The Georgia Department of Behavioral Health and Development Disabilities (DBHDD) determined the need to collect information and input in regards to behavioral health crisis services to better inform planning processes. A first stakeholder’s meeting was convened on October 19, 2012 with the objectives of assessing the current system of crisis interventions, determining the strengths and gaps within the current system, and forging a vision of a continuum of crisis services anchored in the larger recovery-oriented system of care. A second meeting was convened December 10, 2012 to gather input from consumers regarding their lived experience of the current system, bring back together participants from the first stakeholders meeting, and solicit their input regarding a draft continuum of crisis services.

The first meeting resulted in identification of strengths, gaps/challenges, and opportunities, and a vision and concept of a continuum of crisis services that includes prevention, early intervention, acute intervention, crisis treatment, and re-integration, imbedded within a recovery-oriented system.

Most noted strengths in the current system were: progress in recovery-oriented work including WRAP and Advance Directives, Peer Support, Wellness & Respite Centers; GCAL; and specific services/programs depending on location. Most noted gaps/challenges were: geographical inequities, inadequate funding, consistency and coordination within and across services, care coordination/management, continuity of care, transportation, administrative barriers, family system work, shared information and data, evidence-based practice, easy and timely access, and family and community education. Opportunities most often identified were: whole health promotion/integration with primary care, telemedicine, streamlining of processes, workforce development, recovery-oriented practice, trauma-informed practice, and expanding the peer system to include youth and families.

Descriptors used most often in the visioning work were: recovery-oriented, accessible, integrated, inclusive, and responsive.

The second meeting focused on lived experience and review of a draft continuum.

Most mentioned factors precipitating a crisis event were: death in the family, loss of employment, family issues, relationship difficulties, unstable housing, isolation, and significant stress.

While a large number of services and supports were mentioned as being of help in overcoming the crisis, those services/supports most noted were: peer support/wellness centers, group therapy/support groups, family/friend support, the structure of in-patient settings, spirituality, respite, and medication adherence.
Consumers stated the following as the biggest challenges/barriers: accessibility; workforce issues – turnover, skill level, shortages; funding; labeling – stigma; lack of follow-up after in-patient event; and lack of appropriate services, particularly for co-occurring disorders.

Consumers noted the following as the most important issues that could improve their crisis experience and recovery: peer support throughout the continuum of services; ease of accessibility; transitional housing; education of family, community, first responders, etc.; transportation; identification and publication of resources.

A draft continuum was reviewed by participants from the first stakeholder meeting and consumers. Suggestions for revision included: add certain services within each of the categories (prevention, early intervention, acute intervention, crisis treatment, and re-integration); add peer support across the continuum; consider geographical inequities; re-name some of the categories; develop warm-line links between GCAL, Wellness Centers, and Family Support Organizations; and consider a pictorial representation as an array of services/supports versus a linear continuum.

The next step is the appointment of a Steering Committee whose purpose is to formulate views and advise the DBHDD on matters of strategic and operational issues concerning behavioral health crisis services.

The importance of this work cannot be overstated, as crisis services are often the point at which individuals enter on-going behavioral health treatment; an individual’s experience with crisis services can determine whether he/she pursues recommended treatment and his/her attitude toward the behavioral health system.
Behavioral Health Crisis Continuum
Stakeholder Meeting

10/19/2012
Georgia Department of Behavioral Health & Developmental Disabilities

Agenda
Introduction
Overview of Recovery-Oriented Systems
Vision & Guiding Principles
Current Service System
Strengths/Gaps/Challenges/Opportunities
Next Steps
Stakeholder Participants

Implications for Strategic Planning

Submitted by: Cheryl J. Dresser
I. 9:30am-10:30am  Welcome and Introductions
   Monica Saxby Parker, Director Community Mental Health
   Judy Fitzgerald, Deputy Commissioner
   Cassandra Price, Executive Director of Addictive Disease

II. 10:30am-10:45am  Brief Overview of Recovery Orientated Systems
   Mark Baker, Director of Advocacy

Session Facilitator:
Cheryl Dresser

III. 10:45am-11:45am  Vision & Guiding Principles of the Georgia BH Crisis Continuum

IV. 11:45am-12:30pm  Sketching our current BH Crisis Continuum

V. 12:30pm-1:15pm  LUNCH (On Your Own)

VI. 1:15pm-2:15pm  System Review: What’s working / Gaps / Needs

VII. 2:15pm-3:15pm  GA Vision: Crisis Continuum (What’s our ideal model for the future)

VIII. 3:15pm-3:45pm  Data & Resources: (What’s needed to support to future vision & inform decision makers)

IX. 3:45pm-4:00pm  Next Steps

X. 4:00pm-4:15pm  Closing Activity
I. Introduction

As the new administration of the Georgia Department of Behavioral Health and Development Disabilities assessed the status of the agency, particularly in relation to activities required by the Department of Justice Settlement Agreement, a decision was made to collect more information and input in regards to behavioral health crisis services to better inform planning processes.

A stakeholder’s meeting was convened on October 19, 2012 with the objectives of assessing the current system of crisis interventions, determining the strengths and gaps within the current system, and forging a vision of a continuum of crisis services anchored in the larger recovery-oriented system of care.

As an opening activity, participants were asked to introduce themselves and state their hope for the day’s work.

Key words of their responses:

<table>
<thead>
<tr>
<th>Comprehensive</th>
<th>Law enforcement/work force safety</th>
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</thead>
<tbody>
<tr>
<td>Understanding that crisis happens</td>
<td>responsive to all age groups, 5 to 99</td>
</tr>
<tr>
<td>Solutions to current gaps</td>
<td>individualized</td>
</tr>
<tr>
<td>Vision for the future</td>
<td>partnerships/alliances between agencies</td>
</tr>
<tr>
<td>Focus on families/systems of care</td>
<td>recovery-oriented system of care</td>
</tr>
<tr>
<td>Identify critical components</td>
<td>inclusive geographical access</td>
</tr>
<tr>
<td>Spectrum of services requires funding</td>
<td>accessible</td>
</tr>
<tr>
<td>Focus on prevention</td>
<td>timely response</td>
</tr>
<tr>
<td>Focus on good outcomes</td>
<td>right services</td>
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<tr>
<td>Achieving consensus/shared vision</td>
<td>learn from each other</td>
</tr>
<tr>
<td>No cracks in the delivery system</td>
<td>whole health/primary care integration</td>
</tr>
<tr>
<td>Out of the siloes</td>
<td>dual-diagnosis integration</td>
</tr>
<tr>
<td>Less reliance on institutions</td>
<td>care for front-line staff</td>
</tr>
<tr>
<td>Proactive instead of reactive</td>
<td>solution-focused, utilizing technology</td>
</tr>
<tr>
<td>Consideration of fiscal reality</td>
<td>consideration of provider complexities</td>
</tr>
<tr>
<td>Community collaboration</td>
<td>stability for clients</td>
</tr>
<tr>
<td>Eliminate ER as front door</td>
<td>measureable outcomes – accountability</td>
</tr>
<tr>
<td>Cost effective</td>
<td>validated as best practice</td>
</tr>
<tr>
<td>Streamline</td>
<td>keep it real</td>
</tr>
<tr>
<td>Incorporate voice of lived-experience</td>
<td>seamless system</td>
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<tr>
<td>Real choice</td>
<td>clarity</td>
</tr>
<tr>
<td>Harness the energy</td>
<td>funding the journey</td>
</tr>
<tr>
<td>Strategic – local duplication</td>
<td>right size/balance the system</td>
</tr>
<tr>
<td>Creative</td>
<td>learn from our shortfalls</td>
</tr>
</tbody>
</table>
II. Overview of Recovery-Oriented Systems

A brief presentation was given on Georgia’s evolving recovery-oriented system. In an effort to support recovery work beyond the Department of Justice Settlement Agreement, DBHDD has created the Office of Recovery Transformation - to advance the work and develop a true recovery-oriented system of care, informed and sustained by recovery values, strength-based, founded in hope, and nurtured in respect. The work is carried out through continuous healing relationships, evidence-based decision making, and anticipation of needs.

Focus groups have been held to determine the vision of what Recovery is in Georgia, to build the voice of lived experience, to identify what is missing, develop/improve connections to ongoing support, and to engage and utilize peers in the developing crisis system.

III. Vision and Guiding Principles

Participants worked in six (6) small groups to develop a vision and guiding principles or core values for the Georgia Behavioral Health Crisis Continuum.

VISION STATEMENTS DEVELOPED BY THE SIX GROUPS

- Build a comprehensive system of care which is recovery-oriented, responsive, accessible, uses quality professionals and is transparent and accountable
- Comprehensive and recovery-oriented, accessible, integrated, and inclusive
- A proactive, seamlessly integrated and coordinated, person-centered, value-driven crisis continuum that provides evidence-based and appropriate responses to all citizens of Georgia
- Flexible, recovery-oriented, community-integrated continuum of crisis prevention response
- A strength-based crisis recovery system for all ages and levels, that is seamless and understandable for all persons served and practitioners
- People in Georgia have access to a recovery based continuum of crisis services and supports
GUIDING PRINCIPLES/CORE VALUES

Responsive - No wrong door  
Accessible  
Recovery-Oriented  
Quality professionals  
Transparent Accountability  

Relational  
Community-based  
Strength-based & Recovery-oriented  
Culturally sensitive  
Integrated - whole person health  

Accessible & timely  
Dignity & respect  
Clinical expertise  
Integrated & coordinated  
Flexible & adaptable  
Inclusive of all ages & MH & AD  

Respectful & empathic  
Timely & accurate support  
Right support for circumstance  
Information sharing  

Flexible & responsive  
Natural supports  
Accessible & timely  
Facilitate connections  
High quality assessment & diagnosis  

Innovative  
Community-based & collaborative  
Outcome-focused  
Inclusive of prevention & followup  
Evidence-based  

Several key elements were identified by four or more groups:

- Recovery-oriented  
- Accessible  
- Integrated  
- Inclusive  
- Responsive
IV. Sketching the Current Behavioral Health Crisis Continuum

The full assembly was asked to describe the current state of crisis services, and provided with a long sheet of blank paper. As services were named, respondents were asked where the service should be placed on the paper (there was no direction given as to envisioning a continuum or linear picture).

With a lack of clear instructions, participants struggled with placement of services but did, in fact, create a picture of the current system, with the following disclaimers:

- Many of the services are not available state-wide
- To some degree, the picture portrays a time continuum, rather than a service continuum
- Specialty services and deep end services are only as strong as the core services that provide the foundation
- Policies are too restrictive regarding the number of times a specific service can be used
- People enter and exit at many different service points depending on geographical access, familiarity with the system, timeliness
- System is inadequately funded
- There is a lack of consistency and coordination across the services
- Quality is inconsistent across service providers
V. Strengths, Gaps, Challenges, Opportunities/Recommendations

Participants were again divided into small workgroups to identify strengths, gaps, challenges, and opportunities in the current system, using a crisis continuum framework with five (5) components:

<table>
<thead>
<tr>
<th>PREVENTION</th>
<th>EARLY INTERVENTION</th>
<th>ACUTE INTERVENTION</th>
<th>CRISIS TREATMENT</th>
<th>REINTEGRATION</th>
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</thead>
<tbody>
<tr>
<td>Participants self-selected the group they wished to work in, with the exception of those who were interested in Child &amp; Adolescent services. A Child &amp; Adolescent group worked on the entire continuum specific to the needs of children and families.</td>
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Groups reported on their work and comments/additional points were taken from the full assembly.

**PREVENTION - ADULT**

What’s Working:
- Progress in recovery-oriented work; employment
- Some parts work depending on geography
- There are more intervention options in communities

Gaps:
- Geographical inequity
- Expanded out-patient diversion options

Challenges:
- Don’t control the front door
- Contextual misalignment with funding
- Administrative barriers
- Technology
- Information Sharing
- Staff development
- Restrictions defining core customer

Recommendations/Opportunities:
- WRAP – crisis planning as part of well care
- Decrease risk factors, increase resilience factors
- Psychiatric advance directive
- Easy, equitable access to appropriate lower levels of care: prescriber, meds, peer centers, supports
- Mental Health First Aid – mental health wellness promotion; rebuild advocacy
- Whole health promotion
- Resolve authorization/administrative barriers to improve access to care
- Simplify/clarify system to allow consumer control
- Harness natural supports & recovery communities at community level
- Espouse language improvement to align with recovery principles
- Create environment for creativity, flexibility, and innovation (funding, etc.)
- Contextual alignment for recovery – training, funding, administrative
<table>
<thead>
<tr>
<th>What’s Working:</th>
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<tbody>
<tr>
<td>• CSS</td>
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<tr>
<td>• Outpatient</td>
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<tr>
<td>• Accountability Courts</td>
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<td>• Transportation services; Transportation of med management clients</td>
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<td>• Integration with primary care</td>
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<td>• Community education/integration</td>
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<td>• Warm lines</td>
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<td>• Telemedicine</td>
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<td>• Discharge –within 24 hours walk-in access</td>
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<td>• Staff awareness of and competence in risks related to crisis; frequent contact</td>
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<tr>
<td>• Cross-system integration; co-location with healthcare</td>
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<tr>
<td>• Individualized prescribing practices</td>
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<tr>
<td>• Mental Health First Aid</td>
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<tr>
<td>• CIT, PATH</td>
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<tr>
<td>• WRAP; Advance directives</td>
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<table>
<thead>
<tr>
<th>Gaps:</th>
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</thead>
<tbody>
<tr>
<td>• TAPP</td>
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<tr>
<td>• Sufficient warm lines</td>
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<tr>
<td>• Sufficient wellness centers</td>
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<tr>
<td>• Care Management</td>
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<tr>
<td>• Transportation</td>
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<tr>
<td>• Sufficient Accountability Courts; lack of coordination – funding goes to criminal justice</td>
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<tr>
<td>• Formulary that includes community, hospitals, jails, prisons</td>
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<tr>
<td>• Respite</td>
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<td>• Universal screening; SBIRT</td>
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<table>
<thead>
<tr>
<th>Challenges:</th>
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<tbody>
<tr>
<td>• Responsiveness</td>
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<tr>
<td>• Cost of medications</td>
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<tr>
<td>• Retention of professionals – psychiatrists, etc.</td>
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<tr>
<td>• Workforce shortage</td>
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<tr>
<td>• Staff development – quality and quantity</td>
</tr>
<tr>
<td>• Retention of staff</td>
</tr>
<tr>
<td>• GCAL – inefficient and ineffective</td>
</tr>
<tr>
<td>• Cost of provision of services in rural areas</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendations/Opportunities:</th>
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</thead>
<tbody>
<tr>
<td>• Reduce administrative costs and procedures</td>
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<tr>
<td>• More non-traditional hours</td>
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<tr>
<td>• Expansion of tele-medicine</td>
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<tr>
<td>• Funding for development of cross-system integration</td>
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<tr>
<td>• First contact should be with someone with lived experience</td>
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</tbody>
</table>
## What’s Working?
- GCAL provides access to acute services
- Some providers partnerships with police in diversion
- Temporary observation = high diversion rate
- Psychiatric Emergency Room (DeKalb & Albany)
- Providers are not making clinical decisions based on funding
- Safety net exists in CSUs and Grady
- ACT and housing
- Using CSI to maintain recovery
- Mobile crisis
- CST/ diverts from high intensity services
- Opening Doors to Recovery (ODR)

## Gaps:
- CSBs not funded for 24/7 access
- Options to support police in interventions other than arrest
- Lack of funding for 23-hour observation
- Funding and equipment for medical evaluations or referral agreements
- Funding for prescriptions for more than 3 to 5 days
- Case management
- Broader coverage of mobile crisis

## Challenges:
- Rural partnerships with police due to large geographic areas
- Lack of information – shared data/access
- Medications are not funded
- Transportation – funding and expectations
- When discharged, timely appointment to a physician
- Privacy for individuals on 1013s (representative)
- CSUs are not hospitals or inpatient and staffing is different – need med/psych
- When transitioning – new laws regarding identification

## Recommendations/Opportunities:
- Standardize procedures regarding safety of MCR/MCT staff
- Funding for 24/7 staff at CSUs to assess/accept walk-ins
**CRISIS TREATMENT - ADULT**

**What’s Working?**
- Mobile crisis in some areas
- Toll free crisis/access line
- Crisis Stabilization Units
- Current collaboration
- CIT officers
- Mental Health Courts – day reporting centers
- Crisis Service Center
- ACT, CST, CSI
- Peer support
- Residential services
- Intensive Case Management
- Region 1 integrated tracking system
- CARES
- Crisis apartments
- Social detox
- Regional and State Office support

**Gaps:**
- Integrated data system
- Adult system of care/service coordination
- Exceptional rates for residential services
- Medicaid eligibility for persons with addictive disease
- Prevention
- Sufficient AD community-based services – social detox
- Mobile crisis statewide: team model (at least 2 persons – one licensed, one peer)
- Timely access for persons with higher acuity; after hours supports/services
- Staffing and funding to address medical fragility

**Challenges:**
- Inadequate housing resources
- Access to CTP
- Transportation
- Over reliance on beds
- Staffing ratios
- Insufficient funding to hire licensed staff
- Determination of appropriate level of acuity to be served

**Recommendations/Opportunities:**
- Training on new substances/AD
- More 23-hour observation beds in community
- Outcomes based model
- More Crisis Service Centers
- Staffing and resources to address co-occurring needs (MH, AD, DD)
# REINTEGRATION - ADULT

## What’s Working?
- Peer Support Wellness & Recovery Centers; Peer Mentors
- Trained peer workforce
- Peer support whole health
- Support groups
- Learning Collaborative
- Integrated healthcare (CSBs/FQHCs)
- ACT, ICM
- Office of Recovery Transformation
- High level leadership buy-in
- Georgia Recovery Initiative
- GCAL
- Supported employment, education

## Gaps:
- Insufficient number of Peer Support Wellness & Recovery Centers
- Insufficient number of support groups
- AD not included in Learning Collaborative
- Integrated healthcare
- Insufficient number of peer mentors
- Transitional AD housing
- Training for Personal Care Home providers
- Housing continuum

## Challenges:
- ACT and ICM requirements are too restrictive, need more flexibility
- Core service client definition is too restrictive
- Culture shift in organizations
- Funding inequities, insufficient funding
- Housing
- Transportation
- 1013 law is not recovery-oriented
- SA regulations are not recovery-oriented

## Recommendations/Opportunities:
- Promote and expand Office of Recovery Transformation
- Simplify authorization process – transform to outcome-based
- Streamline audit processes
- Promote CPS, CHIPRA, CARES, CSG, P2P, Respect Institute, In Our Own Voice, natural supports
- Expand PSWRCs and Community Recovery Centers
- Create Health Homes; DBHDD/DCH Partnership
- Assertive outreach and follow-up, recovery check-ins by peers
- Funding activities that support housing
- Strength-based recovery to include self-direction and wellness
## PREVENTION – CHILD & ADOLESCENT

### What’s Working:
- MH/SA Clubhouses
- Family Service Organizations
- System of Care framework
- Strong advocacy
- Department cares about children & adolescents
- Interagency Director’s Team
- Trauma-informed child welfare system

### Gaps:
- Family system work
- Safety net system
- Respite
- Insufficient family training and support
- AD services
- DD services for youth who are dually diagnosed
- Transportation
- Integration with primary care
- Insufficient Evidence-Based Practices

### Challenges:
- Inconsistency of core/specialty services, quality, quantity and access to services, follow-up
- Under-utilization of EPSDT
- Fragmentation based on medical insurance
- Understanding the system – providers and families
- Continuity of care/vertical integration
- Rural areas
- Lack of clinical expertise – dual diagnosed (DD/MH)
- Coordination with education
- Continuity of service providers
- Trauma-informed system
- Care Management Organizations
- Multiple access points
- Insufficient number of child psychiatrists

### Recommendations/Opportunities:
- Infrastructure to hold providers accountable to contract/rules and regulations
- State-wide training on trauma-informed care
- Expansion of school based treatment through EPSDT
- Tele-medicine/tele-therapy
- Partnerships with universities/medical colleges
- Expanding peer system to include family and youth
- Electronic medical records
**EARLY INTERVENTION – CHILD & ADOLESCENT**

**What’s Working:**
- Care Management Entities
- Local Interagency Planning Teams (LIPT)
- Same as those listed in prevention

**Gaps:**
- Family system work
- Crisis respite
- Coordination
- Timely access
- SA services for adolescents and DD dually diagnosed
- Insufficient MH and SA courts for youth

**Challenges:**
- Inconsistency across LIPTs
- Assessment processes – children are often over-assessed with differing clinical opinions
- Same as those listed under prevention

**Recommendations/Opportunities:**
- Match practice and service descriptions
- Flexible funding
- Same as those listed under prevention

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**CRISIS TREATMENT – CHILD & ADOLESCENT**

**What’s Working?**
- GCAL
- Crisis Stabilization Units (CSUs)
- Psychiatric Residential Treatment Facilities (PRTFs)
- Private hospitals

**Gaps:**
- Access for youth in the juvenile justice system
- Family system work
- Care Coordination
- Insufficient mobile crisis
- SA services for adolescents and DD dually diagnosed

**Challenges:**
- Access to CSUs
- 1013/2013
- Capacity
- Same as those listed under prevention

**Recommendations/Opportunities:**
- Foster care Medicaid redesign
- 1915 c legislation
VI. Next Steps

Appoint a Steering Committee and Project Manager to create and monitor a plan for development and implementation of a Behavioral Health Crisis Continuum.

Determine data and information needed to support the BH Crisis Continuum vision and inform the development and implementation work moving forward.

Schedule a second meeting of the Stakeholder Group for their review of a draft continuum based on their work.

Conduct focus groups to learn from lived experience of crisis and crisis response.

VII. Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debbie Atkins</td>
<td>REA-BH Region 1</td>
<td>DBHDD</td>
</tr>
<tr>
<td>Mark Baker</td>
<td>Office of Recovery</td>
<td>DBHDD</td>
</tr>
<tr>
<td>Dan Barnard</td>
<td>Clinical Director</td>
<td></td>
</tr>
<tr>
<td>Jason Bearden</td>
<td>CEO</td>
<td>Highland Rivers Health</td>
</tr>
<tr>
<td>Jade Benefield</td>
<td>CEO</td>
<td>Pathways Center</td>
</tr>
<tr>
<td>Linda Bennet</td>
<td>Crisis Access</td>
<td>Phoenix Center PHS</td>
</tr>
<tr>
<td>Chena Blanchard</td>
<td>HCIP TL</td>
<td>Hillside</td>
</tr>
<tr>
<td>Donise Boatwright</td>
<td>Program Associate</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>Joseph Bona</td>
<td>Chief Medical Officer</td>
<td>Dekalb CSB</td>
</tr>
<tr>
<td>Laura Boswel</td>
<td></td>
<td></td>
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<tr>
<td>Ron Boyette</td>
<td>Community Services Adm.</td>
<td>GRHS-Lakeside/MCRS</td>
</tr>
<tr>
<td>Ken Brandon</td>
<td>Regional Coordinator</td>
<td>Region 4</td>
</tr>
<tr>
<td>Allen Brown</td>
<td>CEO</td>
<td>Unison Behavioral Health</td>
</tr>
<tr>
<td>Eve Bryd</td>
<td>Executive Director</td>
<td>Grady/Emory</td>
</tr>
<tr>
<td>Aundria Cheerer</td>
<td>Executive Director</td>
<td>Clayton Center CSB</td>
</tr>
<tr>
<td>Gloria Choo</td>
<td>CEO</td>
<td>Laurel Heights Hospital</td>
</tr>
<tr>
<td>Brenda Cibulas</td>
<td>Chief Clinical Officer</td>
<td>Dekalb CSB</td>
</tr>
<tr>
<td>Michael Claey</td>
<td>ED</td>
<td></td>
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<tr>
<td>Melanie Dallas</td>
<td>Director/Project Manager</td>
<td>Highland Rivers Health</td>
</tr>
<tr>
<td>Versie Davis</td>
<td>Director VPH CSU</td>
<td>View Point Health</td>
</tr>
<tr>
<td>Sue Davis</td>
<td>CFO</td>
<td>Middle Flint CSB</td>
</tr>
<tr>
<td>Shirley Davison</td>
<td>Program Manager</td>
<td>McIntosh Trail</td>
</tr>
<tr>
<td>June Dipolito</td>
<td>CEO</td>
<td>Pineland CSB</td>
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<tr>
<td>Angela Feeser</td>
<td>Clinical Director</td>
<td>SBHS</td>
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<tr>
<td>Michael Finley</td>
<td>Executive Director</td>
<td>Clayton Center CSB</td>
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<tr>
<td>Denise Forbes</td>
<td>CEO</td>
<td>CSB of Middle GA</td>
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<tr>
<td>Tom Ford</td>
<td>CEO</td>
<td>Lookout Mountain CSB</td>
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<tr>
<td>Greg Graham</td>
<td>President/CEO</td>
<td>Behavioral Health Link</td>
</tr>
<tr>
<td>Name</td>
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<td>Organization</td>
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<tr>
<td>Cynthia Greene Jones</td>
<td>MCRS Adult and C&amp;A Director</td>
<td>GRHS Community Programs</td>
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<td>George Harris</td>
<td>State Director</td>
<td>Benchmark Human Services</td>
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<tr>
<td>Shannon Harvey</td>
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<td>River Edge Behavioral Health</td>
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<td>Dietra Hawkins</td>
<td>Consultant</td>
<td>CMHCN &amp; GCSA</td>
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<td>Kay Hill</td>
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<td>Ellen Jeager</td>
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<td>Lee Johnson</td>
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<td>Minnie Johnson</td>
<td>Nurse Manager</td>
<td>Crisis Stabilization</td>
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<td>Bob Jones</td>
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<td>GA Pines CSB</td>
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<td>Neil Kaltenecner</td>
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<td>Ron Koon</td>
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<td>Michael Link</td>
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<tr>
<td>Mark Livingston</td>
<td>Director of Crisis &amp; Access</td>
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<td>Mary Lou Rahn</td>
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<td>Pam McCollum</td>
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<tr>
<td>Elizabeth McQueen</td>
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<td>Camden Pace</td>
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<tr>
<td>Ken Parker</td>
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<td>Robert Prehn</td>
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<td>Bradley Center</td>
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<td>John Quesenberry</td>
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<td>Amy Rene</td>
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<td>Sue Smith</td>
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<td>David Sofferin</td>
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<td>Walker Solomon</td>
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<td>Sally Straten</td>
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<td>Audrey Sumner</td>
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<td>Terri Timberlake</td>
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<td>Eddie Towson</td>
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<td>Cynthia</td>
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<td>CMHCN/Mental Health America</td>
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<td>Paula</td>
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<td>Gwen</td>
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<td>Sherman</td>
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<td>New Horizons CSB</td>
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<tr>
<td>Brent</td>
<td>Wilson Child Psychiatrist</td>
<td>View Point Health</td>
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</table>
VIII. Implications for Strategic Planning

Based on discussion and group report-outs during the Behavioral Health Crisis Continuum Stakeholder’s Meeting, the following issues might be considered in future strategic planning efforts:

- Geographical inequities
- Funding inequities across regions/services
- Technology/Tele-medicine/electronic medical records
- Whole health/Primary Care Integration
- Aligning the system (policies, practices, funding, etc.) to Recovery/Resiliency-Oriented principles
- Family System work
- Workforce Issues
  - Retention
  - Staff development
  - Shortages
- Medication costs
- Transportation
- 24/7 access in services across the continuum
- Case coordination
- Outcome based models
- 1013 – antiquated, not recovery-oriented
- Simplify/streamline authorization and audit processes
- Under-utilization of EPSDT
- Core customer definition
- Inadequate funding for entire system
- Strengthening core services
- Outreach
Behavioral Health Crisis Continuum
Stakeholder Meeting, Part II

12/10/2012
Georgia Department of Behavioral Health & Developmental Disabilities

Agenda
Introduction
Consumer Focus Groups
Focus Group Report Out
Review of Draft Continuum
Steering Committee
Next Steps
Stakeholder Participants

Considerations for Strategic Planning

Submitted by: Cheryl J. Dresser
Behavioral Health Crisis Continuum Stakeholder Meeting (Part II)
Monday, December 10, 2012 – 9:00 am – 5:00 pm
Loudermilk Conference Center
40 Courtland Street NE
Atlanta, Georgia 30309

Session Facilitator:
Ms. Cheryl Dresser

Morning Session (Includes Consumers & DBHDD Staff)

I. 9:30am-9:15am Welcome and Introductions
II. 9:15am-10:30am Consumer Focus Groups
III. 10:30am-10:40am BREAK
IV. 10:40am-12:00pm Consumer Focus Group Report Out & Discussion
V. 12:00pm-1:00pm LUNCH (Morning Participates ONLY)

Afternoon Session (Includes Community Stakeholders, Consumers & DBHDD Staff)

VI. 1:00pm-1:20pm Welcome and Introductions
VII. 1:20pm-2:00pm Consumer Focus Group Report Out
VIII. 2:00pm-3:15pm Small Work Group and Report Out
IX. 3:15pm-3:30pm BREAK
X. 3:30pm-4:00pm Overview of the Steering Committee
XI. 4:00pm Closing Remarks/Next Steps
I. Introduction

As the new administration of the Georgia Department of Behavioral Health and Development Disabilities assessed the status of the agency, particularly in relation to activities required by the Department of Justice Settlement Agreement, a decision was made to collect more information and input in regards to behavioral health crisis services to better inform planning processes.

A first stakeholder’s meeting was convened on October 19, 2012 with the objectives of assessing the current system of crisis interventions, determining the strengths and gaps within the current system, and forging a vision of a continuum of crisis services anchored in the larger recovery-oriented system of care.

A second meeting was convened December 10, 2012 to: 1.) solicit input from consumers willing to share their lived experience and identify those services that worked best for them, and conversely those that were of little, or no benefit and 2.) bring back together participants from the first stakeholders meeting, along with consumers, and solicit their input regarding a draft continuum of crisis services.

II. Consumer Focus Groups

An introductory exercise paired participants to talk together about what helped them in a time of crisis. Responses included:

- Family support
- People who understand
- Peer support
- Self-work
- Twelve step program
- Spirituality
- Belief in self
- Long term treatment
- Group therapy
- Supportive housing

Participants worked in small facilitated groups and were asked to respond to the following questions developed by advocates:

1. What helped you on your recovery journey?
2. If you think back to a recent crisis, what was going on just before it happened?
3. If you got help, how did you get connected? If you did not get help, what failed?
4. Share what you think worked.
5. What, if anything, did you find to be unhelpful or a barrier to treatment?
6. What do you think might have made it easier to get help?
7. Together we are trying to make services better; what recommendations would you suggest? What might have helped you?
8. From what has been shared, what two things do you think are most important, and why?

<table>
<thead>
<tr>
<th>CONSUMER FOCUS GROUP I</th>
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<tbody>
<tr>
<td><strong>What helps on the recovery journey?</strong></td>
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<tr>
<td>• Gaining self-esteem through volunteering – purposeful work</td>
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<td>• Family support, supportive friends</td>
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<td>• Spirituality, meditation</td>
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<tr>
<td>• Peers</td>
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<tr>
<td>• Belief in self</td>
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<tr>
<td>• Therapy</td>
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<tr>
<td>• Work</td>
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<tr>
<td>• Sense of belonging</td>
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<td>• Self-care</td>
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<td>• Stable housing</td>
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<td>• Medication compliance</td>
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<td>• Detox/rehab</td>
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<td>• Pets</td>
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<td>• Music, art, creative activities</td>
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<td>• Hitting bottom, jail, drug court</td>
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<tr>
<td>• Structure</td>
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<tr>
<td><strong>What precipitated your crisis?</strong></td>
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<tr>
<td>• Relationship difficulties</td>
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<td>• Emotional challenges</td>
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<td>• Death of family/friend</td>
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<td>• Major life change</td>
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<td>• Financial stress</td>
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<td>• Unstable housing</td>
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<tr>
<td>• Loss of employment</td>
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<tr>
<td>• Moving</td>
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<tr>
<td>• Unfulfilled expectations</td>
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<td>• Idle time/Isolation</td>
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<tr>
<td><strong>How did you connect to help?</strong></td>
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<tr>
<td>• Friend/Family</td>
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<tr>
<td>• Peers</td>
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<tr>
<td>• Therapist</td>
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<tr>
<td>• Twelve Step meeting</td>
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<tr>
<td>• Warm line</td>
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</tbody>
</table>
- Respite
- Internet
- CPS
- Law enforcement/Court
- Hospital/ER
- Crisis Stabilization Unit
- GCAL

**What worked?**
- Peer
- Respite
- Warm line
- Mobile crisis
- GCAL
- Psychiatrist
- Medication
- Hospitalization
- Person Centered Planning/Crisis Plan
- Holistic approach
- Family support
- Hope/Spirituality

**What was unhelpful or a barrier?**
- Jail alone
- Hospital
- Day program
- Over medication
- ECT
- Psychiatrist
- Damaging therapist
- Diagnosis/Labeling/Stigma
- Blaming individual for failed treatment
- Insurance
- Lack of money/funding
- Fragmented services/Accessibility
- Not knowing how to navigate the system
- Transportation
- Shortage of skilled and caring workforce

**What could have made it easier?**
- Knowing how to navigate the system
- Peer support
- An advocate
- Less red tape
- More training for first responders
- More training of school personnel
- Transportation
- FQHC/Whole health
- Better informed Person Centered Plan
- More housing options
- Better ACT services

**Recommendations:**
- More Peer Support Centers
- Transitional housing
- Continuum of care between high end and home
- More CPS
- Education for ER staff regarding resources
- Better substance abuse treatment continuum
- CPS utilized at every level of service and planning
- One stop crisis centers
- More community services
- Contract with providers for results

**Most important?**
- Accessible housing
- Peer support throughout continuum
- Wellness respite centers
- More supported employment
- Education of community, including first responders, schools, etc.
- Pay for performance
- Person Centered Planning
- One stop crisis centers
- Ease of access
- Transportation
- Better funded substance abuse continuum

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**CONSUMER FOCUS GROUP 2**

**What helps on the recovery journey?**
- Supportive family
- Resources
- Access to treatment
- Twelve Step Program
- Spirituality
- Medication
- Mentors/Advocates
- Educational classes
- Counseling
- Quality providers
- Having a voice
- Lessening of stigma
- Peer support/access to those with lived experience
- Social contact

**What precipitated your crisis?**
- Stress
- Family issues/holidays
- Relationship issues/break-up
- Loss of job
- Suicidal thoughts

**How did you connect to help?**
- Hospital/ER
- Jail
- Twelve Step Program

**What worked?**
- Training for police
- Halfway house

**What was unhelpful or a barrier?**
- Hospitals trying to get people discharged before crisis is over
- GCAL – time to appoint was too long
- Not enough treatment centers
- Money/funding
- Stigma/shame/ignorance of public and professionals
- Lack of jobs
- Lack of support from churches/faith community
- Once in recovery, there is no funding to get out of the situation that triggered the crisis
- Access to long-term treatment
- Inflexibility of probation officers, child support agents, etc.
- Being in jail ends up being easier – less stress and it is free

**What could have made it easier?**
- Quick access to appointments
- Education for family members
- More resources
- Transitional services
- Peer support

**Recommendations:**
- Peer support at all levels
- Need specialists to work with 18-22 year olds
- Affordable medication
- Easier access to treatment and medications
- Develop partnerships with pharmaceutical companies
• Develop partnerships with real estate owners for transitional housing
• Partner with criminal justice system
• Recovery messaging with Rotary, faith community, jails, probation, etc.
• Community access to grant funding
• CSBs doing more

Most important?
• Educating public and legislators
• First responders forming a coalition
• Collaborating with criminal justice system
• Access to effective medications
• Services in jails
• Easy access to detox with effective step-down services
• Stop charging for urinalysis (punitive)
• Specialized recovery for those 20 years old and under
• Strong community services as an alternative to detox
• Collective power of lived experience
• Transitional living
• Sharing the knowledge of what is available and how to access those services

CONSUMER FOCUS GROUP 3

What helps on the recovery journey?
• Family support
• Someone who is reliable, empathetic
• Wellness Center
• CSB
• Peer Support
• Education, life skills, coping skills, job readiness training
• Mentors
• Psychiatrist/medication management
• Attending conferences/developing leadership skills
• Detox
• Residential recovery centers that allow children to stay with mothers
• Learning from the examples of others, group discussion/listening sessions
• Hard work
• Structure
• Learning to trust, self-love

What precipitated your crisis?
• Homelessness
• Dissatisfaction with services
• Loss of spouse
• Financial instability
- Fear
- No will to avoid substance use/not open to recovery
- Family turmoil
- Extreme stress
- Not knowing how to ask for help
- Not connected to services

**How did you connect to help?**
- Court system
- Traveler’s Aid
- Peer support/GMHCN
- Family
- DFCS case manager
- Georgia Parent Support Network
- ST. Jude’s
- Good psychiatrist
- Faith

**What worked?**
- Peer support
- Good providers

**What was unhelpful or a barrier?**
- Required documentation for access to services
- Lack of psychiatrists in the community who accept Medicaid
- Lack of housing
- Lack of jobs/job training
- Police involvement

**What could have made it easier?**
- Housing appropriate for dual diagnoses, choices
- Immediate hotline access to a person, not an appointment
- Wellness Centers/Self-directed recovery
- Alternative to 911
- Peer training and resources
- Better advertisement of GCAL

**Recommendations:**
- Immediate hotline access to help rather than to an appointment
- More Wellness Centers
- More peer support
- Housing choices

**Most important?**
- Peer support
- Follow-up after crisis
- Skills training and education for family members and consumers
## CONSUMER FOCUS GROUP 4

### What helps on the recovery journey?
- Access to care – mind/body/spirit
- Twelve Step Program
- Faith
- Peer support
- Grief work
- Sharing my story
- Having an advocate – Being an advocate
- Long term treatment
- Accurate diagnosis
- Knowledgeable provider staff
- Education and awareness

### What precipitated your crisis?
- Relationship problems
- Health crisis

### How did you connect to help?
- Have a plan, utilize your network
- Twelve Step Program in jail

### What worked?
- Spirituality
- Exercise
- Attending meetings
- Managed environment
- Using the tools you are given

### What was unhelpful or a barrier?
- Isolation
- Requirements for TB and RPR tests to access residential programs
- Not receiving integrated treatment
- Lack of knowledge on how to navigate the system
- Waiting lists for treatment
- Treatment gets disqualified if you say the wrong thing
- Lack of services during detox
- Lack of funding for some specific populations
- Health conditions, i.e. seizures, heart conditions
- Open criminal cases
- How to get help when you have children

### What could have made it easier?
- More accessible safety net
- Larger workforce
- Services must be available when people want them, need them
- Education
**Recommendations:**
- Family education
- Safe place to go between detox and long term treatment
- Staff support to keep people engaged
- Meet people where they are
- Walk with the individual on their path – person centered, flexible

**Most important?**
- Availability of services
- Recognition that there are significant barriers
- Positive impact of recovery
- Education for families and providers
- Identify and publicize services
- Address waiting lists (especially for mothers)
- Flexibility in programming
- Individualized care
- Safe places to go

**CONSUMER FOCUS GROUP 5**

**What helps on the recovery journey?**
- Getting to the root of the problem
- Knowledge of diagnosis and medication
- Using services – knowledge of what services are out there
- Peer support/Peer groups
- Education
- Safe/non-judgmental environment
- Whole health
- Respite
- Warm lines – 24 hour access
- Double Trouble
- Long term treatment
- Acceptance
- SOAR training
- Vocational rehabilitation
- Pets
- Hope
- Family education
- Self-care
- Twelve Step Program
- Spirituality/Faith-based programs
- Community engagement
### What precipitated your crisis?
- Juggling responsibilities
- Undiagnosed co-occurring issues
- Not taking medications
- Hanging with friends who are using drugs
- Feeling trapped
- Co-dependence issues
- Having no place to go
- No insurance
- No resources
- Homelessness
- Not eligible for services
- Could not get appointment with doctor
- Turned away from services

### How did you connect to help?
- CSB
- DFCS
- Roommate
- Pastor
- Counselor
- Recovery community
- Family
- ER
- Doctor
- AA

### What worked?
- Having an advocate
- Compliance with medications
- Being heard
- Education
- Self-advocacy
- Asking for services
- Having someone ask “what works for you?”
- Medication education
- Peer support
- Art therapy
- Wellness Center
- Respite
- Focus on recovery/wellness
- One on one setting
- Personal desire to make it work
- Group therapy
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<thead>
<tr>
<th>What was unhelpful or a barrier?</th>
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<tbody>
<tr>
<td>• Jail</td>
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<td>• Doctors who don’t listen or trust what you say</td>
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<td>• Having to go to another city for treatment</td>
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<td>• Assessed for wrong issue</td>
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<td>• Inpatient care is too fast, no follow-up</td>
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<td>• No person driven help</td>
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<td>• Staff turnover</td>
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<td>• No continuity of care</td>
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<td>• Must tell story over and over</td>
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<td>• Calls not returned</td>
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<th>What could have made it easier?</th>
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<td>• Alternatives to therapy</td>
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<td>• Wellness approach</td>
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<td>• Participating in treatment planning</td>
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<td>• Community integration</td>
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<td>• 211</td>
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<td>• Peer support/someone who has been there</td>
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<td>• More peer staff/jobs</td>
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<td>• More personable staff</td>
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<th>Recommendations:</th>
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<tbody>
<tr>
<td>• More Peer Wellness Recovery Centers</td>
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<tr>
<td>• Long-term recovery center for women</td>
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<td>• More Peer staff</td>
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<th>Most important?</th>
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<tr>
<td>• More Peer Wellness Recovery Centers</td>
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<td>• More Peer staff</td>
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### CONSUMER FOCUS GROUP 6

#### What helps on the recovery journey?
- Trusting the process of a treatment center
- Feeling comfortable with staff
- Seeing examples of recovery
- Faith
- Family/Friends
- Twelve Step Recovery Program
- Learning coping skills
- Individual counseling
- Healthy relationships are essential
- Being honest with self
- Being presented with options

#### What precipitated your crisis?
- Incarceration
- Holidays/loss & regret
- Death in family
- Job loss

#### How did you connect to help?
- Day Center referral to Respite
- GCAL
- Drug Court

#### What worked?
- Family support
- Being treated with respect and dignity
- Structure and safety of inpatient
- Developing own treatment program
- Hearing success stories from peers
- Willingness to change

#### What was unhelpful or a barrier?
- Uneducated court personnel and social workers – did not know resources
- Lack of cultural sensitivity
- Needs dismissed or unheard
- Inconsistency in job readiness definitions and support
- Clinicians that are not trauma-informed
- Gap in resource knowledge between services/providers
- Long wait lists to get into services
- 1013 process – how you get treated, forceful treatment does not work

#### What could have made it easier?
- More compassion
- Non-threatening
- Access to complete, current, and accurate recovery information and resources
- Better coordination across resources
- Education of communities
- Resource kiosk
- Education of families regarding resources, diagnosis, expectations
- Stigma reduction – Mental Health Fist Aid

**Recommendations:**
- More Peer Support
- More Respite
- Stop reliance on 1013s for treatment
- Early identification and education in schools

**Most important?**
- Focus on things that work
- Consolidated, up-to-date information
- Self-direction
- Self-assessment
- Make program expectation for recovery clear
- More patience from clinicians, and more recovery experience
- Healthy balance between dissatisfaction and solutions
- Education and prevention
- Success ratings of programs
- Positive reinforcement

---

**CONSUMER FOCUS GROUP 7**

**What helps on the recovery journey?**
- Support groups with lived experience
- Spirituality
- Family and family support
- Recovery center staffed with people that can relate (staff with lived experience)

**What precipitated your crisis?**
- Job loss
- Grief/depression
- Death of family member
- Isolation

**How did you connect to help?**
- ER
- Jail
- Family

**What worked?**
- Family/Friend support
- Learning how to accept that loss is a part of life
- Support groups
- Peer support
- Asking for what is needed/wanted
- Education and information
- Accepting responsibility for choices made
- Cognitive therapy
- Spirituality
- Discipline, routine, and structure of a treatment center

**What was unhelpful or a barrier?**

- Stigma
- Pride/Ego
- Red tape to get into treatment
- Hospital/ER – ill equipped to work with children/adolescents
- Waiting list
- Requirement for payment up front
- TB testing
- Placement is a barrier to treatment
- Lack of co-occurring services for youth
- Undervaluing what parents and youth know, say, and need to know
- Incomplete information
- Lack of strategies outside of medication
- At point of contact, staff are insensitive to needs of youth and family, can be uncaring, rude
- Availability of resources
- Lack of good help
- Short-term/quick fixes instead of long term strategies with buy-in from consumer
- No real programming
- Lack of checks and balances regarding curriculums to help
- Lack of participation of youth in their own treatment planning
- Processes are not strength-based
- People not realizing that external behaviors are not the only way youth exhibit crisis
- Staff only doing the work for the money
- Lack of professionals that care
- Calling police/ambulance in crisis
- ER waits are too long; youth become calm and no one believes they are still in crisis

**What could have made it easier?**

- Support group at time of crisis
- Opportunities for people with felonies to get jobs
- Warm referrals to supports
- Holistic approach
- Peer supports in all services and agencies for outreach, education, and engagement
- Single point of entry, with person answering, not machines or numbers to push
- Staff being able to differentiate between mental health and substance abuse crisis
### Recommendations:
- Single point of entry
- Community awareness/investment
- Peer support at point of entry/contact
- Peer support and clinical teams working together to help families, youth, and children
- Acknowledgement of the professionalism of peer supports
- Focus groups on higher level to educate local government officials, judges, etc.
- Less paperwork
- Expand peer supports and peer centers
- Expand services into places where youth are – schools, etc.

### Most important?
- Stigma reduction – awareness campaigns
- Less red tape – wait lists, ER times, paperwork
- Single point of entry
- Peer support
- Holistic approach
- Accurate assessment
- Crisis response teams for schools
- Peer supported education
III. Focus Group Report Out

To begin the afternoon session attended by participants from the first stakeholder meeting and consumers who elected to stay, a summary report of the work done by the consumer focus groups was presented by Mark Baker, Neil Kaltenecker, and Dietra Hawkins.

<table>
<thead>
<tr>
<th>WHAT HELPS CONSUMERS? WHAT CONSUMERS NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lived Experience:</strong> Sharing theirs, benefitting from others – in schools; provider agencies; ERs; with, or in place of, police; etc.</td>
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<tr>
<td><strong>Access to Services:</strong> Between crisis and treatment</td>
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<tr>
<td><strong>Resource Directory:</strong> including In Person Recovery Supports</td>
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<tr>
<td><strong>Access, Resources, Sharing &amp; communicating what is available</strong></td>
</tr>
<tr>
<td><strong>Individualized Treatment:</strong> Flexible services that are strength-based; we write our own Recovery Plans</td>
</tr>
<tr>
<td><strong>Stigma:</strong> Knowing how to get help before the crisis</td>
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<tr>
<td><strong>48 Hours Later:</strong> this impacts our whole life, we need support and follow-up</td>
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<tr>
<td><strong>Reduce “Red Tape”:</strong> such as time to get TB and RPR tests, time it takes to see a “real” expert</td>
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<tr>
<td><strong>Transitional Safe Spaces and Places</strong></td>
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<tr>
<td><strong>Accurate/Appropriate Treatment:</strong> for what we need vs. what is available</td>
</tr>
<tr>
<td><strong>More Substance Abuse Services/Programs</strong></td>
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<tr>
<td><strong>Advocacy:</strong> Sharing what is working, cost benefits analysis plus stories, sharing with legislators</td>
</tr>
<tr>
<td><strong>Continuing Focus Groups and Conversations:</strong> with police, local government officials, community partners, land lords, judges, etc.</td>
</tr>
</tbody>
</table>
IV. Review of Draft BH Crisis Continuum/Brainstorming

Participants were placed into small work groups that included representatives of adult mental health and addictive disease, child and adolescent services, and consumers. Participants were instructed to review the draft continuum of behavioral health crisis services and strategies, and to recommend changes, both in format and content.

### STAKEHOLDER GROUP 1

**Prevention:**
- Add GCAL as a way to connect consumers to appropriate services & supports to prevent crisis
- Add CIT training/connection between law enforcement and community
- Add National Suicide Hotline
- Add Mental Health First Aid
- Add SBIRT
- RESPECT seminar (strategy)
- Add Parent/Caregiver Education
### Early Intervention:
- Add GCAL
- Add National Suicide Hotline

### Acute Intervention:

### Crisis Treatment:

### Re-Integration:
- Add Accountability Courts
- RESPECT Seminar (strategy)

### Other Recommendations:
- Add GCAL to all domains
- Availability/Access: state-wideness of services
- Access to peers: resource to other services/supports as needed
- Drop In Centers: AA Clubhouse, Twelve Step
- Education/Outreach/Marketing of GCAL (strategy)
- Add Peer Support across continuum
- Add links to Peer Support and DFCS, DJJ, Corrections/Parole systems
- Use “Personal Medicine” instead of Medication Adherence
- SOAR (strategy)
- Workforce Education and Training
- Ensure that WHAM, CARES, CPPS, and CYPS are all defined as part of peer support – fully define each piece on the continuum
- One single point of entry responsible for access, referral, warm-line transfer
- Community Education

### STAKEHOLDER GROUP 2

#### Prevention:
- Add School-Based services
- Add Peers in recovery
- Add NAMI for Families
- Add Wellness Education (strategy)
- Add Connection/Education for families, i.e. NAMI Family to Family (strategy)
- Add Education for schools on mental health issues, recognizing warning signs (strategy)
- Add Peer mentors in schools (strategy)

#### Early Intervention:
- Add Access to emergent/urgent appointments
- Add Emergent/urgent access to medications
- Access to right medications (strategy)
- Alternate funding resources for medications (grants, etc.) (strategy)
- Better education on 1013s to prevent unnecessary 1013s
Acute Intervention:
- More CPS staff
- Long-term stabilization for youth
- More access for youth with diagnoses such as conduct disorder ODD, ADHD
- Rapid access to medical information (strategy)
- Better integration between Mobile Crisis and First Responders (strategy)

Crisis Treatment:
- Increase number of CSU beds
- Add 23-hour observation beds
- Add treatment on emergency/urgent basis for individuals who do not need detox
- Rapid access to enrollment information (strategy)
- Rapid access to appointments (strategy)
- Access to peers (strategy)

Re-Integration:
- Rapid access/continued medication management
- Get individuals into NAMI
- Alternate funding of medications (strategy)
- Connection to peer/family support (strategy)

Other Recommendations:
- Peers at every step of process

STAKEHOLDER GROUP 3

Prevention:
- Add whole health care
- Add C&A Clubhouses
- Add School-based services
- Access to integrated care (strategy)
- AA/NA/GARR (strategy)
- Double Trouble (strategy)
- Suicide screening (strategy)
- Education of individual, families, stakeholders, first responders, etc. on SA, psychoeducation
- Partnerships with schools, DJJ, DOC (strategy)
- NAMI Family to Family (strategy)

Early Intervention:
- Add C&A Clubhouse
- Add Family Support Organization
- Warm-line for all (strategy)

Acute Intervention:
- Add Specialty Services (ACT, IFI)
- Add In-home Support services
- Core providers to do more
**Crisis Treatment:**
- Add In-home Support services
- Add Residential Services
- Add Crisis Step-down/Respite
- Add Ambulatory Detox
- Add Peer Support
- Update/create WRAP/Crisis Plan (strategy)

**Re-Integration:**
- Add C&A Intensive Residential Treatment
- Add Residential Services
- Add Community Supports – AA, NA, NAMI, etc.
- Add Housing Supports
- Add Employment

**Other Recommendations:**
- Change “Acute Intervention” to “Intensive Intervention”
- Data management/linkage between data and providers = outcome/accountability
- The following should be included in all levels: Case/Care Management; Access to services and medication; Resource Information; Peer/Parent/Family Support; Natural Supports; Housing; Employment
- One call – that’s all! No wrong door, one-stop shop

**STAKEHOLDER GROUP 4**

**Prevention:**
- Add Care Management Entity
- Add Self-Screening Tool
- Add Drop-In Centers
- Add Supportive Housing
- Add GCAL to Warm-line
- Add Peer run transportation
- Coordination/education to schools, community resources, shelters (strategy)
- Pre-early intervention (strategy)
- Centralized resources access (strategy)
- Strike Family Service Organization

**Early Intervention:**
- Add GCAL to Warm-line
- Add Care Management Entity
- Recovery groups (strategy)
- GCAL have WRAP (strategy)
- Strike Family Service Organization

**Acute Intervention:**
- Add CAC, CPS, CARES in MCT
• Add Crisis Housing
• 24/7 access in local community to treatment team
• Standard referral processes – example medical clearance (strategy)

**Crisis Treatment:**
• Add Peer Support within CSU and all other crisis services
• GCAL have access to WRAP (strategy)

**Re-Integration:**

**Other Recommendations:**
• Expansion of Mobile Crisis and other services statewide
• Increase number of CSU and Respite beds
• Non-linear depiction
### STAKEHOLDER GROUP 5

**Prevention:**
- Increase funding capacity to ensure access without barriers and delays

**Early Intervention:**
- Increase funding capacity to ensure access without barriers and delays
- Create incentives for early treatment

**Acute Intervention:**
- Explore ways to share information across providers that could assist in crisis intervention

**Crisis Treatment:**
- Add Peer Support and Peer Mentors
- Add Peer Wellness/Respite Center
- Trauma-training, especially for law enforcement (strategy)

**Re-Integration:**
- Prioritize supports – basic needs, physical health, and then access to services

**Other Recommendations:**
- Expand strategies to other than BH type strategies
- Create/review Crisis Plan in every category
- Encourage community partnerships as strategy to create needed programs
- Outreach and education – local community specific information about how to access services, resources, community programs
- Common database
- Conduct focus groups to look at law as relates to Emergency Receiving Facilities
- Develop alternatives to transport in emergencies
- Consider renaming “Re-Integration” to “Continuation”
- Incentivize outcomes through contracts
- Training on 1013 process; use number of 1013s to evaluate how well system is meeting needs
- Non-linear depiction
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<th>STAKEHOLDER GROUP 6</th>
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<td><strong>Prevention:</strong></td>
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<td>• Add Respite</td>
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<td>• Add GCAL</td>
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<td><strong>Early Intervention:</strong></td>
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<td>• Add GCAL</td>
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<td><strong>Acute Intervention:</strong></td>
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<td>• Add CTP</td>
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<td>• Add Respite</td>
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<tr>
<td><strong>Crisis Treatment:</strong></td>
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<tr>
<td>• Add Peer Support via CTP</td>
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<td>• Add Respite</td>
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<td><strong>Re-Integration:</strong></td>
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<td>• Add CTP</td>
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<td>• Add Respite</td>
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<td><strong>Other Recommendations:</strong></td>
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<tr>
<td>• Change “Family Service Organization” to “Family Support Organization”</td>
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<tr>
<td>• Consistency and State-wideness, Consistency between C&amp;A and Adult</td>
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<td>• Maintain Crisis foundation and funding as it stands today</td>
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<td>• Revisit HFR regulations – screen/test language is a barrier</td>
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<td>• Change Probate mandating treatment</td>
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<td>• Non-linear depiction</td>
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Not all services are included as presented by group, for illustrative purpose only.
V. Steering Committee

Participants were asked to consider applying to serve on the Steering Committee, the purpose of which is to formulate views and advise the DBHDD on matters of strategic and operational issues concerning Crisis Services. Composition of the Committee will be small enough to be efficient and effective; large enough to be representative and inclusive of child & adolescent services, adult services, mental health, & addictive diseases.

Work of the Committee will include, but not be limited to:

- Reviewing research, data
- Identifying and responding to significant developments in the environment
- Developing a strategic plan for behavioral health crisis services
  - Stakeholders – insuring that needs/wants of stakeholders are met to the extent possible – consumers, families, providers, community partners, law enforcement, schools, agencies, etc.
  - Logistics – access, movement/pathways, supply/demand, protocols, information sharing, etc.
  - Competencies – recovery/resiliency-oriented, family-centered, person-centered, strengths-based, trauma-informed, culturally competent
  - Parts – services and strategies

Steering Committee members must be willing and able to commit to full engagement – representing a stakeholder group, attending meetings, and doing the work, for up to one year. Participants were asked to complete a one page Application if they were interested in working on the Steering Committee.
VI. Next Steps

- Appoint Steering Committee and convene first meeting
- Ensure Steering Committee adequately represents stakeholder groups/add members as appropriate
- Steering Committee shall set meeting schedule, develop a work plan, and timeframes

VII. Participants in the morning and/or afternoon sessions

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
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<tr>
<td>Brittni Allor</td>
<td></td>
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<tr>
<td>Debbie Atkins</td>
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<td>REA-BH Region 1</td>
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<td>Mark Baker</td>
<td>Office of Recovery</td>
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<td>Elizabeth Barbone</td>
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<td>Rodriquez Barefaeid</td>
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<td>Community Services Adm.</td>
<td>GRHS-Lakeside/MCRS</td>
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<td>Maya Carter</td>
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<td>Dietra Hawkins</td>
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<tr>
<td>Brent Wilson</td>
<td>Child Psychiatrist</td>
<td>View Point Health</td>
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VIII. Considerations for Strategic Planning

Based on discussion and group report-outs during the Behavioral Health Crisis Continuum Stakeholder’s Meetings, Parts I and II, the following issues will be considered in future strategic planning efforts:

- Linear continuum vs. array of services
- Peer Support – lived experience - across entire continuum/service array
- One single point of entry with connection to other warm-lines
- Geographical inequities
- Funding inequities across regions/services
- Technology/Tele-medicine/electronic medical records
- Whole health/Primary Care Integration
- Aligning the system (policies, practices, funding, etc.) to Recovery/Resiliency-Oriented principles
- Family System work
- Workforce Issues
  - Retention
  - Staff development
  - Shortages
- Medication costs
- Transportation
- 24/7 access in services across the continuum
- Case coordination
- Outcome based models
- 1013 processes
- Simplify/streamline authorization and audit processes
- Reduction of bureaucratic “red tape”
- Under-utilization of EPSDT
- Definitions – of core customer, of services, of peer support entities
- Inadequate funding for entire system
- Strengthening core services
- Outreach
- Education/Marketing
- Cultural sensitivity/competency