REPORT OF THE INDEPENDENT REVIEWER

In The Matter Of

United States of America v. The State of Georgia

Civil Action No. 1:10-CV-249-CAP

Submitted By: Elizabeth Jones, Independent Reviewer

September 17, 2015

INTRODUCTORY COMMENTS

This is the fifth Annual Report issued on the status of compliance with the provisions of the Settlement Agreement in United States v. Georgia. The Report documents and discusses the State's efforts to meet obligations to be completed by July 1, 2015.

As in each year of this Agreement, it is clear that the State of Georgia has undertaken its Settlement Agreement obligations with a commitment to systemic reform. The Governor and the State Legislature have continued to approve the funding requested for the implementation of the Settlement Agreement. Although there are findings of non-compliance with certain provisions, the State, through its leadership at the Department of Behavioral Health and Developmental Disabilities (DBHDD), has demonstrated a consistent good faith effort to work to address acknowledged concerns and to implement its overall obligations. As will be discussed in this Report, discrete aspects of the Settlement Agreement will require additional time and resources in order to reach substantial compliance.

This Report describes the findings of the independent Reviewer and her subject matter consultants. As required, the Parties were provided a copy of the draft Report and the consultants' reports on August 17, 2015. The Independent Reviewer and her consultants carefully considered all comments and recommendations.

OVERALL FINDINGS

Provisions Related to Individuals with a Developmental Disability

On March 20, 2015, the Independent Reviewer's Supplemental Report was filed with this Court. The Supplemental Report focused on the remediation of implementation concerns referenced in both her previous Annual Report, filed by the Parties in September 2014, and her first Supplemental Report, filed in March 2014.

The March 2015 Supplemental Report again documented the failure to resolve non-compliance with key provisions of the Settlement Agreement. Those provisions included the obligations to:

- Move 150 individuals with developmental disabilities from the State Hospitals to the community [III.A.2.b.i (D)];
- Assemble professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individualized Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered [III.A.2.b.iii (A)];

- Assist the individual to gain access to needed medical, social, education, transportation, housing, nutritional and other services identified in the Individual Service Plan [III.A.2.b.iii (B)]; and
- Monitor the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed [III.A.2.b.iii. (C)].

This Settlement Agreement is focused on community integration. In order to meaningfully experience the opportunities and relationships offered in community settings, adults with a developmental disability must receive appropriately individualized supports that help them to develop their skills and to minimize any adverse risks, including injury or death. Essential safeguards must be present at the individual, programmatic and systemic levels. These multiple safeguards must be continually assessed for their adequacy and effectiveness.

As discussed in this Report, as of this date, those areas of non-compliance have not been remedied. Although the State has proposed, and begun to implement, some reasonable plans to rectify these recurrent gaps in the community system, there has been inadequate progress statewide and a failure to establish and meet meaningful timelines. Thus, substantial compliance with these provisions will require additional time, resources and strategies for reform.

As past Reports have documented, on June 30, 2014, the State issued a Priority Plan in response to seven of the nine recommendations made by the Independent Reviewer. Those seven recommendations were:

1. Realign the responsibilities and competencies of support coordinators to include developing and implementing an individualized plan of supports, revising the plan to address changing needs, and oversight to ensure needed services are delivered and outcomes are achieved.
2. Strengthen the transition process from the State hospitals to community-based settings, including providing individualized and relevant competency based training for community providers.
3. Ensure competent and sufficient health practitioner oversight of medically fragile individuals including providing competency-based training on writing and implementing nursing plans of care, proper positioning techniques, and proper monitoring of food and fluid intakes.
4. Design and implement Intensive Support Coordination for high-risk individuals, including pursuing an amendment to the Home and Community-Based Services Waiver.
5. Restructure the roles and responsibilities of regional offices, including examining how the regional offices inter-relate with the DD Division and with community providers, including Support Coordination agencies.

6. Develop and implement sustainable strategies for the ongoing monitoring and evaluation of community placements to remedy issues such as lack of communication, information sharing, and feedback.
7. Recruit and retain provider agencies with requisite experience with individuals with medical and behavioral complexities.[1]

The State has proposed, and has begun to implement to varying degrees, its plans to address these recommendations. Consultants, with the expertise necessary for this major reform, have been retained and qualified DBHDD staff has been assigned to the work involved in transition planning; the oversight of health care; the development of clinical interventions and the realignment of the Regional offices (now called Field Offices).

At this time, however, these new resources and assignments continue to be in the formative stages and to have limited availability.

For example, community-based clinical teams are absolutely essential if the health and therapy needs of medically fragile and behaviorally challenged individuals are to be supported and safeguarded in each Region of the State. As of April 2015, the State has established one Integrated Clinical Support Team (ICST) through Benchmark Human Services, a well-regarded provider agency in Georgia. Reports from the Benchmark ICST indicate that their professional staff's technical assistance and training have been well received but, as of June 2015, they have provided technical assistance to only eight agencies in Region 2 and, for a number of reasons, including scheduling demands and the need for more information, they have not been able to complete all requests for assessments. (There have been ninety referrals from community agencies since April 2015.) Notwithstanding the demand in Region 2 alone, at this time, there are plans only to develop one ICST. Given the size of the State and the highly varied availability of clinical professionals, especially in the rural areas, more than one ICST is required for successful oversight and the delivery of individualized clinical supports.

Given the relative scarcity of clinical professionals, other approaches may need to be considered. In Region 4, the model developed for the Community Clinical Team, established in FY14, utilizes clinical professionals from the now-closed Southwestern State Hospital to provide consultation to community providers, including Primary Care Physicians and medical facilities, serving medically complex individuals. Recently, a physician and psychiatrist have joined the neurologist already assigned to this function. In order to meet statewide demand, there should be consideration of the retraining and reassignment of other clinical professionals currently working within the system.

[1] The other two recommendations focused on conducting independent mortality reviews and identifying exit criteria to enable the State to reach identifiable goals necessary for compliance.

Following the receipt of the draft version of this Report, DBHDD's leadership met with the Independent Reviewer to discuss her recommendation about the expansion for the community-based Integrated Clinical Support Team (ICST). There is agreement that this discussion will continue. A meeting for this purpose has been scheduled for September 29, 2015.

The consultant and leadership resources invested in the systemic reforms, clearly outlined in the Priority Plan and in the Pioneer Project, have placed only four individuals in community residential settings, the last two placements occurring on June 22, 2015. While these placements have been examined by the Independent Reviewer and found to be very positive in both the planning and implementation aspects, they are limited in number. This is especially troubling because 266 individuals are still confined to state hospitals[2] and the completion of a comprehensive transition plan/process has been pushed forward to July 1, 2016. (The Independent Reviewer has been given a copy of the draft Transition Manual, dated August 6, 2015, but it is not yet in effect.) Although the clinical resources are not sufficiently available yet to warrant additional placements of the adults with the most complex behavioral and medical needs, there are other institutionalized individuals who could be placed in a responsible manner with appropriately individualized supports.

In fact, during this Fiscal Year, there were ten individuals with forensic histories who were discharged from State hospitals as a result of Court orders for their release or whose families/guardians requested their discharge. These individuals were reviewed through the Transition Fidelity Committee, a Committee comprised of key DBHDD staff mandated to review each discharge plan for its sufficiency prior to any approval of the community placement. For individuals without medical or behavioral complexity, review by the Transition Fidelity Committee may be sufficient, as long as the engagement of Support Coordination is provided well before discharge.

[2] As of August 12, 2015, it was reported that there were 223 individuals at Gracewood and 43 individuals at Atlanta Regional. Of these, 179 adults are in the ICF units of Gracewood, 44 individuals are in the SNF at Gracewood and 43 individuals are in the SNF at Atlanta Regional. There were 20 people transferred from Southwestern State Hospital when it closed in December 2013. Two individuals are included in the Gracewood census. Fourteen individuals were sent to Atlanta Regional. Of these, 3 have died, 1 was transferred to Easter Seals in Region 4 (she was visited by the Independent Reviewer and the Director of Settlement Services and was doing well), and 10 remain at Atlanta Regional today. When the Craig Center closed in June 2015, there had been 60 individuals transferred to State Hospitals: 2 individuals went to an adult mental health unit; 32 were transferred to Gracewood. Twenty-nine individuals remain at Gracewood, 3 have died; 26 individuals were transferred to Atlanta Regional. Five have died and 21 remain there. Of the 8 deaths, 5 were expected and 3 were unexpected.

Current information from DBHDD reported that there are twenty-three institutionalized individuals on the transition list for community placements. However, major barriers have been identified for seventeen of these individuals; two individuals are having their barriers to placement addressed; and four individuals are well into the discharge process.

Support Coordination is the linchpin to the implementation of the Individual Support Plan. It is also an essential safeguard for minimizing adverse risk. There are plans in the initial stages to strengthen Support Coordination. The four individuals placed under the Pioneer Project in Region 2 had extended engagement prior to their discharges. Intensive Support Coordination resources still are available to a limited number of individuals in Region 4 only. Pending the changes to the State's Home and Community-Based Waiver, there has not yet been an extension of these plans to other areas of the State or to other individuals who are currently institutionalized. The roles and expectations for Support Coordination have not yet been standardized statewide. DBHDD has reported that this change will occur in the second phase of the current cost rate study.

DBHDD is currently revising the Individual Support Plan format to strengthen its person-centeredness. This desired goal is to be implemented in conjunction with the new Administrative Services Organization; the timeline, as reported in the "Interim Quality Management Report," is January 2016.

The "Interim Quality Management Report" issued by DBHDD on August 1, 2015, described in very unsettling detail the lack of trained staff currently responsible for individuals with a developmental disability in twenty-seven provider agencies.[3] The findings point to the urgency to recruit and retain competent providers:

- 41% of the professional staff attached to the organization was not properly trained, licensed, credentialed, experienced and competent.
- 15% of all other staff was not properly trained, licensed, credentialed, experienced and competent.
- Job descriptions were not in place for 64% of the personnel.
- 52% of all staff having direct contact with consumers did not have all required annual training within the first sixty days and annually thereafter.

[3] The findings in this most recent report are comparable to findings described in the Annual Quality Management Report dated February 2015. This report showed a decline in provider compliance with training requirements essential to the safeguarding of individuals under their responsibility.

- 42% of the organizations with oversight for medication or that administer medication did not follow federal and state laws, rules, regulations and best practices.[4]

The "Interim Report" did not describe the specific actions taken to address these failures to meet fundamental expectations. As a result, it is not clear as to whether corrective actions have been implemented. The "Interim Report" did, however, conclude this Section by stating: "The Division of DD must continue to hold providers accountable regarding responsibilities to train staff and conduct background screening, to ensure that there is a greater chance individuals will be treated with respect and maintain health and safety. If staff has the knowledge regarding health issues, medications, rights, safety, and person centered practices, the more likely they are to share this information with individuals served, to help them become more independent and knowledgeable. Technical assistance and accountability will be increased with the implementation of the Georgia Collaborative ASO."[5]

In its recently released "2013/2014 Annual Mortality Report," dated August 15, 2015, DBHDD stated that it would "utilize a database that is being developed to track the identification of deficient practices and the corresponding recommendations and corrective actions that are described in quality review, audit reports, and reports concerning providers' performance including compliance with contractual, regulatory, and programmatic requirements; CMRC (Community Mortality Review Committee) and external mortality review recommendations will be included in his database."[6] DBHDD has reported that this database will be operational in September 2015.

Training for provider agencies on critical aspects for the prevention of aspiration, bowel obstruction, GERD, seizures and dehydration (the "Fatal Five") was led by Karen Green McGowan Consultants, another well-regarded professional team, on June 24 and 25, 2015. (The training was designed originally for agencies in Region 2 but other agencies then were invited to attend.) This training was held over a two-day period; additional training is scheduled. Clearly, this instruction is of very high importance and it is critical that there be much more training of this nature statewide. (During the reviews conducted this summer, at least two provider agencies asked the Independent Reviewer's nurse consultants for additional guidance on preventing aspiration pneumonia. Descriptive material on the importance of oral hygiene was forwarded to them after the visits.)

[4] See page 50. The reviews documented Qualifications and Training as part of the QEPR Administrative Review conducted by Delmarva between July 1, 2014 and March 21, 2015.
[5] See page 55 of the "interim Quality Management Report."
[6] See page 41 of the "2013/2014 Annual Mortality Report," dated August 15, 2015.

The Independent Reviewer's 2014 recommendations were substantially addressed in the Priority Plan issued by DBHDD. The conceptual framework outlined in that Plan is reasonable and reflects expected practices in the field. However, as noted in the March 2015 Supplemental Report,[7] the timeframes and resources available for implementation of the Plan have been of concern. As a result, there has been only incremental progress to date in the implementation of these reforms. A greater sense of urgency is needed, if the critically required changes in Georgia's system are to be accomplished, as intended by the leadership of DBHDD. Explicit timelines need to be established, disseminated throughout the system and met. Given the difficulties described by leadership staff in their attempts to restructure the system, there may need to be additional resources assigned to the Pioneer Project in Region 2 in order to expand its goals and effect its implementation in other parts of the State.

Provisions Related to Individuals with a Serious and Persistent Mental Illness

At this time, based on the information derived from myriad sources over the course of the year, it is the Independent Reviewer's professional judgment that the State has reached substantial compliance with the majority of its obligations under the Settlement Agreement related to the development of a comprehensive community-based system of support for adults with a serious and persistent mental illness. Although there is non-compliance with one specific provision related to supported housing [III.B.2.c.ii(A)] and there are important issues to be addressed regarding discharge planning, significant strides have been made in the availability of Assertive Community Treatment, crisis services, supported employment and supported housing. As documented in the attached supplemental reports:

- The requirement for the provision of supported employment has been exceeded. It has been confirmed that six hundred and fifteen adults are being assisted in their search for competitive employment. Over fifty percent of these individuals have been employed.
- There are twenty-two Assertive Community Treatment teams throughout the State. These teams continue to substantially meet the fidelity scale measures mandated by the Settlement Agreement. There is evidence of an increased, although still evolving, focus on the recovery model. The gains in the implementation of the recovery model are not yet uniform but promising practices have been demonstrated, as a result of

[7] The Independent Reviewer's Supplemental Report stated: "On June 30, 2014, the State's Priority Plan was submitted in a timely manner. Upon review, it was considered to be responsive to the overall obligations of the Settlement Agreement. However, the Department of Justice, the Amici and the Independent Reviewer expressed concern regarding both the availability of resources required for implementation and the time that would be needed to implement the expected reforms." (See page 3)

technical assistance and guidance from the Department's leadership and its Office of Recovery Transformation.

- The components of the crisis service system for adults with a serious mental illness interact appropriately. The work of GCAL, the crisis line and epicenter of referrals for assistance, is especially effective. The use of Crisis Stabilization Programs has reduced the use of state hospital beds. For example, in Region 1, the use of state hospital beds for adults in crisis has declined from 25% (in 2010) to less than 2% (in 2015). In Region 2, there has been a 48% decrease in hospital admissions from a high of 1730 in FY11 to 824 in FY14. Thus far, in FY15, crisis services have diverted 53.6% of the individuals seen in Region 2 from inpatient hospitalization.
- Supported housing vouchers have been made available to 2428 adults who were hospitalized, homeless, or under-housed. Bridge funding was provided to 871 adults. For the fifth consecutive year, the requirements of the Settlement Agreement were exceeded. The collaboration between the Department of Behavioral Health and Developmental Disabilities, its sister agency, the Department of Community Affairs, and Local Housing Authorities is exemplary. The implementation of the Georgia Housing Voucher Program can be considered a national model.

The impact of these successful initiatives on the daily lives of individuals with serious mental illness cannot be overstated. For example:

- A twenty-eight year old woman, who resides in the Augusta area (Region 2), spent most of the last fifteen years in a state hospital with only brief periods in community-based residential programs. She has both a serious mental illness and a developmental disability. For over two years, the Assertive Community Treatment team in that Region worked strenuously with hospital and regional staff to accomplish her discharge. Since November 2014, she has lived in her own (spotlessly maintained) apartment funded with a Home and Community-Based Services waiver. Her ACT team visits her frequently and serves as her representative payee, as she cannot read. She has had one Emergency Room visit for a medical issue. She has learned to manage her own medications. She is demonstrably proud of her success and would like to graduate from ACT services but "not yet."

As the Department refines its information management systems, it is expected that more data about the effect of its reforms can be shared with key stakeholders and with the general public. The Administrative Services Organization (ASO) contract has been awarded and implementation is underway for its work with the mental health and developmental disability services under the Department's responsibility.

Notwithstanding the major strides described above, there are two very critical obligations related to the provision of mental health services that were not found to be in compliance. It is highly recommended that both of these obligations continue to receive independent oversight.

First, as is recognized by the State, compliance has not been achieved with the provision that requires that: "By July 1, 2015, the State will have the capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source." [III.B.2.c.ii.(A.)].

There has been extensive discussion about this provision. The State will require additional time to complete its plans for determining need and choice and for ensuring that adults with serious and persistent mental illness confined to correctional facilities are fully included.

The Independent Reviewer and her consultant on housing, Ms. Knisley, are hopeful that the Parties and the Court will agree to the additional time required to achieve full compliance with the terms of this provision.

Second, the Settlement Agreement states: "Individuals with serious and persistent mental illness and forensic status shall be included in the target population if the relevant court finds that community service is appropriate." (See III.B.1.b.) In order to review the access to community services for individuals included in this definition, the Independent Reviewer began to review discharge planning. This work was performed under provision III.D.3.a. and, in part, under the aegis of the "Notice of Termination of Settlement Agreement and Joint Request to Close Case," filed by the Parties, on February 5, 2014, regarding the CRIPA action. This document states that "The parties agree that effective implementation of the discharge and planning terms are essential to compliance with the 2010 Settlement Agreement and will be subject to the Court's jurisdiction and enforcement, if necessary, in Civil Action No. 1:10-CV-249." After review, it was concluded that the weaknesses and fragmentation noted in the forensic discharge planning process may create barriers to community placement. This finding is in contrast to the very commendable progress recently seen in discharge planning for ten adults with both a developmental disability and forensic status. Their discharges illustrate that, with proper planning, forensic clients can make successful transitions to community-based services.

In addition to the problems with discharge planning, members of the Judiciary interviewed by the Independent Reviewer for this Annual Report cited a lack of confidence in risk assessments; the failure to provide sufficient detail about the plans for community placement, including the levels of supervision and oversight; and the absence of consistent and reliable clinical presence

in the discussion of discharge plans during the Court hearings. Furthermore, Judges (and a District Attorney) expressed an interest in learning more about the fidelity standards for Assertive Community Treatment and other community-based interventions and indicated an interest in actually visiting community-based mental health programs. These are all opportunities for enhanced attention by the State.

The Settlement Agreement requires that the State maintain substantial compliance with all provisions for a period of one year. (See VII. 2). As referenced in last year's Annual Report, there are certain aspects of the mental health system that must not lose focused attention:

- Implementation of a recovery-based model must be present throughout the system. All agencies should demonstrate knowledge of and commitment to these principles in order to receive State funding;
- There must be evidence of continuity of care. The mental health system must work as a whole rather than as a series of parts.
- Access to recovery-based supports must be available for each member of the target population, including those with a forensic history.

Given the significant accomplishments in the mental health system, it would be timely and appropriate for the State to discuss its plans for the forthcoming year and to inform its stakeholders of its strategies for ensuring sustainability. It would also be very important to celebrate these achievements and to recognize the efforts that have been underway by so many people for the last five years.

Summary of Compliance: Year Five

Settlement Agreement Reference	Provision	Rating	Comments
III	Substantive Provisions		
III.A.1.a	By July 1, 2011, the State shall cease all admissions to the State Hospitals of all individuals for whom the reason for admission is due to a primary diagnosis of a developmental disability.	Compliance	The State has complied with this provision. There is no evidence to indicate that individuals with a developmental disability have been transferred between State Hospitals in contradiction of the commitment to cease admissions.
III.A.1.b	The State will make any necessary changes to administrative regulations and take best efforts to amend any statutes that may require such admissions.	Compliance	In House Bill 324, the State Legislature amended Chapter 4 of Title 37 of the Official Code of Georgia Annotated.
III.A.2.b.i(A)	By July 1, 2011, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community and the State shall create 150 waivers to accomplish this transition. In addition, the State shall move from the State Hospitals to the community all individuals with an existing and active waiver as of the Effective Date of this Agreement, provided such placement is consistent with the individual's informed choice. The State shall provide family supports to a minimum of 400 families of people with developmental disabilities.	Compliance	By July 1, 2011, the Department placed more than 150 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A sample of 48 individuals was reviewed. Identified concerns were referred to the Department and corrective actions were initiated. Nine of the 11 individuals hospitalized with an existing Waiver were discharged to community settings. Two individuals remained hospitalized. Delays in placement were attributed to family objections or to provider-related issues. The Department continued to pursue appropriate community placements for these two individuals. More than 400 individuals were provided with family supports. Because there was substantial compliance with this provision, a positive rating was given.
III.A.2.b.i(B)	Between July 1, 2011, and July 1, 2012, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 450 families of people with developmental disabilities.	Compliance	The Department placed 164 individuals with a developmental disability into community residential settings supported by the Home and Community-Based Waiver. A statistically relevant sample of 48 individuals was reviewed. Identified concerns have been referred to the Department and corrective actions are being initiated. Although in compliance, it is recommended that the Department review its policies and guidance regarding expectations for community placement and to provide greater oversight of service coordination at the Regional level. The two hospitalized individuals referenced in the provision above have either been placed or have a placement in process. Two other individuals with existing and active Waivers at the time of the Settlement Agreement were rehospitalized. Those individuals were reviewed by a psychologist consulting with the Independent Reviewer. Community placements are being actively pursued; an experienced provider has been recruited. The Department issued 117 Waivers to avoid institutionalization of individuals with a developmental disability residing in the community. Family supports were provided for 2248 individuals through 38 provider agencies.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.i(C)	Between July 1, 2012, and July 1, 2013, the State shall create at least 250 waivers to serve individuals with developmental disabilities in community settings. The State shall move up to 150 individuals with developmental disabilities from the State Hospitals to the community using those waivers. The remaining waivers shall be used to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.	Compliance	The Court's Order, dated July 26, 2013, modified the language of this provision. The Department has issued 597 waivers to serve individuals with developmental disabilities in community settings. These waivers have been used to prevent institutionalization and to sustain individuals with a developmental disability with their families. The number of individuals with a disability who have moved from state hospitals using these waivers will be reviewed in the Independent Reviewer's report to be issued in late Winter 2014. As of this date, seventy-nine individuals with a developmental disability have been transitioned from state hospitals to community residential settings.
III.A.2.b.i(D)	Between July 1, 2013, and July 1, 2014, the State shall move 150 individuals with developmental disabilities from the State Hospitals to the community. The State shall create 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.	Non-compliance	With few exceptions (three), placements from State Hospitals have been suspended. The Department is planning and developing remedial actions to permit the resumption of individualized community placements. A "pioneer" project is being initiated in Region 2 to demonstrate improved transition, support coordination and habilitation practices. In total, 46 individuals were transitioned from State Hospitals during this Fiscal Year. The State issued 100 additional waivers to prevent the institutionalization of individuals with developmental disabilities who are currently in the community. In FY14, the State provided family supports to a total of 1155 families of people with developmental disabilities.
III.A.2.b.i(E)	**Between July 1, 2014, and July 1, 2015, the State shall attempt to move any remaining individuals with developmental disabilities from the State Hospitals to the community. The State shall create up to 150 waivers to accomplish this transition. The State shall also create 100 additional waivers to prevent the hospitalization of individuals with developmental disabilities who are currently in the community. The State shall provide family supports to an additional 500 families of people with developmental disabilities.**	Non-compliance	**With few exceptions (fourteen), placements from State Hospitals have been suspended. The Department continues to plan and develop remedial actions to permit the resumption of individualized community placements. However, the pace of reform has been slower than anticipated. A "Pioneer Project" has been initiated in Region 2 to demonstrate improved transition, support coordination and habilitation practices. In FY15, the State reported that it provided family supports to an additional 1,136 families of people with developmental disabilities.**
III.A.2.b.i(F)	**Any persons with developmental disabilities remaining in State Hospitals on July 2, 2015, shall be served in the most integrated setting appropriate to their needs.**	Deferred	**It is premature to rate this provision.**
III.A.2.b.ii(B)	Individuals in the target population shall not be served in a host home or a congregate community living setting unless such placement is consistent with the individual's informed choice. For individuals in the target population not served in their own home or their family's home, the number of individuals served in a host home as defined by Georgia law shall not exceed two, and the number of individuals served in any congregate community living setting shall not exceed four.	Compliance	The Department remains in substantial compliance with this provision. All host homes reviewed to date have no more than two individuals. With one recently identified exception, the number of individuals served in any congregate community living setting has not exceeded four.

Settlement Agreement Reference	Provision	Rating	Comments
III.A.2.b.iii(A)	Assembling professionals and non-professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Service Plans, as required by the State's HCBS Waiver Program, that are individualized and person centered.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(B)	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, and other services identified in the Individual Service Plan.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(C)	Monitoring the Individual Service Plan to make additional referrals, service changes, and amendments to the plans as identified as needed.	Non-compliance	**The rating of this provision was deferred initially by Court Order until January 2014. As of July 1, 2015, the Department has not achieved compliance with this provision. There are plans underway to achieve compliance but additional time is needed.**
III.A.2.b.iii(D)	The Independent Reviewer will not assess the provisions of this section, III.A.2.b.iii.(A)-(C), in her report for the period ending July 1, 2013. Instead, the review period for this section will be extended six months until January 1, 2014, after which the Independent Reviewer will report on this section pursuant to the draft, review, and comment deadlines enumerated in VI.A.	Completed	**The Independent Reviewer has complied with this requirement. Her first Supplemental Report was filed with the Court on March 24, 2014. Her second Supplemental Report was filed with the Court on March 20, 2015.**
III.A.2.c.i(A)	By July 1, 2012, the State will have six mobile crisis teams for persons with developmental disabilities.	Compliance	**There are 12 mobile crisis teams for individuals with developmental disabilities. They are located in every Region.**
III.A.2.c.ii(B)(1)	By July 1, 2012, the State will have five Crisis Respite Homes for individuals with developmental disabilities.	Compliance	There are 11 Crisis Respite Homes, including one for children. One individual in the sample of 48 was reviewed in his crisis home; supports were adequate and individualized.
III.A.2.c.ii(B)(2)	By July 1, 2013, the State will establish an additional four Crisis Respite Homes for individuals with developmental disabilities.	Compliance	There are 11 Crisis Respite Homes across the State. There are 2 homes in each Region, except for Region 3 which has one Home. There were 270 individuals served in FY13.
III.A.2.c.ii(B)(3)	By July 1, 2014, the State will establish an additional three Crisis Respite Homes for individuals with developmental disabilities.	Non-compliance	**There are 11 Crisis Respite Homes across the State. A contract for the twelfth Home was issued but as of July 1, 2015 the Home has not been opened. Furthermore, there are serious concerns about the use of these homes for long lengths of stay.**
III.A.3.a	By July 1, 2013, the State shall create a program to educate judges and law enforcement officials about community supports and services for individuals with developmental disabilities and forensic status.	Compliance	**The Department has initiated a program to provide education to judges and law enforcement individuals. In FY14, training was provided to 1433 individuals, including 130 Judges, 1279 law enforcement officials and 24 attorneys. In FY15, training was provided to 889 individuals, including 11 Judges, 827 law enforcement officials and 51 attorneys.**

Settlement Agreement Reference	Provision	Rating	Comments
III.A.3.b	Individuals with developmental disabilities and forensic status shall be included in the target population and the waivers described in this Section, if the relevant court finds that community placement is appropriate. This paragraph shall not be interpreted as expanding the State's obligations under paragraph III.A.2.b.	**Compliance**	**There is evidence that individuals with a developmental disability and forensic status are included in the target population. In FY15, 10 individuals were transferred from State hospitals to community placements. The placements reviewed to date have been appropriately designed and implemented.**
III.A.4.a	By July 1, 2013, the State will conduct an audit of community providers of waiver services.	**Compliance**	The Georgia Quality Management System (GQMS) contract with the Delmarva Foundation mandates that each provider rendering services through the Medicaid waivers to individuals with developmental disabilities has one annual review over the course of five years. Therefore, 40 providers are reviewed each year (39 service providers and one support coordinator agency). The providers are selected randomly. Findings from these reviews are summarized in the Quality Management reports issued by the Department.
III.A.4.b	By the Effective Date of this Agreement, the State shall use a CMS approved Quality Improvement Organization ("QIO") or QIO-like organization to assess the quality of services by community providers.	**Compliance**	**In FY15, the Department again utilized the services of the Delmarva Foundation to design and implement a quality assurance review process. Delmarva also assessed the quality of services by community providers. The Department participated in the National Core Indicator surveys.**
III.A.4.d	The State shall assess compliance on an annual basis and shall take appropriate action based on each assessment.	**Non-compliance**	**The Delmarva Foundation issues annual reports assessing the quality of services by community providers for individuals with a developmental disability. The most recent report was issued to the Independent Reviewer and the Department of Justice on August 1, 2015. Annual reports are posted on the Delmarva website. The State will need to continue its review of the quality of services to ensure that any remedial actions have occured in a timely manner. The Regions receive the information from Delmarva and are expected to take timely remedial action. As cited in this Report, no evidence was provided that remedial action was taken to address serious deficits in provider compliance with training requirements.**
III.B.1.c	Pursuant to the Voluntary Compliance Agreement with Health and Human Services, the State established a Mental Health Olmstead List. The State shall ensure that all individuals on the Mental Health Olmstead List as of the Effective Date of this Agreement will, if eligible for services, receive services in the community in accordance with this Settlement Agreement by July 1, 2011. The Parties acknowledge that some individuals on the Mental Health Olmstead List are required to register as sex offenders pursuant to O.C.G.A. § 42-1-12 et seq. The Parties further acknowledge that such registration makes placement in the community more difficult. The Parties may by written consent extend the application of the date set forth in this paragraph as it applies to such individuals. The written consent described in this paragraph will not require Court approval.	**Compliance**	At the time the Settlement Agreement was signed, there were 27 individuals on the Olmstead List. All of these individuals were discharged from the State Hospitals and were provided community services.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.a.i(G)	All ACT teams will operate with fidelity to the Dartmouth Assertive Community Treatment model.	Compliance	**In FY12, The Parties, with concurrence by the Independent Reviewer, requested that the Court defer evaluation of this provision. The Court approved this request on August 29, 2012 with explicit instructions regarding reporting, root cause analysis and corrective action plans. These instructions were complied with by the Department with close involvement of the Independent Reviewer and her expert consultants. In FY15, this provision continues to be in compliance. All teams funded under this Agreement are expected to operate with fidelity to the Dartmouth model. Certain lower performing teams received additional oversight and review; scores improved after technical assistance was provided by DBHDD. Additional information is included in the attached report by Angela Rollins.**
III.B.2.a.i(H)(1)	By July 1, 2011, the State shall have 18 Assertive Community Treatment teams.	Compliance	The Department has funded 18 Assertive Community Treatment teams.
III.B.2.a.i(H)(2)	By July 1, 2012, the State shall have 20 Assertive Community Treatment teams.	Compliance	The State has funded 20 Assertive Community Treatment teams. However, change in the composition of the teams is underway. The Department is proceeding with remedial action as required by the Court's Order and with consultation by the Independent Reviewer, the Department of Justice and other interested stakeholders.
III.B.2.a.i(H)(3)	By July 1, 2013, the State shall have 22 Assertive Community Treatment teams.	Compliance	**The Department has funded 22 Assertive Community Treatment teams. They are distributed through all six Regions of the state. As of June 30, 2015, there were 1,477 individuals participating in services with the ACT teams. For a discussion of the ACT teams, see attached report by Angela Rollins.**
III.B.2.a.ii(C)(1)	By July 1, 2012, the State will have two Community Support Teams.	Compliance	The State has established two Community Support Teams. Although one team was transferred to another provider beginning in FY13, both teams functioned and provided services from the time of their contract. The two teams supported a total of 71 individuals in FY12.
III.B.2.a.ii(C)(2)	By July 1, 2013, the State will have four Community Support Teams.	Compliance	The Department has established four Community Support Teams (CSTs). They are located in four rural areas of the State. A total of 145 individuals received services from the CSTs in FY13. Under the terms of the Agreement, the Independent Reviewer must assess whether the Community Support Team model provides services that are sufficient to meet the needs of the members of the target population who receive these services. The Independent Reviewer's assessment and recommendations are due by October 30, 2013.
III.B.2.a.ii(C)(3)	**By July 1, 2014, the State will have eight Community Support Teams.**	Compliance	**There are 8 Community Support Teams operating within 5 of the 6 Regions. On June 30, 2015, the number of people participating in CST services was 289.**

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.a.iii(D)(1)	By July 1, 2011, the State will have one Intensive Case Management team.	Compliance	The Department has established two Intensive Case Management teams.
III.B.2.a.iii(D)(2)	By July 1, 2012, the State will have two Intensive Case Management teams.	Compliance	The Department has established two Intensive Case Management teams. The two teams supported a total of 387 individuals in FY12.
III.B.2.a.iii(D)(3)	By July 1, 2013, the State will have three Intensive Case Management teams.	Compliance	The Department has established three Intensive Case Management teams in Regions 1, 3 and 5. These three teams served a total of 235 individuals in FY13. The Independent Reviewer has requested additional information about the caseload in Region 3.
III.B.2.a.iii(D)(4)	By July 1, 2014, the State will have eight Intensive Case Management teams.	Compliance	There are 8 Intensive Case Management teams throughout the 6 Regions. On June 30, 2014, the number of people participating in ICM services was 885.
III.B.2.a.iii(D)(5)	By July 1, 2015, the State will have 14 Intensive Case Management teams.	Compliance	**There are 14 Intensive Case Management teams throughout the 6 Regions. On June 30, 2015, the number of people participating in ICM services was 1450.**
III.B.2.a.iv(C)(1)	By July 1, 2012, the State will have five Case Management service providers.	Compliance	The Department has established five Case Management service providers. Case Management services were provided to 257 individuals in FY12.
III.B.2.a.iv(C)(2)	By July 1, 2013, the State will have 15 Case Management service providers.	Compliance	The 15 case management positions funded by the Department supported 1,893 individuals throughout the six Regions. The Independent Reviewer has requested additional information regarding caseload expectations.
III.B.2.a.iv(C)(3)	By July 1, 2014, the State will have 25 Case Management service providers.	Compliance	There are 25 Case Management service providers throughout the six Regions. On June 30, 2014, the number of people partipating in CM services was 761.
III.B.2.a.iv(C)(4)	**By July 1, 2015, the State will have 45 Case Management service providers.**	Compliance	**There are 52 Case Management positions and 19 provider agencies throughout the six Regions. On June 30, 2015, the number of people partipating in CM services was 1364.**
III.B.2.b.i(B)(1)	By July 1, 2013, the State will establish one Crisis Service Center.	Compliance	The Department opened a 24-hour, walk-in Crisis Service Center on March 1, 2013. From March 1, 2013 through June 30, 2013, 177 individuals received services in this Center. This is not an unduplicated count and some individuals may have received more than one episode of care during this time period.
III.B.2.b.i(B)(2)	By July 1, 2014, the State will establish an additional two Crisis Service Centers.	Compliance	There are four 24-hour Crisis Service Centers. Three are in Region 4; and one is in Region 6. During FY14, 3,309 people received CSC services.
III.B.2.b.i(B)(3)	**By July 1, 2015, the State will establish an additional three Crisis Service Centers.**	Compliance	**There are six 24-hour Crisis Service Centers in operation. A seventh center opened on June 30, 2015. Three are in Region 4; three are in Region 6; and one is in Region 2. During FY15, 7139 people (duplicated count) received CSC services.**
III.B.2.b.ii(B)(1)	The State will establish one Crisis Stabilization Program by July 1, 2012.	Compliance	The Department has established two Crisis Stabilization Programs.
III.B.2.b.ii(B)(2)	The State will establish an additional Crisis Stabilization Program by July 1, 2013.	Compliance	The Department's two Crisis Stabilization Programs have remained operational. They each have 16 beds.
III.B.2.b.ii(B)(3)	The State will establish an additional Crisis Stabilization Program by July 1, 2014.	Compliance	A third 16-bed Crisis Stabilization Program was opened in Savannah on June 30, 2014.
III.B.2.b.iii(A)	Beginning on July 1, 2011, the State shall retain funding for 35 beds in non-State community hospitals without regard as to whether such hospitals are freestanding psychiatric hospitals or general, acute care hospitals.	Compliance	**The Department has continued to fund hospital bed days in community hospitals in FY15. The contract beds are used primarily in Regions 1 and 4.**

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.b.iv(A)	The State shall operate a toll-free statewide telephone system for persons to access information about resources in the community to assist with a crisis ("Crisis Call Center"). Such assistance includes providing advice and facilitating the delivery of mental health services.	**Compliance**	**The Georgia Crisis and Access Line operated by Behavioral Health Link continued to provide these services in FY15.**
III.B.2.b.iv(B)	The Crisis Call Center shall be staffed by skilled professionals 24 hours per day, 7 days per week, to assess, make referrals, and dispatch available mobile services. The Crisis Call Center shall promptly answer and respond to all crisis calls.	**Compliance**	The Georgia Crisis and Access Line complied with these requirements.
III.B.2.b.v(A)	Mobile crisis services shall respond to crises anywhere in the community (e.g., homes or hospital emergency rooms) 24 hours per day, 7 days per week. The services shall be provided by clinical staff members trained to provide emergency services and shall include clinical staff members with substance abuse expertise and, when available, a peer specialist.	**Compliance**	**The mobile crisis services provided by the Department comply with these requirements.**
III.B.2.b.v(B)(1)	By July 1, 2013, the State shall have mobile crisis services within 91 of 159 counties, with an average annual response time of 1 hour and 10 minutes or less.	**Compliance**	Mobile crisis services have been established in 100 counties, exceeding the requirements of this provision. Statewide, there were 840 individuals served by these teams. The average response time ranged from 49 to 56 minutes, again exceeding the requirements of this provision. The disposition for the majority of individuals (230) served was involuntary inpatient hospitalization. The Independent Reviewer will work with the Department's staff to better understand the range of options investigated by the teams and whether the least restrictive measure was consistently employed by the teams.
III.B.2.b.v(B)(2)	By July 1, 2014, the State shall have mobile crisis services within 126 of 159 counties, with an average annual response time of 1 hour and 5 minutes or less.	**Compliance**	There are two mobile crisis providers covering all 159 counties in the State. The average response time was 49 minutes in FY14. As of June 30, 2014, 14,981 people had received mobile crisis services.
III.B.2.b.v(B)(3)	**By July 1, 2015, the State shall have mobile crisis services within all 159 of 159 counties, with an average annual response time of 1 hour or less.**	**Compliance**	**There are two mobile crisis providers covering all 159 counties in the State. The average response time was 55 minutes in FY15. As of June 30, 2015, 18,052 people had received mobile crisis services.**
III.B.2.b.vi(A)	Crisis apartments, located in community settings off the grounds of the State Hospitals and staffed by paraprofessionals and, when available, peer specialists, shall serve as an alternative to crisis stabilization programs and to psychiatric hospitalization.	**Compliance**	The Department has complied with the staffing and location requirements of this provision.
III.B.2.b.vi(B)	Each crisis apartment will have capacity to serve two individuals with SPMI.	**Compliance**	The Department has now complied with this provision. Crisis apartments have the capacity to serve two individuals with SPMI.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.b.vi(C)(1)	By July 1, 2013, the State will provide six crisis apartments.	Non-compliance	The Department has not complied with this provision. There were three apartments operational, for a total of six beds, at the end of FY13. A contract was executed on June 27, 2013 for an additional 4 apartments but they were not yet operational.
III.B.2.b.vi(C)(2)	By July 1, 2014, the State will provide 12 crisis apartments.	Compliance	There are 13 crisis apartments with a total of 25 beds throughout four Regions. 159 individuals were served in FY14.
III.B.2.b.vi(C)(3)	**By July 1, 2015, the State will provide 18 crisis apartments.**	Compliance	**There are 19 crisis apartments with a total of 37 beds throughout all Regions in the State. 313 individuals were served in FY15.**
III.B.2.c.i(A)	**Supported Housing includes scattered-site housing as well as apartments clustered in a single building. By July 1, 2015, 50% of Supported Housing units shall be provided in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing under this agreement. Personal care homes shall not qualify as scattered-site housing.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.i(B)	**It is the intent of the parties that approximately 60% of persons in the target population receiving scattered-site Supported Housing will reside in a two- bedroom apartment, and that approximately 40% of persons in the target population receiving scattered-site Supported Housing will reside in a one-bedroom apartment. Provided, however, nothing in Section III.B.2.c shall require the State to forego federal funding or federal programs to provide housing for persons in the target population with SPMI.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.i(C)	**Bridge Funding includes the provision of deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and a recipient of federal disability or other supplemental income.**	Compliance	**The State has complied with this provision. For detailed information, see the attached report by Martha Knisley.**
III.B.2.c.ii(A)	**By July 1, 2015, the State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. The Supported Housing required by this provision may be in the form of assistance from the Georgia Department of Community Affairs, the federal Department of Housing and Urban Development, and from any other governmental or private source.**	Non-compliance	**As discussed in the attached report by Martha Knisley, the State does not yet have this capacity. Additional work is required; this work is underway. Compliance with this provision will require additional time.**

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.c.ii(B)(1)	By July 1, 2011, the State will provide a total of 100 supported housing beds.	Compliance	Although the Department provided the requisite housing vouchers, concern was noted about the review of eligibility and access for hospitalized individuals.
III.B.2.c.ii(B)(2)	By July 1, 2012, the State will provide a total of 500 supported housing beds.	Compliance	The State has exceeded this obligation. (See Consultant's report.) The Department awarded 648 housing vouchers and reassessed its prioritization for these awards. Further collaboration is planned between the Independent Reviewer and the Department to further analyze referrals for the housing vouchers.
III.B.2.c.ii(B)(3)	By July 1, 2013, the State will provide a total of 800 supported housing beds.	Compliance	The State has exceeded this obligation. In FY13, it awarded a total of 1,002 housing vouchers. The Department made adjustments to its review policies and worked closely with its regional offices, service providers, DCA and other organizations to increase program effectiveness and expand housing resources. (See attached report of Martha Knisley.)
III.B.2.c.ii(B)(4)	By July 1, 2014, the State will provide a total of 1,400 supported housing beds.	Compliance	By July 1, 2014, there were 1,649 individuals served in supported housing beds. (See attached report of Martha Knisley.)
III.B.2.c.ii(B)(5)	**By July 1, 2015, the State will provide a total of 2,000 supported housing beds.**	Compliance	**By July 1, 2015, there were 2428 individuals served in supported housing beds. See attached report of Martha Knisley.**
III.B.2.c.ii(C)(1)	By July 1, 2011, the State will provide Bridge Funding for 90 individuals with SPMI. The State will also commence taking reasonable efforts to assist persons with SPMI to qualify in a timely manner for eligible supplemental income.	Compliance	The Department provided Bridge Funding as required.
III.B.2.c.ii(C)(2)	By July 1, 2012, the State will provide Bridge Funding for 360 individuals with SPMI.	Compliance	The State has exceeded this obligation. (See Consultant's report.) The Department provided Bridge Funding for 568 individuals.
III.B.2.c.ii(C)(3)	By July 1, 2013, the State will provide Bridge Funding for 270 individuals with SPMI.	Compliance	The State has exceeded this obligation. In FY13, the Department provided Bridge Funding for 383 individuals with SPMI. (See attached report of Martha Knisley.)
III.B.2.c.ii(C)(4)	By July 1, 2014, the State will provide Bridge Funding for 540 individuals with SPMI.	Compliance	Bridge Funding was provided for 709 participants in FY14. (See attached report of Martha Knisley.)
III.B.2.c.ii(C)(5)	**By July 1, 2015, the State will provide Bridge Funding for 540 individuals with SPMI.**	Compliance	**Bridge Funding was provided for 871 participants in FY15. (See attached report of Martha Knisley.)**
III.B.2.d.iii(A)	By July 1, 2011, the State shall provide Supported Employment services to 70 individuals with SPMI.	Compliance	The Department provided Supported Employment services to more than 70 individuals with SPMI. Since individuals were assigned to the Supported Employment providers in May, only eight were employed by July, 2011. A higher rate of employment will be expected next year.
III.B.2.d.iii(B)	By July 1, 2012, the State shall provide Supported Employment services to 170 individuals with SPMI.	Compliance	The Department has met this obligation. Supported Employment services were provided to 181 individuals as of June 30, 2012. (See Consultant's report.) A Memorandum of Understanding has been signed between DBHDD and the Department of Vocational Services. The Department is in the process of preparing a written plan, with stakeholder involvement, regarding the provision of Supported Employment. In FY12, 51 individuals gained competitive employment.

Settlement Agreement Reference	Provision	Rating	Comments
III.B.2.d.iii(C)	By July 1, 2013, the State shall provide Supported Employment services to 440 individuals with SPMI.	Compliance	The State has exceeded this obligation. According to a report issued by the Department and reviewed by the Independent Reviewer's expert consultant, Supported Employment services, with strong adherence to the Dartmouth fidelity scale, were provided to 682 individuals during FY13. The monthly rate of employment was 42.1%. (See attached report of David Lynde.)
III.B.2.d.iii(D)	By July 1, 2014, the State shall provide Supported Employment services to 500 individuals with SPMI.	Compliance	The State has exceeded this obligation. Supported Employment services were provided to 988 individuals during FY14. The monthly rate of employment was 47.3%. (See attached report of David Lynde.)
III.B.2.d.iii(E)	**By July 1, 2015, the State shall provide Supported Employment services to 550 individuals with SPMI.**	Compliance	**The State has exceeded this obligation. Supported Employment services were provided to 615 individuals during FY15. The monthly rate of employment was 51.5% across all programs. (See attached report of David Lynde.)**
III.B.2.e.ii(A)	By July 1, 2012, the State shall provide Peer Support services to up to 235 individuals with SPMI.	Compliance	There are 3000 consumers enrolled; there are 72 Peer Support sites in Georgia.
III.B.2.e.ii(B)	By July 1, 2013, the State shall provide Peer Support services to up to 535 individuals with SPMI.	Compliance	The Department has made a substantial commitment to the meaningful involvement of peer support services. The Department's commitment was confirmed by the leadership of the Georgia Mental Health Consumer Network during a July 2013 site visit by the Independent Reviewer. Reportedly, and verified by the submission of names, 571 individuals received peer support services provided by the Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program.
III.B.2.e.ii(C)	By July 1, 2014, the State shall provide Peer Support services to up to 835 individuals with SPMI.	Compliance	Since January 1, 2011, a total of 1,583 individuals have received Peer Support services provided by Georgia Mental Health Consumer Network's three Peer Wellness and Respite Centers and through its Peer Mentoring program. In FY14, there was documentation of 767 discrete units of support.
III.C.1	Individuals under the age of 18 shall not be admitted to, or otherwise served, in the State Hospitals or on State Hospital grounds, unless the individual meets the criteria for emancipated minor, as set forth in Article 6 of Title 15, Chapter 11 of the Georgia Code, O.C.G.A. §§ 15-11-200 et seq.	Compliance	The Department has complied with this obligation.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.2	Individuals in the target population with developmental disabilities and/or serious and persistent mental illness shall not be transferred from one institutional setting to another or from a State Hospital to a skilled nursing facility, intermediate care facility, or assisted living facility unless consistent with the individual's informed choice or is warranted by the individual's medical condition. Provided, however, if the State is in the process of closing all units of a certain clinical service category at a State Hospital, the State may transfer an individual from one institutional setting to another if appropriate to that individual's needs. Further provided that the State may transfer individuals in State Hospitals with developmental disabilities who are on forensic status to another State Hospital if appropriate to that individual's needs. The State may not transfer an individual from one institutional setting to another more than once.	**Compliance**	In FY14, the primary focus of institutional closures has been at Southwestern State Hospital and the Craig Center at Central State Hospital. Southwestern State Hospital closed on December 30, 2013. Currently, placements from the Craig Center are pending further review and approval. Individuals have been transferred to Gracewood and Georgia Regional Hospital in Atlanta. The Independent Reviewer has been closely tracking these transfers and has been conducting site visits to both of these institutions. **In FY15, the Craig Center closed. Individuals were transferred to Gracewood and Georgia Regional Hospital in Atlanta. The Independent Reviewer continues to track these transfers and conduct site visits to both of these institutions.**
III.C.3.a.i	By January 1, 2012, the State shall establish the responsibilities of community service boards and/or community providers through contract, letter of agreement, or other agreement, including but not limited to the community service boards' and/or community providers' responsibilities in developing and implementing transition plans.	**Compliance**	Contract language delineates responsibility for developing and implementing transition planning.
III.C.3.a.ii	By January 1, 2012, the State shall identify qualified providers through a certified vendor or request for proposal process or other manner consistent with DBHDD policy or State law, including providers in geographically diverse areas of the State consistent with the needs of the individuals covered by this Agreement.	**Compliance**	This provision has been implemented.
III.C.3.a.iii	By January 1, 2012, the State shall perform a cost rate study of provider reimbursement rates.	**Compliance**	**A new cost rate study is underway. It is focused on services for individuals with a developmental disability.**
III.C.3.a.iv	By January 1, 2012, the State shall require community service boards and/or community providers to develop written descriptions of services it can provide, in consultation with community stakeholders. The community stakeholders will be selected by the community services boards and/or community providers.	**Compliance**	Two websites have been developed to provide comprehensive information and description of statewide services. Individual community service boards have information on their websites regarding services. Stakeholders are included on the community services boards.

Settlement Agreement Reference	Provision	Rating	Comments
III.C.3.a.v	By January 1, 2012, the State shall require and/or provide training to community service boards and/or community providers so that services can be maintained in a manner consistent with this Agreement.	**Non-compliance**	**Based on DBHDD's latest Quality Management report, compliance with training requirements was not maintained by a significant number of provider agencies responsible for individuals with a developmental disability.**
III.C.3.a.vi	By January 1, 2012, the State shall utilize contract management and corrective action plans to achieve the goals of this Agreement and of State agencies.	**Compliance**	The Independent Reviewer has been informed of actions taken to achieve the goals of this Agreement and of State agencies. Such actions include the termination of provider contracts. In FY14, nine provider contracts were terminated. Seven were providers of developmental disabilities services and two were providers for behavioral health services. **In FY15, six provider contracts were terminated.**
III.C.3.b	Beginning on January 1, 2012 and on at least an annual basis, the State shall perform a network analysis to assess the availability of supports and services in the community.	**Compliance**	**This obligation continues to be met. The Independent Reviewer was provided a copy of the Regional Network Analysis completed this year. The Independent Reviewer appreciated the work that went into the preparation of these reports. It is her understanding that the Regional Network Analysis will be discontinued in its current form.**
III.D.1	By July 1, 2011, the State shall have at least one case manager and by July 1, 2012, at least one transition specialist per State Hospital to review transition planning for individuals who have challenging behaviors or medical conditions that impede their transition to the community, including individuals whose transition planning team cannot agree on a transition plan or does not recommend that the individual be discharged. The transition specialists will also review all transition plans for individuals who have been in a State Hospital for more than 45 days.	**Non-compliance**	**Case Managers and Transition Specialists were assigned at each State Hospital. However, at this time, with limited exceptions, community placements have been suspended.**
III.D.3.a	For persons identified in the developmental disability and mental illness target populations of this Settlement Agreement, planning for transition to the community shall be the responsibility of the appropriate regional office and shall be carried out through collaborative engagement with the discharge planning process of the State Hospitals and provider(s) chosen by the individual or the individual's guardian where required.	**Non-compliance**	**At this time, the entire transition process continues to be under review and placements have been limited. Furthermore, as discussed in the Report narrative, preliminary concerns have been identified about the effectiveness of discharge planning and require further examination by the Independent Reviewer and consultation with the Parties.**
III.D.3.b	The regional office shall maintain and provide to the State Hospital a detailed list of all community providers, including all services offered by each provider, to be utilized to identify providers capable of meeting the needs of the individual in the community, and to provide each individual with a choice of providers when possible.	**Compliance**	The Regional Offices provided a list to the State Hospitals of all community providers. The Independent Reviewer has copies of this information.

Settlement Agreement Reference	Provision	Rating	Comments
III.D.3.c	The regional office shall assure that, once identified and selected by the individual, community service boards and/other community providers shall actively participate in the transition plan (to include the implementation of the plan for transition to the community).	Compliance	In the sample reviewed in FY12, there was evidence of participation by community providers. Although it is evident that community providers continue to participate actively in the transition process, this matter continues to be under review by the Department and the Independent Reviewer. **In FY15, community providers were actively involved in the transitions that did occur.**
III.D.3.d	The community service boards and/or community providers shall be held accountable for the implementation of that portion of the transition plan for which they are responsible to support transition of the individual to the community.	Compliance	**Once problems were identified, community service boards and/or community providers were held accountable. There is continuing evidence of this accountability measure in FY15.**
IV	Quality Management		
IV.A	By January 1, 2012, the State shall institute a quality management system regarding community services for the target populations specified in this Agreement. The quality management system shall perform annual quality service reviews of samples of community providers, including face-to-face meetings with individuals, residents, and staff and reviews of treatment records, incident/injury data, and key-indicator performance data.	Non-compliance	**The Quality Management system plan and the report issued most recently on August 1, 2015 document the focus on the community services implemented for the target population specified in this Agreement. The reports substantiate that annual quality service reviews are conducted by the Delmarva Foundation and APS, the External Review Organizations. Incident/injury data was maintained and reviewed for the community system and key-indicator performance data was referenced in the Quality Management system reports. However, there was no evidence that the negative findings from the annual quality service reviews were addressed in a timely and complete manner. The Quality Management report issued in February 2015 documented similar negative findings.**
IV.A.1	The system's review shall include the implementation of the plan regarding cessation of admissions for persons with developmental disabilities to the State Hospitals.	Compliance	The Department tracks data related to the provision of alternatives to state hospital admissions for individuals with a developmental disability. These data focus on various forms of crisis services, including mobile crisis teams and crisis respite care. Since the Department routinely tracks these sets of information and reviews them on a regular basis in preparation of the Quality Management reports, this provision is rated in substantial compliance.
IV.A.2	The system's review shall include the service requirements of this Agreement.	Compliance	The Quality Management reports issued by the Department document the review of the services provided under the terms of this Agreement. In addition, data regarding services/supports are maintained by the respective Divisions of the Department. The Independent Reviewer was provided with the data from these sources for the preparation of this report.
IV.A.3	The system's review shall include the contractual compliance of community service boards and/or community providers.	Compliance	The Quality Management revised plan and subsequent reports describe the oversight structure for key performance indicators and outcomes as well as the requirements for service providers. External Review Organizations (APS and Delmarva) conduct on-site reviews of provider agencies on an established periodic basis. The Department of Community Health audits community service boards every three years.

Settlement Agreement Reference	Provision	Rating	Comments
IV.A.4	The system's review shall include the network analysis.	Compliance	**A comprehensive network analysis was submitted to the Independent Reviewer on June 30, 2015. In this report, detailed information was provided about available services/supports in each of the six regions as well as the currently existing gaps in services. Detailed information was also provided about the demographics of each region and the target populations to be served.**
IV.B	The State's quality management system regarding community services shall analyze key indicator data relevant to the target population and services specified in this Agreement to measure compliance with the State's policies and procedures.	Compliance	The Quality Management reports submitted to date contain analyses of key performance indicators related to specific services required under this Settlement Agreement. For example, there are key performance indicators related to ACT, supported employment, case management, housing and community support teams.
IV.C	Beginning on February 1, 2013 and ending on February 1, 2015, the State's quality management system shall create a report at least once every six months summarizing quality assurance activities, findings, and recommendations. The State shall also provide an updated quality management plan by July 1, 2012, and a provisional quality management system report by October 1, 2012. The provisional quality management system report shall not be subject to review by the Independent Reviewer under Section VI.B of the Settlement Agreement. The State shall make all quality management reports publicly available on the DBHDD website.	Compliance	**Although this provision ended on February 1, 2015, the Department continues to be in compliance with this provision. Reports continue to be submitted in a timely manner to the Independent Reviewer and the Department of Justice.**
V	Implementation of the Agreement		
V.E	The State shall notify the Independent Reviewer(s) promptly upon the death of any individual actively receiving services pursuant to this Agreement. The State shall, via email, forward to the United States and the Independent Reviewer(s) electronic copies of all completed incident reports and final reports of investigations related to such incidents as well as any autopsies and death summaries in the State's possession.	Compliance	**Although there have been some issues with timeliness, the Department remains in substantial compliance with this provision. The Independent Reviewer and the United States are notified of deaths and the results of investigations. At this time, the Department's mortality review process continues to undergo scrutiny and revision. The Independent Reviewer is working closely with the Department on this matter. The Department has retained a qualified independent entity, the Columbus Organization, to review the deaths of individuals transitioned from State Hospitals to community placements. In addition, the Department has contracted with two consultants who review all deaths by suicide. Furthermore, on August 15, 2015, the Department issued its first Annual Mortality Review Report. The independent Reviewer has continued to track the numbers and causes of death of individuals in the target population. In FY15, she followed up on the implementation of recommendations made by the Columbus Organization. She continues to bring concerns to the attention of DBHDD.**

ADDITIONAL DISCUSSION OF SPECIFIC COMPLIANCE FINDINGS

The following narrative provides further discussion on selected findings related to the provisions summarized in the above Compliance Chart. Extensive examination of the major requirements related to the mental health system is found in the attached reports by the Independent Reviewer's subject matter consultants in supported housing, supported employment, crisis services and Assertive Community Treatment (ACT). Recommendations are summarized at the end of this Report.

METHODOLOGY

The leadership and staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD) have been accessible in a timely and forthright manner to the Independent Reviewer and all of her expert consultants. All requests for documents, interviews and site visits were respectfully and graciously complied with through the assistance of the Director of Settlement Services, Pamela Schuble. The Independent Reviewer and all of her consultants want to express their genuine appreciation for her work.

The Independent Reviewer and her seven expert consultants in supported housing, supported employment, crisis services, Assertive Community Treatment (ACT), behavioral interventions and health care drew from a variety of sources to form their professional judgments regarding compliance with the Settlement Agreement obligations for Georgia's individuals with mental illness and/or a developmental disability. These sources included multiple site visits, throughout the year, in every Region of the State. The on-site work involved attendance at team meetings; observations of staff performing their duties; interviews with staff and the individuals receiving support; and visits, some as long as five hours, to residential and day program locations. In addition, the information and data contained in numerous documents were reviewed. There were many thoughtful discussions with the leadership and staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD) as well as fruitful conversations with provider agency staff, individuals receiving services/supports, their families and their advocates, including members of the Judiciary. Parties' meetings were held until March 2015, the beginning of the Parties' negotiations on a possible extension to certain provisions of the Agreement. When convened, these discussions were collaborative, informative and focused on important issues of concern to both Parties.

The attached reports from the Independent Reviewer's subject matter consultants describe the methods each used to obtain and confirm data and other forms of information.

The Independent Reviewer organized the work performed to review individuals with a developmental disability. Access to individuals, sites and documents was coordinated with and assisted by the Director of Settlement Services. There were several discrete components to these efforts.

First, the list of forty-eight individuals reviewed by the Independent Reviewer and her nurse consultants in 2011, the first year of the Settlement Agreement, was retrieved. The statistician consulting to the Independent Reviewer drew a random sample of twenty-one individuals from the list after the names of three deceased individuals were removed as well as the name of one individual who has asked to be excluded from further review. (After a difficult transition, this young woman is now very successfully living in a group home in Region 2. She is an active member of the Pioneer Project Advisory Group.) Each of the selected individuals was assigned for review to either a nurse consultant or a behavioral psychologist, depending on the major issues identified in their 2011 review. (Both nurses, Marisa Brown and Shirley Roth, have Masters degrees in nursing and both have over thirty years of experience in the field of developmental disabilities. The psychologist, Patrick Heick, is a Board certified Doctoral level Behavior Analyst. He worked with DBHDD's behavior analyst at the time to develop the criteria to be monitored in the Behavioral Interventions section of the Monitoring Tool. The Monitoring Tool and its Interpretive Guidelines have been agreed to by DBHDD and, in fact, have been used with Regional staff.) Twelve individuals were assigned to the "Health Group"; nine individuals were assigned to the "Behavioral Group." Site visits were conducted to each of the selected individuals; the individual was seen at either the residential or day program and the Monitoring Tool was completed based on observation, interview and document review.

In addition, two individuals who were not institutionalized previously and are now receiving residential supports under the Home and Community-Based Services Waiver were randomly selected for review by a nurse consultant. Each received the same level of examination as the individuals described above. Another two women, previously institutionalized in Region 4 and identified in DBHDD monitoring records as at-risk for weight loss, also were selected for review by the nurse consultant.

Second, after it was learned that certain individuals had been placed in Crisis Respite Homes for lengthy periods of time, the Independent Reviewer selected four individuals for review by Dr. Heick. The selection was based on the length of time in the Crisis Respite Home. Both the Independent Reviewer and Dr. Heick made site visits to the two Crisis Respite Homes. In addition, two other individuals, who were seen by a Mobile Crisis Team in Region 1, were selected for Dr. Heick's review after a site visit made by the Independent Reviewer and her consultant on crisis services, Stephen Baron.

Third, the Independent Reviewer asked Dr. Heick to review the two men who were recently placed through the Pioneer Project. Dr. Heick interviewed the men and visited their home.

Finally, the Independent Reviewer asked that three individuals be reviewed to determine the current status of each and whether, if applicable, their community residences appeared to be supporting their needs. The Independent Reviewer and the Director of Settlement Services have followed the two men quite closely over the five years of this Agreement. The third individual is a young woman who was one of the three minors referenced in the Settlement Agreement.

In total, there were 36 individuals with a developmental disability reviewed for this Report.

Copies of all completed Monitoring Tools have been shared with the Parties.

OBSERVATIONS AND FINDINGS

Selected Issues Related to the Support of Individuals with a Developmental Disability

A. Crisis Services:

The Settlement Agreement requires that by July 1, 2014, the State develop and implement an array of community-based crisis services. These interventions include six mobile crisis teams and twelve Crisis Respite Homes. As documented in last year's Annual Report, the provision for mobile crisis teams has been in compliance since July 1, 2012 but the State operationalized only eleven Crisis Respite Homes. It was found in non-compliance with that provision [III.A.2.c.ii.(B)(2)]. As of July 1, 2015, the State remains in non-compliance. There are eleven Crisis Respite Homes and one new contract for a site in Warner-Robbins (Peach County), GA. That Crisis Respite Home is projected to be in use by the latter part of 2015.

However, the review of crisis services conducted in preparation for this Report has identified even deeper concerns. The Independent Reviewer and her consulting psychologist have confirmed that Crisis Respite Homes have been used for long-term residential placements instead of their intended purpose of seven to ten days of respite care. Confirmation of this fact was reached after site visits by the Independent Reviewer and the Director of Settlement Services to eight of the eleven Homes. Further, an intensive review was completed of four individuals who are now placed in Crisis Respite Homes in Region 2. Site visits to and interviews with both the individuals and their staff documented that:

- S.G.'s stay in the Crisis Respite Home has exceeded 2.5 years. There are no plans for an alternative placement.

- T.F. has been living in the Crisis Respite Home for over six months. A placement plan has been discussed but was not approved at the time of the site visit.
- F.D. has been placed in the Crisis Respite Home for fourteen months. There is no alternative placement plan in place. (He was not in crisis at the time of his admission; he had asked to leave his current provider and this option was used as the alternative.)
- T.H. has been in the Crisis Respite Home for more than three years, since June 12, 2012. There are no plans for his discharge; in fact, during the site visits, it was stated that T.H. should remain there since he has formed trusting relationships with the staff.

The Independent Reviewer met another individual, B.B., who has been in the Crisis Respite Home for eight months. This was her third admission. The previous admission lasted nine months. B.B. was not reviewed in depth; staff at the Crisis Respite Home reported that another placement was being explored but was not finalized.

The review of the first four individuals referenced above documented that none of the individuals had a current Behavior Support Plan. There was no guardian/individual involved in any planning for a Behavior Support Plan. There were no descriptions found of the staff training required for work with these four individuals, except in emergency situations, and, therefore, no evidence of training in positive behavioral supports. In fact, the lack of involvement by trained Behavioral Specialists was notably disturbing.

Although reasonable measures certainly must be taken to minimize risk that may be present during a crisis situation, it is important to emphasize the restrictions and the sterile environments experienced in these Crisis Respite Homes, originally designed for short-term placements. There is plexiglass over the televisions and there are no mirrors. Furniture, with the exception of dining room chairs, is bolted to the floor. In two of the three houses referenced above, there is no cooking or preparation of meals. Food for all meals is prepared at either a nearby hospital or day program and delivered to the houses. (The very thoughtful manager of one Crisis Respite Home has planted a garden so that there may be some fresh vegetables.) Space for personal belongings is very limited and there is a notable absence of any personalization. For example, despite the fact that B.B. has had two admissions of at least eight months each, her belongings were crammed onto a small shelf in an alcove of her bedroom wall. She had no dresser and no chair.

The Independent Reviewer has provided DBHDD with examples of less restrictive and more amenable crisis program environments. This provision has been found to be in non-compliance because the twelfth Crisis Respite Home was not operational by July 1, 2015 and because there is clear evidence that these residences are being used for lengthy placement periods, far exceeding the seven to ten days established by policy.

Again, it is strongly recommended that DBHDD complete an intensive review of the use of these houses and prioritize the development of appropriate community-based alternatives for individuals presenting with the need for other places to live.

It is also recommended that DBHDD perform a comprehensive review of its entire array of crisis resources for individuals with a developmental disability. After this thorough analysis, it may be valuable to convert some of the Crisis Respite beds (developed under the terms of the Settlement Agreement) into more specialized residential placement options.

Since the issuance of her draft Report, the Independent Reviewer has been informed that DBHDD intends to begin this comprehensive review in October 2015.

B. Supports for Health Care:

The twelve individuals randomly selected for the reviews by the nurse consultants lived in group homes (8), host homes (3) and with their family (1). (Two of the women lived in the same house as the young woman who was placed from the State Hospital as a minor.)

Four of these individuals (33%) had moved at least once since their discharge from the State Hospital. This is important information given the risks of transfer trauma.[8] In addition, these changes in placement raise questions about the adequacy of transition planning or the sufficiency of the placements themselves. For example, one individual was brought back to his family home due to serious concerns about care in his original placement.

All reports have been forwarded to the Parties. As documented in the nurse consultant reports:

- Two of the twelve individuals received nursing care that did not meet professional standards of care. One individual (C.P.) was referred to DBHDD for further attention. He was experiencing weight loss and blackened stools. There was insufficient attention to these concerns by the nursing staff at this individual's residence. Regional staff investigated the situation and found that, following the nurse consultant's visit and expressed concerns, C.P. had been taken to his physician for further examination and tests. (The results of those tests are not known at this time.) In the other situation, the family of B.M. voiced concern that their brother's physical changes (toe drop) had not been addressed.

[8] Transfer Trauma is a well-researched and documented risk. Avoidance of transfer trauma requires careful planning and support by trained staff. According to information provided by DBHDD, of the 430 individuals with a developmental disability transferred from State Hospitals and now living in community settings, 76 (18%) have changed providers since discharge and 66 (15%) have moved within residential settings under the responsibility of the same provider.

- The three Host Home families for E.L., W.C., and R.T. were observed to provide conscientious care. In addition, it was noted that the individuals had become part of an extended family and were treated with consideration and affection.
- The two women (Cy.P. and M.A.S.) who lived in the same house, along with the young woman placed as a minor, were noted to have a very competent team of nurses providing support. There was evidence of strong coordination in addressing health issues. It was noted, however, that no active treatment was observed in the five hours of the site visit.
- The man (J.M.) living with his sister was noted to require more support than his sister was currently receiving. She raised concerns about the ISP process, the turnover of direct support staff helping her to care for her brother, and the lack of reliable transportation. This individual needed adaptive equipment and environmental modifications, including a communication device and a ramp. (DBHDD has informed the Independent Reviewer that the concerns about adaptive equipment and environmental modification now have been addressed.)
- Nursing staff working with medically complex individuals in two sites asked the nurse consultants for more guidance about minimizing the risk of aspiration pneumonia. It was highly recommended by the Independent Reviewer's nurse consultants that training on this subject be expedited and resource materials be widely distributed. Although aspiration pneumonia is not wholly preventable, there are specific steps, including increased oral hygiene, which can help to reduce its occurrence in vulnerable individuals.
- There were concerns, including a risk for pica and the failure to use her communication book, cited about the day program for Z.C.

C. Behavioral Supports:

The nine individuals reviewed in this cluster lived in group homes (3), Host Homes (3), with family (1), in a crisis respite home, until removed by DBHDD (1), and in the State Hospital (1).

Three of the individuals (33%) had been relocated from their original placements.

The reports from these nine reviews have been forwarded to the Parties. Notable findings included:

- The individual (J.R.) residing in the State Hospital has been confined there since May 31, 2014—more than fourteen months. He has Behavioral Guidelines rather than a more robustly developed Behavior Support Plan. He has been in the community only twice since his admission. On both occasions, his behavior was appropriate. However, he

shows a reluctance for social interaction, perhaps because has difficulty with expressive language. He has limited opportunity for skill development. There is no current plan for his discharge from the State Hospital.

- The Host Home provider for one individual (M.F.) has supported him since his 2010 discharge from the State Hospital. He has made numerous repairs to his home due to the individual's undesired behaviors (urinating, sometimes volitionally, on the bed, floor and his clothing.) There was a strong smell of urine in the bedroom. The Behavior Support Plan was current but there were significant gaps noted, including the identification of positive reinforcement.
- It was observed that staff was vigilant and cautious in observing one individual (M.G.) for pica. As a result of their high level of management, there has been an absence of pica. In addition, the individual's elopement and property destruction behaviors have not been an issue.
- An individual (D.B.) who lives with his family and receives in-home supports is waiting for Medicaid authorization for a swallow study. His Behavior Support Plan does not address his hoarding or self-injurious behavior. As a result, this individual's mother has installed a monitoring device so she can be alerted if her son gets up during the night.
- Finally, one individual (C.B.) in the sample reviewed by the Independent Reviewer's behavioral consultant was reported to DBHDD due to the perceived risks in her host home respite setting. The risks were related to her behavior, the lack of trained staff and the absence of appropriate behavioral programming. After the Independent Reviewer's telephone call, DBHDD took immediate action and removed C.B. to a Crisis Respite House.

D. Additional Reviews:

At the Independent Reviewer's request, there were fifteen targeted reviews completed in addition to the twenty-one randomly selected reviews discussed above. Four of these reviews were referenced in the section regarding crisis services. The other reviews included:

- Two individuals with a developmental disability received crisis intervention from a Mobile Crisis Team and Crisis Respite Home in Region 1. One individual (O.B.) was in jail and, during his interview, described his personal goals for an apartment, a job, and a girlfriend. He will need considerable support to accomplish these goals, which staff think are unrealistic. There was no plan in place for the supports he will require after he leaves jail. It was assumed that he would be placed in a crisis home. The second individual (S.G.) is dually diagnosed and had been admitted to a State Hospital. She declined an attempt to interview her shortly after the interview began.

- One of the individuals placed in 2011 (M.S.) experienced very short community tenure. His provider at the time stated that his discharge was not adequately planned. The Independent Reviewer has followed his treatment trajectory for five years now. He remains confined to the State Hospital and, although his name is on the Region 2 transition list, it is reported that there are major barriers to his release from the Hospital. Although M.S. is not a forensic client, he was placed on a forensic unit based on his treating professionals' opinion that he required more structure than available on the non-forensic units. The Independent Reviewer has noted several times that this is a rights restriction. The decision should be reviewed, especially if M.S. is to move towards discharge in a reasonable period of time.
- A nurse consultant reviewed two women (B.Y. and J.G.) in Region 4 who were reported to have weight loss concerns. Although the provider had been cited for numerous deficiencies at one point, there were no deficiencies in care noted during the site visit.
- A nurse consultant reviewed the young woman (A.C.) included in the group of three minors. She is thriving in her community placement and was described as receiving excellent nursing care. She has gained weight and grown in height. Although the nursing care was very attentive, she has been hospitalized three times for aspiration pneumonia and needs to be watched carefully during meals to minimize risk, as described in her mealtime protocol.
- Both the Independent Reviewer and the Director of Settlement Services have monitored the several precarious community placements of an individual (R.B.) who requires careful attention by trained staff. His last placement, in a crisis host home, raised serious concerns. He was noted to be at risk of falls and choking. As a result, he was transitioned to another provider agency. He was recently observed to have adjusted well to his new surroundings, housemates and staff. The Independent Reviewer had hoped to document his entire history of community placements but his records have not been safeguarded during his changes in placement and there is scant evidence now of his past experiences. It has been recommended that DBHDD take definitive actions to secure records.
- A nurse consultant reviewed two men (R.G. and K.T.) who receive Waiver-funded services and entered services from the community. Both men live in Host Homes. K.T. was placed into his new residence in May 2015. It appeared to be a supportive setting with a number of community experiences, including plans for line dancing. R.G. has lived with his host family since he was six years old. He is now twenty-seven years old and is clearly an integral part of the family. There were no issues or concerns noted at either site.
- The Independent Reviewer's consulting Behavioral Analyst reviewed the two men (G.J. and A.S.) who have most recently been transitioned from State Hospitals to community

placements under the guidelines of the Pioneer Project. Both men expressed satisfaction with their new home and activities. The preparations for their transitions were well thought out and there now appears to be many positive experiences in their daily lives.

These reviews reflect a cross-section of the issues discussed in this Report. The findings range from situations that could or do present risk to the individual to residential settings that offer a nurturing environment with trusting relationships. It is hoped that these examples will provoke thoughtful discussion and be the catalyst for concrete actions to enhance the quality of community supports.

Finally, it will be noted that the Compliance Chart has a rating of Non-compliance for two provisions regarding Quality Management (III.A.4.d and IV.A.) because of the lack of information available to the Independent Reviewer regarding the corrective actions taken to address the negative findings from the QEPR. In addition, the "interim Quality Management Report" stated that the "crisis data shows that the system is operating as it should, with the individual receiving crisis supports in the least restrictive environment as possible…" [9] This is inaccurate. The review of long lengths of stay in residences designed for short-term stays undercuts this assumption.

Selected Issues Related to the Support of Individuals with a Serious Mental Illness

Many of the findings from this year's review of community mental health programs have been discussed or highlighted throughout this Report. Although specific details and examples will vary across the various components of the mental health system, there are several overarching themes that can be identified:

- Continuing education is required throughout the mental health system to move away from the concept of a "readiness model" that arbitrarily establishes prerequisites for greater independence and self-determination. This barrier to a recovery-oriented system of care has been highlighted repeatedly throughout the last five years. In addition to training that is value-based, there needs to be pragmatic examples of successful programmatic strategies for supporting an individual who wishes to have his/her own apartment, for example. The work done by the Beck Institute, funded by DBHDD, is an excellent example of teaching and mentoring new approaches that will have a substantial impact on an individual's recovery from mental illness. The transformation of this work from out-of-state consultants to a locus within Georgia is also illustrative of how practices can be encouraged to change.

[9] See page 14 of the "Interim Quality Management Report."

- Interagency collaboration has been a definite strength in the work to increase supported housing and supported employment. The collaboration between advocates, community providers, DBHDD staff and local jails, such as the Nick Project and the Gwinnett County initiative, are examples that could be expanded statewide, if resources were available.
- Continuity of care across the discrete components of the mental health system will require continuing attention, if reforms are to be sustained. Now that the building blocks of the mental health system are largely in place, it would be useful to take a step back to look at whether the system works as a whole.
- The impact of the systemic reform still needs to be captured through outcome data and data that demonstrate cost-effectiveness. The measures should stretch beyond what is presently done. For example, a reduction in jail days and Emergency Room visits may be as important to quantify as a reduction in the use of state hospital beds.
- The examination of State Hospital discharge practices must be continued, even after the end of the Settlement Agreement. In particular, the lengthy hospital stays of individuals with a dual diagnosis of mental illness and a developmental disability require careful scrutiny, preferably by practitioners who are independent of the system. An additional area of focus should be discharges from hospitals to shelters. This year, the Independent Reviewer interviewed two operators of shelters for homeless adults in Regions 1 and 3 and confirmed that this practice continues to occur, sometimes with very damaging results.
- The State's plans for sustainability should be discussed with key stakeholders. As noted in at least two consultant reports, there are concerns about the cessation or reduction of funding. These concerns should be addressed.
- There should be known consequences for repeated failures to perform to expected standards. This was referenced in the consultant report on Assertive Community Treatment but it applies to other components of the mental health system as well. (DBHDD has informed the Independent Reviewer that the continuing development of both the Office of Accountability and Compliance and the Office of Quality Improvement and Provider Management is the proposed solution.)
- Now that the foundation of the mental health system has gone beyond the initial stages of construction, it would be valuable to investigate other models for discrete program elements. For example, the Crisis Stabilization Units have a distinctly institutional quality with nursing stations and other characteristics of State Hospital admission wards. Effective treatment and safety can be maintained in more welcoming environments, especially with the presence of peer mentors. The recent redesign of the crisis apartments to include some one-bedroom units is an example of a positive action taken by DBHDD.

These themes are meant to help strengthen the system, even as the numerical and programmatic requirements included in the Settlement Agreement are sustained. There is an opportunity now to think into the years ahead and to envision what additional actions can be taken to refine the system's design and to increase its responsiveness to its constituents.

CONCLUDING COMMENTS

As discussed in earlier sections of this Report and as described in detail by the Independent Reviewer's subject matter consultants, this fifth year marks a turning point in the evolution of Georgia's mental health system. The building blocks for a comprehensive system have been put into place and have set the stage for the next set of reforms.

These reforms must focus on ensuring equality of access for all individuals with a serious and persistent mental illness. In addition, members of the advocacy community have suggested that there be enhanced efforts to expand cultural and linguistic access by engaging bilingual or trilingual licensed clinicians. These professional resources are not widely available and will require creative recruitment and retention strategies. At this time, for example, it was reported that Assertive Community Treatment Teams have limited ability to work with the Latino community members who are experiencing mental health challenges. Advocates have also recommended that there be an effort to inquire whether consumer members of Assertive Community Treatment Teams feel supported in their roles and that actions be taken to address any expressed concerns.

The reports prepared by the Independent Reviewer's consultants have stressed the need to continue to incorporate a recovery orientation into every aspect of the mental health system. While there have been significant efforts noted, especially in the past year, ongoing instruction and direction are still essential at this stage in the system's evolution. It will be important to provide further education about the principles of and strategies for recovery to the Courts, housing providers, the staff of community agencies and other key stakeholders.

The initiation of the Administrative Services Organization now permits DBHDD to collect and analyze data to an extent not previously possible. Throughout the last five years, despite valiant efforts by Departmental staff, it has been difficult to capture sufficient data about outcomes. As the focus on sustainability sharpens in the next year, it will be critical to present evidence of the mental health system's reforms and the resulting impact on individuals, communities and the State as a whole. An inter-agency initiative to collaborate on outcome data would be very beneficial to advocates and other stakeholders interested in seeing cost-effective results.

Finally, while it has been challenging to retrieve certain outcome data, the use of the State Health Authority Yardstick (SHAY) has demonstrated, over this five-year period, that the State has facilitated the evolution and implementation of two Evidence-Based Practices. The overall scores for Supported Employment and Assertive Community Treatment have increased from 2.9 and 3.58 respectively in the earliest years to 4.6 and 4.4 in this fifth year. The requisite changes for these two Evidence-Based Practices have been incorporated into critical dimensions of the system's foundation. They now will need to be sustained.

This fifth year of the Settlement Agreement finds the system for individuals with a developmental disability to be striving to ameliorate substantial structural and programmatic weaknesses. Although there was evidence of harm in the early transitions from the State Hospitals, the gravity of the problems was not clearly recognized until the placements were suspended and a deeper investigation was initiated. It was important to suspend the placements; the Commissioner is to be commended for that decision.

Now, the reforms that are beginning to occur require additional time and resources, if adverse risks are to be minimized to the greatest extent possible. The Independent Reviewer strongly urges that additional time be granted for non-compliance to be cured. At this stage in the history of services and supports for individuals with intellectual/developmental disabilities, there are lessons that have been learned that can help shape the new direction and help avoid costly mistakes. The Priority Plan developed by the State outlines many of those lessons. The Pioneer Project includes those lessons in its strategies. However, there also must be a series of stringent timelines, specific outcome measures and a frank assessment of available resources, if the systemic reform is to move forward in a reasonable manner without unnecessary delay and risk.

Georgia is incredibly fortunate to have such a seasoned and committed advocacy and peer support community. The meaningful involvement of such respected and experienced people is especially valuable at this critical time. In the end, the strongest safeguards of quality will come from the knowledgeable and caring members of Georgia's own communities.

I would like to express my deep appreciation for all of the generous assistance, guidance and honest discussion that I have experienced from so many people over the last five years. It has been a privilege to be part of the reform efforts in Georgia and, in my role as Independent Reviewer, to participate in the building of community alternatives to institutions.

2015 RECOMMENDATIONS

There are recommendations included throughout this Report. They include the following:

- In order to ensure the implementation of Individual Support Plans, as required under this Agreement, DBHDD should consider expanding the number of Integrated Clinical Support Teams (ICSTs) throughout the State.

STATUS: the Department's leadership has agreed to consider this recommendation and has held an initial discussion with the Independent Reviewer about it. The discussion wil be continued at a meeting scheduled for September 29, 2015.

- In order to meet statewide demand, there should be consideration of the retraining and reassignment of other clinical professionals currently working within the system.

- In order to ensure timely community placement for currently institutionalized individuals with a developmental disability who are not medically or behaviorally complex, DBHDD should consider appropriate strategies, including comprehensive review by the Transition Fidelity Committee, to expedite the discharge process from State Hospitals. Individuals with previously identified community placements should be prioritized to prevent erosion of skills and to fulfill the individual's expectations for discharge.

- The roles and expectations for Support Coordination should be standardized statewide.

STATUS: DBHDD has reported that this change will occur in the second phase of the current cost rate study.

- DBHDD should continue to take definitive actions to promote continuity of care by cross-training providers responsible for the programs supporting adults with a mental illness.

- DBHDD should complete an intensive review of the use of Crisis Respite Homes and prioritize the development of appropriate community-based alternatives for individuals presenting with the need for a place to live. DBHDD should perform a comprehensive review of its entire array of crisis resources for individuals with a developmental disability.

STATUS: DBHDD has informed the Independent Reviewer that this review is scheduled to begin on October 1, 2015.

- The Independent Reviewer's nurse consultants have strongly recommended that statewide training on aspiration pneumonia be expedited and that the most recent resource materials be widely distributed to the provider community.

- DBHDD should take definitive actions to secure records.

- DBHDD is encouraged to continue to deliver competency-based training related to the implementation of a recovery-oriented system of treatment.

- Interagency collaboration should continue to be a priority and successful initiatives, such as the collaboration between advocates, community providers, DBHDD staff and local jails, as evidenced in the Nick Project and in Gwinnett County, should be expanded statewide.

- Now that the building blocks of the mental health system are largely in place, DBHDD and its stakeholders should take a step back to look at whether the system works as a whole.

- The impact of the systemic reform still needs to be captured through outcome data and data that demonstrate cost-effectiveness. The measures should stretch beyond what is presently done. For example, a reduction in jail days and Emergency Room visits may be as important to quantify as a reduction in the use of state hospital beds.

- The examination of State Hospital discharge practices must be continued, even after the end of the Settlement Agreement. In particular, the lengthy hospital stays of individuals with a dual diagnosis of mental illness and a developmental disability require careful scrutiny, preferably by practitioners who are independent of the system. An additional area of focus should be discharges from hospitals to shelters.

- The State's plans for sustainability should be discussed with key stakeholders. As noted in at least two consultant reports, there are concerns about the cessation or reduction of funding. These concerns should be addressed.

- There should be known consequences for repeated failures to perform to expected standards. This was referenced in the consultant report on Assertive Community Treatment but it applies to other components of the mental health system as well.

STATUS: DBHDD has informed the Independent Reviewer that the continuing development of both the Office of Accountability and Compliance and the Office of Quality Improvement and Provider Management is the proposed solution.

- Members of the advocacy community have suggested that there be enhanced efforts to expand cultural and linguistic access by engaging bilingual or trilingual licensed

clinicians. These professional resources are not widely available and will require creative recruitment and retention strategies.

- Now that the foundation of the mental health system has gone beyond the initial stages of construction, it would be valuable for DBHDD to investigate other models for discrete program elements. For example, the Crisis Stabilization Units have a distinctly institutional quality with nursing stations and other characteristics of State Hospital admission wards. Effective treatment and safety can be maintained in more welcoming environments, especially with the presence of peer mentors.

SUPPORTED HOUSING:

Below is a list of the earlier recommendations and actions. Explanations are provided if the recommendations were modified, developed further, still in progress and/or under review:

1. **Further develop and sustain Supported Housing capacity through the DCA-DBHDD Partnership:** In February's report, the State's progress to develop capacity through this joint arrangement was noted along with recommendations for steps to create capacity for up to 9,000 individuals in the target population who are in need of Supported Housing.

    - **DBHDD and DCA should establish a broad written Memorandum of Agreement (MOA) to meet current commitments and set "actionable" goals to expand Supported Housing resources.** As stated above, a comprehensive actionable MOA was completed in April 2015. Over time, this joint effort will do more than any other feasible activity for the State to reach its maximum supported housing capacity. As stated in the discussion section of this Report, the DCA commitment to "furthering fair housing" is both laudable and unique. Likewise the agencies' approaches to maximize resources are both sound and laudable. Completed

    - **DCA should request an extension of the HUD approved Remedial Tenant Selection Preference Agreement to enable the State to meet its future *Olmstead* obligations, including meeting capacity of up to 9,000 individuals with SPMI as defined in the current Settlement Agreement.** DCA and DBHDD made this request to HUD to extend the Preference Agreement beyond the June 30, 2015 expiration date. This request was granted on April 23, 2015 for the time period necessary for the State to meet its housing obligation under this Agreement. Completed

    - **DCA should request Public Housing Authorities to consider a modest set aside of turnover HCVs over a three year period per the TAC report (in addition to the preference arrangement referenced in the 2014 DCA QAP) to further the State's ability to meet its *Olmstead* obligation and goals.** The DCA refined this recommendation in

their 2015 QAP as part of their overall QAP strategy for meeting their *Olmstead* obligations and as furthered referenced below. In Progress

- **DBHDD was asked to examine their current working agreements (across each initiative) and to refine them to assure adequate resources are in place to maximize the HUD approved Selection Preference Agreement, to meet the 2013 and the 2014 811 PRA requirements and to meet any additional arrangements to implement the 2014 LIHTC program Integrated Supported Housing and Target Population Preference.** Completed

- **DCA should request (and monitor) each project awarded Low Income Housing Tax Credits and implement an Affirmatively Furthering Fair Housing Marketing Plan that meets the intent of the DCA policy for owners/property managers to affirmatively market units to the SPMI population as "tenants with special needs." This includes each selected LIHTC Applicant providing reasonable accommodations for tenants with special needs who are also in the Settlement Agreement target population.** Completed

- **DCA and DBHDD should continuously evaluate the need for expanding housing resources.** As referenced in this report, DCA has added incentives in the QAP; they and DBHDD are working with PHAs to add Project Based Subsidies to LIHTC funded projects (with a disability preference). DBHDD has asked the two "moving to work" PHAs, Macon and Atlanta, to offer HCVs to individuals in the GHVP. As these initiatives are further developed, DCA and DBHDD will have more precise projection of their potential expanded capacity for the next 24-48 months depending on award and production schedules. In Progress

- **DCA should assume responsibility for GHVP inspections which consolidates this function in one place. There may be other functions that need to be consolidated across agencies to maximize sustainability as the program continues to grow. For example, 811 PRA referral processes should be the same or as similar as possible with HCV referrals. DCA and DBHDD should work out how housing search will work simultaneously across these two programs**. DCA and DBHDD are jointly developing a uniform referral process and DBHDD has suggested the Georgia Mental Health Consumer Network take on responsibility for managing GHVP-HCV transition administrative tasks and reauthorization tasks in concert with service providers. In Progress

2. **DBHDD should request an expansion of the GHVP and Bridge funding for FY 2016 to narrow the gap between projected need and capacity to sustain the Settlement Agreement gains**. Completed

3. **DBHDD should assess the potential for increasing referrals from hospitals, intensive residential settings, group homes and personal care homes.** The number of referrals

from hospitals and intensive residential settings has increased but DBHDD depends on referrals from discharge planners and may be unaware of the potential for more referrals. As referenced in February 2015, DBHDD should be constantly targeting these settings for referrals. The same is true for personal care and group homes where low numbers of individuals being referred may or may not reflect the true need or that consumers are given a choice to move. It may be more a reflection of perceived "readiness" or concern on the part of providers that they may lose revenue. Through the newly developed Needs and Choice Evaluation, DBHDD is positioned to track these referrals more closely and provide training and technical assistance where necessary to increase referrals. In Progress

4. **Assessing Need**

   - **Implement process to determine need now and in the future:** DBHDD is well underway with its Supported Housing Needs and Choice Evaluation but this process is complex and will require at least two to three more months to complete. One issue DBHDD is just now adding to their protocol is a baseline assessment of individuals exiting jails and prisons. In Progress

   - **Establish objective criteria for determining need:** Based on the June 1, 2015 Policy and in recent discussions and observation, DBHDD is following through on this recommendation and implementation will occur in the Post Baseline Phase of the Needs and Choice Evaluation. In Progress

   - **Project Capacity and Need for the future.** Based on progress to date and the need for more time to evaluate capacity and need, a finding of Capacity and Need is not being made at this time. However, there are positive signs that this finding can be made during this fiscal year. DBHDD should continue to implement its planned actions. In Progress

5. **Quality and Performance Improvements.** It is recommended that DBHDD and DCA establish performance benchmarks in FY 2016.

6. **The State should make certain that GHVP is resource of last resort.** The State has made good faith efforts to include this provision in their MOA and in their work with PHAs and Regional Transition Coordinators and providers. Making progress.

7. **DBHDD should develop stronger ties across its own programs**. In the 2014 report, a recommendation was made to link the ACT, Supported Employment and Supported Housing strategies, operations, requirements, care management, fidelity or other reviews, expectations and/or training to build stronger ties among these initiatives to improve overall performance and outcomes. The 2015 site visits amplify the urgent need for stronger ties across these initiatives.

DBHDD is taking the opportunity of the Supported Housing Needs and Choice Evaluation to offer more training and create a curriculum for building provider capacity and doing it in a manner to develop stronger ties. Embedding the DBHDD Supported Housing Unit more deeply in the DBHDD Office of Adult Mental Health is a positive move. It is recommended that DBHDD focus on strengthening ties across the forensic initiatives and add technical assistance to the Housing Needs and Choice Evaluation initiative, as training is important but not likely sufficient to improve overall performance to the level needed for this initiative to succeed.

DBHDD and DCA are exploring an additional contract with the Georgia Mental Health Consumer Network for critical administrative tasks. This is also an ideal time to further embed supported housing services interventions into the Certified Peer Specialist certification curriculum and to explore additional options for Certified Peer Specialists to be direct service providers, in addition to managing administrative and evaluator functions.

8. **DBHDD should continue to include individuals with intellectual disabilities as a priority population for its new initiatives**. Making Progress.

DISCHARGE PLANNING:

1. There should be training of all clinical staff, both in the Hospital and for the Regional staff responsible for transition planning, on the DBHDD policies related to transition planning so they know and understand their role and the role of others as recommended.

2. DBHDD should create a database that tracks all Court, treatment meetings and assessments so that important forensic deadlines are stated, evaluations are completed timely and clinical decisions can be thoughtfully prepared.

3. Risk Assessments must be reviewed for clinical sufficiency. Specificity about the current risk factors, and what supports, environment, and skills can be used to mitigate their likelihood, should be standard across all risk assessments.

4. DBHDD must address the serious vacancy issue among most of the clinical disciplines necessary to appropriately plan and effectuate discharge for forensic clients. While forensic status individuals require the expertise of each discipline, the existing clinical staff is called upon to opine on individuals who they may not know well and to sometimes testify on important legal/psychiatric issues without the benefit of time necessary to know the individual.

5. DBHDD should immediately state that all individuals who are ready for discharge should be in the most integrated setting. The Department must, through policy and practice,

demonstrate that housing choices are individualized, taking into consideration all the important domains that reduce risk and increase the likelihood of success.

DBHDD should determine the amount and type of housing options needed for those in forensic status.

6. DBHDD should regularly offer to train the Court, the defense bar, prosecutors and providers regarding behavioral health issues and forensic status. Familiarity and ongoing conversation is needed among all parties.

CRISIS SERVICES:

1. DBHDD leadership should ensure that there is a robust comprehensive crisis system in place that produces regular data reports that are widely shared; that the reports measure the critical components of the system including, but not limited to, timely access to care and the utilization of community based crisis services; that problems are identified in a timely manner and addressed; and that roles and responsibilities for problem solving are well known throughout the Department, with other State agencies, as well as with family members, advocates, law enforcement and other key stakeholders.

2. Addressing the crisis service needs for individuals with a developmental disability must be a priority.

    - Based on the relatively small number of individuals seen more than once by the mobile crisis teams (556) as well as the number of individuals staying far more than the initial seven day limit of the Crisis Respite Homes, a process needs to be put place for formal planning and problem solving for individuals with developmental disabilities who have complex needs and challenges that must be addressed in order for them to have a positive quality of life in the community.
    - While recognizing the geographic challenges of a large state such as Georgia, the State should evaluate if it is offering the right range of services to meet the crisis and immediate needs demands of individuals with developmental disabilities. The State should re-evaluate the way it offers services to see what services are missing and what should be retained. For example, is it cost effective to offer forty-eight beds through the Crisis Respite Homes that have such low utilization rates or are there more efficient ways to utilize these resources that could better address the needs of individuals with developmental disabilities.

STATUS: DBHDD has informed the Independent Reviewer that its review of the crisis service system will begin on October 1, 2015.

3. The Department should continue to support the CSBs to provide open access. The State should determine if it should strengthen its current policy of strongly encouraging same day access to services and, if it does, the State needs to understand the fiscal impact to CSBs as well as the possible return on this investment to the State on using less costly ambulatory services that have some potential to reduce more expensive services offered by BHCCs, CSPs, or other acute inpatient service.

4. The State should determine the number of CSP beds needed statewide and also review if there is any potential revenue from third-party payers that may be available to CSPs.

5. It would be very beneficial for DBHDD to address stakeholder concerns about access and information and to develop viable ways of sharing data about the use of crisis services and their effectiveness with the larger community.

ASSERTIVE COMMUNITY TREATMENT

Areas for improvement remain, including:

1. Sustainability concerns with regard to outcomes monitoring and Medicaid.

    - Although the State did a small evaluation of the impact of ACT on hospitalization over time, this work needs to continue, with an examination of other outcomes, wider sampling methods, and answering other key questions from stakeholders. In addition, the Independent Reviewer's consultant met several consumers with success stories that exemplify the personal impact on consumers underlying the quantitative outcomes in graphs. Both methods should be highlighted for various stakeholder groups in a way that depicts what ACT services can do in Georgia.

    - Some sites reported improvements in Medicaid penetration across ACT caseloads, while others still struggle. The State should continue to work with providers using tools developed for fiscal planning and offering Medicaid enrollment support via regional office staff.

2. Recovery orientation of ACT should continue to be a focus, although much effort was exerted in training and onsite technical assistance and found useful this past year by several teams. Future work could include engaging teams or individual staff that exemplify recovery-oriented ACT to work with other teams, such as offering peers the opportunity to network and shadow strong peers in the field (e.g., one peer observed on a site visit was particularly good at engaging a new consumer).

- Emphasize independent living options for ACT consumers – some teams still seem resistant to this idea while others appear to be doing a good job of helping consumers live independently or semi-independently after periods of long hospitalization.

- Emphasize supported employment and good job development skills for ACT employment specialists. Although the role of the ACT employment specialist was properly clarified this year, most ACT employment specialists continue to struggle with how to do this work (e.g., how to perform proper job development for this population) and maintain productivity standards.

- Re-emphasize the goal of ACT services as person-centered, relationship-centered, intensive mental health services as opposed to getting consumers to take medications. These sentiments vary widely across teams and across staff within a single team.

3. Although progress in the specification and follow-up with corrective action plans was noted this year, continued progress should be to define consequences for repeated non-compliance with DACTS standards in the event this becomes necessary.

SUPPORTED EMPLOYMENT

1. Given the approaching end of the "Settlement Agreement," it is strongly recommended that DBHDD leadership develop a concise SE plan that focuses exclusively on sustaining the progress that the Department and its partners have made in the development of SE services and the infrastructure to support those services. This plan should describe all efforts and strategies underway to diversify and secure funding for SE providers after the completion of the "Settlement Agreement" as well as other activities at the state-level to secure and develop strategic partnerships with agencies like the Georgia Vocational Rehabilitation Agency.
2. It is recommended that DBHDD consider developing a written post-settlement SE document that describes the planned funding integration methods. It is also recommended that DBHDD continue its existing outreach efforts to engage SE providers in a hearty dialogue about TORS funding and SE services.
3. In order to maintain the successful progress that has been made to integrate fidelity measures into the DBHDD system, it is vital for DBHDD leadership to find ways to address and remediate these provider concerns and questions regarding SE fidelity.

RECOMMENDATION SUMMARIES

NOTE: Each year, since 2012, the subject matter experts working with the Independent Reviewer have included recommendations in their respective reports. All of those recommendations will not be repeated here. However, the recommendations described below draw from the findings of the expert consultants as well as from the Independent Reviewer's own observations and experiences.

SUMMARY OF YEAR FOUR RECOMMENDATIONS (September 2014 Report)

The following recommendations were included in the Independent Reviewer's FY 2014 Report. A brief update of the current status of each recommendation is noted below in bold type:

Recommendation One:

It is strongly recommended that the Independent Reviewer prepare a second Supplemental Report under the same timeframes and expectations as the first Supplemental Report filed in March 2014. The second Supplemental Report should be filed with the Court.

The second Supplemental Report should address the status of the provisions related to transitions, support coordination and the implementation of Individual Support Plans for individuals with a developmental disability, including those placed from State hospitals and those receiving Home and Community-Based Waiver Services under the terms of the Settlement Agreement.

In addition, the next Supplemental Report should address the actions taken by the Department (DBHDD) to improve the performance and outcomes of the lower-performing Assertive Community Treatment (ACT) teams identified by the Independent Reviewer and her expert consultants. For each of the limited number of teams, the Department should report on the progress that has been made to improve DACTS scores, especially those related to intensity of service, frequency of contact, and informal supports.

The Independent Reviewer will consult with the Parties to this Agreement to determine whether other provisions should be reviewed and included in the second Supplemental Report.

Current Status: The Independent Reviewer's Supplemental Report, dated March 17, 2015, was filed with the Court, as recommended above. The report contained a review of the actions taken by the State to begin to address acknowledged deficiencies in the community-based systems of support for individuals with a developmental disability. The report also included documentation of the progress made by the Department of Behavioral Health and Developmental Disabilities (DBHDD) in improving the performance of certain Assertive Community Treatment (ACT) teams and in continuing its efforts to achieve full compliance with the Settlement Agreement's provisions regarding supported housing. The Supplemental Report's findings were discussed multiple times in the Independent Reviewer's meetings with the State as well as in the meetings held with the State by her consultants in supported

housing, Martha Knisley from the Technical Assistance Collaborative, and in Assertive Community Treatment, Dr. Angela Rollins, Research Director for the ACT Center of Indiana.

Recommendation Two:

Although there has been some progress documented in the referral of individuals with forensic histories to Assertive Community Treatment (ACT) teams and to supported independent housing, this group of adults remain seriously under-represented in the implementation of the provisions of the Settlement Agreement. Therefore, substantial effort and evidence of inclusion must be confirmed in Year Five.

The Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of community-based housing and other programmatic supports for individuals with forensic histories. She requests that the Department (DBHDD) identify the appropriate staff to work with her as she plans and implements her work related to forensic clients.

Current Status: The Independent Reviewer retained the expertise of Dr. Patrick Canavan, then Director of St. Elizabeths Hospital in Washington, D.C., to advise her on the accessibility and availability of community-based services and supports for individuals with forensic histories, as defined in the Settlement Agreement's target population. He was greatly assisted by DBHDD staff and legal advocates in obtaining the information he needed. His work is under discussion with the Parties.

Recommendation Three:

The review of crisis services requires ongoing attention by both the Department (DBHDD) and by the Independent Reviewer. The need for this review was referenced in FY 2013.

In particular, the Independent Reviewer is concerned that there does not appear to be a concentrated focus on the crisis services provided to individuals with a developmental disability. The Priority Plan addresses crisis management only briefly (see page 30).

It is recommended that the Independent Reviewer continue to work with the Department (DBHDD) as it implements its "Community Behavioral Health Crisis Continuum Strategic Plan." Reports from the quarterly meetings of the Behavioral Health Crisis Continuum workgroup should be provided to the Independent Reviewer.

The Independent Reviewer is in the process of retaining an expert consultant to assist her in the review of crisis services for individuals included in the target population for the Settlement

Agreement. She requests that the Department (DBHDD) identify the appropriate staff to work with her as she plans and implements her work related to crisis services.

Current Status: The Independent Reviewer retained consultation from Stephen Baron, former Director of the Department of Behavioral Health in the District of Columbia and former President/Chief Executive Officer of Baltimore Mental Health Services, a public mental health system. Mr. Baron reviewed crisis services for both individuals with a mental illness and those with a developmental disability. His report is attached. Mr. Baron's recommendations were discussed with the State on September 4, 2015. Mr. Baron was provided with timely and responsive assistance from the leadership of DBHDD.

Recommendation Four:

The Settlement Agreement requires that "By July 1, 2015, the State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support." (See Provision III. B. 2. c. ii. (A).)

As evidenced by the attached report prepared for the Department (DBHDD) by the Technical Assistance Collaborative, efforts have been initiated to identify the sources of available housing that will be essential to compliance with this Provision.

It is recommended that the Parties prioritize their attention to the requirements of this Provision and to the resources and timelines that will be needed for compliance.

An initial discussion is scheduled with the Parties for October 7, 2014. The Independent Reviewer's expert consultant on Supported Housing will be present.

Current Status: As discussed in the attached report by the Independent Reviewer's consultant for supported housing, Martha Knisley, extensive work is underway to reach compliance with this Provision. Numerous discussions have been held with the leadership of DBHDD in order to design a strategic process for achieving the requisite capacity. The work regarding Needs Assessment and Choice has begun but is not yet completed. The State has acknowledged that additional time will be required to reach compliance. Ms. Knisley continues to review the work of DBHDD and its sister agency, the Department of Community Affairs (DCA).

Recommendation Five:

As referenced in the review of recommendations for 2013, the Department has taken steps to educate providers of Assertive Community Treatment (ACT), Intensive Case Management, Supported Employment and Community Support Teams about the resources available to them from other components of the behavioral health system. These efforts are important to increasing collaboration across all parts of the mental health system. It is recommended that they be intensified in Year Five. In particular, added emphasis on the principles and practices of a recovery-orientation would be important to ensuring consistency of performance across all provider agencies.

In this previous year, in an effort to evaluate the mental health system as a whole, the Independent Reviewer has asked her expert consultants to conduct site visits together and to discuss their respective observations. This collaboration has been very useful and will be continued into the next year.

Current Status: As referenced in the attached reports on Assertive Community Treatment, Supported Employment and Supported Housing by Dr. Rollins, Mr. Lynde and Ms. Knisley, respectively, there is evidence of an increased focus on moving the community mental health system towards a recovery-orientation. The efforts of the Office of Recovery Transformation and those of the Georgia Consumer Network have been instrumental to these efforts. It is recognized that these efforts must be sustained.

The Independent Reviewer and her consultants worked together and often conducted joint site-visits to ensure accuracy in their fact-finding and to obtain a deeper understanding of the complexities of the mental health system.

SUMMARY OF RECOMMENDATIONS (MARCH 2014 SUPPLEMENTAL REPORT)

Recommendation One:

As referenced earlier, there is an urgent need to develop and implement sufficient health practitioner oversight of the medically fragile individuals transferred from State Hospitals to community settings. Other state jurisdictions have had to confront similar challenges. As a result, there is a solid base of knowledge to draw from in designing appropriately individualized supports for this group of high-risk individuals. It has been recommended that the Department explore the development of a Medical Safeguards Project, such as those implemented in Pennsylvania and Massachusetts, to assist in the building of its oversight capacity. In addition, there needs to be further examination of the availability of clinical expertise in the community, including occupational and physical therapists, in order to ensure the availability of appropriate supports.

Current Status: This recommendation continues to require decisive and urgent attention if adverse risks are to be minimized/avoided. The development of the Integrated Clinical Support Team and the Pioneer Project are responsive to this recommendation but are currently operational only in Region 2.

Recommendation Two:

The Department took decisive action in removing individuals from poorly performing or negligent provider agencies. However, the options for new placements were limited and, thus, constrained the smooth and timely transition to other residential settings. The need for additional resources should be explored in order to ensure sufficient capacity for emergency situations involving an entire provider agency. In addition, the experiences with these three provider agencies should be the catalyst for additional review of provider agency qualifications once problems/concerns are initially discovered.

Current Status: This recommendation continues to require decisive and urgent attention.

Recommendation Three:

The Department's efforts to strengthen the transition process have identified the clear need to obtain a more complete understanding of those individuals still placed in State Hospitals. An updated assessment would permit more accurate planning for the development of community

resources. It is recommended that these assessments be conducted on a regional basis and that the findings be compared against the current availability of requisite resources, including clinical expertise.

Current Status: Although there has been the beginning of such assessments, this recommendation continues to require substantial attention.

Recommendation Four:

The Department should retain an independent consultant/consultant group to conduct mortality reviews for individuals placed under the Settlement Agreement. Independent review of any such deaths would strengthen the Department's knowledge about provider agencies and the availability/provision of critical supports.

Current Status: DBHDD implemented this recommendation, but only for individuals who have been placed from state hospitals under the aegis of the Settlement Agreement, when it retained the Columbus Organization. DBHDD has reported that it intends to learn from these reviews in order to improve its own investigations and to implement system improvements. It has begun this work and will continue to review it with the Independent Reviewer.

Recommendation Five:

The Department and the Independent Reviewer have agreed to develop a joint review process under the supervision of the Independent Reviewer. Details of team composition are still in the discussion stage but the process is anticipated to begin by early Summer 2014, in time for the preparation of the next Annual Report by the Independent Reviewer. The Department has increased the Independent Reviewer's budget to permit this work to commence.

Current Status: There was initial work implemented to address this recommendation. The Independent Reviewer and staff from Region 2 and 3 completed some joint reviews. However, the initiative was not sustained, primarily because of the other work assigned to the Regional staff.

SUMMARY OF YEAR THREE RECOMMENDATIONS (September 2013 Report)

The following recommendations were included in the Independent Reviewer's FY 2013 Report. A brief update of the current status of each recommendation is noted below:

Recommendation One:

In the professional judgment of the Independent Reviewer, it is critical that there be a more concentrated focus on the analysis and reporting of the effects from the above-referenced cessation of admissions to the state hospitals of people with developmental disabilities. For example, the Department could track the admission of individuals with both an intellectual disability and a mental illness to its psychiatric hospitals in order to evaluate the effectiveness of its crisis system.

Prior Status: Although the Department reported that it tracks this information, the data are not currently used to assess its system or its crisis services. The forthcoming implementation of the Administrative Services Organization (ASO) may affect the utilization of these data.

Current Status: The Independent Reviewer continues to recommend that the state hospital admissions of individuals with both an intellectual disability and a mental illness be tracked and analyzed, especially as it relates to length of stay and the efficacy of treatment modalities.

Recommendation Two:

In concert with the Independent Reviewer, it is recommended that the Department review the components of the crisis services system to determine if they are organized and coordinated as effectively as possible.

Prior Status: The Independent Reviewer and the Department discussed this recommendation. The Department had recognized that "crisis services are often the first point of encounter with the behavioral health delivery system for an individual or family, and can, therefore, set the future course of the individual's or family's attitude toward, and relationship with, the system." Stakeholder meetings held in October and December 2012 were followed by the formation of a Steering Committee that met from February to June 2013. Over the period of August 2013 through April 2014, a "Community Behavioral Health Crisis Continuum Strategic Plan" was developed by a Departmental workgroup that included staff from adult mental health, child and adolescent mental health, addictive diseases, suicide prevention and the Office of Recovery.

The Strategic Plan was based on the findings and recommendations of the Steering Committee. The Departmental workgroup has continued to meet quarterly to move forward the work required for the implementation of the Strategic Plan. The Independent Reviewer was provided a copy of the Strategic Plan. It outlines goals and timelines that extend until June 30, 2016. The Independent Reviewer and Departmental staff intend to meet periodically to ascertain progress towards these goals.

The above initiative did not include the crisis services provided to individuals with a developmental disability. The Independent Reviewer has recommended that a concerted effort be made to pinpoint the responsibility for implementing a similar analysis and developing a strategic plan with measurable goals and objectives.

The Independent Reviewer is in the process of retaining a subject matter expert to assist in her continuing review of crisis services.

Current Status: The report of the Independent Reviewer's consultant has been completed and has been shared with the Parties. It was strongly recommended that the DBHDD prioritize a review of the crisis services for individuals with a developmental disability. This review is scheduled to begin on October 1, 2015.

Recommendation Three:

Attention must be given to infrastructure capacity and collaboration with housing agency partners and community agencies, if future housing targets are to be achieved. While the state met the targets again this year, it was agreed that meeting future targets would 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. It will be important to give further attention to "turnover" and sustaining provider capacity.

Prior Status: The attached report by the Independent Reviewer's expert consultant, Martha Knisley, discusses the Department's efforts to determine and sustain adequate capacity through collaboration with other State and Federal agencies. This issue is the subject of ongoing discussion between the Department and the Independent Reviewer and her expert consultant. The next discussion with the Parties about the status of housing for the Settlement Agreement's target population is scheduled for October 7, 2014.

Current Status: DBHDD and its sister agency the Department of Community Affairs (DCA) have forged an extremely effective working relationship. There also is evidence of strong

partnerships at the Regional level as the respective agencies collaborate to increase the availability of supported housing for individuals with a serious mental illness.

Recommendation Four:

Collaboration must be strengthened with the DCA HCV program staff, Continuums of Care, local jails and prisons, the Veterans Administration and local Public Housing Authorities. It is strongly recommended that action steps and outcomes for these collaborations include, for example, formal referral agreements, interagency training, the DCA-DBHDD-provider "boot camps" and activities, and relationship building events. The development of a work plan would help "size" the planning process and make clear expectations for these activities.

Prior Status: As documented in the attached report by Ms. Knisley, the Department has initiated and implemented numerous positive actions to increase collaboration with its partners in the provision of housing. This issue also continues to be the subject of ongoing discussion between the Department and the Independent Reviewer and her expert consultant.

Current Status: As discussed in the most recent report by Ms. Knisley, these initiatives have continued to be implemented and there is evidence of strengthened collaboration as a result.

Recommendations Five and Six:

For Assertive Community Treatment programs and Supported Housing programs, the Department should assess the potential for increasing referrals from hospitals and intensive residential programs.

For Assertive Community Treatment and Supported Housing programs, the Department should take concrete steps to increase referrals from jails and prisons. These steps include building relationships and working agreements between Regional staff, local providers/community service boards and local Sheriffs and other officials for access, screening and referral arrangements.

Prior Status: Although more work will be required to address both of these recommendations, progress has been documented in the efforts to increase referrals from hospitals, intensive residential programs, jails and prisons. However, as discussed in both the Independent Reviewer's narrative summary and the attached reports by her experts, Ms. Knisley and Dr. Rollins, substantial work remains to be planned and implemented in the Fifth Year, if these provisions of the Settlement Agreement are to be fully satisfied.

Current Status: Both of these recommendations continue to require attention and concerted action in order to ensure maximum access to supported housing for individuals who are currently living in intensive residential treatment programs or who are currently confined to state hospitals, especially the forensic units, jails and prisons.

Recommendation Seven:

The Department should intensify its efforts to make provisions for supported housing for individuals with developmental disabilities and those with co-occurring mental illness and developmental disabilities.

Prior Status: There has been virtually no progress made towards addressing this recommendation. The Independent Reviewer will continue to discuss this recommendation with the Department as it implements its reform efforts, especially those now beginning in Region 2.

Current Status: At this time, it is reported that more than twenty-seven individuals with a developmental disability have been provided Georgia Housing Vouchers through DBHDD. Region 5 has the greatest concentration with fourteen individuals so placed. This is very encouraging and these examples should be used as illustrations of this possibility.

Recommendation Eight:

The Department should consider ways in which to further refine, expand and improve Supported Housing, Assertive Community Treatment, Intensive Case Management and Supported Employment as interconnected initiatives. A simple crosswalk of the initiatives would reveal many opportunities for connecting the programs. As noted, providing opportunities for peers to be a part of these processes will add incredible value.

Prior Status: There is documentation that confirms the Department's efforts to increase collaboration between the programmatic components of its behavioral health system. For example, the agendas for monthly meetings/teleconferences with providers responsible for Supported Employment, Assertive Community Treatment, and Community Support consistently reflect discussion about understanding and using resources, including housing vouchers, available throughout the State's system. On January 15, 2014, providers responsible for these services as well as those responsible for crisis services and Intensive Case Management held a combined meeting/retreat to strengthen their collaboration. On February 20, 2014, providers of Assertive Community Treatment and Community Support met for joint training. On February

25, 2014, a training session on “Recovery-Oriented Engagement and Service Delivery” was held in Macon, Georgia. Further, the Quality Councils for Behavioral Health review the data, discuss the findings and issue recommendations. These efforts are positive and are commended. Nonetheless, continuing and expanded efforts are strongly recommended, especially in the area of recovery-oriented training. As discussed in the attached reports by Ms. Knisley, Mr. Lynde and Dr. Rollins, the understanding of recovery-oriented principles and practices appears to be uneven and some providers are in need of more intense support and supervision.

This recommendation by the Independent Reviewer and her expert consultants is repeated and will be reviewed in future reports.

Current Status: Progress has been noted in this recommendation for increased collaboration towards a recovery-orientation in the various components of the mental health system. These actions are applauded; it is encouraged that they be continued and expanded.

SUMMARY OF RECOMMENDATIONS (September 2012 Report)

The FY12 Report offered the following recommendations for consideration by the State. The Department's leadership and staff addressed the details of the recommendations both in Parties' meetings and in meetings with the Independent Reviewer. On June 1, 2013, a formal response to the recommendations was provided. This response summarized the State's actions to date as well as its future plans.

Recommendation One:

Consider providing training to Department staff and providers on "social role valorization" and more clearly articulate expectations regarding the standards for community placement. This values-based training focuses on developing and sustaining community membership for individuals who have been denied opportunities for meaningful participation in their communities. As the Department continues to establish new community-based services and supports, such values-based training could be helpful in designing and ensuring maximum opportunity for interaction with non-disabled people.

Prior Status: The Department contracted with the highly regarded "Social Role Valorization Implementation Project" to provide a series of introductory sessions to the principles of social role valorization. These seven training sessions were held in various locations across the State; over two hundred and sixty individuals attended the training. Additional training is scheduled in November 2013. The Department has planned to continue this training at least until June 2015.

The provision of this training was responsive to this recommendation and also to the findings of the Delmarva report on the need to increase community integration and membership.

Current Status: This training was not continued as planned. Values-based training continues to be recommended by the Independent Reviewer as well as training in "practical' programmatic strategies to ensure meaningful community integration and participation for members of the target population.

Recommendation Two:

It is recommended that the Department examine the reasons why host homes are not used more frequently for community placements. As demonstrated by current and past site visits, host home placements generally afforded increased individualization and greater likelihood of social integration.

Prior Status: The enhanced value of host home placements was underscored in the most recent Delmarva report (Quarter 3, 2013) issued by the Department. During FY13, site visits by the Independent Reviewer and the Settlement Coordinator to three individuals placed in three host homes again demonstrated the increased social interaction and individualization inherent in this residential setting. The Department supports the use of host homes and has pointed out that 13% of the individuals transitioned from hospitals in the last three years live in homes of their own/family homes or host homes. The Department's focus on the design of individualized supports is appropriate. However, it continues to be recommended that the Department conduct a more systemic analysis to identify any barriers to the expansion of this residential model by community-based providers.

Current Status: The use of host homes as an alternative to group settings continues to be recommended by the Independent Reviewer. The most recent reviews completed by her health and behavioral consultants have confirmed the very positive outcomes achieved in this setting with well-trained and well-supported host home providers.

Recommendation Three:

Consider strategies to more clearly articulate and document the plan for sustaining the structural and programmatic accomplishments resulting from the Settlement Agreement.

Prior Status: In response to this recommendation, the Department stated that it would continue its documentation of Family Support and its capacity to assist families to meet support needs at less than Waiver costs. Such documentation would be provided to the legislature as it considers future funding. Additionally, the Department will continue to work with Family Support providers and the Family Support workgroup to strengthen and sustain its efforts.

It is recommended that the Department continue to explore and document additional strategies to sustain the structural and programmatic accomplishments resulting from the Settlement Agreement. For example, such strategies might build on the Department's "White Paper: Housing for People with Developmental Disabilities and Behavioral Health Needs," issued in July 2013. This document clearly articulates the Department's vision for the development of integrated housing opportunities and its commitment to the principles and mandates of the Olmstead decision and the Americans with Disabilities Act. The document also outlines the challenges and barriers (stigma, resources and paradigm shift) that must be addressed.

Current Status: As this fifth year comes to an end, the State has acknowledged its obligation to demonstrate sustainability. The Independent Reviewer encourages the State to continue

to reach out to stakeholders and to discuss its intentions and plans to continue to evolve and strengthen its array of services and supports for people in the target population. As noted in the most recent reports on supported housing and Assertive Community Treatment, there is evidence of concern and a need for reassurance with specific plans.

Recommendation Four:

In order to ensure equality of access for all individuals in the target groups, work with the Independent Reviewer to analyze referral of supported housing vouchers and Bridge Funding.

Prior Status: As noted in this and previous reports, the Department has exceeded its obligations under the Settlement Agreement in terms of the number of housing vouchers awarded.

The Department has emphasized that it constantly monitors the referral source of each person entering the Georgia Housing Voucher Program (GHVP). Each year, priority is given to those individuals being discharged from state hospitals. The Department also conducted cross training for hospital personnel on community-based resources, transition planning and the GVHP. The Department is partnering with the Georgia Tech College of Public Policy to review GHVP tenants' service history and sub populations to better understand the initial benefits of the program and referral access.

The Department and the Independent Reviewer's expert consultant on housing continue to work together to analyze referrals to the supported housing vouchers and Bridge Funding. There is agreement between the Department and the Independent Reviewer that work on this issue will continue in the year ahead.

Current Status: This work continued as planned.

Recommendation Five:

In conjunction with the Independent Reviewer, review the long-term arrangements for ensuring the availability of housing resources in each of the next three years.

Prior Status: The Department and the Independent Reviewer's housing expert continue to work together on the details related to this recommendation. Additional recommendations will be suggested and discussed in the coming year.

Current Status: This work continued as planned.

Recommendation Six:

In collaboration with the Independent Reviewer, determine if further clarity is needed to ensure that the "ineligibility for any other benefits" is uniformly understood and applied to all applicable benefits.

Prior Status: The Department has revised its intake form to ensure that providers with other housing resources (e.g. Shelter Plus Care) are utilized before requesting resources from the Georgia Housing Voucher Program (GHVP). The Department has entered into a partnership with the Veterans Administration to assist their efforts at fully utilizing the Veterans Administration's supported housing program so that GHVP rental assistance would not be required for a similar settlement population (chronic homelessness.)

Current Status: As discussed in the most recent report on supported housing by Ms. Knisley, the State either has addressed these issues and recommendations or is making progress in doing so.

Recommendation Seven:

In conjunction with the Independent Reviewer, review any potential barriers to community placement for individuals awaiting discharge from forensic units.

Prior Status: Since this recommendation was made, the Department has organized a workgroup consisting of leadership from forensic services, the regions, mental health, community transition planning and others to identify the barriers related to transition. As a result, on June 14, 2013, training was provided to all forensic hospital staff responsible for discharge planning on the purpose, availability and location of such community services as ACT, intensive case management housing, and Community Support Teams. Criteria for access/eligibility were discussed. Case studies were utilized to problem solve specific relevant examples. The workgroup intends to continue to meet to ensure ongoing coordination. In addition, the Behavioral Health Coordinating Council created a workgroup to address the joint concerns of partner agencies regarding individuals with behavioral issues transitioning from correctional institutions into the community. The Department chairs this workgroup. There is an interagency committee charged with identifying barriers and coming up with proposed solutions. This collaborative work is ongoing.

This recommendation continues to be a priority for the Independent Reviewer and further examination of the Department's efforts and outcomes will continue in FY14.

Current Status: The access to integrated community opportunities for individuals in the forensic system continues to require attention and the implementation of remedial actions. The Independent Reviewer continues to discuss this recommendation with the Parties.

Recommendation Eight:

Consider the use of housing vouchers for individuals with developmental disabilities placed under the Settlement Agreement.

Prior Status: The Department is in agreement with this recommendation. In conjunction with the Department's Director of Housing, increased opportunities have been identified for the utilization of housing vouchers for individuals with a developmental disability placed under the Settlement Agreement. These opportunities now are available for individuals transitioning from the state hospitals, from congregate community settings (group homes), or from Waiver-funded residential settings. Individuals with more challenging placement issues, such as individuals with a developmental disability who have a forensic history, may also benefit from the use of housing vouchers. Additional specialized voucher programs available through the Department of Community Affairs are currently planned for the transition of several individuals with a developmental disability from the state hospitals to a community setting.

This recommendation remains a priority for the Independent Reviewer and her expert consultant in housing and will be reviewed throughout FY14.

Current Status: As referenced above, to date, more than twenty-seven adults with a developmental disability have received supported housing through the provision of Georgia's housing vouchers. This opportunity continues to be important for heightened attention by DBHDD at the regional and State Office levels.

Recommendation Nine:

Develop, with stakeholder input, a written plan regarding the implementation of Supported Employment services.

Prior Status: This recommendation has been implemented. The Supported Employment State Plan has been finalized and was reviewed by the Independent Reviewer's expert consultant. Continued dissemination and implementation of the Plan is anticipated.

Current Status: This recommendation has been satisfied.

Recommendation Ten:

Share the findings of the cost rate study, as well as the data and the calculation process used to complete this study, with providers and other stakeholders.

Prior Status: The Department and the Independent Reviewer will continue to discuss this recommendation. The cost rate study for Supported Employment Services has not been completed and continues to be a recommendation from the Independent Reviewer's expert consultant in his FY13 report.

Current Status: DBHDD continues to review rates and this matter continues to be under advisement.

Recommendation Eleven:

Review training curriculum to ensure that all of the defined principles of evidence-based Supported Employment are addressed. Provide access to trainers who can model skills for employment specialists. Specific and explicit fidelity expectations and expectations related to employment outcomes should be revisited with Supported Employment providers.

Prior Status: This recommendation has been implemented. The training is discussed and evaluated in the FY13 report from the Independent Reviewer's expert consultant on Supported Employment.

Current Status: This recommendation has been addressed. DBHDD is encouraged to continue its training initiatives; they are well received.

Recommendation Twelve:

Consider convening Supported Employment coalition meetings in rotating Regions across the State so that providers have the opportunity to attend some meetings in person.

Prior Status: This recommendation has been implemented. The coalition meetings are now held in Macon, a location considered more central to the six regions.

Current Status: This recommendation has been implemented.

Recommendation Thirteen:

Ensure that the outcomes from corrective action plans resulting from critical incidents are transmitted promptly to the Independent Reviewer and the Department of Justice.

Prior Status: The review of critical incidents continues to be a priority for the State, the Department of Justice and the Independent Reviewer. Information requested regarding specific incidents has been transmitted in a timely manner to the Independent Reviewer. The Settlement Agreement Coordinator and the Independent Reviewer are continuing to work together to analyze incidents and any remedial actions that are to be implemented. These efforts will continue in FY14.

Current Status: Although the Independent Reviewer has been provided with whatever information she has requested, it is recommended that the State continue to explore and implement effective actions for the prompt review and remediation of critical incidents. DBHDD is strongly encouraged to include independent oversight.

Recommendation Fourteen:

Ensure that consents for psychotropic and other medications are documented prior to transition from State Hospitals.

Prior Status: The Department concurs with the importance of this issue. Although the Department has planned reasonable steps to address this concern, the actual degree to which this issue has been resolved requires the consideration of additional information. This information is being obtained from the monitoring of community placements currently underway by both the Department and the Independent Reviewer. Therefore, comment on this recommendation will be deferred.

Current Status: This serious issue is not resolved. Recent reviews conducted by the Independent Reviewer document that individuals diagnosed with a profound intellectual disability or with impaired cognitive ability are still being asked to sign consent for medication and other treatment interventions.