

# Georgia's Children's Mental Health System: A New Vision

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## Why Community-Based Care?



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## Community-Based vs. Institutional

- Strong evidence of clinical efficacy
- Cost savings
- Meets Olmstead requirements of the ADA
- Weak evidence base
- Expensive
- Olmstead concerns

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## Surgeon General's Report on Mental Health: Institutional Care vs. Community-Based Care

- **RTCs\***
  - Used by only 8% of children with SMI but consumes nearly 25% of children's MH budget
  - "Only weak evidence for their effectiveness"
- **Hospitalization**
  - Concerns with excessive and inappropriate use
  - Consumes about 50% of children's MH budget
  - Intervention with "weakest research support"
- **Home-based services/SOC**
  - "Strong record of effectiveness"
  - SOC reduce rates of re-institutionalization, reduce out-of-state placement, and improve outcomes
- **Therapeutic Foster Care**
  - Least restr. form of out-of-home care
  - Improvement in behavior, lower rates of re-institutionalization
  - TFC "produces better outcomes at lower costs than more restrictive types of placements"

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## 2006 SAMHSA Data on Children's Community-Based Mental Health Care

- Reduced costs due to fewer days in inpatient care
- Decreased utilization of inpatient facilities
- Reduced arrests translating into cost savings
- Mental health improvements sustained

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## 2006 SAMHSA Data (cont.)

- Suicide related behaviors significantly reduced
- School attendance improved
- School achievement improved
- Significant reductions in placements in juvenile detention and other secure facilities

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**Cost Savings With Better Outcomes:  
Example of Wraparound Milwaukee**

- Cost: RTC monthly cost of \$8-10,000 vs. \$3,900 per month for WM (vast majority funded by Medicaid)
- Outcomes of WM: vast majority of children in RTCs returned to home/communities; reduced number of days in psych hospital; decreased level of dysfunction; reduced recidivism; educational success

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**BASICS OF EPSDT**



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**Early and Periodic Screening,  
Diagnosis and Treatment, 42 USC §  
1396d(r)**

Screening services and such "other *necessary* health care, diagnostic services, treatment, and other measures . . . *to correct or ameliorate* defects and physical or *mental illnesses* and conditions discovered by screening services, *whether or not such services are covered under the State plan.*

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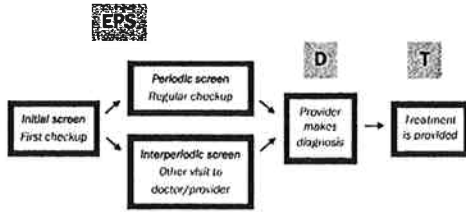
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## Diagnosis and Treatment



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## Treatment

- All **necessary** treatment within 1396d(a)
- To "**correct or ameliorate** physical and mental illnesses and conditions"
- Even if the service is not covered under the **state plan**

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## Medical Necessity

- "Necessary" = medically necessary
- Generally defined as a decision by a health care professional/provider that a person's condition requires a service/course of treatment to address or improve a condition

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**What does "correct or ameliorate" mean when a problem is found during a screening?**

"Correct" means to resolve a health problem or condition.

"Ameliorate" means to lessen the burdens of the problem.

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**State Plan Issues**

- States must provide services so long as they **could be** covered under a state Medicaid plan
- For children, states must cover both mandatory services and services that would be optional for adults
- Fact that another state is covering a service under Medicaid is evidence that the service could be covered under a state Medicaid plan, and therefore, a child in any state should be able to get that service.

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**Medicaid Categories for Mental Health Services:**

- Rehabilitation\*\*\*
- Case management/targeted case management\*\*\*
- Clinic
- Physicians & other qualified providers (defined by state)
- General and psychiatric hospitals
- Prescription drugs
- Transportation

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**Examples of Covered Community-Based Services for Children:**

- Screening
- Assess/eval/diagnosis
- Service planning
- Indiv, grp, fam therapy (incl. FFT, MST, etc.)
- Crisis intervention + mobile
- Case management
- Targeted case management
- Therapeutic foster care (minus R&B)
- Meds management
- Intensive in-home/wraparound services
- Parent ed on disorder
- Behavioral aide/mentoring
- Day treatment
- Ther. Recreation
- School-based MH services
- Transition services
- Skills training
- Substance abuse services

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**No Restrictions on Locations in Which Medicaid Services May Be Provided**

- Medicaid can be used to fund services outside of the hospital and clinic settings.
- The services can be provided in the places where children are – such as the home, school or other community settings.
- May also include after-school programs, summer programs, therapeutic nursery programs, and early intervention programs.

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**States' Coverage of Skills Training as Rehabilitative Services**

- Social skills
- Communication
- Coping skills
- Anger mgmt.
- Behavior mgmt.
- Adaptive skills
- Basic living skills
- Indep. living skills (incl. using transp., \$ mgmt., shopping, accessing comm. resources)
- E-ment skills
- Education skills
- Housing skills

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### Adolescent Substance Abuse Services – Best Practices

- Treatment for adolescents differs from adults – must take into account age, level of maturity, and family and peer environment.
- Social skills building more effective than information or "scaring kids straight"
- For co-occurring disorders, MH and SA treatment should be integrated. Should have planning in collab. with other involved systems (e.g., JJ, CW)
- Adol. SA programs should include daily scheduled activities (incl. positive rec. activ.), peer mentoring, conflict resolution, education and vocational training.

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### Coverage of SA services for Adolescents:

- SA outpatient and intensive outpatient
- Ambulatory detox.
- Crisis services
- Case management/intensive case management
- Counseling (individ., group, family)
- Medication management
- Mentoring
- Peer support
- Skills training (incl. vocational and educ.)
- Social/rec. activities
- Day treatment for SA
- TFC

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### Medicaid Litigation Re: Community-Based Children's Mental Health Services

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