IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	1:10-CV-249-CAP
THE STATE OF GEORGIA, et al.,	)	
	)	
Defendants.	)	
	)	

NOTICE OF JOINT FILING OF THE SUPPLEMENTAL REPORT OF THE INDEPENDENT REVIEWER

Plaintiff United States and Defendants State of Georgia, et al., jointly file the Supplemental Report of the Independent Reviewer pursuant to ¶ VI.B of the Settlement Agreement [Docket Nos. 112, 115, 151 &171]. The Independent Reviewer's report (with its referenced attachments) is included as Attachment A hereto.

Respectfully submitted, this 21st day of June, 2016.

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Local Rule 7.1D Certification

By signature below, counsel certifies that the foregoing document was prepared in Times New Roman 14-point font in compliance with Local Rule 5.1B.

/s/ Regan Bailey
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CERTIFICATE OF SERVICE

I hereby certify that on this 21st day of June, 2016, I electronically filed the **JOINT FILING OF THE REPORT OF THE INDEPENDENT REVIEWER** with the Clerk of Court using the CM/ECF system which will automatically send email notification of such filing to all of the attorneys of record.

/s/ Regan Bailey___
REGAN BAILEY

ATTACHMENT A

SUPPLEMENTAL REPORT

In the Matter of
United States v. Georgia

(Civil Action 1:10-cv-00249-CAP)

Submitted by:
Elizabeth Jones, Independent Reviewer
June 20, 2016

INTRODUCTORY COMMENTS

The Settlement Agreement requires the Independent Reviewer to prepare an annual report, summarizing the State's progress towards compliance with its terms. This annual report is prepared after the close of the Fiscal Year and contains detailed descriptions of the State of Georgia's efforts to provide appropriate planning and services to support individuals at risk of institutionalization. The annual report typically is filed with the Court in September of the following Fiscal Year.

Periodically, a Supplemental Report by the Independent Reviewer has been filed with the Court in order to address matters of heightened interest or importance to the Parties. The Supplemental Report is not intended to be as comprehensive as the annual report or to contain ratings about compliance with the terms of the Settlement Agreement.

This Supplemental Report is being written to provide an update on a selected set of issues relevant to the upcoming annual report. These issues include: access to housing for individuals in the target population with a serious mental illness; the transition of individuals with a developmental disability from the state hospitals to community-based residential settings; and the status of previously placed individuals with a developmental disability who transitioned from the state hospitals in the earlier years of the Settlement Agreement.

The Settlement Agreement has reached the end of its anticipated five-year term. The year of sustainability of effort for certain obligations has been in effect since July 1, 2015 and is scheduled to end on June 30, 2016.

At the time of this report's preparation, the Parties had negotiated and signed a two-year Extension to the Settlement Agreement. On May 27, 2016, the Court granted the Parties' Joint Motion to enter the Extension of the Settlement Agreement and agreed to retain jurisdiction to enforce its terms. [1]

The Extension to the Settlement Agreement will focus on and address the issues discussed in this Supplemental Report.

As with each report, the generous and capable efforts of many colleagues have been critical to the work of the Independent Reviewer. This assistance and guidance is greatly appreciated and has been instrumental to shaping the findings of this Supplemental Report.

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[1] United States District Court for the Northern District of Georgia, Atlanta Division, Case 1:10-cv-00249-CAP, Document 259, filed 05/27/16.

OVERALL METHODOLOGY

The information for this report was obtained through numerous sources and strategies.

Fact-finding was completed between January and the middle of May 2016.

The Independent Reviewer retained consultants with expertise in supported housing, clinical psychology, behavior analysis and nursing in order to complete individual reviews of people in the target population and to assess the implementation of community supports on programmatic and systemic levels. Their work was performed through discussions with staff from the Department of Behavioral Health and Developmental Disabilities, advocates and, in many instances, the individuals eligible for the community-supports under review. Site visits to community programs and state hospitals were completed in Regions 1, 2, 3, 4, and 5. Documentation was provided and reviewed, as relevant.

The Independent Reviewer met often with Department leadership and programmatic staff. The Director of Settlement Services ably responded to requests for documentation and other information. Site visits were conducted to community residential settings on both an unannounced and announced basis. Observations also took place in three shelters for homeless individuals in the metro Atlanta area. Attorneys for the State of Georgia and the United States Department of Justice were most helpful in responding to questions and requests for assistance. Members of the advocacy community, especially members of the Amici, were accessible and responsive with their time and thoughtful observations.

The individuals reviewed during this reporting period were selected both by random and purposeful sampling. A senior researcher at Virginia Commonwealth University selected all samples.

The thirty-one individuals with a developmental disability living in community-based residences were monitored using a questionnaire developed in collaboration with staff from the Department of Behavioral Health and Developmental Disabilities. Copies of the completed questionnaires were provided to the Parties.

As required by the Settlement Agreement, a draft of this report was submitted to the Parties for review and comment prior to its finalization. All comments were carefully considered; changes were made in the narrative, as appropriate.

FINDINGS

Community Supports for Individuals with Serious Mental Illness

Stable housing with supports is a critical component of recovery from serious mental illness. Without this foundation, it is difficult to form and retain trusting relationships, learn and exercise skills, develop a predictable routine and rhythm of the day, manage limited resources effectively, safeguard one's health and safety, and contribute to one's community.

Well-established research in the field of behavioral health has documented the positive effect of housing with supports, especially for individuals with histories characterized by multiple psychiatric hospitalizations, homelessness and reluctance to engage in treatment.

The Settlement Agreement requires the State of Georgia to provide access to housing with supports to members of the target population with a serious mental illness.

Throughout the course of the Agreement, the State has exceeded its obligation to fund housing vouchers and to provide Bridge Funding. In fact, the State has been continuously applauded for its efforts. Without a doubt, numerous individual examples have confirmed that the provision of stable housing with supports has made a critical difference.

The Annual Report filed with the Court in September 2015 documented the State's many successful efforts to ensure access to housing and supports. However, it was agreed that additional time would be needed for the State to comply with Provision III. B. 2. c. ii. (A):

> By July 1, 2015, The State will have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support.

Supported Housing Needs Assessment:

At the end of the last Fiscal Year (2015), a primary objective of the Department of Behavioral Health and Developmental Disabilities was to conduct an assessment of the need for supported housing. The planning for the implementation of the assessment process was shared in a timely and forthright manner with the Independent Reviewer, her expert consultant in housing and with members of an advisory group comprised of advocates and other stakeholders.

As of this date, the Department continues to make progress implementing its Supported Housing Needs Assessment. As part of Phase I, it has established a baseline of the number of individuals who require supported housing and are currently receiving it. The Supported Housing Needs and Choice tool has been

administered in three jails and two correctional facilities. Under the Department's direction, a nationally recognized consulting group, the Technical Assistance Collaborative (TAC), has offered training on the importance of supported housing to the staff of provider agencies.

However, Phase I also revealed a number of significant challenges to the validity of the planned process for defining and implementing the supported housing needs of the target population.

First, the Department's current process for obtaining supported housing may be an obstacle for some members of the target population, especially those exiting jails and correctional institutions. The current protocol requires individuals to be identified, assessed, referred for services to a provider agency and then referred, by that provider, for housing. The Department collaborates with the Georgia Department of Corrections and a few local jails to try to plan for post-release services and housing. Staff have reported that the process can be cumbersome. Institutions where individuals are incarcerated are not always in close proximity to where people are moving upon release. In addition, obtaining housing and benefits takes time. Therefore, it is not always possible to make housing and other needed arrangements in a timely manner for individuals leaving jails or correctional facilities.

Second, as noted since the inception of the Georgia Housing Voucher Program in 2011 and again after this baseline phase, individuals being discharged from state hospitals, or private hospitals under contract with the Department, are referred to providers who make the referral to the Georgia Housing Voucher Program. To date in Fiscal Year 2016, only fifty-five individuals leaving state/private hospitals under contract and fifty-six individuals exiting jails have been housed out of the 614 individuals with signed leases under the Georgia Housing Voucher Program. In addition, the number of people in the target population who are exiting jails and correctional institutions, and could qualify for and benefit from supported housing, is largely unknown. The baseline assessment process was not robust enough to project this number.

The number of individuals leaving the four state psychiatric hospitals and the private psychiatric hospitals, under contract with the Department, who are in need of supported housing, is still unknown primarily because the processes and timeframes for discharge from a hospital do not match with the requirements of the current referral protocol described above. For example, at some point after admission, hospital staff screen and evaluate individuals for their interest in/need for supported housing. Staff utilize the Housing Need and Choice Survey to identify their interest/need for housing. Field Office-based Hospital Transition Specialists, Field Office staff, and Crisis/Inpatient Staff work with Hospital Recovery Planning Teams to integrate these findings into the individual's Transition Action Plan (TAP). This information is then sent electronically to a potential "receiving community provider." The provider then has thirty days from receipt of the electronic referral

to complete a Risk Assessment and Housing Plan. In many cases, the individual is ready for discharge well before the end of the thirty-day period. (The average length of stay is reported as ten days.) As a result, supported housing is not available for the individual in a timely manner and discharge options are limited in scope.

An additional concern is the unfortunate pattern of hospitals, both state and private, discharging individuals to shelters for homeless people. As discussed further below, there is documented evidence that these individuals, many at high risk and with "revolving door" histories of psychiatric hospitalization, are not being referred for supported housing. A significant number of individuals brought to Georgia Regional Hospital Atlanta are not admitted. Thus, they do not receive the Housing Need and Choice Survey, even though they fall under the Settlement Agreement criteria. As a result, many have not been, and are unlikely to be, included in the Supported Housing Need and Choice evaluation process as currently designed and implemented.

At this time, as a result of the lack of inclusion of individuals exiting most jails, all of the State's correctional institutions and state/private psychiatric hospitals, the Department has not demonstrated that it has met the threshold requirement of identifying the need for supported housing for the target population. This matter requires prompt discussion among the Parties to the Settlement Agreement.

Discharges to Shelters:

The review of individuals discharged from state hospitals to shelters for homeless people began in February 2016 as follow-up to the receipt of a Critical Incident Report.

On February 9, 2016, a meeting was held with the Department's leadership to review the protocols for discharge to a shelter, the revised policy directives from the Medical Director, and the number of shelter discharges in Fiscal Year 2015. The Independent Reviewer requested the Department to provide ongoing quarterly data about discharges to shelters. That request has been addressed in a timely manner.

According to the Department's report, in Fiscal Year 2015, there were 217 discharges, for 195 individuals, from three state hospitals to shelters for homeless people. (Some individuals were discharged to a shelter more than once.) This appears to be largely an issue in the Atlanta metropolitan area. During this time period, there were 177 shelter discharges for 157 individuals from Georgia Regional Hospital Atlanta.[2] Thirty-four of these individuals had histories of ten or more hospital admissions.

[2] There were a total of thirty-four discharges to shelters for thirty-two individuals hospitalized in Georgia Regional Savannah. Six individuals were discharged to shelters from East Central Regional Hospital. There were no shelter discharges from the state hospital in Columbus.

In the months of January, February and March 2016 (the third Quarter of the Fiscal Year), there were fourteen individuals discharged to shelters from Georgia Regional Hospital Atlanta. Four of these discharges took place after the initiation of the Department's revised policy on discharge to a shelter; a decrease of one person per month for the previous two months. This policy permits PATH Teams to be contacted directly by the state hospital so that they may begin work with an individual known to be homeless.

On March 30, 2016, the Independent Reviewer made unannounced visits to two shelters in downtown Atlanta to inquire about the admission of individuals with a serious mental illness who were recently discharged from a psychiatric hospital.

On March 31, 2016, the Independent Reviewer examined records of a sample of six individuals discharged from Georgia Regional Hospital Atlanta to shelters in Fiscal Year 2015 in order to become familiar with the documentation and some of the case examples, including the reasons for discharge to a shelter rather than to housing with supports.

Based on that preliminary review, a sample of twenty-three individuals discharged from Georgia Regional Hospital Atlanta to shelters in Fiscal Year 2015 was selected by the Independent Reviewer for further review.[3] On April 21 and 22, 2016, the Independent Reviewer and her housing consultant reviewed sections of these individuals' hospital records; interviewed hospital, Regional Field Office and PATH staff knowledgeable about discharge decision-making; and briefly interviewed two individuals who were readmitted to the hospital after discharge to a shelter. In addition, an unannounced site visit was made to a large shelter for homeless individuals in mid-town Atlanta.[4]

On May 9, 2016, the Independent Reviewer and her housing consultant visited a transitional housing facility and met with Department leadership to discuss the preliminary findings from the work described above.

On May 10, 11 and 12, 2016, a clinical psychologist retained by the Independent Reviewer met with staff at Georgia Regional Hospital Atlanta and reviewed the records of all fourteen individuals discharged to shelters during the months of

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[3] The individuals in the sample all had histories of ten or more psychiatric hospitalizations at Georgia Regional Hospital Atlanta.

[4] The Independent Reviewer has made three unannounced visits to this shelter. In her opinion, and as discussed with the Department, the conditions are simply unacceptable. During her last visit, shelter staff reported that the Department of Health makes two to three visits weekly to test for tuberculosis. It was necessary to walk through standing water from a broken pipe in order to reach the area where the shelter's residents remain during the daytime hours. A man identified, by staff, as having a mental illness was interviewed briefly.

January, February and March 2016. She interviewed two individuals who were readmitted after discharge and were still hospitalized.

The clinical psychologist's report, describing the findings from the last set of reviews and interviews, has been shared with the Parties. In order to protect confidentiality, the information regarding discharge practices, is summarized below:

- Of the fourteen individuals discharged to shelters, five individuals (36%) have been re-hospitalized, since discharge, at Georgia Regional Hospital Atlanta.

- Despite the change in the Department's protocol for discharge to a shelter, only two of the requisite forms (15%) had documentation of the necessary approval.[5]

- Eight of the fourteen individuals (57%) were homeless at the time of admission. Three individuals (21%) lived with family. One individual (7%) was living in a motel and one individual (7%) was living in an apartment.

- Seven of the fourteen individuals (50%) were discharged to the shelter described above in Footnote 4.

- There was documentation that four individuals were referred to a PATH Team, part of the revised protocol implemented by the Department to reduce discharges to shelters.

The record reviews and interviews conducted about discharges to shelters provide important information about the current effectiveness of the Department's policies and practices. For example:

- At this time, there is a lack of consistency in implementing the Department's revised policy about discharge to a shelter, including the requirement that the Medical Director give prior approval.

- Planning for discharge from a psychiatric hospital must begin at the time of admission. Based on information in the records, it was known that 57% of the individuals were homeless at the time they entered Georgia Regional Hospital Atlanta. Preparations for supported housing were not initiated at an early enough point in time to enable the development of a trusting relationship between the individual and a potential provider of housing.

[5] At the February 9, 2016 meeting, the Department's Medical Director indicated that his prior approval was now required for discharge to a shelter.

Although PATH Teams[6] are noted for their expertise in reaching out to people with long histories of homelessness, in these cases, they were not given sufficient time to establish a meaningful connection with the hospitalized person. As a result, the referral to the PATH Team was rejected or not secured sufficiently prior to discharge.

- The Department's protocol for referring individuals to supported housing is not effective or timely for individuals leaving a psychiatric hospital who lack reliable options for transitional housing or who are reluctant to engage in mental health services through a provider agency. A Housing First policy must begin with the provision of housing rather than the requirement to accept treatment. Research in the field clearly confirms that individuals begin to accept the idea of treatment once they are living in stable housing that is consistent with their preferences for self-determination. While not fully meeting the Housing First definition, PATH teams have been allocated funds to assist individuals meeting the Settlement Agreement criteria to move to transitional housing[7] locations that would enable them to have more time to seek housing. While too early to determine the efficacy of this approach, it may provide an opportunity to help the transition for individuals with short-term hospital stays.

- There was scant documentation about the use of Assertive Community Treatment (ACT) Teams for the fourteen individuals reviewed. It was documented that two individuals were referred to ACT Teams; both declined. Overall, the number of hospitalizations experienced in this group of individuals would qualify them for enrollment with an ACT Team.

In order to more fully understand both the dynamics and the outcomes of discharges from psychiatric hospitals to shelters for homeless people, the work initiated for this Supplemental Report will be continued, with emphasis on discharges from Georgia Regional Hospital Atlanta. It is anticipated that the Department will provide new data at the end of the Fiscal Year.

It is recommended that the Department intensify its efforts to prevent discharges to shelters. Staff should be instructed to begin planning for discharge at the time of hospital admission. In addition, it is recommended that the Department review its processes for referral to Assertive Community Treatment so that more people with a history of repeated hospital admissions can be diverted from this cycle.

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[6] The PATH Team working with staff/clients at Georgia Regional Hospital Atlanta is highly regarded and has a reputation for positive outcomes on behalf of people who are characterized as chronically homeless.

[7] The two Atlanta sites identified as "transitional housing" are still being reviewed by the Independent Reviewer and her housing consultant. Both sites are large congregate facilities.

Forensic Individuals:

In preparation for the last Annual Report, the Independent Reviewer retained an experienced forensic psychologist to conduct fieldwork and a review of relevant documentation about the access to supported housing by individuals awaiting discharge from the forensic units/buildings of state hospitals.

The consultant's report identified factors that inhibited the timely discharge of forensic individuals, especially those identified as Incompetent to Stand Trial (IST) or Not Guilty by Reason of Insanity (NGRI). The report also offered recommendations to expedite discharge planning and the transition to community-based residential and other supports.

On February 29, 2016, this report was discussed at some length with leadership staff of the Department of Behavioral Health and Developmental Disabilities.

A copy of the consultant's report is attached.

There continues to be collaboration between the Independent Reviewer and the Department in examining access to housing and supports for individuals with forensic histories who are included in the target population. Further findings will be included in the next Annual Report.

Community Supports for Individuals with a Developmental Disability

Under the terms of the Extension to the Settlement Agreement, there will continue to be emphasis on the development of a responsive system of community-based supports for individuals with a developmental disability included in the target population.

Therefore, the information summarized below is intended to assist the Parties in working together to shape reforms, as needed, and to recognize areas of sustained progress. There will be a more detailed description of the planning list, the transition process, the "high risk" list, the placement of individuals with a forensic history, and the implementation of community-based clinical supports in the forthcoming Annual Report.

The information for this Section was obtained primarily through meetings held by the Independent Reviewer with Department staff and through the site visits conducted by her consultants in nursing and behavior analysis.

There were three groups of individuals selected for review:

- The first group included four individuals placed under the auspices of the Pioneer Project. Three of the individuals, all women, live together in the first

residence established under the Pioneer Project in Region 2. The fourth individual, a man, lives in a house managed by a second provider agency in another city. [8]

- The second group consisted of twenty-three individuals previously placed in the earlier years of the Settlement Agreement. These individuals were selected for review by purposeful sampling. That is, individuals were identified from the notes transcribed by the Department's Regional Quality Review Teams and by Support Coordinators assigned to the individuals. The notes described areas of concern and, in some cases, the actions taken to resolve them.

- The third group of six individuals also was selected by purposeful sampling, as described above. Each individual was known to have behavioral concerns, although the current extent of those concerns was not fully known prior to the site visit and document review. Four of the individuals live in a community-based residential setting; two individuals still were hospitalized at East Central Regional Hospital after earlier community placements were unsuccessful.

Narrative reports were prepared for the two hospitalized individuals; the monitoring questionnaire was completed in all other instances. All reports have been shared with the Parties.

Discussion of Transitions from State Hospitals:

As of June 17, 2016, there have been 524 placements from state hospitals under the Settlement Agreement.

The Department maintains a planning list for community placements. The Director of Transitions is responsible for maintaining the list. Decisions about community placement are made in consultation with families, state hospital staff and, as possible, the individuals themselves. In addition, clinical consultants with the Pioneer Project are actively engaged. Final approval for the placement rests with the Transition Fidelity Committee, comprised of leadership staff at the Department.[9]

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[8] The Pioneer Project refers to a set of policies, protocols and practices established by the Department as part of its reform efforts. Placements have been primarily in Region 2, although placements in Region 4 have occurred in Fiscal Year 2016.

[9] In April 2016, the Independent Reviewer's nurse consultant was asked to advise on three planned placements in order to ensure a comprehensive review of necessary health-related supports. These three individuals are scheduled for placement from Gracewood at a future, yet undetermined, time. (They are not included in this Report.) The Department's request for this consultation is greatly

The Department also maintains a list of individuals who are considered to be at higher risk because of their medical or behavioral complexity. The responsibility for this list is assigned to the Health and Wellness Unit. A sample of individuals on this list will be reviewed for the next Annual Report.[10]

As referenced above, four placements completed under the Pioneer Project in Region 2 were reviewed.

SELECTED RESPONSES FOR FOUR PIONEER PROJECT PLACEMENTS MAY 2016

Demographic Information

Sex	n	%
Male	1	25.00%
Female	3	75.00%

Age range	n	%
41 to 50	1	25.0%
61 to 70	3	75.0%

Level of mobility	n	%
Ambulatory without support	1	25.0%
Ambulatory with support	3	75.0%

The nurse consultant conducting the reviews found that:

Individual Interview Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
25	Is your home located near community resources (i.e. shopping, recreational sites, churches, etc.?)	4	100.0%	0.0%	0.0%
29	Have you met your neighbors?	4	50.0%	50.0%	0.0%
26	Do you have your own bedroom?	4	100.0%	0.0%	0.0%
27	Do you have privacy in your home if you want it?	4	100.0%	0.0%	0.0%
31	Within the last quarter, have you participated in community outings on a consistent weekly basis?	4	75.0%	25.0%	0.0%

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appreciated; it is a good example of the openness that characterizes the transition work.

[10] In the Extension to the Settlement Agreement, this list is called the "High Risk Surveillance List."

32	Do you go out primarily with your housemates as a group?	3	100.0%	0.0%	0.0%
35	Do you have the opportunity to attend a church / synagogue / mosque or other religious activity of your choice?	4	25.0%	75.0%	0.0%
36	Do you belong to any community clubs or organizations?	4	25.0%	75.0%	0.0%

Environmental Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
48	Is the individual's residence clean?	4	100.0%	0.0%	0.0%
49	Are food and supplies adequate?	4	100.0%	0.0%	0.0%
50	Does the individual appear well kempt?	4	100.0%	0.0%	0.0%
51	Is the residence free of any safety issues?	4	100.0%	0.0%	0.0%

Healthcare Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
60	Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	4	100.0%	0.0%	0.0%
63	Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	4	100.0%	0.0%	0.0%
64	Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	4	100.0%	0.0%	0.0%
65	Is lab work completed as ordered by the physician?	4	100.0%	0.0%	0.0%
67	Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	4	100.0%	0.0%	0.0%
83	If applicable, is the dining plan followed?	1	100.0%	0.0%	0.0%
84	If applicable, is the positioning plan followed?	3	100.0%	0.0%	0.0%
85	In your professional judgment as a Registered Nurse: Are the individual's serious physical health care needs met?	4	75.0%	25.0%	0.0%
86	Are the health care interventions consistent with professional standards of care?	4	75.0%	25.0%	0.0%
87	Does nursing care meet professional standards?	4	25.0%	75.0%	0.0%
93	Does this individual receive psychotropic medication?	4	25.0%	75.0%	0.0%

Healthcare Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
96	Is there documentation that the individual and/or a legal guardian/surrogate decision-maker has given informed consent for the use of psychotropic medication(s)?	1	0.0%	100.0%	0.0%
104	Is there any evidence of administering excessive or unnecessary medication(s)?	4	0.0%	100.0%	0.0%

The findings from the review of four individuals in two residential settings must be interpreted carefully because of the small size of the sample. Nonetheless, there are positive indicators about the residential setting (privacy, location in a typical neighborhood, access to resources, condition of the residence) and the opportunities for integration with non-disabled individuals, including participation in a local Senior Citizen Center. Discussion with residential staff indicated that additional resources for social integration were being explored, based on the individuals' interests and choice.

- In particular, one of the three women placed has shown a remarkable response to her new setting. The Independent Reviewer had observed her on three separate occasions at the state hospital. Each time, she was seen with a blanket over her head, huddled in a chair, refusing to interact with the staff who approached her. In her new home, she is responsive to staff; allows them to touch her hand or shoulder; is showing signs of active listening (she was thought to be hearing impaired at the state hospital); and is becoming comfortable with her daily route, including enjoying taking a bath. (She refused showers in the state hospital and had to be escorted by two staff.)

Essential health care supports were in place with physician recommendations implemented in a timely manner, laboratory work completed as ordered, and individualized protocols for positioning and mealtime performed as required.

Psychotropic medication was used for only one individual. There was no evidence of unnecessary or excessive medications.

Issues identified for further attention by the provider and Department staff included the hiring of a Registered Nurse to supervise health care in one residence; obtaining a medical consultation regarding treatment or precautionary measures for the hernia experienced by one individual; ensuring informed consent for the use of psychotropic medication by one individual; and monitoring the completion of data collection and documentation in one residence.

Each of these issues has been brought to the Department's attention for remedial action, as required.

The second group of individuals reviewed included those placed in the earlier years of the Settlement Agreement. These placements did not have the benefit of the protocols, policies and practices designed under the Pioneer Project cited above. For example, support coordination was not involved prior to discharge from the state hospitals. Residential agency staff reported that they were not consistently provided with sufficient information about the individual and his/her needs.

The twenty-three individuals in this group were reviewed by nurse consultants with extensive knowledge of and experience in the field of intellectual/developmental disabilities.

Site visits were conducted in the individual's residence. In some cases, the day program was briefly visited in order to meet the individual being reviewed. All individuals in the sample were observed at some point during the site visit. The responses from the Monitoring Questionnaires were analyzed by the senior researcher/statistician retained by the Independent Reviewer.

The findings include:

SELECTED RESPONSES FOR PREVIOUS PLACEMENTS
MAY 2016

Demographic Information

Sex	n	%
Male	14	60.9%
Female	9	39.1%

Age range	n	%
21 to 30	2	8.7%
31 to 40	5	21.7%
41 to 50	2	8.7%
51 to 60	7	30.4%
61 to 70	4	17.4%
71 to 80	2	8.7%
81 to 90	1	4.3%

Level of mobility	n	%
Ambulatory without support	6	26.1%
Uses wheelchair	7	30.4%
Ambulatory with support	9	39.1%
Confined to bed	1	4.3%

Individual Interview Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
25	Is your home located near community resources (i.e. shopping, recreational sites, churches, etc.?)	23	100.0%	0.0%	0.0%
29	Have you met your neighbors?	23	82.6%	17.4%	0.0%
26	Do you have your own bedroom?	23	100.0%	0.0%	0.0%
27	Do you have privacy in your home if you want it?	23	100.0%	0.0%	0.0%
31	Within the last quarter, have you participated in community outings on a consistent weekly basis?	23	78.3%	17.4%	4.3%
32	Do you go out primarily with your housemates as a group?	21	81.0%	19.0%	0.0%
35	Do you have the opportunity to attend a church / synagogue / mosque or other religious activity of your choice?	23	69.6%	30.4%	0.0%
36	Do you belong to any community clubs or organizations?	23	26.1%	73.9%	0.0%

Environmental Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
48	Is the individual's residence clean?	23	73.9%	26.1%	0.0%
49	Are food and supplies adequate?	23	95.7%	4.3%	0.0%
50	Does the individual appear well kempt?	23	95.7%	4.3%	0.0%
51	Is the residence free of any safety issues?	23	100.0%	0.0%	0.0%

Healthcare Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
60	Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	23	100.0%	0.0%	0.0%
63	Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	23	95.7%	4.3%	0.0%
64	Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	23	69.6%	21.7%	8.7%
65	Is lab work completed as ordered by the physician?	23	91.3%	4.3%	4.3%
67	Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	22	86.4%	9.1%	4.5%

Healthcare Items					
No.	**Item**	**n**	**Y**	**N**	**CND**
83	If applicable, is the dining plan followed?	19	94.7%	5.3%	0.0%
84	If applicable, is the positioning plan followed?	15	86.7%	0.0%	13.3%
85	In your professional judgment as a Registered Nurse: Are the individual's serious physical health care needs met?	23	65.2%	34.8%	0.0%
86	Are the health care interventions consistent with professional standards of care?	23	56.5%	43.5%	0.0%
87	Does nursing care meet professional standards?	23	47.8%	52.2%	0.0%
93	Does this individual receive psychotropic medication?	23	78.3%	21.7%	0.0%
96	Is there documentation that the individual and/or a legal guardian/surrogate decision-maker has given informed consent for the use of psychotropic medication(s)?	18	88.9%	11.1%	0.0%
104	Is there any evidence of administering excessive or unnecessary medication(s)?	23	0.0%	95.7%	4.3%

The findings from these twenty-three reviews again demonstrated that residences were located in typical neighborhoods with access to local community resources. The individuals in the sample were afforded privacy; all had their own bedrooms. Many of the individuals had met their neighbors.

Negative findings about the residential settings were reported to the Department for further attention. These findings included lack of cleanliness, furniture that was damaged and should be replaced or the absence of any personalization in the individual's bedroom or the house as a whole.

Opportunities for community activities were offered consistently to 78% of the individuals reviewed. Attendance at a church, synagogue or mosque was documented for 81% of the men and women in the sample. Most individuals went on community excursions with their housemates so it was difficult to gauge the extent of interaction with non-disabled people.

All individuals had annual physical examinations and the majority of the Primary Care Physicians' recommendations were implemented in a timely manner.

However, as illustrated by the data documented above, there were significant gaps in the provision of health care. The failure to meet professional standards in both nursing care and the implementation of health care interventions led to the finding that 35% of the individuals in the sample did not have their serious physical health care needs met as expected.

- For example, the Department was notified that there were serious questions regarding the oversight of the nutritional needs of one gentleman who was experiencing significant weight loss.

It has been agreed that the Independent Reviewer will meet with Department staff to discuss the findings from these reviews and to ascertain what remedial actions have been or will be taken to address inadequate or inappropriate supports for each individual.

The third group of individuals to be reviewed was identified as having behavioral concerns that affected their health, safety or ability to participate in age appropriate activities.

As referenced above, four of the individuals in this group live in community-based residential settings. They were placed in the earlier years of the Settlement Agreement. Each was known to have challenging behavior(s). As a result, a doctoral level Board Certified Behavior Analyst completed their reviews. The purpose of his review was to determine whether appropriate behavioral supports were in place and whether there were positive outcomes for the individual and the residential provider.

Two hospitalized individuals were also reviewed for this Supplemental Report. They are included on the list of dually diagnosed individuals currently hospitalized at East Central Regional Hospital. The Independent Reviewer's consultant had previously reviewed each of these men; an update on placement plans was again the focus of the reviews. At this time, neither individual has a definite plan for release from the hospital although, reportedly, placement planning is in progress. Narrative reports on the circumstances experienced by both men have been provided to the Parties.

The list of individuals with a dual diagnosis (MH/DD) who are hospitalized at East Central Regional Hospital remains a focus of the Independent Reviewer's work. Updated information has been requested in order to provide a more detailed description of these individuals in the next Annual Report. [11]

The findings related to Behavioral Support Plans included:

- There was not a current Behavior Support Plan in place was for three of the five individuals (60%) who required one to be developed.

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[11] The list most recently obtained from the Department is dated October 13, 2015. There are twenty-one individuals included on that list, including the two men reviewed for this Report. However, two individuals since have been discharged to community placements and plans are underway for nine individuals, including the two men referenced above. The length of stay in some instances continues to be of concern.

- The behavioral planning consistently lacked updated Functional Behavioral Assessments and other key sources of information that are important to the development of effective interventions.

The Independent Reviewer will request that the Transition Fidelity Committee meet with her consultant in order to discuss his findings and his recommendations. His recommendations include:

- A Board Certified Behavior Analyst (BCBA) should conduct the development, training and supervision of behavioral programming for the individuals who require it. Responsibilities of the BCBA at the program agency level should include annual completion or update, at a minimum, of a Functional Behavioral Assessment and, subsequently, a Positive Behavior Support Plan.

- Residential staff would benefit from ongoing training by a Board Certified Behavior Analyst.

- Individuals and/or guardians should be included in the development of the Behavior Support Plan. Informed consent requires that they fully understand the intent, substance and consequences of any behavioral intervention.

In summary, as in past Reports, the individual reviews demonstrate that the foundational requirements for community integration are present. Group homes are located in typical neighborhoods; transportation is available; shopping and other resources are convenient; religious activities are accessible to many of the reviewed individuals. The extent to which the individual exercises choice or interacts with non-disabled peers is less certain.

The Pioneer Project's strengthened approach to planning the transition from state hospital to the community remains notable. Ongoing attention to post-transition implementation of the Individual Support Plan remains essential to ensure that the recommended supports are indeed present. For example, adequate supervision by a Registered Nurse was not evident, at the times of the site visits, in the first residence established under the auspices of the Pioneer Project.

Finally, as documented in particular by the twenty-three previously placed individuals and the individuals requiring behavioral supports, there continues to be evidence of insufficient clinical supports and less than adequate implementation of individualized programmatic interventions. These systemic weaknesses have been the subject of repeated discussions. As a result, specific provisions in the Extension to the Settlement Agreement, such as those focused on the implementation of community-based clinical interventions and oversight, enhanced support coordination, the monitoring of transitions and provider recruitment, will be critical

to strengthening the current system of community supports for individuals with a developmental disability.

It is recommended that the Independent Reviewer and Department staff review each of the individual reports prepared by her consultants in order to identify systemic strengths and weaknesses. The findings from this collaborative discussion should be presented at the next Parties' meeting as part of a baseline assessment for the implementation of the terms of the Extension to the Settlement Agreement.

It is also recommended that the Independent Reviewer and the Department conduct joint monitoring visits to a representative random sample of the thirty-three individuals reviewed for this report to determine their current status. The Parties should discuss the results of these site visits.

CONCLUDING COMMENTS

The recent approval of the Extension to the Settlement Agreement provides a valuable opportunity to implement renewed and revised approaches for the continuing development and implementation of community-based systems of support for people with serious mental illness or a developmental disability.

Hopefully, the information gathered for this Supplemental Report will be useful as this next stage of the Settlement Agreement begins to move forward with enhanced collaboration and energy.

_____/s/_____

Elizabeth Jones, Independent Reviewer

June 20, 2016

ATTACHMENT ONE
Review of Community Access for Forensic Individuals

Patrick J. Canavan, Psy.D
September 17, 2015

NOTE

On February 29, 2016, a meeting was held with the leadership staff of the Department of Behavioral Health and Developmental Disabilities (DBHDD) to discuss the findings of this Report.

The Department expressed two concerns with the Report's findings.

First, the Department was concerned that there was inadequate recognition of the changes being made in its policies regarding the discharge planning and transition processes for forensic individuals. In order to address this concern, the Department was invited to submit additional descriptive information or clarification.

In addition, the Department disagreed with the characterization of its Community Integration Homes as "institutional." Following the meeting, a site visit was made to one of these residences in the company of Department staff. The description of the residence was not revised because, in the opinion of the Independent Reviewer, there were institution-like qualities about the physical environment. For example, there was a locked medication cabinet in the hallway and a fire extinguisher hanging on the wall by the front door. In addition, although the adult men living in the house shared bedrooms, and thereby lacked privacy, because of limited space, there were staff offices on the more spacious lower floor.

Despite the above-referenced characterization, Dr. Canavan and the Independent Reviewer agree that a Community Integration Home can provide essential supports as men and women with a forensic history, who may require this structure, transition into more independent residential settings.

REPORT OF THE REVIEW OF COMMUNITY ACCESS FOR GEORGIA DBHDD FORENSIC INDIVIDUALS

PURPOSE:

This independent review was conducted on behalf of the Independent Reviewer in US v. Georgia. The evaluation reviews the adequacy of community supports available for individuals who are currently hospitalized as Incompetent to Stand Trial and Civilly Committed (IST/CC) or Not Guilty By Reason of Insanity (NGRI). Statistics provided by the Department of Behavioral Health and Developmental Disabilities (DBHDD) indicate the scope of this issue. There were about 630 forensic status individuals in state regional hospital beds; 203 of these forensic status individuals were committed by the Court as IST/CC. The question can be stated this way: "Is there reasonable access to community supports for forensic status individuals who are ready to be transitioned into the community?"

Implicit in the question of reasonable access to community supports is the quality and timeliness of important clinical work that underpins the discharge process. As such, a high quality Transition Planning framework organizes the clinical activity of the Recovery Planning Team (RPT). The framework is built on an Individual Recovery Plan (IRP), a Risk Assessment, a thorough understanding of applicable legal standards, knowledge of and availability of community supports, such as housing options, treatment services and other supports. This evaluation reviewed each of these aspects of a quality Transition Planning framework in the State of Georgia's public behavioral health system. Finally, this review includes recommendations for DBHDD to consider regarding the issues raised.

METHOD:

The present review was conducted through interviews of individuals in care, clinicians and an administrator at regional psychiatric hospitals, program managers at DBHDD, record review, policy review, tours of the hospitals and two residential placement options. In each instance, DBHDD senior leadership, including the Settlement Agreement Director and the Forensic Program Clinical Director, accompanied this writer. In addition, this writer met with advocates, public defenders, and outpatient providers.

This writer toured four DBHDD State Psychiatric Hospitals over three visits. The hospitals visited include Georgia Regional Hospital in Atlanta, East Central Regional Hospital in Augusta, the Cook Building at Central State Hospital and Georgia Regional Hospital in Savannah. During each hospital visit, facility leadership, typically senior administrators and senior clinicians, were met, and clinical managers were interviewed. In addition, a typical tour included meeting an individual in care who was subject to IST/CC, review of their record, and discussion with members of their RPT.

This writer separately toured three residential settings of various types, including a large single-room occupancy facility for individuals who have contact with the Court or were recently released from jail. During these visits, the writer met with the individual, their house staff and, in one case, their advocates. This writer also reviewed treatment summaries and advocates' statements regarding the individual's status and treatment course.

Georgia law and DBHDD policies pertaining to the IST/CC legal status, transition planning, IRP process, risk assessment, and the ADA Planning List process were reviewed. Several flow charts regarding transition planning were considered. This writer spoke with the Independent Reviewer's consultant for housing on matters related to appropriate housing for forensic status individuals.

FINDINGS:

1. The transition planning process for forensic individuals is fragmented, difficult to navigate for the individual, the RPT, supportive family members and friends, and the Court.

There are several important parts to Transition Planning that guide the process of recovery inside and beyond the hospital setting.

Ideally, transition planning starts immediately upon admission. The major considerations for the Recovery Planning Team (RPT) should be "what are the symptom reduction, skill building and supports necessary for this individual to be successful in the community." The specific concerns of the individual guide the RPT as they create a recovery plan to address these issues. This document, called the Individual Recovery Plan (IRP) in the Georgia system, includes several parts that answer these major considerations. The overall case formulation includes: pertinent history, predisposing factors, precipitating factors, perpetuating factors, previous treatments and response and, finally, present status. There is also a section of the IRP called "Discharge Process," where the team considers the reason for admission, discharge criteria for the anticipated placement, a discharge plan and discharge barriers, and a projected target date for achieving goals and objectives.

What is first notable about the Transition Planning process is its complexity. The State has at least three policies that define the discharge planning process for IST/CC and NGRI individuals. There is another policy that is used when an individual, who was forensic status, is no longer forensic because their charges were dropped or when they are being recommended for discharge and the RPT encounters significant barriers to the discharge.
Within the various policies given, there are multiple steps, each with their own process, which illustrates the complexity of the process. For instance, in the policy relating to individuals who are no longer forensic status because their charges were

dropped, when defining roles, there are eight major individuals or groups, and in one group, there are at least five members. There are five key elements of a support system and nine guidelines for understanding transition planning principles. The consideration of the central question of discharge: "What are the symptom reduction, skill building and supports necessary for success in the community?" can easily be lost.

To their credit, DBHDD leaders acknowledge that the transition process is complex and does not work as well for forensic individuals, especially given the role of the Court in actually deciding to discharge. The Department plans to clarify staff responsibilities for discharge planning and they have funded Forensic Community Coordinator positions to address geographic issues that may hamper timely discharge. Most significantly, they have agreed to develop a specific policy regarding forensic discharge planning and process.

The challenge of forensic discharge is that the ultimate decision to proceed with discharge lies with the Court. As such, the Court sets the dates for hearings, which triggers clinical assessments and planning by the RPT. This interface between the Court and the hospital staff must be carefully choreographed. There is currently fragmentation in the process and DBHDD clinicians may not have readily available, timely and useful data, including important administrative issues (schedules of next court date, schedule of important meeting and report production ahead of the court date, focused attention to ongoing progress of the individual). DBHDD states that they have a system in place to record and provide notification of dates for RPT meetings, annual reviews and required court reports. However, in one interview, a manager indicated that such information database was recently created, but was unable to produce the database when requested.

2. The Individual Recovery Plan (IRP) does not focus the various members on the progress that the individual has made to address problems or to ameliorate risk, nor does it properly focus the team on what interventions and supports should be added, so that Transition Planning moves forward, or is possible at all.

Review of the IRPs for several individuals shows IRPs that are long, repetitive, lack focus, and do not prioritize current status of the individual or progress since the previous IRP. Several IRPs appeared to significantly duplicate large portions of prior IRPs, without analysis of progress or new issues to be addressed. The IRPs do not consistently show creative interventions that could help the individual address concerns, so that the individual can then progress in measurable and meaningful ways.

-One individual interviewed has an IRP, in which four of five "discharge criteria" to an "unidentified group home" relate to dangerousness, violence, coping skills when under stress. However, this individual has made only occasional verbal

threats and the last one was six months prior. Yet not one intervention in the IRP is focused on mitigating these risks.

-An individual who is IST/CC status, and has a significant trauma history, is not being treated for trauma. There is no mention of trauma in her IRP goals, objectives and interventions. For instance, while she has a goal that addresses personal hygiene, and the team described to this writer that showering is a particularly difficult because of past trauma, addressing this issue is not contemplated in the IRP.

-An advocate mentioned that the creativity of the RPTs could be harnessed in a different way. Beyond consideration of barriers to discharge, it would be an interesting exercise for RPTs to consider which treatment goals actually would be better addressed in the community rather than the hospital. This movement towards community-focus in the imagination of the treating professionals would align more closely with the views of the individuals in their care: living life in the community.

The format of the IRP document itself is extremely complex, with many redundant parts, often repeating information from history, without clearly tying this information to current concerns or progress. As such, clinicians report being obliged to create rather formulaic statements that may or may not have bearing on the most current functioning of the individual. This focus on the document, rather than on the person, whom the document serves, does not aid the clinical process and, in fact, may stifle creative activity between the individual and the team. The IRP Manual also complicates accurate planning, as it does not list all "Barriers to discharge" definitions, but clinicians are limited to only those in the manual, which may not fully explain the barriers.

The IRP document is partially codified in the electronic medical record. Staff reported that this complicates efforts to revise the IRP into a more clinically useful and person-centered document. And since the entire record is not electronic, staff must go from paper charts to the electronic record for even simple data entry, let alone complicated fact-based treatment planning.

In response to these findings, DBHDD leadership stated that the current structure of the IRP is cumbersome and often thwarts recovery teams in their focus on an individual's primary recovery goals and tracking their progress. They should be commended for piloting a revised IRP at the Savannah Hospital. Once evaluated, it would be important for the Department to train RPT members, individuals in care, their advocates and family members on the process. Training on the recovery-oriented approach is planned currently and with hope this will improve the quality of the IRPs.

3. The Risk Assessment process and documents are of variable quality and often do not differentiate with specificity under what circumstances an

individual is at higher risk of offending. The needed skill building activities, best designed and taught by the clinical team, are minimized. These skills are necessary to mitigate risk, but when not clearly stated in the Risk Assessment, an opportunity is missed for the individual and team to partner on activities that can make transition possible while reducing risk for the community.

Risk Assessment is an important aspect of evaluating readiness for discharge. A specialty of Psychologists in DBHDD, it is required whenever a person is being considered for higher levels of privilege or release. DBHDD has three critical policies that relate to risk assessment, which positively demonstrates their attention to this issue for both the IST/CC and NGRI status individuals. This writer was unable, however, to find reference to a risk assessment in some RPT recommendations for continuation of civil commitment. The risk assessment should include a thorough history of the person, chronology of charges involving violence, the incident that brought them into the system, an evaluation of their current status, various clinical assessments, strengths, relative weakness, response to treatment and their resources to address stressors. These various data points lead to a Risk Formulation, which can guide treatment interventions and recommendations about civil commitment and discharge.

One aspect of a risk assessment is its careful description of situations under which the person is likely to engage in inappropriate behavior AND ways in which these risks can be mitigated. Careful analysis of factors in particular settings that are of greater risk, while also clearly understanding the personal strengths of the individual and skills that can be taught to help in those situations, is the real treatment opportunity. Risk assessments are most useful when they delineate under which circumstances the risk level increases, and what supports, environmental structure or skill building can mitigate these risks.

The skill building aspect of risk assessment cannot be underestimated. The skills necessary to recognize situations in which risk is more likely and what to do to avoid these situations entirely, or manage them appropriately, are key to treatment of forensic status individuals. When stated as a focus of intervention in the IRP document, this situation identification and coping strategy development becomes a central work of the RPT. Several risk assessments were reviewed; while some were notable for their excellent recitation of the important facts of the case, statement of relative risk in various situations, and factors that could ameliorate risk, others lacked specificity. In some cases, risk assessments used non-specific categories of "low, medium, or high" risk, which do not convey useful information that can be used to manage risk.

The customers of the risk assessment are the individual themselves, the RPT who could use it to focus their interventions and skill building, and decision-makers who decide what level of risk is acceptable in a community, namely government officials and the Court. As such, all three consumers are failed by non-specific risk

assessment. In some cases, the Risk Assessment is not meaningfully integrated into the IRP or the deliberation of the RPT.
It is noted that DBHDD has held numerous Risk Assessment workshops over the last five years, led by qualified professionals. This training is important and must be supported by the Department, giving proper level of resources to ensure that this work is informed by the most current standards of professional advice.

4. RPTs use varying standards when deciding to recommend individuals for either release or ongoing civil commitment. Circular thinking leads to ongoing confinement without real consideration of the person's ability to manage in the community with supports, or with little regard for the Georgia civil commitment statute.

The civil commitment of an individual is ultimately the decision of the Court. DBHDD is the government agency responsible to make recommendations to the Court. Georgia law regarding civil commitment (GA. CODE ANN. SS 37-3-1(9.1) states: "Inpatient" means a person who is mentally ill and:

(A)

(i) Who presents a substantial risk of *imminent* harm to that person or others, as manifested by either *recent* overt acts or *recent* expressed threats of violence which presents a probability of physical injury to that person or other persons; or

(ii) Who is so unable to care for that person's own physical health and safety as to create an *imminently* life-endangering crisis; and

(B) Who is in need of involuntary inpatient treatment. [Emphasis added.]"

As italicized above, the civil commitment statute requires that there be a risk of imminent harm through recent acts or recent threats or imminent life-endangering crisis because of inability to care for oneself. In several IRP documents reviewed, statements were made indicating a recent history of violence that actually occurred months prior. There was no consideration of the option of outpatient civil commitment in the review of various individual's medical records.

RPT members' clinical documentation sometimes refer to a "level system" of privileges when deciding on civil commitment matters, often to indicate that since the individual has not achieved a certain level, they cannot be considered for discharge. This is a misuse of the "STEP" system, which, according to DBHDD forensic leaders, was intended to guide decisions on security while inside the hospital. The STEP system describes parameters of movement within a facility, with requisite staff supervision and location established. However, this level system has been used by some RPTs as a rationale to deny privileges or prohibiting activities necessary for discharge, as if it were a behavioral system. For instance:

-An individual who has a Court Order or approval for an overnight visit at a residential facility as a prerequisite for discharge can be prevented from doing so because he is on a STEP that requires "On campus" only.

-Another individual who was previously approved for privileges started to be "non-adheren(t) with treatment and ongoing psychotic symptoms continue to be barriers to progressing through the forensic step level system, due to her resistance to treatment." Subsequently this restriction is inappropriately used as evidence that a person is not ready for discharge.

Another misunderstanding of the RPT regarding readiness for discharge is the criteria for dangerousness. One team used as evidence that a person was ineligible for release from civil commitment, the fact that they only made progress within the confines of the inpatient unit. The team did not state what the danger was, instead relying solely on their judgment that the person could only safely function in the highly structured inpatient setting. The "imminently life endangering" aspect of the law is ignored under this logic.

DBHDD states that it does consider outpatient commitment in preparing its recommendations to the Court and ensures that the RPTs review this option via a comprehensive review form. Greater training of the RPTs would be beneficial.

5. Staffing: While staffing in the regional hospitals, per se, is not within the scope of the present review, there must be enough qualified clinicians to accomplish timely, effective and high-quality treatment and transition planning. Staff who know the individual and know the community resources that are available are central to the creation and implementation of quality Transition Planning. Clinicians who know the individual, know the transition plan, and can explain it to the Court are not consistently available.

RPT members must have the time to learn about the individual, understand their clinical strengths and when they may be at risk. However, given serious vacancy issues within the hospitals, it would be difficult for DBHDD staff to know all of the individuals in their care and about whom they are planning. And, because of the vacancies, staff report that they cover other units or do the work of the vacant position, in addition to their own regular caseload.

RPTs across the visited four hospitals reported staffing issues that prevented staff who know the individual under consideration from participating in treatment planning. Current staff often participates in IRPs for individuals about whom the clinician has limited knowledge. The result is that important data, learned over the course of hospitalization, may not be integrated into the IRP or the discharge process.

RPT members, on the one hand, have very specific areas of responsibility. For instance, the RPT Facilitator manages the data flow and scheduling of the IRP. The

psychiatrist acts as the overall clinical leader of the team and is responsible for medication management. By policy, the psychiatrist is the RPT Leader. The psychologist is often the one who leads an integrated psychosocial assessment, cognitive assessments, or other focused assessments, and integrates this data into positive behavioral support plans that link strengths to new learning and plans for interventions that can move the individual toward realizing their treatment goals.

The registered nurse on the team manages all aspects of the day-to-day clinical interventions of the milieu, from medication administration to activities of daily living. The role of the social worker is to contemplate what resources and supports are necessary to successfully discharge the individual. In addition, moving the TAP from a written plan to a fully implemented set of activities is a major responsibility of the social worker. The social worker also bears the arduous task of compiling documents necessary for benefits upon discharge, including birth certificates, GA photo identification, and social security cards. The lack of any one of these documents can prolong hospitalization.

These are very important jobs; they require training, skill and knowledge of the person and their options. And these jobs require a reasonable amount of time to learn about an individual and plan their care. As the table below indicates, there are serious staffing issues within the DBHDD hospitals: 38% of all Registered Nursing positions are vacant, while 37% of psychiatrist positions and 26% of psychology positions are vacant across the five hospitals. While DBHDD has made arrangement for contract psychiatrists and other clinicians, these temporary employees may or may not understand the DBHDD system, the law, and the practice in their hospital. They are not a satisfactory replacement for full-time, ongoing staff members.

Table: Staffing by Discipline at DBHDD Hospitals

All Hospitals	Psychiatry	Psychology	Social Work	R. Nurse	Allied Therapy
Total Positions	29.5	34.5	51.5	266	31
Total filled	18.5	25.5	44.5	163	22
Total Vacant	11	9	7	103	9
Percent Vacant	37%	26%	14%	38%	29%
Locums	9	4	2	40	3

The regional hospitals each have a position for Director of Social Work. DHBDD staff indicated that two of the five positions are filled, while one has a part-time former staff member acting in the position and two are vacant. This lack of leadership in such an important role is troubling. It is beyond the scope of the current review to determine the sufficiency of the staffing allocated for inpatient care. However, DBHDD itself decided to fund the listed positions, presumably because it considers these necessary to care and treat individuals with serious and persistent mental illness and/or substance use disorders. The vacancy rates reported make it very

difficult for current staff to do high quality Transition Planning. The Department stated that turnover in forensic psychologists has hindered significant progress in addressing risk assessments, an absolutely vital function of the forensic service.

6. Housing: The number and variety of housing options within DBHDD appears adequate to provide access to housing for those forensic individuals who are ready for discharge from inpatient facilities. However, DBHDD is reluctant to utilize non-forensic specific housing options for those in forensic legal status. There should be an effort to place the person in the most integrated setting possible first, and then in forensic-specific housing thereafter.

While Olmstead requires that disabled persons live in the most integrated community setting and contemporary behavioral health standards prefers scattered site housing, some staff within DBHDD continue to be reluctant to move toward providing housing in the most integrated setting. DBHDD has approximately 641 forensic inpatient beds and usually has a census of 630 persons in these beds, with a waiting list of seventy to seventy-five individuals waiting for beds of a specific type. Thus, the forensic status inpatient population represents a not-insignificant portion of the overall DBHDD inpatient cohort and is obviously an important one to plan for housing upon discharge.

Under the terms of the Settlement Agreement, DBHDD has increased the number of housing slots available to those with serious and persistent mental illness, substance use disorders and/or developmental disabilities. These individuals may be unfamiliar with how to be a tenant so their supports include teaching them routine home skills. Another group may have decision-making deficits that require ongoing support. And a third group may be able to quickly return to their previously high level of independence, after a period of instability due to their behavioral health issue. Finally, there is a small group of people who are long-term stable. They need Rapid Rehousing and could benefit from a one to two year subsidy, but their deficits are transitional and their need for supported housing will likely end. This same range of options should be enthusiastically considered for forensic status individuals.

Using an already funded rental subsidy, paid to the landlord, the Department has procured individual leases, which gives the individual a choice of places to live while giving the landlord financial protections. The Department created "bridge funding," which provides up to $3000 per individual to transition into supported housing. The "bridge funding" pays the housing deposit and first month's rent and can be used to purchase furniture. Already five years into the program, 1623 individuals are already under lease, with about 80-85% remaining in housing for more than one year. Capacity also exists in this program, as there are over 2400 units with subsidies in the Department's portfolio. In addition, the DBHDD has access to HCVs through a DCA HCV Preference Agreement and will soon have access to 811 PRA subsidies.

Included in those who have DBHDD subsidized housing are some individuals leaving the Corrections system, including local and county jails, and state detention facilities. These individuals have behavioral health and/or developmental disabilities and legal system involvement. In most ways, they are remarkably similar to those forensic individuals who have been found IST/CC or NGRI. It is important that those in inpatient forensic status be offered these same housing supports.

Because of the Department's specific safety concerns or court orders that require more intensive supervision, there is a perception that there are limited housing options for forensic status individuals. There is a usual step-down style schema for the IST/CC and NGRI status individuals. Often the first housing option considered is the Community Integration Home (CIH). CIH was created for those individuals who no longer require inpatient care, but whose serious crime or long hospital course indicate risk to the community if not in a 24 hour per day, 7 day per week supervised environment. There are fifty-nine CIH beds and a waiting list from ten to thirty individuals at any given time. Advocates indicate that it can take up to two years, once a person was deemed eligible for this type of housing, for a bed to become available. Advocates criticize these facilities for being too institutional, too correctional, without providing enough freedom for the individual to reintegrate into life outside the Hospital.

DBHDD provided summary data indicating that 74% of individuals in forensic legal status are discharged to non-CIH settings. The 26% that go to the CIH frequently do so because the Court often requires a 24-hour supervised setting. In addition, only 2% of hospital readmissions are for individuals discharged to CIH, compared with 10% of those discharged elsewhere, which indicates a stabilizing transition is provided. The Department also acknowledges that the waiting list for a CIH bed is unreasonably long, and the production of the forty-eight new supported beds in apartments (see below) will improve access.

During an interview of an IST/CC individual with a Savannah treatment team, the individual was praised by the team for his ongoing work with his Positive Behavioral Health Specialist, who was able to help him achieve a treatment goal in the past period. The individual expressed a desire to live in his home county, although he was uncertain of what supports he would need. The team was very reluctant to consider this request, with one clinician stating that the Department "doesn't have any other place he can go," except to a CIH. When the reviewer asked what other housing had been considered, another clinician stated that the individual "can't succeed in a CIH," because he required the structure of the Hospital and 24/7 supervision.

DBHDD has also contracted for supported apartments for forensic status individuals that are run by an outside contractor. These account for an additional fifteen housing slots. In a welcomed move to increase the variety of housing options for

IST/CC and NGRI individuals, just this summer, DBHDD appropriated an additional $2.3M for four contract providers to each provide twelve beds in one or two bedroom apartments. These apartments are intended to serve as "step down" from the larger CIH, or for those deemed appropriate for such housing immediately upon discharge from the Hospital. According to DBHDD staff, the ideal client for these sites are IST/CC or NGRI status individuals who are ready to leave the CIH but are not yet ready to live independently. In these "semi-independent" living arrangements, supports and 24-hour awake on-site staff help the person transition to a new level of independence.

7. There appears to be adequate community supports for individuals with a forensic legal status to support successful discharge but accessing these supports is difficult and not routine.

DBHDD policy states that there are several key elements needed for individuals to achieve a meaningful life in the community; simply stated, these are care, a home, meaningful activities, economic support and meaningful relationships. Care and Services include outpatient treatment, medical care, psychiatric care, medication and case management that create a cohesive system of support.

DBHDD offers two Tiers of community supports: Tier 1 providers include the twenty-three Community Service Boards (CSBs), so called "safety-net" providers who offer traditional outpatient mental health services including psychiatrists, RNs, crisis stabilization programs, children's services and other specialty services. Several CSBs have closed over the past several years and, reportedly, many struggle financially.
Tier 2 providers are those providers that offer one or more specialty services, including Assertive Community Treatment (ACT), residential treatment, and Intensive Family Interventions (IFI). ACT is an evidence-based practice that includes multiple fidelity measures, including a maximum of three days from call to enrollment, up to three times per week interaction, and crisis care. ACT requires a specific team of clinicians, including those in the CSB services, plus peer support, employment specialists and case managers. The ACT team follows the individual no matter what setting they are in, no matter what happens to them. The team also helps with benefits eligibility, case management, medical care, crisis housing and/or temporary housing.

Intensive Case Management (ICM) was created under the Settlement Agreement; it was described to this writer as "Case Management PLUS." Functioning as its own team, ICM includes the usual case management functions, but with small caseloads. Rather than an ACT team, which is difficult to offer with fidelity in rural areas, ICM can be used in rural areas. An area of opportunity that DBHDD should consider is whether the ICM teams are running at full caseloads and whether this resource could be applied to forensically involved individuals to assist in their transition from inpatient to outpatient care.

In interviews at residential facilities visited, staff was concerned with the quality and ongoing stability of Community Service Boards; in one instance, a local CSB went out of business a few years back and the individuals were transferred to other CSBs, which the staff considered to be of lower quality. Provider staff was generally happy with the DBHDD transition coordinators who were helpful in bringing clients to the facility, but they wanted ongoing contact with the coordinators, who withdraw from the process after a short transition period. Residential providers also emphasized that when more complex treatment issues are present, they could use technical assistance on how to address these issues in a way that is acceptable to DBHDD.

8. Risk and liberty interests of individuals under Civil Commitment and NGRI are not properly defined or supported by DBHDD; the Court, who must balance risk and liberty, is not properly informed by the assessment process. The Court is sometimes unaware of the services that DBHDD has available and, therefore, is left in the position of making life-changing decisions without a full picture of what are the risks, the mitigating factors, and the supports that are necessary for successful life in the community for forensic status individuals.

DBHDD includes "legal assistance" as a broad element of support needed for successful transition to the community. A well-functioning public behavioral health system takes seriously the obligation to protect individuals who pose imminent harm to themselves or to others, consistent with the law and their authorities. This obligation must be balanced by the liberty interests of individuals to live in the most integrated settings, with the minimal supervision, some say interference, of others. Properly balancing these sometimes-competing mandates is both the art and the science of forensic mental health professions, and in Georgia, is the source of much debate. Truly addressing risk, and risk-management rather than risk-aversion, is a key to access to community supports for forensic-status individuals in DBHDD.

On the one hand, DBHDD has the structure of a well-defined forensic evaluation and treatment system. Individuals with legal charges and behavioral health and/or developmental disabilities are evaluated, stabilized, treated and moved progressively to lower levels of supervision and greater freedom. Supports necessary for these individuals to transition from intensive levels of care, gradually and thoughtfully, to less intensive levels are generally available. What does not work so well is fidelity to the established structure or, in some cases, rigid application of a misperception of the structure, resulting in the individual remaining for too long in the state hospital. The Department is sensitive to its other client, the Court, and attempts to engage the Court and counsel by providing some training and education on mental health issues and resource availability. At this time, these efforts are not sufficient.

DBHDD clinicians expressed two main ideas when considering the other roles in the forensic arena, the Court and the legal advocates. Several DBHDD clinicians

expressed the belief that the Courts are risk-averse and will not allow discharge planning to proceed, particularly in the case of violent felons, until the original potential sentence has been tolled. The second belief is that the Court prefers 24 hour per day/7 day per week on site supervision of IST/CC and NGRI individuals, in most cases. Interviews with individuals who represent the Court and the advocate community offer a more nuanced view.

The "check" that keeps the compulsory treatment system in "balance" is an active and vigorous defense bar that asserts the liberty interests of individuals in the system. Georgia recently was the center of the national movement to enforce the Olmstead Act, so certainly there are advocates who can move forcefully to get attention on liberty matters. The advocates who were interviewed for this review consistently listed three issues that they believe require a change on the part of DBHDD:

DBHDD does not put forward reasonable discharge plans that balance risk with proper supports;

DBHDD discharge plans are not individualized, in that persons are fit into a trajectory from State Hospital to CIH to supported housing, without real consideration of what is the most integrated setting for the particular individual; and

DBHDD does not provide information on treatment and housing resources that are available, which could allow for greater advocacy by counsel.

In the position of having to "decide," the Court is the ultimate balancer of risk and liberty interests. Judges interviewed by the Independent Reviewer expressed similar ideas on what is needed from DBHDD so that discharge is possible:

Well-crafted discharge plans that are specific enough to allow the Court to know important information such as the staff supervision levels, what occurs when respite care is needed, who acts as the backup for the individual, if a problem arises;

A qualified clinician who knows the individual, who can explain the plan in specific detail, and who endorse the plan; and

Training on what DBHDD services are available and the appropriate expectations of a service is needed. For example, helping judges become familiar with basic information about ACT teams, the frequency of their interaction with the individual (daily if necessary), and the standards that various interventions require would be helpful for the Court.

9. Organizational support structure within DBHDD for Transitions:
The DBHDD senior staff and managers with whom this writer met were well-qualified and capable leaders. They clearly understand their work and are committed to achieving the best possible outcomes for those in their care, even given the criticisms previously noted. The current system of transition

planning does not sufficiently authorize and resource these leaders to implement and effect appropriate transition planning for inpatient individuals in a forensic legal status.

While the focus of this report was not on the organizational design of DBHDD, the organizational structure within the Department is a limiting factor for timely and efficient transitions from one level of care to another and from one region of the State to another. DBHDD has a regional structure that focuses on outpatient services and housing based on regions of the state, while Hospitals have become more specialized by population, with long term IST/CC individuals often moved to Savannah. An organizational structural disconnect (regional approach for community, treatment similarity for inpatient) may result in suboptimal transitions. Often, transitions occur when individuals with serious and persistent mental illness, substance abuse issues, and/or developmental disabilities need care provision that is even more supportive than at other points in their recovery.

For example, an individual from northern Georgia may be transferred to Savannah for inpatient treatment when they are expected to remain IST/CC for a longer period. While the RPT in Savannah knows the individual well and becomes expert in their strengths, risks, treatment needs and goals, the Region is responsible for the actual placement of the individual in their home region upon discharge. A case manager from northern Georgia is assigned to develop the outpatient plan, including housing, employment and treatment services. This person has the benefit of the IRP document, but as discussed above, the IRP currently lacks strong Transition Planning aspects.

It would be useful for the Department to consider a review of the various transitions made by an individual in forensic legal status. There is important work to be done before each transition to determine: Is the individual's choice of housing, supports and location considered? Are the major clinical issues identified by those who have worked with the person during their hospitalization supported by services in the new setting? Are risks and risk mitigation strategies clearly known and addressed in the new setting? Who is the responsible and empowered staff at each step in the transition process?

Recommendations:

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

2. DBHDD should consider ways to streamline this process so that once a forensic status individual is recommended for discharge, movement toward transition begins quickly. A new comprehensive policy may be the most efficient way to implement this.

3. There does not appear to be a similar formal mechanism for leadership review of individuals who are not recommended for ending civil commitment. There should be at least an annual review of all IST/CC individuals regardless of the team's opinion about their ongoing civil commitment status and readiness for discharge. In addition, outpatient civil commitment is an option that does not appear to be routinely considered as an option, at least as recorded in the medical record. This may be an option that, if applied sparingly and only when appropriate, could result in an end of unnecessary inpatient civil commitment.

4. DBHDD should ensure that the existing database that tracks all court, treatment meetings and assessments is known to and used by clinical managers. This data system is needed so that important forensic deadlines are stated, evaluations are completed timely and clinical decisions can be thoughtfully prepared.

5. The IRP document and process, either in written form or electronic record, must be simplified so that clinical teams are relieved of voluminous, repetitive documentation requirements, and so the process focuses on current functioning, progress, and interventions needed to reduce symptoms, improve skills and offer supports that lead to transition. The pilot that is underway should be evaluated, and if deemed responsive to the criteria set out in this review, implemented quickly throughout DBHDD. The electronic record should likewise be simultaneously improved for ease of use.

6. Risk Assessments must be reviewed for clinical sufficiency. Specificity about the current risk factors, and what supports, environment, and skills can be used to mitigate their likelihood, should be standard across all risk assessments. The ongoing training activities are applauded; they should become routine and frequent.

7. RPTs should be trained on the standards for civil commitment and, specifically, on the meaning of "imminent harm." Also, retraining on the "STEP" systems' proper use as a guide for in hospital movement, rather than as a behavioral plan, is important.

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

9. DBHDD should immediately state that all individuals who are ready for discharge should be in the most integrated setting. The Department must, through policy and practice, demonstrate that housing choices are individualized, taking into consideration all the important domains that reduce risk and increase the likelihood of success.

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

11. DBHDD should determine whether Intensive Case Management or other community supports could be used so that forensic status individuals can be housed in the most integrated setting.

12. DBHDD should regularly offer to train the Court, the defense bar, prosecutors and providers regarding behavioral health issues and forensic status. Familiarity and ongoing conversation is needed among all parties. DBHDD is commended for the seminars they have offered to the ten District Courts on the invitation of the Court, but this ongoing activity must be properly resourced. For instance, details about what levels of supervision, frequency of face-to-face contact, and types of services available are important for the Court to know, in order to be reassured that services outlined in the Transition Plan are appropriate and sufficient to address concerns about, and properly manage, risk.

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