile Crisis Response Services, an adaptation of Crisis Intervention available in Regions 1, 2, and 3, provide services to the youth in any setting (i.e. emergency room, school, and in the home) during times of immediate crisis. A request for proposal for additional statewide mobile crisis services to be implemented in fiscal year 2009 was cancelled, just before the deadline for responses. IFI was provided to residents of 128 counties in fiscal year 2008, while Crisis Stabilization services were limited to five metropolitan areas (Atlanta, Augusta, Columbus, Rome, and Savannah). According to a MHDDAD official, additional crisis beds are purchased in Atlanta and Albany.

- **Provide services to youth in the child welfare system** – As noted on page 4, MHDDAD became the public provider for mental health services for children and adolescents in the care of the Division of Family and Children Services (DFCS). In fiscal year 2008, the Division reported serving an increased number of youth within DFCS from the previous year. However, there are indications that more youth may need services than received them. Literature cited by MHDDAD suggests that 57% of youth involved in child welfare institutions are likely to have a mental disorder. The Division estimates that of the 18,000 DFCS youth previously involved with Levels of Care, only 40% of those individuals received services in fiscal year 2008. According to the Director of Mental Health, other efforts to provide such services involve staffing positions devoted to linking children with providers and offering technical assistance to increase provider capacity to provide care to this specific population.
- **Increase family-oriented treatment practices** – According to the Director of Mental Health, involving a youth's family members in treatment planning and delivery for their relative by providing family-oriented treatments is a critical need because focusing solely on the child does not have lasting effects. In 2008, Family Outpatient services, which include both family training and family counseling, were provided to 5,000 children and adolescents. In addition, MHDDAD offers services that incorporate families into services already mentioned such as Community Support Individual and IFI. The Division recently hired a Family Liaison in order to integrate family-centered practices into all of its services.

The following priorities/needs were included in several documents and mentioned in discussions with providers. We chose to include an assessment of these oft-cited priorities in addition to those identified by the Division.

- **Reduce admission and readmission rates to hospitals** – Offering a full range of community-based treatments has been shown to be more effective than hospitalization. MHDDAD has traditionally had a heavy reliance on acute care hospital services but is transitioning to increased community services. In recent years, MHDDAD has increased Crisis Stabilization capacity and this year proposed to close state hospital long-term units for children and adolescents. Approximately 1,380 youth were admitted to state hospitals in fiscal year 2008, which was a decline over the previous year. Readmission rates are measured at 30 and 180 days after discharge. The most recent available calculations of these rates are from federal fiscal year 2006. In both the 30- and 180- day calculations, Georgia's rates are higher than the national average.
- **Utilize evidence-based practices** – Experts note that consumers need to have access to effective, state-of-the-art, quality services. Evidence-based practices are well-documented, scientifically-tested treatments and services that have proven effective. While several services offered by the Division have evidence-based practices associated with their implementation, the Division does not systematically track their use. For example, in the delivery of IFI, providers are encouraged to use Multi-Systemic Therapy and Multi-Dimensional Family Therapy. The Division does not report the number of youth using either of these two practices, but rather it reports the total number of youth receiving IFI. In fiscal year 2008, IFI services were utilized by 3,667 youths, just short of the Division's target. Other services, such as Individual and Family Counseling, have evidence-based practices suggested in the Provider Manual, but the Division does not report any indicators associated with their use. In previous years, utilization of Therapeutic Foster Care was reported to CMHS as an evidence-based practice but was below national averages. In 2008, MHDDAD acknowledged that providers were not necessarily implementing Therapeutic Foster Care in line with the evidence-based model. In each case, no additional reimbursements are available to providers who choose to provide an evidence-based practice, which tend to be higher in cost. Division staff members acknowledged that evidence-based practices are, in some cases, too costly to provide.

In absence of distinguishable and clearly communicated Division needs, MHDDAD risks not meeting the most critical mental health needs of the child and adolescent population. MHDDAD should develop consistent, measurable goals based on identified needs to ensure greater accountability.

***DHR Response:** DHR noted that its “identified priorities emerge from a complex external environment with multiple and overlapping funding sources, legal requirements, and oversight bodies. Multiple priorities do not equate, however, to a lack of strategic direction within the program.” According to DHR, “recent DHR performance management activities have been successful in reducing state hospital utilization and improving behavioral health services to youth in DFCS custody.” Performance activities include monthly meetings with state office, regional office, and hospital leadership where the DHR Commissioner and MHDDAD Division Director review performance and evaluate the effectiveness of implemented strategies. Other state and provider agencies may participate depending on the focus of the meeting. The Division used these meetings to plan and oversee the transition of 133 parental custody youth with serious emotional disturbance from DFCS residential placements to private homes and reduced hospital admissions by 177 youth.*

In addition, DHR noted that the 57% prevalence rate of mental disorders for foster care youth is based on a dated review of one county. DHR also noted that its penetration rate increases for older youth and youth who have been in DFCS custody for an extended period.

Finally, DHR responded that it “concur[s] with the report’s finding that outcome measurement and internal performance management processes are areas within the child and adolescent mental health program that require continual improvement.”

Service penetration rates vary considerably by county and among MHDDAD regions. Overall, MHDDAD child and adolescent mental health providers serve about 65% of estimated uninsured youth in need statewide.

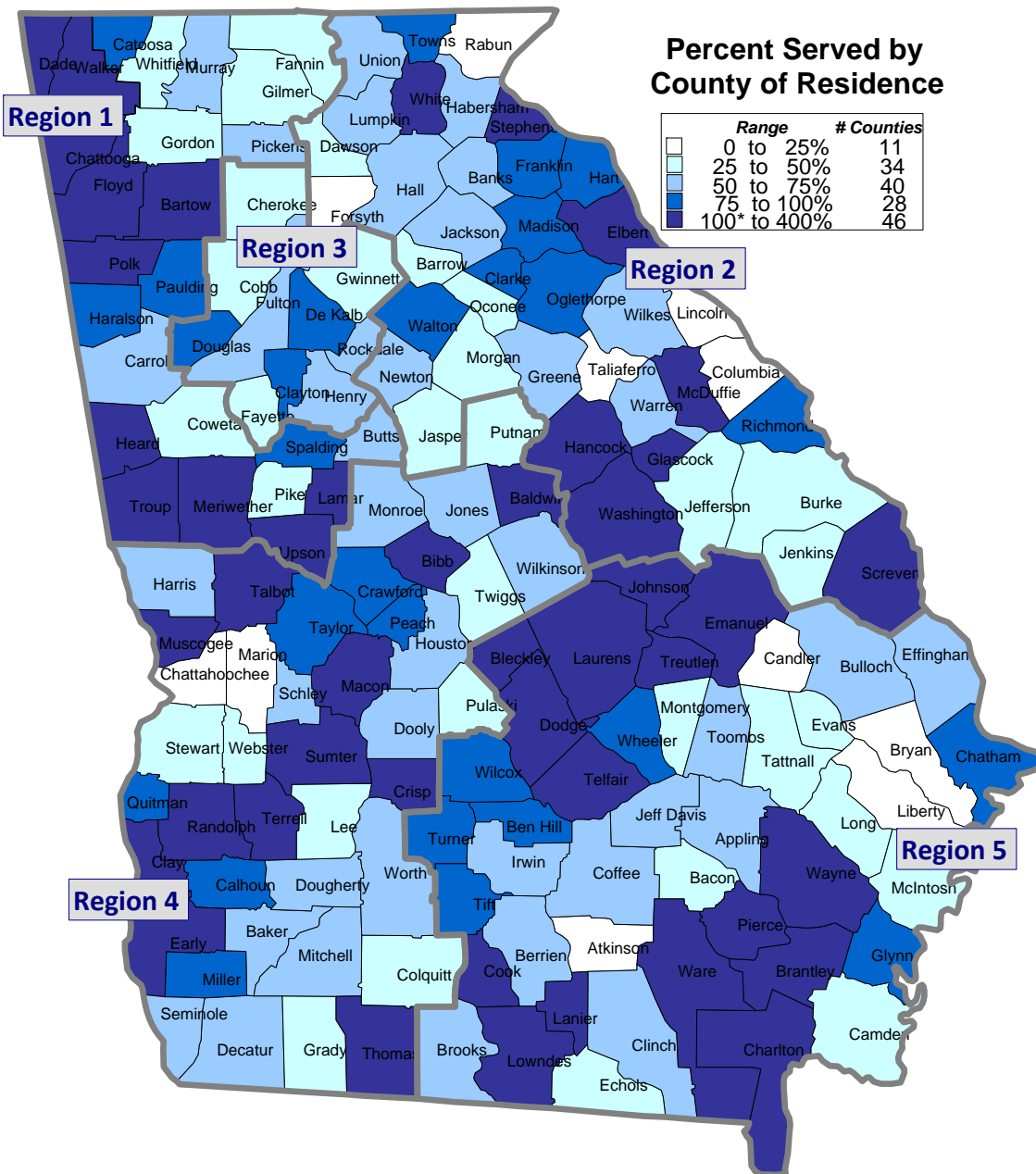
Service penetration rates are calculated by comparing the number of consumers served with the number of consumers estimated to need service in a given area. These rates are a way of measuring how well a provider is reaching the population it is intended to serve. We attempted to determine to what degree the Division is serving uninsured children and adolescents in need of mental health care. Overall, we estimate that the Division is reaching about 65% of the uninsured youth in need, potentially leaving more than 6,000 unserved in fiscal year 2008.

We were unable to determine a service penetration rate for both populations – uninsured and Medicaid – served by MHDDAD. MHDDAD is only responsible for mental health care for a portion of the Medicaid child and adolescent population. DCH’s care management organizations are responsible for a majority of Medicaid youth, and the number served by the CMOs is not available. While we could estimate the number of Medicaid youth in need of service, it was not possible to segregate this number between DHR and DCH. Without CMO data, our service penetration rate calculation was limited to the uninsured population.

To identify the target population for this analysis, we used U.S. Census Bureau 2005 estimates⁷ for the percentage of uninsured youth in each county under the age of 19 and at or below 200% of poverty level. We estimated the prevalence of severe emotional disturbance (SED) in this group at 8% of the age group population, based on national studies. As shown in **Exhibit 6**, our analysis found that the service penetration rates for this population varied considerably from county to county. For example, in 45 counties 50% or less of the youth estimated to be uninsured and experiencing a SED were seen by Division-contracted providers in state fiscal year 2008. Providers reached 75% or more of the expected population in 74 counties (47% of total). Variability is also seen among the Division’s Mental Health delivery regions. As shown in **Appendix D**, overall penetration rates varied from 52% in Region Three (Metro Atlanta) to 89% in Region Four (southwest Georgia).

⁷ Further details on our method for estimating uninsured youth and calculating prevention rates are included in Appendix A. The 2005 estimates were released in 2008 and represent the most recent data available.

Exhibit 6 Penetration Rates of CAMH Services among the Uninsured, FY 2008



Source: APS encounter data, US Census estimates

*Counties with rates in excess of 100% had more residents served than the estimated uninsured. See text for discussion of limitations of these estimates.

Due to data limitations, penetration rates and the variability of those rates should be interpreted with caution. The accuracy of the estimated penetration rates depends on the validity of county-level estimates of age group population and rates of uninsured, as well as the accuracy of the insurance status and county of residence within the MHDDAD data system. In addition, one should not assume that a rate of

100% is a reasonable target, given that DJJ services an unknown number of uninsured youth. Finally, while service penetration rates are a useful indicator of access, they do not give any indication of whether consumers receiving treatment received *enough* care (number of sessions) or the *right kind* of care (type of therapy) required to improve mental health function.

MHDDAD should calculate service penetration rates as one measure of accessibility and determine a reasonable statewide target. While comparable benchmarks from other states are not readily available, tracking its own service penetration rates over time would allow MHDDAD to gauge whether access to services is improving. And while county-level data relies on estimated figures, analysis would be beneficial in identifying potential problems in availability of services.

DHR Response: DHR does not agree that “15,873 uninsured youth in Georgia require behavioral health services, that DHR services are meeting 65 percent of the behavioral health needs of this population, nor that in 46 counties more uninsured youth are receiving services than actually need them. The Department believes penetration rates based upon estimated prevalence to be of limited utility. There are no national epidemiological studies of the prevalence of mental disorders focused specifically upon children and adolescents. Existing national and regional prevalence estimates vary widely (3% - 26%), due largely to methodological differences in the definitions of serious emotional disturbance (SED). Studies also vary in the definition of illness duration and level of functional impairment. All of these factors have led to significant challenges in the measurement of prevalence and in diagnostic assignment. As such, it is not surprising that the Department of Audits and Accounts’ own methodology yielded county service penetration rates that exceed 100% since “service penetration rates are calculated by comparing the number of consumers served with the number of consumers predicted to need services in a given area.”

DHR agreed that variation of service availability and utilization exists across counties. It pointed to multiple factors contributing to this, including “shortages of qualified clinical professionals (general and child psychiatrists, licensed mental health professionals, certified addiction professionals) make recruitment and retention a major challenge in underserved areas, where agencies can be understaffed and overtaxed. Many residents of rural counties face constraints due to lack of public transportation and long distances to travel to service sites. Health seeking behaviors are also impacted by social context. Shame, fear, and stigma can keep individuals from seeking help for issues that are viewed as socially unacceptable, such as mental illness. DHR has worked to make treatment and support services available to those children and adolescents whose mental illnesses and addictive diseases have the greatest potential to become long-term conditions. A core set of essential services are now available in all service areas for these youth. The Department has furthered increased access to needed services by implementing initiatives such as the nationally recognized Georgia Crisis and Access Line (toll-free, statewide access to service appointments and crisis interventions), crisis stabilization capacity in all regions, and mobile crisis teams in most regions.”

Department of Audits’ Response: The limitations of service penetration rates are acknowledged in the finding. However, it should be noted that not only was our 8% prevalence estimate based on data from the federal Center for Mental Health Statistics, but as stated in the 2005 *Georgia Mental Health Gap Analysis*, MHDDAD has published this same “widely used and accepted” 8% figure in prevalence estimates of SED in children and adolescents.

MHDDAD's mental health delivery system for children and adolescents has changed markedly in the past five years. Changes in service availability can be measured across several dimensions, but while some areas show improvement, in others the impact is less conclusive.

We evaluated changes over the last five years in the availability of child and adolescent mental health services from a number of dimensions – populations served, system entry, service array, providers, service locations, and reimbursement processes. Depending on which variable is assessed, the impact on service availability can be hard to measure.

As shown in Exhibit 7, MHDDAD currently oversees the mental health services of a smaller and more transitory C&A population compared to 2004. As a result, state oversight and delivery of C&A mental health services have become fragmented. However, the Division has improved access by facilitating single-point entry into the system. We found that the array of mental health services available to children and adolescents has changed during this period, and the Division has increased choice among providers by significantly increasing the number of provider contracts. These variable indicators regarding the availability of mental health services for children and adolescents are discussed further below:

- **Population served** – The Division is currently responsible for ensuring mental health care for less than half of the youth eligible for public services. In 2004 most youth in the public system were overseen by the Division except for those in the care of DFCS or DJJ. In 2009, although MHDDAD now provides planning and funding for DFCS-custody youth with mental health needs, it is not involved in the services provided to approximately 64,000⁸ youth estimated to have mental health needs that are enrolled in CMOs through the Department of Community Health. As other studies have noted, this segregation of responsibilities results in a fragmented system of care in which no single state entity provides oversight for child and adolescent mental health services.
- **System entry** – Entry into the system appears to have improved with the creation of a single point of access. Previously, access to the system was through 25 CSBs or through local referrals and hotlines, with a few regional “single points of entry”. Since 2007, the Division has contracted with Behavioral Health Link to create a statewide 24/7 hotline for mental health services. The system, called Georgia Crisis and Access Line (GCAL), has won awards and accolades from national professional organizations of behavioral health practitioners and state government managers. A November 2008 report from the American Psychological Association (APA) noted that besides saving an annual \$1.2 million in state funds over the previous 25-point network, GCAL “saved over \$34.5 million in costs in 2 years by diverting callers to community-based services rather than having them inappropriately use ERs and state hospitals.” The report also notes that GCAL has increased accessibility, improved service quality, and improved

⁸ This is an estimate based on the 800,000+ youth enrolled in Georgia Families who are eligible for CMO services through Medicaid or PeachCare for Kids™. DCH was unable to provide data on the actual number of children and adolescents receiving mental health services from CMOs.

accountability. (We did not independently verify the benefits noted by the APA.)

Exhibit 7		
C&A Community Mental Health Services Comparison: FY 2004 vs. 2009		
2004	Component	2009
MHDDAD oversees approximately 36,000 C&A requiring mental health services, just over a third of which (approximately 11,000) are enrolled in Medicaid. These figures do not include youth in DFCS or DJJ custody.	Population Served	MHDDAD serves approximately 25,000 C&A, of which about 10,000 are uninsured and 4,000 are youth in DFCS custody. The rest are Medicaid eligible C&A, including those transitioning to CMOs. Does not include youth in DJJ custody, or those Medicaid-eligible youth served by DCH.
Local referrals and hotlines, some regional "single points of entry"	System Entry	Award-winning statewide access crisis and referral system.
MHDDAD offers a fairly wide range of services, including Day Treatment programs.	Services Provided	Overall, MHDDAD offers less comprehensive services, but menu adjusted frequently. (See Appendix E for comparison.)
A system of 25 Community Service Boards provide 96% of MH services. Services overseen by a regional system of seven MHDDAD offices with dozens of staff members. Balance of services provided by a small number of private providers under contract.	Service Providers	CSBs still provide services, but an additional 123 providers are contracted to provide C&A MH. Services overseen by state-level staff and five regional offices with smaller staff.
Most community services provided in offices or clinics run by Community Service Boards.	Service Locations	More providers under contract, but impact on geographical access undetermined. More services, such as Intensive Family Intervention and Community Services Individual, being delivered in clients' homes, in schools, and other local venues. Fewer clinics operated by CSBs.
Source: 2004 DOAA Audit, Program Documents and Staff Interviews		

- Services provided** – The Division appears to provide slightly less comprehensive services than in 2004, based on a comparison of service listings and descriptions in the MHDDAD provider manuals for these two fiscal years. As demonstrated in **Appendix E**, a number of services offered in 2004 are no longer available or are offered in a diluted form. MHDDAD staff said that changes to the service menu are the result of either removing underused or improperly implemented services, eliminating “bundled” services at the direction of the Center for Medicare and Medicaid Services (CMS), or improving services. They added that, in some cases, the mental health services previously provided through a bundled service could still be offered, if the provider billed separately for the each healthcare service provided.

In addition to our analysis of the provider manuals, our interviews and surveys of CSBs indicated that less comprehensive services are being provided. In our survey, 13 of 19 (68%) reported a decrease in the variety of services offered over the last five years. MHDDAD staff acknowledge that this may be true, because under Grant-in-Aid funding (as was the case in 2004), providers had more freedom to offer a mix of services.

The providers are the entities that ultimately decide what services they can deliver to children and adolescents; therefore, MHDDAD officials may assert that it is possible to provide certain services even when providers will not offer the services. CSBs repeatedly pointed to previously bundled services as those that had been eliminated. We were unable to determine if the unbundled services could be “re-created” through billing for multiple types of services provided, but if the providers do not understand the billing methods for obtaining the necessary funding or do not believe that the funding will be adequate, the service is not likely to be provided.

It should be noted that MHDDAD officials also indicated that the last five years have seen a decrease in the utilization of hospital beds and the increased provision of crisis intervention services for child and adolescents.

- **Provider population** – The Division contracts with significantly more providers than five years ago. In 2004, most services were provided by 25 CSBs, each of which exclusively served its own group of counties. Although the CSBs each are still required to serve specific counties, they are now allowed to expand services to youth from any county. More significantly, the Division contracted with a number of new providers in 2008 and 2009. The expanded provider pool was intended to create “greater consumer choice for services and as a result competition between child and adolescent behavioral health service providers for the state dollar.”

We documented CAMH services provided by 123 non-CSB entities in 2008. This expansion of provider choice seems greatest in metropolitan counties such as Fulton and DeKalb (two of the ten counties served by more than 50 providers). At the other end of the spectrum, youth in 31 counties received services from no more than five providers, which were generally other CSBs.

- **Service locations** – It could not be determined that an increased number of providers has improved access to care in terms of receiving services closer to home (geographical access), because MHDDAD does not track the actual locations in which mental health encounters occur. Contract applications require each provider to document the street address it intends to provide services. However, the Division has no process to ensure this coverage exists. Our review of 2008 encounter data indicates that many FFS providers (33 of 127) served significantly fewer locations than stated in their contracts. Interviews and surveys of CSB providers also indicate that because of competition and other causes of decreased funding, they have reduced their number of service delivery sites. Twelve of 19 CSBs surveyed (63%) noted that they had reduced the number of service locations in the past five years.

While we were unable to quantify the extent, according to DHR there has reportedly been an increase in the type of services that are delivered outside of a clinical setting. CSI and IFI are services that are often delivered in homes, schools, and other non-clinical settings, and these services have become more common in recent years.

Division administrators indicate the intention to improve the availability of community-based mental health services to children and adolescents. Its annual

report to federal block grant administrators noted, “Increasing access to services has been a major thrust of the DMHDDAD and its Regional Offices.” Overall, its success has been mixed. In order to ensure improved availability of service, it will likely be necessary to provide more comprehensive services in the community and continue to expand the locations at which services are provided. In addition, the state must determine how it can ensure that children and adolescents are receiving necessary services when MHDDAD has influence over the delivery system for only a portion of the population that the state is serving.

DHR Response: In its written response, DHR acknowledged that “a comparison of numbers served in FY2004 and FY2009 is complicated by changes in the service population.” However, it added that its analysis indicates that the transition to a FFS system did not decrease the number of state-funded children and adolescents served and that trends indicate that more youth are served now than under the grant-in-aid system.

DHR also wanted to emphasize the “dynamics that have led to the changes described in this finding.” It identified three major drivers related to system change:

- December 2006 Medicaid audit – CMS required that changes be applied to all reimbursable mental health services, resulting in the “unbundling” of services such as Child and Adolescent Day Treatment, which changed from one billing code to five. “This move by CMS was to achieve more discrete accountability at the service delivery level but is construed in this audit as ‘Service No Longer Offered,’ which connotes a loss of services to youth. In fact, services are now more appropriately structured to achieve accountability and therefore [are] of more value to the consumers-at-large.”
- February 2004 [and January 2005] Department of Audits and Accounts, Phase I and II Study of the Community Service Board Delivery System – The reports included the following citations that have led to system changes:
 - Insufficient and unreliable data regarding services provided by its contractors;
 - Inadequate controls on services provided and funds expended; and
 - Lack of correlation between grant-in-aid funding provided and the relative level of population estimated to be in need.

The result of these findings was the migration to a FFS system for child and adolescent mental health, which has provided improved encounter reporting, improved accounting for services and expenditures, and improved accountability for provider funding.

- July 2005 Governor’s Commission for a New Georgia – The Commission “directed several administrative changes which were put into place to achieve greater accountability.” These items included establishing a FFS system and developing an open and competitive environment. “In this 2009 DOAA audit, the CSBs were interviewed and cited that they are providing less service to the [C&A population] in 2009 as opposed to 2004. As there are greater than 100 additional providers added to the system since that time, their response as a collective provider network is not an indicator of failure nor should be seen as ‘less conclusive.’ Services are simply being provided by a greater diversity of provider types.

“In summary, the MHDDAD contends that these are monumental shifts in accountability which provide us many more tools in assuring that funds are provided to the right individuals in the right way and, therefore, should be seen globally as improvements to the MHDDAD service system.”

Department of Audits’ Response: DHR’s response pointed to system improvements and increased accountability that are largely the result of the adoption of a FFS system. However, the finding was written in response to a specific question about the availability of services. A broader discussion of FFS, including its impact on accountability will be included in a report to be released in February 2009.

Regarding the Commission for a New Georgia’s directive for a more open and competitive environment, the audit team is aware (and noted in the finding) that there are more than 100 additional providers available to the C&A population in 2009. However, our interviews of CSB personnel were intended to supplement our analysis of the change in *types of services* provided since 2004, not the *volume of service* provided by the CSBs. We would expect the volume of services provided by CSBs to decrease as a result of the addition of new providers. However, we did not believe that providers that have only been under contract for 1-3 years could provide significant insight into the changes in the types of services offered between the period of 2004 and 2009.

Utilization of Funds Appropriated for C&A Mental Health

The Child and Adolescent Mental Health Program’s reported expenditures do not accurately reflect costs incurred by DHR for the child and adolescent mental health population. Therefore, reported fund balances do not accurately depict the result of financial activities related to child and adolescent mental health.

The CAMH Program reported a fund balance of \$1.8 million in fiscal year 2007 and \$3.1 million in fiscal year 2008, with state fund portions of \$1.7 million and \$2.9 million, respectively. However, because of internal control deficiencies related to posting expenditures to the correct program, we are unable to confirm that these fund balances are the result of an accurate allocation of financial activities related to child and adolescent mental health. Further, the degree of error is unknown.

Previous audit work conducted by the Department of Audits and Accounts State Government Division found that fiscal year 2007 expenditures reported at the program level (by fund source) were not supported with adequate financial records and should not be used to inform management’s decision-making.⁹ For fiscal year 2008, the result of the review is the same. Because of the lack of adequate controls over the posting of revenue and expenditures, one cannot presume that the surplus and deficits at the program and fund source levels are an accurate reflection of

⁹ As noted in the Fiscal Year 2007 Budgetary Compliance Report, multiple state agencies (including DHR) were unable to demonstrate budgetary compliance at the program level for revenues and expenditures by funding source. For example, 61% of appropriated budget units tested reported they had overspent their actual revenues received by approximately \$4.6 billion in fiscal year 2007.

financial activities associated with CAMH's purpose. Though we did not conduct work to evaluate the full magnitude of errors in the program's reported expenditures, the following are examples of problems identified during our review:

- CAMH paid only \$6.2 million to cover the state's costs of youth on Medicaid, despite knowledge that the actual costs to DHR are higher. Since the current program budgeting structure was adopted in DHR, the state share of Medicaid costs for mental health and addictive disease services for both youths and adults have been posted in the Adult Mental Health Program. However, in fiscal year 2008, CAMH paid \$6.2 million to DCH for these services. According to DHR officials, this was the estimated increase in invoiced costs as a result of CAMH becoming the new provider for DFCS-custody youth.¹⁰ The \$6.2 million was not intended to capture all Medicaid costs for the child and adolescent population.
- CAMH paid \$2.1 million in expenditures initially posted to the Direct Care and Support Services Program (DCSS). According to DHR personnel, expenditures were expected to exceed the DCSS budget and incorrect posting of expenditures to the DCSS Program was a partial cause. In an attempt to balance the budget, DHR used one of the state hospital's cost accounting tools to re-rate (or re-allocate) DCSS expenditures to other MHDDAD programs, instead of addressing those incorrectly posted expenditures. We found that documentation did not support the re-rate of \$2.1 million to CAMH. More importantly, the General Assembly provides an appropriation that is intended to fund (and serve as a budgetary control for) DCSS program services.
- CAMH had APS contract expenditures of \$8.3 million (\$7.4 million for fiscal year 2008 contract and \$900,000 for fiscal year 2009 contract) related to claims and data processing, auditing, and training during fiscal year 2008. APS activities serve six MHDDAD population groups – adult and C&A mental health, adult and C&A addictive diseases, and adult and C&A developmentally disabled. Agency officials have stated that the FFS policy (used by CAMH) requires significantly more work to be performed by APS and stated that CAMH was paying approximately one-half of fiscal year 2008 contract costs. However, we found that CAMH covered nearly 76% of contract expenditures (\$7.4 million of the \$9.8 million contract in 2008). As noted in the finding on page 37, we determined that DHR lacks adequate documentation to justify the attribution of the costs to CAMH.

Despite the deficiencies with the financial data, **Exhibit 8** provides (by fund source) the fiscal years 2007 and 2008 amended appropriations for the CAMH program as well as revenue, reported expenditures, and fund balance for the last two fiscal years.

¹⁰ Prior to fiscal year 2008, DFCS had paid the cost of the mental health care for this population. In 2008, CAMH became responsible for this population and received funding to purchase services.

Exhibit 8				
CAMH Program Fund Balances by Fund Source, FY07 and FY08				
Fund Source	2007			
	Final Budget	Revenue	Expenditures	Balance
State Funds	\$50,491,804	\$50,491,804	\$48,819,329	\$1,672,475
Federal Funds	\$15,861,459	\$13,354,808	\$13,354,808	\$0
Other Funds	\$1,554,736	\$1,480,613	\$1,397,531	\$83,083
Total	\$67,907,999	\$65,327,225	\$63,571,668	\$1,755,558
2008				
State Funds	\$77,061,013	\$77,061,013	\$74,198,254	\$2,862,759
Federal Funds	\$9,110,651	\$8,687,149	\$8,105,015	\$582,134
Other Funds	\$1,950,592	\$1,315,462	\$1,631,011	\$(315,550)
Total	\$88,122,256	\$87,063,624	\$83,934,281	\$3,129,343
Source: Final BudgetNet amendment, PeopleSoft accounting records, State Accounting Office records				

Transition to Fee-for-Service, Year-End Fund Balances, and Reserve Requests

Due to the Program's transition to a FFS reimbursement method in the fourth quarter of fiscal year 2007, DHR decided to reserve funds beyond the end of the fiscal year to pay for direct services that have been delivered but have not yet been billed. Unlike prior periods, when a series of 12 monthly GIA payments were distributed to local providers in a fiscal year, payment under the FFS method requires providers to submit claims to receive payment for delivered services. DHR policy grants providers 180 days to submit claims. As such, with the transition to FFS comes a need to establish a reserve in funds at the end of the fiscal year to accommodate the anticipated claims that will come in over the next six months. CAMH's year-end reserve request, along with other DHR program reserve requests, is subject to review by the DOAA State Government Division.

Below are the details of the Program's fund balances and reserve requests for the last two fiscal years.

- **Fiscal Year 2007** – MHDDAD requested that \$834,200 of the Program's reported year-end \$1.7 million state fund balance be reserved for unpaid claims. After an analysis of claim trends, DOAA approved \$333,087. The remaining fund balance was added to the agency surplus.¹¹
- **Fiscal Year 2008** – The Program's reported year-end fund balance of state funds was \$5.2 million. From this, MHDDAD had originally requested that \$5,194,951 be reserved for unpaid claims for FFS and Psychiatric Residential Treatment Facility (PRTF) services. However, \$2.3 million of the reserve request for the PRTF services was added to CAMH expenditures as a post-closing entry, reducing the Program's year-end fund balance to \$2.9 million in state funds. As of December 15, 2008 the DOAA State Government Division anticipated approving \$1.2 million for FFS claims and \$600,000 for PRTF services. The remaining fund balance will be applied to the agency surplus.

¹¹ Unspent funds at the program level would have contributed to the agency lapse of \$10.8 million.

DHR Response: DHR officials disagree with DOAA's conclusion that "CAMH's reported expenditures do not accurately reflect costs incurred by DHR for the child and adolescent mental health population." Additionally, DHR officials do not agree with DOAA's conclusion that "internal control deficiencies related to posting expenditures to the correct program" are present in the examples cited in this finding or that there is a lack of adequate controls over the posting of revenue and expenditures. DHR officials assert that the basis of DOAA's finding is a "lack of documentation" and assert that "the adequacy of documentation is a subjective measure, at best, which could also be caused by a less than complete understanding of the adjustment."

DHR offered a response to each of the material expenditures cited in this finding.

- Regarding the \$6.2 million expenditure, DHR officials noted that although "not all CAMH Medicaid expenditures" are reported in the CAMH Program expenditure reports, the Division "does not agree that this is an internal control weakness." DHR contends that funding to pay CAMH Medicaid expenditures has traditionally been included in the Adult MH budget; therefore, it was correct for the Adult MH Program to cover these child and adolescent costs and this is not an issue of a lack of internal controls.
- DHR officials state that the 're-rate' to move \$2.1 million in expenditures from the Direct Care & Support Services (DCSS) Program to the CAMH Program was approved in accordance with agency practice and in compliance with Policy 4-8-1, Journal Entry Documentation issued by OPB and SAO. Officials assert that compliance with this policy constitutes the internal control of the adjustment. DHR explained that expenditures are "sometimes inappropriately charged" to the Direct Care & Support Services (DCSS) program, and "when this occurs, adjusting journal entries (re-rates) are required." DHR officials indicated that "guidance regarding the types of expenditures that should appropriately be charged to DCSS and those which should be appropriately charged to the program will be provided to the hospitals" to further strengthen budgetary controls.
- DHR officials assert that CAMH did not pay for 76% of the APS contract costs in fiscal year 2008. DHR believes that CAMH paid \$7,084,233 of \$11,342,687 (62%). DHR officials do not believe that increased expenditures in the CAMH Program for APS costs "supports the contention that there was a lack of internal controls and believe there is adequate documentation to support the adjustment." DHR officials note that much of the increased CAMH Program costs were "due to one-time funds spent for system changes which emerged as critical after the implementation of the Fee-for-Service initiative. Because the bulk of these system changes were to streamline the fee-for-service authorization and payment process, most of the one-time dollars were charged to the CAMH program."

Department of Audits' Response: In order to provide appropriate context for the fiscal year 2007 and fiscal year 2008 financial information, it was necessary to note what DOAA financial auditors have found since the introduction of Program-Based Budgeting. Specifically, program-level revenue and expenditures are not supported by adequate documentation and should not be used by decision-makers. And, during this review, we found transactions that support the fact that CAMH program expenditures do not accurately reflect all costs related to the program's purpose, which is to "provide evaluation, treatment, crisis stabilization, and residential services to children and adolescents with mental illness." DHR's own response

acknowledges that the Adult MH Program pays a portion of C&A costs. Therefore, CAMH Program expenditures do not accurately capture the expenditures associated with the C&A population.

Regarding the DCSS re-rate, DHR's response implies that the re-rate was "correcting" inappropriate charges to the DCSS Program. However, the re-rate was not based on a review of the charges made to the DCSS Program, but, as explained in the finding, based on cost report related to one of the two hospitals that served the C&A population. In addition, the actual transaction amount did not equal the amount resulting from the cost report.

Finally, DHR is correct in stating that total fiscal year 2008 costs for the APS contract were \$11.3 million. That amount includes an additional \$1.5 million in fiscal year 2008 funds that were applied to the fiscal year 2009 contract. In calculating the portion of the contract covered by CAMH, the audit team chose to include only the fiscal year 2008 contract amount (\$9.8 million) and CAMH expenditures toward that contract. Had we included the additional \$1.5 million and the CAMH expenditures for that contract, the percentage of fiscal year 2008 contract funds from the CAMH Program would have still been more than 70%. While DHR states that the CAMH Program paid only \$7,084,233 for the APS contract during fiscal year 2008, the official accounting records support our higher figure of \$8,344,052.

Approximately 70% of MHDDAD's spending on community-based services was directed towards providing core and specialty services and/or to address agency-identified critical needs.

Our review found that MHDDAD spent \$70 million on community-based services for children and adolescents in fiscal year 2008. Of that amount, approximately \$43.8 million (63%) was for core and specialty services and an additional \$4 million (6%) on expenditures for other services that the Division had described as addressing a critical need. While some services addressed multiple critical needs, expenditures are counted only once.

It should be noted that our review was limited to determining if existing funds were spent on critical need areas as defined by MHDDAD. We did not assess the sufficiency of funding for the services identified as associated with a need. A comprehensive needs assessment would be necessary to determine if resources are adequate for identified services or even if the services provided are the correct ones.

Exhibit 9 presents MHDDAD expenditures and denotes where spending is directed to a Division-identified critical need. The expenditures are divided into three broad areas: Administrative, Core and Specialty Services, and Other Contracted Services or Activities. Core and Specialty Services are considered DHR's basic services that are paid to contracted providers through either fee-for-service or grant-in-aid. Other Contracted Services or Activities include various other contracted services, including some direct services. These items are generally more discretionary in nature and purchases may be initiated later in the year.

**Exhibit 9
CAMH Community-Based Expenditures Associated with Identified Priorities**

Expenditure/Service	Agency-Identified Priorities					Amount	%					
	Core/Specialty Services	Systems of Care	Crisis Services	Youth in Child Welfare	Family-Oriented Treatment							
Administrative Costs⁽¹⁾						\$4,945,623	7%					
Personal Services						4,508,454	6%					
Regular Operating						320,936	0%					
Other Operating						116,233	0%					
Core and Specialty Services						\$43,768,013	63%					
State Match to DCH for PRTF Services	X					9,759,830	14%					
FFS Payments ⁽²⁾	X					9,029,158	13%					
Community Support Individual	X				X	1,610,101						
Crisis Intervention	X		X			38,583						
Intensive Family Intervention	X		X		X	3,337,476						
Family Outpatient Services	X				X	431,019						
Other Community Outpatient Services	X					3,502,795						
Supplemental FFS Payments Residential Services	X					8,872,441	13%					
State Match to DCH for MH Outpatient Services	X					7,524,488	11%					
Crisis Stabilization Program	X		X			6,161,204	9%					
Community-Based Inpatient	X		X			2,387,892	3%					
Other Contracted Services or Activities						\$21,581,082	31%					
Data Collection and Maintenance (APS)						8,344,032	12%					
Consumer Supports (TPA)						5,060,833	7%					
Mobile Crisis Capacity			X			1,677,324	2%					
KidsNet Pilot Sites (GRN)		X				1,200,000	2%					
Summer Recreation Program						1,197,000	2%					
Other ⁽⁴⁾						1,110,295	2%					
PRTF Transition Services						1,000,000	1%					
Georgia Crisis and Access Line (GCAL)						989,461	1%					
Training ⁽³⁾		X				899,549	1%					
Capacity-building and Infrastructure Development (CASIG Grant)		X				102,568	0%					
Rerate from other program into C&A MH						-317,476	0%					
Total Expenditures						\$69,977,242	100%					
Expenditures towards services and/or priorities⁽⁵⁾						\$43,768,013	\$2,202,117	\$7,474,275	N/A⁽⁶⁾	\$5,378,595	\$47,647,454	68%

(1) Administrative costs include an additional \$101,490 in CASIG grant fund expenditures.
 (2) FFS Payment amount includes the total FFS payments made by the Program during FY08. The amounts for the five subcategories are based on payments for dates of service in FY08, not payments made in FY08. For this reason, the FFS Payments figure is not a total of the five subcategories.
 (3) Includes \$101,714 in CASIG grant fund expenditures.
 (4) The category of other expenditures is comprised of smaller contracts and expenses that we did not consider significant to this analysis.
 (5) Total does not include funds transferred from DFCS for the LOC Transition as these funds were to pay for services that are captured in other categories.
 (6) MHDDAD received a net transfer of \$25.5 million from DFCS in FY08 in order to serve DFCS clients.
Source: People Soft Reports, Unified Accounting System Records, APS Encounter Data, and Division Staff

We used APS encounter data to obtain expenditure information for those services offered to the uninsured population on a FFS basis. For those services not offered on a FFS basis, such as Structured Residential Supports and Crisis Stabilization Program, we report total amounts captured within DHR's accounting system under the related budget code. Other expenditures were obtained from end-of-year

PeopleSoft reports. Because spending for a service or contract may address more than one priority, total expenditures towards priorities will not equate to the sum of expenditures for each priority. Explanations of expenditures relating to each of the critical needs as identified by the Division are as follows:

- **Provide core and specialty services** – MHDDAD spent \$43.8 million on core and specialty services for the C&A population in fiscal year 2008. Core services include fundamental psychiatric treatments such as Individual, Group, and Family Counseling, Community Support Individual (CSI) and Crisis Intervention. Specialty services include Intensive Family Intervention (IFI) and Crisis Stabilization in addition to Structured Residential Services. Over 23,000 youth utilized a core or specialty service in fiscal year 2008.
- **Provide services to youth in the child welfare system** – In fiscal year 2008, the Division received a transfer of \$25.5 million from DFCS in order to provide mental health services to the DFCS population. Funds were directed towards transitioning providers from DFCS's former Levels of Care system into MHDDAD and paying for services provided to DFCS C&A, including the state share of Medicaid costs. These youth are eligible for core and specialty services, as well as some of the other contracted services.
- **Provide crisis service** – MHDDAD spent approximately \$7.5 million to increase the capacity of crisis services for the C&A mental health population. Crisis services include Crisis Intervention, Mobile Crisis Response, IFI, Crisis Stabilization Program, and Community-Based Inpatient. The majority of these funds are for providing IFI services. While expenditures for Mobile Crisis Response Services are included as Crisis Intervention, additional funds were directed to increase capacity of these services in fiscal year 2008.
- **Increase family-oriented treatment practices** – As noted on page 15, MHDDAD provides treatments that can involve family members, such as CSI, IFI, and Family Outpatient Services. The cost of these efforts for the uninsured population totaled approximately \$5.4 million in fiscal year 2008.
- **Develop and implement a System of Care approach** – The Division spent approximately \$2.2 million on this approach, which is intended to better coordinate services to youth. A grant of \$1.2 million was provided to the Gwinnett-Rockdale-Newton CSB for the KidsNet initiative. The funds will ultimately be used to provide “wraparound” services in Fulton County, Northwest Georgia, and Savannah. MHDDAD also spent \$900,000 for training on the systems of care approach and \$103,000 for the development of capacity and infrastructure to serve youth who have serious emotional disturbances, substance abuse and co-occurring disorders and their families. These funds are not used to provide services. The final expenditure was part of \$749,312 federal State Infrastructure Grant awarded in fiscal year 2007.

Just over \$22 million of MHDDAD's expenditures for community-based services were for items not associated with an agency-identified critical need. We did not assess whether each of the remaining services or the amount expended for them was appropriate. We did, however, obtain a description of the services and expenditures,

as well as the agency's stated purpose in procuring them. Some of the expenditures occurred in June 2008 and are discussed in more detail in the finding on page 32. Details of the activities not associated with a critical need are as follows:

- **Administrative costs** – CAMH spent approximately \$5 million on administrative costs such as personal services and regular operating costs.
- **APS contract** – The CAMH Program had expenditures of more than \$8.3 million for a contract with APS to provide data collection and maintenance services. While APS does not provide a core or specialty service, the company processes claims and makes payments for services rendered under the fee-for-service system, collects encounter data from all MHDDAD services, and audits the provision of services by providers. Due to the large influx of new providers into the system, Division officials believe that the contract with APS is necessary to ensure providers understand the services and are accountable to MHDDAD. It should be noted that, in 2008, APS collected information and audited on behalf of all population groups served by MHDDAD – adult and C&A mental health, adult and C&A addictive diseases, and adult and C&A developmentally disabled.
- **Consumer support services** – More than \$5 million of CAMH funds were expended on consumer support services, which are payments to families who have a youth receiving behavioral health services for services such as respite care, parenting instruction, and housing needs (e.g., security deposits, utilities). It should be noted that these services are not provided by clinicians and are not traditional mental health services but are intended to enable the youth to achieve benefits from the time a youth spends in traditional services.
- **Summer recreation programs** – Summer programs are jointly funded by MHDDAD and DFCS to provide summer recreational and therapeutic services for youth who have serious emotional disturbances and co-occurring disorders. The \$1.2 million spent on these services paid for activities such as overnight camps, day camps, field trips, and scout activities. According to the Division, youth served through this program may not have otherwise been able to participate in summer programs due to financial constraints or because of their behavior. These services are intended to keep children involved in productive and skill-building activities thereby reducing the likelihood of juvenile delinquency or the need for hospitalization or other intensive services.
- **Psychiatric residential treatment facility transition services** – In fiscal year 2008, MHDDAD signed a \$1 million contract with an Atlanta provider to provide transition and support services to foster children in DFCS custody who are exiting psychiatric facilities. These services are intended to ensure a stable transition back to their families and community. Only Medicaid-eligible youth are served.
- **Georgia crisis and access line** – A 24-hour accessible crisis and access line serves as a single point of entry into the mental health system and connects individuals with services throughout the state through referrals and

appointment scheduling. These services may reduce barriers to getting help, resulting in less need for intensive services and reduced admissions to psychiatric inpatient facilities. Division officials believe that without this function, families have no centralized resource to link them to services and state funded providers. CAMH spent just under \$1 million on this service in fiscal year 2008.

DHR Response: DHR stated that “MHDDAD expenditures not associated with a critical need in the report are critical to the functioning of a CAMH service delivery system.” “Expenditures for the APS contract ensures that services provided are appropriate to meet the needs of the child and family and providers are held to a set of service delivery standards. Consumer support services such as respite care and summer recreation programs are critical supports to keep youth in their communities. The Georgia Crisis and Access Line (GCAL) is essential to helping youth and their families without knowledge of the mental health system locate and access publicly funded services. In addition, GCAL is available to juvenile court judges, schools, and other child serving entities that often seek behavioral health services for children and adolescents.” In addition, administrative costs constituted only 7 percent of total program expenditures.

Nearly 80% of the funds available on June 1, 2008 were either expended on services that program personnel associated with a critical need, reserved for a critical need, or transferred from the CAMH program.

Entering the final month of fiscal year 2008, approximately 40% of the CAMH program’s appropriated state funds of about \$80 million¹² remained unspent. Because such a large percentage of the Program’s annual operating budget was not expended until the last month in the fiscal year, we were asked to provide a verified list explaining how CAMH program funds were allocated during June 2008 and through the close of the fiscal year.

List of Late-Year Expenditures

Exhibit 10 shows all CAMH program expenditures (including transfers and reserves) from June 2008 through the end of the fiscal year. 53.5% of the late-year depletion of CAMH funds was expended to address a critical need, while 5.1% was reserved to pay fee-for-service and PRTF claims (also critical needs) not yet billed. 20.8% was transferred out of the CAMH program. Taken together, these expenditures accounted for \$28.6 million (79%) of the total year-end financial activity.

Of the remaining \$7.4 million in late-year expenditures, \$2.4 million was spent to amend and renew the APS contract, \$2.1 million was used to pay for Direct Care and Support Services provided by the Central State Hospital, and \$1.2 million was used to provide summer recreation programs.

¹² While the previous finding only included expenditures for community-based services, this finding includes all CAMH Program expenditures for June 2008 through the end of the fiscal year.

Exhibit 10		
End-of-Year CAMH Program Financial Activity, FY 2008¹		
Financial Activity	Amount	%
Expenditure/Service	\$26,664,177	74.1%
Administrative Costs	\$3,776,673	10.5%
Direct Care and Support Services (Re-rate)	\$2,108,299	5.9%
Personal Services	\$1,436,129	4.0%
Other Administrative (Regular Operating, Telecom, etc.)	\$232,245	0.6%
Core and Specialty Services*	\$17,176,798	47.7%
Medicaid Rehab Option (DCH)*	\$6,161,204	17.1%
FFS & GIA Payments*	\$5,723,969	15.9%
Private Residential Treatment Facilities (DCH)*	\$5,291,625	14.7%
Other Contracted Services or Activities	\$5,710,706	15.8%
APS Contract Amendment	\$2,400,000	6.7%
KidsNet Pilot Sites*	\$1,200,000	3.3%
Summer Recreation Program	\$1,197,000	3.3%
Training*	\$899,549	2.5%
Other Activities	\$14,157	0.0%
Transfer of Funds²	\$7,500,000	20.8%
To Child Welfare Program	\$5,200,000	14.4%
To Adoption Services Program	\$1,400,000	3.9%
To Administration Program	\$900,000	2.5%
Approved Reserve Request	\$1,829,109	5.1%
FFS Lag*	\$1,152,558	3.2%
PRTF Lag*	\$617,551	1.7%
Other	\$59,000	0.2%
Total Funding for Expenditures/Transfers/Reserves	\$35,993,286	100.0%
Remaining Balance	\$1,034,196	
1. Includes transactions up to end of period and post-closing entries. 2. Transfers approved by the Fiscal Affairs Committee. * Service/Expenditure associated with an agency-identified critical need Source: PeopleSoft Report (as of 9/08), Unified Accounting System Records, and APS Encounter Data		

Serving Critical Needs/Performance Measurement

In addition to providing a verified list of expenditures, we were asked to determine if funds were expended on the most critical needs in the child and adolescent mental health system and if the Program evaluates the efficiency and effectiveness of the expenditures in meeting C&A critical needs. Our analysis focused on discretionary expenditures (i.e., those that, as of June 1, 2008, the Program was not required to incur) instead of non-discretionary items, such as personal services. Our ability to address this objective was limited because child and adolescent needs had not been previously prioritized by the Program. As a result, we relied upon the critical needs as defined by CAMH personnel. Below is a description of all the year-end expenditures with additional analysis as appropriate.

Administrative Costs

We considered personal services and other administrative expenses to be non-discretionary in nature. However, we did review the transfer into CAMH of expenditures that were originally charged to DCSS.

- \$2.1 million in regular operating costs transferred to CAMH via a re-rate

from the Direct Care and Support Services (DCSS) Program. According to MHDDAD personnel, these funds were used to pay for Central State Hospital services provided to children and adolescents with mental health needs. MHDDAD personnel determined near the end of the year that funds available in the DCSS program were insufficient to cover expenses. In response, a cost allocation formula was used to attribute DCSS costs to the various populations served and expenditures were transferred into programs such as CAMH to cover the DCSS program overrun. Although the Program did provide us with a cost-allocation analysis showing that the C&A population incurs costs related to the provision of direct care and support services, this type of cross-program transfer compromises budgetary controls and impacts the accuracy of program-level expenditure reports.

Core and Specialty Services

These services are associated with a critical need, as defined by MHDDAD.

- **\$6.2 million** to the Department of Community Health (DCH) to pay a portion of the state share of costs for community-based Medicaid services. As noted on page 25, the Adult Mental Health Program has traditionally paid the entire DCH invoice amount for mental health and addictive disease services, including those for children and adolescents. In fiscal year 2008, these costs were estimated to increase \$6.2 million because CAMH was now the provider of mental health services for youth in DFCS custody. While the \$6.2 million represented an estimated annual increase, the entire amount was posted in June.
- **\$5.7 million** to service providers for core and specialty services under fee-for-service and grant-in-aid. For most of the year, CAMH expenditures posted in a month reflect invoices from the prior month. June expenditures include both May and June invoices.
- **\$5.3 million** to psychiatric residential treatment facilities for services. This amount includes the third quarter invoice for \$3.0 million, as well as \$2.3 million for fourth quarter billings.

Other Contracted Services and Activities

Expenditures within the Other Contracted Services and Activities category were deemed to be discretionary in nature. The \$1.2 million contract with Gwinnett-Rockdale-Newton CSB and the \$900,000 contract for training were associated with agency-identified critical needs.

- **\$2.4 million** to amend a contract with APS to expand data collection and auditing capacity for FFS and Medicaid populations and to extend the contract. While the contract was not directly associated with a critical need, MHDDAD officials stated that the APS services are necessary to properly implement the FFS policy.

The June APS expenditure included a \$1.5 million amendment put in place to correct data collection errors in provider authorizations that hampered the Program's ability to collect useful management information. The amendment deliverables included the hiring of 11 additional auditors/analysts, significant modifications to information systems to improve service data collection, and improvements to the APS website used by DHR. MHDDAD also used

\$900,000 of fiscal year 2008 funds to renew the APS contract for 13-month period beginning in June 2008. We did not evaluate the efficiency of APS operations or the economy of the acquired services.

- **\$1.2 million** to the Gwinnett-Rockdale-Newton (GRN) CSB to develop and coordinate local systems of care via the KidsNet program. Associated with the agency-identified critical need, these funds were used to continue these services in GRN counties that were formerly funded with federal money and to expand these services to three additional areas in the state (Northwest Georgia, Savannah, and Fulton County). The Program does receive reports regarding the effectiveness of the intervention in reaching the target population of SED youth and the outcomes attributable to the intervention.
- **\$1.2 million** to 18 CSBs for summer recreation programs that provide services such as summer camps and structured sport and art activities for at-risk C&As and their siblings. These items were not associated with an agency-identified critical need. However, agency officials indicated that researchers have found that summer recreation programs have beneficial effects on at-risk youth by exposing participants to normalized, culturally-valued activities such as day and overnight camps, field trips, and sports. The Program has not evaluated the efficiency of this intervention (e.g., comparison of per unit cost to a benchmark) and has not received any outcome indicators resulting from the intervention.
- **\$900,000** to the University of Georgia's Carl Vinson Institute of Government for provider training and technical assistance for the Local Interagency Planning Teams (LIPT), which support local systems-of-care. This expenditure is associated with a critical need. According to MHDDAD personnel, training needs are determined by management based on the availability of year-end resources, consideration of C&A needs, and the perceived utility based on current services. MHDDAD has contracted with CVIOG to provide similar training for several years and this expenditure is consistent with prior-year expenditures. The Program does not evaluate the efficiency of this service, but does receive evaluations of training provided. We did not evaluate the economy (i.e., reasonableness of price) of the acquired training services.

Transferred Funds

In June 2008, the Fiscal Affairs Committee approved transfers from the CAMH Program. They were:

- **\$6.6 million** to the Division of Family and Children Services (DFCS) for Child and Welfare Services (\$5.2 million) and Adoption Services (\$1.4 million).
- **\$900,000** to the Department of Human Resources' Administration Program for administrative costs in the Department.

Reserves

In addition to posted expenditures, the following reserves were approved by DOAA State Government Division to pay for outstanding encumbrances. These items are core and specialty services, which are an agency-identified critical need.

- **\$1.8 million** to PRTF providers for the remaining portion of fourth quarter billings (\$0.6 million) and FFS providers for the projected lag for service billings (\$1.2 million).¹³

Remaining Balance

CAMH had a remaining balance of just over \$1 million. The balance was primarily a result of a portion of DHR's reserve request not being approved.

DHR Response: DHR officials note that “only \$13.8M of the \$36M total were [for] normal June expenses.” DHR stated that this figure includes annual contract renewals for KidsNet, summer recreation programs & training, as well as reserves—approved by the DOAA—to for pay claims submitted subsequent to the close of the fiscal year. In addition, “\$12.7M of the \$36M represent services delivered earlier in the year but booked in June.” DHR officials attribute this lag in expenditure posting to time required to develop a satisfactory method for projecting accurate Medicaid and Fee-for-Service costs. Finally, “\$9.5M of expenses booked in June” were for transfers out of the CAMH program (\$7.5 million) and one-time expenditures (\$2.0 million).

Inadequate internal controls over re-rates make it possible to circumvent budgetary controls by moving expenditures across programs without adequate justification.

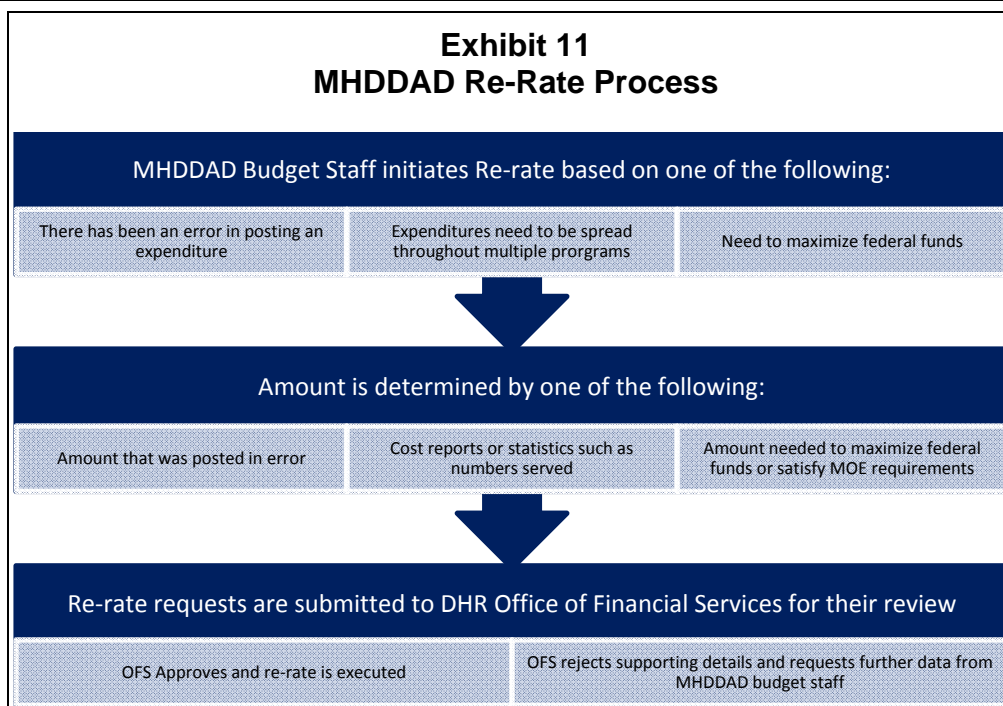
MHDDAD officials define re-rates as manual journal entries made to the general ledger. While such entries are a legitimate and common accounting practice, a review of a sample of four transactions found that three re-rates increased CAMH Program expenditures by \$4.8 million in fiscal year 2008 without adequate supporting documentation to justify the attribution of the expenditures to the Program.

According to Program personnel, a manual journal entry may be initiated by any program personnel charged with reviewing or monitoring expenditures if it is determined that one of the following conditions is met:

1. To correct an expenditure previously posted in error,
2. To accurately allocate expenditures throughout multiple programs, or
3. To maximize the draw-down of federal funds and satisfy Maintenance of Effort (MOE) requirements.

The request to execute manual journal entries is submitted to DHR's Office of Financial Services, which may either approve and execute the manual journal entry, or request further supporting documentation to support the request. **Exhibit II** depicts the manual journal entry process.

¹³ Providers are permitted to bill up to 180 days after service is delivered.



We were asked to evaluate MHDDAD’s process for ensuring that funds allocated to the CAMH program are used to fund child and adolescent mental health services. In order to satisfy this objective, we reviewed all of the fiscal year 2008 manual journal entries. Using a risk-based approach, we identified four entries that accounted for approximately 98% of the expenditures posted to the CAMH program via manual journal entry during the year. These transactions moved previously posted expenditures from another MHDDAD program to the CAMH program, with a net effect of increasing CAMH expenditures by \$8,135,403. Exhibit 12 presents the material manual journal entries that posted expenditures to the CAMH Program in fiscal year 2008.

**Exhibit 12
Fiscal Year 2008 CAMH Program
Material Expenditures Executed via Manual Journal Entries**

Month Posted	#	Reported Reason for Transfer of the Expenditure	Amount
December 2007	1634FMS	To expend to CAMH APS contract costs in proper proportion to actual costs incurred by the various programs served by the vendor.	\$1,259,819
March 2008	2110FMS	To expend to CAMH APS contract costs in proper proportion to actual costs incurred by the various programs served by the vendor.	\$1,478,198
April 2008	2301APS	To allocate PRTF expenses to CAMH which were incorrectly posted to DFCS during the first two quarters of FY08.	\$3,289,087
June 2008	2785FMS	To allocate Direct Care and Support Service (DCSS) expenses to CAMH Program for services provided to C&A patients at Central State Hospital.	\$2,108,299
Total			\$8,135,403
Source: People Soft Accounting and Department of Human Resource Records			

We analyzed each of the expenditures using two criteria. First, we evaluated whether it was appropriate to bill the CAMH program for the activity or service. We also evaluated whether the expended amount correctly reflected costs attributable to CAMH. On this point, we evaluated the methodology used by staff to document the allocation of costs to CAMH when the expenditure was allocated among multiple MHDDAD programs.

We found inadequate documentation to justify the billing of costs to CAMH in the transaction files for three of the four transactions reviewed. Two of the expenditures – \$1.3 million (1634FMS) and \$1.5 million (2110FMS) – previously posted to other MHDDAD programs were related to the APS contract. While APS contract requirements related to CAMH may necessitate the Program paying a higher share of the contract costs than the five other programs served by the contract, the amount of the increased costs attributable to the Program was not supported by documentation provided. We found that MHDDAD lacks a methodology for allocating costs among the six programs. After the two re-rates, CAMH was responsible for \$5.9 million (71%) of the \$8.3 million contract in place at the time.

In June 2008 \$2.1 million in expenditures were posted to the CAMH Program that had previously been posted to the Division's Direct Care and Support Services Program (DCSS). As noted earlier, DHR personnel stated that they expected to exceed the DCSS Program budget in fiscal year 2008, partly because state hospitals were improperly billing the program for services (e.g., payments to private providers) that should have been billed to other programs, such as CAMH.¹⁴ Instead of re-rating these transactions from the accounts of the two hospitals serving the C&A populations, MHDDAD used a cost accounting method to reallocate DCSS costs at one of the state hospitals. However, the amount resulting from the cost accounting spreadsheet does not equal the amount re-rated. We determined that the documentation provided to us does not indicate that the transfer of funds from the CAMH program was justified.

The transaction that occurred in April was reviewed and approved by the DOAA State Government Division as part of its annual review of DHR. The entry was the result of DFCS incorrectly paying two invoices for services that, beginning in fiscal year 2008, were the responsibility of CAMH. The final two invoices for those services were paid by CAMH in June 2008.

DHR Response: DHR officials state that re-rates noted in the report are “adjustments for either corrections of previous erroneous expenditure entries or corrections of accounting estimates of expenditures. In all cases, these adjustments were approved by management levels of MHDDAD and DHR, which acted as two levels of internal control allowing for checks and balances of the process. While the actual entries may have lacked ‘adequate’ documentation, there were supporting documents.”

DHR asserts that “in all cases the adjustments were an attempt to more accurately reflect expenditures in the appropriate budget program.” Despite the fact that these transactions were appropriate, DHR added that “[s]ubsequent to the end of the fiscal year and prior to the audit,

¹⁴ MHDDAD personnel also processed re-rates to cover expenditures charged to DCSS for Adult Nursing, Adult Mental Health, Adult Addictive Diseases, and Adult Developmental Disabilities.

MHDDAD financial management had recognized the need for improvement in the review and approval regarding financial transactions and had already begun a review of its internal processes, including: error adjustments, “re-rates” between programs and funding sources, documentation of adjustments and re-rates, and timely analyses of budget sub-program expenditures. MHDDAD began using the Covey method of performance improvement in fiscal year 2009 to strengthen performance in this area.

“MHDDAD’s overall financial goal is to achieve financial and budgetary accountability and compliance in FY 2009, and an important component of this goal includes an improved identification, documentation, analysis, and approval process for posting necessary “re-rates”. In addition, increased review and analysis of budget and financial performance by sub-program will be performed regularly throughout the fiscal year, with monthly and quarterly budgetary reviews, conducted with both state office and regional management staff. This increased analysis and greater scrutiny will more quickly and easily identify budgetary variances and posting errors, so that corrective action can be taken in a prompt and appropriate manner. These improved procedures will strengthen the internal controls and approval process, resulting in a reduced number of fiscal year-end ‘re-rate’ adjustments.”

Appendix A: Objectives, Scope, and Methodology

This special examination of the Child and Adolescent Mental Health Program within the Department of Human Resources was conducted to satisfy a request submitted by the Senate and House Appropriations Committees on July 21, 2008.

The request had two overall objectives: (1) determine the availability of child and adolescent mental health services and (2) examine the utilization of appropriated for child and adolescent mental health services. (A third objective, to determine the impact of the conversion to Fee-for-Service within CAMH, will be presented in a companion report.)

Objective 1: Availability of Child and Adolescent Mental Health Services

A. How is the Division of Mental Health identifying “needs” for child and adolescent mental health? Is this a best practice measure?

To fulfill this objective, we interviewed Division personnel and reviewed numerous Division planning documents such as its strategic plan and Regional Planning Board annual plans. Because no single document we reviewed provided a list of CAMH needs, we reviewed presentations and meeting minutes from Division and Department leadership teams that may have communicated needs. We also interviewed and surveyed community service boards in order to assess the level of provider input in the needs assessment process. To identify best practice in needs assessment, we searched online for a best practice in assessing children’s mental health needs, but found no single source that prescribed a definitive process. In an effort to determine the Substance Abuse and Mental Health Service Administration’s (SAMHSA) guidelines for conducting needs assessments, we made several unsuccessful attempts to contact the agency. However, we were able to locate a document detailing how to complete a community needs assessment on the SAMHSA website. Using this document, we compiled a proposed list of common elements used when conducting a needs assessment. To validate the use of these common elements as a best practice for assessing need, we located a sample of needs assessments conducted by various agencies at different levels of government and compared them to our compiled elements.

B. Given the current agency identified needs in the State, how well is the state addressing these needs (what is the service penetration rate)?

To fulfill this objective in the absence of clearly communicated Division-identified needs, we asked the Director of Mental Health to identify the Division’s most critical needs for Child and Adolescent Mental Health for us. To determine how well the state addressed these needs we interviewed Division staff, reviewed the Division’s consumer survey information and other reports providing performance measures for Division activities such as performance reports to the DHR Board and Center for Medicare and Medicaid National Outcome Measures reports. We analyzed activity data from the program that captures services provided at the encounter level to determine the numbers served by service where it was relevant to Division priorities. We also interviewed and surveyed CSBs for their input on how well the Division is meeting child and adolescent mental health needs.

To calculate a service penetration rate, we used Census Bureau 2005 estimates¹⁵ for the percentage of uninsured youth in each county under the age of 19 and at or below 200% of poverty level. We then applied these percentages to 2007 census estimates for each county. We estimated the prevalence of severe emotional disturbance (SED) in this population at 8%, based on national studies of SED prevalence. For agency activity, we used encounter data from the Division's contracted claims processor (APS Inc.). The encounters included in the data represent all youth under the age of 18 at time of service, who had a primary diagnosis of CAMH versus addictive disease. The youth's county of residence was used to map service activity, because the APS system does not track where a service is actually provided. We counted unique patients, not numbers of encounters, which varied from 1 to 1000 across individuals.

C. How has mental health service availability for children and adolescents as well as the system of state funded reimbursements for such services changed in the past 5 years? Has service availability declined or increased? Have state funded reimbursements for such services declined or increased?

To determine how service availability has changed in the past five years, we examined multiple factors such as: service provided, providers, provider locations, system entry and population served. We documented services offered according to the Division's Provider Manuals in fiscal years 2004 and 2009 and interviewed Division staff. We analyzed the availability of providers by county using the encounter level data. Where data was unavailable to determine whether service locations had increased, we used interviews and surveys of CSBs to identify their trends per service locations. We compared the Division provider list and the counties they proposed to serve, to that of the encounter level data to determine if providers were serving as many counties as intended. Interviews and surveys with CSBs were used to supplant. We also analyzed the distribution of services provided by county where the information was accessible to do so. We did not provide an analysis of the level of restrictiveness for offered services. We also did not provide an analysis of the intensity of services provided. According to Division staff, the information necessary to perform such an analysis was not available.

A report to be released in February will provide additional detail on CAMH's FFS reimbursement system, which was implemented in April 2007.

D. How does the current prioritization of state funds for services address those needs? Are state funds being directed at the most critical needs?

To determine how the Division prioritizes state funds for services to address critical needs, we relied on PeopleSoft and Division accounting records to capture all fiscal year 2008 expenditures for the Child and Adolescent Mental Health: Community Services subprogram. We compared the expenditures to most critical needs as identified per above. We also analyzed 2008 claims data by service provided to document the amount paid for services to the uninsured population by the MHDDAD.

¹⁵ The 2005 estimates were released in 2008 and represent the most recent data available.

Objective 2: Utilization of Funds Appropriated for Child and Adolescent Mental Health Services

- A. What were the fund balances for appropriations programs that provide child and adolescent mental health services for fiscal years 2007 and 2008 (by fund source)? Please provide an explanation of any funds that were unspent or reserved at the end of each of the fiscal years.**

To satisfy this objective, we limited our review to appropriations made to MHDDAD's Child and Adolescent Mental Health (CAMH) Program for fiscal years 2007 and 2008. To document program fund balances, we analyzed applicable appropriation acts, budget adjustment reports, program accounting records, and the Budgetary Compliance Report and other documents from the State Accounting Office. To identify why funds were unspent or reserved, we interviewed appropriate Program personnel and worked with DOAA State Government Division auditors charged with evaluating the validity of DHR reserve requests.

- B. How did the CAMH Program expend the \$33 million in unspent funds that were available as of June 11, 2008? Were the funds allocated for the most critical needs? Has the Program evaluated whether these funds were spent efficiently and effectively in meeting C&A needs?**

To satisfy this objective we examined MHDDAD accounting records, interviewed MHDDAD staff, Department of Audits and Accounts State Government Division staff, and analyzed pertinent documents such as contracts, strategic plans, and financial/performance reports. We extracted all of the CAMH Program's fiscal year 2008 expenditure data from the PeopleSoft accounting system and isolated those expenditures made in Period 12 and Period 998 (after June 1). To evaluate whether expenditures were for critical C&A needs, we compared the Program's expenditure records against the services identified by the Program management as critical for C&As and made determinations based on the nature of the service being provided.

To evaluate the efficiency and effectiveness of the Program's June 2008 expenditures we first isolated all discretionary expenditures. We then reviewed applicable contract deliverables, professional literature, and interviewed Program personnel to determine monitoring and reporting of efficient and effective use of funds.

- C. Examine the "re-rate" process within the CAMH Program. Are funds in this program appropriately allocated to child and adolescent mental health services?**

To satisfy this objective, we analyzed all of the FY08 manual journal entries that moved revenue or expenditures to or from the CAMH Program. Using a risk-based approach, we identified four entries that accounted for approximately 98% of the expenditures posted to the CAMH Program via manual journal entries during the year.

We interviewed CAMH Personnel and DOAA SGD auditors regarding MHDDAD's manual journal entry procedures, and we reviewed and analyzed supporting documentation provided to our office by Program personnel. We

analyzed each of the expenditures using two criteria. First, we evaluated whether the expenditure was appropriate to bill to the CAMH Program. That is, were the costs CAMH costs? Second, we evaluated whether the expended amount correctly reflected costs attributable to the Program. On this point we evaluated the methodology used by staff to document the allocation of costs to CAMH when the expenditure was allocated among multiple MHDDAD programs.

We conducted this project in accordance Performance Audit Division policies and procedures for non-GAGAS engagements. These policies and procedures require that we plan and perform the engagement to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our project objectives.

Appendix B: MHDDAD Identified Priorities

Priority Identified	Division Documents					DHR Documents	
	MHDDAD Strategic Plan FY07-11	FY08 Block Grant Application*	Division Priorities, FY08-10	Program Measures for Budget*	DHR Strategic Initiatives* (FY09-12)	DHR Board Priorities, 2005-2008	
Develop and Implement a Systems of Care Approach Provide Crisis Services							
Provide Services to Youth in Child Welfare System							
Increase Family-Oriented Treatment Practices Improve Functioning of Youth							
Reduce Admission/ Readmissions to Hospitals Utilize Evidence-Based Practices Increase Number Served							
Reduce Out-of-Home Placements Provide Early Intervention Services Improve School Attendance							
Utilize Evidence-Based Prevention Programs Collaborate with Partner Agencies							
Increase Alternatives to Inpatient Forensic Services							
Increase Services to Homeless Youth							
Develop and implement Parent to Parent Peer Support Program							
Devote Resources to Support Contracting, Information Management, and Quality Improvement							
Purchase and Contract for the Intensity and Variety of Services Needed (Purchasing plan)							
Implement Consumer Directed/ Strengths-based Service System							
Provide the Majority of Services in Community Settings							

Key:

Division Identified "Most Critical" Priority
Identified Priority in 3 or More Planning Documents
Identified Priority in Planning Document(s)

Source: Program Documents and Division Staff

*According to Division staff, FY08 Block Grant Application, Program Measures for Budget, and DHR Strategic Initiatives are not intended to represent all priorities for the Division.

Appendix C: Fiscal Year 2008 Service Descriptions

FY2008 Core Services	
Service Name	Description
Community Support Individual	Planning, coordination, and monitoring activities are provided to the youth in order to promote stability and build toward age-appropriate functioning in his or her daily environment. Community Support staff serve as the primary coordinator of behavioral health services.
Crisis Intervention	Time-limited and present-focused services directed toward the support of a child who is experiencing an abrupt and substantial change in behavior. The service is designed to prevent out-of-home placement or hospitalization and may involve the youth's family.
Diagnostic Assessment and Individualized Resiliency Planning	A comprehensive clinical assessment that determines a diagnosis and assists in screening for and ruling-out potential co-occurring disorders. An Individualized Resiliency Plan is developed based on goals identified by the individual with involvement from the youth's responsible caregiver. Required within the first 30 days of service.
Family Counseling	A licensed clinician provides systematic interactions between the individual consumer, staff, and the individual's family members directed towards the achievement of specific goals defined by the Individualized Resiliency Plan.
Family Training	A mental health professional provides systematic interactions between the individual consumer, staff, and the individual's family members directed towards the achievement of specific goals defined by the Individualized Resiliency Plan.
Group Counseling	A licensed clinician provides therapeutic services in a group setting that are intended to achieve specific goals defined by the Individualized Resiliency Plan.
Group Training	A mental health professional provides therapeutic services in a group setting that are intended to achieve specific goals defined by the Individualized Resiliency Plan.
Individual Counseling	A licensed clinician provides therapeutic services to the youth that are intended towards achievement of specific goals defined by the Individualized Resiliency Plan.
Medication Administration	Administration of an oral or injected medication. Requires a physician's order and supervision.
Nursing Assessment and Health Services	Assessments, evaluations, education, monitoring and care provided by a licensed nurse during the course of a youth's treatment.
Physician Assessment and Care	Specialized medical and/or psychiatric services provided to a youth by a licensed medical physician with behavioral health training that support the youth's Individualized Resiliency Plan.
Pharmacy	Includes dispensing prescribed medications and youth, family, and staff education and monitoring to ensure safe and effective use of medications. Services are not reimbursed by MHDDAD.
Source: FY2008 MHDDAD Provider Manual	

Appendix C Continued: Fiscal Year 2008 Service Descriptions

FY2008 Specialty Services	
Service Name	Description
Community-Based Inpatient Psychiatric and Substance Detoxification Services	A short-term stay in a licensed and accredited community-based hospital for the treatment or rehabilitation of a psychiatric and/or substance related disorder.
Consumer/ Family Assistance	Time-limited payments for goods and services purchased on behalf of the consumer that will help promote support to the youth's responsible family member/caregiver to the benefit of the individual's stability in the home. Goods and services must provide a direct and critical benefit to the needs of the youth in accordance with the Individualized Resiliency Plan. Beginning in February 2008, this service is offered through the Consumer Supports and Services Program.
Crisis Stabilization Program Services	A residential alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization and detoxification services. Facilities must be designated and certified by MHDDAD as an emergency receiving and evaluation facility.
Housing Supplements	State-funded rental subsidy for consumers in community residential services which must be justified by a personal consumer budget. Beginning in February 2008, this service is offered through the Consumer Supports and Services Program.
Intensive Family Intervention	A team-delivered service primarily offered in the home that is intended to stabilize the living arrangement of the youth by improving family functioning.
Respite	Brief periods of support or relief for responsible caregivers of individuals with mental illnesses during times of behavioral crisis, or when the caregivers are in need of additional support or relief. May be provided in or outside the youth's home. Beginning in February 2008, this service began being offered through the Consumer Supports and Services Program.
Structured Residential Supports	Comprehensive rehabilitation services offered in a licensed residential setting serving no more than 16 individuals. Services are provided to develop skills in functional areas that interfere with the ability to live in the community, develop and maintain social relationships, or participate in educational, social, interpersonal, recreational or community activities.
Source: FY2008 MHDDAD Provider Manual	

Appendix D: FY2008 Penetration Rates, Uninsured Youth with Severe Emotional Disturbance

Region	County	2007 Pop<18 ¹	Est. <18 with SED ²	Est. Uninsured ³ with SED	Actual uninsured served SFY08 ⁴	Estimated uninsured	Est. Uninsured Penetration Rate
1	Bartow	26,335	2,107	133	149		1.12
1	Butts	5,639	451	32	18	14	0.55
1	Carroll	29,536	2,363	139	91	48	0.65
1	Catoosa	15,703	1,256	75	58	17	0.77
1	Chattooga	6,054	484	30	38		1.27
1	Coweta	33,605	2,688	204	76	128	0.37
1	Dade	3,576	286	19	33		1.70
1	Fannin	4,805	384	41	18	23	0.44
1	Floyd	23,801	1,904	118	124		1.05
1	Gilmer	7,081	566	70	25	45	0.36
1	Gordon	14,062	1,125	99	39	60	0.39
1	Haralson	7,310	585	32	27	5	0.85
1	Heard	3,038	243	23	23	0	1.01
1	Lamar	4,061	325	19	39		2.07
1	Meriwether	5,689	455	28	51		1.84
1	Murray	11,376	910	79	40	39	0.51
1	Paulding	39,845	3,188	277	228	49	0.82
1	Pickens	7,109	569	58	33	25	0.57
1	Pike	4,402	352	39	19	20	0.49
1	Polk	11,137	891	82	84		1.02
1	Spalding	17,232	1,379	68	55	13	0.81
1	Troup	17,151	1,372	63	81		1.28
1	Upton	6,682	535	27	38		1.39
1	Walker	15,318	1,225	81	97		1.20
1	Whitfield	28,093	2,247	270	134	136	0.50
Region 1 Totals		348,640	27,891	2,107	1,618	623	
Region 1 Penetration Rate							77%
2	Banks	4,200	336	38	25	13	0.65
2	Barrow	19,764	1,581	158	73	85	0.46
2	Burke	6,869	550	62	22	40	0.36
2	Clarke	22,138	1,771	174	160	14	0.92
2	Columbia	29,928	2,394	172	43	129	0.25
2	Dawson	5,437	435	54	20	34	0.37
2	Elbert	4,884	391	34	37		1.09
2	Forsyth	46,837	3,747	367	73	294	0.20

Appendix D Continued: FY2008 Penetration Rates, Uninsured Youth with Severe Emotional Disturbance							
Region	County	2007 Pop<18 ¹	Est. <18 with SED ²	Est. Uninsured ³ with SED	Actual uninsured served SFY08 ⁴	Estimated unserved	Est. Uninsured Penetration Rate
3	Cherokee	58,992	4,719	396	130	266	0.33
3	Clayton	81,802	6,544	386	351	35	0.91
3	Cobb	181,550	14,524	944	373	571	0.40
3	DeKalb	178,533	14,283	1085	637	448	0.59
3	Douglas	36,131	2,890	260	254	6	0.98
3	Fayette	25,263	2,021	148	41	107	0.28
3	Fulton	248,717	19,897	1373	883	490	0.64
3	Gwinnett	226,121	18,090	1809	590	1219	0.33
3	Henry	56,232	4,499	319	196	123	0.61
3	Rockdale	22,455	1,796	158	91	67	0.58
Region 3 Totals		1,115,796	89,264	6,879	3,546	3333	
Region 3 Penetration							52%
4	Baker	888	71	10	7	3	0.68
4	Baldwin	9,395	752	32	108		3.42
4	Bibb	41,945	3,356	124	190		1.53
4	Calhoun	1,269	102	10	8	2	0.81
4	Chattahoochee	3,611	289	51	2	49	0.04
4	Clay	786	63	5	10		1.89
4	Colquitt	12,199	976	90	36	54	0.40
4	Crawford	3,017	241	23	23	0	0.99
4	Crisp	6,176	494	27	42		1.57
4	Decatur	7,617	609	36	35	1	0.97
4	Dooly	2,771	222	17	9	8	0.52
4	Dougherty	26,003	2,080	73	53	20	0.73
4	Early	3,243	259	18	21		1.16
4	Grady	6,642	531	59	25	34	0.42
4	Harris	7,059	565	66	36	30	0.55
4	Houston	35,762	2,861	209	110	99	0.53
4	Jones	6,714	537	47	30	17	0.64
4	Lee	8,623	690	47	12	35	0.26
4	Macon	3,313	265	11	17		1.55
4	Marion	1,873	150	29	7	22	0.24
4	Miller	1,492	119	12	11	1	0.94
4	Mitchell	6,036	483	29	20	9	0.68
4	Monroe	5,820	466	41	28	13	0.68

Appendix D Continued: FY2008 Penetration Rates, Uninsured Youth with Severe Emotional Disturbance							
Region	County	2007 Pop<18 ¹	Est. <18 with SED ²	Est. Uninsured ³ with SED	Actual uninsured served SFY08 ⁴	Estimated uninsured	Est. Uninsured Penetration Rate
4	Muscogee	51,119	4,090	229	310		1.35
4	Peach	6,387	511	39	31	8	0.80
4	Pulaski	2,170	174	19	6	13	0.32
4	Putnam	4,557	365	40	18	22	0.45
4	Quitman	654	52	4	3	1	0.86
4	Randolph	1,837	147	9	16		1.73
4	Schley	1,144	92	10	5	5	0.51
4	Seminole	2,261	181	15	10	5	0.67
4	Stewart	1,022	82	8	3	5	0.39
4	Sumter	8,809	705	43	44		1.02
4	Talbot	1,537	123	16	17		1.06
4	Taylor	2,221	178	17	15	2	0.86
4	Terrell	2,701	216	13	17		1.29
4	Thomas	11,381	910	54	91		1.69
4	Twiggs	2,420	194	16	7	9	0.43
4	Webster	537	43	5	2	3	0.42
4	Wheeler	1,268	101	12	11	1	0.93
4	Wilkinson	2,574	206	20	12	8	0.60
4	Worth	5,287	423	27	18	9	0.66
Region 4 Totals		312,140	24,971	1,661	1,476	487	
Region 4 Penetration							89%
5	Appling	4,681	374	29	21	8	0.73
5	Atkinson	2,557	205	26	3	23	0.12
5	Bacon	2,687	215	21	6	15	0.29
5	Ben Hill	4,889	391	28	22	6	0.78
5	Berrien	4,436	355	27	19	8	0.70
5	Bleckley	3,049	244	17	20		1.15
5	Brantley	3,764	301	28	40		1.44
5	Brooks	3,996	320	32	17	15	0.53
5	Bryan	8,715	697	61	14	47	0.23
5	Bulloch	14,330	1,146	89	48	41	0.54
5	Camden	14,671	1,174	81	34	47	0.42
5	Candler	2,919	234	27	6	21	0.22
5	Charlton	2,453	196	11	18		1.58
5	Chatham	63,355	5,068	329	283	46	0.86

Appendix D Continued: FY2008 Penetration Rates, Uninsured Youth with Severe Emotional Disturbance							
Region	County	2007 Pop<18 ¹	Est. <18 with SED ²	Est. Uninsured ³ with SED	Actual uninsured served SFY08 ⁴	Estimated uninsured	Est. Uninsured Penetration Rate
5	Clinch	1,937	155	9	5	4	0.57
5	Coffee	11,047	884	72	43	29	0.60
5	Cook	4,428	354	30	32		1.08
5	Dodge	4,971	398	24	26		1.07
5	Echols	1,042	83	19	6	13	0.32
5	Effingham	14,104	1,128	82	48	34	0.58
5	Emanuel	5,777	462	36	36		1.01
5	Evans	3,140	251	29	12	17	0.42
5	Glynn	18,917	1,513	136	116	20	0.85
5	Irwin	2,570	206	26	17	9	0.66
5	Jeff Davis	3,636	291	25	15	10	0.60
5	Johnson	2,056	164	15	24		1.64
5	Lanier	2,051	164	12	21		1.68
5	Laurens	12,288	983	53	125		2.35
5	Liberty	20,897	1,672	254	39	215	0.15
5	Long	3,471	278	55	15	40	0.27
5	Lowndes	26,670	2,134	124	191		1.54
5	McIntosh	2,924	234	52	26	26	0.50
5	Montgomery	2,227	178	28	10	18	0.36
5	Pierce	4,673	374	33	52		1.56
5	Tattnall	5,347	428	57	21	36	0.37
5	Telfair	2,566	205	12	18		1.46
5	Tift	11,377	910	91	85	6	0.93
5	Toombs	7,704	616	55	33	22	0.59
5	Treutlen	1,639	131	8	18		2.29
5	Turner	2,559	205	16	13	3	0.82
5	Ware	8,734	699	50	180		3.63
5	Wayne	7,294	584	34	41		1.21
5	Wilcox	1,780	142	12	10	2	0.85
Region 5 Totals		334,328	26,746	2,256	1,829	782	
Region 5 Penetration							81%
State Totals		2,531,609	202,529	15,873	10,310	6,386	
State Penetration							65%

Appendix E: Service Comparison 2004-2009

FY2004 Services Still Offered in FY2009	
FY2004 Services	Equivalent FY2009 Services
Diagnostic/ Functional Assessment	Behavioral Health Assessment
Crisis Intervention	Crisis Intervention
Physician Assessment and Care	Diagnostic Assessment
	Psychiatric Treatment
Nursing Assessment and Health Services	Nursing Assessment and Health Services
Medication Administration	Medication Administration
Individual Counseling	Individual Counseling
Group Training/ Counseling	Group Training
	Group Counseling
Family Training/ Counseling	Family Training
	Family Counseling
Community Support Individual	Community Support Individual
Pharmacy Services	Pharmacy and Lab
Intensive Family Intervention	Intensive Family Intervention
Community Based Inpatient Services	Community Based Inpatient Psychiatric and Substance Detoxification Services
Residential Supports	Structured Residential Supports
Group Home	
System Entry and Linkage	Georgia Crisis and Access Line
Respite	Respite
Family Support	Support Services
	Housing Supplements
	Goods
	Transportation
Room and Board	Housing Supplements
FY2004 Services Replaced with FY2009 Less Comprehensive Services	
FY2004 Services	Related (but not Equivalent) FY2009 Services
Activity Therapy	Structured Activity Supports
	Group Training
Consumer and Family Education	Family Training
Day Treatment for Children and Adolescents	Group Counseling
	Group Training
	Individual Counseling
	Structured Activity Supports
	Support Services
Services Deleted or Added between FY2004 and FY2009	
FY2004 Services No Longer Offered	Additional FY2009 Services
Community Support Team	Psychological Testing
Consumer and Family Education	Service Plan Development
Day Supports for Children and Adolescents	Crisis Stabilization Program
Early Intervention ⁽¹⁾	Behavioral Assistance
Outreach	
Peer Support	
Specialized Therapy Services, Occupational Therapy ⁽²⁾	Key: Core Service Specialty Service Service Offered through a Third Party Administrator
Specialized Therapy Services, Physical Therapy ⁽²⁾	
Specialized Therapy Services, Speech and Hearing Therapy ⁽²⁾	
Therapeutic Foster Care	
⁽¹⁾ Service Provided through the Division of Public Health ⁽²⁾ MHDDAD noted that these services remain available to youth via the Department of Community Health, which is appropriate given that these services are not behavioral health services and more typically delivered outside of a mental health clinic (e.g. schools). In FY2004, despite this service remaining in the Provider Manual, Medicaid utilization data (which was the only utilization data available at that time) indicates that 0 individuals were served in FY2004. These services were therefore discontinued by MHDDAD. Source: Review of Provider Manuals and Interviews with Agency Personnel	

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