2013 Review

Georgia Supported Housing and Bridge Funding

United States of America v the State of Georgia
(Civil Action No. 1:10-CV-249-CAP)

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Introduction

This report to the Independent Reviewer summarizes the progress of the Supported Housing and Bridge Funding programs required by the Settlement Agreement in United States of America v the State of Georgia (Civil Action No. 1:10-CV-249-CAP) for the period of July 1, 2012 through June 30, 2013.

Information analyzed for this report was obtained from written documents provided by the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD); information obtained in a Parties/Experts/DBHDD meeting in June 2013; key informant interviews with DBHDD staff, including interviews with Doug Scott, the Director of Housing, and Assistant Commissioner Chris Gault; Region 5 staff, including a meeting with Charles Ringling, Regional Coordinator; an interview with Julia Collins, an ICM Supervisor with Gateway Behavioral Health Services (Gateway is one of Georgia's contract agencies participating in the Georgia Housing Voucher Program (GHVP)); and three site visits with Ms. Collins to visit GHVP participants in their homes in the Savannah area.

This report focuses on the State's progress in three areas: 1.) meeting the Georgia Housing Voucher Program and Bridge Funding targets by type of housing, number of subsidies funded, target population requirements and bridge funding requirements for the year ending June 30, 2013; 2.) supported housing program implementation for priority target populations, including the DBHDD's ability to implement the proposed program for the target population as contemplated in the Settlement Agreement; and 3.) expansion of supported housing resources.

Observations and Findings

1. Housing (GHVP) and Bridge Funding

Georgia Housing Voucher Program

The DBHDD continues to exceed GHVP numerical targets. DBHDD was required to serve 800 individuals by July 1, 2013 and served 1,002 or 127% of the goal. As of July 1, 2013, 762 participants were housed and another seventy-nine were in housing search. This is the third year the DBHDD has reached at least 120% of goal. Over 350 properties were under contract and forty-five service providers were actively serving participants. Participants are living in GHVP arrangements in seventy-four different counties.

The DBHDD keeps records on referrals from point of "notice to proceed," which is basically the DBHDD Supported Housing Director verifying an individual is eligible for the program and the individual can proceed with housing search. In FY 2013, 71% of individuals with a "notice to proceed" had signed leases before the end of the fiscal year[1]. Data is not reported on time from referral to "notice to proceed" but the pace of "notice to proceed" to leases being signed

[1] The primary reason that only 71% had signed leases is that "notices to proceed" can be issued until the end of the fiscal year and the individual was then signing a lease the following month or in the new fiscal year

seems within normal range. There were approximately 12% of the leases cancelled, which merits further review to determine if there are any negative trends that can be reversed. Likewise, not all referrals resulted in individuals getting housing. Assessing the referrals that don't result in leases and reporting on these reasons is warranted for quality review purposes.

In FY 13, 47% of participants had zero income and the monthly average rental payment was $509.54. Bridge funding was provided to 383 participants in the third year of this Settlement Agreement, which is 147% of the goal (113 above the goal of 270). The average cost per participant is $2,347[2]. Furnishings and first and second month rent account for 50% of this cost and provider fees account for 20%. The remaining funds (30%) are allocated for household items, food, transportation, medications, moving expenses, utility and security deposits and other expenses.

This program's success in meeting targets appears to be the result of a combination of factors, including the DBHDD Supported Housing Director's diligence and understanding of rental housing operations and supported housing requirements; clear direction to and strong staff support from the DBHDD Regional Directors and their staff; and the interest and support of referral sources, especially homeless services system outreach staff. Meeting this target is also related to the well-documented need for affordable rental housing for individuals who have severe and persistent mental illness and are the target population for this Settlement Agreement.

DBHDD methodically tracks their required targets and collects additional data in a timely manner, which enables them to self-monitor their performance and better grasp their challenges. From talking with participants at their homes as well as local and state staff on site visits this year and last year, the DBHDD and their local service agency partners are becoming informed about the local affordable rental markets, fair housing requirements, consumer choice and accessibility features, which is typically related to success in meeting leasing targets.

In looking forward, the Settlement Agreement requires that the program be expanded by 1,200 slots by July 1, 2015. This means that, over the next two years, the program is required to grow by 160% of current capacity.

Bridge Funding

Making Bridge Funding available to participants is crucial to the success of this program. Over $1.2 million was spent on furnishings, first and second month's rent, deposits and household items. Furnishings and rent accounted for 49% of these costs. In addition, over $275,000 was spent on provider fees for managing these funds at the participant level. Three hundred and eighty seven (387) individuals or 147% of the goal received bridge funding assistance. This is $3,140 on average for the number of people who signed leases in FY 13. One challenge reported by DBHDD staff is the ability to maintain this level of support as housing resources are developed beyond what is available for individuals in the GHVP.

[2] This number may go higher when all the requests are reported

2. Program Implementation

Program implementation refers to the State's ability to assist people in the priority target populations to get services they need to live in their own homes and become fully integrated into the community. This task is very challenging. Historically, individuals in this target population haven't often gotten opportunities to move into their own home which means staff may not be fully knowledgeable or familiar with supported housing tasks. Likewise, individuals with a severe mental illness are often labeled "not ready" or incapable of living on their own. Or, if given the opportunity, may get housing but may not be successful in retaining their housing and/or remain very isolated in their community. DBHDD staff appear fully cognizant of these obstacles. They have taken some steps and have more plans for overcoming these obstacles, which are described in more detail in this section of this report. How well they do this is diametrically linked to the State's ability to meet its targets.

For this review, program implementation was measured quantitatively by referral information and housing stability outcomes and other information prepared by the DBHDD staff and qualitatively through key informant interviews and home visits review.

Referrals

Referral patterns for the GHVP have remained consistent with patterns from the two earlier years. Individuals who were homeless at the time of referral comprise 50% of all referrals. Numbers of referrals of individuals increased from 357 to 589 between FY 12 and FY 13. Referrals from hospitals were increased numerically (from 70 in FY 2012 to 196 in FY 13) and as a percentage of the total (from 9% in FY 12 to 17% in 2013); referrals from more intensive settings were down slightly as a percentage (21% to 16% from FY 12 to FY 13) and decreased from 187 to 156 referrals from FY 2012 to FY 2013. Nearly 45% of referrals from more intensive settings in FY 2013 were from group homes or individual care homes. Referrals from families also increased slightly but referrals from jails/prisons remain flat (2 in FY 2013). Most referrals are from Region 3 (205 or 18%) and most homeless referrals are from Region 3 (67%). Region 3 had the highest number of referrals from group homes and individual care homes (29 or 37% of all GH and PH referrals) and hospitals (29 or 37%). Regions 1,2 and 4 have a much higher percentage of referrals from family and friends, 78% of all referrals in this category, and 66% of all referrals in the rent burdened category.

DBHDD is employing a "housing first" approach for many individuals being referred, meaning that referrals come directly from homeless outreach, from hospitals, CSUs or intensive residential programs without first being "transitioned" through group living arrangements. Referrals also come from group homes. DBHDD has not made a policy decision that people need to live there first before moving into supported housing arrangements rather that many group homes were in operation at the time this Agreement was made.

Two referral groups merit attention because of their low numbers; one is the number of referrals from jails and prisons, which is expectantly low at this juncture. Getting referrals from

jails requires a very local hands-on approach, probably most successfully led by Regional Coordinators, although senior DBHDD leadership will also need to be involved. This is already happening from the Commissioner's level on down. Mr. Ringling, the Region 5 Coordinator who has a strong pulse on his community's resources, spoke quite cogently about his commitments and steps he is taking with local officials to increase these referrals in southeastern Georgia. Likewise, a related but separate effort will need to be mounted to increase referrals from state correctional institutions, parole and probation. The Behavioral Health Coordinating Council is in the process of forming a Criminal Justice Transitions into the Community working committee to tackle the problem with this lack of referrals.

The second group of referrals are individuals residing in group or personal care homes, CSUs/CAs, hospitals and intensive residential settings. Combined, these groups only represent 16% of the referrals to the program. Unless these referrals increase substantially and/or there are substantial increases of referrals from jails and prisons, the program will need to increase homeless referrals to meet targets in FY 14 and FY 15. DBHDD is aware of this issue and has made a strong commitment, with additional training and work with regional offices, to expand referrals directly from more restrictive settings this past year.

The current patterns may also be indicative of priorities set at the DBHDD regional levels, where staff are directly responsible for managing this program, and their view of their needs, the strength of referral relationships or a combination of the above. It is likely the homeless issues in Fulton County and all of Region 3 are fairly pronounced and it is also clear from discussions with staff in Region 3 that they have strong connections to all of their referral sources. Most importantly, even with these differences, individuals in the target population are being discharged from more restrictive settings or getting opportunities to move on from congregate or unstable situations which is an underlying goal of this Settlement Agreement.

In Section III.B.2.c.ii(B5) of the Settlement Agreement requires the state to "provide housing supports for approximately 2,000 individuals in the target population with SPMI (by July 2015) *that are deemed ineligible for any other benefits...*" This section has been referenced in earlier reports, as it is highly likely some individuals in the program are eligible for other benefits. However, as a practical matter, being deemed eligible and having access to other benefits may not be the same. It behooves the DBHDD to work closely with Continuums of Care (CoCs), PHAs and DCA to assure individuals in the target population, who are eligible, have as great an access to those resources they are eligible to receive. DBHDD is moving toward a more seamless referral process with the CoCs and has already entered into formal partnerships with the Fulton Co CoC (United Way) and with DCA. This has the effect of maximizing housing resources for the target population, especially those who are deemed ineligible for other benefits.

Housing Access and Stability

The third method for measuring program implementation comes from interviews and site visits. Housing stability is measured by DBHDD at the six month mark, which is the same measure HUD uses to measure housing stability (# < 6 mos leaving/ # > 6 mos in housing). HUD's

standard is 77% at that mark and DBH was at 92% or 15% above that mark for new tenants in each of the first three years of implementation. DBHDD also set their own standard for reengagement of "negative leavers" at 10% and has exceeded that standard with 21% of negative leavers being reengaged. HUD uses these standards to measure Public Housing Authority performance and not necessarily to measure stability of renters. For purposes of this Settlement Agreement, it is helpful to measure stability for the short term but to fully assess tenure and measure the performance of the program, it is advisable to measure tenure at the one and two year mark as well. In addition to measuring tenure, it is also essential to maintain a list of reasons people leave, negatively or positively, to measure the success of individuals being re-engaged and to determine if some reasons individuals are leaving can be reversed.

Taking supported housing programs to scale across a state is a very daunting task. It becomes an even greater challenge if the program experiences a great deal of turnover or if referrals are slow which can happen if referring organizations are either not well organized or not convinced the program can work for the target population. Or this may happen because of the paucity of quality affordable housing in many communities and/or many individuals not meeting background requirements for leasing their own apartments.

Providers are often challenged with shifting their staff's skills to supporting people in their own home. This is a result of their not having done much of that type of work before or because they are much more accustomed to operating group residences, which requires different skills sets, approaches and knowledge. Often this is described as providers having a different philosophy, believing in a continuum approach, where people move from institutions or homelessness to group residences where they are "supervised" before moving on their own. Regardless of the reasons, skills and knowledge or philosophy, the need for a consistent presence (DBHDD Regional and state staff), training and coaching can close the gap between the desired outcomes of this program and current provider knowledge, skill and philosophical differences with this approach. The three site visits revealed several important facts about this program which can best be described through their narratives:

The first individual we visited was a fifty two year old, African American male. This gentleman has had eight incarcerations and has serious medical conditions including diagnoses of COPD, Emphysema and Glaucoma. He started active substance use (alcohol) at age 13 and cocaine at age 18. He has been homeless off and on since 2010. He was in active use without any period of voluntary abstinence until May of 2012 when he entered a substance abuse treatment program (ASAM level II.5). He was abstinent for three months when referred for psychiatric care because of irritability, mood swings, suicidal thoughts and sleeplessness, which was the first time he was given mental health diagnoses as prior symptoms were attributed to substance use. In May of 2012, he tried to get into a men's residential substance abuse program but was denied because of medical conditions. He lived briefly with a sister until able to get into a shelter until the end of May of 2012. He stayed in a shelter until April 2013 when he was referred to ICM and GHVP in March 2013. He was scheduled for eye surgery at the time we met him and was staying very busy with friends and family. His sister called while we were visiting him. His history indicates he will have difficulty maintaining sobriety and his health

conditions will need to be monitored closely.
The second individual we met at his home is a 41 year old Caucasian male who was diagnosed with diabetes in his twenties. He became homeless and was living in shelters in Georgia and Florida after experiencing frequent hospitalizations and bizarre behavior on work sites when his blood sugar was too low. He was also admitted to acute care psychiatric facilities in his twenties due to depression and anger problems. Two years ago, he was admitted to a crisis unit for four weeks and transferred to a state hospital where he remained for eleven months. He was referred for GHVP and has been in housing receiving ICM services for seven months. He uses public transportation to get around and sporadically attends a day program where he helps fix the program's computers. However, he reports spending most of his time at the local library branch. He has been admitted to a local community college where he will be studying computer technology but is very fearful he will not be successful because of his diabetes. According to both him and staff, his diabetes is still not under control and he does not have access to the level of care he needs to measure and control his diabetes. He appears very driven but will need a great deal of support, reassurance and adequate health care to meet his goals.
Our last visit was with a young man, twenty one years old, who left home at age sixteen because of parental abuse. During his childhood, he moved twenty times because of his father fleeing law enforcement when his mother attempted to see their children. After leaving home, he stayed where he could but had problems with depression and mood swings. He was diagnosed with major depression and anxiety after being admitted to acute care for a suicide attempt at age seventeen. He was hospitalized for one week and was hospitalized a second time for one month at age eighteen after a second suicide attempt. He stayed with a friend of the family and was able to finish high school. Then, at age nineteen, he moved to Georgia to find his mother. His mother kicked him out and he began living in a car. After three months of living in his car, in 2012, he was admitted to an acute care psychiatric unit after making suicidal threats. He was referred to ICM/GHVP and has been in housing since November 2012. He is also attending a day program where he is cooking on a regular basis and hoping to get into culinary school.

All three of the gentlemen have long histories of treatment and challenging life experiences. All have experienced failure and periods of homelessness and institutional care. They clearly fall into the target population and without help and support--both formal and informal-- will experience many more difficulties and life challenges. For different reasons, they are all good candidates for supported housing; they would not likely succeed in more traditional group residential living. However, all three will need expert medical, psychiatric help and personal support. They are all good candidates for peer support. But the peer support would need to be tailored because the first gentleman needs support to maintain sobriety, the second a friend and health care advocate, and the third and younger gentleman support from someone his age who understands and can help him overcome traumatic life events. In each of their situations, housing is a stabilizer but won't be enough for them to succeed.

Julia Collins, from Gateway was quite familiar with all three of these gentlemen. She understood the value of life supports, the need for individuals to become connected to their

communities and how crucial stable housing is and will be in their lives. We did not meet other members of Gateway's staff so cannot gauge their interactions and overall strengths.

As referenced above, the behavioral health care system must have the capacity to provide recovery-oriented services and in-vivo supports that are focused, highly individualized and well organized. If the system has this capacity, moving into supported housing will become a gateway to a more integrated life to help participants meet their life goals. Supported housing provider staff must have skills in a number of interventions, have strong relationships with other community professionals and resources, including health care providers, and be able to help individuals access education, jobs and benefits and other resources. Often supported housing is considered "independent housing" where people graduate to from other programs and staff receive very little training to do this type of work. The three gentlemen we met in Savannah are evidence that the opposite is true.

DBHDD recognizes the need for supportive housing providers to receive ongoing training and support to be successful. During the past year, DBHDD has brought providers together and discussion is underway for expansion of training in FY 2014. This expansion is being discussed as embedded into training planned for ACT and ICM. This is an excellent idea. If supported housing is considered "outside" or an "add on" rather than an integral part of their work, it will be less effectively implemented. There are likely a number of scenarios where DBHDD can connect these initiatives. For example, ACT and ICM provider contracts and service requirements will continue to be informed by supported housing requirements. Likewise, ACT and ICM will need to consider what "practice changes" they need to make to successfully assist people to move into housing, get jobs and keep them.

Also, since helping individuals meet their recovery goals is a core principle of supported housing, additional peer support to help someone achieve their goals would also be helpful. Peers are indispensible to successful supported housing programs. Likewise, ensuring everyone living in supportive housing has access to crisis services or respite opportunities in lieu of eviction or another type of "negative" loss of their home is critical.

One area where attention is also warranted is in ensuring that the Regional staff and service providers are open to taking more referrals from intensive residential, hospitals, jails and prisons. This would require individuals being served to have access to respite and crisis services that are often needed even after they have moved into their own home. Provider staff will likely need more clinical and care management support to be successful serving individuals with more complex needs.

3. Program Expansion

Perhaps the greatest challenges for DBHDD in meeting its housing targets lies ahead as it expands housing and services opportunities. As shown in the first two sections of this report, the DBHDD has built a solid infrastructure for the GHVP and Bridge Funding program. Forty-five contract providers are delivering services to people moving into newly developed housing arrangements. However, taking these programs to scale and sustaining them requires

expanded infrastructure, increased provider capacity and performance, the ability to expand referrals from several key referral sources and ability to expand housing availability. The infrastructure issues and overall scalability of the program is heightened exponentially when the state begins adding additional housing resources such as the DCA HCV and 811 PRA.

DBHDD staff recognize that their current Supported Housing program needs to evolve and expand to meet the demands of the program and the Settlement Agreement. Doug Scott is carrying out duties ranging from filing, assuring monthly rent obligations are paid, working with staff in each region--both Regional staff and providers on routine matters -- plus trying to make and manage new housing connections to enable the program to grow. In short, he has been a one-man office. For example, the DCA Housing Choice Voucher Program expansion begun last year and discussed in more detail below is more complex, the GHVP is required to more than double in size over the next two fiscal years, cultivating target population referrals requires added attention and other resources must be tapped. In addition, DBHDD and providers are required to do housing eligibility re-determinations annually which adds to the ever expanding workload. To DBHDD's credit, these issues are acknowledged and Doug Scott will be getting assistance.

Last year, the Independent Reviewer raised a question regarding the potential for expanding the rental program to individuals with developmental disabilities. While this issue was not a focus of this review, it is a question that should be considered. DBHDD is building one infrastructure and is making strides in expanding resources that could be beneficial for individuals with developmental disabilities, assuming service resources could be made available. Below is a brief discussion of three examples of program expansion that are underway or on the planning stages for expansion in the next two fiscal years.

Housing Choice Voucher Program

In 2012, the Georgia Department of Community Affairs (DCA) received approval from the US Department of Housing and Urban Development (HUD) to provide preferences in its Housing Choice Voucher Program (DCA HCV) for individuals with "specific disabilities" identified in this Agreement. This approval is in force until July 1, 2015 and DCA has agreed to allow this preference for up to 50% of their turnover units during this period of time. This is a significant opportunity but comes with several challenges. One, the DCA HCV program operates in mostly rural counties. Rural counties have both fewer staff resources to undertake such a program and will have fewer referrals. Two, at the end of FY 2013, only 55 individuals had been transitioned to this new program and, at this rate, less than 250 people would be able to take advantage of this program. The number will likely rise as the DBHDD, DCA and providers move from this start-up period into full implementation. However, there will be potentially up to an additional 1945 vouchers available through this approach before July 1, 2015. Three, the program is more complex to operate. As a federally funded rental program, it has more requirements than the GHVP and is more cumbersome to navigate, regardless of current attempts to simplify for this settlement agreement. For these reasons, the DBHDD will have to carefully plan and give additional attention to implementation to take full advantage of units that may become available.

DBHDD is fully committed to this program as is DCA and steps are being taken both to intensify the referral process and to ensure that Regional DBHDD and service provider staff are fully cognizant of the HCV requirements and able to make timely successful referrals. DBHDD has indicated it will be meeting quarterly with DCA to review and report on effectiveness of reaching goals set forth in this Settlement Agreement and adjust resources accordingly. A second step being planned are "boot camps" which are intensive one to two day work sessions with providers, regional staff and DCA staff to map out responsibilities and action steps and set targets for leasing within a specific time frame. This activity will be monitored closely to ensure results are achieved. Following this intensive period, goals for each region, which are reported as part of the monthly GHVP and Bridge Funding Program Summary, can be set and carefully monitored over the full life of this Agreement.

Additionally it is important to recognize that Georgia, like most states, is experiencing challenges in the availability of decent, affordable, accessible multi-family rental housing. While home ownership is increasing again after the recession, the market is lagging on rental housing development and continuous Federal actions to reduce PHAs budgets put further strain on the budget. Rental housing prices are again rising. The monthly cost for a one bedroom market rate rental unit in Georgia is equal to 94% of an individual's SSI monthly check. (*Priced Out* , The Technical Assistance Collaborative, 2012).

Working agreements with CoCs, PHAs, the DCA and the VA
Four groups, Continuums of Care (CoCs), which are homeless services planning consortiums, Public Housing Authorities (PHAs), the Veterans Administration (VA) and the DCA, have access to plan, plan for and/or fund affordable housing. DBHDD has begun building these partnerships. To date the expanded partnership with the VA has resulted in nineteen individuals in the GHVP being moved to a Veterans Administration Supportive Housing Voucher (VASH) and through an alliance with the City of Atlanta's "Unsheltered No More" program moved forty-seven high risk chronic homeless individuals into a GHVP supportive housing voucher.

These are small steps but can be expanded with DBHDD, including its Regional Offices, committing staff to building relationships with each of these groups to ensure the priority target populations named in this Settlement Agreement have access to affordable housing resources being planned for and made available by these groups/ organizations. Likewise, DBHDD contract service providers can help identify which individuals are eligible for these resources and can assist to provide services where service gaps exist. For example, the VA funds services, which help defray services costs, but PHAs do not. PHAs can enter into preference agreements, but DBHDD service providers must provide services to make this type of arrangement feasible. There are twelve CSBs and Shelter Plus Care provider organizations, operating across multiple counties, actively working to utilize Shelter Plus and Georgia Housing Voucher programs.

In FY 2013, Georgia was one of the first thirteen states to be awarded an 811 PRA Demo award. This program will be managed by the DCA but DBHDD is a full partner in this new modernized 811 program. DCA will receive funds for 150 permanent project based rental subsidies. Therefore, individuals in the target population will have access to project based rental assistance in selected tax credit properties through a partnership agreement with DCA. The program has not yet started. There may be more opportunities to expand tax credit unit set asides if other project-based subsidies could become available. This is a DCA decision, assuming support from DBHDD.

Organizing and cultivating these relationships appears to be underway but, to achieve consistent success, a well organized, targeted plan will be needed. Each group/ organization has different requirements (statutory, regulatory and local), management staff at the state and local levels, mandates and housing contract arrangements. Tracking and ensuring people get routed to programs that they qualify for and that match their needs will likely require more sophisticated technology and staff support at the state and regional level than is currently in place. DBHDD may want to consider requesting the other systems to take on some of the administrative requirements where possible rather than trying to expand in-house operations.

Jails and Prisons

The two examples for program expansion listed above are related to housing resource expansion. This expansion is related to expanding the program for individuals exiting jails and correctional institutions, as referrals from these facilities are very low. This is an opportune time given the state's focus on reducing overcrowding in prisons. Many states across the country have successfully utilized the Intercept Model (Gains Center) to map and improve the diversion and discharge processes from jails and correctional institutions. Regardless of what approach is used, getting referrals directly from jails and prisons requires several administrative steps, firm agreements and programmatic adjustments at the provider level. Likewise, the referees would likely need GHVP resources rather than the more difficult to qualify for HCV or PRA resource.

Recommendations

The findings section of this report refers to a number of issues that merit recommendations. However, below is a summary of those recommendations:

1. At the conclusion of last year's report, a caution was raised that there must be attention given to infrastructure capacity and collaboration with housing agency partners and community agencies, if future housing targets are to be achieved. This report references a number of specifics for infrastructure capacity and collaboration. While the state met the targets again this year, this reviewer and staff agree that meeting future targets will be more difficult because the expectations are greater. Similarly, maintaining the program at the level required by this Settlement Agreement requires "sustained" capacity at the provider, Regional and state level. As referenced in the first section of this report, giving attention to turnover (beyond the six month performance target) is also important to sustain the program. Attention was not

given in last year's report to provider services capacity. However, as referenced in this report, building and sustaining provider capacity is added to this list of recommendations.

2. In this year's report, focus was also given to the need to broaden collaboration with the DCA HCV program staff, CoCs, local jails and prisons, the VA and local PHAs. It is strongly recommended that action steps and outcomes for these collaborations, including making formal referral agreements, cross cutting training, the DCA-DBHDD-provider "boot camps" and activities and relationship building events, be incorporated in a supported housing work plan for this year. It should be noted that some of these activities and events are underway. However a work plan would help "size" the planning process and make clear expectations for these activities.

3. Specifically, the DBHDD should take concrete steps to increase referrals from jails and prisons. These steps include building relationships and working agreements between Regional staff, local providers/CSBs and local Sheriffs and other officials for access, screening and referral arrangements as well as work with service providers.

4. The fourth recommendation is to assess the potential for increasing referrals from hospitals and intensive residential programs. The numbers of individuals being referred may reflect the true need. It may also be a reflection of problems with the referral processes, lack of agreement on who should be referred, challenges to individuals becoming eligible for a housing program, or being approved as a renter. Therefore, reviewing these referral processes may yield some areas for improvement.

5. The fifth recommendation is to make provisions for supported housing for individuals with developmental disabilities and those with co-occurring mental illness and developmental disabilities. Arrangements in this context means making referrals and assuring best practice services are available to match the needs of individuals with developmental disabilities living in supported housing environments. Many individuals with a developmental or intellectual disability are good candidates for supported housing and, like so many other recommendations in this report, mapping out a plan for this initiative will be key.

6. Lastly, there will be many opportunities for the DBHDD to further refine, expand and improve Supported Housing, ACT, ICM and Supported Employment as interconnected initiatives. A simple crosswalk of the initiatives would reveal many opportunities for connecting the programs. As stated above, providing opportunities for peers to be a part of these processes adds incredible value. Reflecting back to the three case studies in this report, an argument can be made that individuals with their own recovery plan can find a way to go to work, school and restore relationships and build new ones.