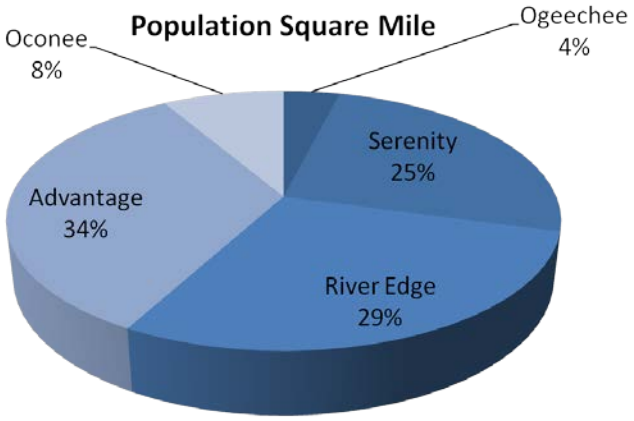
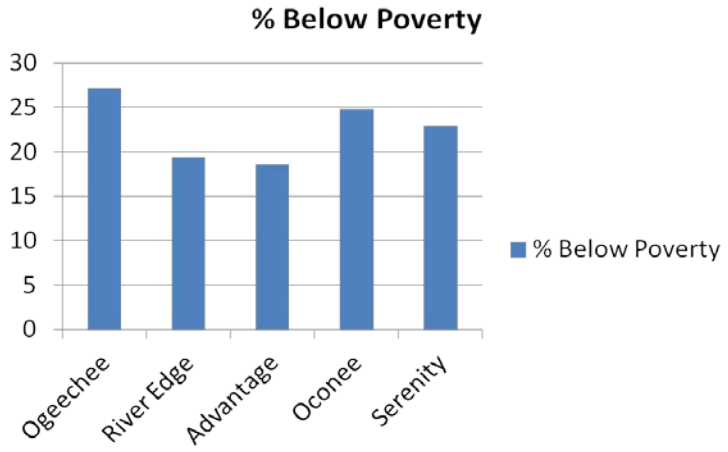
Department of Behavioral Health and Developmental Disabilities
REGION 2 DBHDD Regional Planning Board
Fiscal Year 2016 Annual Plan

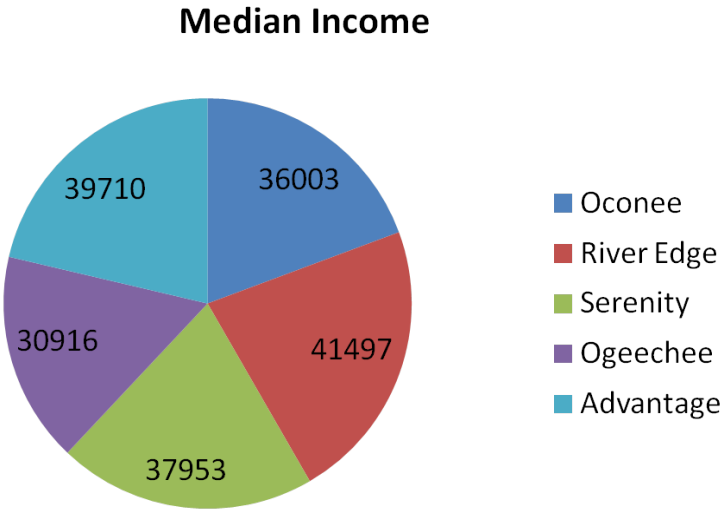
Community Mental Health Centers were created by the State of Georgia to provide publicly-funded mental health, developmental disability and addictive diseases services. In July, 1994 House Bill 100 was enacted, which transformed Community Mental Health Programs operated by the state to Community Service Boards (CSBs) governed by local Boards and funded through contracts with the state. In 2007, the Department of Human Resources/Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) opened up state funding to non-CSB providers of Child and Adolescent services through fee-for-service payments, which allowed a significant increase in consumer choice and service accessibility. In order to increase access to adult mental health and addictive diseases services, the Division allowed for Letters of Agreement to be established with private providers to allow Medicaid billing for core and some specialty services. In addition, over the years, the emphasis in funding for Developmental Disabilities services shifted from funding programs to individual funding through waivers. On July 1, 2009, MHDDAD became a stand-alone agency called The Department of Behavioral Health and Developmental Disabilities.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) is comprised of a system of services in the areas of Mental Health, Addictive diseases and Developmental Disabilities. There are six Regional Offices in the State which are responsible for the oversight and management of providers to assure access, adequacy and appropriateness of services. In accordance with DBHDD initiatives, the Regional Offices are committed to the effective provision of comprehensive, community-based and recovery-oriented programs that assist individuals in their transition to independent living. In Region 2 (R2), there are 33 counties covering 12,214 square miles, with a total population of 1,277,120. The Region is divided into 5 service areas, each specified by the metropolitan areas of Athens, Augusta, Macon, Milledgeville and Swainsboro. R2 is predominately rural and economically disadvantaged, with 22.5% of the population living below the poverty level, compared to the State total of 16.6%. Clarke County has the highest rate of homelessness as well as the highest rate of individuals living below the poverty level at 33%. Oconee County has the lowest level of individuals living below poverty with 8.2%. Furthermore, the median income for individuals in Region 2 is $37,215 compared to the State median of $49,736. The individuals served by DBHDD are predominately uninsured or on Medicaid and have few resources and options. The percentage of uninsured individuals in the Region is 21.6%, with Emanuel County having the highest number at 26.5% and Oconee County having the lowest number at 16.2%.

The following charts correspond to the catchment areas in which the Community Service Boards are located. The information is inclusive of all counties served by each CSB. Advantage Behavioral Health services the Athens area which includes Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe and Walton counties. The Oconee Center serves the Macon/ Milledgeville area and includes Baldwin, Hancock, Jasper, Putnam, Washington and Wilkinson counties. Ogeechee Behavioral Health serves the Swainsboro area and includes Burke, Glascock, Emanuel, Jefferson, Jenkins and Screven counties. River Edge serves the Macon/ Milledgeville area and includes Baldwin, Bibb, Jones, Monroe, Putnam, Twiggs and Wilkinson counties. Serenity Behavioral Health serves the Augusta area and includes Columbia, Lincoln, McDuffie, Richmond, Taliaferro, Warren and Wilkes counties.

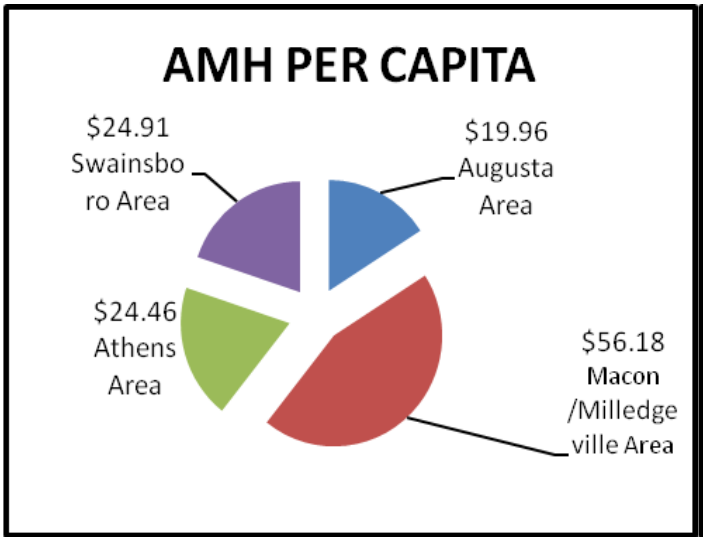


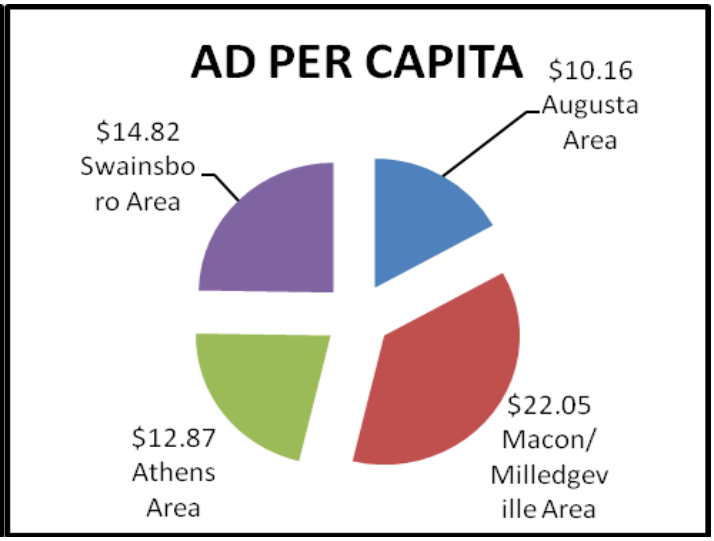




The R2 office is responsible for effective planning, purchasing and monitoring of community based services that meet the needs of the citizens in the region who rely on state supported mental health, developmental disability and addictive diseases services to live in the community. Monitoring activities include accessibilitly of services, service delivery capacity, consumer complaints, coordination of care and the collection and analysis of information to measure against prioritized areas of improvement that have been identified.

As indicated in the charts below, the Macon/Milledgeville area has the highest spending per capita for both Adult Mental Health and Adult Substance Abuse. The increased spending in this area reflects an increase in funding for Crisis Apartments, Intensive Case Management, Case Management and the AD Transition Program at Oconee Center. In FY2013, Region 2 providers served 122,155 individuals in Adult Mental Health and 30,518 in Adult Substance Abuse.





The Regional Office surveyed providers of Adult Core services to determine the most common diagnostic categories and percentage those categories made up of the entire population served. The two most common diagnostic categories were Moderate/ Severe Major Depressive Disorder and Bipolar I Disorder. In the table below, those categories noted "Not Reported" indicated the diagnoses that were not named as one of the six most commonly served by the agency.

Diagnostic Category	Advantage	American Work	Oconee	Ogeechee	River Edge	Serenity
Schizophrenia	9.36%	17%	24%	13.5%	11%	15.6%
Schizoaffective Disorder	10.1%	14%	5%	14.6%	11%	16.6%
Bipolar I Disorder	23.7%	19%	10%	14.7%	20%	19.9%
Bipolar II Disorder	2.1%	3%	2%	Not Reported	2%	2.5%
Major Depressive Disorder Moderate/ Severe	23.3%	26%	26%	41%	18%	23.1%
Major Depressive Disorder Mild	1.9%	1%	3%	Not Reported	3%	4.3%
Anxiety Disorders	5.2%	6%	16%	10.4%	4%	5.5%
Polysubstance Dependence	5.2%	13%	5%	Not Reported	5%	2.1%
Substance Abuse	Not Reported	Not Reported	9%	Not Reported	Not Reported	10%
Co-Occurring MH/ AD Disorder	Not Reported	Not Reported	72.7%	21%	43%	34.5%

R2 providers primarily serve individuals with diagnoses consistent with Severe and Persistent Mental Illness (SPMI). The percentage of individuals with SPMI ranges from River Edge at 62% to Ogeechee at 83.8%. The other individuals served by R2 providers are diagnosed with an Addictive Disease or with less severe diagnoses such as Major Depressive Disorder (Mild Type) or Anxiety Disorder. The percentage of individuals served with co-occurring mental health and addictive disease diagnoses varied significantly between providers. Ogeechee reported 21% while Oconee reported 72.7% of individuals served with co-occurring disorders.

Provider	Percentage of Individuals Served with SPMI Diagnosis	Percentage of Individuals Served with Co-Occurring Mental Health and Addictive Disease Diagnosis
Advantage	68.6%	Not Reported
American Work	79%	Not Reported
Oconee	67%	72.7%
Ogeechee	83.8%	21%
River Edge	62%	43%
Serenity	77.7%	34.5%

Housing - Living in one's own house, apartment or furnished room is a vital aspect of independence for individuals. Permanent, safe and affordable housing that is not dependent upon the acceptance of treatment is a critical aspect of resiliency and recovery, and creates a foundation for establishing stability and instilling hope. The Regional Office coordinates the efforts to strengthen a continuum of community housing options ranging from personal care homes to independent housing. The Regional Office administers the Georgia Housing Voucher Program (GHVP) and has successfully collaborated with multiple providers to place

approximately 218 individuals in housing in FY2013, spending $68,383 per month in rental assistance. Bridge Funding assists individuals in paying rental and utility deposits. Additionally, household furnishings are provided with each voucher, averaging $2,900 per individual.

The GHVP was founded on the models of Housing First and Permanent Supportive Housing. The central premise of the Housing First model is that a homeless individual's first and foremost priority is to obtain stable housing. Other issues that may affect the household can and should be addressed once housing is obtained. Permanent Supportive Housing shares the belief that safe, affordable housing is often out of reach for many and uses rental assistance to maintain housing and needed services in the community. Accordingly, the GHVP has been successful in the prevention of homelessness and the reduction of recidivism from places such as jails, prisons, and psychiatric hospitals through the use of community based programs that provide both rehabilitative and supportive functions to match individual needs and goals. These include Case Management, Intensive Case Management, Community Support Team, Residential Services, Assertive Community Treatment, Psychosocial Rehabilitation, and Supported Employment. Utilization of the GHVP by the providers in the region has remained steady and, along with the community based services, availability to voucher participants has led to 86% of these individuals remaining in their housing for 6 months or more.

Since the program began in FY2011, the GHVP has been successful in assisting individuals with Severe and Persistent Mental Illness (SPMI) who are experiencing homelessness and/or being released from State psychiatric hospitals. Thus far, Region 2 has placed 90 formerly homeless individuals in housing. Furthermore, the Region has increased efforts to serve those individuals who are both mentally ill and incarcerated in jails and prisons. Regional staff has begun to meet with local law enforcement and the Georgia Department of Corrections with the goal of reducing recidivism by assisting in identifying housing and providing community based services to individuals leaving jails and prisons.

In addition to the GHVP, DBHDD recently entered into a partnership with the Georgia Department of Community Affairs and plans to move those individuals currently on a GHVP to a DCA funded voucher. This has allowed DBHDD to free up GHVP funds to expand assistance to other individuals with SPMI in need of housing. Region 2 has begun the process of converting GHVP individuals to DCA vouchers. Individuals continue to receive the same services as under GHVP so there has been little resistance among property owners with accepting this transition. Region 2 will continue to provide technical assistance and consultation for our providers so that we may continue the progress in the area of providing safe, affordable housing to our individuals.

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

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

The Regional Office takes the lead in the evaluation and continuous improvement of R2 crisis services in regards to community integration, cost effectiveness, utilization and accessibility for individuals in rural areas. The expansion of services to rural areas is a priority for the Region. The R2 Crisis System has the following components:

- 24-Hour Crisis Line
- Walk-in Crisis Service Center
- Mobile Crisis Services
- Crisis Apartments
- Crisis Stabilization Units
- 23-Hour Observation Unit

Mobile Crisis Services for the Augusta and Swainsboro services areas were available through Behavioral Health Link (BHL) through May 2013. In June 2013, Benchmark began providing mobile crisis services. They serve Burke, Columbia, Elbert, Emanuel, Glascock, Greene, Jefferson, Jenkins, Lincoln, McDuffie, Morgan, Oglethorpe, Richmond, Screven, Taliaferro, Warren and Wilkes counties. River Edge BHS provides crisis intervention services at the Medical Center of Central Georgia and at Oconee Regional Medical Center. Advantage BHS provides crisis intervention services at St. Mary's Hospital. Mobile crisis services will be available in all R2 counties by 2015. Benchmark provides Mobile Crisis Response to homes, schools, jails and hospitals. They are staffed with Licensed Clinicians and Certified Peer Specialists (CPSs). The CPSs follow-up with individuals for approximately seven days post-crisis and may assist with transportation to their initial Mental Health appointment. They also engage in the recovery process and link individuals with community resources. In R2, Benchmark has formed partnerships with Community Providers, Law Enforcement, Personal Care Homes, Probate Courts, Social Service Agencies and School Systems.

CO-OCCURRING DISORDERS (MENTAL HEALTH AND SUBSTANCE ABUSE)

When compared to patients who have a mental health disorder or a substance abuse problem alone, individuals with co-occurring disorders often experience more severe and chronic medical, social and emotional problems. Due to the presence of two disorders, they are vulnerable to both substance abuse relapse and exacerbation of the psychiatric disorder. Furthermore, the worsening of psychiatric problems often leads to addiction relapse, while the use of substances is directly related to an increase in psychiatric destabilization. Compared with patients who have a single disorder, individuals with dual disorders have a higher utilization of crisis services, require longer treatment and have higher rates of incarceration. In a recently published study, Wilson, Evans, & Hadley (2011) examined recidivism rates among 20,112 inmates admitted to the Philadelphia jail system. After four years, the results were measured among four different groups:

- 54 percent re-incarceration for people with severe mental illness
- 60 percent for those with no diagnosis
- 66 percent for those with substance abuse problems
- 68 percent for those with co-occurring mental illness and substance abuse

Interestingly, this study found that individuals with severe mental illness alone had decreased rates of recidivism for each of the four years, which may indicate greater availability of treatment resources for

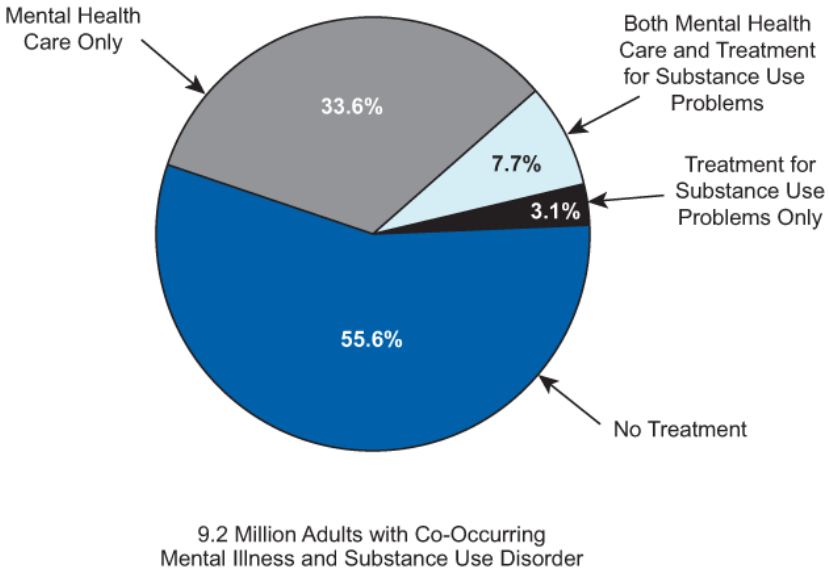


Figure 1 National Survey on Drug Use and Health (2008)

individuals without a co-occurring diagnosis of substance abuse. In another study, Schmidt, Hesse, & Lykke (2011) examined the impact of substance abuse disorders on the course of schizophrenia over a 15 year period. Schmidt et al (2011) found that individuals with co-occurring substance abuse had approximately two to three times more hospitalizations as did patients with schizophrenia only. Furthermore, the study found that individuals with co-occurring disorders were more likely to be admitted to treatment during a given year although they have briefer contact with treatment. The median length of psychiatric hospitalization was 12 days for an individual with a co-occurring disorder as compared to 21 days for individuals with schizophrenia alone (Schmidt et al, 2011).

The Regional Office recognizes the importance of providing appropriate, evidence-based treatment for individuals with co-occurring disorders and strongly encourages providers to utilize the Integrated Dual Diagnosis Treatment (IDDT) model, which emphasizes that individuals achieve "big changes such as sobriety, symptom management and an increase in independent living via a series of small, overlapping, incremental changes that occur over time." IDDT promotes peer and family involvement, stable housing as a necessary condition for recovery a**n**d the possibility of employment for many individuals. The addition of services such as Assertive Community Treatment, Supported Employment, Community Support Team (CST), Addictive Diseases Peer Support and the GHVP also provides support for individuals with SPMI and an addiction disorder.

Jail/Prison Population - The jail/prison population is a major focus for DBHDD due to the significant number of incarcerated individuals with SPMI. Many individuals who cannot get mental health treatment and adequate community supports end up in the criminal justice system after they commit a crime. According the Bureau of Justice Statistics, 56 percent of state prisoners and 45 percent of federal prisoners have symptoms or a recent history of mental health problems. Furthermore, prisoners have higher rates of SPMI. Schizophrenia, bipolar and major depression occur 2 to 4 times more often in incarcerated individuals compared to individuals in the general public. In recognition of this, R2 staff works closely with providers to develop relationships with local sheriff's departments and jails to expand mental health courts and awareness of community resources. There are mental health courts in the Advantage and River Edge service areas which, in conjunction with R2 providers, have been effective in ensuring that program participants are connected to needed community-based treatments, housing and other services that encourage recovery.

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

Addictive Diseases - The basic components of effective addiction treatment should be readily available, focused on the multiple needs of the individual and be of appropriate duration. A treatment delivery system should connect individuals in recovery with other types of help and supports they need utilize evidence based practices, make sure that individuals transition smoothly from one level of care to another and maintain high quality services for everyone who needs them. An effective Continuum of Care for Addictive Diseases begins when an individual enters treatment at a level consistent with their needs. The successful transfer of consumers between levels of care is based on consistency in treatment philosophy and a framework that integrates the distinct levels of care. The American Society of Addiction Medicine (ASAM) has established five main levels in a continuum of care for substance abuse treatment:

- Level 0.5: Early intervention services
- Level I: Outpatient services
- Level II: Intensive outpatient/Partial hospitalization services (Level II is subdivided into levels II.1 and II.5)
- Level III: Residential/Inpatient services (Level III is subdivided into levels III.1, III.3, III.5, and III.7)
- Level IV: Medically managed intensive inpatient services

In R2, the full array of ASAM levels is represented but there is a need for additional long-term residential services. The Crisis Stabilization Unit (CSU) **(Level III.5),** constitutes the highest level of care provided by DBHDD. While in this level of service, it is important to provide motivational interviewing, identify family supports and to begin treatment planning. For individuals leaving CSUs who require short-term residential services, Transition Residences, which are most similar to ASAM **Level III.2-D,** are available. Individuals entering this level must be able to live in an independent setting with some supports. The goal is to achieve initial recovery from the effects of alcohol and/or drugs in an environment that provides peer and social support. Treatment consists of a minimum of 25 hours per week (5 days) in the Intensive Outpatient Program (IOP), consistent with ASAM **Level II.5** requirements. Within IOP or Level II care, treatment often is delivered in sequential stages, with service intensity and structure lessening as individual's progress. As IOP services taper in intensity, the client assumes increasing responsibility and is provided less structure and supervision from treatment staff. A reduction in the intensity of IOP Level II.5 would be transition to Level II.1, which would ideally be in conjunction with transition to a halfway house, progressing to ASAM Level I. Currently, R2 has the following programs that serve individuals for up to one year: River Edge in Macon has a 14-bed facility for men and Oconee has a 6-bed facility for men and a 4-bed facility for women.

R2 currently has an Addictive Disease Transitional Housing Program at the Oconee Center, in which individuals are transitioned directly from a Crisis Stabilization Unit to apartments for up to 30 days. During this time, individuals participate in the Intensive Outpatient Program, attend 12-step meetings and begin to develop independent living skills. Individuals are also linked to residential and substance abuse services once they leave the program, which served 96 individuals in FY13. Furthermore, R2 expanded substance abuse residential services in FY13. In January 2013, Ogeechee opened the Braswell House which provides semi-independent residential services to individuals with addictive diseases. Individuals can be served at the Braswell House for nine months to a year. In FY13 Braswell House served 25 individuals.

Georgia Certified Addiction Recovery Empowerment Specialist (CARES) - The Georgia Council on Substance Abuse is administering a training program that is parallel to the Mental Health Certified Peer Specialist Program and is working directly with the Georgia Mental Health Consumer Network with funding from DBHDD. This is part of an effort to create a recovery-oriented system of care where peer-based support is

used as a fundamental part of community-based services. A CARES Academy has been established to conduct a one week training course and individuals in recovery who are interested in becoming a CARES must apply through the Georgia Council on Substance Abuse Committee. There are three trainings scheduled for CY2014, with the first Academy beginning in January.

CHILD AND ADOLESCENT MENTAL HEALTH AND ADDICTIVE DISEASES

In 2014, the Georgia Department of Community Health (DCH) will transition approximately 27,000 children, youth and young adults in foster care, children and youth receiving adoption assistance, plus certain youth in the Department of Juvenile Justice into the Care Management Organization (CMO), Amerigroup. Currently, Amerigroup is one of the three CMO's overseeing children in the Medicaid and Peach Care programs. According to DCH, the company will be paid about $200 million annually and is expected to save the Medicaid program as much as $27.5 million over the next five years. The rationale behind the move is to address both behavioral and medical needs in a holistic care coordination approach. When the transition is complete, DBHDD will only serve children that are uninsured and/or undocumented immigrants. DBHDD will maintain programmatic oversight over the Crisis Stabilization Units, Clubhouses, Psychiatric Residential Treatment Facilities and the Care Management Entities. DBHDD will continue to be responsible for the Behavioral Health State Plan.

Of the total population, 357,593, or 28%, are children and adolescents 18 and under. Approximately 8% of this population is estimated to have a diagnosis of a Severe Emotional Disturbance (SED) which amounts to 28,607 children in R2. In FY2013, 3,244 children were served by MH providers, reaching 11.3% of the estimated population of children needing MH services. The average cost for individuals receiving C&A services for FY2013 was $4,423, while the average cost for Adult services was $1,246.

Core Services - There are 45 core providers approved to serve children and adolescents in R2. Core providers are required to provide mental health and substance abuse treatment services. Providers per service area are: River Edge - 15; Advantage - 26; Serenity - 8; Ogeechee - 11; Oconee - 11. Although there are multiple core providers per CSB catchment area, some counties have only one provider of C&A core services. This limits choices for individuals and increases times for appointment availability. Expansion of providers into additional counties would increase access.

Intensive Family Intervention (IFI) Services - There are 43 IFI providers serving R2. The River Edge catchment area has 11 IFI providers; the Oconee catchment area has 10 providers; the Serenity catchment area has 6 providers; the Advantage area has 23 providers; and the Ogeechee catchment area has 7 providers. As indicated, there is a significant shortage of IFI providers in the Serenity catchment area which has the second and third most populace counties in the Region, Richmond and Columbia.

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

Psychiatric Residential Treatment Facilities (PRTF) - There are seven PRTFs throughout the state. There are two PRTFs located within R2, Lighthouse Care Center in Augusta and Macon Behavioral Health Treatment Center in Macon. The Region has adequate PRTF services.

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

The Resiliency Support Clubhouse Program for Youth - These mental health programs are designed to provide a comprehensive and unique set of services for children and families coping with the isolation, stigma and other challenges of mental health disorders. The Clubhouse runs on a work-ordered day. Participants of the program are called members. Members and staff work together each day to perform the jobs of the Clubhouse and participate in clinical sessions, social outings, work activity, educational supports, and clubhouse activities. River Edge operates the Clubhouse Program at their Milledgeville facility.

Child and Adolescent Substance Abuse Residential Treatment - There are two 24-hour, supervised, residential treatment programs for children and adolescents ages 13-17 years old who are in need of a structured residence due to substance abuse. Neither program is located within R2, but the two are located in the metro area and southern part of the state in order to afford statewide access. There are also four adolescent addictive disease group homes that are state funded and provide a structured temporary living situation for youth ages 13-17 years old dealing with substance related disorders. There is a need to make these services more accessible to children and adolescents and for programming closer to the youths' home communities.

ADULT MENTAL HEALTH

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

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

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

- Assertive Community Treatment
- Community Support Teams
- Case Management Services
- Crisis Stabilization Units

- Crisis Service Centers (Urgent Care)
- Supportive Housing
- Bridge Funding (from institutions to community)
- Supported Employment
- Peer Supports
- Crisis Apartments
- Mobile Crisis Services

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

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

Case Management - In June 2013 Case Management services became Medicaid billable and are now available for any individual receiving Core services in the region. Case Management services focus on all aspects of the physical and social environment. These involve accessing formal resources such as housing, financial support, transportation, and medical care, as well as informal resources, such as families, roommates and churches. Case Management provides support and structure in response to individual needs, linkage to community resources and continuity of care.

Community Support Team (CST) - In FY 2014, R2 added two Community Support Teams. One team is in the Athens area and serves Barrow, Clarke, Greene, Madison and Oconee counties. Serenity also has a Community Support Team that serves Columbia and Richmond counties. Each Community Support Team can serve up to 60 individuals and provides counseling, case management, individual peer support, crisis intervention and nursing services. The Community Support Team also assists the individual in accessing other services including psychiatric treatment, substance abuse treatment and residential treatment as needed.

Crisis Service Center - River Edge's Crisis Service Center began serving individuals in Baldwin County in April 2012. The Crisis Service Center is a 24-hour walk-in clinic for individuals in psychiatric crisis. Individuals are assessed and observed for up to 23 hours and are then referred to the appropriate level of care. Individuals can be sent to inpatient hospitals or a Crisis Stabilization Unit, if necessary, but can also utilize Crisis

Apartments or be referred for outpatient services if they do not require additional inpatient services. In FY 2013, 64.8% of individuals served at the Crisis Service Center were averted from inpatient hospitalization. River Edge also has a Crisis Response Team at Oconee Regional Medical Center which can assess individuals who present at the emergency room with psychiatric issues, thus reducing the workload of emergency room staff. In FY 2013, 42.9% individuals who were served by the Oconee Regional Crisis Service Center were averted from inpatient psychiatric treatment. River Edge also provides Hospital Companions, Hospital/ CSU Transport Services and Peer Support Services related to their Crisis Services contract. Admissions to East Central Regional Hospital from Baldwin County providers, which include Oconee CSB, Oconee Regional Medical Center and River Edge CSB, have decreased significantly since the Baldwin Crisis Service Center opened. In FY 2011, 100 individuals from Baldwin County were hospitalized at East Central Regional Hospital. This number dropped to 60 individuals in FY 2012 and 31 individuals in FY 2013.

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

Intensive Case Management - Intensive Case Management services were added to the River Edge service area in FY 2014. Intensive Case Management (ICM) services focuses on linking individuals to necessary services and coordinating their care. Intensive Case Managers incorporate an individual's natural supports, as well as utilizing community resources that include housing, financial support, transportation, and medical care. In addition, Intensive Case Managers also coordinate an individual's mental health treatment with other members of the treatment team.

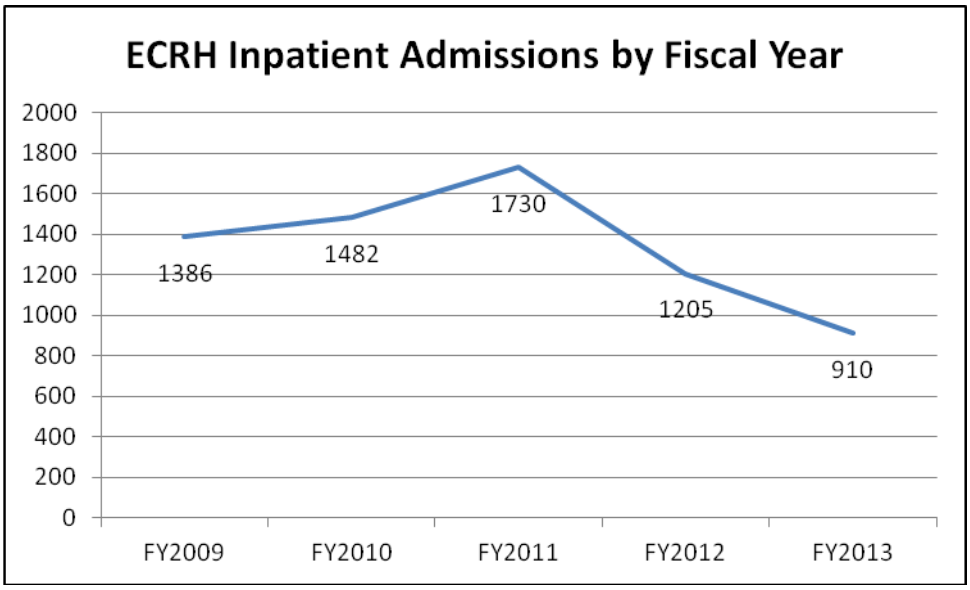
Supported Employment - R2 has Supported Employment in the Advantage, American Work, Oconee, River Edge and Serenity service areas. Advantage has 36 slots, American Work has 48 slots, Oconee has 20 slots, River Edge has 46 slots and Serenity has 40 slots. DBHDD utilizes Individual Placement and Support (IPS), which is an evidence-based model developed by the Dartmouth Psychiatric Research Center. IPS supported employment helps individuals with severe mental illnesses work at regular jobs of their choosing. The focus is on competitive employment and individuals are not excluded on the basis of readiness, diagnoses, symptoms, substance abuse history, psychiatric hospitalizations, and level of disability or legal system involvement. The key characteristics are as follows:

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

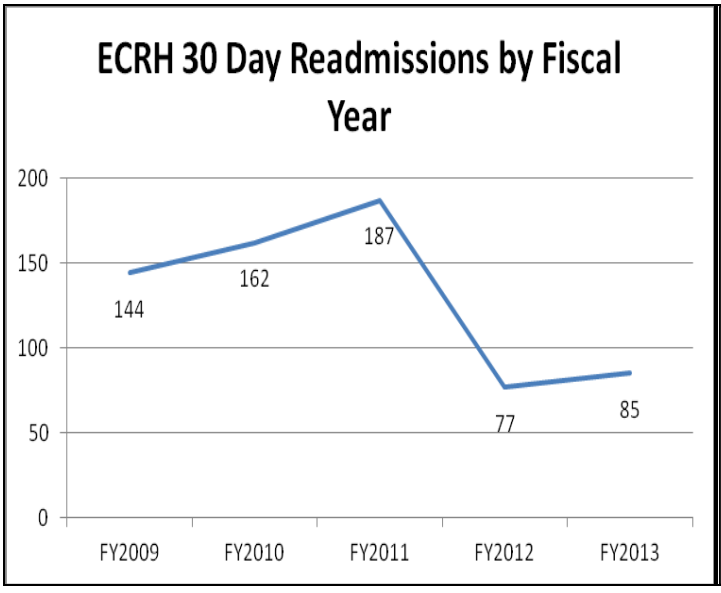
Supportive Housing - The funding allocated for residential services in R2 in FY 2014 follows:

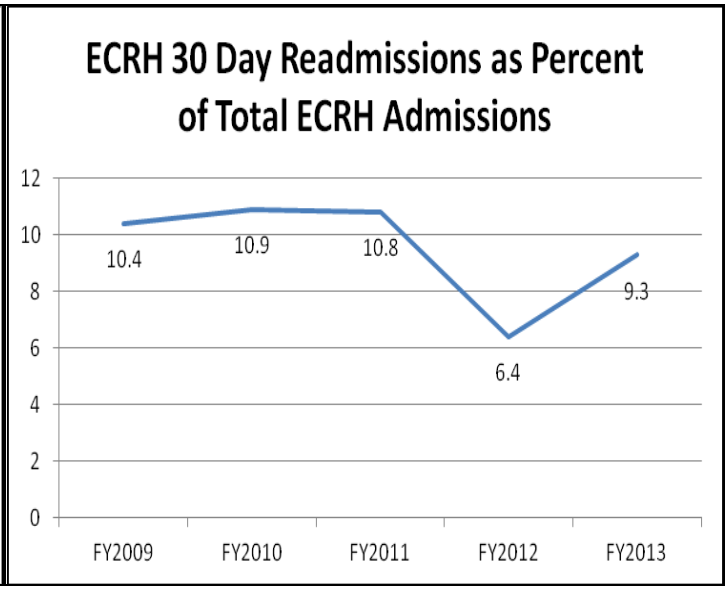
- Advantage Behavioral Health Services - **$896,859.00** - Independent and Semi-Independent Residential Supports provided in apartments/duplexes

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



East Central Regional Hospital provides inpatient psychiatric services for individuals from R2. Central State Hospital provided inpatient psychiatric services for adults with mental illness until March 2010, when the adult mental health unit was closed. Central State Hospital continues to have forensic and skilled nursing units. The graph below illustrates East Central Regional Hospital admissions since FY 2009. In FY 2009, 1386 individuals were admitted to East Central Regional Hospital. Admissions increased by 6.9% to 1482 from FY 2009 to FY 2010 at East Central Regional Hospital. Admissions to East Central Regional Hospital increased by 16.7% to 1730 from FY 2010 to FY 2011. The significant rise in admissions was largely caused by the closure of Central State Hospital in March 2010. East Central Regional Hospital admissions fell by 30.3% from FY 2011 to FY 2012 and fell 24.5% from FY 2012 to FY 2013.





East Central Regional Hospital monitors individuals who were previously hospitalized and re-admitted within thirty days of discharge. In FY 2009, 144 individuals were re-admitted to ECRH within thirty days of discharge. Thirty day re-admissions accounted for 10.4% of all ECRH admissions in FY 2009. This number increased by 12.5% to 162 individuals in FY 2010 and accounted for 10.9% of all ECRH readmissions during that time period. Thirty day re-admissions increased by 15.4% to 187 individuals in FY 2011 which accounted for 10.8% of all ECRH admissions that fiscal year. The number of individuals re-admitted to ECRH within thirty days of discharge fell by 58.8% from FY 2011 to FY 2012 to 77 individuals. The percentage of re-admissions fell to 6.4% of total ECRH admissions during FY 2012. In FY 2013, the number of individuals re-admitted to ECRH increased by 10.4% from FY 2012 to FY 2013 to 85 individuals. This rate of re-admission accounted for 9.3% of all ECRH hospital admissions in FY 2013. East Central Regional Hospital has a goal of no more than 10% 30 day re-admissions and has achieved this goal since the addition of intensive community services.

DEVELOPMENTAL DISABILITIES

Individuals with Developmental Disabilities should have the opportunity to reside in community settings where they may be active and productive, make their own choices and live as independently as possible. Region 2 offers a full array of services through contract or letter of agreement with community providers whose role is to assist individuals to form relationships with others in the community, assist them with having fulfilling lives and to help make their dreams a reality.

To determine the level of satisfaction and service needs of Region 2 individuals, a survey was made available through Survey Monkey. Surveys completed indicated overall satisfaction with services, but many individuals expressed interest in having more supported employment, therapy and transportation services available to them. Frustration at having no funding to address service needs was evident in comments.

Barriers that may lead to decreased satisfaction include:

- Providers of Intellectual/Developmental Disability services do not always have the ability to serve individuals with extensive behavioral or medical support needs.
- Individuals in rural areas do not always have access to the same level of services as those living in more urban areas.
- Individuals who are living semi-independently in their own homes or apartments with provider support and receiving Social Security or Supplemental Security Income may be living at the poverty level, struggling to cover needed expenses.

The number of individuals on the planning lists and in need of developmental disability services continues to rise at a rate greater than the dollars or providers are available to support them. From 2006-2008, about 1 in 6 children in the United Stated had a developmental disability, from speech and language impairments to serious developmental disabilities such as intellectual disabilities, cerebral palsy and autism. The data also showed that prevalence of parent-reported developmental disabilities had increased 17.1% from 1997 to 2008. That's about 1.8 million more children with DD from 2006-2008. The prevalence of autism has also increased 289.5%.

Demographic	Region 2	Statewide	R2 %
Short-Term Planning List	425	2447	17%
Long-Term Planning List	581	4730	12%
Total	1006	7197	14%

Individuals on the Planning Lists range in age from 4 to 81 and the greatest needs are in Bibb, Richmond and Columbia counties. Children up to age 18 have greater access to Medicaid state plan services than do adults.

Individuals identified as being in immediate need of developmental disability services are linked with providers who offer Community Residential Alternative, Community Living Supports, Community Access, Prevocational Services, Supported Employment, assistance with specialized medical supplies and equipment, Behavioral Supports, and Nursing Services for individuals having complex medical needs.

In accordance with the Settlement Agreement reached with the U.S. Department of Justice, individuals with developmental disabilities should be served in the most integrated setting appropriate to those individuals' needs. Georgia ceased all admissions of individuals with developmental disabilities to state hospitals prior to July 1, 2011. All individuals in state hospitals whose primary diagnosis is a developmental disability and who wish to live in the community will transition to community settings by July 1, 2015, per the Agreement, and will be supported with home and community based waiver funds in their own home or their family's home, consistent with each individual's informed choice. Statewide, 208 individuals with developmental disabilities reside in intermediate care facilities (hospitals) in Georgia, with 197 of them residing in East Central Regional Hospital. Other individuals with developmental disabilities reside in mental health and forensic units, as well as in skilled nursing facilities at Central State Hospital, Atlanta Regional and ECRH.

To fund transitions of individuals from the state hospitals to community settings, 750 new Medicaid Waivers (150 per year) are being created. The Regional Office is responsible for coordinating discharges from hospitals to community providers with the right supports in place, ensuring inclusion of individuals and families in the process, and for holding providers accountable for implementation of service plans after transition.

With that in mind, Region 2 is working to develop a system of supports to meet more of the significant and growing unmet needs that have been identified, respond to the shift in preferences toward community integration and self direction, and support individuals to live in, contribute to and participate in their communities as much as possible.

A priority for supporting individuals in community settings involves developing appropriate crisis services to divert individuals from hospitals by increasing the availability of respite service providers, as well as developing a base of providers with the capacity to serve individuals with significant behavioral and/or medical needs. A survey of providers who are interested in and capable of providing these supports was completed, but because it was based on self-reporting, the results were not considered reliable; thus additional surveys are planned. Gaps in services are being identified and addressed through provider recruitment. This will enable both the region and families to choose a provider with the skill-set to support their individual.

The Settlement Agreement reached in FY 2011 specifically addressed the following:

- **Waivers for Individuals in Hospitals** – DBHDD will transition 150 individuals per year from the hospital to the community. Approximately 475 individuals have been transitioned to the community over the course of the Settlement Agreement.

- **Waivers For Individuals In The Community** - To better assist individuals who are most in need and currently living in the community, and to prevent crises from occurring, 400 additional Medicaid Waivers will be created. This has been successful in preventing the institutionalization of individuals currently in the community.

Demographic	Region 2	Statewide	R2 %
NOW	895	5001	18%
COMP	1187	6747	18%
State Funded Services	227	1644	14%
Total	2309	13392	17%

Family Support - By July 1, 2015, DBHDD will create sufficient family support funding to provide an array of goods and services to 2350 families statewide, enabling these families to continue to care for their family member with developmental disabilities at home. Annually, 500 additional families will be supported. During FY 2013 and FY 2014, Family Support funds were increased in Region 2 by $318,000 more than initially proposed so that more individuals and families in need could be assisted.

Crisis Services – By July 1, 2012, the state will have 6 mobile crisis teams for individuals with developmental disabilities, and by July 1, 2014, the state will have established 12 crisis respite homes.

- Mobile Crisis Teams **-** A Region 2 provider collaborative supports three mobile crisis teams which are available to deploy to homes, providers, and emergency rooms and work individually with people in crisis to help them to remain in their homes. MCTs are mobilized when existing behavioral and safety plans or supports have been implemented unsuccessfully and/or the individual is in imminent harm to self or others, the individual is in need of immediate care, evaluation, stabilization or treatment due to the risk, or the individual has no available appropriate community supports to meet his or her needs. Behavior Support Plans and Safety Plans are developed by the clinical team as a part of this service, and the team trains families/providers on techniques to address inappropriate or aggressive behavior.

- **Crisis Homes –** In Region 2, two crisis homes are available and capable of providing out of home supports for more intensive behavioral needs for up to 7 days.

- **Emergency Respite -** After discharge from Crisis Homes, it is expected that a small percentage of individuals will continue to need more extensive supports than their parents or service providers are able to offer. In addition, individuals not known to the Region may need a residence and supports until appropriate services can be put into place in their own or families' homes or, based on their choice, with provider agencies. Some individuals who are abandoned or whose families are no longer able to care for them may need these supports until alternate services are developed. Region 2 is identifying unspent dollars and is working with providers to develop more emergency respite options.

Support Coordination - This service assists individuals in gaining access to needed medical, social, educational, transportation, and housing supports by linking them to these and other services identified in individuals'

service plans. In addition, Support Coordination monitors the services received by individuals to assure that additional referrals and support needs are addressed.

The objective of the Region 2 Office is to enhance the services of individuals in the community through the supports identified above. More specific services needs that have been identified in Region 2 are supported employment, transportation, improved housing, and better education of community providers related to protection of the individuals that they support.

Supported Employment - Individuals with developmental disabilities have historically had few employment options. If employed at all, it has been in segregated environments such as sheltered workshops where they are paid sub-minimum wages and have no benefits. DBHDD has begun a partnership with the Georgia Vocational Rehabilitation Agency to increase access to Supported Employment services. This collaboration will increase utilization of evidence based practices in Supported Employment. It will increase the number of individuals in competitive employment making at least minimum wage while providing supportive services to assist individuals with obtaining and maintaining competitive employment.

Transportation - Individuals and family members have identified transportation as another significant need in Region 2. Many individuals reside in rural areas of the region where no public transportation is available, or where passenger trips offered by the DHS Unified Transportation System are limited by space or the ability to transport individuals who are non-ambulatory.

Housing - Individuals who wish to live semi-independently in the community do not always have the funds needed to support themselves. Limited access to affordable housing leads to reduced ability to lead normal, productive lives in the community.

Abuse, Neglect, Exploitation - A need recently identified by Region 2 is the protection of individuals in services from abuse, neglect and exploitation. With increased numbers of individuals with challenging behaviors living in the community, staff who have not had adequate training have greater difficulty supporting them. Region 2 has begun actively addressing this need by providing training to direct support staff and to individuals in services, helping them to recognize and empowering them to report abuse.

REGIONAL PLANNING BOARD PRIORITIES

The Regional Planning Board and Region 2 Office utilized a variety of sources to develop the 2016 Annual Plan and Regional Planning Board Priorities. Data was obtained from state and federal data resources, the DBHDD and the DBHDD Providers. Regional Planning Board members provided input from their communities during Planning Board meetings. Three community forums were held and were well attended by consumers of services, family members, local officials and provider agencies. In addition, a survey was widely distributed to providers who assisted by distributing it to individuals receiving their services and family members. Data received from the survey is attached.

1) Priority:

Inform and educate consumers, families and other community stakeholders regarding available and needed disability services and other relevant issues impacting the delivery of mental health, developmental disability and addictive diseases services. For Developmental Disability Services, target schools to educate parents and teachers about the process for requesting funding for services. For Behavioral Health Services, target jails,

prisons and homeless advocacy and service organizations to educate systems interfacing with individuals in need of services.

Rationale:
The ADA Settlement Agreement contains provisions for the expansion of community services for adults living with Developmental Disabilities and Mental Illnesses. The citizens of Georgia and agencies interfacing with individuals with disabilities need to understand the services available to individuals living with mental illnesses, developmental disabilities and/or addictive diseases. Likewise, the Department needs to understand the viewpoints of individuals, families and other stakeholders regarding the effectiveness of services and barriers to receiving services.

2) Priority:
Create housing, permanent supportive housing and other residential services to support successful community living, recovery and habilitation and to prevent institutionalization and incarceration. Ensure that housing initiatives are linked to support services needed by individuals to maintain optimum community living opportunities. Maintain or exceed the level of housing supports for individuals with SPMI achieved through the ADA Settlement Agreement. Request funding for housing vouchers for individuals with developmental disabilities who do not have the financial resources necessary to afford decent, safe housing, meet daily living requirements and successfully integrate into the community.

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

3) Priority:
Create and/or purchase opportunities for individuals with disabilities to receive emergency and non-emergency transportation in all parts of the region. Develop initiatives that encourage cooperation between rural communities to achieve transportation services for individuals with MH, DD and AD disabilities.

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

4) Priority:
Increase supported employment (SE) opportunities for individuals with disabilities, including adolescents graduating from high schools, by encouraging schools, Vocational Rehabilitation, DBHDD and other community agencies to work together to meet the needs of individuals. Request SE funding targeted to

individuals with developmental disabilities leaving the school system. As part of the funding request, include publication of a workbook that explains DD services and the process for applying for funding in a manner that is easily understandable.

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

5) Priority:
Strengthen the continuum of treatment and recovery supports for persons with addictive diseases and co-occurring MH/AD and DD/AD disorders.

Rationale:
Substance abuse is a leading cause of many social problems and is a substantial cause of hospitalization and incarceration. Treatment is crucial to improving the lives of individuals with disabilities and their families. Both state and federal funding for Addictive Diseases services has diminished. The Department's goals cannot be met without incorporating sound treatment and recovery supports for addictive diseases into its plans.

6) Priority:
Provide training opportunities for self direction and a community navigator who will promote the development of more services and greater provider capacity in rural areas.

Rationale:
Access issues continue to exist in rural communities. Most of the smaller counties do not have clinics that individuals can access to receive an assessment and information. In addition, the service system for mental health, developmental disabilities, and addictive diseases is complex, making it extremely challenging for individuals to understand how to access the various systems of care. Families and individuals need information and training regarding how to access, self-direct and participate in services and they need navigators who will help them to overcome barriers that are specific to their situations.

7) Priority:
Increase Family Support funding and capacity for respite services for families with developmentally disabled family members living at home.

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

8) Priority:
Encourage and promote court systems to implement accountability courts to guard against the recidivism of institutionalized care and incarceration. Collaborate with the Department of Corrections and the Court

System, including the Probate Courts, to ensure that individuals have access to DBHDD services when they are needed. This may include participation in Accountability Courts, collaboration between DBHDD service providers and early release programs and utilization of involuntary outpatient commitment for individuals who have histories of repeated institutionalization due to non-participation in treatment.

Rationale:
Accountability courts have proven to be very effective in preventing people with mental illnesses, addictive diseases and family problems from cycling through the judicial system; however, many areas in the region still do not have accountability courts. DBHDD should continue to pursue partnerships with the courts and offer support that judges may need to develop accountability courts. Outpatient commitment is being used successfully in some parts of the region to prevent recidivism. Outpatient commitment may be the only option when individuals are repeatedly cycling through jails and hospitals and not engaging in treatment in the community.

9) Priority:
Provide rural areas with mobile technology through community support staff employed by our providers to offer, where appropriate, mobile telecommunications such as, telepsychiatry, teletherapy and other support services to reach the goal of equal access for all Georgians in need of DBHDD services.

Rationale: Telepsychiatry and teletherapy is being used successfully in areas of the region; however, the most rural areas have been the least likely to implement it. Telepsychiatry has increased access to psychiatric care in extremely effective ways with a high degree of consumer satisfaction. Given Georgia's professional workforce shortage coupled with the lack of transportation in rural areas, telepsychiatry and teletherapy present the best opportunities for increasing access to individuals in need of mental health or addictive diseases treatment.

10) Priority:
Improve the quality of services for and ensure the safety of DD individuals living in residential homes operated by DBHDD approved and funded providers by (1) providing online information about provider services, quality and performance (2) providing online information regarding what individuals and family members should expect from residential providers (3) developing and providing a web-based curriculum for direct care staff and requiring that they pass required training before providing care (4) providing clarity regarding the oversight being provided by regulatory and contracting agencies.

Rationale: Most of Georgia's individuals with developmental disabilities are being served in communities and increasing numbers of individuals are receiving residential services, the highest level of care. Individuals with very complex needs can be served in communities; however, the information provided to individuals and families, the training required of caregivers, and the oversight provided by DBHDD and DCH must be enhanced in order to ensure that individuals are receiving high quality services. A standard curriculum would provide greater uniformity in the training that staff members receive. Individuals and families must be provided the information that they need to make informed choices regarding service providers. They may also participate in ensuring that residential providers are meeting their obligations if they know what they should expect from them and if they have tools to compare the quality of services they are receiving to the quality that may be available from other providers.

Region Two MHDDAD
Regional Planning Board

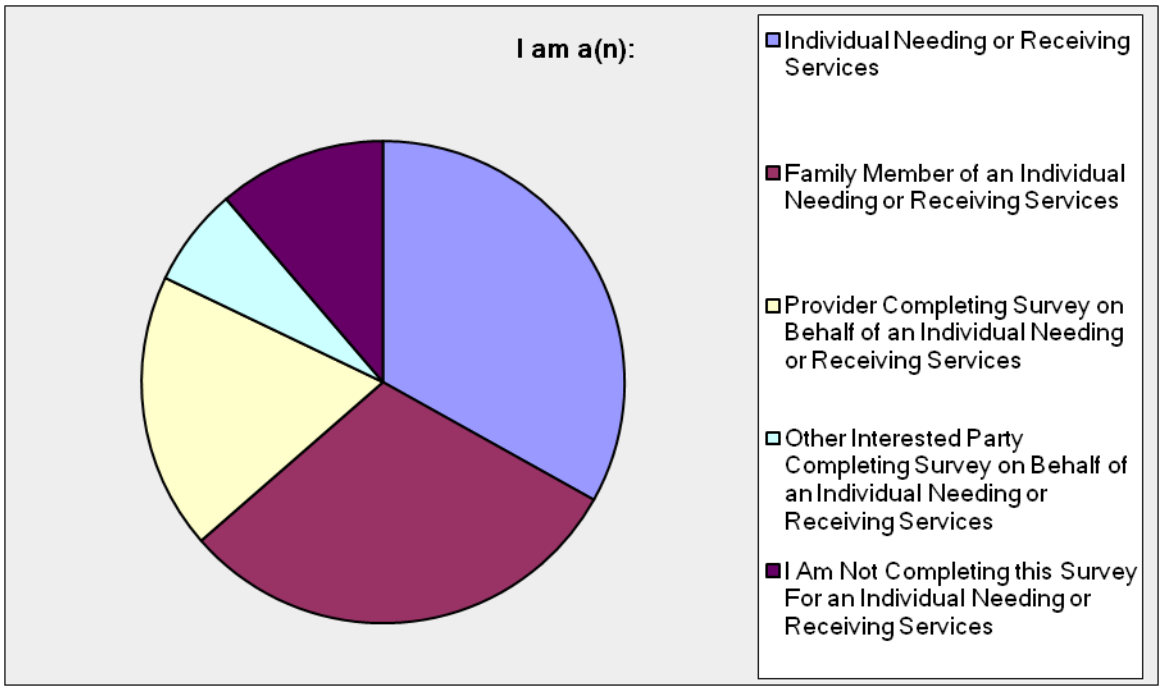
Saundra Brown, Bibb County
Martha Crumbley, Burke County
Ed Glauser, Clarke County
Bradford Bowling, Clarke County
Ryan Hope, Clarke County
Cathy Hayes, Columbia County
Lisa Jones, Columbia County
Don Wilkes, Emanuel County
Linda Foster, Jackson County
Nan Gunn, Jefferson County
Mike Greene, Jones County
Tammy Herring, McDuffie County
Debbie Harbin, Monroe County
Andrew Chase, Morgan County
Ann Hester, Oconee County
Josette Akhras, Putnam County
F. "Laverne" Crawford, Richmond County
Gloria Berry, Walton County
Linda Echols, Wilkes County
Margaree Gibson, Wilkinson County
Meg Loggins, Barrow County

(Attachment 1)

DBHDD REGION TWO SERVICES SURVEY

I am a(n):

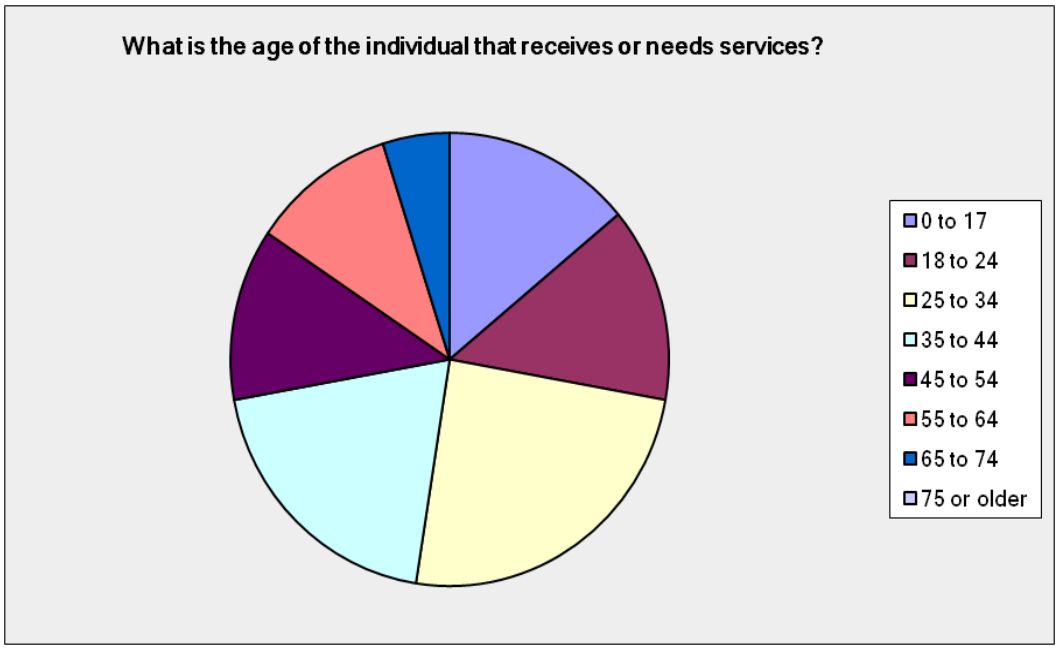
Answer Options	Response Percent	Response Count
Individual Needing or Receiving Services	33.1%	50
Family Member of an Individual Needing or Receiving Services	30.5%	46
Provider Completing Survey on Behalf of an Individual Needing or Receiving Services	18.5%	28
Other Interested Party Completing Survey on Behalf of an Individual Needing or Receiving Services	6.6%	10
I Am Not Completing this Survey For an Individual Needing or Receiving Services	11.3%	17



What county do you live in?		
Answer Options	**Response Percent**	**Response Count**
Baldwin	3.3%	4
Barrow	18.3%	22
Bibb	13.3%	16
Burke	0.8%	1
Clarke	4.2%	5
Columbia	2.5%	3
Elbert	5.0%	6
Emanuel	1.7%	2
Glascock	0.0%	0
Greene	4.2%	5
Hancock	0.0%	0
Jackson	5.0%	6
Jasper	0.0%	0
Jefferson	0.8%	1
Jenkins	0.0%	0
Jones	1.7%	2
Lincoln	0.0%	0
Madison	1.7%	2
McDuffie	0.0%	0
Monroe	4.2%	5
Morgan	1.7%	2
Oconee	2.5%	3
Oglethorpe	2.5%	3
Putnam	3.3%	4
Richmond	18.3%	22
Screven	0.0%	0
Taliaferro	0.0%	0
Twiggs	0.0%	0
Walton	2.5%	3
Warren	0.0%	0
Washington	0.0%	0
Wilkes	0.0%	0
Wilkinson	0.0%	0
Other	3.3%	4

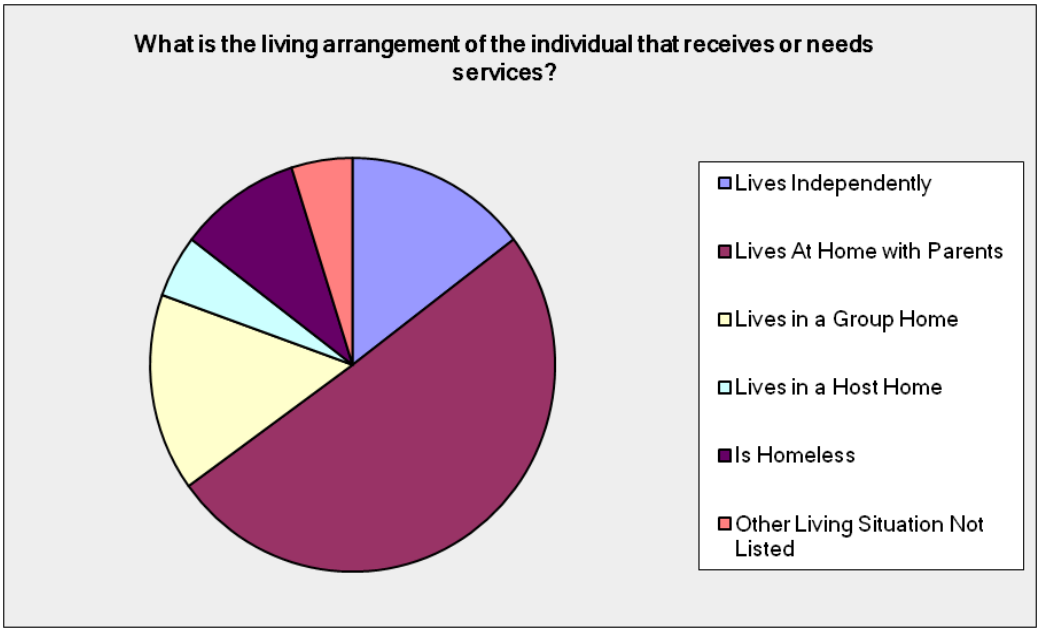
What is the age of the individual that receives or needs services?		
Answer Options	**Response Percent**	**Response Count**
0 to 17	13.9%	17
18 to 24	13.9%	17
25 to 34	24.6%	30
35 to 44	19.7%	24
45 to 54	12.3%	15
55 to 64	10.7%	13

65 to 74	4.9%	6
75 or older	0.0%	0

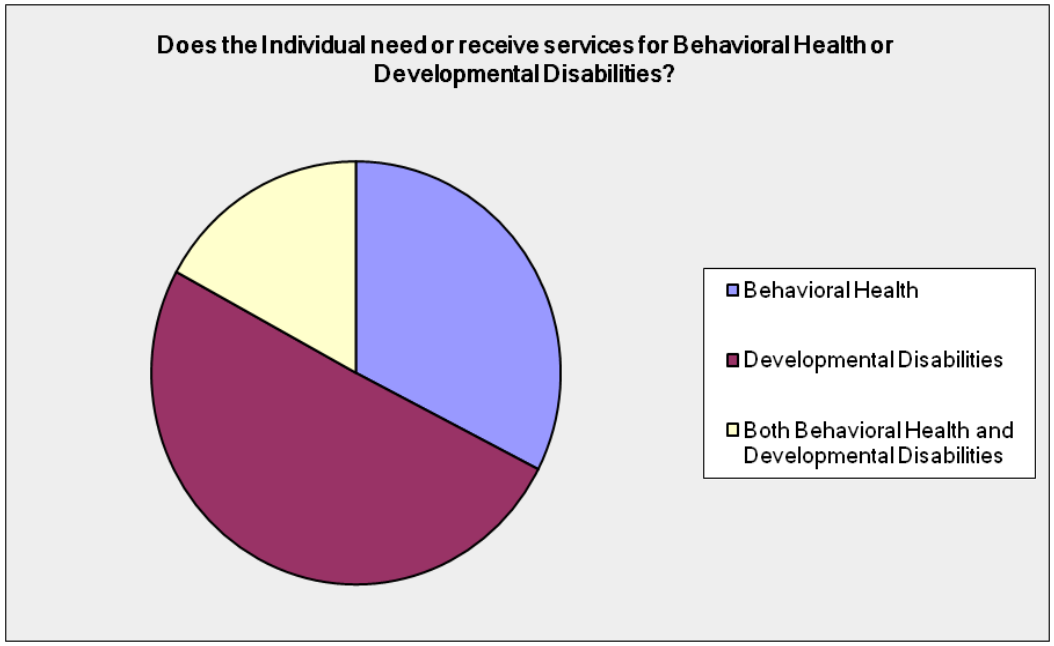


What is the living arrangement of the individual that receives or needs services?

Answer Options	Response Percent	Response Count
Lives Independently	14.6%	18
Lives At Home with Parents	50.4%	62
Lives in a Group Home	15.4%	19
Lives in a Host Home	4.9%	6
Is Homeless	9.8%	12
Other Living Situation Not Listed	4.9%	6

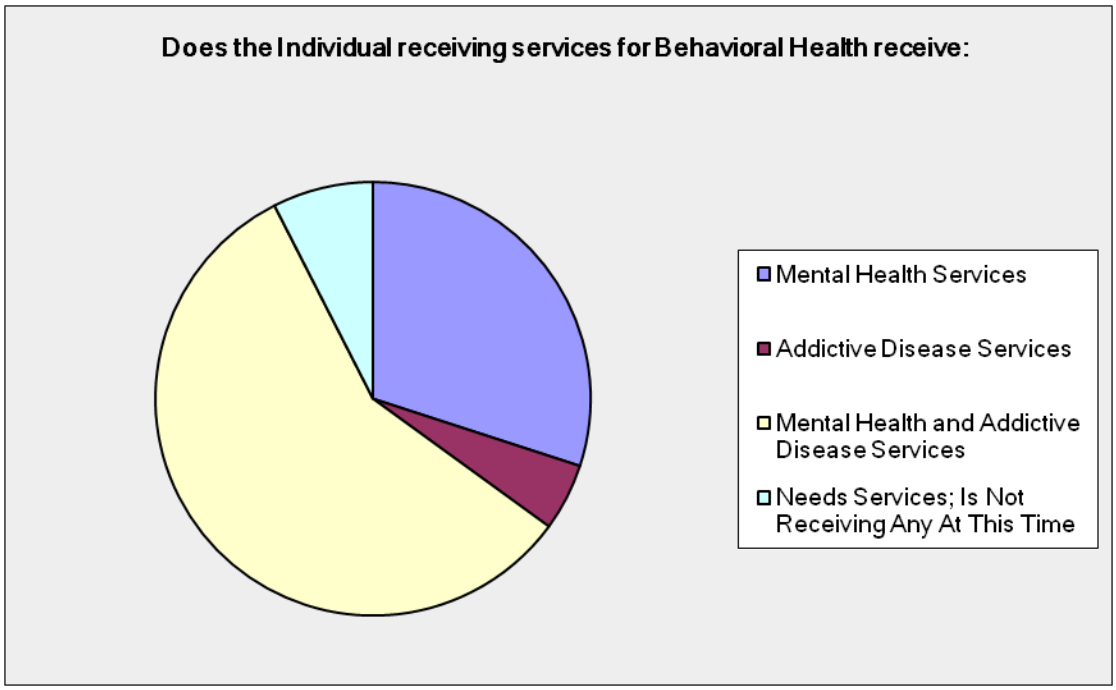


Does the Individual need or receive services for Behavioral Health or Developmental Disabilities?		
Answer Options	Response Percent	Response Count
Behavioral Health	32.5%	40
Developmental Disabilities	50.4%	62
Both Behavioral Health and Developmental Disabilities	17.1%	21



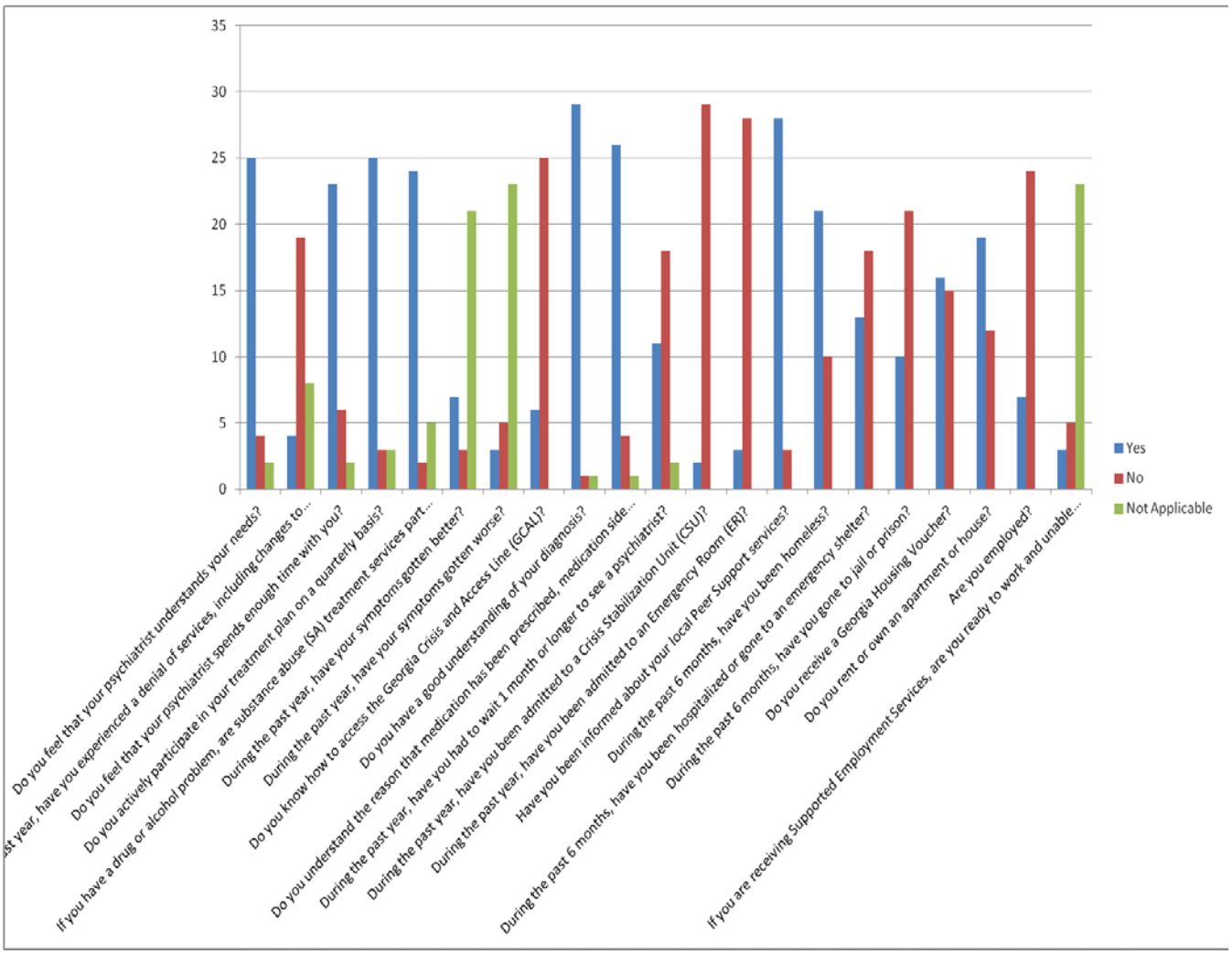
BH/AD RESPONSES

Does the Individual receiving services for Behavioral Health receive:	
Answer Options	**Response Percent**
Mental Health Services	30.0%
Addictive Disease Services	5.0%
Mental Health and Addictive Disease Services	57.5%
Needs Services; Is Not Receiving Any At This Time	7.5%



Unless otherwise specified, please consider your experience over the last year:			
Answer Options	**Yes**	**No**	**Not Applicable**
Do you feel that your psychiatrist understands your needs?	25	4	2
During the past year, have you experienced a denial of services, including changes to your therapist and psychiatric accessibility, case management, medication, and/or vocational support?	4	19	8
Do you feel that your psychiatrist spends enough time with you?	23	6	2
Do you actively participate in your treatment plan on a quarterly basis?	25	3	3
If you have a drug or alcohol problem, is substance abuse (SA) treatment services part of your treatment plan?	24	2	5
During the past year, have your symptoms gotten better?	7	3	21

During the past year, have your symptoms gotten worse?	3	5	23
Do you know how to access the Georgia Crisis and Access Line (GCAL)?	6	25	0
Do you have a good understanding of your diagnosis?	29	1	1
Do you understand the reason that medication has been prescribed, medication side effects, and interactions?	26	4	1
During the past year, have you had to wait 1 month or longer to see a psychiatrist?	11	18	2
During the past year, have you been admitted to a Crisis Stabilization Unit (CSU)?	2	29	0
During the past year, have you been admitted to an Emergency Room (ER)?	3	28	0
Have you been informed about your local Peer Support services?	28	3	0
During the past 6 months, have you been homeless?	21	10	0
During the past 6 months, have you been hospitalized or gone to an emergency shelter?	13	18	0
During the past 6 months, have you gone to jail or prison?	10	21	0
Do you receive a Georgia Housing Voucher?	16	15	0
Do you rent or own an apartment or house?	19	12	0
Are you employed?	7	24	0
If you are receiving Supported Employment Services, are you ready to work and unable to find employment?	3	5	23



BH SERVICES COMMENTS

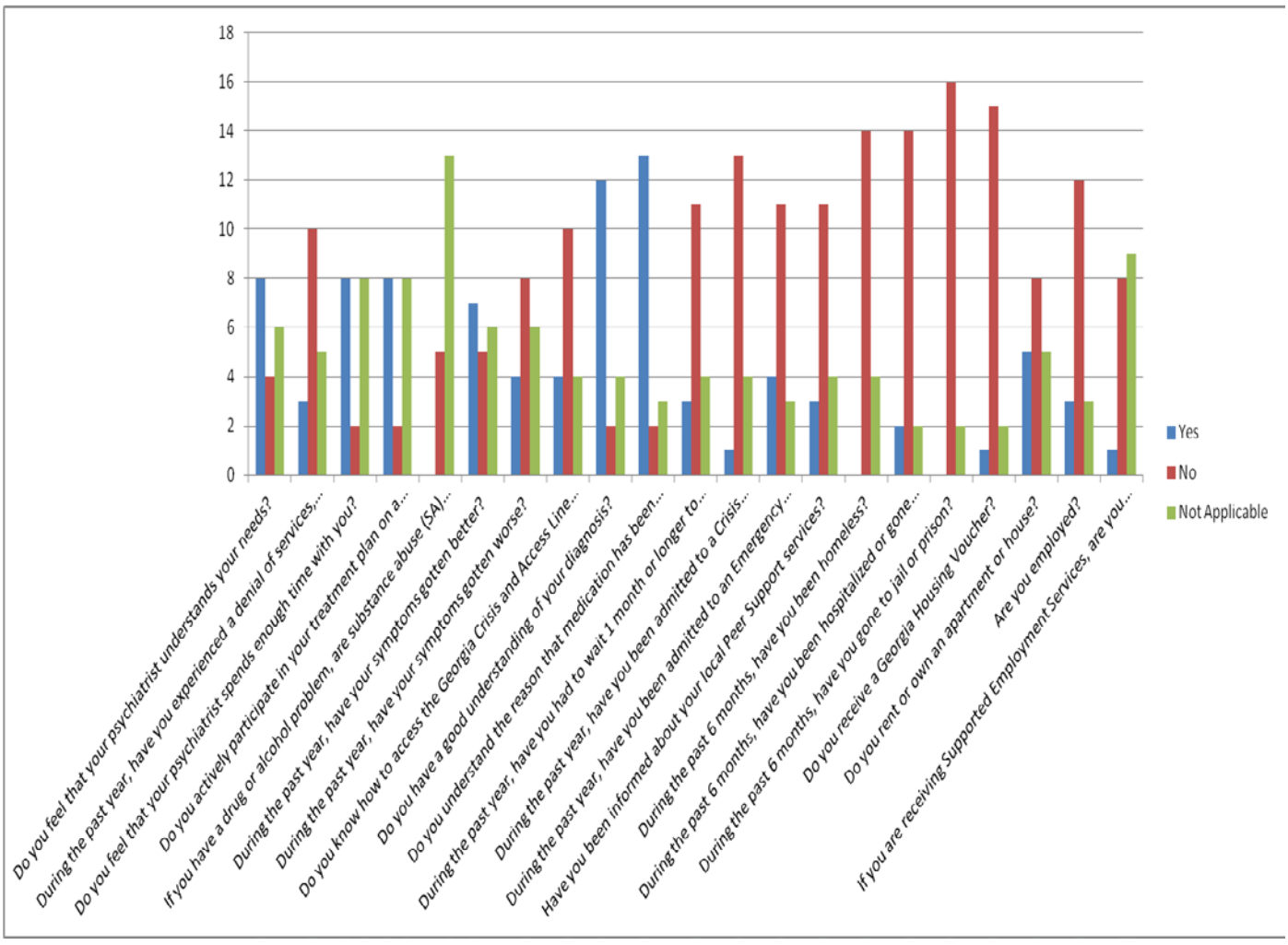
Are there BH services you do not currently receive, but feel you would benefit from? If yes, please list them below.		
Number	**Response Date**	**Response Text**
1	Dec 9, 2013 2:31 PM	needed not available
2	Dec 3, 2013 5:12 PM	I feel like there are too many required visits to the psychiatrist. Considering Medicaid only allows for 12 covered doctor visits per year.
3	Dec 2, 2013 5:58 PM	psychiatrist
4	Nov 25, 2013 8:12 PM	NO.
5	Nov 19, 2013 3:30 PM	Behaviorist services by a behavior analyst
6	Nov 15, 2013 9:10 PM	ABA , RDI

You answered that Behavioral Health and/or Addictive Disease services are needed. Please briefly describe the services needed and/or wanted and how they would be beneficial.		
Number	**Response Date**	**Response Text**
1	Nov 18, 2013 3:20 PM	The individual is suffering from emotional/behavioral health issues. He is unemployed with no income, dependent upon meager earnings of his wife, who also has emotional/behavioral issues. They have been homeless, and/or near homeless on a few occasions during the past several years, due to inability to maintain employment. Struggling with these emotional/behavioral health issues seem to take them two steps backward, after gaining a step forward to a better life. Therapy to regain stability, focus, and positivity towards challenges of each day, should bring forth a more hope and a brighter outlook.

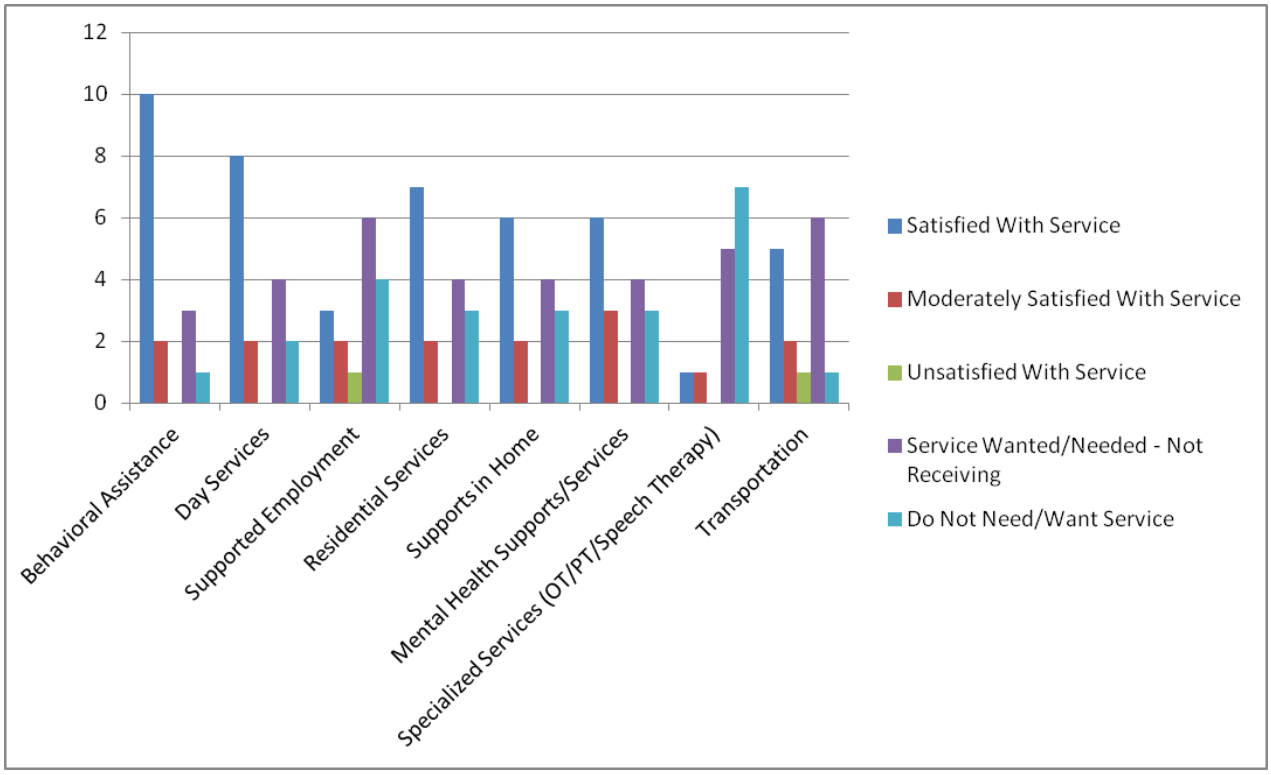
BH/DD SURVEY RESPONSES

Answer Options	Yes	No	Not Applicable
Do you feel that your psychiatrist understands your needs?	8	4	6
During the past year, have you experienced a denial of services, including changes to your therapist and psychiatric accessibility, case management, medication, and/or vocational support?	3	10	5
Do you feel that your psychiatrist spends enough time with you?	8	2	8
Do you actively participate in your treatment plan on a quarterly basis?	8	2	8
If you have a drug or alcohol problem, is substance abuse (SA) treatment services part of your treatment plan?	0	5	13
During the past year, have your symptoms gotten better?	7	5	6
During the past year, have your symptoms gotten worse?	4	8	6
Do you know how to access the Georgia Crisis and Access Line (GCAL)?	4	10	4
Do you have a good understanding of your diagnosis?	12	2	4
Do you understand the reason that medication has been prescribed, medication side effects, and interactions?	13	2	3

During the past year, have you had to wait 1 month or longer to see a psychiatrist?	3	11	4
During the past year, have you been admitted to a Crisis Stabilization Unit (CSU)?	1	13	4
During the past year, have you been admitted to an Emergency Room (ER)?	4	11	3
Have you been informed about your local Peer Support services?	3	11	4
During the past 6 months, have you been homeless?	0	14	4
During the past 6 months, have you been hospitalized or gone to an emergency shelter?	2	14	2
During the past 6 months, have you gone to jail or prison?	0	16	2
Do you receive a Georgia Housing Voucher?	1	15	2
Do you rent or own an apartment or house?	5	8	5
Are you employed?	3	12	3
If you are receiving Supported Employment Services, are you ready to work and unable to find employment?	1	8	9

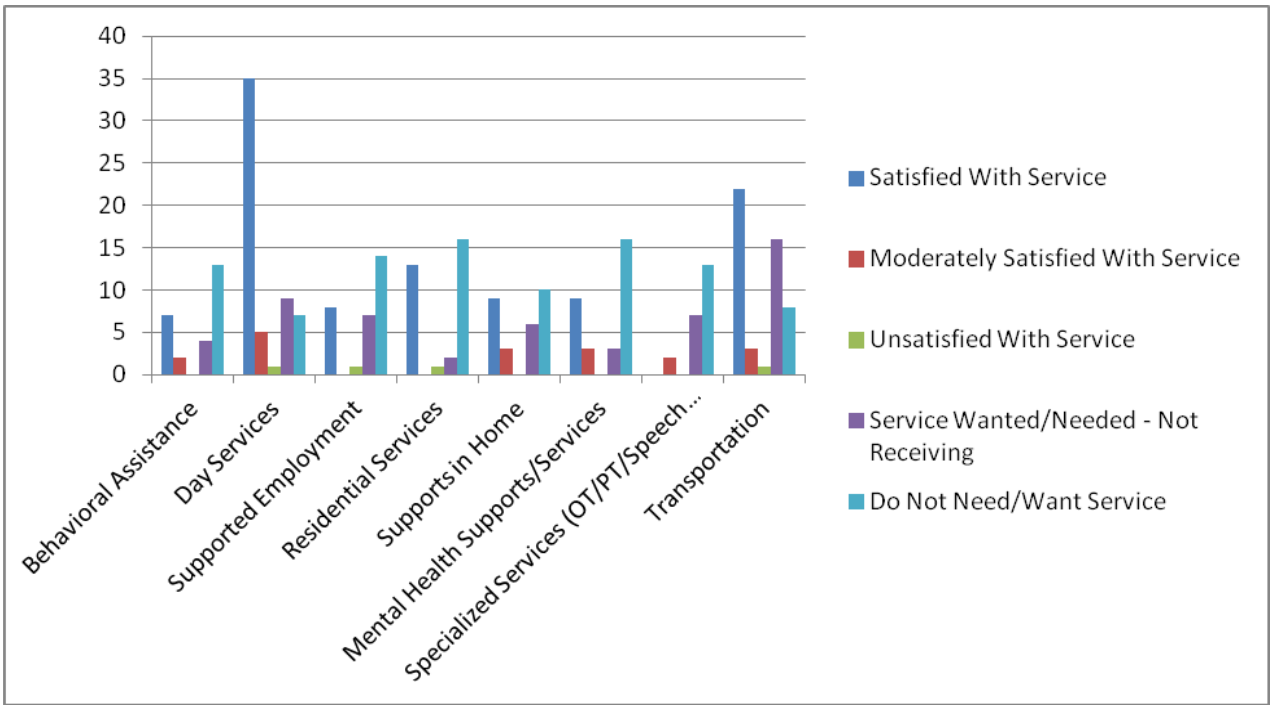


Regarding DD services, please consider the past 6 months:					
Answer Options	Satisfied With Service	Moderately Satisfied With Service	Unsatisfied With Service	Service Wanted/Needed - Not Receiving	Do Not Need/Want Service
Behavioral Assistance	10	2	0	3	1
Day Services	8	2	0	4	2
Supported Employment	3	2	1	6	4
Residential Services	7	2	0	4	3
Supports in Home	6	2	0	4	3
Mental Health Supports/Services	6	3	0	4	3
Specialized Services (OT/PT/Speech Therapy)	1	1	0	5	7
Transportation	5	2	1	6	1



DD RESPONSES

Regarding DD services, please consider the last 6 Months:					
Answer Options	**Satisfied With Service**	**Moderately Satisfied With Service**	**Unsatisfied With Service**	**Service Wanted/Needed - Not Receiving**	**Do Not Need/Want Service**
Behavioral Assistance	7	2	0	4	13
Day Services	35	5	1	9	7
Supported Employment	8	0	1	7	14
Residential Services	13	0	1	2	16
Supports in Home	9	3	0	6	10
Mental Health Supports/Services	9	3	0	3	16
Specialized Services (OT/PT/Speech Therapy)	0	2	0	7	13
Transportation	22	3	1	16	8



DD Services Comments

If you would like to contribute any suggestions or ideas regarding improvement of services, please do so below.		
Number	Response Date	Response Text
1	Dec 9, 2013 2:31 PM	More providers needed in Region 2.
2	Dec 2, 2013 4:46 PM	Would like to come 2 days a week, Tuesdays and Thursdays
3	Nov 25, 2013 8:12 PM	no.
4	Nov 22, 2013 8:05 PM	We need more company vehicle's to accommodate the client's needs.
5	Nov 21, 2013 1:49 PM	MUSIC PROGRAMS/ CLASSES/ WORKSHOPS. WORKS WELL.
6	Nov 20, 2013 2:54 PM	Like services the way they are.
7	Nov 20, 2013 2:00 PM	m
8	Nov 19, 2013 5:04 PM	On waiting list, not currently receiving waiver funds for services rendered.
9	Nov 19, 2013 3:37 PM	In regards to services my thought is that more would be available if the way money way managed was followed closer. In the last recent years many disabled individuals were taken out of facilities and placed in group homes etc. the waiver /money amounts given for a facility is higher than group homes. The waiver amounts need to be looked at an adjusted to their current needs. More available funds can help more disabled individuals. We have been denied for waiver services for in home support. The Augusta office per verbatim said the waiver would only become available when some dies. That is a crock.
10	Nov 18, 2013 8:30 PM	We receive family support funding every year through Arnelle Reeves at River Edge. This fund helps us buy diapers for our severely disabled child. We appreciate this flexible fund in helping us take care of our child at home. We would like to suggest that were this fund increased with flexibility kept the same; we could afford respite services and some equipment as well as meeting our son's hygiene and health needs. Without an increase in the family support fund, we would need the day, respite and medical services provided under the Waiver much earlier in our child's life. We already feel stretched in affording a special vehicle and making home modifications for his needs. As he grows, his needs and being able to afford to keep him at home become a major financial burden. We are determined to keep him at home however, whatever the cost, because we feel that his place is with us, and he is served best with us, his family. Please consider growing the family support fund so that we can do for our child what best meets his needs and not use time and money allotted to him under the waiver until a more critical time in his development.
11	Nov 18, 2013 8:12 PM	none
12	Nov 18, 2013 7:19 PM	We need more providers in Region 2 for those with DD, and mental health issues. We are in a rural area, and have to travel almost one hour (one way) to get anything.
13	Nov 18, 2013 6:08 PM	More funding for the center, so we can have money go to do more fun stuff. I also want group services.
14	Nov 18, 2013 3:03 PM	House Bill 100 and the new NOW/COMP Waivers were supposed to give families and their loved one(s) more choices and greater "nimbleness" in services. That has not happened. The system does not provide enough waivers for the massive waiting list. When a waiver is allotted, assessments and other procedures happen, and then families are alerted that there is no longer funding. This can happen just before a PA is generated. What a "bad taste" this puts in the mouths of people who are on the brink of services. What a ghastly place to put PLAs time and time again who have to tell families, "Well, maybe not!" Families that have been receiving Family Support Funding have to be coaxed into accepting waivers, because of the horror stories that abound. Families may not get much funding on Family Support, but at least they

		know what they are getting. Running DD like a business where customer service is put in the fore front and the state knows EXACTLY how much money it has for waivers and GIA would be great for all concerned.
15	Nov 15, 2013 9:26 PM	The personal support workers that I have hired, I self-direct, desire more training and support in behavioral issues and how to teach functional life skills. The problem is that they cannot get more training because they must be working for or with the individual with a disability in order to get paid. They cannot afford to miss work and not get paid and have to pay for this training out of pocket. I believe this is why we lose so many really good and talented personnel that really desire to pour their lives into helping persons with disabilities. The ones that care need and want more training and support. What can we do about this? Could we share some training with other Providers? How can we get more peer support services in the DD area? How can we find out what services are in our region?
16	Nov 15, 2013 6:29 PM	First of all it needs to be more information out there for parents of a disables and need more help
17	Nov 15, 2013 2:20 AM	Increase in family support funding
18	Nov 14, 2013 5:02 PM	I would like to help create more positive changes for Host Homes that was providing Services 30 years or more.