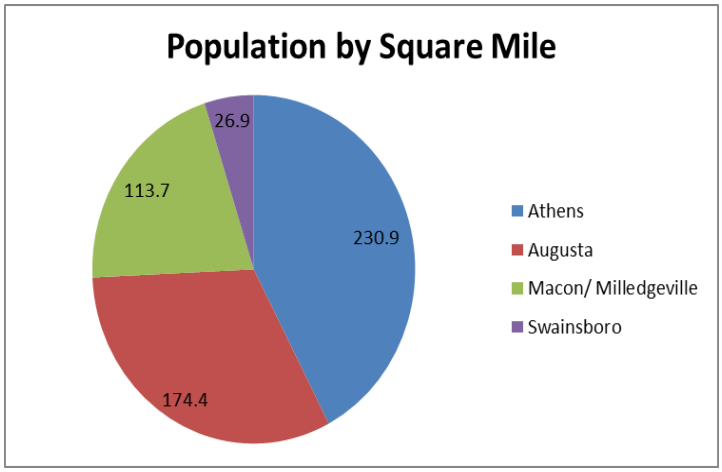
Department of Behavioral Health and Developmental Disabilities
REGION 2 DBHDD Regional Planning Board
Fiscal Year 2017 Annual Plan

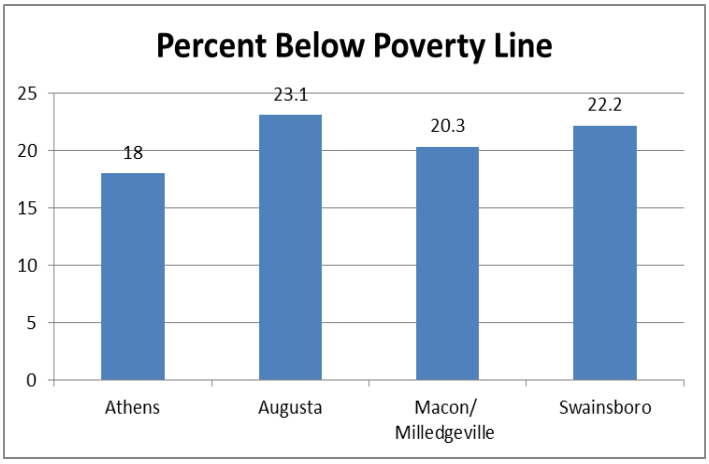
Introduction:

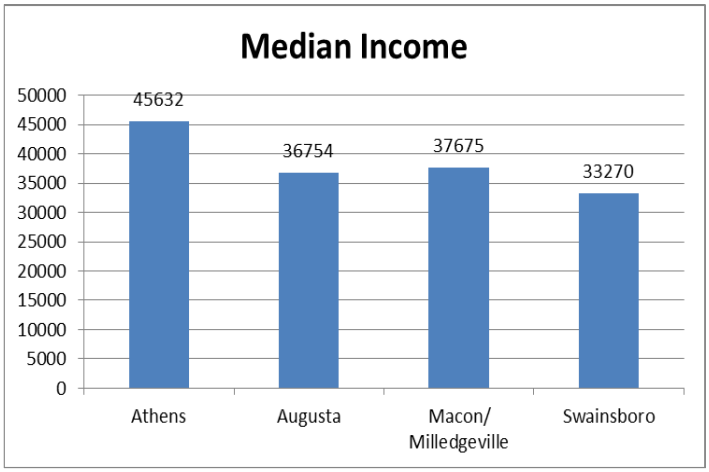
The State of Georgia created Community Mental Health Centers to provide publicly-funded mental health, developmental disability and addictive diseases services. In July 1994, the enactment of House Bill 100 transformed Community Mental Health Programs operated by the state to Community Service Boards (CSBs). CSBs are 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 and/ or state contracts to be established with private providers to allow Medicaid billing for core and some specialty services. 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 throughout 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. 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.

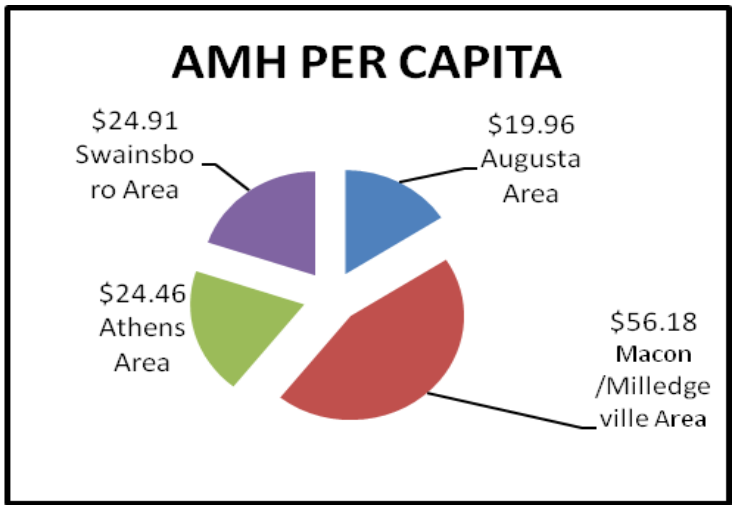


Region 2 (R2) is comprised of 33 counties that cover 12,214 square miles with a total population of 1,276,127 (DBHDD, Office of Decision Support and Information Management, 2015). The Region is divided into 5 service areas, each specified by the metropolitan areas of Athens, Augusta, Macon, Milledgeville and Swainsboro. R2 is predominately rural and economically disadvantaged as evidenced by 42.4% of the population living below the poverty level as compared to the State level of 38.7%. Within R2, Hancock County has the highest rate of individuals living below the poverty level at 65.9%. Oconee County has the lowest level of individuals living below poverty with 20.7%. Furthermore, the per capita income for individuals in Region 2 is $34,405 compared to the State per capita income of $37,845. The individuals served by DBHDD are predominately uninsured or on Medicaid and have few resources and options. The following charts correspond to the major metropolitan areas in R2. The information is inclusive of all counties served by each provider. Advantage Behavioral Health serves the Athens area which includes Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Oconee, Oglethorpe and Walton counties. Both Serenity Behavioral Health Services and American Work serve the Augusta area. Serenity Behavioral Health serves Columbia, Lincoln, McDuffie, Richmond, Taliaferro, Warren, and Wilkes counties. American Work, a private core and specialty provider, serves Richmond and Columbia counties. The Macon/ Milledgeville area is served by the Oconee Center and River Edge. The Oconee Center serves Baldwin, Hancock, Jasper, Putnam, Washington and Wilkinson counties. River Edge Behavioral Health serves Baldwin, Bibb, Jones, Monroe, Putnam, Twiggs, and Wilkinson counties. Ogeechee Behavioral Health serves the Swainsboro area and includes Burke, Glascock, Emanuel, Jefferson, Jenkins and Screven counties.





As noted in the charts below, the Macon/Milledgeville area has the highest spending per capita for both Adult Mental Health and Adult Addictive Disease. The increased spending in this area reflects an increase in funding for Crisis Apartments, Intensive Case Management, Case Management and the AD Transition Program. In FY2014, Region 2 providers served 24,287 individuals in Adult Mental Health and 5,475 in Adult Addictive Disease.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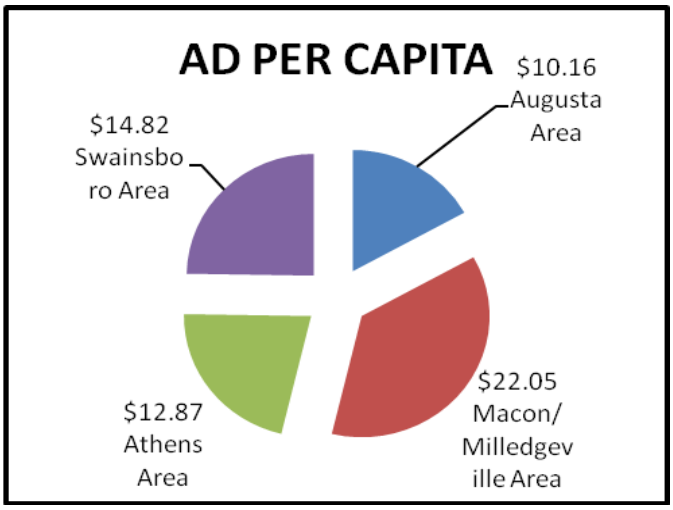
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DEPARTMENT OF JUSTICE SETTLEMENT AGREEMENT

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

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. The Bureau of Justice Statistics reports 56% of state prisoners and 45% 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. DBHDD also R2 staff also work closely with representatives from the Department of Corrections to assist individuals who have behavioral health diagnoses transition from prison to the community.

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. The Regional Office coordinates the efforts to strengthen a continuum of community housing options ranging from personal care homes to independent housing. DBHDD has a strong emphasis on creating and maintaining varying levels of residential supports to assist individuals in their recovery.

<u>BEHAVIORAL HEALTH</u>

ADULT BEHAVIORAL HEALTH

The Regional Office surveyed providers of Adult Behavioral Health Core Services to determine the most common diagnostic categories and percentage those categories made up of individuals served. Major

Depressive Disorder Moderate/ Severe and Bipolar I Disorder were the most common diagnoses. In the table below, those categories noted "Not Reported" indicated diagnoses that were not named as one of the six most commonly served by the provider.

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%

ADULT ADDICTIVE DISEASE SERVICES

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 (Level III.5) constitutes the highest level of addictive disease 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. R2 has CSUs in the Athens area with Advantage, Macon/ Milledgeville area with River Edge, and Augusta area with Serenity.

Individuals leaving CSUs who require short-term residential services can utilize Transition Residences, which are most similar to ASAM Level III.2-D. 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. 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 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 support group meetings (AA/ NA), and begin to develop independent living skills. Individuals are linked to residential and substance abuse services once they leave the program. Oconee's Addictive Disease Transitional Housing Program served 94 individuals in FY14. The Braswell House at Ogeechee CSB 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 FY14 Braswell House served 15 individuals.

Georgia Certified Addiction Recovery Empowerment Specialist (CARES) - The Georgia Council on Substance Abuse administers a training program that is parallel to the Mental Health Certified Peer Specialist Program and works directly with the Georgia Mental Health Consumer Network with funding from DBHDD. This supports the creation of 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. Numerous training opportunities were offered throughout FY14 and those training opportunities continue in FY15.

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

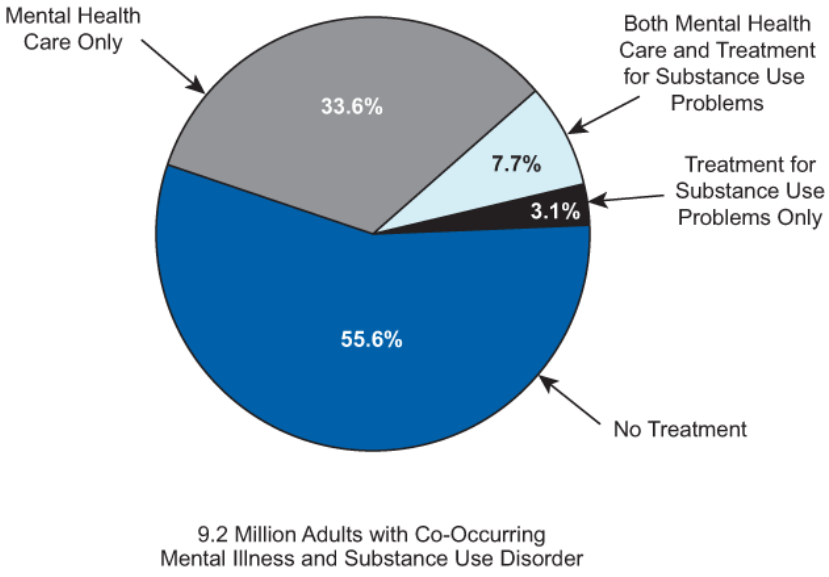


Figure 1 National Survey on Drug Use and Health (2008)

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 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 and 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.

ADULT MENTAL HEALTH SERVICES

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
- Case Management Services
- Community Support Teams
- Crisis Respite Apartments
- Crisis Service Centers (Urgent Care)
- Crisis Stabilization Units
- Intensive Case Management
- Mobile Crisis Response Services
- Peer Support
- Supported Employment
- Supportive Housing and Bridge Funding

Assertive Community Treatment (ACT) - In FY 2015 the region had Assertive Community Treatment (ACT) teams. Advantage serves Clarke and surrounding counties, American Work serves Richmond and Columbia counties, and River Edge serves Bibb and Baldwin counties. ACT teams have a geographic radius of about 40 miles or 45 – 60 minute 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 - Case Management services are available for any individual receiving Core services in the region. Case Management services focus on all aspects of the physical and social environment such as accessing housing, financial support, transportation, and medical care, as well as informal resources including families, roommates and churches. Case Management provides support and structure in response to

individual needs, linkage to community resources and continuity of care. All core providers in R2 can provide case management services.

Community Support Team (CST) - R2 has had two Community Support Teams since July 2014. Advantage's CST serves the Athens area and covers Barrow, Clarke, Greene, Madison and Oconee counties. Serenity's CST 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.

Crisis Respite Apartments – River Edge has two Crisis Respite Apartments in Baldwin County. Each Crisis Apartment can house up to two individuals at a time. Crisis Respite Apartments are intended to provide a safe and stable living environment for individuals transitioning out of CSUs or state hospitals. Crisis Respite Apartments are also used to help avoid hospitalization in situations where an individual's living situation or lack thereof could impact the need for hospitalization. R2 plans to add six additional Crisis Respite Apartments before the end of FY15.

Crisis Service Center - River Edge's Crisis Service Center has served individuals in Baldwin County since 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 2014, 58.8% of individuals served at the Crisis Service Center were diverted 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 2014, 49.1% individuals who were served by the Oconee Regional Crisis Service Center were diverted from inpatient psychiatric treatment. River Edge provides Hospital Companions, Hospital/ CSU Transport Services and Peer Support Services related to their Crisis Services contract.

Crisis Stabilization Units (CSU) - Adult Behavioral Health CSUs are located in Augusta, Athens and Macon with a total of 68 beds. Serenity's CSU in Augusta serves the Augusta and Swainsboro service areas; Advantage's CSU in Athens serves the Athens service area; and River Edge's 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 (ICM) - Intensive Case Management services were added to the River Edge service area in FY 2014 and the Athens and Augusta service areas in FY15. Intensive Case Management (ICM) services link individuals to necessary services and coordinate their care. Intensive Case Managers incorporate an individual's natural supports, as well as utilizing community resources such as housing, financial support, transportation, and medical care. In addition, Intensive Case Managers also coordinate an individual's mental health treatment with other treatment providers.

Mobile Crisis Response 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 to avert future crisis situations. Crisis teams are often successful in the prevention of ER visits and psychiatric hospitalizations. Key components of an effective crisis response team:

- 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 restrictive and 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

Crisis Response services are comprised of the Georgia Crisis and Access Line (GCAL) and Mobile Crisis Response Services. GCAL is a 24-hour crisis line which provides telephone assessment, linkage to community services, and can dispatch mobile crisis teams as needed. GCAL serves the entire state from a central location. Mobile Crisis Response Services are provided by Benchmark and are available in all Region Two counties. Mobile Crisis Response can be dispatched to homes, schools, jails hospitals, or other community locations. 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 follow-up behavioral health appointment. They also engage in the recovery process and link individuals with community resources. Other R2 CSBs provide limited crisis response services. River Edge BHS provides crisis intervention services at the Medical Center of Central Georgia and at Oconee Regional Medical Center.

Peer Support – R2 has both individual and group Peer Support services throughout the region. Group Mental Health Peer Support provide structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community living skills. Services are provided by Certified Peer Specialists. Group Mental Health Peer Support is available through Advantage in the Athens area, American Work and Serenity in the Augusta area, Oconee and River Edge in the Macon/ Milledgeville area, and Ogeechee in the Swainsboro area. Individual Peer Support promotes socialization, wellness, self-advocacy, development of natural supports, maintenance of community living skills, and community integration but is provided on an individual basis.

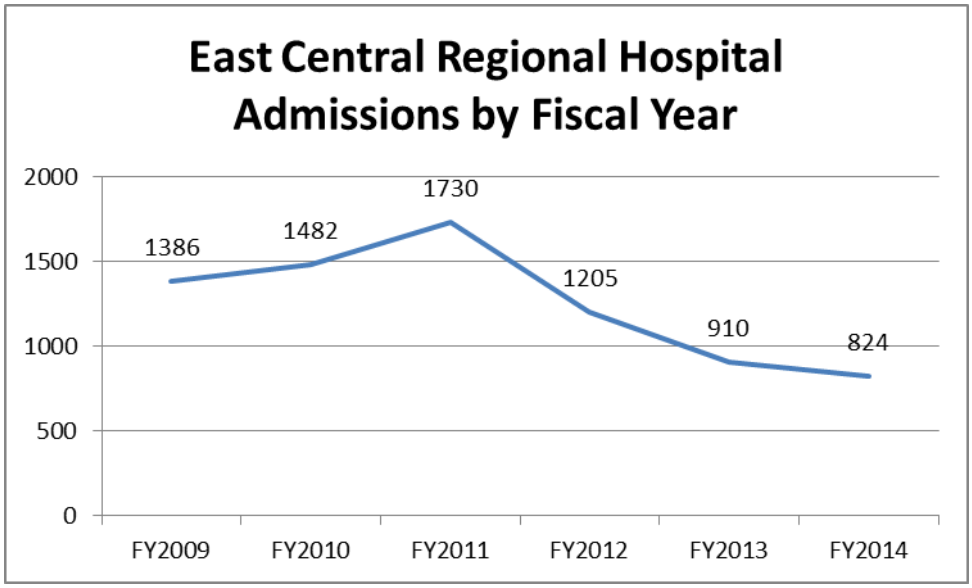
Supported Employment - Supported Employment in provided by Advantage, American Work, Oconee, River Edge and Serenity in R2. Advantage has 40 slots for adults and an additional 10 slots for Transitional Age Youth and Young Adults, American Work has 51 slots, Oconee has 24 slots, River Edge has 50 slots 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

There is a strong partnership between DBHDD Supported Employment and the services provided by the Georgia Vocational Rehabilitation Agency (GVRA). Throughout FY14 and FY15, DBHDD and GVRA worked closely to build an integrated system to improve the provision of Supported Employment services. This new system allows for more interaction between DBHDD Supported Employment providers and GVRA staff as well as additional funding for the service.

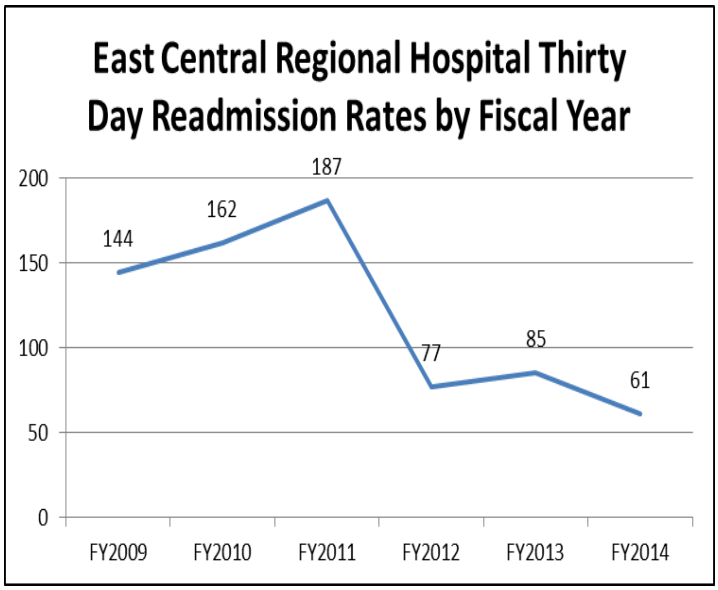
Supportive Housing – Supportive Housing encompasses a variety of residential options which include Intensive Residential Treatment, Semi-Independent Residential, Independent Residential, and Housing Supplements. DBHDD has contracted to provide $2,908,188 in residential funding for R2 providers in FY15. Advantage provides independent and semi-independent residential services as well as uses housing supplements to assist individuals with housing. American Work provides semi-independent residential services and housing supplements. Oconee provides intensive residential services, semi-independent residential services, independent residential services, and housing supplements. Ogeechee provides independent residential services and housing supplements. River Edge provides semi-independent residential services and independent residential services as well as housing supplements. Serenity provides semi-independent and independent residential services along with housing supplements.

DBHDD has also provided supportive housing using the Georgia Housing Voucher Program (GHVP). The GHVP was founded on the Housing First and Permanent Supportive Housing models. 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. The GHVP has been successful since its implementation in FY2011. As of February 2015, the GHVP in Region 2 has served 370 individuals with a voucher. Of that number 127 individuals were previously homeless and 114 were in a state hospital. The monthly average amount of rental assistance provided on the program is $105,397.50. The housing stability rate in Region 2 as well as the state has been surpassing the Housing and Urban Development housing stability rate since the inception of the program. Currently R2 has a rate of 88% while the program across Georgia enjoys a 93% stability rate. The HUD standard is 77%.

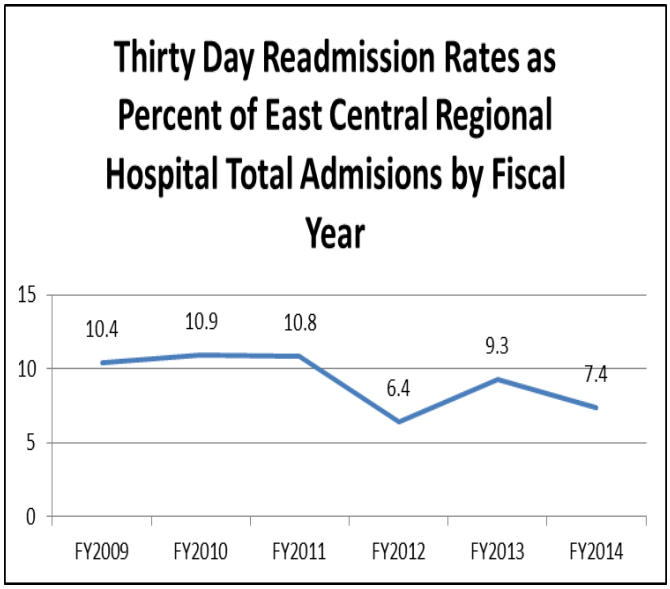


IMPACT OF ADULT MENTAL HEALTH SERVICES

Over the past four years DBHDD's focus has been to move individuals out of inpatient psychiatric facilities and provide community-based treatment. The impact of the community based services has been a vast decrease in the number of psychiatric



inpatient admissions at state psychiatric facilities. East Central Regional Hospital (ECRH) provides inpatient psychiatric services for individuals from R2. Central State Hospital (CSH) provided inpatient psychiatric services for adults with mental illness until March 2010, when the adult mental health unit was closed. CSH continues to have forensic and skilled nursing units. The graph depicts ECRH admissions since FY 2009. In FY 2009, 1386 individuals were admitted to ECRH. Admissions increased by 6.9% to 1482 in FY 2010 at ECRH. Admissions to ECRH increased again in FY2011 by 16.7% to 1730. The significant rise in admissions was largely caused by the closure of CSH in March 2010. ECRH admissions fell by 30.3% in FY 2012 and 24.5% in FY 2013. East Central Regional Hospital admissions fell another 9.5% in FY14.



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 to 162 individuals in FY 2010 and accounted for 10.9% of all ECRH readmissions during that time period. Thirty day re-admissions increased to 187 individuals in FY 2011 which accounted for 10.8% of all ECRH admissions. The number of individuals re-admitted to ECRH within thirty days of discharge decreased by 58.8% from FY 2011 to FY 2012 to 77 individuals. The percentage of re-admissions was 6.4% of total ECRH admissions during FY 2012. In FY 2013, the number of individuals re-admitted to ECRH increased to 85 individuals. This rate of re-admission accounted for 9.3% of all ECRH hospital admissions in FY 2013. In FY2014, the number of individuals re-admitted to ECRH decreased to 61 individuals. The rate of re-admission accounted for 7.4% of all ECRH hospital admissions in FY2014. East Central Regional Hospital has a goal of maintaining the thirty day readmission rate below 10%. ECRH has achieved this goal since the addition of intensive community services. Overall, the impact of adult community mental health services has resulted in significantly fewer inpatient psychiatric admissions at ECRH as well as a low rate of thirty day readmissions.

CHILDREN, YOUTH, AND YOUNG FAMILIES BEHAVIORAL HEALTH

In 2014, the Georgia Department of Community Health (DCH) transitioned 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 to the Care Management Organization (CMO) Amerigroup. 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. DBHDD now only serves children that are uninsured and/or undocumented immigrants. DBHDD maintains programmatic oversight over the Crisis Stabilization Units, Clubhouses, Psychiatric Residential Treatment Facilities and the Care Management Entities. DBHDD also continues to be responsible for the Behavioral Health State Plan. In FY15, DBHDD changed the name of the Division of Child and Adolescent Services to the Division of Children, Youth, and Young Families (CYF) to better define the population served.

Of the total population, 311,372, or 24.5%, are children and adolescents under the age of 18 years. Approximately 8% of this population is estimated to have a diagnosis of a Severe Emotional Disturbance (SED) which amounts to 24,910 children in R2. In FY2014, 3,987 children between the age of nine and seventeen years old were served by BH providers. This corresponds to 16% of the estimated population of children needing MH services. The average cost for individuals receiving CYF services for FY2014 was $3,336, while the average cost for Adult services was $1,304.

CHILDREN, YOUTH, AND YOUNG FAMILIES BEHAVIORAL HEALTH SERVICES

Core Services - There are 45 core providers approved to serve children and youth in R2. Core providers are required to provide mental health and substance abuse treatment services. Providers per service area are: Macon - 15; Athens - 26; Augusta - 8; Swainsboro - 11; Milledgeville – 11. Although there are multiple core providers per CSB catchment area, some counties have only one provider of CYF core services. This limits choices for individuals and increases times for appointment availability.

Intensive Family Intervention (IFI) Services - There are 43 IFI providers serving R2. The Macon area has 11 IFI providers; the Milledgeville area has 10 providers; the Augusta area has 6 providers; the Athens area has 23 providers; and the Swainsboro area has 7 providers. 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 CYF CSUs across the state. River Edge operates a 16-bed unit serving 5-14 year old children. 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 has historically been difficult and typically was done by Sheriff Departments. Mobile Crisis Response Services can provide transportation for individuals in crisis to and from CSUs when it is safe to do so.

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 Lake Bridge 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.

The Resiliency Support Clubhouse Program for Youth - This mental health program is 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. 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 a Mental Health Clubhouse in Milledgeville.

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 that are in need of a structured residence for treatment of addictive disease. The two programs 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. R2 has identified a need to make these services more accessible, including being closer to the youth's home community.

DEVELOPMENTAL DISABILITIES

Individuals with developmental disabilities (DD) should have the opportunity to reside in community settings where they may be active and productive as well as make their own choices and live as independently as possible. In a CDC report on Developmental Disabilities "Key Findings: Trends in the Prevalence of Developmental Disabilities in U. S. Children, 1997–2008", it was noted that developmental disabilities (DDs) are common: about 1 in 6 children in the U.S. had a DD in 2006–2008. These data also showed that prevalence of parent-reported DDs has increased 17.1% from 1997 to 2008. This study underscores the increasing need for health, education and social services, and more specialized health services for people with DDs. The rise in the number of individuals with developmental disabilities coupled with limited funding has resulted in an increase in the number of Georgia citizens being placed on planning lists. Essentially the number of individuals on the planning list and in need of DD services continues to rise at a rate greater than the funding and providers available to support them.

In accordance with the Settlement Agreement, individuals with developmental disabilities should be served in the most integrated setting appropriate to those individuals' needs. In response to the Settlement Agreement, Georgia ceased all admissions of individuals with developmental disabilities to state hospitals prior to July 1, 2011. Per the agreement, 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. These individuals will be supported with both home and community based waiver funds, which allow them to live in their own home or their family's home as they choose. Statewide, approximately 260 individuals with developmental disabilities reside in intermediate care facilities (hospitals), mental health or forensic units or skilled nursing facilities across the state.

The Settlement Agreement identified the following goals:

- **Waivers for Individuals in Hospitals** – DBHDD will transition 150 individuals per year from the hospital to the community. Almost 500 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	828	4674	18%
COMP	1267	7059	18%
State Funded Services	237	1746	14%
Total	2332	13,479	17%

R2 maintains both a short-term and long-term planning list for individuals in need of DD services. Individuals in the planning lists range in age from 4 to 81 years old with the greatest need in Bibb, Richmond, and Columbia counties. Children and youth up to age 18 have greater access to Medicaid state plan services than do adults. As depicted in the chart below, R2 has 1037 individuals out of 7928 individuals statewide on planning lists. R2's short-term planning list has 477 individuals which accounts for 16% of the statewide total. R2's long-term planning list has 560 individuals which is 11% of the statewide total.

Demographic	Region 2	Statewide	R2 %
Short-Term Planning List	477	2909	16%
Long-Term Planning List	560	5049	11%
Total	1037	7928	13%

In an effort to meet the goal of individuals with DD living and receiving services in the community setting of their choice, 750 new Medicaid waivers, at the rate of 150 per year, were created. Regional Offices are tasked with 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.

DEVELOPMENTAL DISABILITY SERVICES

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. 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 community members, assist individuals in living fulfilling lives and assisting individuals in making their dreams a reality. 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.

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 with a goal of enabling these families to continue to care for their family member with DD at home. Thereafter, 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 receive assistance.

Support Coordination – This service assists individuals in gaining access to needed medical, social, education, transportation, and housing supports by linking them to these and other services identify in the individual's service plan. Support Coordination also monitors services received by individuals to assure that additional referrals and support needs are addressed. There have been significant changes in this service with an addition of Early Engagement and Enhanced Early Engagement for individuals who are transitioning from hospitals and for Intensive Support Coordination for individuals who have transitioned to the community.

Crisis Services – 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. The Agreement was that, by July 1, 2012, the state would have 6 mobile crisis teams for individuals with developmental disabilities, and by July 1, 2014, the state would have established 12 crisis respite homes. During FY 2015, one of the crisis homes was closed leaving 11 crisis homes across the state.

- **Mobile Crisis Teams -** A Region 2 provider collaborative supports three mobile crisis teams which are available to deploy to homes, provider sites, and emergency rooms to 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 not been successful; 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 –** R2 has two crisis homes located in Baldwin and Richmond counties. Crisis homes are capable of providing out-of-home supports for individuals with DD who 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, it is anticipated that there will be individuals with DD who have not received prior services in R2 that need emergency residence and/ or supports until such services can be provided through a waiver. For example, individual with DD who has been abandoned by their family or an individual whose family is no longer capable of providing the needed supports (due to age, illness, etc.) may need these emergency supports until alternative services are developed. R2 actively identifies under-utilized funds to reallocate for development of additional emergency respite services.

Behavioral Support Services – A recent amendment in the waiver allows for Behavioral Supports Consultation and Behavioral Supports Services to be available in all settings as stand-alone services. Previously, these were

components of other services, essentially a service within a service, i.e., an expected responsibility of the provider to assure that all needs were being met, but not otherwise billable.

Nursing Services – Skilled nursing services were separated from the context of community residential and community living services. In addition, this was added as a stand-alone service with a recent waiver amendment.

Supported Employment - Individuals with developmental disabilities have historically lacked employment options. If employed, jobs have been in segregated environments such as sheltered workshops where they individuals are paid sub-minimum wages and no benefits. DBHDD has formed 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, which will enhance the supports needed to assist individuals with DD in obtaining and maintaining competitive employment. This will result in individuals with DD working in jobs in the community that pay at or above minimum wage.

Transportation – The lack of adequate public transportation, especially in rural areas of R2, has been identified by individuals with DD, their families, and providers as a significant barrier to successful community integration. Although transportation is available through the DHS Unified Transportation System, limitations of space and barriers for non-ambulatory individuals continue to be a hindrance for transportation.

Housing – Funding for housing is often a barrier for individuals with DD who wish to live either independently or semi-independently in the community. Limited access to affordable housing leads to a reduced ability to lead a normal, productive life in the community.

R2 is initiating an interest in co-housing as an option for individuals with DD in two primary areas: Co-housing with peers who have identified one another as desirable roommates and co=housing with elderly family members in provider sites that offer services to both the DD individual and the aged family member.

Abuse, Neglect, Exploitation – Protection of individuals from assault, neglect, and exploitation is a continuing area of concern for R2. The concern is reality-based with the increased numbers of individuals (many with challenging behaviors) living in the community and being assisted by staff who have not had adequate training to meet their needs. R2 actively addresses this need through the provision of training on assault, neglect, and exploitation to both individuals in services and staff providing direct services. A two-hour curriculum focusing on the identification of, protection from, and reporting of assault/ neglect/ exploitation has been offered to over 600 people. The training has also been offered to aged individuals who receive services through the Area Agency on Aging and Division of Aging staff including Adult Protective Services workers. Seven individuals with DD assisted staff in developing the training and serve as trainers for the ANE (Assault, Neglect, Exploitation) curriculum.

Other – Region 2 maintains an ADRC Resource Program Specialist position that liaisons between the Division of DD and the Division of Aging. The ADRC Resource Program Specialist ensures that individuals 60+ with DD and/or their caregivers 60+ are informed of resources from both DBHDD and the Division of Aging. The ADRC Resource Program Specialist is involved in special projects initiated by either the R2 Office, the three assigned Area Agencies on Aging (CSRA, Middle GA, and Northeast GA), and/or the Division of Aging. R2 is committed to sharing resources and initiating projects that assist both aging individuals with DD and their aging families.

R2 staff assisted the Division of Aging's ACT Unit in the development of a curriculum addressing communication challenges for individuals with DD in their interactions with law enforcement and justice officers. The training will be offered to Georgia law enforcement and justice officers and a counter project is planned for similar training to be offered to individuals in service to familiarize them with interactions with law enforcement and justice officers.

R2 is committed to the professional and personal development of service providers in order to ensure that individuals in services are provided with quality service. R2 staff has offered training in Compassion Fatigue and Moral Dilemmas as Team Building trainings with the belief that as service providers better understand themselves they become more open to understanding the strengths and deficits of others.

R2 offers grief counseling and debriefing services for individuals with DD after the death of family members, peers, and providers. Services are also offered to family members and service providers after tragic and/or unexpected deaths.

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.

COMMUNITY SERVICES SATISFACTION SURVEY

A Community Services Satisfaction Survey was created and distributed to citizens in R2 during Community Forums and other community events at the end of 2014. Information from this survey coupled with information obtained from the Community Forums helps identify priorities for R2. The surveys were divided into four parts which covered a wide variety of topics including general information as well as information about DD, MH, and AD services. Services were rated on a Likert Scale which had the following responses: Don't Know, Very Poor, Poor, Adequate, Good, and Very Good.

Two hundred seventeen surveys were completed with respondents noting they were from the following geographical areas: Athens area, Augusta area, and Macon/ Milledgeville area. No surveys were received from the Swainsboro area. Almost half of the respondents identified themselves as an individual with a developmental disability, mental illness, or addictive disease. Friends or family members of individuals with disabilities and those who work with individuals with disabilities were the next two most commonly identified groups of respondents. The majority of the surveys were incomplete which complicates statistical analysis of the data. Because the data was incomplete, only broad trends will be reported for the purpose of this plan.

The majority of respondents indicated they had never used GCAL, visited the DBHDD website, communicated with a member of the Regional Planning Board, or had contact with the DBHDD Regional or State Office. The majority of respondents who had contact with the above noted groups rated the contact as Adequate, Good, or Very Good. The other portions of the survey dealt with services for individuals with DD, services for individuals with mental illness, and services for individuals with addictive diseases. In all disability areas, the majority of the respondents reported "Don't Know" as a response. Of the respondents who rated services for individuals with DD, the majority rated the services as Adequate, Good, or Very Good. The majority of rated responses for the following mental health services fell into the Very Poor or Poor categories: Housing/ residential choices and supports, Supported Employment opportunities, Day programs, Educational opportunities, Job

training opportunities, Transportation alternatives, Mental Health Clubhouse, Telehealth/ Online treatment, and Coordination of comprehensive services. The majority of the rated responses for the following addictive disease services fell into the Very Poor or Poor categories: Housing/ residential choices and supports, Supported Employment, Day Programs, Job Training Opportunities, Transportation Alternatives, Early Intervention programs for children and youth, Addictive Disease Clubhouse, Telehealth/ Online treatment, and Coordination of comprehensive services.

Comments from the surveys can be found in Appendix B.

REGIONAL PLANNING BOARD PRIORITIES

The Regional Planning Board and Region 2 Office utilized a variety of sources to develop the 2017 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. A survey was distributed to providers who assisted by distributing it to individuals receiving their services and family members. In addition, Regional Planning Board members distributed the surveys at community meetings.

Priority:
Increase Suicide Prevention Coalitions in Region 2 and across the state by ensuring that adequate resources are available to educate and support local coalitions.

Rationale:
Suicide rates have risen sharply in the United States in the past decade. DBHDD has successfully implemented suicide prevention activities in Georgia, including Suicide Prevention Coalitions; however, the scale has been limited due to the small amount of dedicated funding available. More is needed to ensure that local areas have the tools and resources they need to keep suicide prevention in the forefront of communities in Georgia.

2) Priority:
Create additional semi-independent and intensive residential supports for individuals requiring mental health residential services in Region 2.

Rationale:
Although the Georgia Housing Voucher Program (GHVP) has been very effective in helping individuals living with severe and persistent mental illnesses find and maintain affordable housing, too many individuals with personal support needs are being served in private personal care homes that may not provide all of the support needed. In addition, private personal care homes are not under the oversight of DBHDD and living conditions vary widely. Region 2 still has inadequate intensive and semi-independent residential services available, resulting in extended hospital stays and readmissions. Additional residential support services are needed in order to have better outcomes for individuals.

3) Priority:
Expand the Georgia Housing Voucher Program (GHVP) 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:

The GHVP has been very successful in helping individuals living with severe mental illnesses have more rewarding and successful lives in the community. Individuals who are developmentally disabled have very limited access to the GHVP. Opportunities for decent housing, community integration and enhanced independence are restricted by the poverty conditions under which many individuals live. Rental assistance through the GHVP would improve the quality of life for many individuals with developmental disabilities who are living independently.

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

Rationale:
Persons with mental illnesses, developmental disabilities and addictive diseases often do not have access to transportation, thus, diminishing opportunities for continuity of care, community integration and recovery. Lack of transportation is a factor in poor outcomes and is especially a problem in rural areas. 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.

5) Priority:
Implement strategies for increasing Supported Employment services across all disability areas, including incentivizing providers, developing transportation resources, educating communities and employers about the benefits to employment for individuals with disabilities, and joint planning with Vocational Rehabilitation and the Department of Education.

Rationale:
Jobs create opportunities for success and independence that other avenues of support cannot; however, the number of people in DBHDD services who are competitively employed and the number receiving Supported Employment services remain relatively low across all disability groups. New strategies are required to increase opportunities for individuals to have and keep jobs.

6) Priority:
Increase the amount of funding allowed for families receiving Family Support goods and services.

Rationale: The majority of individuals with developmental disabilities live with their own families. Family Support funding provides a small amount of financial assistance to families so they can remain together. The cost of goods and services needed often puts a tremendous strain on already stressed families. The amount of funding available should be increased and allocated based on the specific situation and need.

7) Priority:
Encourage and promote court systems to implement mental health and addictive diseases accountability courts. Meet with judges to educate them about the benefits of accountability courts and to offer technical assistance.

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. Regional Office staff and Regional Planning Board members should meet individually with judges in areas without accountability courts to identify their needs and concerns and to offer assistance and support.

8) Priority:
Provide rural areas with mobile technology through community support staff employed by our providers to offer telehealth, including psychiatric and counseling services. Allow providers to bill for counseling provided through videoconference technologies.

Rationale: Telehealth is being used successfully in many parts of the region and has increased access to psychiatric care in extremely effective ways with a high degree of consumer satisfaction. However, providers are not able to bill for counseling services delivered via teleconference, although research supports its effectiveness. Given Georgia's professional workforce shortage, which is critical in many areas of the state, we encourage DBHDD to support the expansion of telehealth services and to advocate for funding of counseling delivered via video-conference.

9) **Priority:**
Improve access to mental health services for older adults and individuals receiving SSDI by allowing Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) to bill for Medicare services.

Rationale:
Many areas of Region 2 are designated professional workforce shortage areas which limits opportunities for counseling services for all populations served by DBHDD. Access is further limited for individuals who receive their health care funding through Medicare by the fact that, while counseling services provided by Licensed Clinical Social Workers are billable, Master's level LPCs and LMFTs are not able to bill. This leads to a lack of available counseling services for many older adults and other individuals.

10) **Priority:**

Enhance partnerships with Family Connections programs in the region and provide some funding to support this initiative.

Rationale:
Georgia Family Connections is the largest network of its kind in the country and brings local and state agencies together to streamline services and share resources in order to improve outcomes for youth and families. This non-profit organization provides tremendous opportunities for collaboration as many counties have excellent participation by local stakeholders; however, there is no funding to support administrative costs in many localities, limiting outreach and communication efforts.

11) **Priority:**
Support state legislation allowing LPCs the privilege to diagnose mental illness and substance abuse disorders and LMFTs the privilege to execute 1013/2013 orders.

Rationale:
In 2014, the state legislature passed legislation allowing expanded privileges for LPCs and LMFTs. Additional changes to the law are needed to allow LPCs and LMFTs the same privileges as LCSWs. Given the shortage of

the professional workforce needed to serve individuals needing MH, DD and AD services, we urge DBHDD to take a strong position in favor of this change in the law.

12) **Priority:**
Increase education about the Georgia Crisis and Access Line (GCAL) and mobile crisis services to schools, hospitals, advocates and other stakeholders.

Rationale:
In addition to a statewide crisis and access line, Georgia now has mobile crisis services in all 159 counties serving individuals with mental illnesses, substance abuse issues or developmental disabilities who are in crisis. These are tremendous resources and the community needs education about how to use them in order to maximize their effectiveness.

13) **Priority:**
Improve education/training for DD Support Coordinators, including information about accessing community resources and providing effective advocacy.

Rationale:
Support Coordination is a crucial service to ensure that individuals in DD services are aware of and able to access needed services and supports. In order to be effective in their responsibilities, Support Coordinators need a well-coordinated training program that provides information, tools, and resources.

14) **Priority:**
Increase the number of certified peer specialists working in AD services by educating individuals in recovery about this opportunity and supporting them through the certification process.

Rationale:
DBHDD has expanded the Peer Support Certification Program to include a curriculum for individuals in recovery from an addictive disease. It is important to build the workforce so that these services are available to more people. This will require education of potential certified peer specialists and support for individuals as they go through the certification process.

Appendix A

Region Two
MHDDAD Planning Board

Saundra Brown, Bibb County
Martha Crumbley, Burke County
Ed Glauser, Clarke County
Bradford Bowling, Clarke County
Ryan Hope, Clarke County
Lisa Jones, Columbia County
Don Wilkes, Emanuel County
Linda Foster, Jackson County
Mike Greene, Jones County
Tammy Herring, McDuffie County
Debbie Harbin, Monroe County
Velde Hardy, 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
Hugh Bowie, III, Screven County
George Menke, Greene County
Faye Smith, Baldwin County

Appendix B

Developmental Disability Comments:

Hope Haven Respite Care Services has been great in the past but has been unavailable this year due to permanent residents from what I understand. Also wish there were more job training opportunities in Madison County.

No services once out of school - most sit at home few providers. Transportation is nonexistent in small town. Waiting years for waiver do not know where to get behavior service what is online treatment?

I know some of these are offered in our community - it is hard for me to judge they are poor or adequate.

I just enjoy connecting with these individuals whenever and wherever I meet or see them and they always respond so positively. So many folks ignore them or turn away from them.

I am not educated concerning the services of DBHDD.

SID retired teach Bibb County. Job training is adequate if the family is informed and gets helps with the forms. Behavior supports some parents need assistance.

About to transition - he needs live in and day program. As of Jan 26, 2015 - impart me!

Need more housing

In our area we need affordable transportation.

Live at home with sister.

Need to have affordable housing and residential choices and supports.

Need to continue to explore supported employment opportunities for individuals with DD.

More lift vans and ambulatory. Slide doors more equipped for wheelchair. Entrance when getting off the van. Bigger handicap restrooms for Jackson/ Commerce County.

Lift vans, ambulatory vans, sliding doors more equipped for wheelchair entrance. Handicap restrooms for wheelchair in Jackson/ Commerce County.

Lift vans, ambulatory vans, sliding doors more equipped for wheelchair entrance. Bigger handicap restrooms for wheelchair in Jackson/ Commerce County.

No respite care service providers in Walton/ Morgan counties. Poor access to mental health treatment for individuals with DD. Poor telehealth/ online treatment - clients want to see a live doctor. More waiver openings needed.

Need dental clinics that accept Medicaid that are trained to help disabled. Need better response to answering telephones at mental health clinic clients may get frustrated and give up. Not receiving the help they need.

I want to learn how to count money.

Everything is good.

[Name retracted] gets alone with others and she enjoys being around her peers. She also wants to thank everyone for what they do.

Therapist at Advantage BH excellent. Staff at ABH very helpful. Doctors overworked. ABH crisis intake in Athens seems never to have any beds.

Supported Residential Opportunities Unlimited Services is very good. Mental health in Walton County is very poor, no real doctors TV doctors; I know a lot of people have found other providers. I stopped using Advantage.

The state needs to hire more personnel to assist families. The current staff is amazing and very dedicated but spread too thin. It would help to have better communication with families.

Service providers don't provide service or know their job.

Licensing of homes is a tedious process because it involves repetition of inspections, too much paperwork. All this is expensive when it takes up to nine months to gain a tracing number. Since the provider has to bear the expense then the regulatory agencies are not motivated to activate the process. Individual rights are being compromised by decisions made again by regulatory agencies whose personnel are so involved in policy making common sense is lost too often.

When an adult is their own legal guardian they should be allowed, if medically cleared, to stay by themselves without fear of being taken from their home and activities to live independently. Just because they can stay by themselves for short periods of time does not mean they can live alone. They also should be allowed to go places where their friends are without the caregiver having to be there especially if it is a volunteer job and there are at least three staff and a nurse on duty.

I am thankful for Hope Haven/ Athens GA. They are very supportive for my special needs son.

Son is transitioning to adult services. No services have been made available. No planning for what comes next. We need help in all areas.

Services not available for Twiggs residence. Poor or no transportation funding is never available.

This is a county where there is no supported employment for students who are transitioning out of the school setting. Day program is limited - waiting list. People are sitting at home with no activity. Parent are not aware of options or given the run around. Majority of the mental health individuals are spending their time in jail because of their mental issues rather than being given services.

There is no place for a person with disabilities to work when they get out of high school in Bibb County. Also we need social activities and recreation for people with disabilities.

We do not receive services but are very interested. Son-24. I'm not sure of possible services that are available in our community. Needs: transportation, supported employment opportunities, social and rec, OT, PT, education (?), unsure of housing in the future.

Transportation, valued roles, friends, social engagement, volunteering.

Our son, age 43, is a resident of Wesley Glen Ministries. It is WONDERFUL!!

More services for adults provided in the county

The services are underfunded and overloaded. Housing services are virtually nonexistent and the economic climate for this population is incredibly bleak.

Need more counselors. DBHDD need to help people who want to work in these fields get certified instead of making harder it's a shame.

Didn't know these services were available.

We currently have no service providers located in the city of Madison and are in desperate need of such. The majority of the clients our organization serves are low income families and do not have transportation to services in other surrounding cities.

There was available mental health here at one time but as I understand it the stigma of mental illness, etc. caused it not to be economically feasible to maintain a mental health department or other counseling services.

Application for DBHDD should be on website and if it is, I could not find it - regional representative should be available for County School Systems to get children on Planning List before they leave school. Once in waiver and receiving set services, very difficult in getting changed to other services, though needs of recipient have changed. also difficulty myself, but the consumers that said that they have called have indicated that contact was not helpful - in one instance a team was sent out, but family members said that they did not know what to do with client. When DBHDD clients no on planning list and in crisis, difficulty with accessing needed services - services not always meeting client needs.

There are many deficits in MH services - specifically housing options and day programs/ in home case management services.
Very challenging to move from DeKalb region to Athens Clarke County region. Process too three months and proved to be a very frustrating experience. Since we got our loved one moved to Athens Clarke County, the services have been wonderful and without flaws.
There needs to be more done to help severely disabled adults with self-injury. This has been ignored for too long.
There is an issue with funding the partnering agencies which limit needed and mandated services.
More supported employment opportunities needed both for client's self-esteem and monetary benefits. Service centers, homes do a fine job.

Mental Health Comments:
I used to work at the State Hospital in Milledgeville.
I am not educated concerning the services of DBHDD.
Good peer supports in school
Need housing
Need more info on LIPT and telehealth
Need better job training opportunities for people with mental illness
Need more housing and supported employment opportunities for individuals with mental illness.
NAMI chapter now getting started with classes and family support meetings. ABH very heavily booked and used.
Families have very limited or no resources (transportation). Home phone and no educational services or limited or not available.
DBHDD need to help people who want to work in these fields get certified instead of making it harder it's a shame
The people working with this population are working so hard with so few resources.
These counties have a huge population of those struggling with SPMIs and are faced with this and economic disadvantage. These counties need SO much more.
Need services in the county
Didn't know these services were available.
There are no mental health waivers, and I see mostly mental health clients falling through the cracks for housing, employment, health insurance, any benefits.
Our loved one is not mentally ill. He has Down's Syndrome which is a disability.
Advantage Behavioral Health Systems provides excellent services for its 10 county area.

Addictive Disease Comments:
I am not educated concerning the services of DBHDD.
Al-Anon great. AA the best.
Housing Needed
Need to have an Addictive Disease clubhouse in Jackson County. Need to have training on telehealth and online treatment.
No services available in Twiggs County
No assistance for those without insurance.
Need service in the county

These counties could easily sustain an IOP program with ambulatory detox. AOD is even more underserved than MH.

the same reason as before people wanting to help the state making it harder background issues stupid stuff like what recovery addict you know that doesn't have a felony keep leaving it up to DJ then will keep us lock up no problem.

Didn't know these services were available.

Our loved one does not have an addictive disease. His disability is Down's Syndrome.

Excellent cooperation between agency services and Department of Justice. Respecting reforming rehabilitation.