Department of Behavioral Health and Developmental Disabilities
REGION 2 DBHDD Regional Planning Board
Fiscal Year 2015 Annual Plan

Region 2 is comprised of 33 counties covering 12,214 square miles, with a total population of 1,277,120. The Region is divided into 5 service areas, each specified by the metropolitan areas of Athens, Augusta, Macon, Milledgeville, and Swainsboro. R2 is predominately rural and economically disadvantaged, with 33% of the population living below the poverty level compared to the State total of 16.6%. The Ogeechee service area consists of 6 counties, 5 of which are among the 10 most severely impoverished in R2, with 38.4% of the population being Medicaid recipients. The Region is comprised of 24.3% individuals under the age of 18 years old and 14.3% above the age of 65 years old. This is comparable with the state totals of 25.7% for children and 10.7% for people over the age of 65 years old. Oconee County has the highest percentage of children in the region with 28.4% of the population. Greene County has the highest percentage of people over the age of 65 years old at 21% (United Census Bureau, 2010 Census).

Provider	Medicaid	Pop/Sq. Mile	Below Poverty
Ogeechee	38.5%	27	28.7%
Serenity	35.0%	165	31.6%
River Edge	30.6%	154	23.1%
Oconee	28.0%	45	31.6%
Advantage	28.3%	162	36.3%

The population per square mile is as follows: Ogeechee - 27; Oconee – 45; River Edge 154; Advantage – 162; Serenity – 165. The area is served by a total of 77 Developmental Disabilities providers, 58 Adult Behavioral Health Providers and 60 Child and Adolescent Providers.

On October 19, 2010, the State of Georgia entered into a settlement agreement with the United States Department of Justice to assure that integrated services, programs and activities are available in Georgia's Community Behavioral Health System.

For the purposes of the ADA Settlement Agreement, the target populations for the community services are persons with developmental disabilities who would otherwise be served in Intermediate Care Facility/Mental Retardation facilities and persons with serious and persistent mental illness (SPMI) who would be served in State Hospitals without community services. The target population for the community services is approximately 9000 individuals with SPMI:

- Who are currently being served in the State Hospitals
- Who are frequently readmitted to the State Hospitals
- Who are frequently seen in Emergency Rooms
- Who are chronically homeless, and/or
- Who are being released from jails or prisons.

The Region Two (R2) office is responsible for effective planning, purchasing and monitoring of community based behavioral health services that meet the needs of the citizens in the region who rely on state supported Mental Health services to live in the community.

Region 2 surveyed our providers of CORE services to determine the most common diagnostic categories and the percentage those categories made up of the entire population served. The most common diagnostic category was the Moderate and Severe types of Major Depressive Disorder. Other common diagnoses included Schizophrenia and Bipolar Disorder although the percentage of clients served who are diagnosed with Bipolar Disorder varies significantly among providers. The survey found that ten percent or less of clients served by the providers in Region 2 are diagnosed with less severe diagnoses such as Major Depressive Disorder, Mild or Anxiety Disorders or with Polysubstance Dependence. In the table below, those categories noted "Not Reported" indicated those diagnoses were not named as one of the six most common diagnoses by that agency. The majority of individuals served with diagnoses consistent with SPMI range from 55% with Oconee to 81% with Ogeechee.

Percentage of Individuals with Specific Diagnoses by Provider						
Diagnosis	**American Work**	**Advantage**	**Oconee**	**Ogeechee**	**River Edge**	**Serenity**
Schizophrenia	14%	9%	22%	28%	11%	7%
Schizoaffective Disorder	13%	10%	4%	Not Reported	11%	10%
Bipolar I Disorder	18%	27%	6%	11%	25%	27%
Bipolar II Disorder	Not Reported	3%	Not Reported	Not Reported	Not Reported	3%
Major Depressive Disorder – Moderate/ Severe	25%	31%	23%	42%	25%	31%
Major Depressive Disorder – Mild	4%	Not Reported	5%	4%	3%	Not Reported
Anxiety Disorders	Not Reported	9%	8%	10%	3%	9%
Polysubstance Dependence	6%	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported

Total Percentage of Clients Diagnosed with SPMI						
	American Work	**Advantage**	**Oconee**	**Ogeechee**	**River Edge**	**Serenity**
Diagnoses Consistent with SPMI	88%	80%	55%	81%	72%	78%

The Region Two Office plays an integral role in ensuring a coordinated system of service delivery to promote successful community integration of individuals with SPMI. Region Two staff work toward the defragmentation of community services so that individuals with SPMI are provided tailored supports that are accessible, coordinated, and developmentally appropriate. Specific areas of need include mental health, substance abuse, vocational rehabilitation, housing, whole health and wellness, social security, peer support, community programs, and family support. Successful community integration also requires multi-agency sharing of resources and a person-centered approach that builds on the strengths of individuals. The Regional Office actively promotes the vision that long-term services and supports encourage individual's preferences regarding where they want to live, the types of services they receive, and who provides the services.

To accomplish this goal, the Regional Office works directly with East Central Regional Hospital and community providers to coordinate an individual's successful transition to the community. In order to maintain a recovery-oriented mental health system, R2 staff are tasked with the identification of strengths and gaps in the current system and major barriers that prevent individuals from receiving recovery-oriented services.

Housing

In accordance with the DOJ Settlement Agreement and the recognition that living in one's own house, apartment, or furnished room is a vital aspect of independence for individuals, permanent, safe, and affordable housing that is not dependent upon the acceptance of treatment is a critical aspect of resiliency and recovery and creates a foundation for establishing stability and instilling hope. The Regional Office coordinates the efforts to strengthen a continuum of community housing options ranging from personal care homes to independent housing. The Regional Office administers the Georgia Housing Voucher Program (GHVP) and has successfully collaborated with multiple providers to place approximately 150 individuals in housing. The GHVP has been successful in the prevention of homelessness and the reduction of recidivism from places such as jails, prisons, nursing homes, and psychiatric hospitals. Community based programs provide both rehabilitative and supportive functions in a flexible manner to match individual needs and goals. These include Case Management, Residential Services, Assertive Community Treatment (ACT), Psychosocial Rehabilitation, and Supported Employment.

DBHDD recently entered into a partnership with the Georgia Department of Community Affairs Plans are to move those individuals currently on a GHVP to a DCA funded voucher. This will free up GHVP funds to expand assistance to other individuals with SPMI in need of housing. Region 2 has begun the process of converting GHVP individuals to DCA vouchers and has found that the majority of landlords and property owners are agreeable to the change. Individuals will continue to receive the same services as under GHVP and this has been instrumental in the acceptance of the change. Region 2 will continue to provide technical assistance and consultation for our providers so that we may continue the progress in the area of providing safe, affordable housing to our individuals.

Crisis Services

Crisis Response is also a key component of our Mental Health System. The ability to rapidly respond face-to-face with an individual in crisis often de-escalates the situation and provides linkage to community mental health resources for those individuals in need of ongoing services. Crisis teams are often successful in the prevention of ER visits and psychiatric hospitalizations. Key components of an effective crisis response team include:

- Provision of services for individuals with multiple service needs, specifically individuals with co-occurring disorders and/or medical issues
- Provide a range of crisis services that divert people from inpatient psychiatric hospitalization and emergency rooms to less costly services
- Coordinate with the individual's primary behavioral health provider for follow-up care
- Provide appropriate linkages and arrangements that minimize the use of law enforcement as the primary responder to individuals in crisis

The Regional Office takes the lead in the evaluation and continuous improvement of R2 crisis services in regards to community integration, cost effectiveness, utilization, and accessibility for individuals in rural areas. This involves working closely with local Sheriff's Departments, Emergency Receiving Facilities, and Behavioral Health Providers. The expansion of services to rural areas is a priority for the Region. The R2 Crisis System has the following components:

- 24 hour crisis lines
- Walk-in Crisis Service Center
- Mobile Crisis Services
- Crisis Apartments
- Crisis Stabilization Programs
- 23 hour unit

Dual Diagnosis

The evaluation and treatment of individuals with co-occurring mental health and substance abuse disorders continues to be a challenge for the Behavioral Health system as a whole. The consequences of untreated co-occurring disorders include increased hospitalizations, homelessness, law enforcement involvement, and medical issues. A recent survey (National Alliance on Mental Illness 2012) indicates that 47% of individuals with schizophrenia had a substance abuse disorder (more than four times as likely as the general population), and 61% of individuals with bipolar disorder had a substance abuse disorder (more than five times as likely as the general population). The Regional Office recognizes the extent of this problem and has promoted an Integrated Treatment model that combines elements of mental health and addiction treatment into a comprehensive treatment program. Significant challenges to the viability of this model include financial constraints, lack of clinicians who are cross-trained in the treatment of co-occurring disorders, and long-term care that is available across the stages of treatment, relapse, and recovery. Individuals with co-occurring disorders also have high utilization of the most expensive level of care in the mental health system and a high degree of addiction severity with temporary substance-induced suicidal syndromes. According to a 2006 report by the Office of Applied Studies, 50% of all suicide attempts involve alcohol and illegal drugs and 25% of completed suicides occur among drug and alcohol abusers. Furthermore, a psychiatric condition was diagnosed in 41 % (43,176) of drug-related suicide attempts treated in the ER; the most frequent psychiatric diagnosis was depression.

Dual Diagnosis by Age Group

The chart to the right shows the association between addiction and psychiatric conditions in suicidal populations.

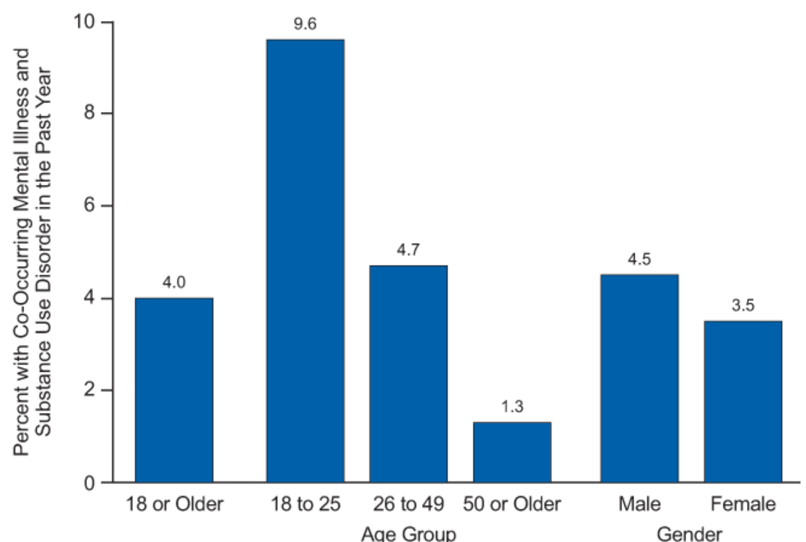

Figure 1 National Survey on Drug Use and Health (2008)

Jail/Prison Population

The jail/prison population is a major focus of the Settlement Agreement due to the significant number of incarcerated individuals with SPMI. Many of the individuals who cannot get mental health treatment in the community end up in the criminal justice system after they commit a crime. According the Bureau of Justice Statistics, 56 percent of state prisoners and 45 percent of federal prisoners have symptoms or a recent history of mental health problems. Furthermore, prisoners have higher rates of SPMI such as schizophrenia, bipolar, and major depression that are 2 to 4 times higher than individuals in the general public. In recognition of this,

Region 2 staff is working closely with providers in developing relationships with local sheriff's departments and jails to expand mental health courts and awareness of community resources. There are mental health courts in the Advantage and River Edge service areas which, in conjunction with R2 providers, have been effective in ensuring that program participants are connected to needed community-based treatments, housing, and other services that encourage recovery.

Homelessness
Another key goal of the Settlement Agreement is the reduction of homelessness. Homeless individuals with mental health disorders remain homeless for longer periods of time and have less contact with family and friends. They encounter more barriers to employment, tend to be in poorer physical health, and have more contact with the legal system. The Regional Office has prioritized the engagement of homeless individuals through a range of supportive housing and treatment options that are responsive to the needs of the individual. When combined with access to therapy and meaningful daily activities, appropriate housing can provide a firm foundation for recovery.

Substance Abuse
For those individuals with a Substance Abuse Disorder as their primary diagnosis, progress has been made in creating a continuum of care based on the American Society of Addiction Medicine (ASAM) levels of care, but there is a significant need for long term residential placements to provide stability in the initial stages of recovery. Region 2 currently has a Transition Program at the Oconee Center, in which individuals are transitioned directly from a Crisis Stabilization Unit to apartments for 2 to 4 weeks. During this time, individuals participate in the Intensive Outpatient Program and attend 12-step meetings. Prior to discharge, a community transition plan is developed to ensure the continuation of treatment and that basic needs are met. Many individuals that participate in this program are homeless, so a challenge is to provide placement options to bridge the gap between treatment and daily living. The availability of long term transitional housing allows individuals to live in a drug free environment while working on issues such as finding gainful employment and making plans for a new place to live.
(Ogeechee here)
(Serenity here)

The basic components of effective addiction treatment should be readily available, focus on the multiple needs of the individual, and be of appropriate duration. A treatment delivery system should connect individuals in recovery with other types of help and supports they need, utilize Evidence Based Practices, make sure that individuals transition smoothly from one level of care to another, and maintain high quality services for everyone who needs it.

Child and Adolescent Mental Health and Addictive Diseases

Child and Adolescent (C&A)
Of the total population, 310,588 or 24.3%, are children and adolescents 18 and under. Approximately 8% of this population is estimated to have a diagnosis of a Severe Emotional Disturbance (SED) which amounts to 24,847 children in R2. In FY2011, 3872 children were served by MH providers, reaching 15.6% of the estimated population of children needing MH services

Core Services - There are 68 different core providers approved to serve children and adolescents in R2. Core providers are required to provide mental health and substance abuse treatment services. Providers per service area are: Macon - 26; Athens - 21; Augusta - 15; Swainsboro - 9; Oconee – 13. Although there are multiple core providers per CSB catchment area, some counties have only one provider of C&A core services. This limits choice for consumers and increases times for appointment availability. Expansion of providers into additional counties would increase access.

Intensive Family Intervention (IFI) Services - There are 67 different IFI providers serving R2. The Macon catchment area has 31 IFI providers. The Baldwin catchment area has 16. The Augusta catchment area has 14.The Athens area has 24 and the Swainsboro catchment area has 6 IFI providers. Although all CSB catchment areas have multiple IFI providers, some counties do not have an IFI provider servicing their area or only one IFI provider. Expansion of current providers into these areas is needed for choice and availability of intensive services.

Crisis Stabilization Units (CSU): There are 4 Child and Adolescent CSUs across the state. River Edge operates a 16-bed unit serving 5-14 year old children and purchases inpatient beds at other facilities if they do not have the capacity to manage a child in their unit. Children from R2 can also receive services in any other CSU in the state. However, most children within the region are referred to River Edge or to the CSU in DeKalb County operated by Viewpoint Health, which serves children ages 14-18 years old. Transportation to and from CSUs may be difficult for families and youth are often transported by Sheriff Departments on 1013s. The region needs a psychiatric emergency transportation system serving all counties.

Psychiatric Residential Treatment Facilities (PRTF): There are seven PRTFs throughout the state. In FY 2012, 35 children from R2 were served in PRTFs at any given time. There are two PRTFs located within R2, Lighthouse Care Center in Augusta and Macon Behavioral Health Treatment Center in Macon. The Region has adequate PRTF services.

Mobile Crisis Services - In FY 2013, mobile crisis services for the Augusta and Swainsboro services areas were available through Behavioral Health Link (BHL). They provide services in the community and in Emergency Departments in the counties of Richmond, McDuffie, Wilkes, Screven, Jefferson, Emanuel, Jenkins, and Burke. They respond to Emergency Departments at University Hospital, Trinity, Eisenhower Medical, Wilkes Memorial, McDuffie Medical, Georgia Health Sciences University (C&A only), Screven County Hospital, Burke Medical Center, Emanuel County Hospital, and Jenkins County Hospital. In addition, Ogeechee CSB provides mobile crisis services at the emergency rooms for their catchment area during business hours, with the exception of Jefferson County, where BHL provides 24/7 coverage. River Edge BHS provides crisis intervention services at the Medical Center of Central Georgia and at Oconee Regional Medical Hospital. Advantage CSB provides crisis intervention services at St. Mary's Hospital. Mobile crisis services will be available in all R2 counties by 2015. R2 is slated to received additional funding for mobile crisis services in FY

Care Management Entity (CME). There are two CMEs currently operating in the state. CMEs use a process called High Fidelity Wraparound to support families. Families are referred to these services either through the Community Based Alternatives for Youth (CBAY) waiver or through meeting certain targeted criteria. Viewpoint Health and Lookout Mountian both serve state wide. Currently CBAY services have been approved to be funded via Medicaid dollars however this is in process of being developed as to exactly how that is to take place.

The Resiliency Support Clubhouse Program for Youth – These mental health programs are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma and other challenges of mental health disorders. The Clubhouse runs on a work-ordered day. Participants of the program are called members. Members and staff work together each day to perform the jobs of the Clubhouse and participate in clinical sessions, social outings, work activity, educational supports, and clubhouse activities. In FY 2012, R2 received funding for a Resiliency Support Clubhouse in Milledgeville. Data is still being collected and the program reviewed as to whether a clubhouse is indicated in other areas of the region.

Clubhouse For Kids – R2 does not have a Clubhouse for Kids; however, this program provides a comprehensive substance abuse treatment model designed to engage children and adolescents and their families in their own recovery. The Clubhouse is a supportive environment where children and adolescents are members. Staff and members work together to perform the jobs of the clubhouse and participate in clinical sessions, social outings, educational supports, and specific clubhouse activities. The Clubhouse Model is a comprehensive program of support and opportunity for recovery and psychological growth. In contrast to traditional day-treatment and other day program models, Clubhouse participants are called "members" (as opposed to "patients" or "clients") and restorative activities focus on their strengths and abilities, not their illness. The Clubhouse is unique in that it is not a clinical program, meaning there are no therapists or psychiatrists on staff. Instead, the program focuses exclusively on the strengths of the individual. R2 needs Clubhouses for Kids in all service areas.

Child and Adolescent Substance Abuse Residential Treatment - There are two 24 hour, supervised, residential treatment programs for children and adolescents ages 13-17 years old who are in need of a structured residence due to substance abuse. Neither program is located within region 2 but the two are located in the metro area and southern part of the state in order to afford statewide access. There are also four adolescent addictive disease group homes that are state funded and provide a structured temporary living situation for youth ages 13-17 years old dealing with substance related disorders. There is a need to make these services more accessible to children and adolescents and for programming closer to the youths' home communities.

Region Two Planning Board Membership					
County	**Board Member**	**County**	**Board Member**	**County**	**Board Member**
Bibb	Saundra Brown	**Jenkins**	Mandy Underwood	**Richmond**	Geneice McCoy
Bibb	Linda Ellis	**McDuffie**	Sherri Cunningham	**Screven**	Kathy Fitzner
Burke	Martha Crumbley	**McDuffie**	Tammy Herring	**Taliaferro**	Rosie Cullars
Clarke	Ed Glauser	**Monroe**	Debbie Harbin	**Twiggs**	Bessie Bonds
Columbia	Cathy Hayes	**Morgan**	Andrew Chase	**Walton**	Gloria Berry
Columbia	Lisa Jones	**Oconee**	Ann Hester	**Wilkes**	Linda Echols
Emanuel	Don Wilkes	**Putnam**	Josette Akhras	**Wilkinson**	Margaree Gibson
Jefferson	Nancy Gunn	**Richmond**	Laverne Crawford		

Adult Mental Health

In FY 2011, the Department of Behavioral Health and Developmental Disabilities reached a Settlement Agreement with the U.S. Department of Justice, targeting services to persons with severe mental illnesses resulting in institutionalization or risk of institutionalization. Priority populations include:

Severe and Persistent Mental Illness

- Individuals with severe and persistent mental illnesses being served in state hospitals
- Individuals frequently readmitted to state hospitals
- Individuals frequently seen in emergency rooms
- Individuals who are chronically homeless
- Individuals released from jails or prisons.

The provisions of the Settlement Agreement require that 9000 persons with severe and persistent mental illnesses be served through the following intensive services by 2015:

- Assertive Community Treatment
- Community Support Teams
- Case Management Services
- Crisis Stabilization Units
- Crisis Service Centers (Urgent Care)
- Supportive Housing
- Bridge funding (from institutions to community)
- Supported Employment
- Peer Supports
- Crisis Apartments
- Mobile Crisis Services

Assertive Community Treatment - In FY 2013, the region had Assertive Community Treatment (ACT) teams in Clarke and surrounding counties, in Richmond and surrounding counties, and in Bibb/Baldwin and surrounding counties. ACT teams have a geographic radius of about 40 miles or 45 – 60 minutes drive time. Each ACT team can serve 70 – 100 consumers. ACT serves individuals with severe and persistent mental illness who have not responded well to traditional outpatient mental health treatment and have severe functional impairments. These individuals often have co-existing problems such as homelessness, substance abuse problems, and involvement with the criminal justice system. The ACT model adheres to the following principles:

- Primary provider of services and small consumer to staff ratio. The team is made up of a psychiatrist, team leader, paraprofessionals, nurses, vocational rehabilitation specialist, peer specialist, and licensed mental health counselor, and substance abuse counselor.
- Services are provided out of office.
- Highly individualized services.
- Emphasis on vocational services.
- Assertive approach
- Psychoeducational services.
- Substance abuse services.
- Assertive approach.
- Family support and education.
- Community Integration.

Case Management – Region 2 has Case Managers in the following service areas: 2 at Oconee; 1 at River Edge; and 2 at Advantage. Case Management services focus on all aspects of the physical and social environment. These involve formal resources such as housing, financial support, transportation, and medical care, as well as informal resources, such as families, roommates, and churches. Case Management provides support and structure in response to individual needs, linkage to community resources, and continuity of care.

Crisis Service Center - River Edge's Crisis Services began serving individuals in Baldwin County in April 2012. The contract included a variety of crisis services. The Crisis Service Center is a 24 hour walk-in clinic for individuals in psychiatric crisis. Individuals are assessed and observed for up to 23 hours then are referred to the appropriate level of care. Individuals can be sent to inpatient hospitals or a Crisis Stabilization Unit, if necessary, but can also utilize Crisis Apartments or be referred for outpatient services if they do not require additional inpatient services. River Edge also has a Crisis Response Team at Oconee Regional Medical Center which can assess individuals who present at the emergency room with psychiatric issues, thus reducing the workload of emergency room staff. River Edge also provides Hospital Companions, Tele-Psychiatric Services, Hospital/ CSU Transport Services, Case Management Services, Crisis Apartments, and Peer Support Services related to their Crisis Services contract. Admissions to East Central Regional Hospital from Baldwin County providers which include Oconee CSB, Oconee Regional Medical Center, and River Edge CSB decreased significantly when comparing the time period that the Baldwin County Crisis Services have been present in 2012 to the same time period in 2011. From April to November 2012, there have been a total of 56 individuals referred to East Central Regional Hospital from Baldwin County providers compared to 90 individuals in that time period in 2011. Of those individuals referred to East Central Regional Hospital 34 were admitted to the hospital in 2012 compared with 60 in 2012. This corresponds with a decrease in the percentage of individuals admitted from 66.7% in 2011 to 60.7% in 2012. While the decrease in referrals and admissions cannot be directly attributed to the Baldwin County Crisis Services it is likely that there is a correlation between the availability of crisis intervention services and the decrease in East Central Regional Hospital referrals and admissions.

Crisis Stabilization Programs (CSPs) - CSPs are located in Augusta, Athens, and Macon with 68 beds. The CSP in Augusta serves the Augusta and Swainsboro service areas; the CSP in Athens serves the Athens service area; and the CSP in Macon serves the Macon and Baldwin service areas. In addition to these Emergency Receiving and Evaluating Facilities, East Central Regional Hospital has 90 beds and provides Emergency Receiving, Evaluating and Treatment.

Supported Employment - Region 2 has Supported Employment in the Advantage, American Work, Oconee, River Edge, and Serenity service areas. Each team has 20 slots with the exception of American Work, which has 33 slots. DBHDD utilizes Individual Placement and Support (IPS) model, which is an evidence-based model developed by the Dartmouth Psychiatric Research Center. IPS supported employment helps individuals with severe mental illness work at regular jobs of their choosing. The focus is on competitive employment and individuals are not excluded on the basis of readiness, diagnoses, symptoms, substance abuse history, psychiatric hospitalizations, level of disability, or legal system involvement. The key characteristics are as follows:

- Eligibility based on individual choice
- Integration of Rehabilitation and Mental Health Services
- Attention to individual preferences
- Personalized benefits counseling
- Rapid job search
- Systematic job development
- Time-unlimited and individualized support

Supportive Housing - The funding allocated for residential services in R2 in FY 2013 follows:

- Advantage Behavioral Health Services - **$896,859.00 –** Independent and Semi-Independent Residential Supports provided in apartments/duplexes.
- Oconee Community Service Board - $**1,182,180.00** - Intensive Residential Supports, Semi-Independent Residential Supports, and Independent Residential Supports provided in apartments, houses, mobile homes, duplexes and personal care homes.
- Ogeechee Behavioral Health Services - $**282, 374.00** - Independent Residential Supports and Housing Supplements provided in apartments and personal care homes.
- River Edge Behavioral Health Center - $**110,010** – Independent Residential Supports provided in apartments and homes.
- Serenity Behavioral Health Systems - $**368, 147.00** –Independent Residential Supports and housing supplements provided in apartments, duplexes and personal care homes.

Regional Planning Board Priorities

Priority:
Inform and educate consumers, families and other community stakeholders regarding available and needed disability services and other relevant issues impacting the delivery of mental health, developmental disability and addictive diseases services (e.g., ADA Settlement, Regional Planning Board, etc.).

Rationale:
The ADA Settlement Agreement contains provisions for the expansion of community services for adults living with Developmental Disabilities and Mental Illnesses extending into 2015. The citizens of Georgia need to understand the changes planned by the Department that will impact the availability and delivery of services to individuals and families. Likewise, the Department needs to understand the viewpoints of individuals, families and other stakeholders before and during implementation of such provisions in order to ensure that the needs of individuals, families and communities are met in all stages of service changes.

Priority:
Create housing, permanent supportive housing and other residential services to support successful community living, recovery and habilitation and to prevent institutionalization and incarceration.

Rationale:
Efforts to deinstitutionalize persons living in psychiatric facilities and ICF-MRs have too often led to persons receiving inadequate community services and/or re-institutionalization in nursing homes, jails and prisons. Persons with mental illnesses, developmental disabilities and addictive diseases require varying degrees of supports. These supports must be available in order to avoid the heartbreak and suffering of individuals and families that have accompanied deinstitutionalization efforts too often in the past. Housing with the appropriate level of supports needed and desired by individuals is a prerequisite to successful community living.

Priority:
Create and/or purchase opportunities for individuals with disabilities to receive emergency and non-emergency transportation in all parts of the region.

Rationale:
Persons with mental illnesses, developmental disabilities and addictive diseases often do not have access to transportation, thus, diminishing opportunities for continuity of care, community integration, and recovery. Family members of persons with disabilities are put into the position of jeopardizing employment due to the need to transport loved ones to services and sometimes have to choose between accessing needed services and sustaining the family economically. Lack of transportation is implicated in a large number of treatment failures. In addition, Sheriffs' Departments transport individuals in crisis to emergency receiving facilities, putting strain on law enforcement resources and exposing individuals to additional emotional trauma.

Priority:
Increase supported employment opportunities for individuals with disabilities, including adolescents graduating from high schools, by encouraging schools and other community agencies to work together to stimulate more community participation.

Rationale:
Jobs create opportunities for success and independence that other avenues of support cannot. People living with disabilities may need additional support to find and maintain employment. Jobs provide economic stability, opportunities for community integration, and a sense of accomplishment and are stabilizing influences in people's lives. Assistance to young people graduating from high school in transitioning to employment can set the tone for a lifetime of better functioning, greater independence, and overall well-being.

Priority:
Strengthen the continuum of treatment and recovery supports for persons with addictive disease and co-occurring MH/AD and DD/AD disorders, as well as encourage and promote court systems to implement accountability courts to guard against the recidivism of institutionalized care and incarceration.

Rationale:
Substance abuse is a leading cause of many social problems and is a substantial cause of hospitalization and incarceration. Treatment is crucial to improving the lives of individuals with disabilities and their families. While treatment for addictive diseases was not the focus of the ADA Settlement Agreement, the Department's goals cannot be met without incorporating sound treatment and recovery supports for addictive diseases into its plans.

Priority:
Develop more services and greater provider capacity in rural areas to families who do not have the ability to access services a distance from their homes. Provide rural areas with mobile technology through community support staff employed by our providers

to offer, where appropriate, mobile telecommunications, such as, telepsychiatry, teletherapy , and other support services for equal access for more rural utilization.

Rationale:
For individuals with developmental disabilities to remain in their own homes, families must be able to work to support them. The development of host homes, Community Living Support Services, Supported Employment and Community Access Services lags behind in counties that are not populous enough to be as financially feasible for providers.

Priority:
Increase the funding and capacity for respite services for families with developmentally disabled family members living at home.

Rationale:
Families may need minimal assistance to keep loved ones at home, whereas, if that help is not available, the individual may ultimately be placed in residential services at a much greater cost to the family, in guilt, and to the state, financially.