



# JUSTICE FOR PEOPLE WITH MENTAL ILLNESS IN GEORGIA

*A Report on Conversations with Leaders in the Field*

*June 26, 2007*



**GEORGIA  
APPLESEED**

*Sowing the Seeds of Justice  
throughout Georgia*

Georgia Appleseed Center for Law and Justice is an affiliate of the national Appleseed network of nonpartisan, nonprofit, public interest law centers. Georgia Appleseed leverages the pro bono work of lawyers and other professionals to produce systemic solutions to difficult social justice problems.

**KING &  
SPALDING**

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## Preface

On July 11, 2006, Georgia Appleseed Center for Law and Justice invited 30 local stakeholders, all experienced practitioners in their respective fields, to attend a meeting at the law offices of King & Spalding. Our purpose: to consider the stakeholders' concerns around the lack of access to justice for persons with mental illness.

Virtually every person at the table held a strong opinion about the gaps and failings in Georgia's criminal justice system as it intersects with the special needs of persons with mental illness accused or convicted of violating the law. Given our society's articulated values of treating the accused as innocent until proven guilty and of our commonly held notions of fair play, many at the table spoke of all too common situations where neither due process nor fair play were evident in the stories surrounding these vulnerable citizens when caught up in the criminal justice system. One could not help but think of the admonition to pay particular attention to how we treat the vulnerable for that is a reflection of who we are as a community. The stakeholders assembled gave thoughtful consideration not only for the mentally ill defendant, but also for the innocent victim of crime, whose rights must also be protected.

The conversation was clearly heart-felt and yielded perspectives and observations that, in spite of the recitations of chronic injustice, seemed to fuel new hope around the table for finding some practical way, together, to break down the barriers of injustice often faced by persons with mental illness. Caution, though, was also at the table. The stakeholders knew all too well the challenges ahead, which have been seemingly insurmountable for so long despite the best efforts of many.

After considering the options and the remarkable energy around this topic that summer day, Georgia Appleseed understood that much is going on and that much still needs to be done to address the needs of persons with mental illness<sup>1</sup> in Georgia's courts. Yet, in the real world of limited time and limited resources, we cannot do everything all at once. One meeting was enough to get a flavor of the work that needs to be done in our state, but was not enough to make the hard decision among competing choices for future work. Therefore, Phase I of the project has been to continue the conversation with the originally

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<sup>1</sup> Georgia Appleseed also understands from the stakeholders that this work should include persons with developmental or cognitive disabilities. In collaboration with key agencies serving persons with developmental disabilities, Georgia Appleseed is preparing Georgia editions of the Texas Appleseed handbooks for attorneys and families of defendants with developmental disabilities. The Georgia edition of these handbooks will be published in the fall of 2007.

assembled stakeholders and others as well. This report is intended to be the distillation of those conversations and is not intended to be a survey of all that is or should be happening in Georgia to promote justice for persons with mental illness. Indeed, the reader will undoubtedly find omissions that seem incongruent with a goal of finding better paths to justice for persons with mental illness. Those omissions may mean one of two things: either that no stakeholder chose to highlight that topic or that our efforts to record all the insights and opinions fell short of our own high levels of expectation for this report. If the former, we would assume that the stakeholder's own decision to highlight one topic over another was motivated by the urgency felt by the stakeholder over the topic discussed. If the latter, we offer our sincere apology for any oversight on our part.

Because this is not a peer-reviewed, research-based document, but is instead a recitation of conversations held with highly respected individuals who know, often because of their own direct experience with those who have suffered greatly in our criminal justice system, of the injustices of which they speak, the reader may find much that resonates with his or her own experiences. We did not intend to identify the answers, but we did intend for these conversations to become the baseline for Georgia Appleseed's decision about its next steps with its Justice for People with Mental Illness Project. We view our ability to share this report with the Chief Justice-led Task Force to Promote Criminal Justice/Mental Health Collaboration as pure serendipity, for which we are grateful. We hope that our collective efforts, as presented in this report, also prove to be of use to the Task Force as it goes forward with its own important work on behalf of the citizens of Georgia.

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**Mission of Georgia Appleseed:** To listen to the unheard voices of the poor, the children, the marginalized; to uncover and end the injustices that we would not endure ourselves; to win the battles for our constituency in the courts of public opinion or in the halls of justice that no one else is willing or able to fight.

## **Acknowledgements**

This report is primarily funded by the in-kind support of King & Spalding LLP, without which this report would not be possible. Georgia Appleseed would like to extend its sincere thanks to all the volunteers from King & Spalding who took the lead on scheduling, conducting and preparing the interview notes that formed the basis of this report's content. Law students from Mercer University's Walter B. George School of Law, for whose assistance we are grateful, also worked with the King & Spalding volunteers. Special thanks goes to the two lead King & Spalding attorneys, Diane M. Janulis and Megan M. Michelsen, whose constant dedication to this project kept us on track and whose own previous work experience in the field of mental health services, one as a psychiatric nurse and the other as a mental health counselor, kept our discussions regarding content grounded in the realities of the mental health system as they had experienced it on a daily basis. We also wish to extend our thanks to Jane H. Martin, Assistant Director for Grants and Performance Outcomes, Division of Government Affairs, Georgia Administrative Office of the Courts, and to Judge Susan P. Tate, Clarke County Probate Court, for their vision for collaboration and their idea to bring the thoughts and opinions of the assembled stakeholders to the attention of the newly established Chief Justice-Led Task Force to Promote Criminal Justice/Mental Health Collaboration for its consideration. Finally, Georgia Appleseed wishes to express its great appreciation for the time given generously by the stakeholders whose thoughts, opinions and experiences form the basis of this report.

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## **Thank You**

We are indebted to the following individuals who provided information and opinions either through interviews or attendance at the July 11, 2006 stakeholder meeting:

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**Sgt. S.A. Steed**

Atlanta Police Department, Zone 5/Underground Precinct

**Hon. Susan P. Tate**

Probate Court Judge  
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# KING & SPALDING

King & Spalding was excited and privileged to have been asked to continue its association with Appleseed by leading this project. The needs of those individuals with mental illness, and especially those also entangled in the criminal justice system, are boundless. We hope that this Report will contribute to a beginning resolution of the problems encountered by those individuals, their families, and those who try to assist them.

Many individuals contributed to this project and are listed at the end of the report. Without their great work this project could not have been performed. We thank them greatly.

Our association with Appleseed would not be as strong if it were not for the insight and talents of Ted Hester, Joe Loveland, and Bill Hoffmann from King & Spalding. Their unflagging service and dedication to pro-bono and community causes are legend. The work of Horace Sibley, a retired King & Spalding partner, in service to the homeless in Atlanta, this project and a multitude of other pro-bono causes also cannot be understated.

We want to give special thanks to Shella Blaustein who took the entirety of the interview results and, from them, created a fine first draft. Regina Myers, Emily Culpepper and Tracy Klingler assisted us in revisions to Shella's work.

And then, of course, there is Sharon Hill, Director of Georgia Appleseed. We are convinced that almost nothing would have happened without her boundless energy, tireless direction and inexhaustible list of contacts.

The opinions, findings and recommendations contained in this Report are solely those expressed by the stakeholders to our volunteers. They do not necessarily reflect the opinions of either Georgia Appleseed or King & Spalding, nor unanimity among the stakeholders. Some may have discomfort with the opinions and scope of recommendations found in the Report.

It is not the purpose of this Report to validate opinions or to referee differences, but rather, to present these differences as a basis for frank discussion of the status and needs of Georgians with mental illness in the criminal justice system and how best to meet these needs. These differences may represent the inevitable push-pull of services and approaches to solutions, and, at times, competition for scarce resources.

It is hoped that this Report will serve as a jumping off point for others to investigate, validate and determine where we go from here.

Diane M. Janulis  
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# Justice For People With Mental Illness In Georgia: A Report On Conversations With Leaders In The Field

## EXECUTIVE SUMMARY

In late 2005, at its inception, Georgia Appleseed identified three areas in which its work would be directed: (1) public education; (2) economic security and public safety; and (3) access to justice. In developing specific projects that fell under the “Access to Justice” umbrella, it learned that many dedicated workers in the mental health field were frustrated that far too little had been done in Georgia to identify or address access to justice for people with mental illness.<sup>2</sup>

Georgia’s prison population tripled between 1982 and 2000 and continues to increase. Prison overcrowding and recidivism create urgency to find solutions to these problems.<sup>3</sup> Mental illness is a significant factor in the growth of the prison population. According to the research report, *Prisoner Reentry in Georgia*, in 1997 ten percent of state prisoners nationally were reported as having mental illness (compared to two percent in the general population). In 2000, midyear estimates indicated that 16.2 percent of state prisoners submitted self-reports of mental illness; one in eight state prisoners received mental health treatment or counseling and nearly ten percent received psychotropic medications (such as antidepressants, stimulants, sedatives, tranquilizers, or antipsychotic drugs).<sup>4</sup> Twelve percent of Georgia prisoners, released in 2002, had received outpatient treatment or were in supportive living prior to their incarceration.<sup>5</sup> By 2004, the Georgia Department of Corrections (DOC) reported that 15% of its prisoners were diagnosed with mental illness and the number was increasing steadily at the rate of one percent per year.<sup>6</sup> An independent audit of Georgia’s DOC revealed 16% of state inmates were identified as needing mental health services as of June 2006.<sup>7</sup> Reportedly, it costs \$21,000, on average, to incarcerate a person with mental illness for one year compared to an annual cost of \$3,076 to provide adult outpatient mental health

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<sup>2</sup> There is no single definition of “mental illness” in use in Georgia. Our use of this term in the report is designed to be as broad as possible, inclusive of all definitions.

<sup>3</sup> See Vigney, N. and Mamalian, C. *Prisoner Reentry in Georgia, Research Brief*. Urban Institute, Justice Policy Center (2004), at 1.

<sup>4</sup> *Id.* at 19.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* and See Georgia Department of Corrections Annual Report: FY 2004. “With regard to the mental health caseload growth at the end of FY04 there were 7,128 mentally ill inmates within the correctional system, an increase of more than 500 from the same time a year ago. At the end of FY04, approximately 15% of the total inmate population was on mental health caseload, a number that has continued to increase at the rate of 1% per year.” <http://www.dcor.state.ga.us/Reports/Annual/AnnualReport.html>.

<sup>7</sup> See Simmons, A. “Prisons see more inmates requiring mental health care.” *Gwinnett Daily Post*, 7/30/06.

services in DeKalb County.<sup>8</sup> With closure of many residential treatment facilities and reduced funding for other community-based mental health programs previously available as alternatives to incarceration, individuals with mental illness have contributed to the rising prison population and increased costs associated with incarceration and prison-based mental health care. Using DOC estimates, by 2010, 20% of the state's inmates may need treatment for mental illness. Given these statistics, it is imperative to discover what could be done to decrease the numbers of people with mental illness who have contact with the criminal justice system in Georgia and also increase their access to justice once contact is made.

Fortunately, there are numerous individuals in the public and private sectors who are knowledgeable about these issues. In the summer of 2006, Georgia Appleseed and King & Spalding LLP invited many of them to come together to assist in identifying a project we could undertake on behalf of people with mental illness in the criminal justice system in Georgia. What we learned, as is so often the case, is that identifying the needs in the community is a project unto itself. Thus the Justice for People with Mental Illness Project was born.

This Report was designed to be a springboard from which a discrete project (or projects) could be selected where Georgia Appleseed and its partners might be able to bring about some positive change for Georgians with mental illness. Therefore, this Report is not a comprehensive review of available mental health services. It focuses solely on issues relating to individuals in the criminal justice system with mental illness and the opinions of leaders in the field on how best to prevent not only recidivism, but also initial entry into the system. Its methodology was simplistic and designed to elicit opinions and create an initial report in a limited amount of time. Brief research was performed to supplement references to specific services mentioned by the interviewees, but this was the exception, not the rule.

Opinions from over 35 individuals were obtained from the July 2006 meeting and subsequent face-to-face interviews.<sup>9</sup> These individuals work in government, the private sector, law enforcement, criminal defense, and mental health services, representing approximately 24 different agencies or services. They were asked to identify or respond to a number of areas of concern:

- Issues they see arising when people with mental illness have contact with the criminal justice system;
- The assistance currently available for people with mental illness in the criminal justice system;

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<sup>8</sup> See Jones, G. and Connelly, M., Maryland State Commission on Criminal Sentencing Policy. *Mentally Ill Offenders and Mental Healthcare Issues: An Overview of the Research*. State Commission on Criminal Sentencing Policy. February 2002.

<sup>9</sup> King & Spalding attorneys conducted the interviews with some assistance from law students from Mercer University School of Law.

- Needed services or programs for people with mental illness (and their families) in the criminal justice system;
- The most common or significant problems facing people with mental illness in the criminal justice system;
- Obstacles faced when new services or programs have been implemented or attempted in the past; and
- The reasons programs or services fail or are ineffective.

Our interviewees consistently expressed concern about the inadequacies faced by Georgians with mental illness:

- Inadequate access to diagnosis and treatment;
- Inadequate training and education of the law enforcement officers, attorneys and judges with whom they come into contact;
- Inadequate access to diagnosis and treatment in our jails and prisons;
- Inadequate release planning and coordination of services; and
- Inadequate post-confinement outpatient treatment options and monitoring.

This Report is the result of these interviews and limited research into the problems facing individuals with mental illness in Georgia's criminal justice system. It identifies a myriad of issues, criticisms, problems and recommendations. It demonstrates that while the system is essentially broken there are some promising programs and efforts to fix it. Unfortunately, these efforts are woefully underfunded, understaffed and geographically unbalanced. Alone and without additional funding, they are insufficient to create adequate change and improvement for individuals with mental illness.

Also absent, and just as critical, is the existence of a system, singular agency or person to coordinate and monitor the services currently available to ensure that an individual can find and access needed services----a continued piecemeal approach to these problems almost certainly is a recipe for failure.

## **DISCUSSION OF FINDINGS AND RECOMMENDATIONS**

### **I. Inadequate Access to Diagnosis and Treatment**

Many individuals with mental illness enter the criminal justice system because they have not received adequate treatment and exhibit behaviors that could be considered “quality of life crimes” that are, in fact, manifestations of mental illness, not criminal intent. Once in the criminal justice system these individuals’ problems are compounded by well-meaning, but sometimes inadequate, assistance. Adequate mental health assessment and treatment from childhood forward is the linchpin to stop the cycle of initial entry, release and re-entry into the criminal justice system for those individuals with mental illness. If these individuals can be offered proper mental health treatment before the first contact with police ever occurs, the cycle has the best opportunity to be thwarted. Even after the initial contact with police and others in the criminal justice system, especially for those who have committed low-level offenses, there are opportunities for diversion and treatment. Incarceration may actually exacerbate their underlying illness and the chances of recidivism, not rehabilitation. Complicating remedial efforts are public ignorance and misinformation, often rooted in fear, regarding the realities of mental illness. The emphasis for change must be on awareness, education, advocacy, coordination, communication and most importantly, increased services accompanied by increased funding, not simply reallocation of inadequate monies.<sup>10</sup>

#### **A. Findings**

##### **Perceptions**

- Individuals with mental illness are generally at higher risk for homelessness and crime. Minor offenses, such as quality-of-life crimes, are often attributable to their current mental health status or living situation. These offenses may be criminalized with arrest and prosecution rather than being viewed as symptoms of mental illness requiring treatment not incarceration. Common offenses include: panhandling, trespassing, terrorist threats, loitering, unruly behavior or disorderly conduct, obstruction of justice, public urination and giving a false name. At times, the family and friends of an individual with mental illness will seek police intervention when they feel they are no longer able to control a situation, fear its escalation and are not aware of alternative options. In this situation, police often believe they have no choice but to arrest and process the individual. Police intervention comes from different types of law enforcement agencies, each with its own way of handling the situation. In Fulton County alone there are

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<sup>10</sup> An interviewee expressed frustration with a situation in which money “saved” by perceived increased efficiency in one service is not reallocated to other underfunded programs.

police, sheriff, marshals, and police forces from municipalities within the county's borders, Georgia State University, Georgia World Congress Center and MARTA, coming into contact with individuals who have mental illness and are in crisis.

- There are inconsistent definitions of mental illness. The Diagnostic and Statistical Manual of Mental Disorders (DSM), Georgia Code Annotated and the National Alliance on Mental Illness (NAMI) all utilize different definitions. Since access to community funds and treatment often depend upon diagnosis and terminology, lack of consistency in defining mental illness is a critical issue. Developmental disabilities and cognitive impairment are included by some individuals when speaking about mental illness, but not by others. Receiving the correct diagnosis is key to treatment. Failure to do so may create more difficulty for an individual and greatly affect his or her ultimate disposition.
- The stigma associated with mental illness further complicates treatment for individuals diagnosed. This stigma may cause some to avoid seeking effective treatment. Individuals and their families may refrain from disclosing a mental illness for fear of negative reactions, mistreatment, or family dishonor. The media often highlight horrific crimes committed by people with mental illness. Ignorance of mental health advances and treatment may partially explain the relative lack of “champions” lobbying for needed funds and inadequate budget allocation for needed mental health programs.
- The lack of public and legislative focus negatively impacts mental health funding. It is not a priority and is often one of the first places cuts will be made. Many view mental health services as an expense to be avoided rather than as an investment to be made, ignoring the ultimate costs to the state in failure to provide these services. This “penny-wise, but pound foolish” approach is an important obstacle to ultimate resolution of these issues. In Georgia, more individuals are treated for mental illness within the criminal justice system than in hospitals or other community-based programs combined.<sup>11</sup> Georgia ranks 44th in per capita spending on mental health services out of the 50 states.<sup>12</sup> Absent aggressive advocacy, there is nothing to suggest that this sad state of prioritization will change.

### **Access**

- First contact with law enforcement is a critical time for individuals with mental illness. The police officer may have the discretion to bring the

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<sup>11</sup> According to individuals interviewed.

<sup>12</sup> See NAMI. *Grading the States 2006-A Report on America's Health Care System for Serious Mental Illness*. [www.nami.org](http://www.nami.org).

individual into the system often leading to criminal charges for the individual or divert him/her to a community-based treatment facility. Even if sufficiently educated about mental illness, law enforcement officers are hamstrung if there are no viable alternatives to jail. Many communities, especially in rural areas, lack sufficient alternatives causing jail to become the only place an individual can go.

- For those individuals who have been deemed “hard to serve,” (the ones who have acted out or have been barred from a Community Service Board (CSB) due to behavioral issues) there may be even fewer community programs available.
- Many of the currently existing community services in Georgia do not provide adequate services despite the good intentions and hard work of their employees and volunteers. Many individuals have difficulty locating services or getting to them, even if found. Many of Georgia’s CSBs service many counties and may be far from an individual’s home. Public transportation is practically non-existent in Georgia. There are not enough hospital beds in the public or private sectors for those with mental illness in need of in-patient services.
- Admission to a state mental hospital in Georgia, rather than incarceration, is not a good alternative to jail. Recent reports have highlighted significant problems within this system. For example, the state mental hospital in Atlanta sits “at a precipice of a dangerous and swift downward spiral” riddled with problems endangering its patients, a consulting team has concluded. A scathing report on Georgia Regional Hospital/Atlanta, dated May 3, 2007 and reported in the *Atlanta Journal-Constitution*,<sup>13</sup> detailed an array of serious issues: medical records not retained, medical exams not performed, physical restraints of patients not recorded, widespread medication errors not investigated, unexplained deaths, and abuse of patients by some employees.<sup>14</sup>
- Medicaid does not pay for certain critical supportive mental health services. Medicaid payment is needed for services that address the needs of individuals with mental illness, including group outreach, doctor visits, group therapy, and medications. Payments are not allowed for periods long enough to permit effective therapy. Currently, Medicaid payments for mental health services appear to recipients and providers, to be administered in very restrictive ways, thus preventing many from receiving the type and extent of therapy and treatment needed. Because Medicaid has reduced the money it pays to mental

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<sup>13</sup> See Judd, A. and Miller, A. “Report blisters mental hospital.” *Atlanta Journal-Constitution*, 05/09/07.

<sup>14</sup> The Department of Human Resources (DHR), which operates Georgia’s seven state hospitals, commissioned a study during a recent *Atlanta Journal-Constitution* investigation of patient deaths in its psychiatric facilities.

health care providers, many such providers are leaving the new Medicaid system in “droves,” according to one interviewee, which will soon lead to an even greater crisis in available mental health resources.

- Based on these interviews, there is no functional multidisciplinary approach to mental health treatment in Georgia. Individuals have difficulty obtaining information about community mental health services. Competition is stiff among groups with varying needs (children, adults, and criminal defendants) for the same resources, with advocates for these groups prioritizing the needs of one group over another if there seems to be no workable way to serve everyone. Even though state law gives everyone the right to adequate mental health services,<sup>15</sup> what is available may be hard to access. Despite an existing hotline number for a single point of entry into the system, observers report that many individuals and their families still have considerable difficulty identifying available resources, locating a complete list of options in their area and obtaining needed services in a timely manner. This is particularly true for those individuals with mental illness recently released from Georgia’s prisons and jails, who may have been given only several days of needed medication, and have no time to spare in accessing meaningful treatment after release.
- According to the field experts, notwithstanding requirements mandated under the Americans with Disabilities Act (ADA), treatment in Georgia is not provided in the most integrated setting available. The *Olmstead* standard<sup>16</sup> has not been met in Georgia and is not incorporated into many facilities’ evaluation processes.
- While there are 25 regional Community Service Boards which contract with the Department of Human Resources to provide services, they are too few and widespread. Created as regional entities, CSBs are insufficiently funded. Many counties are underserved since the CSB typically is located in a larger county, making it difficult for those unfamiliar with the area or without adequate transportation to access its services. Some centers serve 10 or more counties, leading to a lack of available resources and personnel for effective and adequate treatment in

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<sup>15</sup> See O.C.G.A. § 37-2-1 (2006). “It is the policy of this state to provide adequate mental health, developmental disability, addictive disease, and other disability services to all its citizens. It is further the policy of this state to provide such services through a unified system which encourages cooperation and sharing of resources among all providers of such services, both governmental and private.”

<sup>16</sup> In 1999, the United States Supreme Court decided *Olmstead v. L. C.* and concluded that under Title II of the Americans with Disabilities Act (ADA), unnecessary institutional segregation constitutes discrimination by reason of disability. States are required to place persons with mental disabilities in community settings rather than in institutions when the State’s treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

many parts of its service area. Recently, according to individuals interviewed, some CSB mental health care satellite offices have closed, leaving individuals with no continuity of care if they are unable to access services at another location.

- Funding is a major impediment to implementing community-based programs. Helpful programs do exist for individuals with mental illness, but they are not available state-wide. Some are available only in the Atlanta metro area. There have been several reorganizations of Georgia's mental health system, and more recently, efforts to privatize Georgia Medicaid which have caused even more people to get lost in the system. Cost-shifting by the government has led to the elimination of some public health programs further burdening the private sector. There is insufficient long-term planning for mental health care services.
- There is a lack of coordination among those who provide community mental health services. There is little coordination between prisons and community facilities, thus disrupting the continuity of care as individuals leave one system and enter another. Individuals may find a way to access treatment, but may be denied their medication because they are not yet re-entered in governmental assistance programs or cannot afford their co-payment.
- A lack of comprehensive knowledge and inadequate training of medical and mental health providers, who control access to mental health services, is sometimes seen.
- Mental health services for juveniles are inadequate and fragmented. Addressing mental illness during childhood and early adulthood is key to obtaining adequate treatment for individuals to prevent future problems or the potential for entry into the criminal justice system. While the majority of individuals begin showing signs of mental illness between the ages of 17-23 the conditions begin to develop much earlier. We are not catching the signs early enough:
  - ❖ School and social systems are not properly funded nor staffed to recognize and assist children with mental illness.
  - ❖ Assessment tools frequently used with children were designed for use with adults, leading to inaccurate assessments and misdiagnosis.
  - ❖ Effective medications are often unavailable for children, as many medications are studied and tested for use only in adults.

- ❖ Some judges use the juvenile justice system as a mental health care system for children in a well-intentioned, but arguably misguided, attempt to secure mental health services that would almost assuredly be unavailable otherwise.
- ❖ Some educators, school counselors, law enforcement, and courts seem to have the view that getting children into “the system” is the best way to obtain appropriate mental health care. In reality, this move may only put a child into a juvenile justice system which is not designed and was never intended to provide primary mental health care for children. Ironically, however, often the dispositions in juvenile court do not provide for mental health services. Juveniles may be recommended for community confinement in a residential facility, potentially isolating the child from friends, family and support groups. If they remain confined in these facilities for long periods of time, they could potentially lose (or not gain) the social skills necessary to function in society.
- ❖ The educational community seems somewhat resistant to community-based solutions and prefers to keep unruly or disruptive children out of the classroom. Georgia has one of the worst records for removing students from regular classrooms and warehousing them in severely restrictive educational environments until graduation.<sup>17</sup>
- ❖ Due to lack of adequate information presented to juvenile court judges during disposition, these judges are often unable to adequately consider all factors: circumstances, context, and mental illness.
- ❖ There is a disparity of mental health resources available to treat children due to place of residence.
- ❖ Some schools may not want a mental illness diagnosis made to avoid the cost incurred with undertaking required care, or for fear of labeling a child with a psychiatric diagnosis or simply labeling a child as “bad.” Because of this, many juveniles have undiagnosed and untreated mental illness and may have committed a crime because they did not get needed help. This begins a long and unfortunate relationship with the criminal justice system.

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<sup>17</sup> As reported by one individual interviewed.

- ❖ Judges face a “double bind” situation when determining disposition of a child. If the judge commits the child to the Georgia Department of Juvenile Justice (DJJ), to the Georgia Department of Human Resources (DHR), or the Division of Family and Children Services (DFCS), he/she then loses authority to direct placement and services and may fear the disposition will not lead to adequate treatment. On the other hand, judges are also concerned about releasing the child back into the community without assurances of appropriate community-based services for the child.
- ❖ The juvenile justice system and the mental health system are not one in the same. They have different purposes, structures and services.
- ❖ Privacy concerns (HIPAA<sup>18</sup>, sealing juvenile records) make disclosure, coordination and oversight of mental health treatment difficult for adults, and particularly so for children.
- ❖ Juvenile psychiatric residential treatment facilities (PRTF) may face an urgent crisis due to new Medicaid regulations. A recent overhaul of Medicaid regulations, effective July 1, 2007, changes the way in which residential psychiatric care for children in DFCS custody is handled. The per diem charge that these facilities have negotiated with Georgia, which covered housing, food, education, counseling, therapy, medication and related services, will no longer be covered by Medicaid and these services will be unbundled. There may also be limits on the length of stay for children despite their mental health status. Significant funds will be directed to a third party subcontracted auditor, hired by Medicaid, which will conduct bi-annual audits of each PRTF to assess whether the treatment rendered was “medically necessary.” PRTF operators are worried that “recovery” of funds expended for treatment deemed not medically necessary could result in closure of facilities due to lack of operating capital. CSBs are also subject to these independent audits and have already begun eliminating some of their community-based programs.

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<sup>18</sup> The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required improved efficiency in healthcare delivery by standardized electronic data interchange and protection of confidentiality and security of health data. The Act called on the Department of Health and Human Services to publish new rules, including requiring standardization of electronic patient health information and security standards to ensure confidentiality of individual identifiable health information. See <http://www.hhs.gov/ocr/hipaa/>.

- ❖ The new Medicaid rules will also prohibit non-licensed individuals from providing counseling services at these facilities, even those who have bachelors or masters level social work degrees and currently work in the field. The new regulations do not provide for “grandfathering” of these long-time experienced workers and come at a time when the field is already significantly understaffed.

## **B. Recommendations**

### **Education**

- Georgia has a strong Recovery Movement, part of the National Recovery Movement, which aims to educate the public about mental illness and increase awareness about treatment options and the fact that mental illness is treatable in most cases. To increase public awareness and understanding, this program needs to be expanded and awarded more formal recognition.<sup>19</sup>
- Better marketing and promotion of counseling as a profession to increase interest and awareness regarding mental health issues.
- Increased awareness is the first step to increased funding. Emphasize the fact that mental illness is not highly correlated with violence, as highly publicized incidences might suggest.

### **Diversion**

- Atlanta established the Gateway Center (275 Pryor Street) two years ago as a place where the police could divert people with mental illness in crisis. The Gateway Center was created from the efforts of the Regional Commission on Homelessness to impact chronic homelessness. Supported by more than 50 agencies, departments, faith-based groups and service entities, it serves as a single point of entry for homeless individuals, many of whom have mental illness. It provides drop-in services where individuals can have access to bathroom and laundry facilities, store personal belongings, access general information and obtain referrals. It handles outreach, intake, assessment and assistance

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<sup>19</sup> Research did not reveal whether the Recovery Movement has been widely adopted in Georgia but it does appear to have been formally adopted by the DOC and/or DHR as part of their mental health care policies.

obtaining benefits and offers limited counseling. While the Gateway Center has served to provide the Atlanta Police Department with an alternative to jailing offenders who committed non-violent misdemeanors, it reportedly no longer provides “24/7” availability as when it first opened in 2005. The funding has been increased to handle more chronically homeless persons with long-term disability conditions, but its hours of intake are limited to 7:00 a.m. to 5:00 p.m. due to limited professional health staff, significantly reducing it as an alternative to incarceration. The Gateway Center needs sufficient funding to return to its original operating hours of 24/7, add new personnel and expand counseling services. Additional Gateway Centers should open around the state. Such centers must solicit private and faith-based organizations and additional state funding of services to provide operating capital.

- Add and utilize short-term residential facilities or crisis units to help stabilize individuals in emergency situations to free up beds in the state mental hospitals needed for more serious cases of mental illness.
- Services need to be expanded statewide as not everyone can be treated in the Atlanta metro area. Increase the number and geographic diversity of CSBs. While the ideal would be to place one in every county, a more attainable alternative might be to provide transportation among facilities.
- Establish incentive programs to encourage neighborhoods to reach out. Efforts to establish permanent supportive housing (affordable housing with services) often are met with fear and hostility as community members say “not in my backyard.”
- Emphasize diagnosis and treatment of mental illness in children. Encourage parents and school systems to address these issues. Institute screening in schools for mental illness and developmental disabilities as is done for vision and hearing deficits.
- Discourage school officials from arresting students for petty offenses which may have the effect of criminalizing behavior of children with mental illness.

## **Funding**

- Look to private organizations to fund various programs; they are not utilized enough. Seek contributions from businesses, hotels, restaurants, and sports venues that are impacted by panhandling, loitering, and disorderly conduct of individuals with mental illness who tend to gravitate to these business areas.
- Allocate funds in a way that will bring in federal matching dollars. Provide adequate mental health services under the Medicaid program.

- Resources should be “front-loaded” by focusing on prevention, addressing community mental health services and other services for juveniles and adults.
- Lobby at the state and federal levels to make changes in the Medicaid waiver system to allow equal access to funds for mental health services. Create an application process for Medicaid funding that increases the number of people who can provide mental health care services.
- Stop the unbundling of services.
- Increase Supplemental Security Income (SSI) enrollment and liberalize the disability standards.
- Direct funding to residential services aiding “hard to serve” individuals.
- Fully fund supportive housing. Experts say that funding even 75 case managers would go a long way to stabilize the chronically homeless, many of whom are regular users of regional mental health hospitals. It is not unusual for a chronically homeless individual to cost the state \$40,000-\$50,000 per year. The use of case managers has proven effective and less costly than hospitalization. The Regional Commission on Homelessness funded 14 organizations to provide such care and over 90% of individuals stayed in the program or went on to better circumstances. The cost for a day of supportive housing is one tenth that of a day in a hospital.
- Fund housing connected to services. Continue to push to use tax credits for “special needs” housing.
- Better compensate those working in the counseling field to attract and retain more providers.

## **Legislation**

- Social work counselors with bachelors and masters degrees who have been working in the field, should be permitted to continue working and eligible for payment by Medicaid; “grandfather” them so they are not dismissed, disrupting continuity of care, merely because they lack a state license.
- Establish a lobby for issues relating to mental health care in Georgia; get these issues in front of the legislature and the governor. Create a bi-partisan committee to help de-politicize mental health care.
- Judges in the juvenile justice system need more alternatives to delinquency adjudications for children whose behaviors, though

delinquent, are more appropriately considered symptomatic of mental illness or serious emotional or behavior disorders. Alternative adjudication under statutory schemes such as CHINS (Child In Need of Services) or PINS (Person In Need of Services), not available under Georgia's juvenile code, is needed for children with mental illness.

- Expand treatment courts across the state.

### **Coordination and Communication**

- Increase public awareness of mental health issues and services through advertising campaigns on MARTA, TV, and radio as well as brochures on counters in places such as fast food restaurants.
- Improve services of the one-call service hotline, recently established by DHR, which allows individuals to call and obtain referrals to local treatment providers. Information about local treatment providers must be kept current regarding what services are available, where, hours of operation, contact information, etc. An effective statewide program should take control of such a service, helping to bridge the gap between providers, funding, and those in need. Internet information must be more easily accessible.
- Mental health services need to be integrated and provided using a multidisciplinary approach. Services need to encompass not only counseling and medication issues, but housing, employment assistance, transportation and continuity of care when individuals transition from one service provider to the next.
- Create a manual with “here’s where help is supposed to be available” and “here’s what to do when that channel doesn’t work.” Create a comprehensive directory of services and keep it current. Funding must be allocated to the important task of periodically checking with facilities regarding availability of services, which could be done by simple e-mail communication.
- Make inter-agency cooperation and coordination the norm and not the exception. Entities need to communicate with one another to share information related to service success and failures, funding options, personnel needs, referrals, etc. Funding needs to be increased to establish a central body or core team from existing agencies, such as the Leadership Interagency Council on Homelessness.
- Agencies must continue to establish partnerships with non-profit and faith-based organizations which can help to create additional community outreach.

- Provide a “wrap around” system of services bringing all parties to the table for children. Include social workers, mental health professionals, school counselors, and others to develop appropriate treatment plans for juveniles with mental illness.

## **II. Adequate Training and Education of Law Enforcement Officers, Attorneys, and Judges is Not Universal, Not Easily Accessible, Leading to Missed Opportunities for Appropriate Diversion**

When individuals with mental illness enter the criminal justice system, they encounter law enforcement officers, attorneys, and judges at each step of the way. At each point of contact an opportunity exists for mental illness to be recognized and dealt with appropriately.

### **A. Findings**

- As discussed, in some situations certain alternatives exist to arresting and incarcerating those with mental illness. For example, if an individual has committed a so-called “quality of life” crime, an officer may have discretion to arrest or divert the individual to an alternative facility, if one is available, where evaluation and/or treatment can be provided. The determination of the seriousness of the crime, i.e. felony v. misdemeanor, may also be a discretionary decision that has huge implications for future disposition.
- Even if necessary facilities are available, diversion of individuals with mental illness cannot occur if law enforcement officers lack necessary training in recognizing mental illness. While police officers in some departments receive Crisis Intervention Training (CIT) to help them recognize and respond appropriately when an individual facing arrest displays signs of mental illness, these training programs are not widespread.
- If an individual with mental illness cannot be “diverted” from the criminal justice system due to lack of facilities and/or the nature of the crime, it is important for the lawyer defending the individual to be trained to recognize signs or symptoms of mental illness.
- Criminal defense counsel should be educated about mental illness and how it could affect a defense strategy. Relevant training is currently available. For example, continuing legal education (CLE) classes are available to members of the bar on the topic of insanity pleas. However, training relating to the representation of a client with mental illness is not mandatory even for those who specialize in criminal defense of those with mental illness.
- Defense counsel’s lack of training may cause the lawyer to pursue a strategy that may not serve the client’s best interests. For example, defense counsel might be inclined to assert a defense of Not Guilty by Reason of Insanity (NGRI), believing that an insanity acquittal would be the best result for the client. To the contrary, in some cases a client

found NGRI might end up indefinitely confined in a state hospital, when, if convicted, the prison sentence may have been relatively short.

- Defense counsel must acquire adequate familiarity with alternatives to traditional adjudication, such as the growing number of mental health courts in the state.
- Georgia's counties began establishing mental health courts in 2002, the first in Dougherty County. Currently, they are operating in other counties, including Muscogee, Hall, Fulton and DeKalb counties, and strides are being made to establish courts in Chatham and Clarke counties. These courts were established in recognition of the fact that individuals with mental illness do not function well in the criminal justice system.<sup>20</sup> These individuals are often not able to meet standard benchmarks that are part of a sentence or probation period. Mental health courts divert select defendants with mental illness to judicially supervised, community-based treatment. These diversions are voluntary and defendants are invited to participate only after a screening and assessment process. A multi-disciplinary team works with the individual to develop a treatment plan and supervise the individual. The participant appears at regular status hearings where incentives are offered for compliance and sanctions imposed for non-compliance.<sup>21</sup>
- It is important for prosecutors to receive training similar to that of defense counsel. It may positively impact the manner in which a prosecutor handles a case, including the charges brought, the sentence requested, and the pleas he or she is willing to recommend. Training may provide prosecutors with a better understanding of advantages of community-based placement for defendants with mental illness.
- Judges will also benefit from expanded continuing education about mental illness. Judges have a certain amount of discretion about a defendant's sentence or disposition that may be more strategically exercised if based upon the latest information and research in this field.
- Judges also need accurate, regularly updated information about the available mental health services in the community and how those services may be accessed.

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<sup>20</sup> Many individuals with mental illness also have substance abuse problems; however, drug courts are not designed to deal with individuals with co-occurring conditions.

<sup>21</sup> See Council of State Governments. *Mental Health Courts: A National Snapshot*. [www.ojp.usdoj.gov/BJA/pdf/MHC\\_National\\_Snapshot.pdf](http://www.ojp.usdoj.gov/BJA/pdf/MHC_National_Snapshot.pdf).

**B. Recommendations**

- Provide comprehensive, widespread CIT training for law enforcement officers, including training on recognizing mental illness and the alternatives to arrest available in the community.
- Publish a manual for defense counsel explaining issues relevant to representing a client with mental illness.
- Consider mandating CLE relating to mental health issues for those representing criminal defendants.
- Publish monographs or a bench book supplement for judges explaining the unique issues that arise when an individual with mental illness enters the criminal justice system.
- Establish more mental health courts and establish programs to educate bench, bar, mental health care providers and the public regarding the existence of these courts and what they do.
- Compile a directory of community resources for law enforcement officers, bench, and bar.

### **III. Inadequate Access to Diagnosis and Treatment in Our Jails and Prisons**

For the large number of individuals with mental illness whose only contact with the criminal justice system in Georgia occurs at a county jail, proper diagnosis, treatment and rehabilitation is essentially non-existent with only a few exceptions. Detection of an individual's symptoms of mental illness is often solely dependent upon the perception and compassion of jail staff members who usually are not trained mental health care providers. Funding for medication and jail-based mental health care varies from county to county, and, it is often the case that rural counties are not financially able to support any aspect of mental health care for their inmates.

Although Georgia's prisons are staffed with psychologists, psychiatrists and mental health caseworkers, the assessment, screening and treatment of inmates with mental illness is not consistent. In many prisons, inmates are treated only on an "as needed" basis. There may be few continuing therapeutic treatment programs available and/or attended regularly. Prison psychologists are over burdened with administrative tasks and often have little or no time for clinical work. Moreover, due to budget cuts, Georgia prisons no longer have full-time clinical chaplains on staff nor are they staffed with full-time special education teachers. Finally, the Georgia Department of Corrections has eliminated the behavioral specialist position, previously responsible for testing individuals who exhibited symptoms of mental illness. Without the proper testing, diagnosis, and treatment, rehabilitation is more difficult.

#### **A. Findings**

##### **County Jails**

- Due to disparate resources our county jails, on the whole, do not provide a consistent nor adequate level of mental health services. The amount and quality of jail-based mental health care varies by county.
- Many jails do not have access to a psychiatrist, nurse or mental health care provider. In some counties they may only be available on an "on call" basis. In others, a staff psychiatrist may only be able to come to the jail once every two months.
- While some jails may provide access to community mental health services, the actual use of community mental health care providers is dependent upon the cooperation and willingness of the county sheriff's department.
- The size of the county does not always determine the adequacy of mental health services. While Fulton County is home to Atlanta, the largest city in the state, its jail does not consistently address healthcare for individuals with mental illness, according to individuals interviewed. In DeKalb County, the situation appears to be better: a mental health

team is available that includes psychiatrists and counselors facilitating continuity and adequacy of care.

- Release plans generally fail to connect people with community mental health services and housing. Without making a community connection to ongoing services upon release, the funds spent on jail treatment will not provide a long-term solution or prevent re-entry.

## **State Prisons**

- Reportedly, Georgia's prison system does not offer anything approximating optimal treatment and rehabilitation opportunities to inmates with mental illness.
- Although the Department of Corrections has a system for screening incoming inmates for mental health issues, there are deficiencies in the system that undermine treatment and the reduction of recidivism. According to the stakeholders interviewed, screening, assessment and treatment of inmates with mental illness is not consistent among the various prison facilities.
- Most healthcare services in our prisons are provided on an "as-needed" basis. For example, inmates are seen by a healthcare provider for specific medical problems pursuant to a "sick call slip." If an inmate raises an issue, including mental illness, that is not referenced in the "sick call slip," the medical provider will not address the additional issue at that time, but instead will require the inmate to present at another time with a new "sick call slip," creating a delay in attention and treatment.
- According to our interviews, cuts in funding related to a push for privatization of prison healthcare have left Georgia's prisons without full-time clinical chaplains, full-time special education teachers and no activity or recreation specialists.
- The Department of Corrections has also eliminated the position of behavioral specialist, a job many feel is crucial to proper testing for and diagnosis of mental illness.
- There are a limited number of in-prison therapeutic communities offered in Georgia's prison system, and those that are provided focus on substance abuse issues.
- While it is often the case that inmates with mental illness also have a substance abuse problem, most of the stakeholders interviewed agreed that inmates with mental illness are not able to address their substance abuse problems as well as inmates without mental illness are able to do.

- There is a staffing crisis in caring for inmates with mental illness in the prisons: caseloads are high, pay is dismal, and warden support for mental health care varies among the facilities.
- Some prisons have segregated units within the prison to treat individuals with mental illness that provide somewhat more effective treatment.
- The “pill call” line in prisons is a great source of agitation for prisoners with mental illness. Prisoners may have to stand in line 2 or more times a day, sometimes for up to an hour each time, to receive their medication.
- There is insufficient communication between prison staff and outside healthcare providers regarding prisoners’ pre-incarceration mental health care.
- It is often difficult to balance the security needs in the prisons and the mental health care needs of the inmates. Security may take precedence over treatment.

## **B. Recommendations**

- Counties need to provide training to ensure better and more consistent assessment, diagnosis and treatment of individuals with mental illness who enter the criminal justice system through our county jails. Local sheriff’s departments should be required to maintain communication with community mental health services and have knowledge of the services offered.
- Additional funding is imperative if there is any hope whatsoever of county jails providing services to individuals with mental illness. Communities need to conduct creative searches for additional funding from all levels of government, private groups, non-profit organizations, corporate sponsorships, etc.
- The Department of Corrections must adopt a consistent standard for screening, assessing, diagnosing, treating inmates and obtaining information about an inmate’s prior mental health treatment, if any. It should also review the processes relating to “sick call slips.”
- The job descriptions and evaluation standards of wardens and other prison staff members must be rewritten to require attention be given to proper treatment of inmates with mental illness, hopefully eliminating some of the reported inconsistencies.

- The Department of Corrections operates with a limited budget. Increased targeted funding to allow the training of prison staff and hiring of mental health professionals is needed.
- While keeping security a priority, develop new procedures that would be sensitive to the needs of prisoners with mental illness especially in the “pill call” line.

#### IV. Inadequate Release Planning

It is generally believed in the mental health community that failure to provide adequate and coordinated services before and upon release and re-entry into the community to those treated for mental illness while incarcerated, leads to a higher risk of recidivism.

The problem is not limited to Georgia. In 2000, the Bureau of Justice Statistics Study<sup>22</sup> found that 34% of adult correctional facilities in this country provided no release and re-entry services to these individuals. For the 66% that claimed to provide at least some of these services, both the numbers of individuals receiving those services and the quality of those services are unknown.

The failure to provide adequate release services has been successfully litigated. In 1999, in an Eighth Amendment claim of cruel and unusual punishment, an individual plaintiff in California alleged that the facility failed to provide him with the two-week supply of psychotropic medications prescribed by his physician on release. The 9<sup>th</sup> Circuit found that the state must provide a supply of medication reasonably adequate to allow him time to consult a physician and receive a new supply. Failure to do so was an “abdication of its responsibility to provide medical care.” Wakefield v. Thompson, 117 F.3d 1160, 1164 (9<sup>th</sup> Cir. 1999).

In the same year, the New York City jails settled a class action suit brought by mentally ill inmates who had been provided, upon release, the grand sum of \$1.50 in cash and \$3.00 in subway fare but had not been provided any mental health services, housing assistance, government benefit assistance or any other help whatsoever in planning and executing their re-entry into the community. The Court, in granting an injunction requiring services, characterized the consequences of their failure to do so as causing “irreparable harm” to the released inmates which would result in a return to the cycle of likely harm to themselves and/or others through substance abuse, mental and physical health deterioration, homelessness, indigence, crime, re-arrest and re-incarceration. Brad H. v. City of New York, 712 N.Y.S. 2d 336, 345 (Sup. Ct., N.Y. County) (6/12/00).

The Bureau of Justice Statistics Study outlined the immensity of the problem in the United States: 81.2% of mentally ill in state prisons have prior criminal histories, 26.3% have 3-5 prior sentences to probation or incarceration, 15.6% have 6-10 and 10% have eleven or more. The statistics for jail inmates are similar. The rate of recidivism is highest in the first six months following release.

In the best scenarios, a wide range of coordinated services and support including corrections, parole, mental health, employment, housing, welfare, health and private providers should be involved and available to facilitate re-entry. It is best to have these agencies view their services as part of an integrated plan.

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<sup>22</sup> See Bureau of Justice Statistics. *Mental Health Treatment in State Prisons*, 2001.

Additional serious obstacles to community re-entry exist. Some states, although not required to do so by the federal government, remove prisoners from Medicaid and require re-application upon release. Automatic termination of Supplemental Security Income (SSI) benefits is required if incarceration is for 30 days or longer; Social Security Disability Income (SSDI) must be suspended, but not automatically terminated, upon incarceration and is not automatically reinstated upon release. Prisoners may be prohibited from re-applying prior to release and reactivation of benefits can take a minimum of forty-five days or more from the date of reapplication.

Following the maze of required steps to become a functioning member of society post-release is difficult for any former inmate, but especially so for a recently released individual with mental illness, especially if he or she is released without medication, a treatment plan, housing and transportation.

States, including Georgia, may assert various fiscal crises to support decisions to cut costs. Programs for individuals with mental illness and, even more so, programs for those incarcerated with mental illness are particularly vulnerable to such budget deductions. Proper funding of release planning and post-release programs is critical and a serious public policy issue. Viewing this issue from a purely monetary perspective, humanitarian considerations aside, failure to fund these services is fiscally short-sighted. The cost of returning those with mental illness to prison is clearly greater, in the long term, than any cost reduction in the short term. When one includes the non-monetary consideration, ---the possibility of increased crime and violence, the sundering of family units, and the wasting of human potential--- the actual cost from under-funding these services is staggering.

With this background, one might ask, how does Georgia compare to the nation as a whole? As stated earlier, Georgia ranks 44<sup>th</sup> of the 50 states in per-capita spending for mental illness. As we have learned, at least 15% of Georgia prisoners currently are diagnosed with mental illness and this percentage is increasing steadily. Georgia is one of the states that, by official policy, provides exit planning and release services to those treated for mental illness while incarcerated in prisons, however, no such program exists for those in county or city jails. There are programs currently existing in Georgia that have begun to address release and prevention of re-entry, including the start of Fulton County's Discharge Program. Interviewees, however, insist that the current services remain sporadic, inadequate, and geographically limited, resulting in most released prisoners with mental illness eventually falling through the cracks. Georgia presently has a tremendous opportunity to improve its services for re-entry and prevention of recidivism for prisoners with or without mental illness.

In 2004, Georgia was one of nine states chosen to participate in the Federal Re-entry Initiative. Using Department of Justice funds, the "Transition from Prison to Community Initiative" (TCPI) provided Georgia officials with intensive counseling, training and technical assistance by experts in the fields of correctional policy and prisoner re-entry. The goal of TCPI is to strengthen Georgia strategies for reducing recidivism by developing transition plans for inmates from the moment they enter prison

and would identify offenders' problems including substance abuse and mental health disorders.

In September 2005, The Transition To The Community Initiative, as part of the Georgia Re-entry Impact Project, released a Survey Progress Report.<sup>23</sup> This report is exceedingly valuable in assessing the status of re-entry efforts. It demonstrates that much still remains to be done.

In 2006, the State Board of Pardons and Paroles and the DOC entered into an agreement to conduct a project designed to provide housing for work-release convicted felons who remained in prison due solely to having no residential options. Some released prisoners with mental illness could be included in this program.

## **A. Findings**

### **Release/Re-entry Planning**

- Planning that is provided is not begun early enough. Some field experts suggested that release planning that begins “day one” of incarceration is needed.
- Surveys indicate that, in Georgia, at least half of all general and mental health counselors in prisons performed no pre-release planning for 42-47% of their caseloads.<sup>24</sup>
- No representatives from Georgia's Department of Human Resources (DHR) are available in the prisons to help with exit planning. Field experts interviewed suggested that DHR expertise and resources would make a positive difference if made available to inmates while still imprisoned.
- Efforts to connect release to affordable housing programs are limited.

### **Transitional Services**

- Despite protocols requiring “adequate” medication be given, individuals are often released without their psychotropic medication or are, perhaps, provided a week's supply.
- At time of release, many have neither an appointment with a mental health provider nor a referral to one.

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<sup>23</sup> See The Georgia Re-entry Impact Project Policy Team. *Transition from Prison to the Community Initiative: Treatment Subcommittee Survey Project*. September 1, 2005.

<sup>24</sup> *Id.*

- Many have no knowledge of what services are provided in the county or service area of the prison. The individual most likely resided elsewhere prior to incarceration.
- Often released prisoners have to fend for themselves without any assistance in obtaining identification, housing, jobs, transportation as well as continuity of mental health services, quickly falling through the gaps into homelessness.
- In a few counties in Georgia, there are no doctors, hospitals, halfway houses, CSBs, and, apparently, no money to obtain needed services.
- As true for all individuals seeking treatment for mental health, there are not enough outpatient services to fulfill the need. The fact that an individual was incarcerated may also be an obstacle to obtaining needed services.
- Community resistance and financial obstacles have dismantled parts of the network of halfway houses that once existed.
- There are public housing limitations for some released prisoners with mental illness who have been convicted of a felony.
- Even if services were available, there is insufficient public transportation for the individual to use to get to them.

### **Coordination and monitoring of post-release services and compliance**

- Presently, too much reliance for post-release assistance is placed upon probation officers who, in the main, lack necessary training.
- There is little or no continuity of mental health services provided to an individual while incarcerated and within the community upon release.
- Existing services to assist in transition currently include the following:
- TAPP (Transition and Aftercare for Probation and Parolees)
  - ❖ DOC, Department of Pardons and Paroles, and DHR joint program to provide intensive case management program linked with mental health care, substance abuse treatment, housing, federal entitlement, etc.
  - ❖ Its goals are to ensure the released individual is compliant with attendance at therapy and use of medication and also to assess the stability of the individual following release.

- ❖ Assistance begins prior to release for prisoners who received mental health care while in prison and provides for re-evaluation before release. Prisoners sign an agreement to remain compliant with the treatment plan and, within five days of release, must have an appointment with a mental health provider.
- ❖ The end goal is to stabilize the individual and help him or her avoid behaviors that tend to initiate repeat entanglements with the criminal justice system.
- Faith Based Organizations
  - ❖ These organizations provide valuable post-imprisonment community re-entry services and in some places also provide pre-release services.
- Patient Advocacy Groups
  - ❖ Community Mental Health Network.
  - ❖ National Alliance on Mental Illness (NAMI).
  - These assist released prisoners to access private and public resources for treatment.
- Community Service Boards (CSBs)
  - ❖ There are 25 regional boards which contract with DHR to provide community mental health services. They are generally located in larger counties and some may serve more than 10 counties.
- Peer Support Program in Georgia
  - ❖ National model, which provides peer counseling or peer monitoring to prevent recidivism.
- ACT (Assertive Community Treatment)
  - ❖ Non-court-mandated program that monitors released individual's compliance with treatment plans and is funded by community service providers. Currently, Medicaid is inadequate to meet costs. DHR supports other programs that could come through Medicaid.

- DeKalb County Program
  - ❖ Includes services inside the jail to provide soon to be released prisoners with information about available resources.
  - ❖ May provide needed transportation for the released prisoner to the county's CSB, if no other transportation is available.

**B. Recommendations**

- Create and strengthen pre-release services and make the connection to affordable housing.
- Encourage community service providers, faith-based and other organizations to become involved in pre-release programs. (Talks, brochures, maps, and telephone numbers).
- Improve access to CSBs (increase number, improve transportation).
- Adequately fund currently available programs.
- Provide ombudsmen to coordinate release planning and continuation of services in the community.
- Create or appoint a single entity responsible for coordination and monitoring of post-release mental health services.
- Make compliance a term of parole or probation.
- Re-educate probation and parole officers to monitor compliance.
- Improve general mental health services, including community services, resulting in improved community re-entry.
- Expand supportive housing opportunities connected to mental health services.

## **V. Inadequate Post-Confinement, Outpatient Treatment Options**

When released from jail or prison, individuals with mental illness enter the same community where they experienced failure in the first place. They face inadequate access to treatment, negative public reception, lack of coordination among treatment providers, and all too often a lack of compassion. They again carry the stigma of mental illness which is now compounded by the stigma of a criminal record. They may have an appointment with a therapist or counselor as they leave prison, but there is no available transportation for them to get there. They may have a prescription in hand, but may not be able to afford the co-payment and thus never fill it. Faced with the same obstacles as outlined in Section I, a door opens, but it all too often leads back to jail.

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