SUPPLEMENTAL REPORT OF THE INDEPENDENT REVIEWER

In the Matter Of

<u>United States v. Georgia</u>

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

Independent Review: Supported Housing

December 18, 2018

Independent Reviewer's Introductory Note

This report prepared by the Independent Reviewer's subject matter consultant, Martha Knisley, was planned originally to be included in the Report of the Independent Reviewer, filed with the Court on September 19, 2018. However, additional fact-finding became necessary in order to sort through conflicting information about the capacity of the State's system to meet specific obligations of the Settlement Agreement (SA) and its Extension (EA) regarding Supported Housing. The additional fact-finding now has been completed and is discussed in the Addendum.

Overall, the primary conclusion of this supplemental report is that the State has failed to provide Supported Housing to individuals in the Target Population with Serious and Persistent Mental Illness (SPMI) who need such support. Information in the report itself reveals that the State has failed to conduct sufficient outreach to all of the sub-groups within the Target Population definition, especially those who are frequently seen in hospital Emergency Rooms (ERs) and those in jails and prisons. In fact, the State is still developing its processes to assess housing needs for individuals in State Psychiatric Hospitals and in ERs. This results in under-counting the numbers of individuals who may need such support; especially members of these sub-groups, thereby denying or preventing individuals who may need and benefit from Supported Housing from receiving it.

The SA and its EA require that the State have the capacity to provide Supported Housing to any of the approximately 9,000 individuals in the Target Population with SPMI who need such support. The State, at best, only has the current capacity to provide Supported Housing to slightly over 3,100 individuals and the potential capacity to provide Supported Housing to approximately 4,700 individuals. The State's potential capacity includes some housing slots that only will be available on turnover, subsidies or units that also can be utilized by individuals with other disabilities or with other eligibility criteria or subsidies that can become available only if there are sufficient referrals. Potential subsidies are only one part of the capacity equation. Equally important is the need for adequate safe and affordable housing with property owners willing to rent to eligible individuals in this income group. Undoubtedly, the State's potential capacity, based on available subsidies, is diminished without adequate housing stock.

The State may assert that the need for Supported Housing is less than 9,000. However, if outreach and the processes to assess need are not yet fully developed and, in fact, are flawed, the need for less capacity cannot be asserted.

On November 19, 2018, the State reported that, during the period from October 2017 through June 30, 2018, there were 512 referrals made for housing through the Unified Referral Process. Of these referrals, 255 were for individuals who were homeless; only 5 were for individuals who were released from jail or prison; and only 22 were inpatients in a psychiatric hospital.

Furthermore, it is of considerable concern that the utilization of the Georgia Housing Voucher Program (GHVP) has declined in each month from January to July 2018. (There were 2,628 vouchers utilized in January and 2,390 utilized in July.) As of the most recent information

request, on November 1, 2018, there were 2,224 members of the Target Population receiving a GHVP voucher.

The successful Housing First model relies on the premise that individuals will be willing to accept supports once they are stably housed, although the acceptance of mental health services is not a prerequisite for a housing voucher or subsidy. During the preparation of the Addendum for this report, it was documented by the State that 652 individuals with a Georgia Housing Voucher (GHV), approximately 29% of the total, had declined mental health services. Regrettably, unlike the standard practice in other states, Georgia did not conduct any Health and Wellness checks to determine whether the individual had changed his/her mind or whether they needed any additional assistance. Although Health and Wellness checks were initiated in July 2018 for new recipients of the GHV, the group of 652 individuals will not be contacted until their lease is next renewed.

It has been demonstrated both nationally and in Georgia that Supported Housing is a highly effective strategy to help individuals with SPMI achieve recovery, greater independence and meaningful participation in integrated community activities. When Supported Housing is provided, psychiatric hospitalizations are reduced in frequency and length. The failure to maximize the resources allocated for the Court-mandated obligations related to Supported Housing has serious consequences for vulnerable individuals with SPMI and for the mental health system as a whole.

The Parties were given the opportunity to review this report in its draft form. All comments were considered carefully and changes made, as deemed appropriate.

Submitted By: Elizabeth Jones, Independent Reviewer

Independent Review: Supported Housing

Martha Knisley[1]

Purpose

The purpose of this report is to assess the State's compliance with the Settlement Agreement Provisions related to Supported Housing and Bridge Funding.

The "Target Population" for Supported Housing is defined, in Provision 30, to include the approximately 9,000 individuals with SPMI who are currently being served in State Hospitals, who are frequently readmitted to the State Hospitals, who are frequently seen in emergency rooms, who are chronically homeless, and/or who are being released from jails or prisons. The Target Population also includes individuals with SPMI and forensic status in the care of DBHDD in the State Hospitals, if the relevant court finds that community services are appropriate, and individuals with SPMI and a co-occurring condition, such as substance abuse disorders or traumatic brain injuries.

Under the terms of the Settlement Agreement, by June 30, 2018, the State is required to have the capacity to provide Supported Housing to any of the individuals in the Target Population who have a need for such support.

In Provision 36, Supported Housing is defined as "assistance, including psychosocial supports, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD."

Bridge Funding and the Georgia Housing Voucher Program (GHVP) are defined, in Provision 31, as specific types of housing assistance that may include the provision of security deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and receive federal disability or other supplemental income.

Methodology

The methodology for this year's review follows the methodology used in previous years. It also references year-to-year comparisons on the Georgia Housing Voucher and Bridge Funding Program Summary to achieve accurate comparisons of progress from year to year. The methodology included:

[1] This report was prepared in August 2018 based on data and information provided by the State for FY2018. The Addendum was prepared in November 2018 following further discussion with the Parties.

1. A review of representations of progress and compliance on each obligation made by senior leadership of the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Affairs (DCA) in meetings that included the Independent Reviewer and/or her consultants;
2. A review of materials provided by the two above referenced agencies to written questions submitted by this writer and by the Independent Reviewer;
3. Interviews with the Amici, numerous community-based mental health agencies and other key stakeholders engaged in developing Supported Housing and/or in providing services to the Target Population;
4. Research on standard practice, Target Population prevalence and needs; and
5. Information on resources that are and could be available to Georgia for making Supported Housing available to the Target Population in order to meet the capacity requirements of the Settlement Agreement.

Findings

A. Systemic Strengths

The strength of Georgia's implementation of the Settlement Agreement obligations pertaining to Supported Housing is the continued availability of resources in the Georgia Housing Voucher Program (GHVP) and in Bridge Funding for recipients of Supported Housing. The State has relied on an annual appropriation as well as funds from turnover (funding for vouchers that becomes available when someone vacates their unit). The State has had the opportunity to use other subsidies and vouchers for new referrals.

DCA and DBHDD have formed a working partnership vital to maximizing and expanding resources for individuals in the Target Population. DBHDD Regional Office staff, selected service providers and Community Service Boards (CSBs) have demonstrated a willingness to conduct housing outreach and make housing referrals.

During the course of the Agreement, DCA secured a Housing Choice Voucher (HCV) preference for individuals in the Target Population for their Public Housing Authority "balance of state" rental assistance program. DCA also sought HUD 811 funds for program rental assistance (PRA) for individuals with disabilities, including individuals in the Target Population in 2012 and sought HUD Mainstream Voucher rental assistance resources through a HUD competition in 2018[2]. DBHDD sought an agreement with the Atlanta Housing Authority in 2015 that became effective in 2017.

B. Implementation of the Provisions' Requirements

Below is a listing of each of the Supported Housing Provisions, with the status of implementation as of June 30, 2018. (Data provided for work completed after that date could not be confirmed in time for this report.) :

[2] In September 2018, it was announced that Georgia was awarded 135 vouchers; of these, 99 are disability-specific.

1. Bridge Funding and Georgia Housing Voucher Program

Bridge Funding and the Georgia Housing Voucher Program (GHVP) are specific types of housing assistance that may include the provision of security deposits, household necessities, living expenses, and other supports during the time needed for a person to become eligible and receive federal disability or other supplemental income. The Extension Agreement established numerical obligations to be met by June 30, 2016 and June 30, 2017.

Discussion: The State continues to fund and administer the GHVP, including allocating Bridge Funding. State data illustrate that the program is no longer in a growth mode.

At the end of June 2018, there were 2,405 individuals living in Supported Housing with a Georgia Housing Voucher (GHV).

Figure 1: Georgia Housing Voucher Program Performance[3]

GHVP Assistance	6/30/15	6/30/16	6/30/17	6/30/18
Individuals with a Notice to Proceed	236	321	360	469
Individuals with a signed lease	1,623	1,924	2,432	2,405

Sixteen hundred and one individuals (35%) have separated from housing over the life of the program and 170 of those separated (11%) have returned to housing.

If the needs assessment process is operating as required by this Settlement Agreement, turnover alone cannot meet demand. This year, DBHDD transitioned some administrative functions, including payment to landlords, to DCA. There were the initial transition challenges associated with getting landlords to sign new agreements and ensuring timely payment but current information suggests this problem has been remedied. This did discourage some landlords, which, in turn, created problems with agency providers. Despite some owners being reported as leaving the program, DBHDD does not report a decrease in the number of properties actively leasing to individuals with a GHVP. Reportedly, from various sources, housing markets in urban areas are getting tighter, which typically means property owners can increase rents to attract a different segment of the rental market.

Bridge Funding was provided to 1461 participants in FY 2018, a 25% increase over FY 2017 and well above the requirement in the Extension Agreement of "an additional 300 individuals in the Target Population by June 30, 2017." However, the total expenditure for Bridge Funding was $2,150,600, approximately 30% less than FY 2016 and 40% lower than FY 2017. The average "bridge" cost per participant is $1,211, a reduction of 50% from the previous year. Spending patterns remained the same, with lower amounts attributed to each category. Furnishings and first and second month rent account for 24% of this cost and provider fees account for 16% of

[3] These data are provided in the Georgia Housing Voucher and Bridge Funding Program Summary produced annually by DBHDD. However, a list of all individuals with signed leases as of July 5, 2018, provided by DBHDD, shows that 2390 individuals receive this funding. As noted above, in November 2018, there are 2224 individuals with a GHV.

the expenditures. The remaining funds were allocated for household items, food, transportation, medication, moving expenses, utility and security deposits and other expenses.

The total FY 2018 expenditure for the GHVP and the Bridge Funding combined was approximately $19.7 million, a 1% increase over FY 2017. The 1% increase appears to be attributable to a carry-forward of funds. For planning purposes, DBHDD now combines Bridge Funding and the GHVP funding categories into one category to maximize flexibility. This is important going forward, especially as the program expands with more individuals accessing federally subsidized housing vouchers such as the Housing Choice Vouchers (HCV), Veterans Housing Assistance (VASH) and HUD 811 rental assistance (PRA). By combining line items, DBHDD has the flexibility to allocate more funding for Bridge resources for individuals moving into units with other subsidies.

Recommended Finding Regarding Compliance: It is very clear that the State has not yet achieved the capacity to serve the approximately 9,000 people in the Target Population who need Supported Housing. Current capacity, even with generous assumptions, is approximately half of the 9,000 figure set out in both the SA and EA. A finding of noncompliance is recommended for this obligation (SA III.B.2.c.ii.(A) and EA 30). A finding of substantial compliance is recommended for the narrower obligations regarding Georgia Housing Vouchers and Bridge Funding, required by EA 31 through 35.

2. Supported Housing Assistance

Supported Housing is assistance, including psychosocial supports, provided to persons with SPMI to assist them in attaining and maintaining safe and affordable housing and support their integration into the community. Supported Housing includes integrated permanent housing with tenancy rights, linked with flexible community-based services that are available to consumers when they need them, but are not mandated as a condition of tenancy. Under this Agreement, in Provision 36, Supported Housing is available to anyone in the Target Population, even if he or she is not receiving services through DBHDD.

Discussion: This requirement has a number of sub-parts. First, the Target Population is to be assisted to attain safe and affordable housing. Overall, individuals are getting this assistance, although there are a number of key informants who are concerned with the amount of time and steps that are required for individuals to meet eligibility requirements and to access housing. These perceived obstacles might very well lead individuals to drop out, to disappear and/or to seek shelter in unsuitable housing.

DBHDD has not successfully provided assistance to individuals in the Target Population who are being discharged from institutions or who are frequently seen in Emergency Rooms who need support to access Supported Housing. DBHDD does not employ all the necessary strategies[4] that can be applied for this purpose with this Target Population. For example, individuals often get released from prison or jail with few resources and no place to live or individuals return

[4] It is standard practice today to use *critical time intervention* or other strategies to provide intensive assistance to individuals during transition from jails, prisons, homelessness and hospital discharge.

frequently to Emergency Rooms when they are homeless or unstably housed. Three years ago, there was an attempt to provide such assistance in Atlanta with PATH taking referrals of individuals who were homeless and hospitalized at Georgia Regional Hospital Atlanta (GRHA). As discussed in previous reports, this process only worked for approximately 10% of the individuals referred because the steps needed to ensure this was done were not added into the process. Other states have shown remarkable success when the process was fully understood and carried out; transitional or bridge support is considered standard practice today. For example, a recent review of a similar program in North Carolina demonstrated a success rate of 94% for individuals accessing permanent housing over a two-year period. DBHDD has reported that it is making plans to provide such assistance. However, these efforts are in the early stages and have not progressed sufficiently for the purposes of the present review.

Additionally, this obligation requires support for individuals to be integrated into their community. Community integration can be made more possible with individuals having opportunities to access typical community activities and generic services, amenities, personal relationships and natural supports. In attempting to assist individuals with community integration, providers are often challenged in finding housing in convenient locations with nearby services and supports but providing Supported Housing is key to these opportunities being more accessible.

Second, Supported Housing includes integrated permanent housing with tenancy rights. Neither the Independent Reviewer nor this writer has received any information to suggest that individual or tenancy rights are being violated.

Third, the State is challenged with linkage to flexible services. Based on DBHDD's most recent report, approximately 28% (684/2405) of the individuals living in Supported Housing units were not engaged in services. A review of other states suggests the number is generally in the 10% range. The high number of individuals living in housing but not receiving services may be an indication that staff are either not applying well tested strategies, including assertive outreach techniques and interventions for engaging individuals, and/or staff are not skilled in those techniques. It also could be related to DBHDD not monitoring and holding providers accountable or incentivizing providers for housing stability. Effective linkage requires effective engagement, monitoring and provision of incentives. Reportedly, DBHDD has revised its policy to require a "health and safety check-in" once a month, a widely used method to engage individuals and ensure their safety and wellbeing. This policy was not in effect during the Settlement Agreement period to date and would require monitoring to determine if it is being carried out as a linkage to flexible services.

<u>Recommended Finding Regarding Compliance:</u> A finding of compliance with Provision 36 cannot be recommended because of clear evidence of ineffective linkage and, as discussed further below, because Supported Housing is not yet being made available to anyone in the Target Population.

3. Scattered Site Requirements

Supported Housing includes scattered-site housing as well as apartments clustered in a single building. Under Provisions in both the SA, at III. B.2.c.i. (A), and the EA, at 37, the State shall continue to provide at least 50% of Supported Housing units in scattered-site housing, which requires that no more than 20% of the units in one building, or no more than two units in one building (whichever is greater), may be used to provide Supported Housing.

Discussion:

DBHDD reported that, in FY 2018, 78% of housing was scattered-site (1864/2405), 22% above the minimum standard; this is a 13% decrease from FY 2017 when 2,029 individuals were living in scattered-site housing. A review of a report on locations and on rental payments confirms earlier reports that housing is generally scattered-site. However, it should be noted, there are large disbursements to three different rental companies that raise the question of DBHDD staff and their contractors utilizing these rental properties in excess of this requirement.

During FY 2018, one on-site review, as well as data submitted as of June 26, 2018 by DBHDD, confirmed that there were 34 individuals with housing vouchers living in one congregate site, a building that is well known in the community as a haven for drug dealing and crime. Six of these tenants did not receive services nor had they been contacted to determine whether they wanted/needed supports. DBHDD is advised to ensure that individuals in the Target Population are not placed in an unsafe, poorly maintained environment, either for convenience or because the individual may have difficulty securing a lease due to his/her background.

Recommended Finding Regarding Compliance: The State continues to be in substantial compliance with the scattered-site requirement.

4. DBHDD-DCA Capacity Building Memorandum of Agreement (MOA)

According to Provision 39 of the Extension Agreement, the State shall continue to build capacity to provide Supported Housing by implementing a Memorandum of Agreement between DBHDD and DCA, which includes the following components:

a. a unified referral strategy (including education and outreach to providers, stakeholders, and individuals in the Target Population) regarding housing options at the point of referral;

b. a statewide determination of need for Supported Housing, including developing a tool to assess need, forming an advisory committee to oversee the needs assessment, developing a curriculum to train assessors, training and certifying assessors, and analyzing and reporting statewide data;

c. maximization of the Georgia Housing Voucher Program;

d. housing choice voucher tenant selection preferences (granted by the U.S. Department of Housing and Urban Development);

e. effective utilization of available housing resources (such as Section 811 and public housing authorities); and

f. coordination of available state resources and state agencies.

Discussion: The two Departments continue to work together collaboratively. However, the outcomes of their work to "build capacity" indicate there are weaknesses in their approach and that there has not been enough time and resources made available to achieve the desired outcomes of this Agreement.

As reported in February 2018, the unified referral strategy is not yet fully implemented for "anyone in the Target Population" to have access to the (unified) referral process and then access to housing (3a.). DCA and DBHDD are making a concerted effort to explore other resources beyond the GHVP so that the GHVP can be the last resort for individuals not eligible for other resources. Their performance falls short related both to capacity and to the ability to have reached stakeholders and individuals in the Target Population. (See the Need/Referral section below.)

The statewide determination of need process (3b.) is underway but the determination of need process which is now the gateway into Supported Housing for most individuals is still not available to "anyone" in the Target Population. To be available to "anyone," individuals in all the sub-populations at least would have to have the potential to ask for and/or have someone ask them to complete the survey. This is not yet possible, as described below.

DBHDD recently changed the required focus of the advisory committee to oversee the needs assessment (3b.) by eliminating this role and instead saying it would use the "forum through our scheduled meetings with the Department of Justice and the Amici.[5]" However, based on interviews with advisory committee members, it is unclear as to whether the advisory committee serves this purpose.

Housing Outreach Coordinators (HOCs) have begun completing the tool to assess need in "select" jails and prisons and in emergency rooms. Based on information obtained through interviews with eleven Housing Outreach Coordinators (the twelfth person resigned and did not keep the scheduled interview appointment), they have made attempts primarily by going to the front desk, asking to speak to staff (and often leaving their business card), in a subset of the facilities, asking for meetings and trying to establish contact through other mental health representatives who work closely with law enforcement or with hospital staff. The success to date using these methods is mixed. Housing Outreach Coordinators report not getting any response from some of the facilities. In some situations, they have been able to arrange meetings to discuss benefits of the programs or to be invited to come to the facility to interview someone about to be discharged.

[5] "*Changes in the Supportive Housing Advisory Board.* Memo from the Commissioner's Office: March 13, 2018

These methods of contact are quite laborious and often not fruitful in establishing the level and type of relationship that will result in referrals. Because the HOCs are disconnected from the processes that lead to someone getting housing, it is likely the referrals will decline overtime, if facility personnel do not see rapid results or any results at all.

Eleven of the twelve funded HOC positions were filled by April 2018 and one position was filled in June 2018. Two Housing Outreach Coordinators have already resigned and supervisors were required to fill in. One replacement since has been hired. Finally, and very significantly, the target areas served by these 12 HOCs do not cover the entire state.

Provision 39.c. of the EA requires that the GHVP be maximized. Through a review process developed at DCA, if an individual meets requirements for another funding source for Supported Housing, such as a HCV, HUD Shelter Plus Care (rental assistance for individuals who are homeless), VASH, 811, etc., they are referred to the other program, thus freeing up GHVs for individuals not eligible for the other resources. Even though this is occurring, the process for this review is not automated, requiring an extra review step for staff to determine eligibility. As a result, potential placements are slowed down. To the extent that other funding sources are utilized before approving the use of the GHV, the State has complied with the intent of this provision. However, it must be noted that over 430 GHVs from FY 2018 remain unused at the time of this report so, in that sense, they have not been maximized.

Regarding EA 39.d., the housing choice tenant selection preference approved by the United States Department of Housing and Urban Development (HUD) in 2012 and renewed in 2015 is set to expire at the end of the Settlement Agreement. While this initiative held great promise, the total number of individuals transitioned to the Housing Choice Voucher Program was 319 as of April 2018. (The reporting of this number has been inconsistent over time but, after review of all the data provided by DBHDD for this reviewer, it appears to be the most accurate number.) In 2012, DCA committed to allocating 100 vouchers in FY 2012 and 500 vouchers in each of FY 2013, 2014 and 2015 for persons covered by the Settlement Agreement. DCA obtained approval from HUD on May 3, 2012 to set these specific preferences.

Two years ago, DCA reported that they felt they could transition 1,000 individuals that year given their turnover. This was a reasonable estimate of the annual number based on turnover; it represented a strong commitment from DCA. DCA is not fully responsible for ensuring referrals and using these vacancies. DBHDD has the obligation to work with landlords and property managers with GHVP tenants to get their agreement to make a shift to the HCV program. In the early years of this Agreement, DBHDD would often pay above the HUD payment standard to entice landlords into the program. DCA can only offer payment up to 110% of this standard so landlords refused to make the shift. Recently, a decision was made to offer this type of voucher first, not the GHVP, when possible to take advantage of these resources.

To clarify earlier reporting, DCA has the authority to offer every other voucher available in their “balance of state” HCV program, now covering 149 of 159 counties in the State under this preference agreement.

Recent reports from people working in the community-based programs across the state suggest that the scarcity of available affordable rental housing and the unwillingness of property owners to participate in the DCA program has resulted in some HCVs going unused. This adds to the argument that the State does not have capacity to expand the program to meet need, if the need was being assessed as required. Reducing the shortage of available, affordable, decent housing would have to be added as a strategy under this MOA. The City of Atlanta Continuum of Care is working on this strategy but DBHDD has had limited involvement in this effort.

Effective utilization of available housing resources (such as Section 811 and public housing authorities) is required (39.e.) as part of the Memorandum of Agreement between DCA and DBHDD. This provision is key to the State's ability to expand capacity and meet demands for new housing. The HUD Project Rental Assistance was first funded in 2012. Georgia was one of the first thirteen states in the country to receive an award for this new program. DCA received $4.27 million to cover the costs for the extended use agreements for rental assistance for 134 units. Georgia listed two target populations in their application, individuals who qualify in this Settlement Agreement's Target Population and individuals who qualify under the State's Money Follows the Person program. DBHDD reports 100 of these units are to be utilized by the Target Population. To date, 27 individuals in the Target Population have been approved for rental assistance in this program. The program is challenging to administer and Georgia and other states have made some adjustments, with HUD approval, for how funds will be used. However, the plain fact is that the program is under-utilized.

As stated above, the coordination of available state resources and state agencies is important. It is also required as an action step in the Memorandum of Agreement (3f.). One constant theme that has emerged from discussions with DBHDD is that Regional and state office staff attend a number of re-entry and other justice related Committee, Task Force and Project meetings around the state with local and statewide organizations that have both an interest in securing Supported Housing and resources to increase housing and supports. There are examples of CSBs and providers who are engaged in these groups as well. DCA is reaching out to CSBs to provide information on the Re-entry Housing Partnership (RHP).

Yet, DBHDD initiated the Housing Outreach Coordinator program only last year in order to contact jails, prisons and Emergency Rooms directly. This is due in large part because of the paucity of referrals from those locations.

This means in part that DBHDD staff attending meetings over the years cannot be viewed as a path to increase referrals. Attending meetings does not substitute for action. This is not to say DBHDD should stop attending meetings. Instead, they should attend with the goal to secure agreements.

There have been a few exceptions where local stakeholders and Regional offices have in fact taken action to establish a referral process; the NIC project and the Gwinnett and Chatham County jail projects are examples[6]. Local Continuums of Care and the DCA in its role in the balance of state Continuum of Care are also other examples of collaborative relationships that have produced results. Local Continuums, though, asked for access to the GHVP rather than

[6] The new HOC reports getting a large number of referrals as a result of a pre-existing project in Chatham County.

offering Shelter Plus Care. On one hand, this is helpful to making resources available to the homeless population that is part of the Settlement Agreement's Target Population. On the other hand, it masks the need for greater capacity.

Nonetheless, all these partnerships are valuable. DCA has had a successful partnership with the Department of Community Supervision (DCS) in the Re-entry Partnership Housing (RPH) Program. However, this collaboration did not appear to translate into DBHDD working collaboratively to increase prison or jail referrals for individuals in the Target Population.

Recommended Finding for Compliance: There has only been minimal progress since this item was reviewed and reported on in March 2018. As such, the State is not yet recommended as in compliance with this obligation. Specifically, the unified referral strategy is not available for "anyone" in the Target Population and the determination of need is not statewide. There is also not yet an effective utilization of housing resources as listed in the Settlement Agreement and coordination with available state resources and state agencies, while in progress, is not yielding sufficient benefits. The benefits that yield some referrals are solely from scattered local initiatives and DCA's agreements, as reflected in the data in **Figure 3** below.

5. Referrals of Individuals in the target population in Need of Supported Housing

According to EA 40, the State is required to implement procedures that enable individuals with SPMI in the Target Population to be referred to Supported Housing, if the need is identified at the time of discharge from a State Hospital, jail, prison, Emergency Room, or homeless shelter. The Target Population is defined in the beginning of this report. By June 30, 2018, the State is required to have the capacity to provide Supported Housing to any of the 9.000 individuals in the Target Population who have a need for such support.

Discussion: The State has worked continuously over the past four years to identify individuals in need of Supported Housing-- first through Phase I, a pilot to test the process, then following development of new policies and processes, Phase II, which is ongoing. However, as reported consistently in the annual reviews completed by the Independent Reviewer and this writer, this process has failed to identify individuals in need across all the sub-populations in the Target Population. DBHDD defined the criteria used for identifying each sub-population. Likewise, the protocols developed by DBHDD do not provide timely and complete action steps for standard referral processes for this Target Population. This is a huge undertaking and, as stated by DBHDD staff, "change takes time."

The discussion in this section is divided into three parts. The first is to describe the current challenges of and progress toward identifying need, including a description of the processes to identify individuals in the Target Population. The second is to describe the current challenges with referrals being made, once identification is complete. The third is to summarize how DBHDD is reporting capacity.

Much has been written regarding these issues in earlier compliance reports submitted by the Independent Reviewer and references will be made to issues raised especially in her March 2018 Report to the Court.

Current Progress and current challenges with identifying need: Figure 3 depicts the number of individuals identified as accessing housing from all but one of the sub-populations in the Target Population. The number of individuals frequently using Emergency Rooms who are in need of housing has never been reported.

Figure 3: Prior Residential Status by Percentage of Individuals Placed in Housing

Categories	**Regions**						**7 Yr. Total**	**7 Yr. Ave.**
	R 1	**R2**	**R3**	**R4**	**R5**	**R6**		
Homeless	61%	38%	71%	51%	42%	50%	2789	54%
Residential	7%	13%	6%	7%	10%	25%	509	10%
PCH or GRH	2%	5%	4%	2%	4%	7%	188	4%
Hospital	3%	26%	10%	10%	9%	4%	544	11%
CSU or CA	1%	1%	0%	0%	3%	0%	48	1%
Rent Burdened	1%	2%	0%	3%	2%	1%	71	1%
Family/ friends	22%	11%	5%	19%	17%	7%	694	13%
Jail or Prison	2%	3%	2%	7%	13%	0%	258	5%
Unknown	2%	1%	0%	2%	2%	4%	68	1%
Total (by #)	765	782	1397	771	966	496	5169[7]	

In each of these categories, the percentages across Regions have not changed significantly over time. In the review of Supported Housing prepared for the Independent Reviewer's March 2018 report, a description of the number of individuals being released from jails and prisons, who could be surveyed for determining their need for Supported Housing was made. According to the United States Department of Justice, Bureau of Justice statistics, the Georgia Department of Corrections, and the Prison Policy Initiative Research Clearinghouse Report on Georgia, the number that could be surveyed in the past year was 3,750.

Figure 3 references the percentages of individuals placed in housing from hospitals as variable, based on location. For example, the rate of placement is much higher in Region 2 (26% or 203 individuals versus 10% or 140 individuals) than Region 3. In Region 3, you are more likely to be placed in Supported Housing if you are homeless (71% of all referrals) but not from other categories, including being released from jails and prisons (2% of all referrals). Referrals of individuals who meet the homeless eligibility criteria in Region 3 can be explained in part because of the high rate of homelessness in the Atlanta metro region but can also be attributed to the assertive street outreach coordinated by the Atlanta Continuum of Care.

Referrals of individuals who are homeless are 54% of the total referrals, trending slightly higher than previous reports. Referrals vary from residential programs and from family and friends. Referrals in Region 6 of individuals who are homeless or being referred from residential

[7] The DBHDD reports the total number of individuals placed in housing on the Funding Program Summary as either 5137, 5167 or 4533.

programs are 75% of their total referrals, yet, that Region does not report any jail or prison referrals. Current reports reveal that Region 5 accounts for 50% of all referrals from jails and prisons and, when combined with Region 4, is nearly 70% of all referrals.

As referenced earlier, a few HOCs began working in late 2017 and all but one HOC had begun their work by the end of April 2018. The HOCs have had orientation, attended training, in part related to their job, and they participate in weekly calls. All HOCs interviewed report the calls are useful, especially problem solving with and getting information from their peers. Several HOCs report being on a steep learning curve. All are enthusiastic about their work. A few are worried that their jobs will end soon. Most HOCs reported not being aware if their referrals resulted in the individual they surveyed receiving housing. In part, this is understandable given the short duration of this program and the program design.

The HOC's task is limited to conducting outreach to jails, prisons and Emergency Rooms selected as priority by DBHDD. The program is not designed and implemented for the HOCs to assist with the transition of an individual through the entire referral process. They are largely unaware of what happens to individuals after they complete their survey. The surveys are sent to Regional staff. Those HOCs who are aware of what follow through occurs are working in agencies where the Agency where they work and their Housing Coordinator get the referrals for determining eligibility and placement after the unified referral process is completed. This may occur within a week or perhaps longer. Often individuals have been released from jail or prison by then and then often not followed at all. This reflects the disjointed nature of the referral process in Georgia. Engagement and then staying in touch with the individual, which is vital to individuals getting and keeping housing, is largely impossible. It is too early in the process to determine the number of individuals who have been lost in the process because the contact is so limited.

Despite DBHDD reporting meetings with the Department of Corrections and both the local staff and state staff of the Department of Community Supervision, the HOCs' contact is often limited to their leaving their cards at the front desk of a jail or Emergency Room and then working with a line staff person, or in some cases a supervisor, in the facility. Access to prisons is almost always more complicated. HOCs are being required to get clearance to gain access. When contact is made, the HOC asks the staff member they spoke with to call them and they will come to the facility and complete the needs assessment. Nearly all the HOCs reported attempting to meet with the Department of Community Supervision. Some meetings have occurred and others are scheduled.

There are 146 counties in Georgia with detention centers or jails[8]. A number of these institutions are very small and some small counties do not have jail or detention capacity but have agreements with neighboring counties for jail space and services. DBHDD has asked that HOCs target 74 jails. The end of June data reflected that the 12 HOCs had attempted contact with 33 state and county prisons and 10 or 31% had agreed to complete surveys. Three HOCs report not getting approval with access to selected prisons. Most HOCs had not gotten referrals from

[8] The list of jails and the list of prisons provided by DBHDD to the Independent Reviewer had duplicates on both the lists of county jails and prisons. The numbers shown above are only as reliable as the information provided by DBHDD.

prisons and/or did not have state prisons in their jurisdiction. Two HOCs reported getting a "warm hand-off" from an HOC in another area in order to follow-up and contact individuals who may have been released to an address in their area.

The percentage of individuals with SPMI, who could be in need of Supported Housing, who are frequently using Emergency Rooms is unknown. This number is routinely collected by hospitals across the country and used to develop strategies, including quick access to Supported Housing, in order to reduce this high use. One hospital administrator in Region 3 described his process for identifying high utilizers and connecting them to housing. He has not been contacted to demonstrate how this is done, even though he has frequent contact with DBHDD. From all accounts, DBHDD simply did not attempt a process commonly used in most states to get referrals of these "high utilizers" until a few months before the end of FY 2018. This is a process that can be successful but takes careful planning and collaboration.

DBHDD reports they will begin analysis of crisis call data and fund High Utilizer Management (HUM) Navigators to provide support to individuals who are experiencing challenges and barriers to accessing and remaining enrolled in Supported Housing services. This will include individuals who may present in a hospital emergency department more than two times in 90 days. DBHDD plans to pilot this program for a year and will hire three Navigators to cover rural areas and three to cover urban areas. For full implementation, DBHDD plans to fund a Navigator position in each CSB. This information was submitted after the end of the FY 2018 year. Therefore, its "potential" implementation cannot be evaluated for compliance.

Current Challenges with Referrals: This report explains that need cannot be determined yet because the needs assessment survey and referral process has not been extended to a sufficient number of individuals in the Target Population. The needs process often leads to challenges with referrals getting made. DBHDD has been working for nearly two years to put an effective discharge planning process in place for the discharges of individuals from Georgia Regional Hospital Atlanta. DBHDD reports they have not finished this planning process

DBHDD has established a Quality Improvement study and plan, which is just now progressing to the implementation phase. A recent national review of "standard" practice in discharge planning includes eleven essential steps that start with discharge planning beginning at admission. The DBHDD process includes some, if not all, the standard practices. It's a good start but, based on experience, this process will take time to develop.

Likewise, the above referenced challenges for doing the needs assessments in jails, prisons and Emergency Rooms are similar to challenges with referrals from State Hospitals. Unless there are staff who remain in contact as individuals are released, discharged or move, these individuals with SPMI can be lost to the system. Securing eligibility requires not only getting identification documents but also submitting to a clinical assessment review, which often does not occur until after an individual is discharged from an institution. This does not occur simultaneously with the unified referral process but consecutively. During this period, an individual may go without medication and any funds to live on as their SSI check has not arrived or even been sent to them. For individuals with no income and no place to live, this can be a challenge too great to overcome. In some Regions, regional housing staff, providers and Continuums of Care step up

to provide support during this difficult transition period. But, for others, this does not occur and is almost nonexistent for individuals exiting jails, prisons and frequently using Emergency Rooms.

DBHDD cites a number of workgroups, taskforces and committees that have been developed as evidence of their work to expand access. However, it appears that the deliberate actions needed to secure effective working relationships and to establish timely referral processes have not occurred at the level required to meet the terms of this Agreement. This has been described consistently in detail by a number of participants and administrators in both community-based and facility-based programs. Most of these informants reach these opinions on their own; they are not in contact with others who have the same experience. The data from the number and type of successful referrals confirm this view.

Current Challenges with Building Capacity: The first question when trying to determine if the State has needed capacity is, "What is the need." If the need is not 9,000 individuals with SPMI, then what is it? This is discussed in the narrative above. Assuming that DBHDD is taking steps to identify more qualified individuals in need and fixes the problems with the referral process, the State can then make reliable assumptions of needed capacity. Regardless of what that level of capacity will need to be, there will always be a need to build capacity and constantly work to maintain it.

Building capacity begins with determining what affordable stock is available and making a plan to increase it. DBHDD recently reported they had no problems with capacity. However, the need for affordable rental units for individuals with disabilities and individuals in low-income renter households is not being met in Georgia.

Current data, widespread reports from the field and DCA's own assessment is that the availability of safe and affordable housing is not meeting demand. Rather than denying the problem exists, it is far better to acknowledge the issue so it can be more fully addressed. All but one HOC has reported that availability of housing is an issue; most have been in close contact with Housing Outreach Specialists in their agency or the CSB, who best understand their rental markets. Likewise, stakeholders are raising this issue, citing local data to demonstrate the problem.

Acknowledging a problem is always the first step to taking actions steps to attempt to solve it. It helps build credibility for staff, for HOCs and stakeholders who can be enlisted to help overcome the problem. It also helps DBHDD build a case for why more affordable housing is needed; it is the predicate to expanding capacity along with building relationships with funders and other partners.

In Georgia, there are only 38 available rental homes/apartment units per 100 renter households whose income is at 30% of area median income. There are only 55 affordable and available homes per 100 renter households for individuals at 50% of the area median income[9]. Even with a rental subsidy, individuals whose income is only approximately $750 per month (SSI) will

[9] *The Georgia Housing Profile.* The Gap Report: National Low income Housing Coalition, Washington D.C. (June 26, 2018)

have difficulty finding housing in most Georgia rental markets. SSI is only 21% of the area median income in Georgia[10]. DBHDD reports that DCA acknowledges this need as well as the scarcity of available decent affordable rental units for the Target Population, which in turn affects capacity.

Most affordable housing in Georgia is already occupied and/or available to a wider population of individuals and families with low incomes that qualify them for the HCV program and the LIHTC program or to individuals who qualify for support from categorical programs such as VASH, HOPWA, ESG and re-entry programs. Occupancy rates run very high. The state cannot simply count the number of slots/ subsidies for these groups and report this as capacity. Capacity in programs that do not typically expand significantly will also rely on turnover for new referrals.

Beyond the broader question of increasing availability, there is a need to develop a pipeline of affordable housing, where possible, dedicated in whole or part to the Target Population. In Georgia, this includes the GHVP, 811 and the HCV units available through the time-limited preference. It also includes the HUD McKinney Shelter Plus Care and HUD (disability) Mainstream Vouchers. There are written agreements and eligibility criteria for the target population for these programs. DBHDD and DCA have made limited progress with affordable housing slots/vouchers under DCA control and even less progress accessing resources identified as needed for Supported Housing through the unified referral process.

Concluding Comments

The work for this report revealed two overarching findings. First, DBHDDD is endeavoring to meet requirements that they have been unsuccessful in meeting to this point. This includes assessing the need of individuals in the Target Population being released from jails and prisons and those individuals frequently using Emergency Rooms. For these groups of individuals, DBHDD will need to significantly modify the processes being put into operation now or being planned for later in order to be recommended as achieving substantial compliance. DBHDD started late in the compliance period to take on these complex tasks. They are not achievable in such a short period of time. Examples above demonstrate that the new HOCs are making progress with their required tasks; but HOCs are challenged with securing referrals and are disconnected from the continuous process of connecting individuals with SPMI to Supported Housing.

Second, DCA, stakeholders, providers, housing specialists and HOCs, all agree that finding decent affordable housing is increasingly more difficult to locate and that the time and steps involved to get an individual through the needs and referral process are difficult. Objective housing data back up this finding. The attempts to increase capacity through federal programs and partnerships that were at one time promising have not materialized, as hoped. This is partly the challenge inherent in increasing capacity and partly because of the methods DBHDD has employed to build capacity. As an example, the Memorandum of Agreement between DBHDD and DCA is not yet producing these results. DCA's HCV preference agreement could have

[10] *Priced Out: The Housing Crisis for People with Disabilities.* . The Technical Assistance Collaborative, Boston Massachusetts. (2017)

yielded more units and will expire at the end of the Settlement Agreement. This problem is complicated by DBHDD indicating that they don't find "capacity" to be a problem. To work towards solving such an apparent problem requires recognition of the problem. DCA's recent application for HUD Mainstream Vouchers was encouraging, although they could have done more to encourage local PHAs to also apply and there is potential for a second round of funding.

Based on the current evidence, the only reliable predictors of an individual in the Target Population getting placed in Supported Housing are where a person lives, who makes the referral and to what group in the Target Population the individual belongs. DBHDD staff attend a significant number of meetings and are members of taskforces and workgroups but going to meetings and being members of groups is not the same as taking action steps to increase referrals and housing capacity.

DBHDD and DCA are making efforts to produce results now but DBHDD staff are correct when they say "change takes time."

Addendum

Purpose

The purpose of this Addendum is to supplement and clarify information related to the independent assessment of the State's compliance with the SA/EA provisions regarding the current utilization and potential capacity for Supported Housing and Bridge Funding within the State's community mental health system. Current utilization refers to the number of filled/leased units. Potential capacity refers to the State's arrangements to gain access to housing and vouchers or subsidies necessary to provide Supported Housing with a subsidy or voucher. This applies to anyone in the Target Population with a need for Supported Housing, as required in the SA.

This addendum addresses three issues. First, it clarifies potential capacity based on the information given to the Independent Reviewer and this subject matter consultant for this assessment. Frankly, it has been a challenge – and remains a challenge to this day -- to assess potential capacity because of unknown factors and because the State has provided multiple, often conflicting, numbers or has failed to provide sufficient information for this purpose. Second, this addendum identifies the source and/or the assumptions for the potential capacity calculations. Third, it clarifies how the Independent Reviewer and this subject matter consultant are calculating potential capacity. (This writer has tracked the State's progress in meeting its Supported Housing requirements for seven years, has analyzed the "use" patterns and variables that predict future use, and has continuously researched changes in the State and federal affordable housing system, especially as it pertains to opportunities for Supported Housing for individuals with psychiatric disabilities.) It is important to underscore that potential capacity can only be calculated accurately when the State has mechanisms in place to ensure that it is only projecting the number of subsidies or units that will be reliably available to individuals who meet the Target Population requirements. This proves to be difficult when individuals who are not in the Target Population also qualify for some of these same subsidies/units.

On October 23, 2018, at the request of the Independent Reviewer, the Parties, including leadership staff from the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Community Affairs (DCA), met with the Independent Reviewer and this consultant at the DBHDD office in Atlanta. The purpose of the meeting was to discuss outstanding questions regarding the calculation of current and potential capacity for Supported Housing. There also were questions as to whether or not the State's potential capacity will be sufficient to meet the needs of the Target Population. In the meeting, the State also provided information on its plans to improve its outreach to members of the Target Population in order to assess and address their needs for Supported Housing.

Methodology

The meeting on October 23, 2018 provided an opportunity for this consultant to reiterate her review methodology and to summarize data included in reports provided by the State since 2012. This summary included an explanation of the analysis of the GHVP Annual Program Summary

and a review of the numbers presented for each of the types of housing, by funding source and eligible population, upon which the State relies to meet its Supported Housing obligations.

Following the meeting, on October 26, 2018, the Independent Reviewer submitted a set of questions asking for further clarification of information provided by the State at the meeting. On November 9, 2018, the State provided a written response to these questions. The State's response, while helpful, did not include an updated or complete GHVP Annual Program Summary. (Prior to the meeting, a request was made for this report.) This request was made again in the meeting, and, again, in the questions forwarded on October 26, 2018 and November 9, 2018. In addition, the State indicated that it could not find where it had provided a number reported by this consultant; this information, including the date received and the source was provided to the State on November 13, 2018. Further, the State's response on November 9, 2018, did not include information detailing where individuals were routed for subsidies as a result of the Unified Referral process initiated in the Fall of 2017. The Independent Reviewer sent a request for the missing information on November 9, 2018. The State responded to that request on November 19, 2018. The response did not address all the questions submitted.

Overall, the meeting was helpful to reaching independent conclusions regarding the State's current utilization and potential capacity. Although the State will continue to provide information about its efforts to comply with the Settlement Agreement's obligations, including furthering assessing need for Supported Housing, it should be emphasized that the work of this consultant is focused on the period ending June 30, 2018, the end of Fiscal Year 2018.

Current and Potential Capacity

Below is a chart that depicts: a) current utilization by program or type of subsidy and b) potential capacity assuming the State utilizes potential resources. Footnotes delineate the sources used for this chart. This is followed by a list of calculations and assumptions for six of the program/subsidy types:

Program/Subsidy Type	Current Utilization	Potential Capacity
GHVP (Existing)	2405	2405 [1]
GHVP (Annual Allocation)	NA	439 [2]
Shelter Plus Care	Unk	952 [3]
DCA HCVs (PHA preference)	381	422 [4]
Public Housing Authority Partnerships (HCV or PBV)	54	54 [5]
VASH (Veterans Administration Supported Housing)	274	309 [6]
HUD PRA	27	54 [7]
Housing Opportunity Program for Persons with AIDS (HOPWA)	Unk	Unk [8]
HUD Mainstream Vouchers	NA	99 [9]
Total	3141 [10]	4734

[1]Current GHVP utilization is used for potential capacity, even though some individuals will leave their units in FY 2019 and utilization appears flat.

[2] This assumes a FY 19 annual allocation of $5,721,600 for Bridge Funding and GHVs adjusted for the average Bridge funding use, rate units are filled or refilled monthly and rental increases over the past two years.
[3] The current number of individuals in the Target Population in SPC is unknown. Based on referral patterns since the Unified Referral start-up, the percentage of individuals who are likely to be found eligible in the target population and DBHDD's projected turnover, the Target Population potential capacity appears to be approximately 952 or 50% of the 1,884 available total units. The State may be awarded new units in FY 2019. This may change this number, but not in the near term. The State will need to verify that this number of units is being occupied by individuals in the Target Population.
[4] Only available until the Settlement Agreement ends so calculated at the potential number based on the average increase per year since first preference granted. This increase is slightly greater than past performance. It assumes the State will make a good faith effort to utilize this time-limited resource.
[5] DCA has not reported the source of this number so it is not increased. The State did not produce any information from HUD for other PHA preferences.
[6] Revised number based on review; increase is average of 5 years of available data. DBHDD data did not reflect a consistent increase each year, making this projection difficult.
[7] DCA was awarded funds for 300 PRA 811 rental subsidies for this target population in 2013. However, the State is only filling an average of 5.4 of the units annually. Unless the State makes substantial change in utilization of this program, the State will likely only fill another 27 units over the next 5 years.
[8] HOPWA provides subsidies for a broader population then individuals with SPMI, including individuals with substance abuse disorders and other individuals with mental health problems. Neither DBHDD nor DCA designate the disability; therefore, any count is not a reliable figure, is not included and is likely very small.
[9] Based on recent award to DCA from HUD. An additional 36 vouchers were awarded but are not disability-designated.
[10] Excludes an unknown number of SPC filled slots.

Additional Notes

1. DBHDD reported a "balance forward" of $6,040,036 for Fiscal Year 2019, which includes both Bridge and GHV funding. Bridge Funding typically accounts for 10-15% of the total. Based on historical data, this means the DBHDD "balance forward" for Fiscal Year 2019 could cover the annual costs for 700 subsidies based on the average month's rent paid ($591) by GHVP. However, based on reports from Housing Outreach Coordinators, key informants and an analysis of state and national data, the availability of GHVP funding does not equal capacity. The DCA-DBHDD agreement has not yielded strategies to create more affordable housing stock. There simply are not enough available affordable rental units to utilize the GHV funding. The DBHDD and DCA must acknowledge this reality, focus on increasing affordable housing stock and/or create more set aside units for the Target Population as part of the number of units being funded by DCA. Until the State can demonstrate availability in areas of the State where units are needed, balance forward cannot be included in potential capacity.

The FY 2018 GHV balance forward of $6,040,733 illustrates this point. There was a net increase of 30% in funding for the GHVP as a result of the balance forward yet the number of individuals with a signed lease went down in Fiscal Year 2018 compared to Fiscal Year 2017 and the program has seen a decline in property owners in the program over time. Therefore, the balance forward should not be counted as expanded capacity. Capacity includes available housing not just subsidies

2. It is estimated the GHV annual allocation of $5,721,600 will yield 685 vouchers. This assumes 15% of the total is estimated to be allocated to Bridge Funding; rents are based on 110% of the current Fair Market Rate(s) in Georgia, skewed toward the higher rates in the Atlanta and

Savannah metro areas; and at least 70% of the participants have SSI as income to cover their portion of rent. This voucher total could be greater or fewer depending on a range of factors including rent increases, location and how early in the year the vouchers were allocated.

3. Individuals who meet the Settlement Agreement requirement of a Serious and Persistent Mental Illness and who are homeless may qualify for HUD funded Shelter Plus Care (SPC) units. The availability of SPC units varies in some, mostly metropolitan, jurisdictions, as do the methods for determining priority for access to this program. Over time, the State has provided varying counts of SPC numbers. In December 2017, the State reported 149 units; that number seemed low and likely represented the newly filled units for the year. Later, the State said this number was incorrect but, in September 2018, it reported an annual estimated turnover of 277.

The State indicated, in September 2018, that there was funding for 1,884 slots, but did not report how many were full and did not report if these slots were filled by individuals in the Target Population. Based on this consultant's work in other jurisdictions, it is expected that 66% of the individuals in the SPC have a disability that matches the Settlement Agreement's Target Population. DCA reported that it expected a 277 unit turnover. It is likely they have two to three hundred vacancies. Turnover is not counted as new capacity since total capacity is the number of units in the program. With the exception of the DCA HCV vouchers, the DBHDD and DCA cannot switch the GHVP state funded subsidies for federal vouchers because of the eligibility criteria. DBHDD, DCA and their provider agencies can refer individuals to the other federal programs directly.

4. Other potential funding sources are not dedicated solely to the Target Population nor are the eligibility requirements the same as those for the Target Population. As a result, organizations may report numbers for individuals not in the Target Population. DCA and DBHDD must sort out who is eligible but claims it cannot do so because of confidentiality requirements. This is especially true for HOPWA, VASH and Section 8/HCVs. DCA and DBHDD must get an agreement with the entity that manages those subsidies in order for those subsidies to be counted, available and accessible to this SA/EA Target Population. This is possible even with privacy concerns as each individual being counted as accessing supported housing will be referred to a provider; with releases of information, individuals can be counted. Current capacity can be identified without releasing names or through releases at the outset of services. DBHDD had an agreement for access to HOPWA that expired some time ago and has not been renewed. DCA recently stated that getting agreements is something they do not control. In other states, it is standard practice to obtain these agreements.

5. Because DBHDD has provided Bridge funds to VASH recipients, this provides an avenue for DBHDD to count individuals who meet the Target Population requirement. This provides a reliable number of individuals receiving VASH since VASH has broader eligibility criteria.

6. DCA reported, on November 12, 2018, that it does not have any current agreements with PHAs for Housing Choice Vouchers (HCVs); DCA and DBHDD indicated that DeKalb and Fulton Counties have preference agreements for the Target Population. However, when a request was made for copies of the required letters from the HUD General Counsel's office

approving this type of preference (same as the one DCA has with approval of the HUD General Counsel), the State did not provide the letters. Its unlikely this preference was awarded.

DBHDD has referenced a Memorandum of Understanding (MOU) with the Atlanta Housing Authority (AHA) but reported that the AHA was "undergoing a leadership transition" and that a conference call was being set up with AHA to discuss "updating" the MOU. DBHDD reported that 54 units were filled as a result of these agreements. DBHDD also had an earlier agreement with the Columbus Housing Authority; that agreement has since expired.

Summary

As discussed above, the rationale for adding this Addendum was to verify sources of data and to correct information that was incomplete or contradictory. There are still unanswered requests but sufficient information to complete this Addendum.

Other factors must be weighed when assessing and/or predicating potential capacity. One important factor is the degree to which estimated capacity is based on how many individuals in the Target Population can qualify for units or subsidies in all of the housing categories (units or subsidies). This is especially true for HOPWA, VASH and SPC. Qualifications overlap, but are not the same across the SA/EA and each of these programs.

There are some other challenges in the system. Property owners and property managers may not agree to lease to individuals with criminal records. Public Housing authorities are reporting that property owners are no longer accepting vouchers and that the GHVP is losing property owners.

DCA has consistently projected a higher number of units shifting from GHVP funding to federal HCVs than actually materialize in a subsequent reporting period. A number of factors have contributed to DCA not meeting their projections for this shift. One reason is that DBHDD allowed rents to rise above 110% of the applicable Market Rate rent. DCA cannot pay rents that are above 110% of the published Market Rate for their jurisdiction. Property owners are not going to agree to this shift if it means lower rents. With the paucity of available rental units, it may be tempting to pay the higher rent initially just to get an individual a decent place to live. However, this should only be done on a case-by-case basis and typically for individuals who may not qualify for Section 8 in order to maximize federal resources and build total capacity.

Service providers play a key role in helping individuals get and keep housing. These agencies experience relatively high turnover so their staff need assistance to learn their jobs; they also need information about housing, including fair housing and reasonable accommodations. Although staffing changes or adding new staff with housing responsibilities at the state and regional levels may help increase referrals, the steep learning curves and workflow adjustments when staff are added may impede these efforts.

It is important to note that the affordable housing market and Federal and State budgets influence these projections, in both positive and negative directions. For example, rents could rise faster than anticipated in metropolitan areas, thus, lowering the number of subsidies that could be made available. Construction prices influence the amount of safe affordable multi-family rental

housing that can be increased. HUD's budget changes from year to year. Southern states, including Georgia and surrounding states, have experienced a rise in deadly hurricanes, five in two years, that have destroyed rental properties resulting in higher housing construction costs and higher insurance and lost rental property, not just in Georgia but in surrounding states. There is always a dysphoria after a storm with families moving out of harm's way into neighboring states.

There are number of indicators of a high performing state-level Supported Housing program. These include the degree to which the managers assertively seek out new resources, enter into agreements with state and local housing agencies who control resources or can seek resources, make certain that subsidies and vouchers are easily accessible, adhere to "Housing First" principles and put them into policy and practice. This is how high performing programs meet their potential capacity goals.

At this time, although there have been notable accomplishments over the years of the Settlement Agreement and its Extension, there is not yet evidence that the capacity explicitly required in these Court documents has been reached. Additional time and effort is still required if this obligation is to be met.