Forsyth County Mental Health Needs Assessment: Diverting from the County Criminal Justice System Using the Sequential Intercept Model

September 2018

Samuel Gonzales
Research and Evaluation Program Director, Statistical Analysis Center

Kelsey Martin
Research Analyst, Statistical Analysis Center

Stefanie Lopez-Howard
Statistical Analysis Center Director

Table of Contents

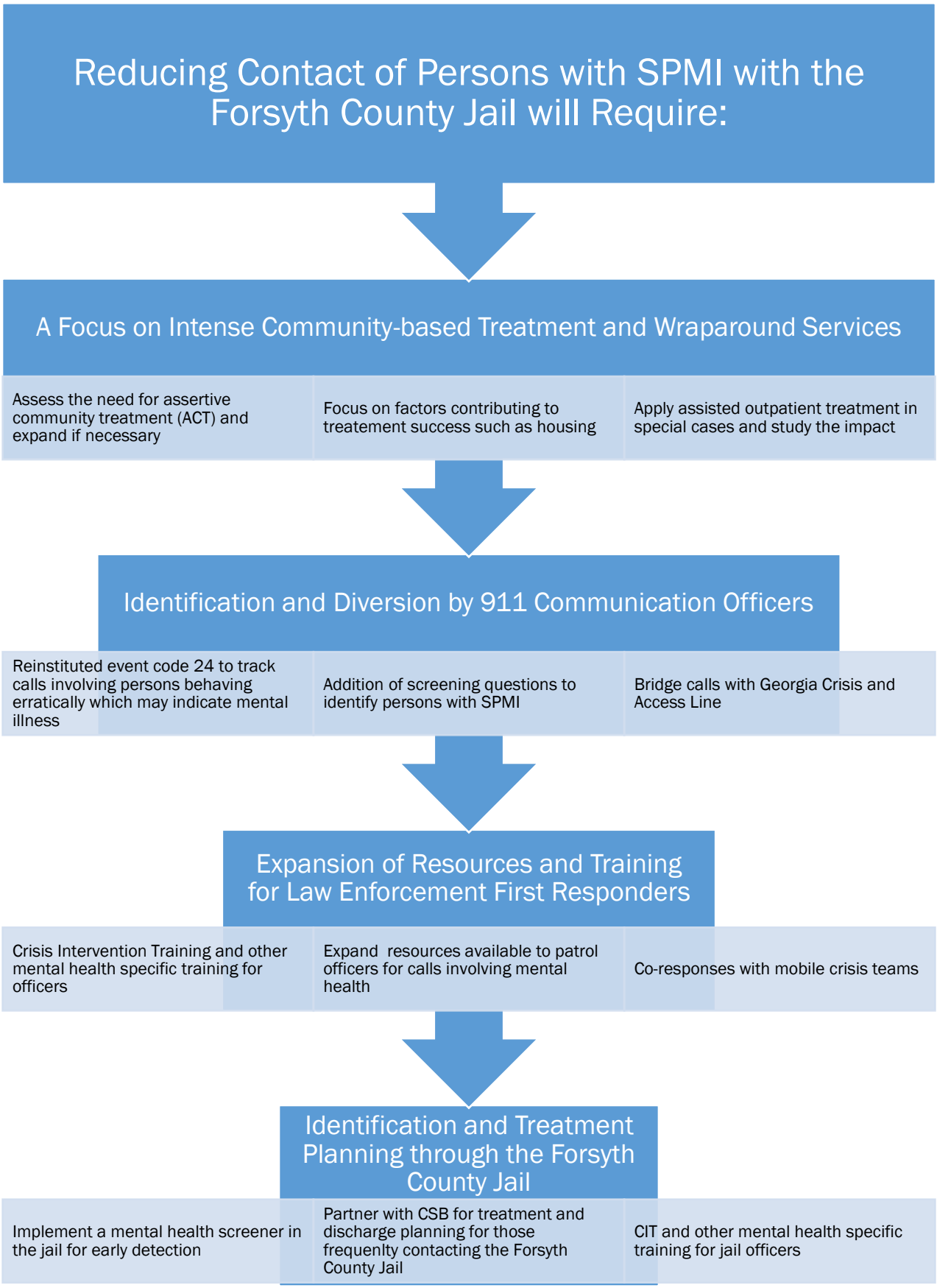
Executive Summary

Introduction

The Criminal Justice Coordinating Council (CJCC) was invited to work with the Forsyth County Mental Health Task Force (FCMHTF) to assess the scope of interaction between persons with serious and persistent mental illness (SPMI) and the criminal justice system, the resources available to treat those persons in the community, and the linkages between those resources and the county criminal justice system. In March of 2016, the CJCC contracted with the Forsyth County Commission for the Statistical Analysis Center (SAC) to conduct this needs assessment in partnership with the FCMHTF.

The objective for the needs assessment was to identify what is required to ensure that persons with SPMI are diverted from the criminal justice system to crisis intervention and/or treatment. The goal is to identify ways to limit incarcerations in the county jail, provide necessary treatment for persons with mental illness who frequently contact the county's criminal justice system ("frequent jail users"), and ensure that law enforcement, 911 dispatchers, and the courts can direct patients and their families to appropriate resources in Forsyth County.

For the needs assessment, 29 different stakeholders were interviewed to understand how someone with SPMI may transition from managing their illness to making contact with the criminal justice system and identifying the processes and rules that drive decision making. Surveys were deployed to four key professions, as well as family members of persons with SPMI, to identify areas of need and knowledge about current policies or procedures. A review of legal decisions, along with both federal and state laws, was conducted to understand the constraints of sharing information, initiating involuntary treatment, and to contextualize the push for treatment in the community. Finally, five data sets were analyzed to help determine the prevalence of contact that persons with SPMI have with various systems. The SAC has 19 recommendations for reducing contact between persons with SPMI and Forsyth County's criminal justice system.


Reducing Contact of Persons with SPMI with the Forsyth County Jail will Require:
A Focus on Intense Community-based Treatment and Wraparound Services
Assess the need for assertive community treatment (ACT) and expand if necessary
Focus on factors contributing to treatement success such as housing
Apply assisted outpatient treatment in special cases and study the impact
Identification and Diversion by 911 Communication Officers
Reinstituted event code 24 to track calls involving persons behaving erratically which may indicate mental illness
Addition of screening questions to identify persons with SPMI
Bridge calls with Georgia Crisis and Access Line
Expansion of Resources and Training for Law Enforcement First Responders
Crisis Intervention Training and other mental health specific training for officers
Expand resources available to patrol officers for calls involving mental health
Co-responses with mobile crisis teams
Identification and Treatment Planning through the Forsyth County Jail
Implement a mental health screener in the jail for early detection
Partner with CSB for treatment and discharge planning for those frequenlty contacting the Forsyth County Jail
CIT and other mental health specific training for jail officers

Recommendations for Diversion

911 Call Center: Identification and Tracking

- Reinstitute the use of Event Code 24 (Irrational Person) and report it within the system like any other event code (not the narrative).
- For calls categorized as Event Codes 24, or for events that include the identification of the presence of alcohol or drugs, incorporate the following guided questions:
    - Are any involved persons known to use prescription psychotropic drugs?
    - Has any of the involved persons been recently treated or hospitalized for mental illness?
- Create a unique identifier for 911 calls to be added to police reports so that the two datasets can be merged for analysis.
- Create policy and train staff to identify and bridge calls to the Georgia Crisis and Access Line (GCAL). A model for this exists in the City of Atlanta.

Forsyth County Sheriff's Officer Patrol Officers: Accessing Resources and Co-responses

- Provide Crisis Intervention Training (CIT) and other mental health specific training for patrol and jail officers to help identify mental illness and de-escalate situations.
- Educate officers about GCAL and train them on how to access their services during a call for service or field contact involving a person with mental illness whose conduct does not meet probable cause for arrest.
- Work with Benchmark, the company providing mobile crisis response in Forsyth County, to develop and implement a coordinated response strategy.
- Maintain a comprehensive list of Emergency Receiving Facilities, and work with GCAL to limit any rejections due to bed availability.

Assisted Outpatient Treatment: Application and Study

- As a coordinated community response strategy, develop criteria for assessing "frequent jail users" for assisted outpatient treatment (AOT), which should include the use of a validated treatment assessment tool such as the START.[1]
- Study compliance to outpatient treatment and determine if AOT reduces frequent flier use of crisis stabilization and inpatient treatment, as well as jail contact. Further assess whether AOT improves adherence to treatment plans and likelihood of recovery for persons with SPMI.

Intake and Discharge Planning from Jail and Pre-Trial Diversion

- Implement a systematic mental health screener at the jail – such as the validated Brief Jail Mental Health Screen.[2]
- Work with AVITA, the community service board, to develop a graduated system of treatment engagement for persons with SPMI who have frequent contact with law enforcement or frequent jail stays.
- Work with AVITA and other community mental health providers to devise a standardized consent protocol for limited information sharing with law enforcement and Forsyth County Jail to facilitate treatment referral.
- Incorporate AVITA and other community-based mental health providers into discharge planning for persons with SPMI who have stays in jail that are greater than 24-hours.
- Work with the Solicitor General, District Attorney's Office, and Pre-Trial services to assess and identify persons with SPMI who have a history of frequent contact with the Forsyth County jail to develop treatment planning and protocols in partnership with AVITA.

---

[1] BC Mental Health and Substance Abuse Services. *Short-Term Assessment of Risk and Treatability*. Retrieved on January 30, 2018 from: http://www.bcmhsus.ca/health-professionals/clinical-resources/start

[2] Policy Research Associates (2005). *Brief Jail Mental Health Screen*. Retrieved on January 30, 2018 from: https://www.prainc.com/wp-content/uploads/2015/10/bjmhsform.pdf

Assertive Community Treatment: Expansion

- Review current patient mix in Forsyth County to identify if there is a patient need for additional ACT resources.

Housing: Focusing on Factors Contributing to Treatment Success

- Work with AVITA to identify frequent jail users who have insecure housing and assist with the Georgia Housing Voucher Program, where appropriate.
- Assess the housing need for the population with SPMI and the availability of housing stock to determine if there is a shortage.

Introduction

In the United States, one in five adults experience mental illness in his or her lifetime and one in twenty-five live with SPMI.[3] Prior to the *Olmsted* Decision in 1999, where there was a shift to community based treatment, approximately 7% to 10% of contact with law enforcement involved persons with mental illness.[4], [5], [6], [7], [8] Mental illness is highly associated with addiction disorders and homelessness[9], which could also increase contact with law enforcement and result in incarceration.

Nationally, 24% of state prisoners report a recent history of mental illness.[10] In Georgia, the percentage of inmates requiring outpatient services, at minimum, while incarcerated was around 18% in 2017.[11] This is slightly higher than the percentage requiring treatment over a decade ago in 2005 (14%).[12] In December 2017, 252 inmates in GA state prisons claimed Forsyth as their home county, and 22% of those have a documented mental health level of 2 or greater (requiring at least outpatient treatment).[13]

Treating mental illness while someone is incarcerated provides numerous challenges and costs, specifically with respect to the costs of psychotropic drugs and staffing and training psychiatrists and therapists. Incarceration could disrupt the continuity of care and make one's disorder worse due to the strictly controlled environment and unfamiliar spaces. Persons with mental illness may cycle through the criminal justice system more frequently than those without illness, but suffering from a mental disorder does not need to lead to unnecessary incarceration.[14]

The CJCC was invited to work with the FCMHTF to assess the scope of interaction between persons with SPMI and the criminal justice system, the resources available to treat those persons in the community, and the linkages between those resources and the county criminal justice system through

---

[3] National Alliance on Mental Illness (2015). Mental Health Facts in America. Retrieved on October 19, 2015 from http://www.nami.org/NAMI/media/NAMI-Media/Infographics/General-MHFacts-9-23-15.pdf

[4] Borum, R., Swanson, J., Swartz, M., & Hiday, V. (1997). Substance abuse, violent behavior and police encounters among persons with severe mental disorder. *Journal of Contemporary Criminal Justice*, 13, 236-250.

[5] Borum, R., Williams, M., & Deane, M.A. (1998). Police perspectives on responding to mentally ill people in crisis: Perceptions of programs effectiveness. *Behavioral Sciences and the Law*, 16, 393-405.

[6] Ditton, P.M. (1999). Mental health and treatment of inmates and probationers (Bureau of Justice Statistics Special Report). Washington, DC: US Department of Justice.

[7] Lamb, H., Weinberger, L.E., & DeCuir, W.J. (2002). The police and mental health. *Psychiatric Services*, 10, 1266-1271

[8] Steadman, H.J., Deane, M.W., & Borum, R. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51, 645-649.

[9] See, e.g. Treatment Advocacy Center (2016). *Serious Mental Illness and Homelessness*. Retrieved on January 29, 2017 from http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-and-homelessness.pdf.

[10] Ibid National Alliance on Mental Illness (2015). Mental Health Facts in America. Retrieved on October 19, 2015 from http://www.nami.org/NAMI/media/NAMI-Media/Infographics/General-MHFacts-9-23-15.pdf

[11] The percent of inmates with diagnosis of mental illness is calculated by taking the average of the percent of inmates with mental illness from the monthly inmate profile reports for the year 2014. The reports were retrieved from http://www.dcor.state.ga.us/Research/Monthly_Profile_all_inmates.html.

[12] The percent of inmates with diagnosis of mental illness is calculated by taking the average of the percent of inmates with mental illness from the monthly inmate profile reports for the year 2005. The reports were retrieved from http://www.dcor.state.ga.us/Research/Monthly_Profile_all_inmates.html.

[13] Georgia Department of Corrections (January 2018). *Inmate Statistical Profile: All Active Inmates*. Retrieved on January 30, 2018 from: http://www.dcor.state.ga.us/sites/all/themes/gdc/pdf/Profile_all_inmates_2017_12.pdf.; and also, Georgia Department of Corrections (January 2018). *Inmate Statistical Profile: Active Inmates with Mental Health Level 2 and Above.* Retrieved on January 30, 2018 from: http://www.dcor.state.ga.us/sites/all/themes/gdc/pdf/Profile_mental_health_2017_12.pdf. According to the Inmate Statistical Profile, 252 inmates in the prison system are from Forsyth County. Of those, 82 were assessed with a mental health level of 2 or greater, meaning they required at least active outpatient treatment.

[14] Munetz, M.R., Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services,* 57(4), 544-549.

a needs assessment. In March of 2016, the CJCC contracted with the Forsyth County Commission for the SAC to conduct this needs assessment in partnership with the FCMHTF.

The objective for the needs assessment was to identify what is required to ensure that persons with SPMI are diverted from the criminal justice system to crisis intervention and/or treatment. The goal is to identify ways to limit incarcerations in the county jail, provide necessary treatment for persons with mental illness who frequently contact the county's criminal justice system ("frequent jail users"), and ensure that law enforcement, 911 dispatchers, and the courts can direct patients and their families to appropriate resources in Forsyth County.

To accomplish these goals, the needs assessment seeks to answer these research questions:

1. What policies or procedures guide law enforcement and EMS response when interacting with individuals suspected of having a mental illness? Do officers understand and use these policies, and do they feel safe doing so? Do officers and EMS personnel feel comfortable identifying signs that a person is experiencing a mental health crisis?
2. What resources are available to law enforcement and EMS to handle incidents with individuals suspected of having a mental illness who are in crisis? Are these resources being used and are there barriers to use?
3. What can law enforcement and EMS do to divert persons with mental illness to crisis intervention or treatment? Are these resources being used and are there barriers to use?
4. Do resources need to be deployed to specific areas of the county based on the frequency of calls involving persons with mental illness?
5. How are persons with mental illness identified at the county jail? Once identified, what services and resources are available in the jail to treat identified inmates?
6. What policies or procedures are in place to provide crisis intervention or treatment for a person with mental illness while detained? Do correctional officers and other corrections personnel feel comfortable identifying signs that a mentally ill inmate is decompensating and do they have resources to intervene? Are these resources and policies being used and are there barriers to use?
7. Once arrested, how can an individual with mental illness be diverted out of the criminal justice system? How do judges, prosecutors, and public defenders make decisions about whether to divert persons with mental illness into treatment or crisis intervention? What is the level of involvement that offender families or support systems have in these early diversion decisions? Are these policies and resources being used and are there barriers to use?

The Sequential Intercept Model is the framework the SAC used to prioritize analysis on the first points of contact with the criminal justice system. This model is used to separate individuals who commit crimes due to symptoms of their mental illness and develop interventions to limit their progression through the criminal justice system by intervening at specific points of contact.[15] For the needs assessment, the focus is on the first two points of contact with the criminal justice system. The first intercept is with first responders, which includes contact with 911 dispatchers, law enforcement, and emergency personnel. The second point of intercept is at the county jail intake following an arrest, the bond hearing, and then at arraignment. These are the two major decision points where the largest number of individuals can be diverted out of the criminal justice system, but various stakeholders affect outcomes at these intercepts.[16] These two intercepts are also open to the greatest local control.

[15] Munetz, M.R., Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. Psychiatric Services, 57(4), 544-549.
[16] Ibid

Methodology and Data Sources

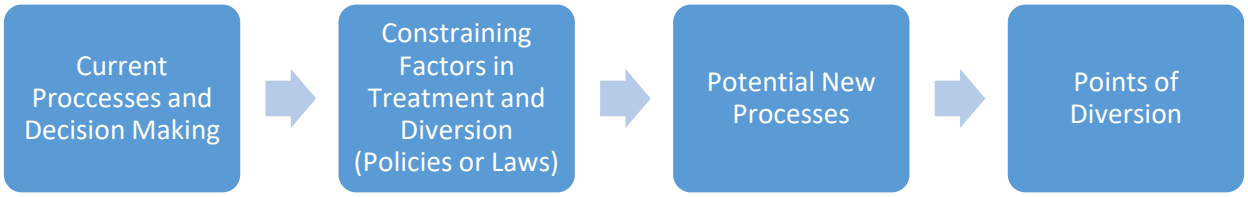
Process Model Mapping

Because various stakeholders are involved with the mental health and criminal justice systems the SAC first wanted to ensure that everyone understands clearly the various paths a person with SPMI can follow while being in the criminal justice system and how the cycle of treatment can work. Mapping the decisions that guide and limit someone's trajectory through the criminal justice system is also important process to illustrate. To clearly define the process, we developed a series of process maps that are outlined in Appendix A. The process maps graphically depict these paths and the decisions that guide one's trajectory, so that it can be easily referenced.

Initially, 18 individuals were identified as key stakeholders for interviews. Using the research questions identified by the FCMHTF, the SAC developed ten sets of semi-structured interview questionnaires tailored to extract the institutional knowledge of key stakeholders in the nine sectors targeted for the needs assessment. From the 18 individuals identified by the FCMHTF, the SAC interviewed 17 with only one declining our request to be interviewed.

From the original 17 interviews, 12 other individual stakeholders were identified and referred, which resulted in 29 total interviews representing nine sectors. These included law enforcement, fire fighters/ first responders, 911 communication officers, judges, family members of persons with SPMI, treatment providers and other intervention resources, pre-trial services, prosecutors, and defense attorneys.

The Process Mapping Resulted in a Clear Understanding of:



Inventory Development

A comprehensive system of community-based care is critical to preventing those with SPMI and/or developmental disabilities from extensive contact with the criminal justice system.[17] . Since the *Olmstead* decision in 1999, persons with SPMI have sought these resources in their local communities. Like many intricate social welfare systems, the community-based mental health system involves government, medical, and non-profit agencies.

The SAC developed an inventory of mental health providers within Forsyth and its bordering counties. These counties include: Cherokee, Cobb, Dawson, DeKalb, Fulton, Gwinnett, Hall, Lumpkin, and Pickens. This geographic determination was used to create a base of agencies and services that may reach those residents of Forsyth County with varying levels of access (both financially and geographically).

[17] See, e.g. Van Dorn, R.A., Desmarais, S.L., Petrila, J., Haynes, D., and Singh, J. (2013). Effects of Outpatient Treatment on Risk of Arrest of Adults with Serious Mental Illness and Associated Costs. *Psychiatric Services* 64(9), pp. 856-862. Retrieved January 30, 2018 from: https://doi.org/10.1176/appi.ps.201200406

The inventory identifies core subcategories of both service providers and service types that may be accessed at various decision points described in the process model developed for this needs assessment. The subcategories of service providers currently include: acute care hospital, adult crisis stabilization units, adult day care centers, assisted living services, behavioral health services, child/adolescent crisis stabilization units, children youth services, community living support, developmental disabilities, expanded community services, medical rehabilitation, opioid treatment programs, and private and state psychiatric hospitals. The categories of service providers are based on the most common descriptions and distinctions used by the Georgia Collaborative Administrative Services Organization, the Department of Behavioral Health and Developmental Disabilities (DBHDD), and several counseling and therapy accrediting agencies (CARF, CQL, COA). The table below summarizes the services and their associated subcategories:

Service Subcategory	Included Services
Psychological/Psychiatric Services	• Group Counseling • Intensive Family-Based Treatment • Medication Administration • Outpatient Opioid Treatment • Peer Support • Psychiatric Treatment • Psychosocial Rehabilitation • Voluntary and Involuntary Patient Services • Voluntary and Involuntary Outpatient Treatment
Pre-Crisis Services	• Behavioral Health Assessments • GCAL/Mobile Crisis • Initial Assessment and Dispatch • Involuntary Assessment • Service Plan Development • Triage
Crisis Intervention	• Assertive Community Treatment • Crisis Stabilization Units/Services • Emergency Receiving Facility • Treatment Facilities • Evaluation Facilities
Wraparound Services	• Assisted Living Services • Behavioral Support and Case Management • Community Support Team • Employment, Housing, and Legal Services • Nursing Assessment and Care • Transition Planning • Transportation Services/Assistance

All service providers and their core services were initially accessed through the Georgia Collaborative Administrative Services Organization (www.georgiacollaborative.com) or through the accrediting agencies. The CJCC SAC team confirmed or expanded provider core services through an extensive verification process via website searches, online reviews, and in some cases, contact with the agency. The SAC recommends that this inventory become part of a coordinated community response of referring to community-based services those persons with SPMI who encounter the criminal justice system.

Secondary Data

Forsyth County Jail and CorrectHealth Data

Two sources of data were used in this needs assessment to understand the population of persons with SPMI contacting the Forsyth County Jail. The first was pharmacy data collected by CorrectHealth, which contracts with Forsyth County to provide medical services for inmates in the jail. The pharmacy data were limited to only inmates who were prescribed antipsychotics or lithium while in jail between 2015 and 2016. These drugs cover treatment for psychotic disorders and some mood disorders. These data were limited to 2015 and 2016 because the pharmacy CorrectHealth used prior to this period did not have an electronic tracking system that could easily be queried with our parameters. From these data, the monthly census of inmates on psychotropic drugs, their length of stay, and the cost of their medications were calculated.

The second data source was directly from the Forsyth County Jail's inmate tracking system. The first data pull included booking information on individuals and a second data pull included charge information. The analysis of the Forsyth County jail data focused on the years 2011 to 2015. Unfortunately, over 84% of the bookings could not be matched to any charge information or description, which made it difficult to perform a comprehensive analysis of the types of charges that "frequent jail users" accrue.

Georgia Crisis and Access Line (Behavioral Health Link)

Behavioral Health Link is a private corporation that has contracted with DBHDD as the single point of entry for crisis services, stabilization units, and inpatient services through GCAL. The SAC requested GCAL data from DBHDD's service region one, which encompasses 31 counties in north Georgia, including Forsyth County. The data provided were for the number of calls to GCAL by acuity from 2012 to 2015. The SAC also received the number of referrals to inpatient treatment and the number of mobile crisis dispatches over the same three-year period for Forsyth County in 2016. Information about the number of calls to GCAL that were law enforcement initiated and those involving someone who had called more than 4 times in a calendar year ("frequent GCAL users") were also used in the assessment. Data specific to Forsyth County were available for the total number of calls but not acuity level. Mobile crisis dispatches and response times were also available for Forsyth County.

Online Analytical Statistical Information System (OASIS)

Hospital emergency room admission data maintained at the Georgia Department of Public Health were analyzed to assess health system usage involving persons whose chief admission complaint included mental health issues. Data from 2011 to 2015 from OASIS were analyzed to identify ER admission rates for persons complaining of behavioral health symptoms in Forsyth and the 5 counties that share a border with it - Cherokee, Dawson, Fulton, Gwinnett, and Hall counties. OASIS data was also used to determine the percentage of ER Admissions paid for with public healthcare assistance programs (Medicare, Medicaid, and Peachcare) versus private insurance or other means.

Children's Hospital of Atlanta

Children's Hospital of Atlanta (CHOA) at Scottish Rite sent the SAC the total number of ER and hospital admissions from 2011 to 2015 for patients who reside in Cherokee, Dawson, Forsyth, Fulton, Gwinnett, and Hall counties. Additionally, CHOA specifically provided the number of admissions involving a patient with some form of diagnosed mental illness to provide insight on comparable or diverging trends during this 5-year period. The SAC specifically looked for the following complaint categories:

1. Anxiety
2. Behavioral complaint

3. Bipolar
4. Depressed
5. Emotional problems
6. Ingestion
7. Psychiatric problem
8. Psychology referral
9. Psychology / social concern
10. Self-injurious behavior
11. Suicidal

Primary Data

In addition to the semi-structured interviews which informed the process maps, the SAC conducted anonymous surveys to families of persons with SPMI, firefighters, EMS, law enforcement, 911 communications officers, and county jail officers. All surveys were presented to the FCMHTF for review and edit. The SAC worked closely with the Georgia chapter of the National Alliance on Mental Illness (NAMI) for Dawson, Lumpkin, and Forsyth counties; Forsyth County C.A.R.E. Court; the Forsyth County Sheriff's Office; and the Forsyth County 911 Center to edit and develop a deployment strategy. Appendix C contains the surveys used for the needs assessment for reference.

Family Survey

Interviews with family members of persons with SPMI indicated a family survey would be beneficial to obtain a broader perspective of the barriers and issues families face while seeking services. The family survey consisted of 36 questions that examine the experience a family member may have with a loved one receiving mental health care and what, if any, contact they may have had with the criminal justice system.

The family survey was deployed to 60 family members who are involved with NAMI of Dawson, Lumpkin, and Forsyth Counties. The survey was open for two weeks and reminder emails were sent after one week of being deployed and three-days before the close of the survey. Eighteen family members responded for a 30% response rate.

Law Enforcement and Fire First Responder Survey

The Fire and First Responder survey consisted of 19 questions aimed at understanding how Fire and EMS personnel responded to situations involving someone with SPMI who may be in crisis. The Fire/First Responder survey was deployed in late July 2016 by the Forsyth County Fire Department Division Chief of Field Operations. The Chief of Operations distributed the survey electronically to the Battalion Chiefs at the 12 firehouses in the county. The Battalion Chiefs then distributed the surveys over a seven-day period to the Fire Fighters and other staff located at the firehouses. The surveys were completed electronically and on paper and the Chief of Field Operations collected the completed surveys from the 12 firehouses. Sixty of the 170 Firefighter First Responder employees returned surveys for a 35% response rate.

The Law Enforcement survey was sent electronically to patrol officers of the Forsyth County Sheriff's Office. Of 238 patrol deputies employed by the Sheriff's office, 99 completed it for a 42% response rate.

911 Center Survey

The survey for 911 Communications Officers consisted of 15 questions that aimed at ascertaining how a call is identified as involving someone with SPMI in crisis and how that information is currently transferred to law enforcement and first responders. The SAC worked with the director of the 911

center to distribute the survey electronically to her staff of 38 communication officers and 20 completed the survey for a 53% response rate.

Forsyth County Jail Survey

For the needs assessment, a 12-question survey was deployed to officers at the Forsyth County Jail to understand how and at what point(s) the Sheriff's Office becomes aware that someone they are detaining has a mental illness and how do these staff respond to someone in crisis. The survey was distributed electronically. A total of 30 surveys where completed, which was a 33% response rate.

Findings

Legal Framework

Through the interview process, the SAC identified many laws that guide decision making and the sharing of information involving persons with SPMI at the first two points of the sequential intercept model. This legal framework – comprised of state and federal law, as well as court precedent – determines possibilities and constraints regarding treatment and continued involvement with the criminal justice system. The graphic below summarizes the essence of these laws. A key consideration is the distance between law and application. For instance, while Georgia code specifically provides for both involuntary inpatient and outpatient treatment, our interviews revealed that many stakeholders – including judges and treatment providers – were unfamiliar with the latter application. While many were versed in the processes for involuntary inpatient treatment, the use of involuntary outpatient treatment was foreign.

Similarly, while law enforcement is not a covered entity under HIPAA, we encountered barriers in obtaining jail data to link to diagnosis data. Indeed, even if the jail maintained diagnosis or medication information in their jail management system – which they do not – law enforcement expressed concerns over disclosing those data for privacy issues. Similarly, 911 communications officers are hesitant to collect and document information indicative of mental health status during a distress call because those may be subject to open records – if law enforcement and not medical services is dispatched – and that raised privacy concerns about protected health information.

Americans with Disabilities Act (ADA) Title II: Olmstead Decision

In June 1999, Supreme Court concluded "that under Title II of the ADA, States are required to provide community based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[18]

Involuntary Treatment

OCGA § 37-3-1

OCGA § 37-3-41

- **Criteria - Inpatient:**
  - Mental illness diagnosis
  - Risk of imminent harm to self or others manifested through recent overt acts
  - Unable to care for own physical health and safety
  - Physician, psychologist, clincial social worker, licensed counselor, or clinical nurse specialist can initiate involuntary treatment via 1013 Form
  - May also be initiative via Two-Party affidavit petition to Probate Court
- **Criteria - Outpatient:**
  - Mental illness diagnosis
  - Mental Illness, mental health status, or mental health history indicates inability to comply with outpatient treatment
  - Inpatient can discharge to involuntary outpatient. Facility must request probate court hearing within 5 days to determine need for involuntary outpatient treatment
  - Involuntary outpatient treatment status may not exceed one year
  - Physician or psychologist in charge of outpatient service plan may also petition probate court to initate involuntary outpatient treatment

Health Insurance Probability and Accountability Act (HIPAA)

- Sets procedures to protect the privacy of individual health information
- Many state agencies and most state and local police or other law enforcement agencies are not required to comply with HIPAA privacy rules
- Generally, these agencies are not collecting personal medical information, but may inquire about any medical issues for the safety of first responders and the safety of the person of interest or the patient. This information can be shared with any agency or internal personnel to whom care is transferred

Officer Discretion

OCGA § 37-3-42

- Under Georgia Code 37-3-42, peace officers are given considerable discretion about whether to arrest and formally charge a person with whom they have probable cause to believe is both mentally ill *and* engaging in behavior that warrants an arrest.
- Peace officers may transport the person to a physician or psychologist in the county or adjoining county, or to an emergency receiving facility in the county. The officer does not have to formally charge the individual, but this does not preclude charges from being filed in the future.

Criminal Procedure: Mental Competency and Insanity

- Article 6 of Title 17 Chapter 7 of the Georgia annotated code covers the pretrial proceeding regarding insanity and mental incompetency.
- If there is sufficient evidence that the accused is incompetent to stand trial, they can file a plea alleging this with the court. This will initiate a bench trial and if the court agrees, the accused will be transferred to DBHDD's custody for competency evaluation and restoration.
- If the accused can stand trial and is found not guilty by reason of insanity at the time of the crime, the court will retain jurisdiction over the person and they will be detained in a state mental health facility for a period not to exceed 30 days from the date of the acquittal order as an evaluation period

Survey Analysis

911 Communication Officer Surveys

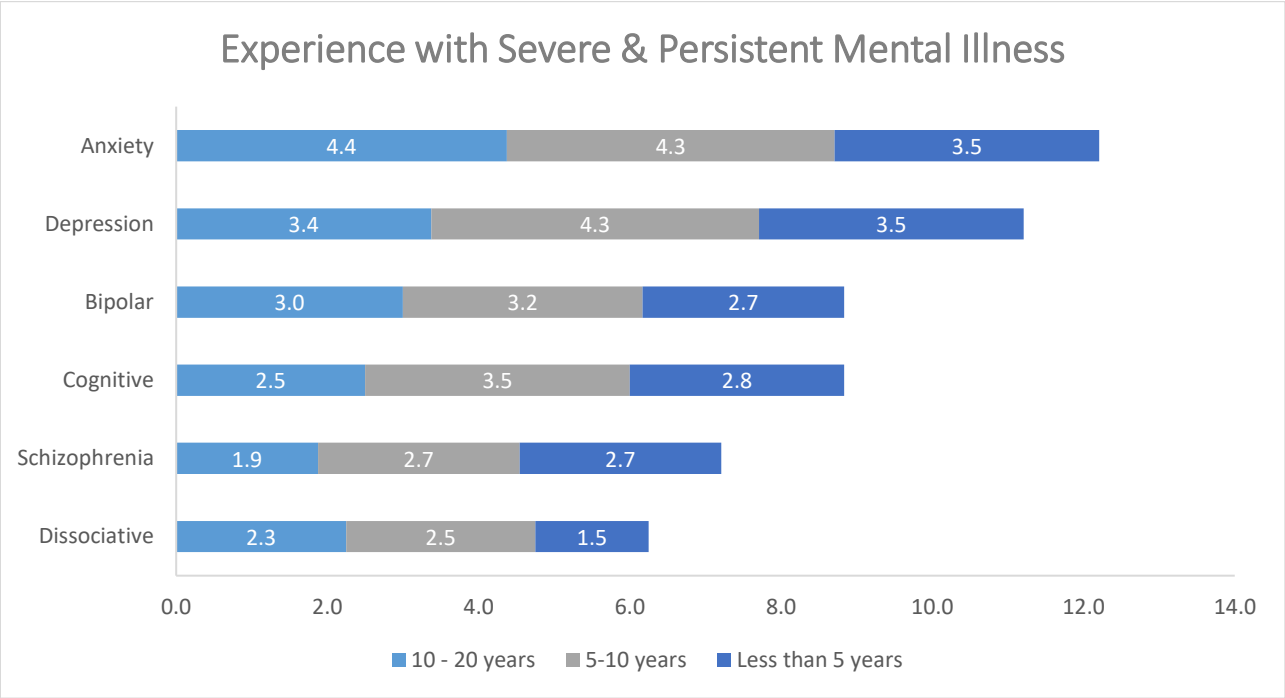
In many situations, communication officers answering 911 calls are the first persons to have contact with someone in a decompensated state or may be the first to collect information on an individual in crisis. We thus designed the Communication Officer survey to understand the perceptions and resources that communication officers use when responding to calls involving someone in a mental health crisis. The goal is to identify current practices or policies and where new policies and procedures may aid in the identification of persons with SPMI to better divert into treatment.

Of the 20 communication officers responding to the survey, 40% have been working as a communication officer between 10 to 20 years with an average overall career experience of 15 years. For all communication officers, the average career experience was almost nine years. Those with fewer than five years' experience comprise 30% of responding communication officers.

Years as Communications Officer	Number of Respondents	Average Years in Forsyth	Average Years Total
10 - 20 years	8	14	15.8
5-10 years	6	6.5	6.5
Less than 5 years	6	2.3	2.3
Grand Total	20	8.3	9

Communication officers were asked to rate their personal and professional level of experience with persons experiencing a mental illness or crisis on a 5-point scale, where 1 was no experience and 5 was substantial experience. Officers expressed more experience, regardless of the number of years on the job, with anxiety and depression as compared to the categories of cognitive disorders, schizophrenia, and dissociative disorders.

Chart 1. Communication Officer Experience with Persons who have Severe and Persistent Mental Illness



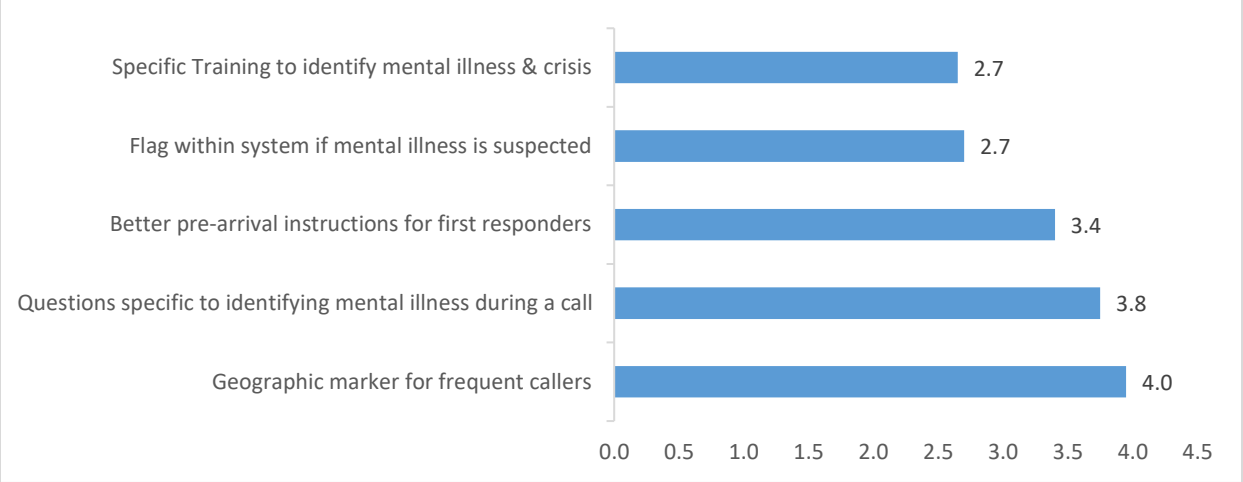
Communication officers report that on average they receive 15 calls every six months that involve someone with mental health issues and 80% of those calls involve someone in crisis. Considering that in 2016 Forsyth County 911 fielded over 250,000 calls, well under 1% of those calls involve someone suspected to have mental health issues. Communication officers in Forsyth County use informal indicators to identify callers who may have mental health issues. Erratic behavior, suicidal thoughts or actions, and seeming disconnectedness from reality are the three main behaviors that are noted for identification. There is not a substantial difference between those with extensive experience, or not, in the criteria used for identification. Of note, those with fewer than 5 years' experience rely less on identified "frequent callers" than those with 10 or more years' experience.

Unique to the Communication Officer's jobs, is both the formal and informal use of what are called "frequent callers." Often these are individuals within the community who call multiple times for assistance as they, or a family member, are in crisis. Ninety percent of the officers reported that they keep track of "frequent callers" officially through notes or unofficially through the recollection of previous calls that are communicated to dispatch. Most communication officers use some combination of name, history, or address to determine whether the call involves a "frequent caller." When asked if the ability to identify those "frequent callers," regardless of type of indicator, would aid in dispatching specializes resources, 85% of respondents indicated it would improve their ability to appropriately dispatch specialized resources.

The SAC asked communication officers whether law enforcement or EMS dispatch considered their notations when responding to a call that may involve persons with mental health issues or crisis and almost 70% of respondents said they did. Since mental health information is taken into consideration when responding to a call, we asked what changes might be made to the current system to make it easier to identify situations that may involve mental illness or crisis and subsequently communicate this information to first responders. Respondents were asked to rank these changes from one to six in order of importance and the average of each ranking was taken. Although "other" methods of

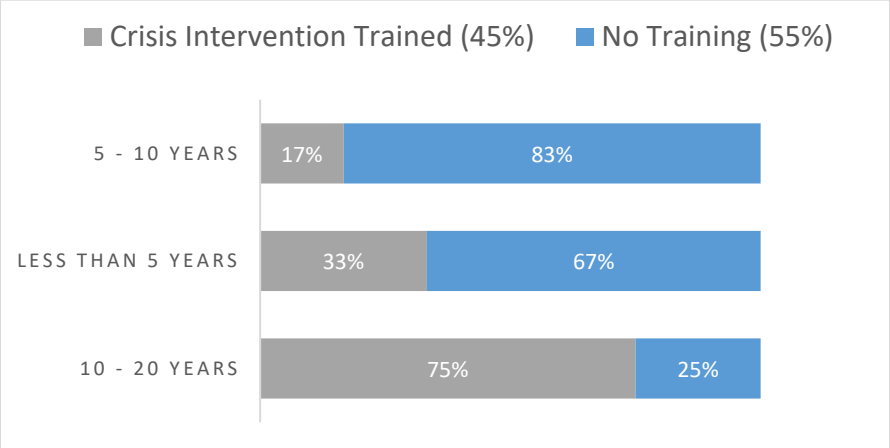
identifying and communicating were consistently ranked more important, no clarifying information was provided on follow-up. This leaves specific trainings to identify calls involving mental illness and someone in crisis and a flag within the system as the highest ranked tools to help identify and communicate that a call involves a person with mental health issues.

Chart 2. Ranking of Ways to Best Communicate to Dispatch Calls Involving Mental Illness



Of the 20 respondents, nine (45%) indicated that they had received CIT and 88% of those said they found the training helpful. The training ranged from two to eight hours. Most respondents (55%) who had not received CIT indicated interest in receiving it. The largest disparity in training is for those with fewer than ten years' experience.

Chart3. Crisis Intervention Trained Communication Officers



We asked several questions to understand what additional resources Communication Officer's need to better respond to calls involving mental health. When Communication Officers were asked whether they felt they could engage additional resources beyond Law Enforcement and EMS to aid callers suspected of having mental health issues or being in crisis, 45% of respondents were unsure and an additional 35% indicated that they did not have the means to access additional resources. However, 69% of participants indicated additional resources outside of Law Enforcement and EMS would be helpful. The respondents who did access additional resource all indicated they used GCAL.

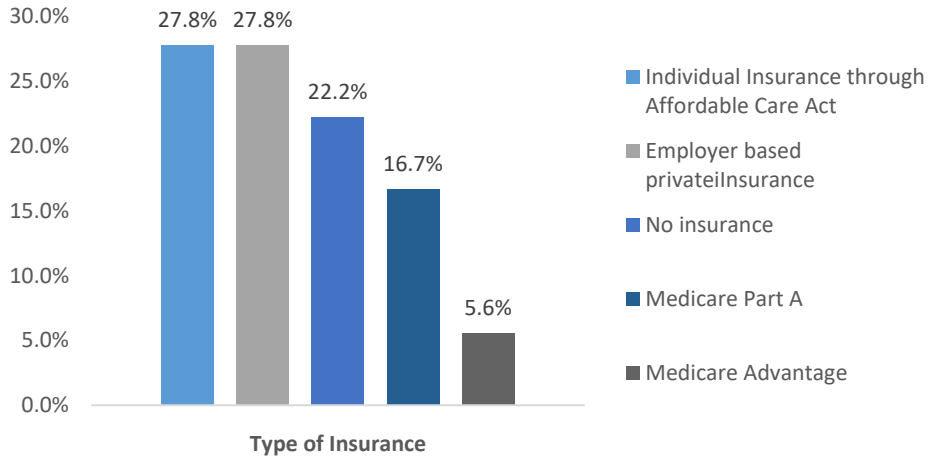
One of the easiest ways to access additional resources, whether for crisis intervention or for access to treatment, is GCAL. In certain situations, communication officers can recommend a caller use GCAL for additional resources specific to mental illness and crisis. Only 35% of respondents indicated that they typically provide callers with GCAL's phone number.

Family Surveys

The families of persons with severe and persistent mental health issues are in many cases intimately involved in their loved one's care and can provide a unique perspective and insight to understanding this issue. Family members in the local NAMI chapter were surveyed about their family member's mental health, their use of mental health services in the Forsyth County area, and their interactions with the criminal justice system. The respondents had family members who were diagnosed with depression, bipolar disorder, PTSD, and schizophrenia. Some respondents indicated that their loved ones had a secondary diagnosis that varied from the original diagnosis including substance abuse and anxiety disorders. Of this sample, just over 16% of the participants had guardianship over their loved one.

The cost of mental health services can create a barrier to accessing care for some people with mental health issues, so we asked respondents about their family member's health insurance status. Following the passage of the Affordable Care Act, mental and behavioral health services are reclassified as essential health benefits. This means that plans must cover behavioral health treatment, mental and behavioral health inpatient services, and substance use disorders. Respondent family members often relied upon Medicare advantage and Medicare Part A (22%), with ACA and Private Insurance each representing approximately 28% of family members' coverage. The remaining 22% of respondents' family members are without health care coverage.

Chart 4. Type of Insurance Currently Accessed by Family Member



Respondents indicated that the resource their family members most frequently accessed was a psychiatrist followed by psychologists, support groups, and licensed professional counselors. Those with private insurance and Medicare Part A received more of a variety of services compared to those without insurance or with Medicare Advantage. Those respondents whose loved ones did not have insurance indicated that they were receiving services from a psychiatrist or a licensed professional counselor (LPC). This is compared to eight or nine distinct types of resources accessed by those with private insurance.

Respondents were asked how their family members paid for the outpatient services most frequently used to manage their mental health. Most paid through insurance, but those without it most often paid for psychiatry or LPC services on their own. One respondent who bought private insurance through the ACA paid out of pocket for their psychologist. Two additional respondents indicated that they received private insurance through the ACA, but paid out of pocket for their psychiatrist. The only other notable exception was that those with Medicare Advantage or Medicare part A self-paid for support group therapy.

Mental Illness & Crisis Intervention in Forsyth County

The SAC surveyed respondents regarding their family member's mental health while living in Forsyth County. Approximately 83% indicated that their family member had experienced a mental health crisis, or state of decompensation, while living in Forsyth County. While a third of the respondents Indicated that their family member had only decompensated once in the past year, 27% indicated their family member had decompensated at least 3 or more times. Ideally, during a mental health crisis, family members would voluntarily use either inpatient or outpatient services, but 60% of respondents indicated that their family member either did not voluntarily agree to treatment or would only sometimes agree to services.

Only three respondents had used the various means of initiating an involuntary mental health assessment through a 10-13 or a Two-Party Affidavit. Of the three respondents who had utilized involuntary assessment/treatment protocols, the process was initiated through first responders, the local emergency room, or Benchmark. One respondent did file a two-party affidavit in probate court. Those who called 911 for assistance would do it again or are indifferent about whether they would call again for assistance, indicating the response and actions of the first responder were as expected.

Mental Health Care in Forsyth County

The SAC also asked respondents their perception of patient care available in Forsyth County to gain insight into various needs and stages of mental health care. Respondents were asked to describe access to outpatient mental health care in Forsyth County using a scale from 1 – 5, with 1 being Extremely Poor and 5 being Excellent. Approximately 40% of respondents indicated that they found the outpatient services to be either poor or extremely poor. No one indicated that access to outpatient mental health services was "Excellent" in the county, but just over a quarter indicated that it was "Good".

"I don't know what to ask for. I don't know where to go to get help. I don't think there are resources to turn to in Forsyth."

"Like a lot of other services, it takes time to find the right therapist for the issues that need to be addressed. However, there are not that many choices in the county."

"[It's] Hard to navigate the system and it changes frequently"

Respondents were also asked about their perception of accessing inpatient care in Forsyth County. A third of the respondents indicated that they found access to inpatient services to be either poor or extremely poor. Just over a quarter of respondents indicated that they felt access to inpatient care was either good or excellent. The greatest barrier to inpatient care is that there are no inpatient beds available in Forsyth County.

"No inpatient bed[s] in Forsyth County…Avita has a Crisis stabilization unit, but it is in Hall county."

"We had to go outside the county for inpatient care"

Finally, family members were asked how they perceived continuity of care in Forsyth County. Continuity of care is defined as the consistent adherence to mental health treatment as recommended while transitioning between two different providers or types/levels of treatments. Only 11% of respondents felt that continuity of care was good, while an additional 40% of respondents felt that continuity of care was either poor or extremely poor.

"… in general, so often, it is during the time of transition that people are lost in the shuffle. Patients lose interest, forget that they are ill (lack in-sight), feel over-confident in their recovery, fail to keep up with their medications and appointments, and return to old ways and friends."

"Service providers lack commitment/follow-through to help their patients and are more concern[ed] for their profit margin. They lack accountability and measure their successes based on in-patient care, not over-all long-term recovery level of the patient. Long-term case management does not seem to exist."

Criminal Justice Interaction

Half of the respondents in our survey indicated that their family member had zero contact with the criminal justice system. Of the respondents who had family members contact the criminal justice system, these interactions were primarily regarding the arrest or incarceration of their family member. A substantial portion of those arrested (43%) had been prosecuted and subsequently jailed. The family members in some cases initiated the contact with the criminal justice system and helped their loved one through the court process. Some paid the attorney fees and bail. Others monitored their loved one through the process and served as a resource for treatment history and compliance.

Over half of the respondents who's loved one had contact with the criminal justice system indicated that they were ambivalent about the responding officer's ability to de-escalate the situation to avoid arrest. However, a third of respondents felt that the responding officer could have worked to de-escalate the situation and avoid an arrest. One third of respondents felt that **they would not have called 911 had they known that their family member was likely to be arrested**.

Of those respondents who indicated that their family member had spent time in jail over the past three years, more than half had been in jail multiple times, with the typical length of stay ranging from a little less than a week to a month. Regardless of how often, or how long, family members were in the Forsyth County Jail, 58% of respondents indicated that they do not believe their family members received the mental health treatment they needed while in jail. Slightly fewer (43%) indicated that their loved one did not receive the medication they needed to manage their mental illness in jail. The same number of respondents (43%) did feel their family members received the proper medications while in jail. Some respondents indicated that their loved one was sometimes separated from the general population and one indicated that they needed crisis stabilization about a year after entering the jail. Nearly three quarters (71%) of respondents indicated that the continuity of mental health care following time in jail was "somewhat poor" or "poor." Just one response indicated good continuity of care.

"Patient[s] must actively engage the mental health system, if not nothing happens. Mental health patients are not always accepting of the fact they are suffering from mental health issues thus…cannot be expected that they will follow through on their own or voluntarily at all."

Of the respondents who participated in our survey, only three indicated that their family member had been prosecuted following arrest. When asked whether there was an opportunity to divert their family member into mandated treatment through pre-trial services, two thirds felt that opportunity existed. Of those family members who had been prosecuted, all the respondents felt that their family member's

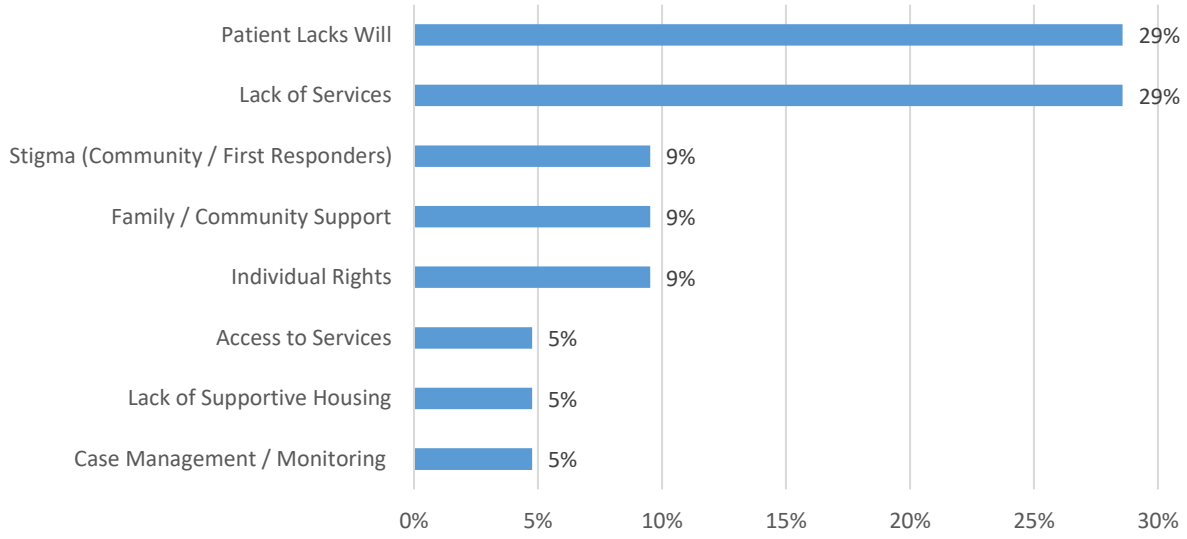
mental illness was not a factor in the judge's decision. Additionally, these respondents felt that they did not have the ability to advocate on behalf of the family member for leniency and/or diversion.

"DA's are not interested in hearing about mental health issues and instead focused on the criminal aspects of the case. Even when defense brings up mental health DA's downplay these issues and instead focus on the crime itself without accounting for any mitigating factors."

"If they committed a crime, then I believe they should not get diverted. But I feel that the jail should be able to assess them to determine if they have an illness and get them treatment."

We asked respondents what they felt were the most significant challenges to keeping a person with SPMI from contacting and entering the criminal justice system. The top responses were the patient's willingness to receive services and the lack of services in the community.

Chart 5. Challenges to keeping persons with SPMI from contacting the criminal justice system



We asked respondents about additional resources they would like to see in Forsyth County that would help to manage their family member's mental illness. Increased access to better quality and all types of care ranked as the number one requested resource. This matches their concern of access to care as the largest barrier to stability and recovery.

Table 1. Resources requested by family member ranked by number of responses

Resources Request by Family Members	Rank in Responses
*Increased Access to Better Quality and All Types of Care	1
Community / First Responder Education and Training	2
Supportive Housing	3
Job Counselors and Assistance	4
More Peer-to-Peer Programing	5
More Resources for Parents / Family / Care Givers of MH Patient	6
Booking Assessment	7
Platform for Self-Advocacy	8
Transparency	9

*Those surveyed suggested increased access to and quality of:

- Day Programming
- Mental Health Services in the Jail
- Quality Psychiatrists
- Inpatient Hospitals
- Residential Facilities
- Affordable Counseling
- The number of Mental Health Professionals in Forsyth County

Community and first responder education and training ranked second in need. Respondents indicated that CIT would help remove some of the stigma associated with mental health and, at least in the case of first responders, change their response to someone in crisis. Finally, supportive housing was the third highest ranked resource that family members requested for Forsyth County.

Law Enforcement and Fire First Responder Surveys

Work Experience

The survey for law enforcement and fire services was combined to better understand how first responders – law enforcement, fire services/EMS – approach or adapt to situations that may involve someone with SPMI. Of the 160 first responders who completed a survey, 67% of patrol officers and those in fire services had 10 or more years job experience. The average years of service in Forsyth County for patrol officers and fire services are 11 and 19 respectively. Fifteen percent of respondents from both groups indicated that they have fewer than 5 years of job experience.

Years as a Patrol Officer	Number of Respondents	Average Years in Forsyth	Average Years Total
20 or more years	20	10.9	27.9
10 - 19 years	47	12.0	13.8
5 - 9 years	17	6.6	6.8
Less than 5 years	15	5.4	1.8
Totals	99	9.9	13.6

Years in Fire Services	Number of Respondents	Average Years in Forsyth	Average Years Total
20 or more years	17	18.6	24.5
10 -19 years	24	10.4	14.7
5 – 9 years	11	5.7	6.7
Less than 5 years	9	1.3	1.3
Totals	61	10.5	14

Mental Illness

First responders were asked about both their personal and professional experience with persons who have SPMI. Both law enforcement and fire services indicated they had the most experience with anxiety disorders, although the averages in all the work experience categories ranged from 3 to 3.4, which indicates some but not extensive experience. Patrol officers did have some experience with major depression and bi-polar disorder, but little substantive experience with dementia, schizophrenia, and dissociative disorders. Fire services respondents similarly indicated some experience with dementia and major depression but little substantive experience with bi-polar disorder, schizophrenia, and dissociative disorders. Except for anxiety disorders, those with fewer than 5 years' experience indicated less experience with various mental health disorders than their more seasoned counterparts.

In many situations, first responders determine whether their interactions with the public involves persons with SPMI. Top indicators that a call involves someone with SPMI come from dispatch, disclosure from the person's family members, or observed erratic behavior. Other indicators include known "frequent callers" or addresses, suicidal behavior, and that the person seems disconnected, belligerent, or disoriented. They may simply ask the person of interest.

"Each call is different and using all the above allows us to make a reasonable decision of the mental status of the p[a]t[ient]."

First responders were asked to approximate how many calls they suspected involved a person with mental health issues, or an individual in crisis, within the past year in Forsyth County. Both classes of first responders averaged between 14 and 16 percent of calls. The percent of calls for service involving someone in crisis averaged between 10 and 11 percent.

More law enforcement individuals were trained in crisis intervention (64%) as compared to those in fire services (21%). Law enforcement officers with 10 or more years of experience were more likely to be trained in crisis intervention (74% of those with 10 to 20 years of experience and 60% of those with more than 20 years). Regardless of the years' experience, nearly half of respondents were trained in crisis intervention. Almost universally, fire services and law enforcement who were trained felt that the training was helpful. Over half (54%) of the attended trainings lasted a full day or less and about 5% of law enforcement respondents attended a full 40-hour or more CIT. Fire services reported that their CIT ranged from 2 to 10 hours and one respondent indicated receiving 32-hours of training.

Of the respondents who indicated that they had not received CIT, nearly half of those in law enforcement indicated there is someone on staff available to them with CIT and they utilize their services when needed. When fire services were asked if crisis trained personnel were available on each shift to aid in a call, approximately a third believed they were available, another third did not think they were available, and the final third were uncertain. Unlike law enforcement, fire services overwhelmingly indicated that they did not ask for assistance from these personnel (13%) on calls

potentially involving mental health crisis. Over 97% of law enforcement and 85% of fire services respondents believe CIT would be helpful.

Chart 6. Fire Services trained in crisis intervention

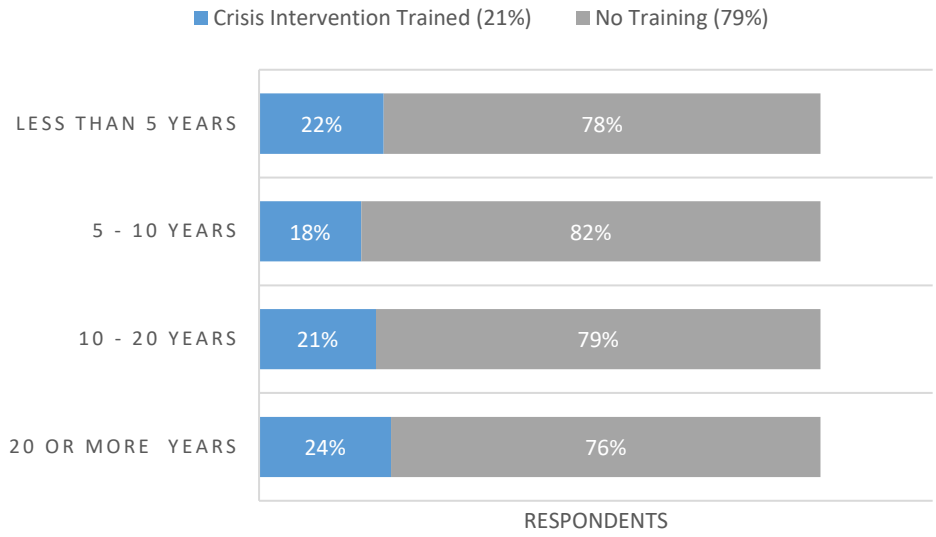
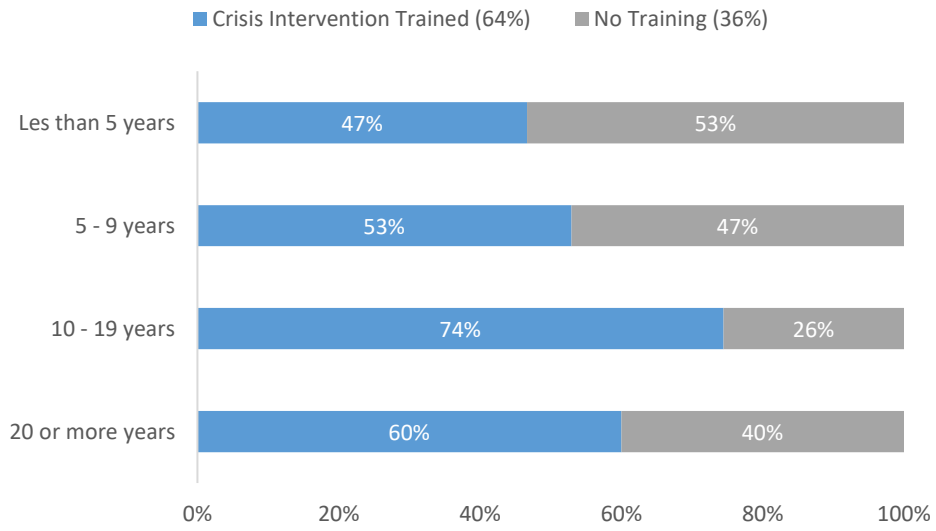


Chart 7. Law Enforcement trained in crisis intervention



When responding to calls possibly involving someone with SPMI, the number one safety concern is for themselves or others at the scene. Irrational thinking and behavior from the person in crisis could result in violent or physical confrontation and injury for those involved. Another concern that first responders expressed is a lack of resources or not having the proper tools to deal with calls for service. This included training and treatment for the POI/patient.

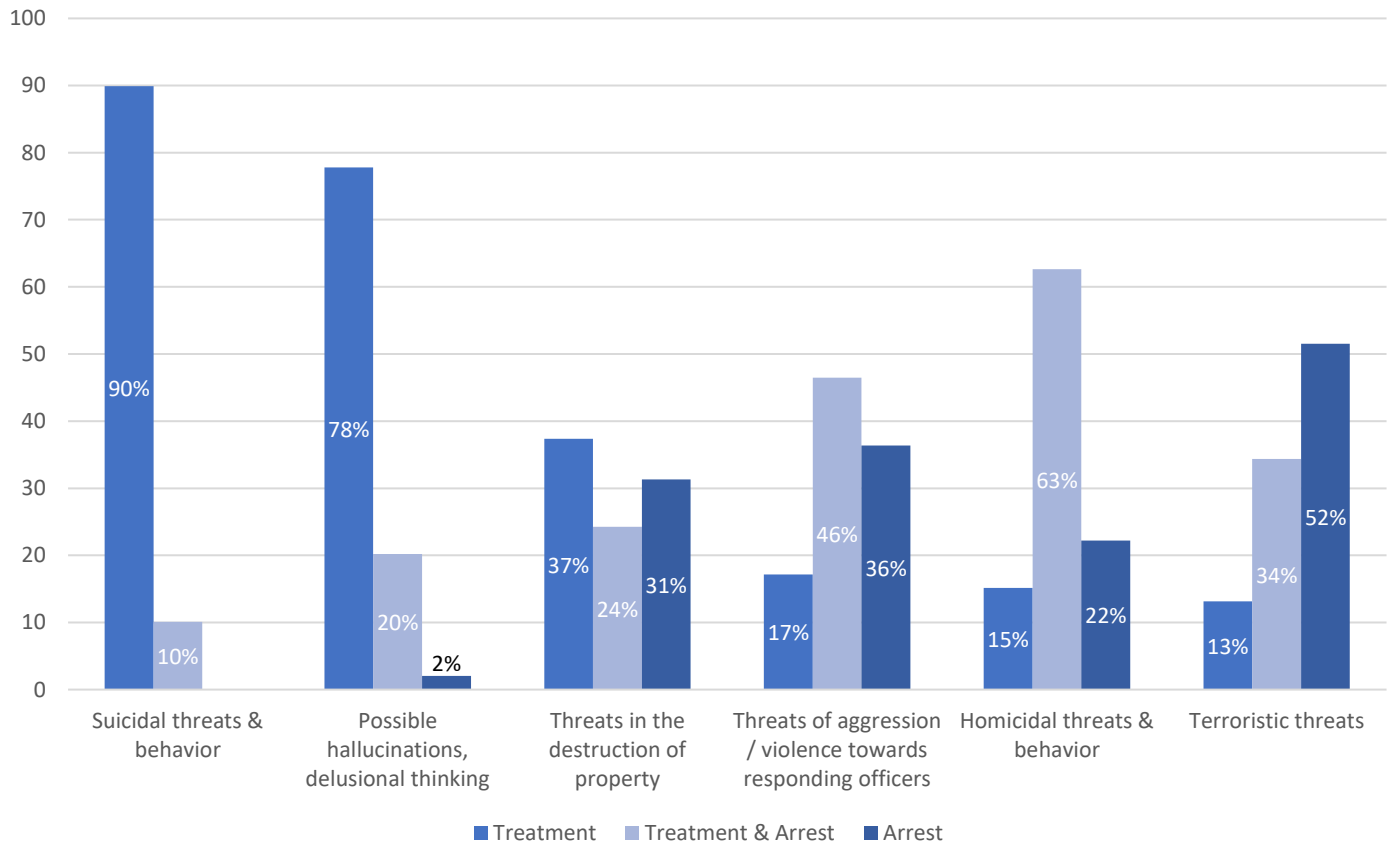
"The label 'mental health crisis' is [a] very enveloping term that can have a myriad of meanings. Ultimately a mental health call leaves me expecting the unexpected and somewhat concerned for the

safety of myself and my subordinates. For example, I have little faith that a subject that means to harm themselves will be concerned with my safety when considering their actions. "

First Responders were also asked about their perceived ability to de-escalate situations involving individuals who are experiencing a mental illness crisis. Law enforcement, especially those with 20 or more years' experience, felt somewhat confident in their ability to de-escalate situations where there are threats of aggression, threats of the destruction of property, suicidal behavior, terroristic threats, and homicidal behavior. Law enforcement respondents on average indicated neutral responses in their ability to de-escalate situations involving hallucinations or delusional thinking. Fire services indicated little confidence in their ability to de-escalate situations involving a person in mental health crisis.

According to GA law, law enforcement has the discretion to transport a person to an emergency receiving facility for a mental health assessment when there is probable cause for arrest and they believe that person has a mental illness. Many respondents indicated that this ability is outlined in their Standard Operating Procedure. The chart below summarizes the situations the majority of law enforcement respondents indicated would lead to arrest, diversion to treatment, or treatment then arrest. When asked, 79% percent of patrol officers who completed the survey indicated that the severity of the crime will determine if they forgo arrest and transport to a treatment facility for a mental health evaluation. Additional considerations are made when a crime involves a victim.

Chart 8. Scenarios Likely to Lead to Arrest, Treatment, or Both



Interviews with key stakeholders revealed misconceptions surrounding the process for transporting individuals for a mental health evaluation at an emergency receiving facility. Under Georgia Code, law enforcement officers can transport individuals directly to an emergency receiving facility when there is probable cause for arrest and they believe that person has a mental illness. However, 45% of the patrol respondents indicated they needed medical clearance before transporting to an emergency receiving facility, believing that ER staff needed to issue the 10-13 for an involuntary evaluation. Others indicated that the receiving facility required medical clearance or that in certain situations a person's physical health would need to be checked before transporting to a facility for an emergency evaluation.

Finally, 54% of respondents in fire services indicated that they felt they did not have access to resources outside their agency to engage with someone in mental health crisis, while 81% of patrol officers survey indicated they did. Eighty-two percent of patrol officers and 69% of fire services respondents felt that engaging additional resources during a call identified as involving someone with SPMI would be beneficial. For law enforcement, 43% indicated a need for an on-call psychiatrist, counselor, or treatment professional to respond to an emergency call or advise the officers. Although DBHDD funds mobile crisis teams through Benchmark to provide crisis intervention in the community, a small percentage of respondents (6%) indicated that they wanted a faster response time for the crisis teams or trained mental health professionals on staff at the Sheriff's Office. Other patrol officers indicated a more preventative approach by requesting better access to quality treatment facilities, which includes an inventory of resources they could use to help individuals find treatment options. Fire services respondents indicated they wanted more training in crisis intervention and mental health disorders. The second most requested resource was an on-call psychiatrist, counselor, or treatment professional to respond to a call or to advise. In addition, 9% of the respondents indicated the need for trained mental health professionals on staff.

"Mental health professionals that are on call, and can respond to incidents. Preferably with authority to sign 10-13 if needed"

Forsyth County Jail Officer Survey

We surveyed officers at the Forsyth County jail about their personal experience, the policies they follow, and what they would like to see changed when interacting or responding to someone with severe and persistent mental illness. Over half (53%) of respondents who completed the survey had fewer than 5 years of experience, while 37% of respondents had over 10 years of experience as a jail officer.

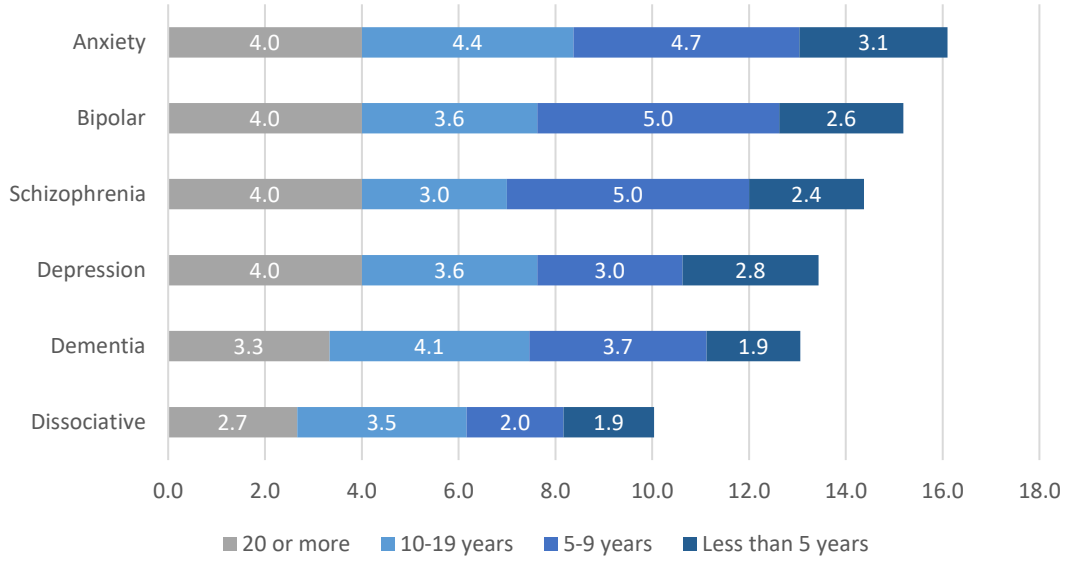
Table 2. Average Years of Experience as a Jailer by Age Category

Years as a Corrections Officer	Number of Respondents	Average Years in Forsyth	Average Years Total
20 or more	3	22.3	27.3
10-19 years	8	13.6	14.9
5-9 years	3	3.3	6.3
Less than 5 years	16	1.8	1.6
Grand Total	30	7.1	8.2

Jail officers were asked about both their personal and professional experiences with mental illness and those experiencing mental health crisis. Much like the other professions surveyed, jail officers generally indicated that they have more experience with anxiety disorders, but also indicated more experience with bipolar disorder and schizophrenia as compared to the other professions. Officers in

the jail with 10 or more years of experience cited more exposure to depression as compared to their less seasoned counterparts. The only group that consistently reported low level of experience with mental health disorders were those with fewer than 5 years of experience, which represented the largest subgroup of employees from the sample.

Chart 9. Jailer Experience with Severe & Persistent Mental Illness

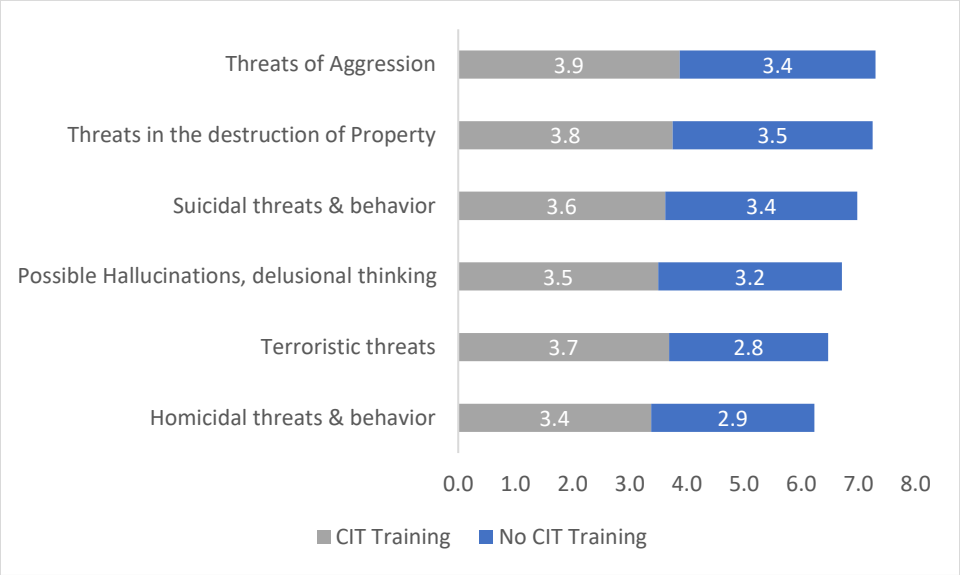


Half of the jail officers indicated that they are notified if someone has a mental illness and require additional supervision. They often learn of this either through the intake process (17% of the respondents) or from medical staff (40% of respondents). However, there are times where mental health information is not relayed to the officers through the intake process. Jail officers relied on their experience to identify various indicators to determine whether someone was decompensating, Including erratic behavior, belligerence, disconnection from reality, disorientation, or suicidal ideation. They also paid attention to frequent jail users.

If jail officers notice signs of an inmate decompensating, they contact medical staff. The medical staff determines whether the person needs intervention. If the situation is urgent and the inmate is in crisis, the jail officers will take the inmate to the medical wing for a mental health observation. The medical staff will determine the level of care required for the inmate. Officers in the jail indicated that, in the six months prior to taking the survey, the average number of inmates experiencing mental health crisis ranged from 0 to 50, with an average of 8.

Of the thirty surveys completed, sixteen respondents indicated they received CIT and all believe the training was helpful. The duration of the trainings reported ranged from 1 hour to 50, indicating that there was some variation in the types of CIT training. The most common training hosted by the Georgia Bureau of Investigation and NAMI requires 40 hours of training, which 17% of the respondents received. Half of those not trained in crisis intervention indicated that there are staff available on each shift to respond to a crisis and only one respondent indicated that they have relied on these personnel for dealing with a person in mental health crisis. All respondents who did not have CIT felt it would be helpful in identifying and dealing with situations that may require crisis intervention. Regardless of training, respondents felt somewhat confident that they could de-escalate most situations. However, those without CIT did not feel confident in de-escalating situations involving homicidal or terroristic threats.

Chart 10. Self-report of ability to de-escalate situations involving persons with mental health issues



Jail officers were also asked what their biggest safety concerns were when responding to incidents involving inmates with mental health issues. They expressed concerns that they may end up in a situation resulting in physical or violent injury, contracting diseases, or having to use force on the population.

The resource respondents most frequently requested was additional training, which included CIT, to better identify and deal with situations involving persons with SPMI. The second most requested resource was a state facility available for treating people (15% of respondents). Other resources requested were additional medical staff in the jail, counseling available in the jail, and avenues for alternative sentencing, with each representing 7.5% of the responses.

Secondary Data Analysis

For the needs assessment, five sources of data were collected and analyzed to gain a better understanding of the prevalence of mental illness in Forsyth and surrounding counties, as well as the extent to which persons with SPMI contact the jail. These data are a snapshot of the different systems within the county or that served the county, and, together, begin to highlight the extent of mental health need and the issues surrounding the provision of services.

Georgia Crisis and Access Line (GCAL) Analysis

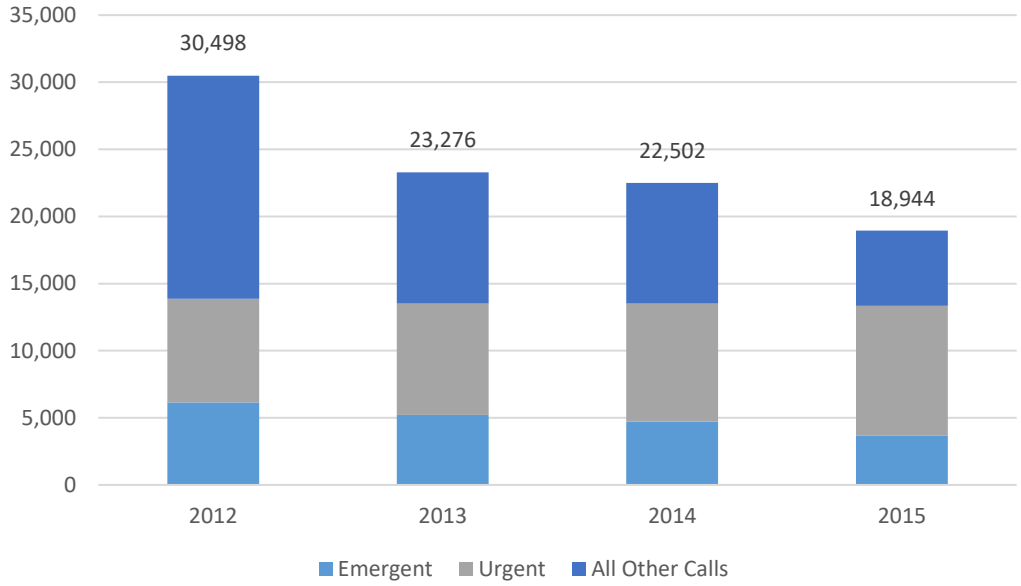
The Georgia Department of Behavior Health and Developmental Disabilities (DBHDD) contracts with Behavioral Health Link (BHL) to staff and maintain the Georgia Crisis and Access Line. GCAL acts as a single point of entry for crisis services, stabilization units, and inpatient services. Data from 2012 to 2015 were retrieved from DBHDD Region 1, which encompasses a 31-county area that includes Forsyth.[18]

[18] DBHDD region one includes Banks, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Hart, Lumpkin, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White, and Whitfield Counties.

BHL classifies the calls to the Georgia Crisis and Access Line as emergent, urgent, routine, or as a referral. Emergent callers exhibit suicidal or homicidal intent or are actively psychotic. Emergent calls with suicidal or homicidal intent require 911 dispatch, but other emergent calls could require dispatch of the mobile crisis or ACT team if the caller is enrolled. Alternatively, GCAL may schedule the person to be seen at a nearby treatment facility within two hours. Urgent calls could require the dispatch of the mobile crisis team or the scheduling of an appointment with a mental health professional within 24 to 48 hours. Routine calls involve persons experiencing some impact of their illness on daily living, but no major impairments in judgement or impulse control. For the purposes of this analysis, routine calls were grouped together with calls for referral to services.

DBHDD Region 1 has seen a 38% decrease in calls to GCAL from 30,498 in 2012 to 18,944 in 2015. This was largely driven by the 66% decrease in routine calls and referrals from 2012 to 2015. The number of emergent calls have also substantially decreased over the 4-year period by 40%. What has increased substantially are urgent calls, which accounted for 25% of all the calls in 2012, but 51% in 2015. This was a 25% increase in urgent calls over a four-year period.

Chart 11. DBHDD Region 1 Calls by Acuity



Calls to GCAL from Forsyth County did not markedly decrease over the 4-year period. From 2012 to 2015, Forsyth County averaged 600 calls to GCAL per year. Acuity level data were not available from Forsyth County to conduct a longitudinal analysis during this period.

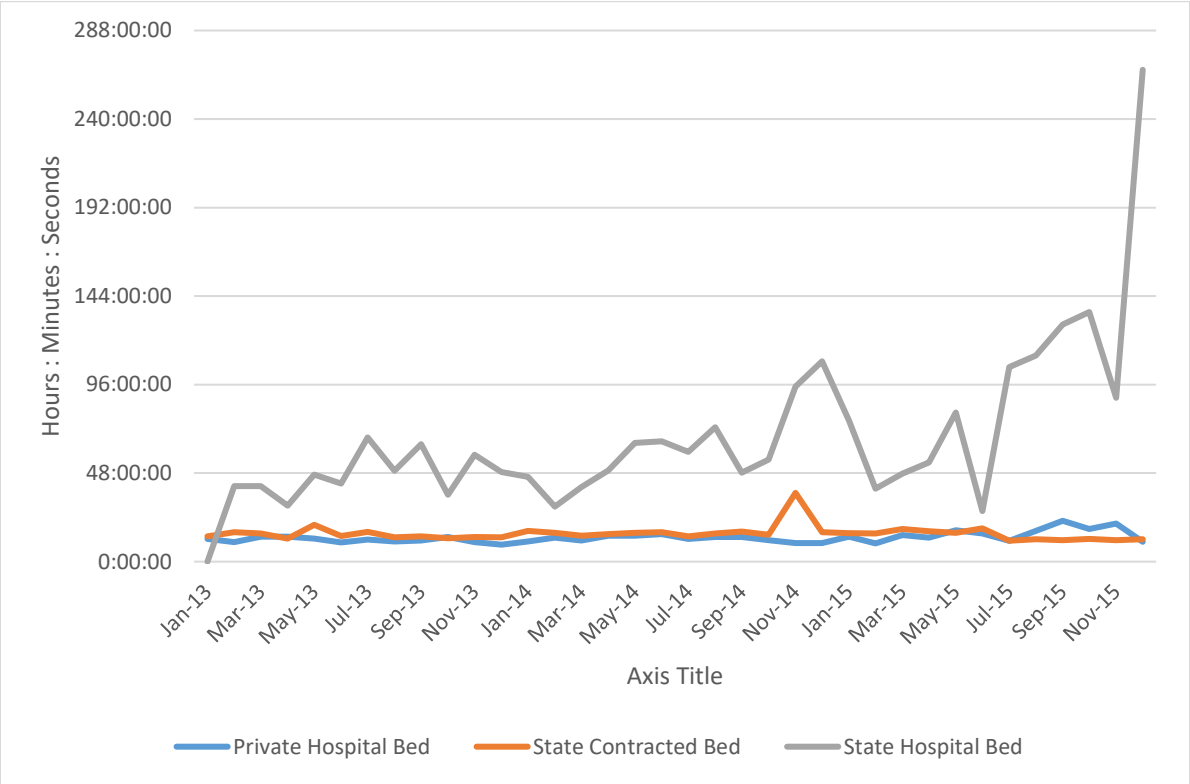
Table 3. Number of Calls to GCAL form Forsyth County

Year	2012	2013	2014	2015	Total
Number Calls	556	603	686	555	2400
% Change	-	8.45%	13.76%	-19.10%	-0.0018

Many stakeholders interviewed expressed that there were not enough inpatient beds available for those requiring that level of care. GCAL is the single access point to inpatient services for all providers throughout the state. Wait times were gathered from DBHDD Region 1 on the three types of inpatient beds that are available - private hospital, state contracted hospital/crisis stabilization unit, or state-run hospital - from 2013 to 2015. DBHDD policy is to place individuals first into private and state

contracted hospitals due to the fact that they far outnumber state run hospital beds and are more geographically dispersed throughout the state. Private and state contracted hospitals averaged 13 hours and 15 hours, respectively, for inpatient placement. State Hospitals averaged over two and a half days before placement, and the average did not change much after removing an outlier of 266 hours for placement.

Chart 11. Hours for Referral to Inpatient Treatment Bed



Mobile crisis teams consist of two individuals trained in crisis intervention, of which one person is a mental health professional able to issue a 10-13 to initiate an involuntary mental health evaluation. Benchmark contracts with DBHDD to provide mobile crisis resources for the 31 counties in Region 1, which includes Forsyth. Interviewed stakeholders dismissed mobile crisis as a resource to effectively intervene with someone in a decompensated state because of perceived long response times. Benchmarks' policy is to respond within one hour on average for the mobile crisis team. The mobile crisis response times for calls originating from Forsyth County were collected from Behavioral Health Link for 2016. Over the twelve-month period there were three months during which the response times averaged slightly over an hour. However, for the year the response times averaged 55 minutes.

Table 4. Mobile Crisis Completed Dispatches to Forsyth County 2016

Month	Completed Dispatches	Average Response Time of Completed Dispatches
Jan	10	0:53:00
Feb	8	0:49:00
Mar	6	0:53:50
Apr	11	1:04:55

Month	Completed Dispatches	Average Response Time of Completed Dispatches
May	11	0:49:27
Jun	5	0:51:24
Jul	3	0:44:00
Aug	8	1:07:30
Sep	10	0:47:58
Oct	7	0:56:56
Nov	10	1:02:43
Dec	9	0:51:07
Total	**98**	**0:55:04**

The average annual number of mobile crisis dispatches by county in Region 1 from July 2013 to December 2015 was 76. In 2016, ninety-eight dispatches originated from Forsyth County, which is 29% more than the region average over the previous two and a half years. In the 31 counties in Region 1 during the same period, there were 211 co-responses of the mobile crisis team with law enforcement. Of those, 72 were for safety reasons, and in another 72 dispatches law enforcement took the lead in their joint response. Joint responses with law enforcement represented nearly 5% of mobile crisis dispatches

Table 5. Region 1 Mobile Crisis Dispatches from July 2013 to December 2015

Region 1 Mobile Crisis Dispatches July 2013 to December, 2015	
Mobile Crisis Alone	5675
Co-response with Law Enforcement	211
Law Enforcement Leads	72
Total Mobile Crisis Dispatches	5958

From 2013 to 2015, law enforcement initiated nearly 4% of mobile crisis dispatches from GCAL. The largest number of calls (65%) were urgent.

Table 6. Law Enforcement Initiated Calls to GCAL by Type – 2013 to 2015

Emergent	Urgent	Routine	Referral	Warm Support	Info Only	Total
23	143	13	1	16	24	220

Online Analytical Statistical Information System (OASIS)

Since frequent jail users typically tax both the criminal justice and emergency medical systems, hospital data from 2011 to 2015 was analyzed to identify any changes in emergency room admissions or general hospital admission involving persons whose chief complaint centered around mental

health.[19] Using Georgia's Department of Public Health data from OASIS, the percentage of hospital and ER admissions that involved individuals whose chief complaint included mental health from Forsyth County and the 5 counties that share a border with Forsyth were calculated.

ER admissions that involved someone with a chief complaint involving mental health from Forsyth County represented between 2.7 and 3.3 percent of ER admissions between 2011 and 2015. Although during the period, Forsyth experienced a 14% increase in these admissions, the increase resulted in a less than 1% change in the proportion of ER admissions. No other bordering county saw increases in mental health ER admissions by more than 4%. The proportion of Mental Health admissions in border counties mirrored Forsyth with between 2 to 4 percent. Forsyth had the second smallest number of ER admissions, so a slight change will result in a larger measured percent change.

Table 7. Percent of ER Admissions Related to Mental Health by County

County	2011	2012	2013	2014	2015
Cherokee	3.2%	3.1%	3.1%	3.3%	3.0%
Dawson	2.7%	2.9%	2.7%	3.2%	2.8%
Forsyth	2.7%	3.1%	3.2%	3.3%	3.1%
Fulton	3.3%	3.4%	3.6%	3.9%	3.4%
Gwinnett	2.4%	2.3%	2.3%	2.5%	2.4%
Hall	2.6%	2.6%	2.1%	2.5%	2.6%

By comparison the proportion of hospital admissions involving a mental health chief complaint was between 3.5 and 6 percent, which is slightly higher than the percent of ER admissions. Unlike ER admissions, general mental health admissions decreased in Forsyth County by 12%.

Table 8. Percent of Hospital Admissions Related to Mental Health by County

Percent of Hospital Admissions Related to Mental Health by County					
County	2011	2012	2013	2014	2015
Cherokee	5.9%	6.0%	5.8%	4.8%	4.7%
Dawson	4.9%	5.5%	5.4%	4.8%	4.9%
Forsyth	5.0%	5.4%	5.8%	4.1%	4.4%
Fulton	6.1%	6.0%	6.2%	5.5%	5.4%
Gwinnett	5.3%	4.9%	4.2%	3.8%	3.6%
Hall	5.5%	6.1%	5.6%	5.7%	6.1%

Children's Health Care of Atlanta (CHOA) Scottish Rite

Interviewed stakeholders expressed that the number of children going to CHOA Scottish Rite with a chief complaint related to mental health has increased. Therefore, an analysis was done of CHOA Scottish Rite ER and hospital admissions from 2011 to 2015 to determine whether its ER and hospital services had treated an increasing proportion of children having mental health issues over time.

[19] The OASIS data queried on the chief complaints of anxiety, behavioral complaint, bipolar, depressed, emotional problems, ingestion, psychiatric problem, psychology referral, psychology / social concern, self-injurious behavior and suicidal complaints.

Table 9. Percent of Mental-Health Related CHOA ER Admissions by County

County	2011	2012	2013	2014	2015
Cherokee	1.00%	1.82%	2.83%	2.48%	2.54%
Dawson	1.60%	1.90%	1.48%	1.27%	2.62%
Forsyth	0.78%	2.61%	1.79%	1.44%	2.17%
Fulton	0.85%	1.93%	2.20%	2.38%	2.80%
Gwinnett	0.82%	1.61%	1.47%	1.71%	2.55%
Hall	0.32%	2.79%	0.47%	0.67%	3.38%

Up to 3.5% of the CHOA admissions involved chief complaints of mental illness. Seven Forsyth County children were admitted to the ER in 2011 for mental health issues and that increased to 25 children in 2015. Hospital admissions were slightly larger than the ER admissions, with up to 4% of them consisting of chief complaints related to mental illness.

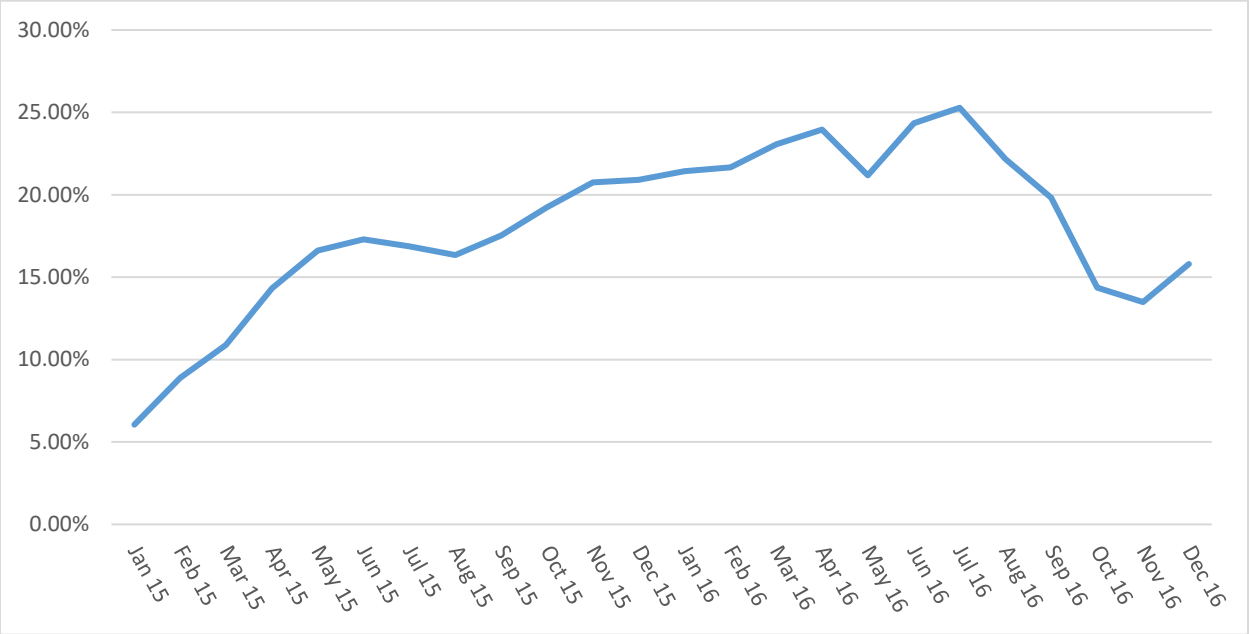
Table 10. Percent of Mental Health Related CHOA Hospital Admissions by County

County	2011	2012	2013	2014	2015
Cherokee	1.69%	1.23%	2.42%	1.63%	2.47%
Dawson	3.03%	2.22%	2.22%	2.22%	4.00%
Forsyth	-	1.00%	2.66%	0.84%	1.52%
Fulton	0.86%	2.34%	2.62%	3.28%	3.19%
Gwinnett	0.62%	1.67%	1.53%	1.39%	1.90%
Hall	-	2.01%	0.69%	0.69%	3.89%

Jail Data

In January of 2015, 6% of the Forsyth County Jail monthly population consisted of persons with mental health disorders who required the use of antipsychotics or lithium. By July of 2016, that percentage grew to over a quarter of the monthly jail population, which is the peak during the two-year period of jail pharmacy data used for this analysis. At the end of 2016, that number dropped to 16%. The average length of stay for someone prescribed antipsychotics or lithium in the Forsyth County Jail was just over 190 days. This is compared to the overall average length of stay in the jail of 23 days. The average cost for the various medications for inmates was just over $8 per prescription.

Chart 12. Monthly Jail Population Prescribed Antipsychotics or Lithium



Points of Diversion

911 Calls

Interviewed stakeholders consistently reiterated that the earlier a situation is identified as involving someone in mental health crisis, the earlier specific interventions can be used to divert them from the criminal justice system. The earliest point of diversion is with Communications Officers in the County 911 call center.

Currently, the Forsyth County 911 call center does not systematically identify or track calls related to mental health, even though many Communication Officers know of frequent callers that they believe have mental health issues. Of interest from our conversations was the belief that their job was not to diagnose mental illness. In addition, there were concerns about HIPAA in this designation.

The 911 call center operates using event codes. These codes indicate distinct types of calls, e.g. code 14 indicates a Homicide. The event codes then correspond to specific *Call Guide Questions* that appear in the Call Aided Dispatch (CAD) system for the Officers to ask the caller and to record in the call log section of the CAD. In the past, Code 24 was labeled "Demented" and used to indicate calls involving a person that the caller or Communication Officer believed to be mentally ill. The event code has since been changed to indicate an "Irrational Person," and current 911 policy in Forsyth County is not to use this code in the event code field of the CAD. This prevented an in-depth analysis of the code in Forsyth County to capture the volume of calls potentially involving someone in mental health crisis.

To better identify and track 911 calls involving persons with SPMI, additional guide questions could be added to extract pertinent facts from callers related to the emergency situations unique to someone in mental health crisis. Examples included whether an individual has taken or is on psychotropic drugs and whether the person has been recently treated or hospitalized for their mental illness. Currently, guided questions for three different event codes urge Communications Officers to ask questions about medical history and an additional three event codes guide them to ask specifically about the use of

medications. Therefore, adding these two questions to the appropriate events could help identify calls that involve a person with severe or persistent mental illness, and thus deploy a CIT trained officer.

Issues in collecting mental health data from 911 calls:

- No systematic identification of calls potentially involving mental health.
- No agency wide Call Guide questions to identify whether a call involves mental health crisis.
- No convenient way to link 911 call data to arrest records and court records.
- Currently, there is no policy to connect callers with GCAL for resources.

Recommendations:

- Reinstitute the use of Event Code 24 and report it within the system like any other event code (not the narrative).
- Include in the following guided questions for Event Code 24, and those events that include identification of Alcohol or Drugs in the event:
    - Are any involved persons known to use prescription psychotropic drugs?
    - Have any of the involved persons been recently treated or hospitalized for mental illness?
- Create a unique identifier for 911 calls to be added to police reports so that the two datasets can be merged for analysis.
- Create policy and train staff to identify and dispatch calls to GCAL.

First Responder Contact

Law enforcement will be the focus of recommendations at the initial contact point in the community due, in part, to the discretion they have to divert persons with suspected SPMI into treatment or to arrest. Additionally, law enforcement is required to take the lead on calls where someone exhibits erratic behavior, creating a safety concern for EMS. Finally, EMS will only be transporting individuals for medical intervention, therefore playing little or no role in further contact with the criminal justice system.

Our surveys indicate that law enforcement would need additional resources to aid in the identification of persons with SPMI and to help de-escalate situations. If the Forsyth County 911 call center implemented the recommendations above, identification of SPMI will be resolved. However, the outcomes of interactions between deployed law enforcement and the person on the scene will depend on training, officer decision-making, and availability of resources such as GCAL.

The two areas of focus for the recommendations are training and access to a mental health professional. Surveys indicated that law enforcement personnel, on patrol and in the Jail, would benefit from CIT or other training to better respond to those with SPMI. The training requested included CIT and training to better identify and understand distinct types of mental illness. Although there are CIT trained officers available on each shift, many officers did not call these officers for backup, or indicated that they are not always available. Understanding symptoms and characteristics of different mental illnesses could help move some officers to make the decision of diversion where they may not have done so in the past.

Nearly half of survey participants indicated they would like access to a mental health professional that could guide them through or help them directly with a call. GCAL operators are trained mental health professionals and can connect those in crisis to several types of services, including the dispatch of the mobile crisis team, yet no officers indicated they typically access GCAL or work in tandem on a call with the mobile crisis teams. There is some indication from the Benchmark data that co-responses with the mobile crisis team are happening in Forsyth County's region, but it is unclear if this is happening in the county itself. There is also some indication that law enforcement officers are calling

GCAL for resources, both for high need emergent situations and service referrals. However, it is unclear what proportion is occurring in Forsyth County.

In cases where law enforcement does not have probable cause for arrest, but probable cause to believe the person about whom a call is initiated has SPMI, the officer could provide the family with the information for GCAL, and perhaps stay on the scene while the call initiates. Such a call may escalate the situation again and the officer's presence may keep the person calm. Conversely, where probable cause for both arrest and the presence of SPMI exist, officers need clear guidance about which offenses should be unequivocally diverted to treatment, which should result in both arrest and transportation for involuntary treatment assessment, and which should result in arrest only. The Solicitor General and District Attorney's offices should work together to provide such guidance to law enforcement.

Finally, if law enforcement decides to divert, under Georgia Code 37-3-42, many officers expressed the following concerns: 1) the time commitment involved in transporting to an emergency receiving facility, 2) the Crisis Stabilization Units rejecting the person for lack of medical clearance, and 3) the over utilization of the emergency room for diversion. Currently, there are no designated emergency receiving facilities in Forsyth County. Many stakeholders expressed concern about transporting to emergency receiving facilities in Hall County, which are designated by DBHDD as the Avita CSU in Flowery Branch and Northeast Georgia Medical Center / Laurelwood in Gainesville. Also, officers expressed frustration at being turned away because of bed availability, which resulted in officers being pulled from their patrol for an extended period. A coordinated community response, and perhaps MOU, between the Sherriff's office and the two closest emergency receiving facilities which outlines expectations regarding wait times for drop off, whether and when someone needs medical clearance for treatment, and alternatives in instances where the facility reaches capacity may alleviate these concerns.

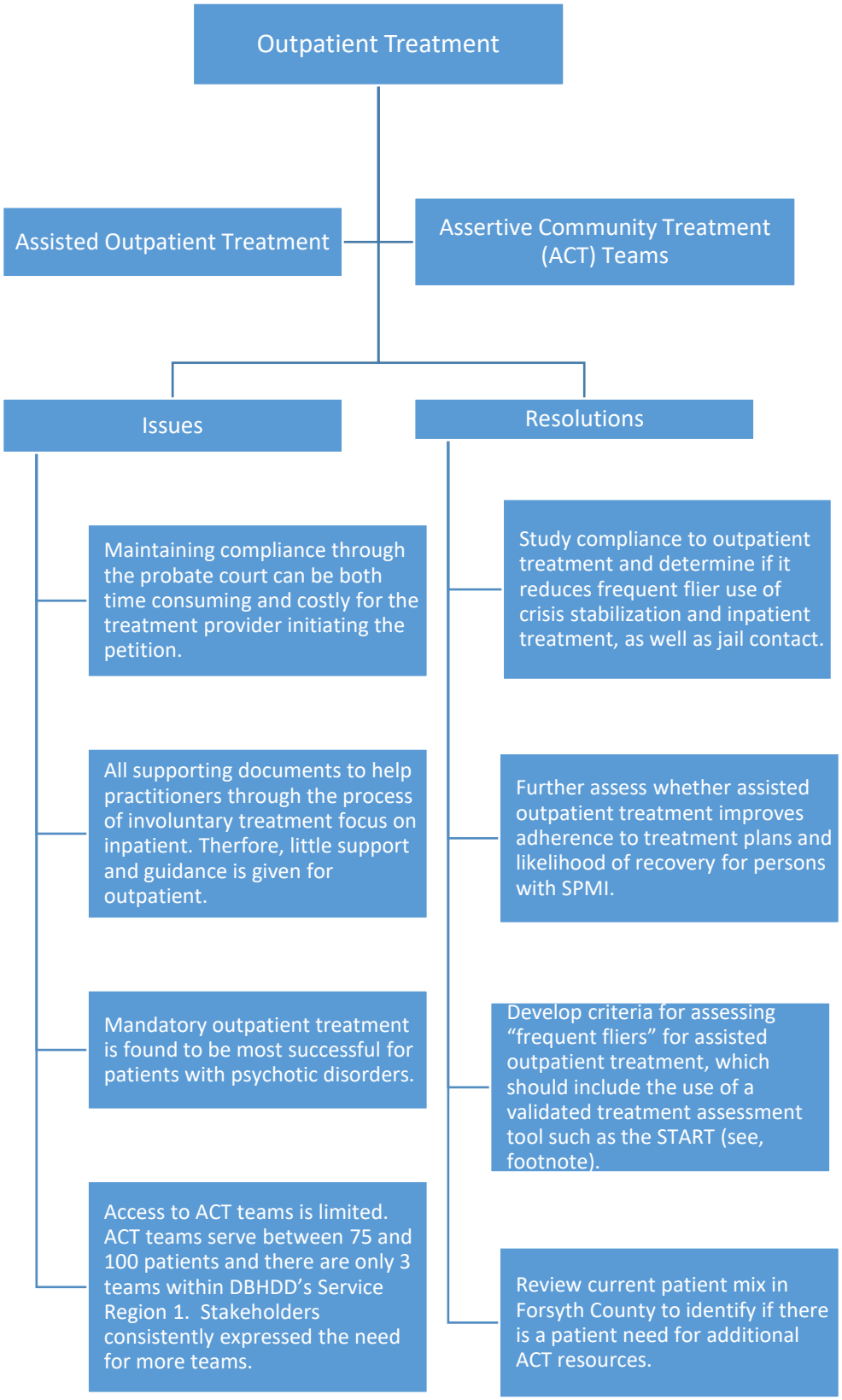
Issues Affecting the Law Enforcement response to persons with SPMI

- CIT Training is 40-hours, which is a major resource commitment for the Sheriff's Office.
- Officers are requesting access to mental health professionals to aid in a call while failing to access these services which are already available through GCAL.
- Transporting to emergency receiving facilities:
    - Requires a major commitment of time and resources from the Sheriff's Office;
    - Is difficult because Crisis Stabilization Units my reject the patient;
    - Creates an over utilization of ER services, because the ER is believed to be the place to transport for an emergency evaluation.

Recommendations

- Provide CIT and other mental health specific training for patrol and jail officers to help identify mental illness and de-escalate situations.
- Educate officers about GCAL and train them how to access their services when responding to a call that is determined to include someone with mental illness.
- Work with Benchmark, the company providing mobile crisis response in Forsyth County, to develop a coordinated response strategy and implement that strategy.
- Maintain a comprehensive list of emergency receiving facilities and work with GCAL to limit any rejections due to bed availability.

Points of Need



Outpatient Treatment

Almost every interviewee, and many of the survey respondents, expressed that more intense or better-quality outpatient care was needed to keep persons with SPMI from contact with the criminal justice system. A coordinated community response that includes NAMI/family members, AVITA, law enforcement, and at least one or two other outpatient treatment providers may be necessary to shape a triage strategy for helping those with SPMI access more robust outpatient services – from group treatment, to partial hospitalization programs, to peer recovery programs. Further assessment of assertive community treatment programming waitlists and use in Forsyth County may help identify how many patients in the county need these intense services.

Assisted Outpatient Treatment

Many expressed that it is "not illegal to be mentally ill" referring to the challenges in requiring someone to undergo treatment voluntarily and the frustration they may have felt about the inability to require treatment for someone that, to them, clearly needs help. Many of the stakeholders interviewed expressed that the only way to require treatment was if someone was a harm to themselves or others, and they felt this threshold unnecessarily delayed urgently needed care.

Through the course of the needs assessment, the SAC team discovered that the probate court did not order involuntary outpatient treatment for persons with SPMI who meet the criteria for "outpatient" under OCGA 37-3-1. Additionally, medical and mental health service providers did not seek involuntary treatment based on outpatient criteria. Involuntary commitment to treatment – inpatient or outpatient – can be controversial among mental health advocates and the patient community. Many professionals in Forsyth County who work with persons with SPMI were not aware of this provision in GA law upon initial interview and it is not at all used. No forms were identified that provide guidance on how to initiate an emergency evaluation for involuntary outpatient treatment.

The SAC identified a narrowly tailored and promising use of assisted outpatient treatment in Muscogee County. There the probate court works with the community service board to initiate involuntary outpatient treatment. The service provider leading this effort indicated that, in their experience for mandatory outpatient treatment to be successful, the patient must respond to long acting injectable medications typically prescribed to persons with psychotic disorders or mood disorders with psychotic features.

While the evidence regarding treatment uptake for those involuntarily committed to outpatient treatment is mixed, quality studies have shown positive reductions in inpatient hospitalizations, arrest, and ER use from the use of involuntary outpatient commitment. Successful use shares certain features:

- Typically use is restricted to discharge planning to ensure treatment continuity upon hospital (or jail) release;
- Orders for treatment must be paired with access to robust outpatient services;
- Orders should be in force for at least 180 days and should be reviewed periodically.[20,21,22, 23]

---

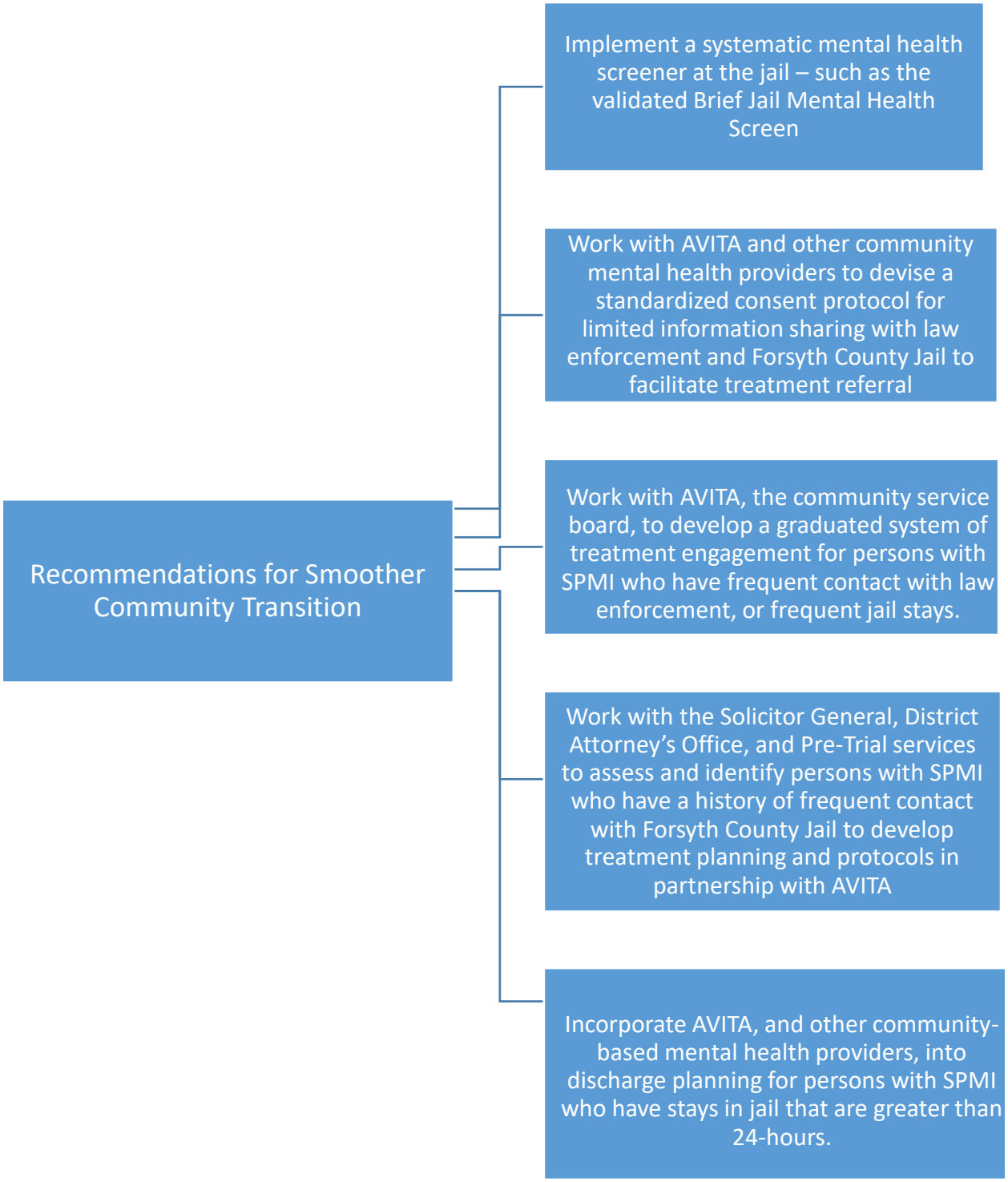
[20] Van Dorn, R.A., Desmarais, S.L., Petrila, J., Haynes, D., and Singh, J. (2013). Effects of Outpatient Treatment on Risk of Arrest of Adults with Serious Mental Illness and Associated Costs. *Psychiatric Services* 64(9), pp. 856-862. Retrieved January 30, 2018 from: https://doi.org/10.1176/appi.ps.201200406

[21] New York State Office of Mental Health, (2005). *Kendra's Law: Final Report on the Status of Assisted Outpatient Treatment*. Retrieved January 30, 2018 from: http://bi.omh.ny.gov/aot/files/AOTFinal2005.pdf

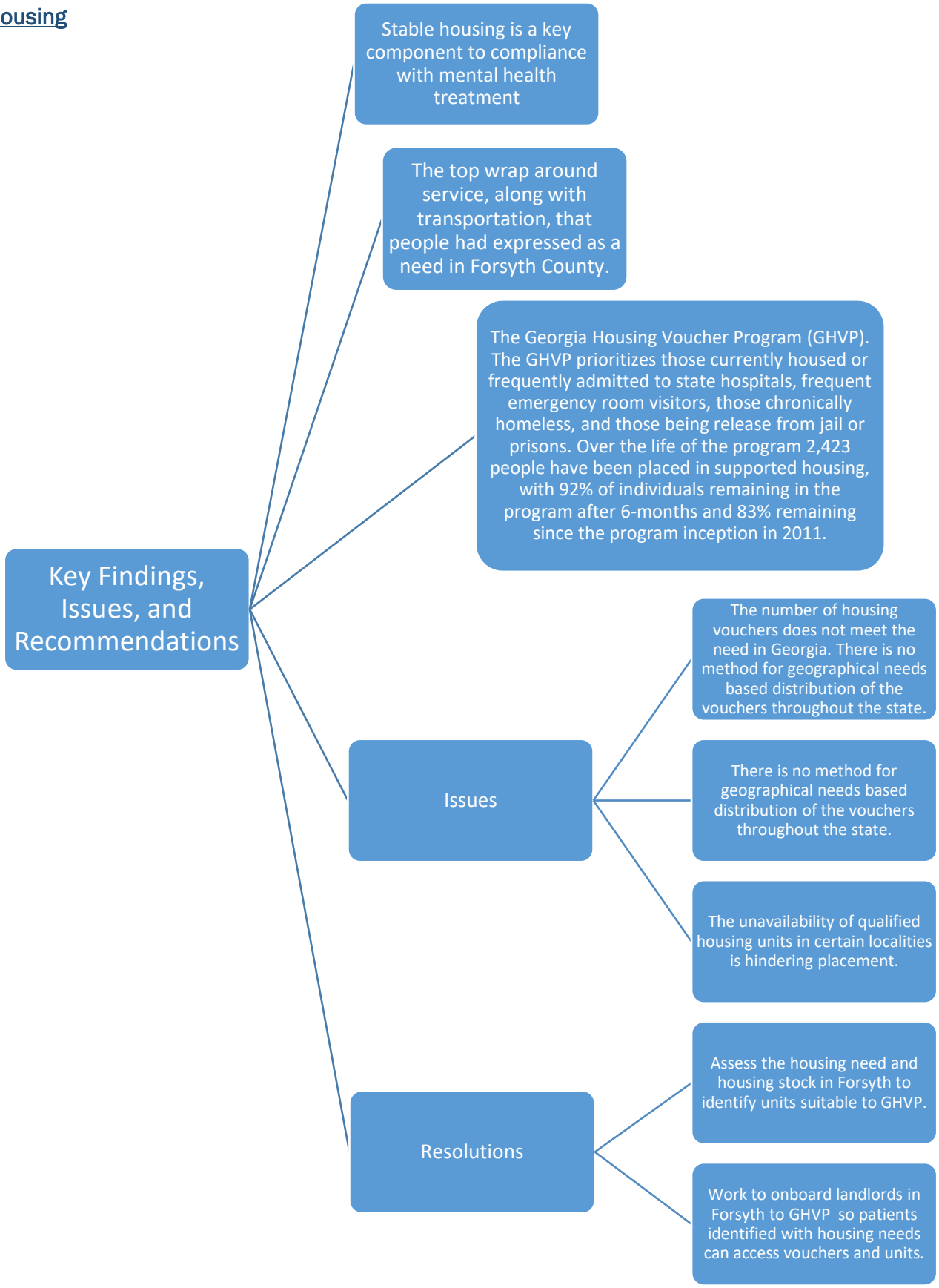
[22] Ridgely, M.S., Borum, R., Petrila, J. (2007). *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*. RAND Health. Retrieved January 30, 2018 from: https://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf.

[23] Swartz, M.S., Swanson, J.W. (2004). Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What's in the Data?. *Canadian Journal of Psychiatry* 49(9) pp. 585-591.

Intake and Discharge Planning from Jail and Pre-Trial Diversion



Housing


Key Findings, Issues, and Recommendations
Stable housing is a key component to compliance with mental health treatment
The top wrap around service, along with transportation, that people had expressed as a need in Forsyth County.
The Georgia Housing Voucher Program (GHVP). The GHVP prioritizes those currently housed or frequently admitted to state hospitals, frequent emergency room visitors, those chronically homeless, and those being release from jail or prisons. Over the life of the program 2,423 people have been placed in supported housing, with 92% of individuals remaining in the program after 6-months and 83% remaining since the program inception in 2011.
Issues
The number of housing vouchers does not meet the need in Georgia. There is no method for geographical needs based distribution of the vouchers throughout the state.
There is no method for geographical needs based distribution of the vouchers throughout the state.
The unavailability of qualified housing units in certain localities is hindering placement.
Resolutions
Assess the housing need and housing stock in Forsyth to identify units suitable to GHVP.
Work to onboard landlords in Forsyth to GHVP so patients identified with housing needs can access vouchers and units.

Conclusion

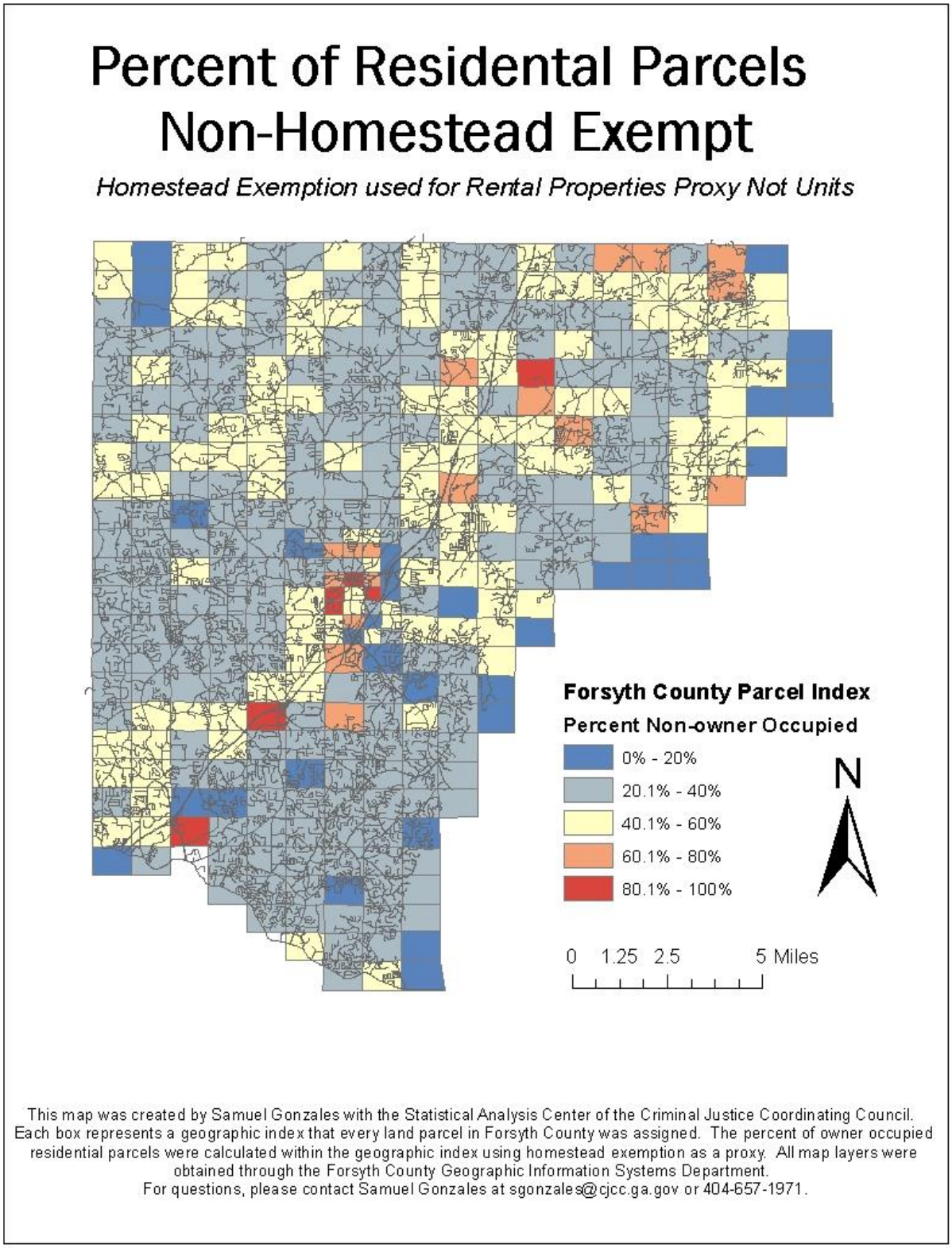
Since the *Olmstead* decision in 1999, the treatment must be administered in the least restrictive setting possible. The State of Georgia has taken the steps necessary to move many receiving mental health treatment in the state hospitals to treatment in the community through a network of public and private mental health services providers. Many family members with loved ones who have SPMI, and many first responders, expressed frustration that the intensive services that were once available at State Hospitals are no longer available. As a result, many believe the criminal justice system has become the institution where those who have fallen through the cracks from the shift in services have congregated for care.

Forsyth County Jail has indeed seen a rapid increase in the proportion of the monthly census that requires psychotropic medications. From 2011 to 2015, there has been a slight increase in hospital admissions where the chief complaints are mental illness. To fully understand the extent to which persons with SPMI contact the jail and the criminal justice system, a comprehensive data set from the Forsyth County Sheriff must be merged with the electronic pharmacy data for the medical provider in the county jail. Although we have started the process to gain an understanding of the scope of the issues, more work must be done to understand its full extent.

Any intervention to thwart entrance to or divert persons with SPMI from the criminal justice system must contain the following key components:

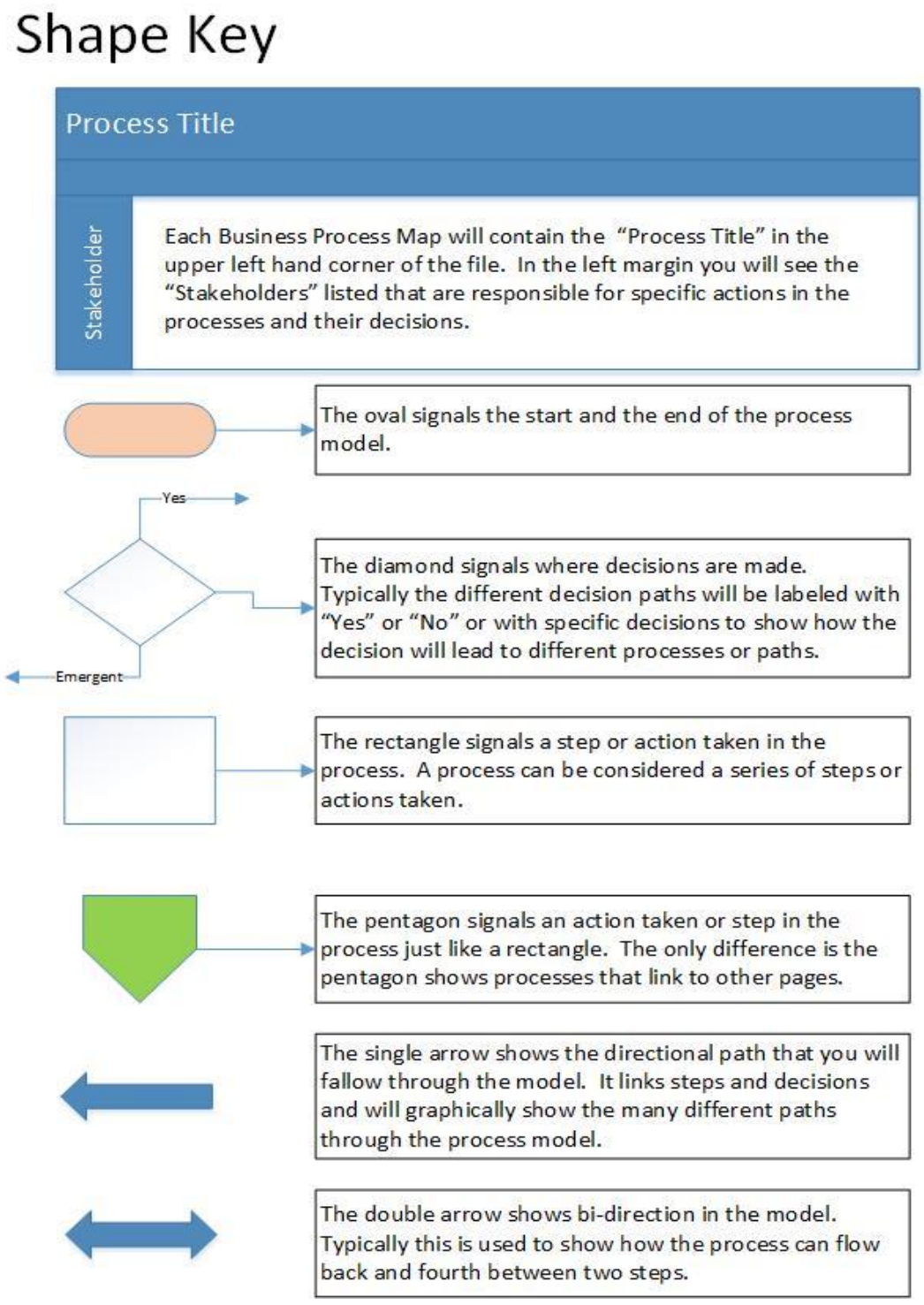
1. Mechanisms for sharing data and information about persons with SPMI who contact both the criminal justice and mental health/health systems;
2. Mechanisms for tracking treatment uptake and other outcomes for persons diverted from the criminal justice system into services;
3. Comprehensive, wrap around outpatient services and a coordinated community response to incidents involving persons with SPMI in crisis – from the point of the 911 call through jail discharge planning.

Map 1. Percent of Residential Parcels Non-Homestead Exempt



Appendix A: Process Models

Below is a key for the different shapes that you will find in the business process maps. Each shape has a meaning and that meaning is helpful to understand how the process flows and how the different maps connect. The eight process maps can be found imbedded in links in this Appendix.



Accessing Treatment Process

This map outlines the process in which a person with severe and persistent mental health issues can cycle through various treatment types to manage their illness.	

Initiating First Contact

This map works to show how contact with the community or with friends and family by a person or loved one with severe and persistent mental illness in a decompensated state will initiate contact with different systems.	

911 Process

This map shows the process 911 Communications Officers follow to dispatch law enforcement or fire first responders. What is outlined in red are processes that are currently not in practice, but could be an option to aid in diverting persons with severe or persistent mental illness into treatment.	

GCAL and Mobile Crisis Process

This map outlines how an individual with a mental health need can contact the Georgia Crisis and Access Line and be connected to various levels of treatment. This map highlights how triage decisions are made and how crisis mobilization and assertive community treatment teams are dispatched.	

First Responder Contact

This map highlights how law enforcement and fire first responders interact on a call to service. This map also highlights the decision process that law enforcement officers make on whether to arrest an individual with severe or persistent mental illness or to divert to treatment or for an involuntary assessment. The processes in red are processes that law enforcement could focus training and policies to widely adopt to better divert PMI into treatment.	

Initiating Involuntary Treatment Process

The map outlines how the process of involuntary treatment is initiated through law enforcement, medical professionals and the probate court through an involuntary assessment. The processes in red are to highlight the option for temporary involuntary outpatient treatment, which is currently not used regularly by service providers servicing Forsyth County.	

First Appearance and Bond Process

This map shows the process of how treatment services connect through the jail and where Pre-trial Services can identify mental health need through a risk and needs assessment administered at the Forsyth County Jail. This map is also useful for understanding the court process, the stakeholders involved and what decisions they make.	

Post Indictment Process

This map highlights the arraignment process and how treatment services can be integrated in pre-trial diversion. This map is also useful for knowing what stakeholders are involved in the arraignment process and how decisions are made.	

Appendix B: Inventory of Resources

A copy of the mental health services inventory was provided with the final draft of this report to the Forsyth County Commission. It was designed as an operational tool within Excel for easy navigation and editing. It is expected that stakeholders within Forsyth County will continue to add and edit the inventory over time to keep updated. The table below summarizes the services and their associated sub categories that you will find in the inventory:

Service Subcategory	Included Services
Psychological/Psychiatric Services	• Group Counseling • Intensive Family-Based Treatment • Medication Administration • Outpatient Opioid Treatment • Peer Support • Psychiatric Treatment • Psychosocial Rehabilitation • Voluntary and Involuntary Patient Services • Voluntary and Involuntary Outpatient Treatment
Pre-Crisis Services	• Behavioral Health Assessments • GCAL/Mobile Crisis • Initial Assessment and Dispatch • Involuntary Assessment • Service Plan Development • Triage
Crisis Intervention	• Assertive Community Treatment • Crisis Stabilization Units/Services • Emergency Receiving Facility • Treatment Facilities • Evaluation Facilities
Wraparound Services	• Assisted Living Services • Behavioral Support and Case Management • Community Support Team • Employment, Housing, and Legal Services • Nursing Assessment and Care • Transition Planning • Transportation Services/Assistance

Appendix C: Surveys

Family Survey

1. Who in your family has a mental illness? (Single Response)
   a. Parent
   b. Sibling
   c. Child
   d. Spouse/Partner
   e. Other Family Member:

2. What is their primary diagnosis? (Single Response)
   a. Anxiety Disorders
   b. Major Depression
   c. Schizophrenia
   d. Bi-polar disorder
   e. Dementia
   f. Dissociative Disorders
   g. Post-Traumatic Stress Disorder
   h. Borderline Personality Disorder
   i. Substance Abuse Disorder

3. Does your family member have a secondary diagnosis? (Single Response)
   a. Anxiety Disorders
   b. Major Depression
   c. Schizophrenia
   d. Bi-polar disorder
   e. Dementia
   f. Dissociative Disorders
   g. Borderline Personality Disorder
   h. Post-Traumatic Stress Disorder
   i. Substance Abuse Disorder
   j. My family member does not have a secondary diagnosis

4. What type of insurance does your family member currently have? (Single Response)
   a. Medicaid
   b. Medicare Part A
   c. Medicare Advantage Plan
   d. Individual Insurance through the Affordable Care Act
   e. Employer Based Private insurance
   f. No insurance

5. Please select the resources your family member most frequently uses to manage their illness on an outpatient basis. (Multiple Response)
   a. Psychologist for individual therapy
   b. Psychiatrist for outpatient medication and therapeutic management
   c. Licensed Professional Counselor for individual therapy
   d. Licensed Clinical Social Worker for individual therapy

e. Partial hospitalization / IOP day program
f. Support Groups/Therapy
g. ACT Team
h. Supportive/Assisted Living
i. Other / Not applicable
    i. Please Explain:
j. Not Applicable

6. How does your family member access and pay for these mental health resources? (This grid will pull from the answers in 5 and the respondent can choose the payment methods listed below for each resource selected)
    a. Private insurance
    b. Public Insurance
    c. Community Service Board (e.g. Avita)
    d. Self-Pay (Themselves or Family)
    e. A combination

7. Generally, how would you describe access to outpatient mental health care in Forsyth County?
    a. Likert Scale: Excellent, Good, Neither good or poor, Poor, Extremely Poor
    b. Please Explain

8. How would you describe access to inpatient crisis stabilization care?
    a. Likert Scale: Excellent, Good, Neither good or poor, Poor, Extremely Poor
    b. Please Explain:

9. How would you describe the continuity of care from inpatient crisis stabilization to outpatient mental health care in Forsyth County? We define continuity of care as the consistent adherence to mental health treatment as recommended while transitioning between two different providers or types/levels of treatment
    a. Likert Scale: Excellent, Good, Neither good nor poor, Poor, Extremely Poor
    b. Please Explain:

10. How many times in the last 3-years has your family member decompensated (worsening of clinical condition) to the point of crisis intervention?
    a. (Numeric Response)
    b. Option, “Too many to accurately recall”

11. Has your family member experienced a mental health crisis while living in Forsyth County? (Single Response: Y/N/Not Applicable)

12. If yes to #11: Did they agree to voluntary treatment? (Y/N/Sometimes)

13. If yes to #12, Please rank the resources your loved one used or uses most frequently when they are in crisis. (Ranking of top three)
    a. Private Psychiatrist, Psychologist, Licensed Professional Counselor or Licensed Clinical Social Worker

b. Call 911 for Police or Fire Service / First Responder
c. Georgia Crisis Access Line (GCAL)
d. Georgia Crisis Intervention Team (Benchmark)
e. Private In-Patient Treatment Centers
f. Community Service Board (Avita)
g. Emergency Room at Local hospital
h. Other (please explain)

14. Do you have guardianship over your family member? (Single Response: Y/N)

15. Have you ever petitioned the court with a two-party affidavit or had a clinician 1013 your loved one so they could be involuntarily assessed or treated? (Single Response)
    a. Yes, two party affidavit only
    b. Yes, requested 1013 only
    c. Yes, via both two-party affidavit and requested 1013
    d. No, I have never requested that my loved one involuntarily treated or assessed

16. If Yes to #15: Which of the following resources did you use to initiate involuntary treatment for your loved one? (Select all that apply)
    a. Private Psychiatrist
    b. Call 911 for Police or Fire Service / First Responder
    c. Georgia Crisis Access Line (GCAL)
    d. Georgia Crisis Intervention Team (Benchmark)
    e. Private In-Patient Crisis Treatment Centers
    f. Emergency Room at Local hospitals
    g. Probate Court

17. IF CHOOSE EITHER 911 OR GCAL in #16: What did you or your family member hope would be the outcome from calling 911 or GCAL? (Open Ended)
    a. I would call 911 again if my family member is in crisis.
        i. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree
        ii. Please Explain:
    b. I would call GCAL again if my family member is in crisis.
        i. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree
        ii. Please Explain:
18. Thinking of the most recent time your family member experienced a mental health crisis, how long did it take for them to enter inpatient crisis stabilization? (Single Response)
    a. Within 24 hours of seeking inpatient admission
    b. Within 48 hours of seeking inpatient admission
    c. 3 to 7 days after of seeking inpatient admission
    d. Over a week after of seeking inpatient admission

19. Has your family member had any contact with the criminal justice system (i.e. ever been arrested, prosecuted, incarcerated, etc.)? (Single Response: Y/N)

If Yes: Questions 20 Through 35

20. What is the extent of your family member's interactions with the Criminal Justice system? (Multiple Response)
    a. Arrested
    b. Prosecuted
    c. Spent Time in Jail
    d. Spent Time in Prison
    e. Participated in Forsyth County Care Court

22. How were you involved, if at all, with your family member's criminal justice case? (Open Ended)

If Arrested: Question 21 and 22

Please tell us the degree to which you agree or disagree with the following statements about the responding officers' conduct:

21. I believe that the officer could have de-escalated the situation and the arrest been avoided?
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree
    b. Please Explain:
22. I would not have called 911 if I thought my family member was likely to get arrested.
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree
    b. Please Explain:

If Prosecuted: Question 23-25

Please tell us the degree to which you agree or disagree with the following statements:

23. I believe there was an opportunity to divert my family member into mandated treatment through pre-trial services?
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree, N/A
    b. Please Explain:

24. I felt able to advocate on behalf of my family member for leniency and/or diversion because of their mental illness.
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree, N/A

25. I believe that my family member's mental illness was a factor in the judge's decision to divert them from incarceration?
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree, N/A

26. What do you believe are the most significant challenges in diverting persons with persistent mental health issues into treatment instead of jail or prison? (Open Ended Question)

If Spent Time in Jail: Question 27-34

27. How many times in the past 3 years has your family member spent time in jail? (Single Response)
    a. Only once
    b. Two or three times
    c. 3 or 4 times
    d. More than 4 times

28. Typically, what length of time did your family member spend in jail? (Single Response)
    a. Less than 24 hours

b. Less than 48 hours
c. 3 to 7 days
d. 1 week to 1 Month
e. Between a Month and 1 Year
f. Over 1 year

Please tell us the degree to which you agree or disagree with the following statements:

29. I believe that my family member received the mental health treatment they needed while they were in jail?
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree

30. I believe that my family member received the medication they needed to manage their mental illness in jail?
    a. Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree

31. Was your family member separated from the general population? (Single Response: Yes/ No / Sometimes)

32. Was your family member sent to inpatient crisis stabilization care while in jail? (Single Response: Yes / No / Don't know)
    a. If yes: How soon after arriving at the jail were they transferred to inpatient crisis stabilization care?
        i. Within 24 hours
        ii. Within 48 hours
        iii. 3-7 days
        iv. 1 week to 1 Month
        v. Between a Month and 1 Year
        vi. Over 1 year
33. How would you describe the continuity of mental health care in the community following your family member's release from jail? Continuity of care as the consistent adherence to mental health treatment as recommended while transitioning between two different providers or types/levels of treatment
    a. Likert Scale: Excellent, Good, Neutral, Somewhat Poor, Poor
    b. Please Explain

34. Thinking of your family member's most recent release from jail, how long did it take for your loved one to start outpatient treatment following their release from jail? (Single Response)
    a. Within 24 hours
    b. Within 48 hours
    c. 3 to 7 days
    d. 1 to 2 weeks
    e. 2 weeks to a month
    f. Greater than a month

35. What do you believe are the most significant challenges to keeping a person with severe and persistent mental health issues from contacting and or entering the criminal justice system? (Open Ended Question)

36. What additional resources would you like to see in Forsyth County to help manage your family member's mental illness? (Open Ended Question)

First Responder Survey

1. Do you work as Emergency Fire Service / First Responder or Law Enforcement?

☐ Fire Service / First Responder ☐ Law Enforcement

2. How many years have you been working in Forsyth County as a patrol officer or Fire Service / First Responder?

☐ (Years)

3. How many years total have you worked as a patrol officer or as a Fire Service / First Responder?

☐ (Years)

4. What is your experience, either personal or professional, with the following categories of severe and persistent mental illness?

***Rank by checking on box using the scale of 1 – 5.**
1 = No experience, 5 = Significant experience)

a. Anxiety Disorder
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
b. Major Depression
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
c. Schizophrenia
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
d. Bi-polar
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
e. Dementia
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
f. Dissociative Disorder
   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

5. What is your experience, either personal or professional, with the following categories of developmental disabilities? (Scale of 1 – 5. 1 = No experience, 5 = Significant experience)

***Rank by checking on box using the scale of 1 – 5.**
1 = No experience, 5 = Significant experience)

a. Autism Spectrum

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

b. Down Syndrome

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

c. Pervasive Development Disorders

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

d. Intellectual Disability

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

6. When you arrive on the scene, how do you identify whether an incident involves mental health crisis? Please select all that apply. (Multiple response question)

☐ Indication from Dispatch

☐ Suicidal

☐ Acting Erratically

☐ Disclosure from Person of Interest

☐ Disclosure from Family Member

☐ Experience on the job

☐ Person of Interest seems disoriented

☐ Person of Interest seems disconnected from reality

☐ Person of Interest acting belligerently without reason

☐ Person of Interest is a "frequent flier"

☐ Address is a "frequent flier" for calls involving mental illness

☐ Other

Please Explain:

7. What percent of the calls for service that you have responded to in the past year have involved a person with mental health issues in Forsyth County? (Numeric Response)

_____ (Percent)

8. What percent of calls for service that you have responded to in the past year have involved a person as being in need of crisis intervention? (Numeric Response)

(Percent)

9. Have you received any training on Crisis Intervention while working at Forsyth County?

☐ Yes ☐ No

If YES to question 9,

a. Did you find this training helpful? ☐ Yes ☐ No

b. How many hours was the training?

c. Who conducted the course?

If NO to question 9,

Are crisis intervention trained personnel available on each shift to aid in a call?

☐ Yes ☐ No ☐ Not Applicable

Do you utilize Crisis Intervention Trained personnel for calls involving persons in mental health crisis?

☐ Yes ☐ No ☐ Not Applicable

Would training in identifying situations that may require crisis intervention be helpful to your work?

☐ Yes ☐ No ☐ Not Applicable

10. What are your biggest safety concerns when responding to a call involving mental health crisis?

11. On a scale of 1 – 5, how confident are you in your ability to de-escalate situations involving individuals who are experiencing a mental illness crisis who may be exhibiting the following signs, symptoms and behaviors.

*Rank by checking on box using the scale of 1 – 5.
1 = No experience, 5 = Significant experience)

e. Possible Hallucinations, delusional thinking
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

f. Suicidal threats and behavior
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

g. Homicidal threats and behavior
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

h. Threats in the destruction of property
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

i. Threats of aggression/violence towards responding officer
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

j. Terroristic threats
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

12. If you arrive on the scene and the person is acting in any of the ways described in the previous question, what are the top 5 actions you take in order of precedence?

13. If you arrive on the scene and the person is acting in the any of the ways described below and there is probable cause for arrest, in what scenario would you use your discretion to divert someone into treatment evaluation? (treatment, arrest)

a. Possible Hallucinations, delusional thinking
☐ Treatment ☐ Arrest ☐ Not Applicable

b. Suicidal threats and behavior
☐ Treatment ☐ Arrest ☐ Not Applicable

c. Homicidal threats and behavior
☐ Treatment ☐ Arrest ☐ Not Applicable

d. Threats in the destruction of property

☐ Treatment ☐ Arrest ☐ Not Applicable

e. Threats of aggression/violence towards responding officer

☐ Treatment ☐ Arrest ☐ Not Applicable

f. Terroristic threats

☐ Treatment ☐ Arrest ☐ Not Applicable

14. Does the severity of the crime determine if you transport to a treatment facility or hospital?

☐ Yes ☐ No ☐ Not Applicable

15. What policies influence your decision to divert someone suspected of mental health issues into treatment?

☐ I typically don't divert

If you typically don't divert, Please Explain:

16. Do you need medical clearance before your transport to a treatment facility for an evaluation?

☐ Yes ☐ No ☐ Sometimes

Please Explain:

17. Are you able to engage resources, outside of Law Enforcement and Fire Service / First Responders, to aid a call identified as involving someone with mental health issues?

☐ Yes ☐ No ☐ Sometimes

If Yes: What are those resources?

18. Do you believe that accessing more resources, outside of Law Enforcement and Fire Service / First Responders, would be beneficial to aid a call identified as involving someone with mental health issues?

☐ Yes ☐ No ☐ Not Applicable

19. What additional resource would you like to see to better address the needs of a call involving someone with mental health issues?

911 Survey

1. How many years have you been working in Forsyth County as a Communications Officer? (Numeric Response)
2. How many years total, have you worked as a Communications officer? (Numeric Response)
3. What is your experience, either professional or with someone you may know personally, with the following categories of severe and persistent mental illness? (Scale of 1 – 5. 1 = No experience, 5 = Significant experience)
    a. Anxiety Disorders
    b. Major Depression
    c. Schizophrenia, or other Psychotic Disorders
    d. Bi-polar, or other mood disorders
    e. Cognitive Disorders (including dementia)
    f. Dissociative Disorders
4. What is your experience, either professional or with someone you may know personally, with the following categories of developmental disabilities? (Scale of 1 – 5. 1 = No experience, 5 = Significant experience)
    a. Autism Spectrum
    b. Down Syndrome
    c. Pervasive Developmental Disorders
    d. Intellectual Disability
5. Are you currently identifying “frequent jail users”? By “frequent jail users” we mean callers who contact 911 often enough for you to recognize who they are and have an idea about what they might be calling. Such callers may contact 911 as frequently as daily, weekly, or quarterly (Single Response: Yes / No)
    a. If yes: How do you currently identify “frequent jail users (Open Ended)

   b. If no: Would the ability to identify "frequent jail users" aid in dispatching specialized resources (Single Response: Yes / No)
6. How do you identify whether a call may involve someone with mental health issues? Please select all that apply. (Multiple Response)
   a. Expressed Suicidal thoughts or actions
   b. Acting Erratically
   c. Disclosure from caller
   d. Experience on the job
   e. Caller seems disoriented
   f. Caller seems disconnected from reality
   g. Caller acting belligerently without reason
   h. Caller is a "frequent flier"
   i. Call from address is a "frequent flier"
   j. Don't currently identify mental health status during calls
   k. Other
      i. If "Other" Explain
7. What percent of the calls that you answered do you suspect involved a person with mental health issues in the past 6 months? (Numeric Response)
8. What percent of the calls that you answered do you suspect involved a person in mental health crisis (a danger to themselves or others) in Forsyth County? (Numeric Response)
9. Have you received any training on Crisis Intervention for persons with mental illness while working at Forsyth County? (Single Response: Y/N)
   a. If yes, did you find this training helpful? (Single Response: Y/N
   b. How many hours was the training? (Numeric Response)
   c. Who conducted the course? (Open Ended)
   d. If no, would you find training helpful in identifying situations that may require Crisis Intervention for persons with mental illness? (Single Response: Y/N/Don't Know)
10. How do you communicate situations that may involve a person with mental illness (whether the person is in crisis, as previously defined, or simply has mental health issues)? (Open ended)
11. What changes to your call response system would make communicating situations that may involve mental illness to first responders easier? Please rank these. (Ranking 1-6)
   a. Creating a flag in the system when mental illness is suspected
   b. Creating a geographic marker for frequent callers
   c. Better pre-arrival instructions for first responders about a potential mental health crisis
   d. Ability to ask questions specific to identifying mental illness during a call
   e. Specific training about mental illness and identifying signs for it while on a call
12. Do you provide callers with the Georgia Crisis Hotline (GCAL) number? (Single Response: Y/N)
13. Do you feel that the information you provided identifying a call involving a person with mental health issues or in crisis is taken into consideration when law enforcement or EMS are dispatched? (Single Response)
   a. Yes, but only for law enforcement
   b. Yes, but only for EMS
   c. Yes, for both law enforcement and EMS
   d. No, I do not feel these notations are considered
   e. I am not sure whether or how these notations are considered
14. Are you able to engage resources, outside of Law Enforcement and EMS, to aid a call identified as involving someone with mental health issues? (Single Response: Y/N)

   a. If Yes: What are those resources? (Open Ended)

15. Do you believe that accessing more resources, outside of Law Enforcement and EMS, would be beneficial to aid a call identified as involving someone with mental health issues? (Single Response: Y/N)

   a. If Yes: What additional resource would you like to see to better address the needs of a call involving someone with mental health issues? (Open Ended)