Region One DBHDD Planning Board
705 North Division Street
Building 104
Rome, GA 30165

2016 ANNUAL PLAN

Chairperson:
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2016 ANNUAL PLAN CONTENTS

EXECUTIVE SUMMARY

The vision of DBHDD is to have a community based system of care that is accessible, responsive, flexible and able to effectively meet the needs of people with a Behavioral Health or Developmental Disability. DBHDD's Region One continues to implement that vision by supporting new services that were added in the past three years with the closure of NWGRH and by working with all providers to better meet the needs of the target population. The new behavioral health services included two new crisis stabilization units for adults; three new Assertive Community Teams (ACT), three levels of Case Management, expanded residential options for adults, intensive outpatient substance abuse services, expanded supported employment, two new peer-operated Wellness Centers, and the addition of mobile crisis teams covering all 31 counties in the region. These teams are to conduct fact-to-face assessments within one hour of being dispatched for anyone experiencing a behavioral health related crisis. People who need inpatient psychiatric treatment go to one of seven different community based psychiatric hospitals under contract. With almost three years of experience utilizing these hospitals, people are being stabilized and linked with an aftercare provider in one-third the time that happened at NWGRH. New residential and other supports were developed that allowed all of the people in NWGRH's DD unit to relocate to community settings, and people continue to be transitioned from the other State facilities.

Most of these new services had been identified in prior Planning Board Annual Plans and were included in the State's Settlement Agreement with the Department of Justice. On-going efforts will focus on coordinating the new services with existing providers, ensuring ease of access to them, and building relationships at the local level among the various agencies, advocates, providers, and other stakeholders who have an interest in building an effective community system of care. Notwithstanding the improvement realized with the new services, this Annual Plan has identified remaining gaps in having a comprehensive system of care.

DBHDD utilizes Regional Planning Boards to develop annual plans, to identify service needs and to specify service priorities for its area of the state. Local needs for Region One's 31 counties were assessed based upon feedback received from participants and families, input from providers, information from social services agencies and community stakeholders such as juvenile court judges, law enforcement, probate judges, county commissioners, and the demographics of the region. In addition, the services called for in the ADA Settlement Agreement inform its planning.

The Planning Board focuses its long-range priorities on the need for services that are more accessible, responsive, flexible, and accountable in order to prevent out-of-home placements and unnecessary use of "high cost" programs. To assist with this focus, it is necessary for there to be closer involvement with other public agencies such as local school systems, Department of Family and Children Services (DFACS), Department of Juvenile Justice (DJJ) and law enforcement to prevent eligible consumers from "falling through the cracks" and to better coordinate available resources, especially children and adolescents with serious emotional disturbance or addictive diseases.

The Planning Board has identified many gaps in services that need addressing. The priority needs for Region One which are recommended in the 2016 Annual Plan are:

1. Housing Options
2. Transportation
3. Employment Opportunities and Supports
4. Rural Resource Coordination/Development
5. Improved Visibility of Public Information On Accessing Non-Emergency Services

By closing these service gaps, it is expected that more people will be able to receive needed services in their community, there will be less use of in-patient facilities, and the health and quality of life will improve.

The 2016 Annual Plan reflects the Planning Board's commitment to "listen to its customers" and to help improve services for the targeted populations.

REGION ONE DBHDD PLANNING MEMBERSHIP

As of March 2014, members of the DBHDD Region One Planning Board are:

County	Name	Vacancies
Banks	Dr. Melody Stancil	0
Bartow	J. Paul Newell, Cindy Smith, Cynthia Wainscott	0
Catoosa	Denny Whitesel	1
Chattooga	Betty Brady	0
Cherokee	Irene Butcher, Joseph Davis, Kirby Pruett	2
Cobb	Wallace Coopwood, Dr. Bill Hudson, Laura Searcy, Judith Steuber	10
Dade	Thomas Black	0
Dawson	Val Dodson	0
Douglas	Faneashia Allen, Romona Jackson-Jones, Ginny Pavey	0
Fannin		1
Floyd	Deborah Malone, Sheila May	0
Forsyth	Nancia Leath	3
Franklin		1
Gilmer	Ross Evers	0
Gordon		2
Habersham		1
Hall	Troy Brandon, Scott Crain, Marty Owens	1
Haralson		1
Hart		1
Lumpkin	Sara Cohen	0
Murray	Steve Spivey	0
Paulding		3
Pickens		1
Polk		1
Rabun	Tammy Wilbanks	0
Stephens	Danny Yearwood	0
Towns		1
Union	Kris Gooch	0
Walker	Katherine Markham, Eddie Upshaw	0
White	Gail Browning	0
Whitfield	Brittany McMillian, Pam Massingale, Nicky Starling	0

DESCRIPTION of REGION

Region One covers 31 counties of Northwest and Northeast Georgia with a total population of over 2.5 million people, according to the 2011 Population Estimates, (cc_est 2012), released June 2013 by the U.S. Census Bureau. Adults with high acuity of behavioral health needs are served in Crisis Stabilization Programs (CSP) that are operated by Community Service Boards (CSB). In addition to the CSP's, DBHDD contracts with seven private hospitals to provide psychiatric in-patient adult services when necessary. A very small percentage of adults who need extended care can be served in Georgia Regional Hospital in Atlanta. Children and adolescents who have high acuity are served in CSP's in Greenville and Atlanta.

The demographic diversity is increasing in pockets of the region and several counties continue to experience growth. Demographic information from the U.S. Census Bureau, 2011 County Population Estimates, indicates that the primary population distribution for Region One is 80.8% Caucasian, 14.1% African American and 5.1% all other races. Of the total distribution of races, the Hispanic/Latino population makes up 11.4% of the Region One ethnic population with the highest distribution of county population as follows: Whitfield (32.8%), Hall (26.9%), Gordon (14.5%), Murray (13.4%), Habersham (13.1%), Polk (12.8%), Cobb (12.6%), and Gilmer (10.4%).

The number of citizens eligible for services funded through the Public sector is calculated as individuals living at two times (200%) the federal poverty guidelines and below. According to data from the 2011 U.S. Census Bureau, at least 30% of the population in 27 of the 31 counties has annual income less than 200% of poverty level. Due to the high percentage of people living at or near the federal poverty level, there has been an increase in people eligible for services.

Fifteen of the thirty-one counties have total populations of less than 30,000 people which present challenges to efficiently provide a range of services in all counties.

In fiscal year 2013 there were over 25,100 adults served in community based mental health programs and another 6,777 adults with addictive diseases served in programs funded through the Region One office. In addition, there are 362 people from the Region who were admitted to adult mental health services in State Hospitals with a discharge length of stay of 14 days. There were also 1,633 admissions to the private psychiatric hospitals under contract with DBHDD with an average 5.7 day length of stay.

There were over 4,260 individuals with developmental disabilities served in Region One community based programs during fiscal year 2013. During fiscal year 2013, there were 1,379 individuals in Region One eligible for DD services but not yet in service. Two hundred and eighty-four (284) individuals are on the short term planning list and 1,095 people are on the long-term planning list. The Regional Office receives approximately twenty-five (25) new applications per month. Based on current funding levels and the number of new individuals who present with an immediate need, many individuals graduate from high school or age out with no supports other than their natural supports and must remain on the planning lists. This results in a loss of skills and isolation and often creates hardship for family members who must remain unemployed to provide care and support. Caregivers and individuals with developmental disabilities would benefit from scheduled case management supports up to four years before an individual reaches the age of 18 along with funding to transition from the school system programs into ones that are funded through the DBHDD system.

There were approximately 4,315 children and adolescents aged 9 - 17 enrolled in programs for Severe Emotional Disturbance and over 250 adolescents aged 12 – 17 enrolled in programs for substance abuse.

ASSESSMENT of REGIONAL NEEDS

Stakeholders from Region One are continually assessing needs to build a service system that will adequately provide the services and supports needed by the core customers of the Department of Behavioral Health and Developmental Disabilities. Those services and supports include stable housing, transportation, employment, and physical health care as well as the creation of partnerships with other resources, both public and private, that have a significant impact on the mental health of consumers. The vision for that system of care includes an array of services that are responsive, flexible, comprehensive, effective, and accessible which incorporate evidence-based practices. There must be a strategy that seeks to maximize the utilization of existing resources, while informing officials of the unmet needs.

The Region One Planning Board values and is committed to the design of a community-based comprehensive spectrum of mental health, developmental disability, addictive disease and support services that will allow individuals to live their lives as free as possible of the disabling effects of these conditions. The region will focus on promoting choices for consumers within a network of providers that concentrate on recovery and maximum potential considering a participant's unique strengths and abilities. The goal is to enhance the quality of life for all individuals who receive services funded by DBHDD.

To assist in identifying needs and priorities for the fiscal year 2016 planning process, Board members sought information from county commissioners, law enforcement, public officials, community members, participants, families, and the general public in their respective counties. The Regional Office received feedback from providers, through town hall meetings hosted by board members, and bi-monthly board meetings which served as a venue for the public and providers to share information with the Board. Use of the 2010 Georgia County Guide and the 2011 United States Census information were also important in assessing needs.

REGIONAL PLANNING BOARD PRIORITIES

A. PRIORITIES COMMON TO ALL DISABILITIES

Children and Adolescents with Severe Emotional Disturbance, Adults with Serious Mental Illness, Persons with Developmental Disabilities, Adults with Addictive Diseases, Adolescents with Addictive Diseases, Individuals with Co-occurring Disorders.

Service Priority 1: *Housing Options*

Develop more funding, locations, program options, and levels of housing to offer independent, semi-independent, supervised, permanent, transitional, and respite opportunities.

Rationale:

Continue the growth of resources for individuals still needing secure community housing. Additional semi-supervised/supported housing options are needed to strengthen individuals' skills in managing independent living prior to moving to permanent independent living. A range of supported living arrangements are essential for those who need ongoing assistance.

Housing choices need to be broadened for individuals with developmental disabilities. Quotas imposed by some funding sources regarding the percentage of such individuals who can live in an apartment complex create a road block to independent living options in low density population areas. More locations are needed to provide individuals with choices in where they live.

Rural housing options need to be expanded to ensure individuals do not need to leave existing vital support systems.

Service Priority 2: *Transportation*

Expand services to include transportation that can cross county lines and expand the hours/days of available service.

Rationale:

Current transportation options lack the routes and flexibility to meet the needs of individuals. Transportation services are limited in their capacity to accommodate assistive devices for mobility such as wheelchairs. Trained certified support animals are allowed to travel with the individuals they serve. The aids who travel with individuals who cannot travel without assistance should be included in the service without extra cost.

Transporters are limited to the county of origin. When travel to other counties for access to care and medications is not available rural consumers are not able to access basic ongoing services.

Schedules need to be expanded. Child and Adolescent services offered around school schedules and Adult evening/weekend services are not accommodated. School transportation is limited, which jeopardizes parents' employment. Access to social activities is often denied due to lack of appropriate transportation. The limitation of transportation services to business hours prohibits evening and week-end access to medical and psychological services as well as social outlets.

Service Priority 3: *Employment Opportunities and Supports*

Increase job development, placement and training in order to assist individuals in obtaining and maintaining competitive employment in the community. Also expand transportation services to accommodate variable work schedules. More providers are needed who are able to support and develop opportunities for individuals with mental illness and developmental disabilities.

Rationale:

More employers in the business community and more providers to develop and coordinate services are needed to provide a variety of job supports which include not only job skills but also education on success behaviors to meet employer expectations for conditions of employment. Provider programs need to be developed to provide a variety of training opportunities that identify and meet the interests, strengths and needs of consumers seeking employment.

Employment opportunities must be broadened beyond stereotypical low performance tasks. Creativity in identifying niche job descriptions that truly enhance productivity for the employer and the dignity of the consumer is vital to develop a realistic and dynamic lifestyle tapping the maximum potential of each consumer. Expand opportunities for employment offering a variety of shift and weekend hours.

Service Priority 4: *Rural Resource Coordination/Development*

Services in rural counties need intensive resource coordination, recruitment of providers and increased choice in care. Children and adolescents have to be sent out of the region to get services, which prohibit family reunification and maintenance of family bonds. There is insufficient support for individuals in recovery from addiction or after crisis care. The probability for relapse is elevated as a result. Individuals with developmental disabilities do not have the same access to choices that are available in areas with higher population density.

Low population density is a barrier to maintaining viable support programs resulting in a diminished standard of care for rural consumers.

Rationale:

Resource coordination is a strategic need for all disabilities in children, youth and adults. Creative solutions such as telemedicine and improved recruitment of psychologists, psychiatrists, licensed providers and allied health professionals need to be funded. Any barriers to telemedicine through restrictions of professional licensing or practice groups need to be lifted. Difficulty in accessing services is compounded by lack of transportation.

Service Priority 5: *Improved Visibility of Public Information on Accessing Non-emergency Services*

Increase awareness of providers through multiple media information sources. This would include a DBHDD website that lists and explains available resources and how to access those resources. Public information should also provide locally based information phone lines or offices for individuals who do not access the internet.

Rationale:

Consumers of all services, their families and non-family networks need ease of access to accurate and complete information about available resources, and how to access non-emergency services. Particular attention to:

- Parents of children who need mental health services and effective planning for developmental disability supports through the life cycle.
- Consumers, and their friends & families, who do not always have knowledge - beyond initiating emergency services through 911 - regarding how to access appropriate help before an individual becomes a danger to themselves or others.
- How the routine communication of information on when and how to access services can increase awareness of need associated with access.

B. ADULTS WITH SERIOUS MENTAL ILLNESS
CHILDREN & ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

Individuals of all ages, and their families and other involved persons, benefit from well coordinated mental health services. Service priority areas are defined to include a group of supports that work together for optimum benefit to individuals, their circle of association and the community at large.

Service Priority: 1 *Enhance Community Supports*

Increased wrap-around services, including services that address the transition from child and adolescent to adult, in-home supports for the families of youth, and in-home supports for adults.

Rationale:

Families with multiple needs have limited to no access to support systems that facilitate access to services. Each individual's disability presents obstacles to receiving the care that would free them to receive therapy. An individual's physical needs may limit access to caregiver services that might allow other family members to travel to needed mental health services. Case management supports for multiple categories of care is critical for families.

There are limited options for youth who fall into a service gap as they transition from psychiatric residential treatment facilities (PRTF) and Foster Care programs. Develop a more visible collaboration between the Department of Education and DBHDD for the provision of in-school services in all school systems. Support families through early identification of and intervention in behavioral health issues in schools

Additional peer support centers are much needed in both rural and urban locations. Offering 7 days/evenings per week hours, with a variety of activities - such as exercise, basic medical access, education, job, social and family skills classes - builds success and provides an environment in which peer intervention, in the event of early decompensation, can preserve dignity and enhance the use of non-emergency but high level care resources.

Service Priority 2: *Justice/Mental Health Collaboration*

Improved collaboration between the Criminal Justice and Mental Health systems.

Rationale:

Increase access through imbedded mental health care professionals in all jails; include clear continuing care plans following release.

Supports for the education of law enforcement personnel in recognizing and responding to special needs in crisis and non-crisis encounters will empower first responders to better manage such encounters with individuals who need therapeutic intervention.

Supports for the education of judges and additional staffing for mental health courts will provide appropriate diversion to mental health intervention instead of incarceration.

Service Priority 3: *Increase Non/Pre-crisis Services & Access*

Access to non-crisis services includes widely available walk-in clinics providing assessment, pre-crisis intervention, supportive counseling, case management, information and referrals, and follow up. Add an intermediate level of residential care to provide safe longer term stabilization for the most serious and persistent mental illnesses that do not respond to short term crisis and wrap-around services.

Rationale:

Outside of emergency rooms, crisis calls to 911 or the Georgia Crisis Access Line, individuals needing help to manage escalating mental health issues often have to wait for services, resulting in further escalation to the level of imminent risk to the consumer.

Walk-in clinics would provide a range of supportive services that would divert individuals from relying on intensive emergency services. Clinics would provide information to the general public through education -delivered to schools, civic groups, etc. - on accessing assistance and available services. On-site staff can quickly assist individuals to link up with appropriate level of care providers. Professional staff provide walk-in crisis assessment and referral to available community based supports.

Intermediate residential care to provide up to six months of care to stabilize, monitor medication efficacy and complete transition to independent living are a necessary level of care. This supervised and structured intervention would provide continuous support, in particular, for consumers who revolve in and out of crisis facilities.

Service Priority 4: *Early Intervention and Prevention*

Early intervention includes the timely use of screening instruments and evaluations, which results in access to age-appropriate professional treatment.

Rationale:
The identification and treatment of mental health needs at the onset of symptoms ensures youth and adults the opportunity to learn about successful management of symptoms and treatment of illness. This increases success in interpersonal and professional environments. It provides individuals the personal satisfaction and confidence of a quality lifestyle.

Early intervention coupled with treatment reduces the likelihood of substance abuse that results from unsuccessful symptom management. Appropriate use of mental health services, when learned early, facilitates success. Early intervention reduces the need to utilize higher levels of care in adult services as a coping or management mechanism.

C. ADULTS, CHILDREN & ADOLESCENTS WITH ADDICTIVE DISEASES

Individuals of all ages, their families, and other involved persons benefit from state-of-the art best practices designed for substance related treatment.

Service Priority 1: *Develop More Treatment Programs*

Increase addiction treatment funding to develop more therapeutic programs and long-term follow-up, based on best practices, to optimize success. Best practices involve evidence based and practical interventions to prevent and/or treat mental and substance abuse disorders.

Rationale:
The absence of adequate services for dealing with addictive disorders results in over use of emergency rooms, crisis units and psychiatric hospitals. Rural areas have special needs including: transportation and residential centers close to family/community supports.

Individuals need reliable, strong and long-term supports that will help them establish and maintain healthy lifestyles. Additional residential treatment facilities are needed for consumers who need evidence based longer term (90 to 180 day) treatment and have limited or no payor sources. Residential supports which provide structured treatment, build coping skills, and assist the consumer with housing options upon discharge will reduce the cycle of abuse.

Service Priority 2: *Early Intervention & Prevention Education for Youth and Parents.*

Substance abuse prevention and education, which includes prescription abuse awareness training, enhances early recognition and intervention. Aggressive programs that address parental perceptions of limited harm are critical to the provision of a full continuum of services that address this growing problem.

Rationale:

Research has shown that the use and abuse of prescription medications and substances is increasing in younger populations, including primary school population (SAMHSA 2010 National Survey).

Education on the prevention of addiction through the reduction of risk behaviors, involvement of caretakers, and school peer activities is needed in all child and youth venues. Behavioral Health sponsored youth and family programs need to be available through the correction and justice systems and child care providers, as well as schools.

Reimbursement codes for Screening, Brief Intervention, and Referral to Treatment (SBIRT), a comprehensive, integrated, public health approach to the delivery of early identification, intervention and treatment for persons with substance abuse disorders, as well as those at risk of developing these disorders, need to be activated by Georgia. The lack of reimbursement prevents a recognized approach (SAMHSA) for addressing addiction in our state.

Service Priority 3: *Drug Courts & Diversion*

Drug courts and diversion options for judges and parole/probation officers.

Rationale:

The needs of individuals are not adequately met in jails or youth detention centers. Effective diversion programs are lacking in adult and juvenile court systems. Interagency cooperation limits redundancy of services, which does not work to the best interests of the individual, and helps fill in the gaps (such as family supports) that go unidentified as a result of a lack of such cooperation. More levels of treatment with oversight, in partnership with Behavioral Health, will provide quality treatment options not available through incarceration.

D. PERSONS WITH DEVELOPMENTAL DISABILITIES

Service Priority 1: *Access and Array of Services*

Improve access to an array of service options in all areas of the Region

Rationale

Individuals who live in rural areas of the region need access to the same array of services as individuals who reside in more densely populated areas. There is little or no transportation in many areas, limiting access to jobs and other services. Some areas have only one Provider of services. This leads to limited choice in the rural areas, especially if that one Provider is unable to provide the supports needed to meet the needs of the individuals and families in the area.

There are challenges to finding qualified and capable staff to work with DD individuals. New and existing Providers need to develop services in geographic regions where choice is limited.

DBHDD should consider offering financial incentives for providers to develop services in low population density areas.

We need to ensure that those receiving services are clearly informed of the most appropriate services that can meet their family members' needs. Families and concerned others need to be made aware of the process to have treatment concerns addressed, and feel comfortable with the process. More day programs and housing options are needed in both rural and densely populated areas to meet the needs of the community.

Service Priority 2 *Stage-of-life Continuum of Services*

Ensure a continuum of services from school to adulthood for those who are graduating or aging out from High School and those who have already transitioned but who are currently receiving no or limited services.

Rationale

DBHDD system must coordinate with local school systems to create a transitional plan to insure no disruption of individual services upon graduation from school to the DBHDD provider system. The Individualized Education Plan process needs to include services such as Vocational Rehabilitation to strengthen service delivery through partnerships with the Department of Education in order to increase the number of students with disabilities receiving transitional supports from school to independent living. We also need to empower families with as much information as possible so they can easily navigate our system and find what they need, whether it is for a child getting ready to graduate or an aging parent trying to find assistance for their adult son or daughter. Information should be shared with schools, local groups such as churches, law enforcement and other community groups, who can assist in getting information to families. Families with limited reading and comprehension skills need assistance to fill out applications for services.

A system must be developed to identify consumers who will be entering adult services, at least four to five years prior to reaching that threshold. This ability to predict future demand for services will insure preparation time for the Regions to put in place needed resources. The planning list will then become a real tool for planning future individualized supports as individuals come of age.

Service Priority 3 *Assurance of Adequate Documentation for Transition of Services*

Assure adequate documentation as individuals transition out of schools, to facilitate smooth access to, and provision of, services.

Rationale

Documentation can be a bridge or a barrier to receiving services. There must be a concerted approach to facilitate interagency partnership between schools, behavioral health and human services to ensure a smooth transition for individuals to receive services with no gaps or obstacles. Interagency transition planning is critical.