COMMUNITY SERVICES AND PROCEDURES FOR PEOPLE FOUND INCOMPETENT TO STAND TRIAL, NONRESTORABLE

SEPTEMBER 20, 2016
STATE BAR OF GEORGIA

PROGRAM MATERIALS

CO-SPONSORED BY:
Georgia Appleseed Center for Law and Justice
Georgia Department of Behavioral Health and Developmental Disabilities
Atlanta Legal Aid Society
COMMUNITY SERVICES AND PROCEDURES FOR PEOPLE FOUND
INCOMPETENT TO STAND TRIAL, NONRESTORABLE
September 20, 2016

Presiding: Rob Rhodes, Georgia Appleseed Center for Law and Justice

PROGRAM

8:00 a.m.- 8:45 a.m. REGISTRATION AND CONTINENTAL BREAKFAST

8:45 a.m.- 9:00 a.m. WELCOME AND PROGRAM OVERVIEW
• Rob Rhodes
• Amy Howell, Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)

9:00 a.m. – 10:15 a.m. DBHDD FORENSIC HOSPITAL PROCEDURES REGARDING DISCHARGE PLANNING
• Dr. Karen Bailey, DBHDD
• Lisa Kuglar, DBHDD

10:15 a.m. – 10:30 a.m. BREAK

10:30 a.m. – 11:45 a.m. COMMUNITY MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SERVICES AVAILABLE TO FORENSIC INDIVIDUALS
• Dr. Karen Bailey, DBHDD (Community integration homes, forensic apartments)
• Dr. Terri Timberlake, DBHDD (Community mental health services and how to access them)
• Beth Shaw, DBHDD (Community services for people with developmental disabilities)
• Doug Scott, DBHDD (Georgia Housing Voucher Program)
• Pejman Mahdavi, LCSW, View Point (ACT team)

11:45 a.m. – 12:00 p.m. BREAK, GET BOXED LUNCH

12:00 p.m.-12:30 p.m. ADDRESSING STIGMA ASSOCIATED WITH IST-N INDIVIDUALS
• Gab Rich, Atlanta Legal Aid Society
• Sharon Williams, Georgia Mental Health Consumer Network
• Tariq Abdur Rashid, Georgia Mental Health Consumer Network

12:30 p.m.-12:40 p.m. BREAK
12:40 p.m. – 2:20 p.m.  ADVOCATING FOR AN IST-N INDIVIDUAL: EVALUATING CIVIL COMMITMENT CRITERIA, REVIEWING DISCHARGE PLANNING, REQUESTING RELEASE/COMMUNITY SERVICES
- Susan Walker Goico, Atlanta Legal Aid Society
- Annie C. Deets, Law Office of the DeKalb Public Defender, Mental Health Division
- Ken Mauldin, District Attorney, Athens-Clarke and Oconee Counties
- Greg Bagley, DBHDD Legal Department

2:20 p.m. – 2:30 p.m.  BREAK

2:30 p.m. – 3:30 p.m.  A VIEW FROM THE BENCH: JUDGES DISCUSS CHALLENGES AND SUCCESSES IN IST-N CASES
- Judge Doris L. Downs, Superior Court of Fulton County
- Judge Marc E. D’Antonio, Probate Court of Muscogee County
- Judge Kathy Gosselin, Superior Court of Hall and Dawson Counties
COMMUNITY SERVICES AND PROCEDURES FOR PEOPLE FOUND INCOMPETENT TO STAND TRIAL, NONRESTORABLE
September 20, 2016
State Bar of Georgia, Auditorium

PRESENTERS AND PANELISTS

HONORABLE MARC E. D’ANTONIO
Judge D’Antonio took office as Muscogee County’s elected Probate Judge on January 1, 2013. Prior to taking office, since January 2006, he worked in the Probate Court as the Hearing Officer/Chief Clerk and later as Associate Judge.

Judge D’Antonio received his Bachelor’s Degree in Political Economy from Tulane University. He graduated from Vanderbilt University School of Law in 1991 and was admitted to the State Bar of Georgia that year. Judge D’Antonio is married to Catherine Dietrich D’Antonio and they have two children, Kate and Jack, and a significant number of dogs and cats.

GREGORY A. BAGLEY
Greg Bagley earned his law degree from UGA School of Law in 1992 and began working as a prosecutor of crimes against children in the Piedmont Judicial Circuit. After prosecuting for a little over a year, he accepted a position with the Georgia Legal Services Program (GLSP) as an advocate for individuals with disabilities and worked with GLSP for more than five years. After GLSP, he worked in the county attorney’s office for Douglas County, advising the Board of Commissioners from 1999 to 2005. In 2005, he started working for the Georgia Department of Human Resources concentrating in the area of contracts and procurements. He transferred to the Department of Community Health in 2009 and worked in the area of Medicaid legal services until 2012. In 2012, he joined DBHDD and now works primarily with the state hospitals advising hospital staff on issues involving potential litigation, risk management, forensics, contracts, employment, and civil rights.

DR. KAREN BAILEY
Dr. Karen Bailey completed her doctorate in clinical psychology at Auburn University with an internship at the Federal Correctional Institution in Butner, North Carolina. She began her career as a forensic psychologist at the state psychiatric hospital in Columbus, Georgia. During her ten years at that hospital, she developed a dedicated forensic unit and became involved with a team that helped the remaining state hospitals create dedicated forensic units. In 1999, she moved to Atlanta where she assumed her current position as the state director of forensic services. In that capacity, she has helped design and plan for forensic services across Georgia. Dr. Bailey regularly provides educational workshops for forensic psychologists, judges, and other legal professionals. She has consulted with other states on forensic systemic development. She previously served as the chair of the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD). She is adjunct faculty of the National Judicial College, Emory
University’s School of Medicine, and Georgia Regents University (formerly MCG). Although Dr. Bailey serves in an administrative capacity as state forensic director, she is often found at the state hospitals and in the community working directly with clients, as she finds that is the most enjoyable and rewarding part of her position.

ANNE C. DEETS
Annie C. Deets graduated from Vanderbilt Law School in 1999, where her interest in representing the underdog was first stoked and developed while a student working in the Vanderbilt Legal Clinic. While at Vanderbilt, Annie was awarded the Carl J. Ruskowski Clinical Legal Education Award, which was awarded to the student who demonstrated excellence in practice of law and best exemplified the highest standards of the legal profession.

Over the last 15 years, she has remained steadfast in her passion for and commitment to representing indigent individuals. In her capacity as a public defender in the Mental Health Division at the Law Office of the Public Defender DeKalb County, Annie has handled some of the most high profile cases in DeKalb County over the last several years. Annie advocates passionately for the rights of this population, which she believes is perhaps the most vulnerable population she has had the opportunity to serve during her career.

Annie currently is also currently employed as an adjunct professor by Emory University School of Law, where she teaches a course in Mental Health in the Criminal Justice System, coaches the Emory Mock Trial Society, and serves as faculty at the Kessler-Eidson Program for Trial Techniques.

HONORABLE DORIS L. DOWNS
Judge Doris L. Downs has served as a Fulton County Superior Court Judge, Atlanta Judicial Circuit, since March of 1996. After serving on the Court’s Executive Committee, her peers elected Judge Downs as Chief Judge in April of 2004 and she served as Chief Judge until May, 2010.

In that role, Judge Downs emphasized improved case management, spearheading the Superior Court’s non-complex criminal trial division. Under this calendar non-violent drug and property crimes, which comprise 70 % of the Court’s criminal case filings, reach a trial calendar within eight weeks of arrest. This initiative dramatically reduced the pending caseload for these non-violent felony cases and allowed the Court’s judges, prosecutors, defenders and security personnel to focus their limited resources on the most serious felony offenses. Judge Downs is also recognized for her own personal case management skills quickly processing cases where she presides. She is often called upon to teach other judges across the state methods and strategies on how to better manage their caseloads.

Judge Downs has led various alternative court initiatives within the Superior Court. In April of 2002 Judge Downs began oversight of Fulton County’s Drug Court Program
where drug-addicted criminal defendants participate in a highly structured outpatient rehabilitation program lasting from 6 months to 2 years. In June of 2006, Judge Downs helped create and she now supervises Fulton County’s Felony Behavioral Health Court, which helps find treatment, housing and community support for criminal offenders who have a diagnosed mental illness. The goal of both these alternative courts is to provide assistance, structure and support so that the participants do not return to a life of crime.

Judge Downs is the recipient of The St. Thomas More Award in 2007; Leadership Award from the Atlanta Bar Association in 2009; the EPIC Inspiration Award for Outstanding Leadership from the Emory Public Interest Committee in 2010 and the Pillar of Maimonides Award from the Maimonides School of Brookline, Massachusetts in 2010.

Judge Downs served as the Administrative Judge for Georgia’s Fifth Administrative District. Judge Downs sat on the Judicial Council, the governing body for the judiciary in Georgia, and served as a member of the Executive Committee for the Council of Superior Court Judges.

Prior to assuming the bench, Judge Downs had extensive criminal litigation experience. Judge Downs practiced for a total of thirteen years with the Fulton County District Attorney’s Office where she handled over 50 jury trials. During her last six years as a prosecutor she handled exclusively high profile/complex felony litigation. In addition to her trial work, she also assumed a significant role in the administration of the District Attorney’s 64 lawyer office.

She graduated with honors from the University of Georgia and received her Juris Doctor Degree with honors from the Lumpkin College of Law, University of Georgia.

She is married to Stephen C. Andrews who is a litigation partner in the law firm Bodker, Ramsey, Andrews, Winograd & Wildstein, P.C

**SUSAN WALKER GOICO**

Susan Walker Goico is a staff attorney at Atlanta Legal Aid Society’s Disability Integration Project. Her advocacy focuses on the implementation of Olmstead v. L.C, for people with mental illness and developmental disabilities who are confined in state psychiatric hospitals or the DeKalb County Jail. Her work on behalf of inmates in the jail is part of the Nick Project, a collaboration with the DeKalb County Public Defender’s Office, the jail’s mental health provider, community mental health providers, and the Georgia Department of Behavioral Health and Developmental Disabilities. Susan has worked in the disability rights arena since she graduated from the University of Georgia School of Law in 1998. Aside from her years working on Olmstead implementation at Atlanta Legal Aid, Susan has also been a contract attorney for the U.S. Department of Health and Human Services Office for Civil Rights (OCR), where she investigated Olmstead violation complaints and monitored an Olmstead-based voluntary compliance agreement between OCR and the state of Georgia.
HONORABLE KATHY GOSSELIN
Kathy Gosselin was born in Chicago, Illinois. She graduated from Southern Illinois University and the University of Chicago Law School. She came to Georgia in 1980, and practiced law in Gainesville from 1981 until 1987, when she was elected to the Hall County State Court. She presided in State Court from 1987 until 1998, when she was appointed by then Governor Zell Miller to the Superior Court of Hall and Dawson Counties. She has run unopposed since that very first contested election in 1986. She served both the Council of State Court Judges and the Council of Superior Court Judges as their President, has served on a number of committees concerning the advancement of the administration of justice, such as the Governor’s Commission on Family Violence, Georgia Supreme Court Alternative Dispute Resolution Commission and the Georgia Supreme Court Professionalism Committee. She served as the chair of the Council of Superior Court Judges’ Legislative Committee and is currently on the Executive Committee of the new Council of Accountability Court Judges. She has presided over a mental health court since 2004. Locally, Judge Gosselin has served the community in a number of volunteer capacities - President of the Board of Gateway House in the 80’s and the board of the then Gainesville Community Foundation, on the board of Teen Pregnancy Prevention, Inc, the Gainesville Rotary Club and is currently on the Advisory Committee of the Good News Clinics. She is a member of Grace Episcopal Church.

She is married to Bill Galardi and between them they have four grown and delightful children.

AMY V. HOWELL
Amy Howell serves as general counsel to the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). She was appointed to this position by Governor Nathan Deal in November 2011 and brought expertise in transforming state systems under federal oversight. In addition to being a member of the executive leadership team, Ms. Howell serves as the advisor to the commissioner, boards, and committees. She is responsible for all of DBHDD legal affairs including board governance, compliance, contracting, dispute resolution, litigation management, administrative hearings, privacy, open records, legislation, and general business activities.

Ms. Howell has a long history of public service, system transformation, and innovation. In January 2011, she was appointed by Governor Deal to serve as the first female commissioner of the Georgia Department of Juvenile Justice (DJJ) where she led 4,000 employees working in 26 facilities and 92 court service offices to affect restorative justice for more than 22,000 incarcerated youth. She joined DJJ in 2005 as the legal services director and was appointed deputy commissioner the following year. Prior to her appointment as commissioner, she served in several capacities and managed nearly every portion of the agency, including legal services, human resources, training, internal investigations, apprehensions, transportation, education, and medical and behavioral health.
Prior to joining DJJ, Howell was an assistant public defender with the Stone Mountain Judicial Circuit in the DeKalb County Juvenile Court, where she represented youth in delinquency cases.

Ms. Howell has also served as the managing attorney for the Southern Juvenile Defender Center (SJDC) at Emory School of Law. She received a post-graduate Equal Justice Works fellowship to work at SJDC. Her work focused on policy and systemic improvements for youth with disabilities in the justice system and culminated in the founding of the Barton Juvenile Defender Clinic at Emory School of Law.

Ms. Howell holds a bachelor of arts degree from Connecticut College and a juris doctor from The Temple University School of Law.

LISA KUGLER
Lisa Kuglar, LCSW, is the acting social work chief at East Central Regional Hospital in Augusta. She obtained a master’s degree in social work from the University of South Carolina in 1988 and has worked for the state of Georgia in the mental health field since 1982. Lisa’s hospital experience includes acute care psychiatric, substance abuse, developmental disability, geriatric, forensic, and children services. She also has experience in community mental health emergency services. Lisa was awarded Mental Health Advocate of the Year (2014) by the Augusta Mental Health Association, and Social Worker of the Year (2015) by the Georgia chapter of the National Association of Social Workers.

PEJMAN MAHDAVI
Pejman “Pej” Mahdavi is a Licensed Clinical Social Worker and Team Lead for the View Point Health Accretive Community Treatment Team serving DeKalb and Fulton Counties.

Pej was born in Tehran, Iran at the beginning of the Iranian Revolution. His family was forced to leave Iran to avoid religious persecution. He obtained his Bachelor’s Degree in Sociology from the California State University, Northridge in 2004 and later earned his Masters of Social Work from The University of Southern California (the REAL USC) in 2010. Mr. Mahdavi became a fully Licensure Clinical Social Worker in 2014.

Pej has worked in social services for at least ten years. His work experience includes investigating child abuse and working with juvenile offenders in Los Angeles County, working in state forensic hospitals in both California and Georgia, and assessing and assisting in competency restoration.

Pej is married with two daughters. He is an avid Laker fan, GA Bulldog, and USC Trojan. He enjoys four wheeling, mountain biking, and anything outdoors.

KEN MAULDIN, DISTRICT ATTORNEY
Ken Mauldin has served as the elected District Attorney for the Western Judicial Circuit of Georgia covering Athens-Clarke and Oconee Counties since 2001. He has been a
practicing attorney for more than 36 years. Before his current position, he served 10 years as Solicitor-General of Athens-Clarke County, the prosecuting attorney for misdemeanors. For the 10 years prior, Ken served in Oconee and Athens-Clarke Counties as an Assistant District Attorney from 1980-88, and then as a public defender with the Legal Aid Clinic. Since 1990, Ken has been an Adjunct Professor at the University of Georgia School of Law, teaching a course in Trial Practice one to two semesters a year.

Ken received both his bachelor and law degrees from the University of Georgia in 1977 and 1980, respectively. Subsequently, he earned an LL.M. (Master of Laws) in Litigation degree from Emory Law School in 1989.

TARIQ ABDUR RASHID
Tariq Abdur Rashid is currently a Forensic Peer Specialist Mentor with GMHCN. He is also a Certified Peer Specialist, Certified Addiction Recovery Empowerment Specialist/Addictive Disease and he recently graduated from Respect Institute. Tariq is originally from NYC and has been a chaplain at Riker’s Island Correctional Facility. Tariq is a motivational speaker and has given lectures here and abroad. His travels include University Of Leeds in England, University Of Trinidad and University of Sidney in Australia. Tariq is an avid student in political science and psychology. He has been an Imam /Spiritual leader of several communities including Atlanta and Valdosta. Presently, Tariq is dedicated to serving his community and peers, he teaches webinar classes on human development, offer marriage counseling, and volunteers at Fulton County Correctional Facility.

GAB RICH
Gab earned her bachelor’s degree in Psychology from Emory University in 2011 and her MSW from Georgia State University in 2014. She has worked as an intern at the Fulton County Office of the Child Attorney and the Southern Center for Human Rights. She joined the Disability Integration Project of Atlanta Legal Aid Society in 2014 and became a Licensed Master Social Worker in 2015. Gab’s work for the Disability Integration Project is based on the implementation of Olmstead v. L.C.. She advocates for adults, adolescents, and children with mental illness or developmental disabilities who are institutionalized or at risk of institutionalization to receive home and community-based services.

Gab also works on behalf of inmates in the DeKalb County Jail with severe and persistent mental illness as part of the Nick Project, a collaborative that connects individuals to community mental health services and housing. The community partners involved in the Nick Project are Atlanta Legal Aid Society, the DeKalb County Public Defender’s Office, the mental health unit of the DeKalb County Jail, community mental health providers, and DBHDD.

ROB RHODES
Robert L. ("Rob") Rhodes serves as the Director of Projects for the Georgia Appleseed Center for Law & Justice where he leads social justice research and advocacy efforts in a number of areas including juvenile justice, public education, and community-law
enforcement relations. Prior to joining Georgia Appleseed in March, 2009, Rob enjoyed a more than 32-year career as an environmental and water resources lawyer with the law firm of Holland & Knight where for many years he headed the firm's Environmental Practice. During his private practice tenure, Rob worked out of firm offices in Lakeland and Tallahassee, Florida, in Washington, D.C., and in Atlanta where he arrived in 2003. Rob held many leadership positions in the law firm including service for several years as firm-wide Deputy Managing Partner.

During his private practice years Rob was active in bar activities and served both as Chair of the Environmental & Land Use Law Section of The Florida Bar as well as Chair of the American Bar Association Standing Committee on Environmental Law. He also served as Chair of the National Advisory Council on Environmental Policy & Technology, a group providing advice to the United States Environmental Protection Agency.

Since moving to Atlanta, Rob has played an active role in local community service. He is a graduate of the 2007 Class of Leadership Atlanta. Rob served for several years on the Board of Directors of Hands on Atlanta and was Chair in 2008-2009. More recently, Rob served as Chair of the Board of Directors of Path to Shine, a ministry that helps to provide tutoring and other support to low income youth in multiple communities around the state. Rob is also a member and President-Elect of the East Cobb Civitan Club.

Rob received his undergraduate education at Emory University where he was elected to Phi Beta Kappa and earned a Bachelor of Arts with High Honors. Rob obtained his law degree from the University of Virginia School of Law. There, he was a member of the Editorial Board of the Virginia Law Review and was awarded the Order of the Coif. He is admitted to practice law in Georgia, Florida and the District of Columbia.

Rob resides in Smyrna, Georgia, with his wife, Marie. Collectively, they have six children and seven grandchildren. He is a constant reader, a lover of world travel, a sniffer of fine wine, an enthusiastically bad golfer, and he dances like no one is watching.

DOUG SCOTT

Doug Scott holds the position of supported housing director for the Georgia Department of Behavioral Health and Developmental Disabilities, where he is responsible for the Georgia Housing Voucher Program. To date, the program has helped more than 3,100 individuals find and maintain independent housing. Prior to working at DBHDD, Doug was responsible for not-for-profit housing development and special needs programs at the Georgia Department of Community Affairs. He holds degrees from Alma College and Purdue University.

BETH SHAW

Beth Shaw is a native Virginian and graduate from Virginia Commonwealth University with a bachelor of science in rehabilitation counseling. Beth started her career working in the field of supported employment in Richmond. She later moved into the public sector, working in Arlington County government where she began working in behavioral health and then returned to serving people with intellectual and developmental disabilities.
During this time, she gained valuable person-centered planning knowledge through attending conferences, seminars and workshops, which enabled her to assist in implementing a paradigm shift in support coordination service planning and delivery. In 2010, she joined Washington, DC’s Department on Disabilities Administration where she served as a program manager for service coordination. Beth worked closely with the administration to develop and implement the 2010 Evans Compliance Plan. She worked closely with Elizabeth Jones, court monitors, and the plaintiffs to help bring the department into compliance with class action lawsuit that began in 1976. In 2013, Beth relocated to Atlanta to be closer to family and to join DBHDD in its efforts to transition individuals out of state institutions into homes in communities of their choice.

**DR. TERRI TIMBERLAKE**

Dr. Terri Timberlake is Director of The Office of Adult Mental Health, for the Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD). In this position with the state mental health authority, she has programmatic oversight responsibility, including fiscal, policy, program development, planning and evaluation of statewide community adult mental health programs and services. Prior to her relocation to Atlanta and joining DBHDD, Dr. Timberlake was Director of Mental Health Services for New York City Health and Hospitals Corporation.

Dr. Timberlake holds a Master of Arts degree from The George Washington University and a Doctoral Degree from Temple University. She is a licensed psychologist with years of distinguished administrative, programmatic and clinical experience. She has been a programmatic innovator in developing, expanding and improving clinical services for mental health treatment. She is also an experienced clinical practitioner, supervisor and trainer and her work has led to multiple publications and articles in journals, lectures and presentations at local and national meetings.

**SHARON WILLIAMS**

Sharon Williams is a person in long term recovery. And what that means to her is that she has not used any mood altering chemicals against her will in over sixteen years. Today she is a mother, wife, homeowner, taxpayer, productive member of society, just to name a few. Sharon speaks loudly about her recovery because she believes everyone who has the disease of addiction should have the same opportunity such as herself, to live and not just exist. Sharon still attends weekly Narcotics Anonymous meeting to enhance her recovery and facilitates a weekly Double Trouble in Recovery meeting at the White County Peer Support and Wellness Center in Cleveland, GA.

Sharon is a proud mother of three wonderful children, ages seventeen, nineteen and twenty-eight. Her husband Tommy of twenty-two years is also a person in long term recovery. Sharon received her CPS-AD in May of 2011 and her CPS-MH in April 2015. She was previously employed with Advantage Behavioral Health Systems from April 2004-January 2015 and is now currently employed with the Georgia Mental Health Consumer Network as one of the first Forensic Peer Mentors in the state of Georgia. Sharon contracts with the Department of Corrections at Lee Arrendale State Prison as a FPM working with Returning Citizens who will soon return to their communities by
sharing her story, experience, strength, hope and assisting RCs with identifying positive goals in hopes of reducing the recidivism rate.

Sharon continues to progress in her passion for helping others and her enthusiasm for getting a job well done in the process.
COMMUNITY SERVICES AND PROCEDURES FOR PEOPLE FOUND INCOMPETENT TO STAND TRIAL, NONRESTORABLE

DBHDD HOSPITAL
FORENSIC DISCHARGE PLANNING

Dr. Karen Bailey
Lisa Kugler
Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)
Recovery and Discharging Planning for IST-N Individuals

KAREN BAILEY, PH.D.
OFFICE OF FORENSIC SERVICES
GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
SEPTEMBER 20, 2016

Not Competent, Not Restorable

OCGA 17-7-130:
Within 1 Year of Adjudication of Incompetency

Focal issue changes:
From:
Competency (Facilitate Capacity to Proceed)
To:
Civil Commitment (Facilitate Community Re-Integration)
Civil Commitment Hearing

- DBHDD offers an opinion
- Court hears all information offered
- Court issues a decision:
  - No civil commitment
  - Inpatient civil commitment
  - Outpatient civil commitment
- Commitment may be for a 1 year period
  - Non-violent felony: maximum or 5 years, whichever less
  - Violent felony: maximum of most serious offense charge

O.C.G.A. § 37-3-1(9.1)

Mentally ill
- 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 present a probability of physical injury to that person or another person

OR

- Who is so unable to care for that person's own physical health and safety as to create an imminent life-endangering crisis
Comprehensive Review Meeting

Assessments and Input from Different Perspectives:
- Psychiatrist
- Nursing
- Social Work
- Activity Therapy
- Psychology
  - Behavioral Summary
  - Risk Assessment
- Individual

Violence Risk Assessment

Violence:
"Actual, attempted, or threatened infliction of bodily harm of another person"

Risk:
"A threat/hazard that is incompletely understood and thus, whose occurrence can be forecast only with uncertainty"

Assessment:
"Method of gathering information in a consistent manner and guided by the best available scientific and professional knowledge for use in for decision making"

-From HCR-20 (V4) Manual
Conceptualizing the Risk

- Nature of the hazard
- Likelihood that it will occur
- Frequency/duration
- Seriousness of consequences
- Imminence

From: HCR-20 (V4) Manual

Georgia Department of Behavioral Health and Developmental Disabilities

Treatment and Discharge Planning

- Understand factors & events that increase that individual's risk
  - Impedes successful and safe transition to the community

- Identify treatment targets:
  - Behaviors/skills that need to be developed, increased, or decreased

- Develop treatment strategies to decrease or manage those risks

- Practice those skills and provide opportunities to demonstrate "working proficiency"

- Build discharge plan with supports to address remaining risks
Recovery Team Meetings: Where are We?

Did We Get There?

If recommending inpatient civil commitment:
• What behaviors are preventing recommendation for discharge?
• What changes have been made to the recovery plan?
• What minimum criteria must be met for discharge?

If recommending discharge/outpatient commitment:
• What are the individual’s salient risk factors
• How are these risk factors addressed?
Discharge Plan

Focused on mitigating risks

- Residential Placement
  - How much supervision needed
  - Skills for independent living

- Treatment Needs
  - Medication
  - Psychosocial Rehabilitation (PSR)
  - Peer Support
  - Substance Use/Abuse

- Occupational and Diversification Activities
What is Discharge Planning?
Discharge Planning

• Per the Centers for Medicare and Medicaid Services:
  ○ Discharge planning is conducted to plan for when a patient or resident leaves a care setting. Health care professional(s) and the patient or resident participate in discharge planning activities.

Discharge Planning

• The Joint Commission uses the term, “transitions of care”:
  ○ Multidisciplinary communication, collaboration, and coordination – including patient/caregiver education – from admission through transition
DBHDD Definition of Discharge Planning

- Discharge planning begins the moment an individual is admitted to a DBHDD hospital in an effort to ensure that he/she returns to the community as quickly as possible.

- Discharge planning requires a team-approach and the active participation of each individual to develop a plan that allows for the smooth transition into the community.

- Supports are put in place to assist in the individual's continued recovery, and to encourage further use and development of the skills he/she acquired during the hospital stay.

Transition Planning (DBHDD)

- **Person-centered**
  - Requires a partnership between the individual receiving care, people from his or her personal support system, DBHDD hospital and regional staff, and community provider staff.
Discharge Planning Focuses

- Assessment
- Planning
- Facilitation
- Case Coordination
- Evaluation
- Advocacy

Assessment Process

- Interviews, individual and collateral contact
- Prioritization of needs
- Identification of:
  - Strengths
  - High-risk issues
  - Community services
  - Possible barriers to discharge
Planning

- Person-centered
- Development of treatment plans with identified goals and objectives
- Planning is done collaboratively with the individual
- Planning can involve the individual, identified natural supports, hospital staff, regional office, and community liaison or specialty provider
- Discharge criteria is established

Facilitation

- Referrals initiated
- Communication and coordination with outpatient community services, engagement in treatment/recovery planning and transitional needs
- Natural supports/education and collaboration
- Ongoing communication with individual and attorney or public defender
Care Coordination

- Coordination of service delivery
- Developing a detailed written plan with identification of responsibility and accountability for individuals and providers
- Social workers ensure that services are in place, and that communication and collaboration is ongoing

Evaluation

- Evaluation of the plan, presentation to Forensic Review Committee for approval
- Presentation to court
- Monitoring/transitional period
- Reassessment, ongoing
Advocacy

- Knowledge of admission criteria for referral sources
- Knowledge of laws, rules, and regulations as they pertain to eligibility
- Skills in negotiation and problem-solving
- Identification of gaps in services

Identified Barriers to Transition

- Individuals admitted to forensic units may not meet eligibility criteria for community services
- Increase in individuals with intellectual and developmental disabilities
- Process for determining eligibility and obtaining services can be lengthy
- Suspended or terminated Social Security benefits
  - Pre-release process can be long once approved
  - It may take 30-45 days to re-establish benefits once the person is discharged
  - Bridge funding is available only for those who meet DBHDD service eligibility
- Delay in getting court approval for discharge or transition can result in loss of placement option
System Barriers

- Court may require conditions, such as 24/7 monitored care, for release into community-based settings
- High risk for interruption of mental health care for people found competent to stand trial

Positive System Improvements

- Forensic Community Coordinators
- Enhanced communication within DBHDD, collaborative training for hospital and community staff on transition planning
- Increase in specialty services
  - Assertive Community Treatment/Community Support Team
  - Intensive Case Management
  - Forensic Semi-Independent
  - Community Integration Homes
  - DBHDD-Supported Treatment Courts for Mental Health and Substance Abuse
  - Early Psychosis Intervention Collaborative
Community Behavioral Health and Developmental Disability Services Available to Forensic Individuals

Dr. Karen Bailey  
Dr. Terri Timberlake  
Beth Shaw  
Doug Scott  
Georgia Department of Behavioral Health and Developmental Disabilities

Pejman Mahdavi  
View Point Health
Forensic Residential Resources

KAREN BAILEY, PH.D.
OFFICE OF FORENSIC SERVICES
GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH
AND DEVELOPMENTAL DISABILITIES
SEPTEMBER 20, 2016

Community Integration Homes

COLUMBUS
Upatoi Lane
Hunter Road

ATLANTA
Greenridge Circle
Crow Street
Morning Side

CENTRAL
St. Paul CIH

SOUTHWESTERN
Thomasville CIH

EAST CENTRAL
Main House
Cottage
The Community Integration Home network in Georgia is comprised of 10 residences, located in Metro Atlanta, Macon, Augusta, Douglasville, Thomasville, Columbus, and soon in Savannah. Two of the homes are females residences, located in Macon and Columbus.

Georgia DBHDD Forensics Residential Resources

Guiding Principles:
- To follow the recovery-oriented model
- To promote individual rights
- To partner with individuals to achieve their desire goals
St. Paul CIH

Forensic-Supported Apartments

Aspire Behavioral Health & Developmental Disability Services

Gateway Behavioral Health Services

Advantage Behavioral Health Services

Behavioral Health Services of South Georgia
Savannah Apartments

Valdosta Apartments
Albany Apartments

Athens Apartments
Services Provided

**Community Group Homes**
- Offers 24/7 monitoring
- Allows choice and flexibility for individuals served
- Promotes the development of employment and education; enables people to live independently
- Coordinates all mental health and substance use disorder treatment and/or support needs with other health and/or recovery services

**Supervised Apartments**
- 24/7 staff available
- Licensed staff person on site 20 hrs/week (even on weekends)
- Allows choice and flexibility for individuals served
- Promotes the development of employment and education
- Enables residents to graduate from our semi-independent group living programs into independent housing with through the Georgia Housing Voucher Program

---

CIH Beds Total: 43 Males, 12 Females
Currently Total Beds Filled: 29 Male Beds, 11 Female Beds

<table>
<thead>
<tr>
<th>City</th>
<th>Vacant Beds</th>
<th>Available Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macon</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Columbus</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Thomasville</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Augusta</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Metro</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Note: Vacant beds shown have been reserved for specific individuals awaiting court orders approving hospital discharges.

---

Georgia Department of Behavioral Health and Developmental Disabilities
Referral Process

**Community Group Homes**
- Referral/Admission Form
  - Forensic Director Signature
- Within 365 days:
  - Psychiatric, Psychological, Nursing, SW Assessments
  - History and Physical/Meds
  - Dietary Consult
  - Risk Assessment/CR or COB Plan
- Signed Court Order for Visits
- Social Security contacted & Protective Filing Date established
- **Community provider and hospital staff** to coordinate appropriate community services prior to court order request

**Supervised Apartments**
- Referral/Admission Form
  - Forensic Director Signature
- Able to demonstrate independent living skills (cook, laundry, clean, etc.)
- Express a willingness to work with support staff
- Low risk for elopement
- Providers requested assessments
- Social Security contacted & Protective Filing Date established
- **Community provider and outpatient forensic staff to coordinate appropriate community services prior to court order request**

Referral Process

- Anticipated length of stay between 1-1.5 years
- Does the applicant have a Court Order for discharge: Yes_______ No_______
- Does the applicant have a Court Order for overnight visits: Yes_______ No_______
- Registered Sex Offender Yes_______ No_______
Criteria for Admission Approval

☐ Capable of **fully independent self-administration** of medication

☐ Able to **independently** perform blood sugar reading using his/her diabetic monitoring machine

☐ Able to complete household chores (e.g. vacuuming, cooking with staff oversight, cleaning bathroom, assisting with outdoor tasks, etc.) to ensure required sanitary conditions.

☐ Does not require assistance with ambulating.

☐ Active symptoms do not preclude from participating in social events (movies, park, fairs, restaurants, etc.)

---

Criteria for Admission Approval

☐ Has a plan outlining appropriate daytime activities outside the CIH, including a day program, scholastic activities, and a work training program, steady volunteer work or income-earning employment.

☐ Is low risk for AWOL

☐ Is low risk for VIOLENCE

☐ Demonstrates willingness to comply with his/her conditional release plan (NGRIs) or conditions of bond (ISTs).

☐ Demonstrates willingness to comply with the rules of the CIH (e.g. chores, sharing & loaning, diet orders and restrictions as ordered by the physician, medication compliance, etc.)
Adult Mental Health Services

TERRI TIMBERLAKE, PH.D.
DIRECTOR, OFFICE OF ADULT MENTAL HEALTH
DIVISION OF BEHAVIORAL HEALTH
GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND
DEVELOPMENTAL DISABILITIES
SEPTEMBER 20, 2016

Adult Community Mental Health
Array of Services Fiscal Year 2016

- Assertive Community Treatment (ACT)
- Supported Employment (SE)
- Case Management (CM)/Intensive Case Management (ICM)
- Community Support Team (CST)
- Crisis Stabilization Unit (CSU)
- Core
- Mobile Crisis
- Crisis Respite Apartments
- Residential Support Services; Community Residential Rehabilitation (CRR);
  Supported Housing, Bridge
- Crisis Service Center (CSC)
- Behavioral Health Crisis Center (BHCC)
- Projects for Assistance in Transition from Homelessness (PATH)
- SSI/SSDI Outreach, Access, and Recovery (SOAR)
- Peer Supports
- Mental Health Treatment Courts
- Community Transition
Assertive Community Treatment (ACT)

- 22 state-funded teams
- 4 Medicaid teams
- Provide community-based, recovery-oriented, consumer-driven, multi-disciplinary treatment team delivered, high-level service, reduction of re-admission, homelessness and incarceration, for people meeting ADA Settlement criteria
- Service delivery includes nursing, psychiatry, psychology, social work, substance abuse, vocational rehabilitation and peer support
- In-reach to jails and hospitals following referral

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Avita Community Partners, Cobb-Douglas CSB, Highland Rivers Health</td>
</tr>
<tr>
<td>2</td>
<td>Advantage Behavioral Health Systems, American Work, River Edge Behavioral Health Center</td>
</tr>
<tr>
<td>3</td>
<td>Fulton-DeKalb/Grady Health System (3), View Point Health (2), Georgia Rehabilitation Outreach (2)</td>
</tr>
<tr>
<td>4</td>
<td>Aspire Behavioral Health and Developmental Disability Services, Behavioral Health Services of South Georgia, Georgia Pines Community Service Board</td>
</tr>
<tr>
<td>5</td>
<td>American Work (2), Gateway Behavioral Health Services</td>
</tr>
<tr>
<td>6</td>
<td>Pathways Center for Behavioral Health, McIntosh Trail CSB, American Work</td>
</tr>
</tbody>
</table>
Community Support Team (CST)

- 10 DBHDD-contracted CST teams
- Located rural communities
- Community-based, recovery-oriented, consumer-driven, for persons meeting ADA Settlement criteria
- Goals to reduce
  - Re-admission
  - Homelessness
  - Incarceration
- Smaller team composition
- Multi-disciplinary approach

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Avita Community Partners, Highland Rivers Health, Lookout Mountain</td>
</tr>
<tr>
<td>2</td>
<td>Advantage Behavioral Health Systems, Serenity Behavioral Health Systems</td>
</tr>
<tr>
<td>4</td>
<td>Aspire Behavioral Health and Developmental Disability Services</td>
</tr>
<tr>
<td>5</td>
<td>Pineland Behavioral Health and Developmental Disabilities, CSB of Middle Georgia</td>
</tr>
<tr>
<td>6</td>
<td>Phoenix Center Behavioral Health Services</td>
</tr>
</tbody>
</table>
Crisis Services

- Crisis Stabilization Units
  - 22 CSUs
  - Provide assessment, crisis stabilization, therapeutic education, referral/linkage to appropriate services
- Mobile Crisis Services
  - Time-limited, rapid crisis response, assessment, referral/linkage to appropriate services
  - Multidisciplinary response team
  - 159 counties covered
    - Benchmark: regions 1, 2, 4 and 6
    - BHL: regions 3 and 5
- Behavioral Health Crisis Centers
  - 8 BHCCs
  - 24/7 access, combines walk-in, crisis assessment and stabilization; referral/linkage to services

Crisis Respite Apartments

- Brief periods of crisis respite, support services, linkage to treatment and other community services
- Prevention of CSU, ER re-admission/re-hospitalization
- Transition from a higher level of care into the community

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cobb-Douglas CSB, Avita Community Partners</td>
</tr>
<tr>
<td>2</td>
<td>Advantage Behavioral Health Systems</td>
</tr>
<tr>
<td>3</td>
<td>View Point Health</td>
</tr>
<tr>
<td>4</td>
<td>Aspire Behavioral Health and Developmental Disability Services, Behavioral Health Services of South Georgia, Georgia Pines Community Service Board</td>
</tr>
<tr>
<td>5</td>
<td>McIntosh Trail CSB</td>
</tr>
<tr>
<td>6</td>
<td>Gateway Behavioral Health Services</td>
</tr>
</tbody>
</table>
Case Management

- 14 state-funded intensive case management teams
- 52 state-funded case management services
- Individual support to increase access to community-based services, care coordination
- Individual recovery plan implementation
- May be combined with other core services

Supported Employment

- 21 supported employment providers
- Vocational assessment, rapid job search, competitive job placement, job maintenance support, benefits counseling, rehabilitative support
- Task Oriented Rehabilitation Services (TORS): new Medicaid-reimbursable component for vocational rehabilitation support services
Supported Employment Providers

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Avita Community Partners, Briggs &amp; Associates, Cobb-Douglas CSB, Highland Rivers Health, Lookout Mountain Community Services</td>
</tr>
<tr>
<td>2</td>
<td>Advantage Behavioral Health Systems, American Work, Oconee Community Service Board, River Edge Behavioral Health Center, Serenity Behavioral Health Systems</td>
</tr>
<tr>
<td>3</td>
<td>Briggs &amp; Associates, Community Friendship, Inc., DeKalb Community Service Board, View Point Health</td>
</tr>
<tr>
<td>4</td>
<td>American Work, Behavioral Health Services of South Georgia, G &amp; B Works, Inc.</td>
</tr>
<tr>
<td>5</td>
<td>American Work, Gateway Behavioral Health Services, Pineland Behavioral Health and Developmental Disabilities, Unison Behavioral Health</td>
</tr>
<tr>
<td>6</td>
<td>American Work, Briggs &amp; Associates, McIntosh Trail CSB, New Horizons Community Service Board, Pathways Center for Behavioral Health</td>
</tr>
</tbody>
</table>

Comprehensive Community Providers (CCP) of Core Services

- Community service boards
- Community mental health services
- Comprehensive psychosocial, psychiatric and nursing assessment
- Therapy/counseling
- Medication management
- Community support
- Referral and linkage to supports
- Psychosocial rehabilitation
Community Residential Rehabilitation

DBHDD Residential Services:
- Staff support in residential settings, continuous monitoring and supervision
- Skills training, community integration activities and personal support services/activities to restore and develop skills in functional areas that interfere with the individual's ability to safely live in the community, continue with recovery and increase self-sufficiency
- 32 providers of residential support services
- 1,921 statewide supported beds for residential rehabilitation
- Residential levels of care:
  - 22% intensive: 24-hour/on-site supervised; 5 hours of skills training
  - 29% semi-independent: 36-hour/on-site supervised; 3 hours of skills training
  - 49% independent: minimum of one contact per week; 1 hour of skills training

Supported Housing

Funding for rental assistance for target population:
- Staff support in residential settings, continuous monitoring and supervision
- Georgia Housing Voucher Program
- Bridge funding
- Collaboration Georgia Department of Community Affairs to increase capacity for target population to access supported housing options:
  - 811 Program
  - Shelter Plus Care
  - Housing Choice Voucher Program/Section 8
  - Forensic Supervised Housing/Community Home Integration (CIH)
PATH and SOAR

- Projects for Assistance in Transition from Homelessness (PATH)
  - 11 PATH teams throughout the state
  - Case management
  - Housing access
  - Outreach and linkage to services for the homeless

- SSI/SSDI Outreach, Access and Recovery (SOAR)
  - Provides increased access to Social Security disability benefits for people who are homeless or at risk of homelessness and who have mental health challenges or other co-occurring disorders

Mental Health Treatment Courts

- 7 accountability courts that combine judicial supervision and community mental health treatment
- Geared towards reducing criminal activity, improving stability
- Alternative to incarceration for people with serious and persistent mental illness, substance use disorders, or co-occurring disorders, who consent to treatment

<table>
<thead>
<tr>
<th>Region</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cobb-Douglas CSB, Highland Rivers Health, Avita BHIS</td>
</tr>
<tr>
<td>3</td>
<td>City of Atlanta</td>
</tr>
<tr>
<td>4</td>
<td>Aspire Behavioral Health and Developmental Disability Services, Georgia Pines Community Service Board</td>
</tr>
<tr>
<td>5</td>
<td>McIntosh Trail CSB</td>
</tr>
</tbody>
</table>
Transition Planning

Transition coordinators to support each state hospital in transition planning via:

- Reviewing transition plans
- Monitoring planning for persons with inpatient stays of +45 days
- Collaboratively coordinating care between state hospital, regional field office, and community service provider

Peer Support

- Peer support and wellness centers: programs led by certified peer specialists
- Structured activities that are provided for individuals with common issues and needs
- Promoting self-directed recovery and supporting people in developing and attaining individual life, recovery, and wellness goals
- Georgia is the first state in the U.S. to be able to bill Medicaid for whole health peer support
- Forensic peer mentors: currently working in state prisons and day reporting centers
DBHDD

- Georgia Crisis and Access Line (GCAL)
  - 24/7 crisis line
  - (800) 715-4225
  - mygcals.com

- Adult Mental Health Resource Directory
  - http://dbhdd.georgia.gov/adult-mental-health
Hospital Transitions Update

BETH SHAW, DIRECTOR
OFFICE OF TRANSITIONS
DIVISION DEVELOPMENTAL DISABILITIES
GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES
SEPTEMBER 20, 2016

Transitions Re-Started

Pioneer Process, Fall of 2014

Development of the Office of Transitions

First 2 transitions, December 2014
Phases of Transition

PRE-TRANSITION
TRANSITION
POST TRANSITION

Pre-Transition

- Early Engagement
  - Support Coordination
  - Integrated Clinical Support Team

- Housemate Matching

- Provider Risk Review
Transition

- Individual Support Plan Narrative
- Home Development
- Transition Training
- Transition Fidelity Committee Review

Post-Transition

- Regional Quality Review
- Integrated Clinical Support Services
- Enhanced Support Coordination
Keys To Our Success

- Functional Alignment of Case Expediters
- Development of Transition Manual and Policy
- Transition Process Map
- Relationships and Partnerships
- Communication Plans
- 26 people transitioned out of state hospitals in FY16
- Continuing transitions at a reasonable pace

Future State of Transitions

- “Lessons Learned” following every transition

- Successful Transition
  - How is it measured?
  - What is the evidence?
Questions?
Georgia Housing Voucher and Bridge Funding Programs

DOUG SCOTT
OFFICE OF ADULT MENTAL HEALTH
DIVISION OF BEHAVIORAL HEALTH

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

SEPTEMBER 20, 2016
Settlement Agreement Requirements

To provide supported housing and bridge funding to people with serious and persistent mental illness

- Priority is given to people who are
  - Currently being served in state hospitals
  - Frequently readmitted to state hospitals
  - Frequently seen in emergency rooms
  - Chronically homeless
  - Being released from jails or prisons
Program Design

- A “Housing First” approach
- Voluntary, flexible, community-based services
- Access to community activities based on the individual’s preference
- Lease in individual’s name
- Fair market rent standard with a utility allowance
- 30 to 40% of individual’s income toward housing cost
- Unit must meet Housing Quality Standards (HQS)
- Housing separate from service compliance
Referral Source (as of June 15, 2016)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>17%</td>
<td>47%</td>
<td>50%</td>
<td>47%</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Residential</td>
<td>41%</td>
<td>21%</td>
<td>16%</td>
<td>15%</td>
<td>8%</td>
<td>8%</td>
</tr>
<tr>
<td>Hospitals</td>
<td>7%</td>
<td>9%</td>
<td>17%</td>
<td>16%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Families</td>
<td>22%</td>
<td>9%</td>
<td>8%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Jails/Prisons</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>2%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td>14%</td>
<td>9%</td>
<td>7%</td>
<td>11%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Total Approved 3,851
Georgia Housing Voucher Program
Total Number Placed in Housing by State Fiscal Year
(as of June 15, 2016)

Goal: 100 Served by July 1, 2011
  • Result: 117
  117% of Goal

Goal: 500 Served by July 1, 2012
  • Result: 600
  120% of Goal

Goal: 800 Served by July 1, 2013
  • Result: 963
  120% of Goal

Goal: 1,400 Served by July 1, 2014
  • Result: 1,607
  115% of Goal

Goal: 2,000 Served by July 1, 2015
  • Result: 2,423
  121% of Goal

Goal: 2,358 Served by July 1, 2016
  • Result: 3,213
  138% of Goal
Performance Measures (as of June 15, 2015)

Housing stability: % of individuals who remained in the program after 6 months

- 2,502/2,674  94%
- DBHDD/HUD Standard  77%
- Above (Below) Standard  17%

Reengagement: number of successfully engaged out of total number of “negative leavers”

- 149/723  22%
- DBHDD Standard  10%
- Above (Below) Standard  12%
Long-Term Housing Stability
(as of June 15, 2015)

- SFY 2011 GHVP Tenants 77/114 68%
- SFY 2012 GHVP Tenants 305/467 65%
- SFY 2013 GHVP Tenants 244/346 71%
- SFY 2014 GHVP Tenants 460/614 75%
- SFY 2015 GHVP Tenants 690/882 78%
- SFY 2016 GHVP Tenants 731/788 94%
- SFY 2017 GHVP Tenants 65/65 100%

Overall Program Stability:
2,572 in stable housing of 3,276 placed 79%
## Current Status by Prior Living Situation
(as of June 15, 2015)

<table>
<thead>
<tr>
<th></th>
<th>CSU/CA</th>
<th>Family</th>
<th>Homeless</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>0</td>
<td>2</td>
<td>29</td>
</tr>
<tr>
<td>Signed Lease</td>
<td>23</td>
<td>197</td>
<td>1,159</td>
</tr>
<tr>
<td>Terminated</td>
<td>7</td>
<td>111</td>
<td>448</td>
</tr>
<tr>
<td>Transferred</td>
<td>2</td>
<td>52</td>
<td>159</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>362</strong></td>
<td><strong>1,626</strong></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>Residential</th>
<th>Jail/Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>5</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Signed Lease</td>
<td>195</td>
<td>153</td>
<td>110</td>
</tr>
<tr>
<td>Terminated</td>
<td>149</td>
<td>76</td>
<td>49</td>
</tr>
<tr>
<td>Transferred</td>
<td>25</td>
<td>40</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>374</strong></td>
<td><strong>276</strong></td>
<td><strong>167</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>PCH/GH</th>
<th>Rent Burdened</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Death</td>
<td>4</td>
<td>3</td>
<td>54</td>
</tr>
<tr>
<td>Signed Lease</td>
<td>63</td>
<td>55</td>
<td>1,955</td>
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<tr>
<td>Terminated</td>
<td>50</td>
<td>54</td>
<td>944</td>
</tr>
<tr>
<td>Transferred</td>
<td>14</td>
<td>30</td>
<td>326</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>131</strong></td>
<td><strong>67</strong></td>
<td><strong>2,279</strong></td>
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</table>

Georgia Department of Behavioral Health and Developmental Disabilities
## Bridge Funding
(Cumulative as of June 15, 2015)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Fees</td>
<td>$2,211,971</td>
<td>21%</td>
</tr>
<tr>
<td>Essential Furnishings</td>
<td>$2,487,308</td>
<td>24%</td>
</tr>
<tr>
<td>Household Goods</td>
<td>$817,597</td>
<td>8%</td>
</tr>
<tr>
<td>Utility Deposits</td>
<td>$765,184</td>
<td>7%</td>
</tr>
<tr>
<td>Security Deposits</td>
<td>$1,042,774</td>
<td>10%</td>
</tr>
<tr>
<td>Initial Rent</td>
<td>$2,664,729</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>$564,393</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$10,553,940</strong></td>
<td></td>
</tr>
</tbody>
</table>
GHVP and Keys to Success:
Regional Transitional Coordinators

Regional transition coordinators:
• Best-trained and most knowledgeable community integration specialists in Georgia
• DBHDD’s presence in the community
• Liaison between providers and DBHDD at the local level
• Administer DBHDD housing programs; work with providers to expand their understanding of programs and solve barriers for each individual
• Interpret clinical issues, recovery plans, and provider capacity
• Train providers in housing quality standards and expand relationships with property owners, continua of care, diversion courts, jails and prisons, and other community based “in-reach” activities
• Make the whole system work
GHVP and Keys to Success: Providers

- 70+ providers added staff, engaged private rental market in a more meaningful way, and gained valuable experience in conducting HQS inspections
- GHVP increased options for expanding services (ACT, ICM, CST, CM), and allowed for better coordination with hospital transitions, crisis stabilization units, and crisis apartments
- Providers able to engage consumers in a stable living environment
- Time saved by knowing consumers’ location, rather than seeking them out on the street or in shelters
- Housing key to meeting service fidelity models
GHVP and Keys to Success: Referrals

- Strong coordination between Projects for Assistance in Transition from Homelessness (PATH) teams and assertive community treatment (ACT) teams, which supports a seamless system of homeless outreach, service coordination, and housing (including partnership with Atlanta United Way)

- Referral system based on meeting the individual’s need

- Hospital discharge planning coordination with hospital staff, transition coordinators, and providers, which expedites housing placements

- “In reach” efforts into prisons/jails and coordination with mental health courts
GHVP and Keys to Success: Administration

- Simple, flexible rules, simple forms that only ask for necessary information.
- Efficient review of files submitted by providers to the regions for processing.
- Efficient turnaround from the initial invoice through a quality check with DBHDD’s third-party contractor (Cobb Douglas CSB)
- One-day processing average by DBHDD accounts payable staff
- Referral form that asks about the individual’s eligibility, services needed, and how the provider will support those needs.
- Service planning is person-centered and unique to each individual
GHVP and Keys to Success:
DBHDD

DBHDD
- Supports a wide range of housing options for people with disabilities, especially those with mental illnesses
- Is the 8th largest provider of rental assistance in Georgia
- Has the internal staff capacity to understand local real estate markets, engage property owners, continua of care, and public housing authorities
- Helps reduce stigma is reduced one property at a time as the most difficult to house become readily accepted as good tenants (986 properties and counting)
- Is equipped to directly affect the lives of chronically homeless individuals (though support services, PATH teams, and a wide array of housing options), as well as those leaving institutions
- Plays a role in criminal justice reform through services and housing
- Has created a coordinated referral “flow” through it’s other residential programs
Effect of Housing on Individuals
In Their Own Words:
Living Situation Before GHVP

- I was living in the woods without a tent or sleeping bag. I was able to take a shower every once in a while at friends’.
- Living post-to-post/homeless basically in and out of mental hospital.
- I was in jail and on the wrong road.
- One room shack that leaks infested with bugs.
- Before I received a GHV, I was homeless. I found refuge in places that [were] not safe and or healthy for anyone. No water, no gas, no electricity, no ventilation, no heat or air.
- Homeless and then was in Waycross for trying to kill myself.
- I used to be in foster care and bounced from place to place all my life. People only let me stay with them because I had a check. They took my money and left me with none; when they were tired of me they put me out. I have been in the hospital so much, I feel that is my home.
Effect of Housing on Individuals
In Their Own Words:
GHVP

- It gave me a sense of independence. Helped me get my kids back. It
gave me a sense of stability and security. I feel safe.
- Takes away the worry of a house and lets me concentrate on recovery.
I’m not sure about the neighborhood yet, so I’m still watchful.
- I have a space to live for me and my kids, and I feel safe.
- I feel like I have a purpose now.
- I know that I will be some where I can call home.
- Not homeless.
- I now have a safe place I can call my own, and I don’t feel like I’m
thrown away.
- I would be homeless and in jail but for this Georgia housing voucher.
- My entire outlook on my life has improved. No longer feel vulnerable
to becoming a victim again. I feel completely in control.
Effect of Housing on Individuals’
In Their Own Words:
Bridge Funding

• I had nothing; I had lost everything.
• Very proud of my home
• It gives my great confidence, and my ego is sky high
• All the items helped the apartment become a home and start off on the
  right tack.
• The bridge funding purchases has made a tremendous difference
  bringing a positive quality to my life. It allows me the fundamental
  necessities for basic living.
• I have all nice, clean, new furniture. I don’t feel ashamed anymore.
• It’s nice to have your own foundation, and furnishing it was a
  blessing. I have a home now that I can be proud of. I can’t do nothing
  but grow from this. It gives me mental and emotional stability too.
• I would have never thought I could have all these nice things without
  the program. My daughter even has a bed now. I feel a sense of
  relief. I feel like I have more than a house to provide to my daughter;
  I have a home.
Effect of Housing on Individuals
In Their Own Words:
Community Connections

- Haven’t made any friends yet. I do feel connected and involved with the neighborhood and my activities are centered around the apartment complex.
- I don’t socialize with many people, but I have met a few people in the complex. I mostly stay within the apartment.
- Right now, my friends are outside the complex—my church family, but I am very respectful and kind to my surroundings and look forward to meeting nice, good-hearted people.
- I have met some neighbors, but I haven’t made any friends yet. People exclude me because I’m in mental health program.
- The housing voucher has allowed me to establish boundaries with those who might want to take advantage of me having my own place because they might try to stay here, but they can’t stay here cause no one is allowed to be here but me, and I like that, knowing no one can come in and root me out of my safety.
Addressing Stigma Associated with IST-N Individuals

Gab Rich
Atlanta Legal Aid Society

Tariq Abdur Rashid
Georgia Mental Health Consumer Network

Sharon Williams
Georgia Mental Health Consumer Network
THE FRIDAY COVER

I Spent Seven Years Locked in a Human Warehouse
America shouldn't treat the mentally ill worse than it treats criminals.

By KETEMA ROSS | April 16, 2015

On the morning of June 24, 2007, I kicked in my elderly neighbors' door and brutally beat them with a broom handle. I then immediately called the police to tell them what I had done. I was arrested and charged with first-degree burglary, second- and third-degree assault and third-degree unlawful imprisonment.

If my motive for this attack had been a dispute over money or drugs, my story would be common, hardly remarkable. Had there been noise complaints from either side, a tawdry affair, a parking dispute or any other conflict, the public would have understood. Not approved, but understood. The community would rightfully have demanded justice, in the form of punishment, stating: "You did the crime, now do the time." Based on a plea offer I received, that time would likely have been three years in
prison. Then, despite the fact that there would have been an approximately 75 percent chance that I would reoffend, I would have been released, likely on parole but otherwise a free man, and rejoined society. The fact that most convicted criminals remain dangerous does not provide grounds to keep them locked up forever. They still have rights.

But my motivation for the attack was very different. It was caused by a mental illness. I sincerely believed that I had to attack them, at the order of the president and CIA, in order to stop a terrorist attack. I did so despite the fact that I very much did not want to. I had no conflict with my neighbors; I had never exchanged even a word with either of them. While I now regret what I did with every fiber of my being, at the time I thought I was doing the right thing.

I was found not guilty of the charges against me, by reason of insanity. But with the way our society operates, I may have been better off had I been motivated by evil, anger, greed or malice and been found guilty. Society understands malice. We understand retribution. But we do not understand mental illness and are often unable to see the humanity in those with mental illness. Thus, instead of being locked in a prison for three years, I was locked in a mental hospital for seven years. And I am one of the lucky ones. I know many others who have recovered from their illness but still have spent decades, even their whole lives, locked inside mental hospitals, simply because we choose to fear rather than understand mental illness. It is just so much easier and more convenient to throw people away. Many people with mental illness would love to have the rights that are given to convicted criminals.

***

In my early adulthood, I completed my Bachelor of Arts degree at Colorado College, worked as a claims adjuster for a major insurance company and attended Yale Law School for one year. I was, and still am, a good and decent human being with compassion for others and a loving heart. It was during my time at Yale, after becoming increasingly angry, frustrated and disillusioned with the law, that I had my first “psychotic break.” I believed that the federal government was following me and would kidnap and torture me because of my “revolutionary” beliefs. I fled the country in the fall of 2001 for Caracas, Venezuela, in fear for my life. I returned a few weeks later, destitute and homeless.

I would be in and out of various psychiatric wards more than a dozen times over the
next six years. I strained or ruined several relationships with friends, family and romantic partners, would struggle with unemployment and was using drugs in an attempt to “self-medicate” the voices in my head, the virtually constant overwhelming fear and anxiety, and the crisis of losing my identity as a successful scholar and academic. I had completely given up hope of a fulfilling life and believed (and often attempted to prove) that death would be a better state to attain than my own nightmare existence. When I committed those atrocious acts, I believed I was the only one who was sane, that everyone else was wrong, evil or actively conspiring against me. I believed I was following the will of the Almighty when I did what I did. This scares people. I understand completely, because it terrifies me as well.

On June 24, 2007, still believing that I was working for the federal government, I called the police after the assault. I thought they would take me in and debrief me about the violent action I had just taken against my neighbors. It was not until after sitting in a cell at the Whitman County jail for a full two months that the reality would hit me: I was not a member of the CIA. I had been tricked, my own sick mind had led me to commit an act that I will forever regret. I was not to be rewarded, but punished.

If I had taken a plea offer from the prosecutor, the form of that punishment would have been three years in a state penitentiary. There was another possibility, though: I could plead not guilty by reason of insanity and, if I confessed to my criminal activity on that terrible day and the court agreed, I would be sent to a mental hospital for an “up to life” maximum commitment.

The six months after the assault would pass very slowly as I waited to learn my fate. I was treated for my apparent mental illness with medications and was eventually transferred to the jail’s general population. The dangers of life in the jail as well as the realization, guilt and pain related to what I had done took over my days.

Then came a blessing: After pleading not guilty by reason of insanity, I was committed to Eastern State Hospital in Medical Lake, Washington. I was diagnosed with chronic paranoid schizophrenia, the chief symptoms of which were deeply ingrained delusions that I worked for the CIA, command-type hallucinations that I was receiving orders from the CIA and president via satellite, which resulted in the violent actions of that horrific morning. I steadily took the medicine I was prescribed to treat symptoms of psychosis. I began the process of recovery.

The medication worked. After about two years, I was no longer experiencing the
psychosis that caused my earlier conduct and thus was no longer dangerous. I was able to walk the grounds of the hospital and take supervised trips into the community, without ever doing or saying anything even vaguely dangerous. I assumed that I would soon be allowed to leave the hospital, with continued treatment and monitoring, and spend time with my family again. But I was very wrong. The state was going to keep me locked up for another five years, at a cost to taxpayers of approximately $250,000 per year, simply because it could.

The reality that I would not be leaving the hospital took time to set in. It happened after my first “offense” of using a pillow stuffed with books as a weight for working out. I was accused of “destroying state property” and lost weeks of time toward the all-important next category. I was angered, hurt, devastated. This experience served as a prelude to the next several years. No matter what I did, or how well I was, I could not overcome the system. The system works to serve its own ends, not those of patients.

This was made crystal clear by another event in 2009, after I had recovered enough to walk the hospital grounds and take supervised trips into town. One patient abused the privilege and walked away from an outing. He was eventually found and didn’t hurt anyone; he just couldn’t resist the urge after decades in the hospital. The media whipped up a panic. The state legislature responded by passing a bill requiring all patients to obtain a court order before being allowed supervised walks on hospital grounds or trips beyond the facility. These orders could, of course, take months to get. This bill passed both chambers unanimously. The citizens of the state, through their representatives, chose to act entirely out of fear and punish all of us collectively, rather than see us as individuals and trusting the doctors who know us best.

In Washington state, many patients would have served only six months in county jail if they had pleaded guilty but ended up “maxing out” their five-year maximum commitment to the hospital. Others were found not guilty of more serious offenses and so will likely never be released, even when they have substantially recovered, even in a supervised conditional release. A recent study of Washington state hospitals found that patients are more likely to be released to the coroner’s office than to the community on conditional release.

While I am grateful for the care I initially received, life in a mental hospital is often torment, with constant loneliness, hopelessness and depression. It can also be
terrifying, as patients who are truly dangerous are often on the same ward as people who were charged with check fraud. All of this became exponentially worse when the legislature took away what little freedoms we had and the hope of being released. You can imagine what effect it would have to not be able to take a walk and get fresh air, leave your house on occasion or visit family. Now imagine that instead of being trapped in your home, you are trapped in a mental hospital, even though you are well. Add to this the realization that your confinement is indefinite. You would struggle not just for your sanity, but also your humanity.

The sheer drudgery of living in a state hospital, combined with the countless pitfalls that beset patients, has convinced me that I recovered despite, not because of, my confinement to Eastern State Hospital. Life at the hospital feels like an enormous, endless exercise in futility. Hours pass like years, and years pass like hours. We suffer because we cannot express our remorse for the criminal activity we committed and be truly heard by our treatment teams, let alone our victims. We suffer because the cold, sterile environment that is to make us better sucks away our identities and, if we’re not careful, our very humanity.

Life at the hospital was difficult when I arrived in December 2007. Yet patients were allowed to visit each other’s rooms, play musical instruments with one another, share food and compact discs and otherwise be social. But then the walk-away happened and all hell broke loose. Patients were placed on lockdown—even those patients who had court-approved visits to town could not leave the hospital grounds. At a record pace, state laws were passed taking away re-integration trips and placing a state panel over the hospital as another level of scrutiny to any form of release. Hopelessness abounded on the forensic wards at the hospital. Shortly afterward, a patient was murdered at the hands of another patient.

Then came the mandate from the federal government that visiting one another’s rooms was too dangerous. Everything from guitars, to compact discs, to stereos, to shoelaces, belts and potted plants was deemed a “dangerous” item. They were henceforth removed from patient access. On my ward, there was almost a full-scale riot when these mandates were passed down. More policy changes followed making it a punishable offense for a patient to share food with another patient. While staff potlucks were carried out mere feet away, patients could help one another only by passing food in a bathroom or to a roommate, as these were the only places on the wards not monitored by camera 24/7.
“Long-term stability” is the name of the game when it comes to seeking release from the hospital. This translates to remaining cool, not giving in to the temptation to voice human emotions (such as frustration or anger) and following a laundry list of rules that can take away category levels (a hierarchical numbered system of labeling patients and granting them privileges), at any given moment. It also means participating in a monotonous routine of waking up early for breakfast, taking medications, then lining up for the walk to another building to participate in the “treatment mall” for five hours on weekdays.

The treatment mall is the part of the program most despised by patients. Though all classes are considered by the hospital to be “active treatment” (and thus it’s a mortal sin in the eyes of the treatment team to not participate), classes (such as “Table Games,” “Sewing,” “Journaling” and “Volleyball”) are rarely changed and become a sign of the drudgery, boredom and hopelessness that pervade the hospital environment. The routine continues back at the ward, where patients are distributed mail (an intense 15 minutes), followed by yard time, dinner, then ward store, community meeting on some nights, more medication distribution, then snacks and most patients going to bed. Most patients’ lives revolve around phone calls from attorneys, visits from loved ones or trips to court.

Adding to the state of despair is that some patients have nothing to lose because they know they will literally die in the hospital. Unsurprisingly, some are known to try to sabotage patients who are “working the program” by trying to start fights with them. This does not deter treatment teams from punishing the cooperating patient one iota when it comes to the enforcement of policies and rules—despite the knowledge that they are being provoked by someone who is known for aggressive behavior.

I was granted my release by a judge who, despite the testimony of hospital employees, was willing to give me a chance in the community. The stories of patients who are not so fortunate are too numerous to count.

I and a group of other patients, represented by attorney Andrew Biviano and the watchdog organization Disability Rights Washington, filed a federal suit against the Washington state system last fall. It is our claim that patients at Washington state hospitals are being denied their constitutional and legal rights when they are punished for minor transgressions, denied access to the outdoors and the community and held for years past the point they could have been re-integrated into the community. None
of the plaintiffs, including myself, will profit monetarily and, as I was conditionally released in January, I do not stand to gain in any way with the exception of seeing a grievous injustice addressed.

***

I am now applying for positions in the mental health industry as a “peer specialist,” hoping to use my training and experience to counsel others who are currently suffering from mental illness. I work out at the local YMCA, stay active in Narcotics Anonymous and am making connections in the local community. And for the first time in almost a decade, I prepare my own meals. I am responsible for my own rent and bills. I wash my own dishes.

I don’t pretend to be perfect. I don’t pretend to have answers to some incredibly difficult questions about what to do with those who commit horrible acts in the throes of psychosis. What I do is wonder. I wonder what it would be like to live in a society in which everyone admits that they are not perfect and we do not blame people for having a mental illness that they most certainly did not ask for.

The fact is that, statistically, I have a 0.6 percent chance of re-offending. The fact is that if I so much as have a beer in my refrigerator, break curfew, smoke marijuana in a state where that is legal or break any of a number of other stipulations to my newly found freedom, it will be taken from me. I do not want that to happen, so I take care not to break any of these conditions. But I still wonder. Is it fair? Is it fair that I must have practically perfect behavior in order to avoid being thrown back in the psychiatric hospital at a moment’s notice? Is it fair that I find my skin crawling when I hear the words “crazy,” “delusional” and “psychotic” tossed around without regard for those who live the reality of mental illness? Probably not.

I am encouraged by the stories of recovery I hear from others. I am encouraged by the words of wisdom I find in the Bible. I am encouraged by the changes I see in myself when I continue to take the medication I am prescribed because I want to continue living the new life I have been granted. I am encouraged by the people who are doing God’s work in this world—the Ebola workers, the nonprofit employees, the charity volunteers.

I had become isolated from the rest of the world long before I broke down my neighbors’ door and assaulted them in 2007. Society did not care about me until it felt
the need to protect itself from me. But perhaps the next chapter in my life will be filled with a moral, and perhaps legal, victory on behalf of patients who otherwise have no voice. Perhaps the liberties and freedoms that this nation cherishes will be afforded even to those with no power. Perhaps we will all commit to the difficult task of reflecting on ourselves and discovering what it is that makes us feel so afraid, and how we can be more understanding.

Perhaps there will be many more meals prepared for the forsaken, the demonized, the scapegoated of our nation. Not in the confines of mental hospitals, but as part of a larger conversation on what mental illness truly is.

Until then, I have some more dishes to do.
Recover

to Consumers

Helping Consumers

Support "Peer"

Support Peer

Georgia Mental Health Consumer Network
246 Sycamore Street
Suite 260
Decatur, Georgia 30030

Institute Support

Peer Georgia
Peer Support: A cornerstone in consumer recovery

Why attend G.P.S.I.?

The President’s New Freedom Commission Report on Mental Health states that peer support, a mutual relationship based on similar experience, is an important resource in the recovery of individuals with mental health problems. Peer support offers a sense of connection, validation, encouragement, and helpful information. Whether in a structured Peer Support Program or one’s natural community, peer support provides the opportunity to experience one’s self as valuable and capable of making a positive difference in another’s and therefore one’s own life.

The Georgia Peer Support Institute (GPSI) is a three-day immersion in peer support designed to teach the principles of recovery from mental illness; characteristics of consumer-directed, peer-run and recovery-oriented mental health services; and skills to take an active role in one’s recovery and creation of a meaningful life. Throughout the Institute, participants share knowledge and experiences and develop new relationships with peers and themselves.

Each spring and fall thirty-five mental health consumers are selected to participate in the GPSI. Those selected are expected to plan and implement a project on some aspect of the training when they return to their community. All expenses for training materials, lodging and meals will be covered and travel expenses reimbursed. Any consumer can apply. Dates and applications for the next GPSI can be found at www.gmhc.org or www.gacps.org.

What can you learn?

Principles of Recovery and Self-Determination
How to start and sustain mutual self-help peer support groups
How the WRAP can become a vital tool for your own recovery
How supported employment promotes recovery
How to get the most benefit from your mental health services
New information and perspectives about yourself

Interested? Know anyone who is? Fill out this form and send it to:

Attention: GPSI Project Coordinator
Georgia Mental Health Consumer Network
246 Sycamore Street, Suite 260
Decatur, Georgia 30030
Phone: 404-687-9487
Toll Free: 1-800-297-6146

PLEASE SEND GPSI APPLICATION TO:

Name (PRINT CLEARLY)

Address

City

State Zip

Daytime Telephone Number with Area Code

Email address
FOR MORE INFORMATION

RESPECT is a movement begun by international consultant Joel Slack. Its purpose is to educate the public by telling personal accounts of the powerful impact that respect (and disrespect) has on a person recovering from a mental illness.

RESPECT speakers are graduates of the RESPECT Institute of Georgia, which was developed by Joel Slack, founder of RESPECT International, LLC. The RESPECT Institute of Georgia is a collaborative effort between the Georgia Mental Health Consumer Network, Mental Health America of Georgia and the Georgia Department of Behavioral Health and Developmental Disabilities.

FOR SPEAKER REQUEST FORM

I would like more information about the RESPECT Institute of Georgia.

Name ____________________________
Organization ______________________
__________________________________
Address __________________________
__________________________________
City ______________________________
State _____________________________
Zip Code __________________________
Phone # __________________________
E-mail: __________________________

Detach and fax this panel to (404) 687-0772 or email or call the phone number provided.

For more information contact:

Shelia Corn, CPS
RESPECT Institute of Georgia Outreach Coordinator
Georgia Mental Health Consumer Network
246 Sycamore Street, Suite 260
Decatur, GA 30030
Office: 404-687-9487 Cell: 770-501-5243
Email: shelia@gmhc.org

Mental Health America of Georgia

GIVING RECOVERY
AND HOPE
A VOICE

DBHDD
Georgia Mental Health Consumer Network
The RESPECT Institute of Georgia facilitates the sharing of individuals’ unique stories of recovery from mental illness to a broad range of audiences throughout Georgia.

Each RESPECT Institute of Georgia is a 3 ½ day program which provides 12 individuals with the skills and coaching necessary to transform their mental illness, treatment, and recovery experiences into educational and inspirational presentations.

**In Their Own Words**

RESPECT Institute of Georgia graduates share their stories to help others who may encounter similar obstacles. The Institute empowers people with mental illness by acknowledging, honoring, and valuing their personal experiences and insights. Through this recognition and acceptance, individuals reclaim their sense of self, educate their community, and eliminate stigma.

“When I share my story I am strengthened. RESPECT has been very liberating. This feels like the beginning of a big journey. I have a sense of purpose. I have a mission.”

- RESPECT Institute of Georgia Participant

“I am not ashamed of what I have been through anymore. This means a lot on the road to recovery.”

- RESPECT Institute of Georgia Participant

“This is the first time that I have been able to get people a full understanding of my recovery and mental health challenges. It feels good to know that I will be helping to reduce stigma against others with mental challenges.”

- RESPECT Institute of Georgia Participant

“The speakers... really opened my eyes to those who are living with a mental disorder. I know people with mental health illness had to learn how to cope with their disorder; however, I never really thought of the work that goes into coping with it.”

- RESPECT Audience member

“I will never forget anyone’s stories or names because of all that you have shared with us. Powerful!”

- RESPECT Audience member

RESPECT speakers are available to present to all types of groups in most areas of the state.

To schedule a speaker, use the form provided in this brochure or contact a local institute by phone or email.
Our Mission

It is the mission of the Georgia Certified Peer Specialist Project to identify, train, certify and provide ongoing support and education to consumers of Mental Health Services to provide Peer Supports as part of the Georgia Mental Health service system and to promote self-determination, personal responsibility and empowerment inherent in self-directed recovery.

The Georgia Certified Peer Specialist Project is a partnership between the Georgia Mental Health Consumer Network & the Georgia Department of Behavioral Health and Developmental Disabilities

DBHDD
Georgia Department of Behavioral Health and Developmental Disabilities

GEORGIA CERTIFIED PEER SPECIALIST PROJECT
246 SYCAMORE ST
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TOLL FREE: 1-800-297-6146
FAX: 404-687-0772
WWW.GACPS.ORG

"MY TREE OF HOPE"
by Dana Roderick

SHARING THE HOPE
Key to the successful implementation of CPSs in service delivery roles in consumer-operated Peer Centers and in Peer Supports is how to build environments conducive to recovery in Peer Support services. This role is not interchangeable with traditional staff that usually works from the perspective of their training and/or their status as licensed health care providers. CPSs work from the perspective of their lived experience, or “Having been there.” They lend unique insight into mental illness and what makes recovery possible.

The training and Certification process prepares a CPS to promote hope, personal responsibility, empowerment, education and self-determination in the communities in which they serve. Recovery is no longer only about what clinicians do to consumers, it has become, with the assistance of CPSs, what consumers do for themselves and each other. CPSs are trained to assist consumers in skills building, problem solving, conducting Recovery Dialogues, setting up and maintaining self-help mutual support groups and in assisting consumers to build their own self-directed recovery tools, including the Wellness Recovery Action Plan (WRAP). A critical role is supporting consumers in developing their recovery goals and specific steps to reach those goals.

HOW DO I BECOME A CPS?

▷ Candidates must have diagnosis of mental illness or a dual diagnosis of mental illness and addictive disease and must desire to identify themselves as a person with mental illness (current or former consumer of mental health services)
▷ Applicants must hold a high school diploma or a GED, and may be requested to provide a copy of this document.
▷ Must demonstrate strong reading comprehension and written communication skills as indicated on their responses on the pre-test, which is part of the application.
▷ Must have demonstrated experience with leadership, advocacy or governance.
▷ Must be well grounded in recovery (At least one year between diagnosis and application to the training)

Consumers who are interested in becoming a CPS make application through the CPS Project Manager. Candidates are selected based on their employment status and the ability to meet training guidelines. Consumers who are employed by a public or private provider of Medicaid billable services are the highest priority. Consumers who have distinguished themselves as peer leaders and are being sponsored by a Medicaid provider for possible hire are given next priority. Consumers who work for a peer service that does not bill Medicaid, or that are seeking certification to improve marketability are given next priority.

Please contact the CPS Project if you have any questions about your qualifications.
Our Goals

- Host an annual peer conference that promotes recovery, wellness and identifies the top priorities of consumers of behavioral health services statewide.

- Promote employment with emphasis on quality jobs that foster true independence.

- Offer training opportunities for peers including the Certified Peer Specialist Project and Whole Health Wellness Coaching.

- Support the development of new peer leaders through the Georgia Peer Support Institute.

- Support consumer access to transportation.

- Support the expansion of Recovery Through the Arts and the Double Trouble in Recovery Program.

- Promote Peer Supports and wellness including the Peer Support, Wellness and Respite Centers and Peer Support Whole Health.

How we are funded?

GMHCN is funded by grants, contracts, donations, and membership fees. The cost of joining our organization is a donation of $5.00 per year for peers (scholarships available) and a minimum of $20.00 per year for supporters. Membership includes a subscription to the GMHCN quarterly newsletter “The Pipeline.”

246 Sycamore St., Suite 260
Decatur Georgia 30030

GEORGIA MENTAL HEALTH CONSUMER NETWORK

Telephone: 404-687-9487
Toll free: 1-800-297-6146
Fax: 404-687-0772
E-mail: office@gmhcen.org
Website: www.gmhcen.org
What is the Georgia Mental Health Consumer Network?

The Consumer Network is a Georgia non-profit corporation founded in 1991 by consumers of state services for mental health, developmental disabilities and addictive diseases. It hosts one of the largest statewide annual consumer conferences in the nation. The corporation evolved from a meeting of 30 consumer leaders held in Tucker, Georgia in October of 1990. The membership is now over 4,000.

Mission Statement

Our mission is to promote recovery and wellness through advocacy, education, employment, empowerment, peer support, and self help, and to unite as one voice to support the priorities set each year at our annual statewide consumer conference.

- Initiated the Georgia Peer Support and Resiliency Project and Statewide Peer Wellness Initiative.
- 20 To Work By 2000—The Consumer Network’s nationally acclaimed employment initiative that helped to move 20 percent of all consumers in day programs into jobs in the community.
- Since 1992 has hosted one of the largest statewide annual consumer conferences in the nation.
- Provides Wellness Recovery Action Plan (WRAP) and WRAP for Work trainings statewide.
- Facilitates Double Trouble in Recovery groups Statewide for people in recovery from mental health and addictive diagnoses.
- Publishes a quarterly newsletter called “The Pipeline.”
- Supports Recovery Through The Arts.
- Implemented the Georgia Certified Peer Specialist Project.
- Conducts the Georgia Consumer Satisfaction Survey.
- Provide Mental Health First Aid training.
- Developed the Peer Mentoring Project to assist peers transitioning out of regional hospitals into communities.
- Opened five Peer Support, Wellness and Respite Centers to provide peer support, daily wellness activities, 24/7 warm lines, and 3 respite beds per center.
- Conducts the Georgia Peer Support Institute.

Please fill out the membership form and mail it to the Consumer Network along with $5 or your donation.

Print Name
First _____________________________

Last _____________________________

Street Address
______________________________________ Apt._______

City ______________________________

County____________________________

State _____ Zip _____________

Phone (____)_______ – ________

Email ________________________________

246 Sycamore St., Suite 260
Decatur Georgia 30030

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Fax: 404-687-0772
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Website: www.gmcn.org
Advocating for an IST-N Individual: Evaluating Civil Commitment Criteria, Reviewing Discharge Planning, Requesting Release and Community Services

Materials By:

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Ken Mauldin
District Attorney, Athens-Clarke and Oconee Counties

Susan Walker Goico
Atlanta Legal Aid Society
Advocating for Community Services for Individuals Found Incompetent to Stand Trial

Susan Walker Goico
Disability Integration Project

Atlanta Legal Aid Society, Inc.
Decatur, Georgia
September 20, 2016

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I. Introduction

Lawyers in Atlanta Legal Aid Society’s Disability Integration Project advocate for people with disabilities to receive disability services and supports in their own homes and communities. Our work is based on the landmark civil rights decision *Olmstead v. L.C.*¹ In *Olmstead*, the United States Supreme Court held that unjustified segregation of people with disabilities in institutions is unlawful discrimination under Title II of the Americans with Disabilities Act (1990). The essence of *Olmstead* is this: If a person with a disability is receiving state-funded services in an institution, and could instead be appropriately served in the community, then the State must provide the supports and services in the most integrated setting appropriate to the individual’s needs.

In our efforts to implement *Olmstead*, we in the Disability Integration Project represent people with disabilities—individuals with mental illness, intellectual and developmental disabilities, physical disabilities, or brain injuries— who want to leave institutions like state psychiatric hospitals, nursing homes, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and receive support in the community. We also represent people who are at risk of entering an institution due to a lack of community-based support services.² We advocate for these citizens to receive the state-funded supports

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¹ 527 U.S. 581 (1999). The *Olmstead* case was brought by the Disability Integration Project’s founding attorney, Sue Jamieson, on behalf of two women with both mental health and developmental disabilities.

² We also facilitate the Nick Project, which is a collaborative reentry initiative that seeks to connect inmates in the DeKalb County Jail with community mental health supports and housing.
they need to live meaningful lives in the community. The Georgia Department of
Behavioral Health and Developmental Disabilities (DBHDD) is the state agency
in charge of providing community services for people with mental illness and
developmental disabilities. The Georgia Department of Community Health
(DCH) provides community services for people with physical disabilities and
traumatic brain injuries.

People with forensic status, in particular people who have been civilly
committed to a forensic hospital after being found Incompetent to Stand Trial,
Nonrestorable (IST-N), also have Olmstead rights. However, in order for an
individual found IST-N to transition into the community with appropriate
supports, the criminal court, which also has jurisdiction over the person’s civil
commitment, must find that he no longer meets the inpatient civil commitment
standard set out in O.C.G.A. § 37-3-1(9.1). As will be discussed below, when
analyzing civil commitment, it is imperative to consider all of the available
mental health and developmental disability supports and housing that are now
part of Georgia’s service system for people with disabilities.

This paper provides an advocate’s overview on when and how to evaluate
whether your forensic client meets the inpatient civil commitment criteria and, if
your client does not meet the inpatient civil commitment criteria, how to
advocate for community-based supports and services so that the client can be
released from the forensic hospital and begin a meaningful life of recovery in the
community. The focus of the paper will be on individuals found Incompetent to
Stand Trial, and specifically those who have already gone through the restoration
period and have been found “nonrestorable.”
II. The IST-N individual and civil commitment

A. What are the Inpatient and Outpatient Civil Commitment Standards?

Before describing the points in the process where an advocate can challenge a client’s inpatient civil commitment, it is important to understand the very strict criteria one must meet to be civilly committed to a state forensic hospital, as well as the criteria for outpatient civil commitment. Both inpatient and outpatient civil commitments (and full release) are available statutory options for people found IST.

The IST statute’s definition section refers us to Georgia’s Mental Health Code definition of outpatient and inpatient civil commitment. O.C.G.A. § 17-7-130(a)(6),(8). These definitions set out the criteria for civil commitment that the advocate must understand in order to determine whether to challenge a civil commitment recommendation.

i. Inpatient civil commitment

An individual meets the involuntary inpatient treatment criteria (meaning civil commitment in a hospital setting) if he is a mentally ill person:

(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 present 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.

O.C.G.A. § 37-3-1(9.1)(A)(emphasis added).
Note how the inpatient commitment criteria of section (i), often referred to as the “harm to self or others” prong, specify that any threats or acts of violence must be recent. This time-bound requirement arguably does not mean that the threat or act was months or even weeks ago. Any threat must also present a risk of imminent harm. Moreover, any overt threats of harm (toward the individual or others) must create a “probability of physical injury,” meaning the threats cannot be simply empty threats of violence that could not actually be carried out (e.g. someone in a mental hospital threatening to “blow up the place,” perhaps expressing frustration with a situation, when there is obviously no way the individual could actually perpetuate this act of violence, would probably not pass this test).

Section (ii) of the inpatient civil commitment criteria, known as the “unable to care for self” prong, must not be considered in isolation. Rather, you must consider the individual’s ability to care for himself if he is provided all the available support and housing through the public mental health system (which will be discussed below). One must consider these community services because people with mental illness have a civil right to such support under Olmstead. So, instead of asking whether a person with mental illness is at risk of an imminently life endangering crisis if he were simply ushered out the hospital doors onto the street, one must consider his risk if he receives all the mental health services and housing he is entitled to, such as the high quality support of an Assertive Community Treatment (ACT) team and supported housing in a forensic apartment, Community Integration Home, or a Georgia Housing Voucher apartment.
ii. **Outpatient civil commitment**

An individual meets the involuntary outpatient treatment criteria ("outpatient civil commitment") if he is a mentally ill person:

(A) Who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;

(B) Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment.

O.C.G.A. § 37-3-1(12.1)

“Outpatient treatment” is further defined as

a program of treatment for mental illness outside a hospital facility setting which includes, without being limited to, medication and prescription monitoring, individual or group therapy, day or partial programming activities, case management services, and other services to alleviate or treat the patient's mental illness so as to maintain the patient's semi-independent functioning and to prevent the patient's becoming an inpatient.

O.C.G.A. § 37-3-1(12.2)

Although many disability advocates, people with mental illness, and even community mental health providers oppose the use of outpatient civil commitment because it is, in effect, coerced treatment that may result in an individual’s distrust of the community service system, the outpatient civil commitment criteria are easier to meet than the inpatient criteria because they consider both the individual’s past experience in the community and current

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mental status. The Court with jurisdiction over the criminal case of an individual found IST would similarly have continuing jurisdiction to enforce an outpatient civil commitment.

Involuntary outpatient treatment is not universally favored because, it is argued, for mental health treatment to be truly effective and for the clinical relationship to be completely therapeutic, it must be voluntarily accepted and the treatment provider should not play a role in “punishing” a person by reporting noncompliance to the court. However, many clients often find outpatient commitment preferable to inpatient commitment, if this is the only alternative to another year in the hospital. Because mental health treatment is most effective and has the best chance of long-term engagement when it is voluntarily sought and the treatment plan is developed with the client’s input (rather than being imposed on him), you must be diligent in helping your client get out of the outpatient commitment and continue with all appropriate voluntary services once a court order for treatment is no longer necessary.

**B. When and how can civil commitment be challenged?**

There are several opportunities in the IST process for an advocate to challenge a client’s inpatient civil commitment: After the nine-month “restoration” period and, if the client is civilly committed at this point, again at the annual civil commitment reassessments. An advocate also can petition for his client’s release at any other time. Because inpatient commitment should be reserved for people who are determined to be dangerous and because institutionalization results in an individual’s loss of liberty, it is critical for the advocate to very carefully analyze and monitor the client’s status and
appropriately challenge the hospital’s recommendation if you determine it is not based on the client’s actual clinical condition and behaviors. Importantly, you should simultaneously advocate for your client to be connected to all available community mental health supports and services.

i. **Civil commitment after the restoration period.**

After an individual has been in the state mental hospital for up to nine months for competency restoration treatment following an initial finding of incompetency, DBHDD must determine whether the individual is still mentally incompetent to stand trial. Georgia law requires DBHDD to report the findings regarding competency and the reasons to the Court. O.C.G.A. § 17-7-130(c)(3). Further, if the evaluation shows that there is no substantial probability that the individual will attain competency in the foreseeable future (what will be called here “nonrestorable”), and the individual is charged with a felony ⁴, the Department reports to the Court whether or not the individual meets the criteria for civil commitment. O.C.G.A. § 17-7-130(e)(2). The Court may order an independent evaluation in order to get a second opinion on the individual’s current mental and emotional condition. *Id.*

After receiving the Department’s report and any report of an independent evaluator, the Court can consider entry of a nolle prosequi of the charges and

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⁴ If the individual is charged with a misdemeanor, at this point the Court considers entry of a nolle prosequi and can request that DBHDD petition the probate court for civil commitment. O.C.G.A. § 17-7-130(e)(1)(A). If the Court finds that the person does not meet the criteria for civil commitment, the person is released. O.C.G.A. § 17-7-130(e)(1)(B). If your misdemeanor client is going to be released and requires mental health supports and housing, request that the hospital perform discharge planning and connect the individual with housing and all appropriate supports, including an ACT team, if appropriate.
request that the Department petition the probate court for civil commitment, or it retains jurisdiction and conducts a trial to hear evidence on whether the individual meets the standard for civil commitment. O.C.G.A. § 17-7-130(e)(2)(A),(B). At this civil commitment trial, the State has the burden of proof and must prove by clear and convincing evidence that the individual meets the criteria for civil commitment. O.C.G.A. § 17-7-130(e)(2)(B).

It is at this crucial point, when the individual is found “nonrestorable” and a civil commitment determination is being made for the first time, that defense counsel must look closely at the evidence presented by the State to determine whether the client actually meets the inpatient civil commitment standard. Often, it is not always clear in the letter evaluation submitted to the Court the reasons for the hospital’s recommendation, and the advocate must then request and evaluate the medical records and discuss the matter with the client and his hospital treatment team. The following parts of the medical records are helpful to review to analyze whether your client meets the inpatient civil commitment standard: Individualized Recovery Plans, annual psychiatric evaluations and assessments, risk assessments, client progress notes, discharge plans, assessments and notes by the Forensic Review Committee.

When you review these medical records, try to determine: When was the last incident of violence? Was it “recent,” as required by the definition in the mental health code? If the inpatient civil commitment recommendation is based on a threat of violence, was the threat recent and did it present a probability of physical injury? If the recommendation is based on the “unable to care for self” prong of the inpatient civil commitment criteria, have all appropriate community
mental health services and housing been considered and have providers been brought into the hospital to develop a community plan for services? Because an ACT team is the most intense level of the community-based services and is for people with the most complex needs, find out if a referral has been made to an ACT team to address the client’s needs in the community. (See Appendix A for link to DBHDD’s ACT team FAQ.) If your client has an intellectual or developmental disability, it is critical that he be considered for and connected to a Developmental Disability Medicaid Waiver (discussed below), which can provide him with 24/7 support in the community.

This is a crucial point in the process because if the individual does not meet the inpatient civil commitment standard and he prevails at this initial civil commitment trial, he can be released to the community with all of the appropriate mental health supports, services, and housing that he needs. (Ensuring that your client receives all the services he needs may take some advocacy as well, as will be discussed below.) Careful advocacy at this stage can prevent an unnecessary and expensive forensic hospitalization that could last for years. The client gets to re-start his life with the help of a full panoply of community supports, and he avoids the hopelessness that so often accompanies long-term institutionalization.

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5 An ACT (Assertive Community Treatment) team is often called a “hospital without walls” because of its intense level of services and the interdisciplinary team approach. ACT teams serve people who are frequently hospitalized, homeless, or incarcerated, and provide services and support in the client’s own home instead of a clinic. The team is comprised of a team lead, a psychiatrist, nurse, psychologist, peer specialist, vocational counselor, substance abuse counselor. The team provides everything from 24/7 crisis response to assistance with medication management, activities of daily living, and housing.
ii. **Annual civil commitment evaluations.**

If a person found IST-N is initially civilly committed after the period of restoration, the Court can order civil commitment on an annual basis, which provides another opportunity for you to challenge the inpatient civil commitment, if necessary. If the individual is charged with a nonviolent offense\(^6\) the Court can order civil commitment on an annual basis, but only for a period not to exceed the maximum period the person could have been sentenced for the most serious nonviolent offense charged or else for a period of five years, whichever is less. **O.C.G.A. § 17-7-130(e)(2)(B)(iii).** The civil commitment must be reevaluated by a DBHDD physician or psychologist every year. **Id.**

If the individual is charged with a violent offense (those listed at **O.C.G.A. § 17-7-130(a)(11)**), the Court can order civil commitment annually, only for as long as the maximum period the person would have been sentenced on the most serious violent offense charged. **O.C.G.A. § 17-7-130(e)(2)(B)(iv).** A DBHDD professional must similarly reevaluate the individual every year. **Id.**

To comply with the annual reevaluation requirements above, DBHDD must send an evaluation to the Court as to whether the individual continues to meet the criteria for civil commitment. **O.C.G.A. § 17-7-130(e)(2)(B)(v).** The Court mails the evaluation to the individual’s attorney or if the individual is pro

\(^6\) A nonviolent offense is any offense not included in the list of violent offenses at **O.C.G.A. § 17-7-130(a)(11),** namely: A serious violent felony, a sexual offense, criminal attempt to commit a serious violent felony, criminal attempt to commit a sexual offense, aggravated assault, highjacking of a motor vehicle or aircraft; aggravated battery, aggravated stalking, arson in the first degree or in the second degree, stalking, fleeing and attempting to elude a police officer, any offense which involves the use of a deadly weapon or destructive device, and the catch-all provision of “those felony offenses deemed by the court to involve an allegation of actual or potential physical harm to another person.”
se, to the individual and the prosecuting attorney. *Id.* Implicit in this requirement that the Department submit an evaluation is that the evaluation specify the reasons why the individual meets – or does not meet -- the very specific criteria for civil commitment.

A hearing is not automatically scheduled to hear evidence on the matter of whether the individual meets the inpatient civil commitment standard. Indeed, if no hearing is requested by either the individual or the State, the Court will review the case and enter an order either renewing the civil commitment, changing the civil commitment status (to either on outpatient civil commitment or no civil commitment), or, if the charges are dismissed, the Court may enter an order transferring the jurisdiction of the case to the probate court where the individual lives for further civil commitment in a “regular” adult mental health state hospital. O.C.G.A. § 17-7-130(e)(2)(B)(v).

At the point of this annual evaluation, if the hospital is recommending another year’s civil commitment, it is imperative for the advocate to closely examine whether or not the individual continues to meet the inpatient civil commitment criteria. As with the initial civil commitment letter to the Court, it is not always clear in this annual letter the reasons for the hospital’s recommendation, and the advocate must then request and evaluate the medical records, asking the same questions as you would with the initial civil commitment. When was the last incident of violence? Was it “recent,” as required by the definition in the mental health code? If the inpatient civil commitment recommendation is based on a threat of violence, was the threat recent and did it present a probability of physical injury? If the recommendation
is based on the "unable to care for self" prong of the inpatient civil commitment criteria, have all appropriate community mental health services (like an ACT team) and housing been considered and have providers been brought into the hospital to develop a community plan for services?

Again, it is helpful to meet with the treatment team at a monthly Individual Recovery Plan (IRP) meeting to understand the team's position on the civil commitment. If it becomes clear that your client does indeed meet the civil commitment standard, you can ask the treatment team how the challenging behaviors are being addressed in the treatment plan. O.C.G.A. § 37-3-1(9) requires individualized service plans to have treatment goals or objectives, based upon and related to a proper evaluation, which can be reasonably achieved within a designated time interval. Are the treatment goals and objectives in your client's IRP addressing the problem behaviors? Find out what STEP level your client is on, and ask the team how it is affecting the team's recommendation for inpatient civil commitment. The STEP level should not prevent your client from being considered for discharge.

If there is any question at all regarding the civil commitment recommendation, it is important to request a hearing, pursuant to O.C.G.A. § 17-7-130(e)(2)(B)(v). The burden is on the State to prove that the person meets the inpatient civil commitment criteria. Is the State's witness from the treatment team familiar with the individual? If not, consider subpoenaing someone who is

7 The STEP system assigns patients a STEP level, which governs the intensity of supervision required. STEP A is the highest security level and STEP F allows the individual to go on overnight passes. (See Appendix A for a link to DBHDD policy explaining the STEP system.)
more familiar with the individual's day-to-day behavior and functioning on the unit.

iii. Application for release.

Defense counsel can also make an application for release from civil commitment for their client pursuant to O.C.G.A. § 17-7-130(e)(2)(B)(vi). This application can be outside the time of the annual civil commitment recommendation. The IST statute refers to the parallel procedure in the Not Guilty By Reason of Insanity (N.G.R.I.) code section, O.C.G.A. § 17-7-131(f), but points out that unlike in the NGRI application for release, if a person found IST makes an application for release, the burden of proof is on the State. O.C.G.A. § 17-7-130(e)(2)(B)(vi). Further, the IST statute allows an indigent individual to petition the court for an independent psychological evaluation, to be paid for by the County. *Id.* This is another point in the process that the advocate can challenge an individual's civil commitment and request a hearing. However, if such an application for release is filed and the Court finds that your client still meets the inpatient civil commitment criteria, the individual cannot request release again until 12 months have elapsed from the date of the hearing. *See* O.C.G.A. § 17-7-131(f)(3).

III. Advocating for community-based services

A. Using community services to help make your case.

Whether the advocate is challenging an initial determination of civil commitment (O.C.G.A. § 17-7-130(e)(2)(B)), challenging an annual recommendation of civil commitment (O.C.G.A. § 17-7-130(e)(2)(B)(v)), or applying for release outside the annual commitment stage (O.C.G.A. § 17-7-
130(e)(2)(B)(vi)), it is important to simultaneously advocate for your client to be provided with all available community services, including housing.

For example, as mentioned above, O.C.G.A. § 17-7-130(e)(2)(B)(v) permits the Court to “change the civil commitment status” at the annual civil commitment decision point, which means the Court could hear the evidence at an annual commitment hearing (which you must request) and decide that the person no longer meets the inpatient civil commitment criteria and meets, instead, the outpatient civil commitment criteria. Or the Court could find that the person does not meet the civil commitment standard at all and should be released. Either way, it is imperative that community services already be contemplated by both the individual’s advocate and the treatment staff at the hospital. Everyone deserves and needs appropriate healthcare in order to live safely and fully in the community, and community mental healthcare is no exception. Having a plan with a full array of community services will not only help you make the best case to the judge that the individual no longer meets inpatient civil commitment and will be fully supported if he is released, it is also simply the right thing to do so that someone who has been institutionalized can receive the supports he needs to have the best chance at living a healthy life in the community.

If you learn that the hospital treatment staff have not actively pursued community services for your client, you can suggest that community services be explored as an alternative to another year of civil commitment. Some of the community-based services to recommend include: an Assertive Community Treatment (ACT) Team or Intensive Case Management, along with appropriate
housing like a Forensic Apartment, a Community Integration Home, a Georgia Housing Voucher Program apartment, or a personal care home, depending on your client’s preference. *(See Appendix A for link to DBHDD’s Adult Mental Health Resource Directory.)* Hospital treatment teams are often very receptive to considering these alternatives and are instrumental in the development of a plan to present to the judge. Because some housing alternatives, like the Community Integration Homes, may have no vacancies at times, insist that your client be placed on the waiting list, if clinically appropriate. Because judges need details on the types of services and housing a person will receive if released, it is important for the treatment team to engage the community mental health provider and invite the provider to come into the hospital to assist with discharge planning and to build a rapport with the client. This is a billable community service called “Community Transition Planning.” The community mental health provider should be brought to court to explain the community plan of care, since these professionals are most familiar with the services your client will receive through their agency.

If your client has a developmental disability, the treatment team should apply for the Comprehensive Supports Medicaid Waiver (“Comp Waiver”). *(See Appendix A for link to DBHDD’s Developmental Disabilities resource webpage.)* The Comp Waiver is a program that provides 24/7 supports and services to people with intellectual disabilities and people with developmental disabilities. There is a long waiting list for this valuable service, and advocacy is often needed to help move the person up the list. Being in an institution, such as a forensic
hospital, should give your client priority for a Comp Waiver. (See U.S. v. Georgia discussion below.)

B. A word about discharge planning

Discharge planning is an essential part of treatment at the forensic hospital. (See Appendix A for link to DBHDD’s discharge planning policy.) The Georgia Mental Health Code states that it is the policy of the State that the “least restrictive alternative placement be secured for every patient at every stage of his medical treatment and care.” O.C.G.A. § 37-3-161. It goes on to explain that it is the “duty of the facility to assist the patient in securing placement in noninstitutional community facilities and programs.” Id. This is important to keep in mind, as it requires an ongoing commitment by the hospital treatment team to move people toward living in the community. IST individuals should be connected to community mental health providers, like ACT teams, and these providers should be invited into the hospitals to help with discharge planning. One problem, though, is that often an IST-N individual is in a forensic hospital far from his home county, making it difficult for community mental health providers to travel to the hospital to participate in discharge planning. Because the community provider is so crucial to developing a good transition plan, and because it is essential for the community provider to get to know the individual and develop a rapport, you can request that telemedicine be utilized when in-person meetings are not possible.

C. U.S. v. Georgia

In 2010, Georgia and the United States Department of Justice entered into an Olmstead-type settlement agreement that transformed the State’s community
mental health and developmental disability system. (See Appendix A for a link to the 2010 settlement agreement.)

The mental health Target Population, as defined in the settlement agreement, includes people with severe and persistent mental illness ("SPMI") who are currently being served in the 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. Notably, the target population also includes people with SPMI and forensic status "if the relevant court finds that community service is appropriate." U.S. v. Georgia, Civil Action 1:10-CV-249-CAP, Section III. B.1.b. There is a similar provision in the developmental disability section of the settlement, clarifying that people with developmental disabilities and forensic status are included in the target population if the Court finds that community placement is appropriate. Id. at Section III.A.3.b.

To comply with the settlement agreement, the State pumped more than $73 million into the community service system, creating a robust array of mental health services including ACT teams, Community Support Teams, Intensive Case Management, Crisis Service Centers, Crisis Stabilization Programs, Mobile Crisis Services, Crisis Apartments, Supported Employment, and Peer Support Services.

Along with the development of these community mental health services, the State agreed to have capacity to provide Supported Housing to any of the 9,000 persons in the target population who need such support. Id. at Section III.B.2.c.ii.A. To help meet this requirement, DBHDD created the Georgia Housing Voucher Program, which provides a rental subsidy and "bridge funding"
(to pay for things like furniture, moving expenses, etc.) so that people with mental illness can live in their own apartments.  

The developmental disability section of the agreement requires the State to cease admissions to State Hospitals for people with developmental disabilities and also enhances the community service system with additional Medicaid waivers designed to transition those individuals who are in the hospitals into the community with all necessary supports. These Medicaid waivers are available to individuals with developmental disabilities in forensic hospitals, and there has been a clear recent effort by DBHDD to award Medicaid waivers to forensic individuals who have developmental disabilities, leading to extensive transition planning and ultimate release to community placements. (See Appendix A for link to DBHDD Community Transitions from State Hospitals manual.)

Because people with forensic status are only considered members of the target population if the Court finds that community services are appropriate, it is critical to educate the judge in your client’s case about the array of services developed under the Settlement Agreement that are available to support people coming out of forensic hospitals. It is equally important to advocate for your client to receive these services if it does not appear that hospital discharge planning is progressing adequately. This can be accomplished through regular contact with your client’s treatment team. Again, ask that your client be connected with a community provider and that the provider come to the hospital

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8 The U.S. v. Georgia settlement agreement was recently extended to July 2018. The mental health part of the agreement will focus on expanding the State’s capacity to provide supported housing.
to meet with your client and your client's treatment team to provide Community Transition Planning. It is important for the mental health or developmental disability provider to testify at any hearing that concerns your client's inpatient or outpatient civil commitment. This helps communicate the level of supervision and support your client will receive in the community, and if the judge has questions or concerns, the community provider is there to answer them.

The Independent Reviewer of the Settlement Agreement periodically publishes reports on the State's progress, and has mentioned challenges with the forensic system in past reports. In the Independent Reviewer's June 2016 report, there is an Attachment entitled "Review of Community Access for Forensic Individuals," authored by a forensic expert hired by the Independent Reviewer. (See Appendix A for link to June 21, 2016 report; forensic report starts on page 22.) This report on the forensic system highlights many issues that could affect your client's release to the community. Namely, the forensic expert found that the transition process is "fragmented" and "difficult to navigate." The expert found that Individual Recovery Plans do not properly address ways to creatively support forensic patients so that transition planning can move forward. Most critical to the issue of this paper, the expert found that the Treatment Teams 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.” Supplemental Report of the Independent Reviewer, U.S. v. Georgia, Civil Action 1:10-CV-249-CAP, June 20, 2016, Attachment 1, page 28. This finding in the
Independent Reviewer’s report makes it especially important for defense counsel to appropriately question and challenge the civil commitment recommendations made by the hospital.

Again, if your client has been incorrectly recommended for another year’s inpatient civil commitment, you must ask for a hearing and simultaneously advocate for community services. If no hearing is requested, the judge will most likely order another year’s civil commitment, and your client will not get to benefit from the array of community services available to him under the U.S. v. Georgia settlement agreement.

IV. Conclusion

Advocating for your IST-N client in a forensic hospital presents many opportunities and challenges. You have the unique ability to not only advocate for release, by carefully examining whether or not your client continues to meet the inpatient civil commitment standard, but you also have the opportunity to advocate for your client to receive all necessary public mental health and developmental disability services to which he is entitled so that he can live a life of recovery and meaning in the community.

Most importantly, your zealous continued advocacy provides your institutionalized IST-N client with something else that is of utmost significance, yet is so often easily lost: Hope.
Appendix A: Recommended Resources (links current as of 9.15.16)

- DBHDD Policy Stat (policies that govern hospital operations and community services)
  - Evaluation and Treatment of Defendants Adjudicated Incompetent to Stand Trial, 06-102:
    https://gadbhdd.policystat.com/policy/1393165/latest/
  - The STEP System, 06-103:
    https://gadbhdd.policystat.com/policy/580028/latest/
  - Risk Assessment on Forensic Units, 06-104:
    https://gadbhdd.policystat.com/policy/475641/latest/
  - Discharge Planning, 03-560:
    https://gadbhdd.policystat.com/policy/1907371/latest/
  - Forensic Review Committees, 06-105
    https://gadbhdd.policystat.com/policy/523568/latest/

- DBHDD page with US v. Georgia Settlement links:
  http://dbhdd.georgia.gov/settlement-agreement
  - 2010 U.S. v. Georgia Settlement Agreement:

- DBHDD Adult Mental Health webpage: http://dbhdd.georgia.gov/adult-mental-health
  - DBHDD Office of Adult Mental Health Resource Directory:
  - DBHDD ACT team FAQ:
• DBHDD Developmental Disabilities webpage:
  http://dbhdd.georgia.gov/developmental-disabilities
  o Community Transitions from State Hospitals Manual:
ADVOCATING FOR COMMUNITY SERVICES FOR INDIVIDUALS FOUND INCOMPETENT TO STAND TRIAL

Presented by: Susan Walker Goico
Atlanta Legal Aid
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September 20, 2016
Georgia Appleseed CLE:
Community Services and Procedures for Individuals Found IST-N

WHAT THIS PRESENTATION WILL COVER:

- I will discuss the process after your client has been found IST Non-Restorable.
- Quick review of available community services/housing available to forensic individuals; *U.S. v. Georgia* settlement.
- At what points in the process can you advocate for your client to be released and receive community-based services?
- How do you analyze the inpatient and outpatient civil commitment criteria?
- What do you look for in the medical record?
- How do you work with the treatment team to move toward discharge?
U.S. v. Georgia Settlement and People with Forensic Status

B. Serving Persons with Mental Illness in the Community

1. Target Population

a. The target population for the community services described in this Section (III.B) shall be approximately 9,000 individuals by July 1, 2015, with SPMI who are currently being served in the 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.

b. Individuals with serious and persistent mental illness and forensic status shall be included in the target population, if the relevant court finds that community service is appropriate.

Advocacy Tip:

- A judge will be more likely to find community services appropriate if you present the judge with a solid community service plan.
U.S. v. Georgia Litigation

- DOJ Olmstead Settlement October 2010
  - Developmental Disabilities: Close Hospitals, Medicaid Waivers, Family Supports
  - Mental Health: ACT, Case Management, Peer Supports, Housing, Supported Employment, Crisis Services, Community Support Teams (like ACT, but fewer team members; for rural areas)
    - Settlement extended through June 30, 2018
      - Particular emphasis on availability of supported housing for people with mental illness.
      - Continued transitions of people with developmental disabilities out of hospitals, including forensic hospitals.

Assertive Community Treatment (ACT): “Hospital without Walls”

- Team of Mental Health Workers
  - Team Lead
  - Psychiatrist
  - Psychologist
  - Social worker
  - Nurse
  - Substance abuse counselor
  - Peer specialist
  - Vocational counselor
  - Assistance getting what your client wants/needs
    - For people with more complex needs
    - Tailored to the individual; daily visits, if needed
REVIEW OF HOUSING AVAILABLE TO FORENSIC INDIVIDUALS

- Georgia Housing Voucher Program (DBHDD)
- Community Integration Homes (CIHs)
- Forensic apartments
- Personal care homes

SO HOW DO YOU GET THESE SERVICES FOR YOUR CLIENT?
YOUR CLIENT HAS BEEN IN THE HOSPITAL FOR
COMPETENCY EVALUATION AND THEN RESTORATION
(INITIAL 90 DAYS PLUS UP TO 9 MONTHS):

- If after nine months, the Department physician or
  psychologist determines your client is mentally
  incompetent to stand trial, the Department reports to
  the court the finding and reasons.
  O.C.G.A. § 17-7-130(c)(3)

AT THIS "ONE-YEAR MARK:"

- Client must be either CIVILLY COMMITED or
  RELEASED.
- Opportunity for defense counsel to challenge
civil commitment and advocate for community-
based services. DOES YOUR CLIENT
ACTUALLY MEET THE CIVIL COMMITMENT
CRITERIA?
- O.C.G.A. § 17-7-130(e)
WHAT ARE THE **INPATIENT** CIVIL COMMITMENT CRITERIA?

- IST statute refers to Title 37, the Mental Health Code
- Inpatient Civil Commitment
  - O.C.G.A. § 37-3-1(9.1):
    - A mentally ill person 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 present a probability of physical injury to that person or other persons; or
    - Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis.

***You must read this prong with an eye toward the full array of community services that are available.***

WHAT ARE THE **OUTPATIENT** CIVIL COMMITMENT CRITERIA?

- Outpatient Civil Commitment
  - O.C.G.A. § 37-3-1(12.1)
    - A mentally ill person who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;
    - Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and
    - Who is in need of involuntary treatment.
ADVOCACY TIPS:

- If the hospital is recommending civil commitment at the "one year mark," defense counsel should take a close look at the hospital's letter to the court to see if there is evidence that the client actually meets the strict standard for inpatient civil commitment.
- REVIEW THE MEDICAL RECORDS.
- Talk to treatment team to understand if intensive community services have been considered for your client. Attend a monthly IRP meeting.
- Consider challenging the recommendation of civil commitment at the civil commitment trial.
- Does your client meet outpatient criteria instead?

WHAT COMMUNITY SERVICES HAVE BEEN CONSIDERED FOR YOUR CLIENT?
ONCE CLIENT IS CIVILLY COMMITTED, AN ANNUAL COMMITMENT ORDER IS REQUIRED.

○ Nonviolent offense:
O.C.G.A. § 17-7-130(e)(2)(B)(iii): Court may order civil commitment on an annual basis, but in no case for a period to exceed maximum period the accused could have been sentenced on the most serious nonviolent offense charged or a period to exceed five years, whichever is less
○ Provided that civil commitment shall be reevaluated by department physician or psychologist on an annual basis.

Do you have any "5-year" clients?

ANNUAL COMMITMENT FOR VIOLENT OFFENSE
O.C.G.A. § 17-7-130(e)(2)(B)(iv)

○ The court may order civil commitment on an annual basis, but in no case for a period to exceed the maximum period for which the accused could have been sentenced on the most serious violent offense charged,
○ Provided that civil commitment shall be reevaluated by a dept. physician or psychologist on an annual basis.
ANNUAL EVALUATION SENT TO COURT

O.C.G.A. § 17-7-30(e)(2)(B)(v)

The Department physician or licensed psychologist must submit to the court his or her annual evaluation as to whether the civilly committed accused continues to meet the criteria for civil commitment.

- Court shall mail the annual evaluation to the attorney for the accused or, if pro se, to the accused and to the prosecuting attorney.
- Court shall review the case annually and enter the appropriate order to (1) renew the civil commitment, (2) to change the civil commitment status, or in the event the charges are dismissed, (3) to transfer the jurisdiction of the case to the probate court of the jurisdiction of the accused's residence for further civil commitment.

RIGHT TO A HEARING

O.C.G.A. § 17-7-130(e)(2)(B)(v)

- If after the Department submits its annual evaluation/letter the state or the accused requests a hearing regarding civil commitment, the court shall hold a hearing.
  - Does your client meet the strict standard for inpatient civil commitment?
  - How about outpatient civil commitment instead?
  - ASK FOR A HEARING.
Advocacy Tips:

- The annual evaluation is another point where defense counsel should carefully evaluate whether or not the individual truly meets inpatient civil commitment criteria.
- What about outpatient commitment?
- Have community supports been considered?
- Review medical record.
- Attend treatment team meeting at hospital.
- Talk to the hospital's lawyer.


- Independent Reviewer's Forensic expert found:

  "Recovery Planning Teams 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."

APPLICATION FOR RELEASE
O.C.G.A. § 17-7-130(e)(2)(b)(vi)

ANOTHER OPPORTUNITY FOR DEFENSE COUNSEL.

- An accused who is civilly committed may make an application for release (refers to NGRI § 17-7-131(f)).
- The burden of proof is on the state.
- Accused may petition court to have an evaluation performed by a physician or licensed psychologist of the accused's choice, and the court may order the cost of the evaluation to be paid for by the county.
- If the finding of the court is adverse to release, accused cannot request release again until 12 months have elapsed from date of hearing.

CIVIL COMMITMENT CRITERIA REVIEW

**Outpatient Civil Commitment**
O.C.G.A. 37-3-1(12.1)

- Requires outpatient treatment in order to avoid predictably and imminently becoming an inpatient;
- Unable voluntarily to seek or comply with outpatient treatment.

**Inpatient Civil Commitment**
O.C.G.A. § 37-3-1(9.1)

- Presents substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury; or
- Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis.
REVIEW THE MEDICAL RECORDS

- Important documents to review:
  - Individualized Recovery Plans (IRPs) – updated monthly
  - Annual psychiatric evaluations
  - Risk assessments
  - Reports sent to the court assessing whether your client meets civil commitment criteria
  - Notes and reports from Forensic Review Committee

Review the Medical Records (continued)

- Important information to look for:
  - Does your client meet the inpatient civil commitment criteria? If so, why? How are the issues keeping your client in the hospital being addressed in the Individual Recovery Plan?
  - What are the discharge criteria and has your client met them?
  - Can the discharge criteria be reasonably achieved within a designated time interval?
  - What is your client's diagnosis? Does she have an intellectual or developmental disability?
Review the Medical Records (continued)

- More important information to look for:
  - What STEP level is your client on? Is the STEP level preventing consideration of discharge?
  - Discharge planning – what progress has been made?
  - Has your client been involved in any instances of violence? If so, when was the last instance and what was the nature of it? Did it rise to the level of meeting inpatient civil commitment criteria?
    - How are these behaviors being addressed in treatment?

COMMUNITY SERVICES

- What community supports have been considered for your client?
- Ask treatment team if a community mental health provider could come to the hospital to do “Community Transition Planning.”
O.C.G.A. § 37-3-161

- It is the policy of the State that the Least Restrictive Alternative placement be secured for every patient at every stage of his medical treatment and care. It shall be the duty of the facility to assist the patient in securing placement in noninstitutional community facilities and programs.

What if the hospital wants your client to be released, but the judge is skeptical?

- Present the judge with a solid plan of community services and housing.
  - Work with treatment team at hospital.
  - Connect client to community provider while he is in the hospital ("Community Transition Planning.")
  - Bring the community provider with you to court to explain the plan and answer questions.
DOES YOUR CLIENT HAVE A DEVELOPMENTAL DISABILITY?

- Make sure the hospital has applied for a Medicaid waiver for people with DD (COMP waiver).
- DD population gets special attention in U.S. v. GA settlement.
A View from the Bench: Judges Discuss Challenges and Successes in IST-N Cases

The Honorable Doris L. Downs
Superior Court of Fulton County

The Honorable Marc E. D’Antonio
Probate Court of Muscogee County

The Honorable Kathy Gosselin
Superior Court of Hall and Dawson Counties