Mental Health Issues in Law Enforcement: Concept and Issues White Paper Review and Recommendations

Submitted by the Ad Hoc Committee on Mental Health

Adopted by the Georgia Association of Chiefs of Police
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Ad Hoc Committee on Mental Health Issues in Law Enforcement

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Introduction, Formation and Purpose of Ad Hoc Committee

In August 2013, Georgia Association of Chiefs of Police (GACP) President David Lyons appointed an Ad Hoc Committee (Committee) to gather facts and provide recommendations regarding Mental Health Issues in Law Enforcement. The committee was composed of diverse representatives including municipal, county, and state law enforcement, psychologists, state service providers, and mental health advocates. This report is divided into two parts. First, in 2008 the Georgia Association of Chiefs of Police produced a "White Paper" entitled "Mental Health and Law Enforcement Encounters: A Review of Current Problem and Recommendations". A review of their findings will be provided as well as progress made in Georgia's mental health service delivery and law enforcement's response to mental health consumers. Second, an examination of the issues relating to mental health issues experienced by law enforcement officers will be provided. In particular, the severity of the issue, contributing causes, and resources to address the issue will be addressed.

In the 2008 "White Paper", a variety of concerns were identified by members of the law enforcement community regarding mental health consumers and the response to their needs. Those concerns included:

- Severe inconsistency in how mental health cases are handled throughout the state. It varies greatly from jurisdiction to jurisdiction;

- Extraordinarily long times being spent by law enforcement having patients committed and transported to emergency receiving facilities or approved treatment centers;

- Refusal of mental health providers to accept patients at all or without law enforcement being required to stay with them until an examination is completed. Law Enforcement is told they must stay at the facility, against their will, until the examination concludes;

- Patients are constantly being returned to the community without any meaningful disposition being made in their case. A revolving door so to speak; with the community and the patient suffering the consequences of this failure as a result. This non-treatment posture has resulted in the death of patients;

- Lack of a statutory requirement or refusal to comply with existing statutory requirements on how patients are to be admitted for treatment. A need exists for a quality standard admittance procedure that is followed statewide;

- No money to support mental treatment locally;

- Lack of political support for dealing with the mental health system and its problems;

- Mental health patients becoming wards of the criminal justice system due to the fact that mental health systems cannot or will not provide treatment or care for these patients. While these patients may have violated the laws of the State, they are becoming members of a secondary mental health system which are the county jails and state prison system;

- Lack of suitable placement of the mentally ill or suicidal inmates that are scheduled for release. Inmates with no formal charges against them often have to be released back into the community. Unfortunate instances exist whereby a released inmate attempts to

overtake a civilian staff member outside the facility or steps out into traffic and is struck by an oncoming vehicle;

- If the regional hospital servicing a particular county is out of bed space, a patient with a 1013 will need to be transported to another receiving hospital. Two deputies may spend an entire shift on patient transport and placement; and

- Inmates incompetent to stand trial and who are remanded to the custody of the Georgia Department of Human Resources remain in jail due to lack of bed space. Average length of stay at one county jail is 5 months. The sheriff's department becomes the primary mental health care provider.

One member of this committee that served on the 2008 committee stated that all of these issues are still relevant and perceived by many law enforcement executives to be ongoing today to one degree or another.

Historical Perspective

In 1963, Congress passed the Community Health Act (CMHA) to provide federal funding for community mental health centers. In addition, the Act also required that only individuals "who posed an imminent danger to themselves or someone else" could be committed to state psychiatric hospitals. As a result, thousands of previously institutionalized mental health consumers were released into communities that did not possess the resources to serve these needs. Over the years, States never fully funded the community mental health programs to serve this growing community.

Because of limited access to mental health services, many of these individuals have been funneled into the criminal justice system and incarcerated for behavior that could have been prevented if the individual had access to adequate mental health services.

More recently, a number of very high profile incidents have stirred public attention to the severity of the problem of mental illness in America. A few of these included:

- On April 2, 2014, Ivan Lopez shot and killed three soldiers and wounded sixteen more before killing himself;

- On April 29, 2014, 19 year old package handler, Geddy Kraner, walked into the Kennesaw, Georgia FedEx warehouse and shot six people before taking his own life.

- On December 14, 2012, Adam Lanza shot and killed twenty-six people, twenty students and six adults, at the Sandy Hook Elementary School in Newtown, Connecticut; and

- On July 20, 2012, James Holmes set off several gas and smoke canisters in an Aurora, Colorado movie theater before he shot and killed twelve and wounded seventy other people.

These are some extreme examples that illustrate how out of control these situations can become. Still these 'high profile' incidents are 'outliers' that do not accurately depict the majority of consumers. In reality, most mental health consumers are not violent. Studies indicate that only about 10% of the homicides in United States are perpetrated by individuals who are severely mentally ill and are not being treated.[1]

Nevertheless, dealing with persons who are severely mentally ill can be dangerous and should be considered an officer safety issue. Officers have often been required to use physical force to effect an arrest. Unfortunately, in some cases officers have had to use deadly force to defend themselves. These dangerous encounters are a threat to the police, mental health consumers, and the public. People with mental

[1] Matejkowski, JC, Cullen SW, Solomon PL; "Characteristics of persons with severe mental illness who have been incarcerated for murder." Journal of the American Academy of Psychiatry Law, 2008, 36: 74-86.

illnesses killed law enforcement officers at a rate of 5.5 times greater than the rest of the population. People with severe mental illnesses are killed by police in justifiable homicides at a rate nearly four times greater than the general public.[2] In the end, these events are emotionally challenging for the officers involved and require lengthy investigations, scrutiny, and criticism.

This paper will consider some of the facts that law enforcement officers must become aware of when dealing with persons with the mentally ill or who are in a state of extreme emotional disturbance.

Facts Relating to Mental Illness

Mental illness is a major public health concern in the United States. Mental illness (MI) is a health condition characterized by changes in thinking, mood and/or behavior associated with distress and/or impaired functioning. Any mental illness that causes substantial interference or limitation in one or more major life activities is defined as a serious mental illness (SMI) and in urgent need of treatment.

Recent studies indicate that approximately 18% of adults in the United States experience a mental illness every year and four percent of the population has experienced a severe mental illness within the past year.[3]

Despite effective treatment options that allow people with SMIs to recover and live productive and meaningful lives, a large number of people do not seek treatment. According to national surveys, only 62.9% of adults with SMI received mental health treatment within the year. Even fewer adults with less serious mental health conditions have received treatment.

[2] http://mentalillnesspolicy.org/crimjust/law-enforcement-mental-illness.html

[3] (Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (February 28, 2014). *The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health*. Rockville, MD

Stigma is the most significant barrier to seeking treatment. Fear of being labeled as mentally ill prevents many people from acknowledging their own mental health problems, much less disclosing them to others. For those who do acknowledge a mental health condition, stigma may result in anger, hurt, sadness, and discouragement; diminished self-efficacy; fear to pursue one's goals; difficulty trusting others; loss of self-esteem; hesitancy to engage in society; and loss of social opportunities. Stigma causes individuals to distance themselves from people with mental illnesses and deters the public from wanting to pay for care, thus reducing access to resources and opportunities for treatment.[4] "For our Nation to reduce the burden of mental illness and to improve access to care, stigma must no longer be tolerated."[5]

With 18% of adults in the general population experiencing a mental health condition, it is reasonable to assume law enforcement officers will encounter people with mental illness. Law enforcement officers are often the first personnel to come into contact with a consumer in distress. This contact can result from a family disturbance, when a mental health consumer is in crisis through lack of medication, or being overwhelmed by their environment. In many instances the situation may have escalated to the point that the mental health consumer committed a crime. As a result, inconsistent or non-existent mental health care often places officers in situations of being the first line mental health provider, when these services and expertise should be provided by other trained individuals and agencies. In the end, the criminal justice system is forced to function as the default mental health provider. According to the U.S. Department of Justice, 56% of inmates in state prisons and 64% in local detention facilities reported having mental health problems.[6] Such that, the two largest providers of mental health services in the

[4]Barczyk, Amanda N. "The Relationship Between the Public's Belief in the Potential of Recovery and Level of Mental Illness Stigma." Diss. U of Texas at Austin, 2011. Web. 19 July 2014

[5] "Executive Summary: A Report of the Surgeon General on Mental Health". Satcher, D. S., Public Health Report, Jan. – Feb. 2000, Vol. 115, No. 1, pp. 89-101.

[6] James, Doris J. and Lauren E. Glaze, Mental Health Problems of Prison and Jail Inmates, Bureau of Justice Special Report, U. S. Department of Justice, Office of Justice Programs, September 2006, (NCJ213600).

United States are state prisons and county jails. A joint survey by the Treatment Advocacy Center and the National Sheriff's Association reported "three times more seriously mental ill persons in jails and prisons than in hospitals." "Forty percent of individuals with serious mental illnesses have been in jail or prison at some time in their lives."[7] The study went on to add that persons who are incarcerated with mental health conditions are more likely to be incarcerated for longer periods of time and the cost of housing mental health consumers is considerably more expensive with estimates ranging from 36% to 127% more.[8]

There are also several other challenges to law enforcement when dealing with the mentally ill such as:

- transport of the mentally ill;
- the lengthy periods of time required of officers when dealing with these consumers prevent them from performing other duties or responding to other calls for service;
- the inadequate service delivery strategy for mental health services results in a revolving door that places these individuals back in the community before they have been stabilized;
- lack of facilities for placement of the mentally ill; and
- the lack of training necessary to ensure that these situations are handled in the most positive and non-confrontational manner.

[7] Torrey, E Fuller, Aaron D. Kennard, Don Eslinger, Richard Lamb, James Pavle, More Mentally Ill Persons are in Jails and Prisons than Hospitals: A Survey of States, Treatment Advocacy Center and National Sheriff's Association, May 2010, p 1.
[8] Torrey, et al., pp. 9- 10.

Legal Issues

One legal hurdle that has been identified by the law enforcement community as an impediment to working with individuals with mental health issues relates to O.C.G.A. § 37-3-42. This code section requires two mandates before an officer can take a person into custody. First, there must be a penal code violation and there must also be an affirmation that the person is a danger to themselves or to another. Chiefs from throughout the state are constantly running into circumstances where no penal code violation has occurred and they cannot involuntarily take the person in for an evaluation. Law enforcement officers would like to see the need for a penal code violation removed from the statute. The secondary problem with being able to make this change to the penal code is that some in the mental health community believe that law enforcement wants to criminalize mental health. This is far from the truth and better communication between these two groups is needed to facilitate this change.

Law Enforcement Officers are statutorily authorized to pick up and transport a mentally ill person to an emergency receiving facility pursuant to a Physician's certificate (O.C.G.A. § 37-3-41(a)), a Court Order (O.C.G.A. § 37-3-41(b)), or a request from a facility to pick up a person because the person left without permission during involuntary hospitalization (O.C.G.A. § 37-3-5). An officer will have civil and criminal immunity when acting pursuant to O.C.G.A. §37-3-4 which provides immunity from civil or criminal liability for "any physician, psychologist, peace officer, attorney, or health official, or any hospital official, agent, or other person employed by private hospital, state-operated facility, political subdivision, or hospital authority created pursuant to §31-7-4 who acts in good faith in compliance with admission and discharge procedures…". This should offer law enforcement

officials some measure of peace of mind while performing their official duties although anyone can file suit even if there is little chance of winning.

Health Insurance Portability and Accountability Act (HIPAA)

Federal law protects health information in the Health Insurance Portability and Accountability Act (HIPAA). While this legislation is not new, many law enforcement officers are unfamiliar with the provisions that relate to criminal investigations. HIPAA does authorize the release, without consent, of medical information regarding individuals who are victims of a crime to law enforcement. Specifically, federal law provides:

45 C.F.R. § 164.512 (f) HIPAA Exception for Law Enforcement

> (f) Standard: Disclosures for law enforcement purposes.
>
> (3) A covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime.

There is also an exception for coroners attempting to identify a deceased person or determine their cause of death. The Appendix contains additional information regarding these provisions of federal law.

HIPAA makes no provision for obtaining the records of a witness or a suspect should they become necessary as a part of the investigation. Officers may attempt to obtain medical records of a witness or suspect by obtaining consent. A copy of a consent form that may be adapted for individual department use is also attached in the Appendix. In the event the individual will not consent, the officer should obtain a search

warrant. The Committee recommends that each agency establish a point of contact with their local hospitals and health care agencies to establish a procedure for coordinating the release of information and/or search warrants.

Department of Justice Oversight

In recent years, the U. S. Department of Justice has provided greater attention to law enforcement agencies' response to the mentally ill. Working under authority of 42 U. S. C. 14141, the Department of Justice, Civil Rights Division, Special Litigation Section, has issued several Letters of Findings and entered into Consent Agreements with law enforcement agencies to eliminate perceived 'patterns and practice' of police misconduct relative to dealing with the mentally ill.

A review of these reports provides law enforcement executives with insight into those factors that may come under scrutiny and what steps agencies must employ to protect against federal oversight.

DOJ investigators typically examined how the department's operational policies, training, and supervisory review of officers' use of force may have affected the interaction with individuals suffering from mental illness or who may have suffered from diminished capacity.

In the Department of Justice's report of the Investigation of the Portland Oregon Police Department, investigators noted the serious deficiencies that existed within the State of Oregon's Mental Health System. The investigation of the Oregon Mental Health System related to their compliance with "Title II of the Americans Disability Act ("ADA"), 42 U. S. C. 12132, as interpreted in Olmstead v. L. C., 527 U.S. 581

(1999)"[9] This failure of the mental health services led to more consumers experiencing encounters with law enforcement. It is important to note the DOJ had a similar finding against the State of Georgia Psychiatric Hospitals in 2009.[10] This places Georgia officers in a similar situation.

Many of the DOJ's recommendations to agencies relative to officers' interaction with persons in mental health crisis were consistent across a number of their investigations. Some of the recommendations for implementation by these agencies included:

- Require all officers attend crisis intervention training.

- Develop a specialized unit of crisis intervention officers who are selected based on their temperament, experience, and desire to interact with individuals with mental illness or in mental health crisis.
- Revise polices to place greater emphasis on de-escalation techniques and require officers to consider less intrusive alternatives before employing force.

- Develop policies and implement procedures to improve the response to individuals in behavioral or mental health crisis, and to minimize the use of unnecessary force against such individuals.

[9] U. S. Department Of Justice, Civil Rights Division, Letter of Finding to Portland Mayor Sam Adams, September 12, 2012, RE: Investigation of the Portland Police Bureau, p. 6.
http://www.justice.gov/crt/about/spl/documents/ppb_findings_9-12-12.pdf
[10] U. S. Department of Justice, Civil Rights Division, Letter of Finding to Governor Sonny Perdue, RE: Investigation of State Psychiatric Hospital, December 8, 2009,
http://www.justice.gov/crt/about/spl/documents/Georgia_Psychiatric_Hospitals_findlet_12-08-09.pdf

- Implement scenario-based training to ensure officers do not use excessive force and only use force justified to meet the governmental interest.[11]

These recommendations by the Justice Department provide a roadmap for other organizations to implement processes to minimize adverse occurrences when dealing with mental health consumers.[12] They also provide risk management processes to minimize the potential of a negative finding by a DOJ investigation or law suit.

Operational Procedures

In order to properly prepare for encounters with mental health consumers it is incumbent upon agencies to prepare officers with proper direction through operational procedures, advanced training regarding issues specific to the mentally ill and working relationships with mental health service providers.

The first step to developing a policy directive is to review relative professional standards. The Commission for the Accreditation of Law Enforcement Agencies (CALEA) has established a standard, 41.2.7, which addresses this issue. The standard requires that: The agency has a written directive regarding the interaction of agency personnel with persons suspected of suffering from mental illness that addresses:

- guidelines for the recognition of persons suffering from mental illness;

[11] Letter of Finding to Portland Mayor, pp. 40 – 41. Also U. S. Department of Justice, Civil Rights Division, Letter to Albuquerque Mayor Richard Berry, April 10, 2014, RE: Albuquerque Police Department. U. S. Department of Justice, Civil Rights Division, Investigation of the New Orleans Police Department, March 16, 2011, http://www.justice.gov/crt/about/spl/nopd_report.pdf

[12] It is recommended agency leaders examine each of these letters and findings to identify specific measures that should be incorporated into the department's operational procedures.

- procedures for accessing available community mental health resources;

- specific guidelines for sworn officers to follow in dealing with persons they suspect are mentally ill during contacts on the street, as well as during interviews and interrogations;

- documented entry level training of agency personnel; and

- documented refresher training at least every three years.

The Georgia Law Enforcement Certification Standards also address contacts with the mentally ill in several different areas. The most pertinent are:

> **Standard 1.13**
> The agency has a written directive that requires affected personnel receive annual training in the following critical tasks:
>
> - Search and Seizure;
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> - Transportation of Detainees;
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> - Domestic Violence/Employee (all personnel);
>
> - Property and Evidence;
>
> - Off Duty Conduct (all personnel);
>
> - Sexual Harassment (all personnel);

- Selection and Hiring;
- Citizen Complaints/Internal Affairs (all personnel);
- Special Operations/SWAT, etc.; and
- Dealing with the mentally ill or persons with diminished capacity (all personnel).

Commentary: The intent of this standard is to provide training to all personnel who are affected or need to know the tasks and duties surrounding each assignment/task.

Training will be provided to each employee who has job duties, assignments, or responsibilities dealing with each bullet. Domestic Violence, off duty conduct, sexual harassment, citizen complaints/internal affairs, and dealing with the mentally ill or persons with diminished capacity shall be taught to all personnel.

Standard 8.13
The agency shall have a written directive that requires that detainee "receiving screening" information be obtained and recorded when detainees are admitted to the holding area and before transfer to another facility. Receiving screening must include an inquiry into:

- current health of the detainee;
- medications taken by detainee;
- behavior, including state of consciousness and mental status; and

- body deformities, trauma markings, bruises, lesions, jaundice, ease of movement, etc.

Commentary: The purpose of the screening is to determine whether medical attention is required. Female detainee screening should take into account the special needs of women.

Receiving screening may be performed by allied health personnel or by trained correctional officers at the time of booking. The information obtained may be recorded on a separate form designated for this purpose or recorded with other information obtained during the booking process. In addition, a record should be kept of all treatment and medication administered to a detainee, including circumstances or events necessitating such treatment.

Standard 8.16
The agency shall have a written directive which requires 24-hour supervision of detainees by agency staff, including a count of the detainee population at least once every shift, and establishes procedures to ensure that the detainee is visually observed by agency staff at least every thirty minutes.

Commentary: Twenty-four hour supervision is essential for maintaining security and ensuring the safety and welfare of detainees. Supervision, as used in this standard, assumes agency staff is present in the same building that houses the holding facility and not at a remote location. One intent of this standard is to prohibit delegating supervision to a trustee. In addition to a count of the detainee population at least once every eight hours, other counts may be necessary prior to and

following certain activities, such as night lockup, recreation, and meals.

Care should be taken during physical checks that the detainee does not anticipate the appearance of agency staff. Detainees who are security risks should be under closer surveillance and require more frequent observation. This classification includes not only detainees who are violent but also those who are GA Fifth Edition Standards Manual suicidal or mentally ill or demonstrate unusual or bizarre behavior.

Training

Officers often do not have the most updated training to enable them to properly react to consumers in crisis. Currently, officers attending the Basic Mandate Academy are provided with four hours of training regarding the issues of mental illness and developmental disabilities.[13] This is a good start in training officers on these issues, but more advanced training is needed.

Most agencies do not require their staff to attend refresher in-service or advanced training on the topic of encountering and interacting with mental health consumers.

Georgia Crisis Intervention Team Program

One method used in Georgia to address the issue of law enforcement training is the Georgia Crisis Intervention Team (CIT). This program is funded through the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). This program began in Georgia

[13] "Mental Health, Mental Retardation, and Substance Abuse", Basic Law Enforcement Program of Instruction, Georgia Public Safety Training Center, Basic Training Division, November 2011, pp. 45-51.

after a group of Georgia stakeholders traveled to Memphis, Tennessee to develop a comprehensive look at the nation's first CIT program, The Memphis Model. That group returned to Georgia and laid the foundation for the current CIT program that was piloted in Atlanta in December 2004. The mission of this program is to equip law enforcement officers with the skills to recognize and assist citizens with behavioral health disorders in crisis, thereby advancing public safety, and reducing stigma.

The Georgia CIT Objectives are to:

- Train law enforcement officers to safely respond to persons in behavioral health crisis;
- Protect the rights of citizens with behavioral health disorders;
- Ensure that people with behavioral health disorders always receive treatment in lieu of incarceration, when appropriate;
- Improve the quality and quantity of behavioral health services; and
- Promote adequate training for criminal justice system personnel about mental illnesses, developmental disabilities, addictive diseases and Alzheimer's disease.

Between 2004 and 2012, the Georgia CIT program has trained personnel from 106 Police Departments, 65 Sheriffs Offices, 10 state agencies, 17 colleges and universities, five federal agencies and MARTA. All of these agencies have CIT trained officers on staff.

This program has received a number of honors. First, it has participated in more academic research than any other program in the nation. In 2008, the Georgia CIT Program hosted the National CIT Conference and was the recipient of the International Association of Chiefs of Police Civil Rights Award for Multi-Agency Collaboration. In 2013, the

Georgia CIT Course Coordinator was named the CIT Coordinator of the Year at the National CIT Conference. In addition, a delegation from the Georgia CIT program travelled to Liberia to assist the war torn nation with implementing the first CIT program in the country. As of June 2014, 7036 persons have been trained through the Georgia CIT program including more than 6800 Georgia law enforcement officers. In addition, several organizations including the Georgia Bureau of Investigation, Georgia State Patrol, LaGrange Police Department, Roswell Police Department, and the Waycross Police Department have implemented plans to require all of their officers to attend the CIT program.

One study has noted that persons with more than 2-3 years of experience in law enforcement were more likely to retain and use the material taught in the CIT course. Officers need to have completed some level of basic training and on the job training prior to being exposed to this more advanced level of training.

Currently, several sections of the program's curriculum are being revised to address the evolving needs of the community. The classes that will be offered to select law enforcement agencies in the future, other than the regular 40 hour CIT class, will include:

- Alzheimer's Association: Safe Return Program and the Search and Rescue Program;

- All About Developmental Disabilities: Autism and law enforcement;

- Georgia State Patrol: Officers Peer Support Program;

- Governor's Council on Commercial Sexual Exploitation of Children (CSEC): Recognizing signs of exploitation, prosecuting offenders, assisting victims; and

- DHS Division of Aging Services: Recognizing and prosecuting adult abuse and neglect.

Mental Health Service Delivery in Georgia

An noted earlier, many law enforcement officers still perceive mental health service delivery is inadequate. Some of this perception is a result of inadequate communications of the progress the State has made in mental health service delivery

In February 2014, the U.S. Department of Justice (DOJ) filed a motion to close the 2009 Civil Rights for Institutionalized Persons Act (CRIPA) settlement agreement related to care in Georgia's state psychiatric hospitals.

DBHDD continues to work on fulfilling the agreement, which requires a shift from crisis-oriented, hospital-based care to a recovery-oriented, community-based system of care. In partnership with other agencies and with the full support of Governor Nathan Deal and the General Assembly, DBHDD is dramatically expanding community-based services so individuals can live in the least restrictive community setting according to their needs in accordance with the U.S. Supreme Court's Olmstead decision (OLMSTEAD V. L. C. (98-536) 527 U.S. 581 (1999)).

DBHDD Adult Behavioral Health Services Associated with the ADA Settlement Agreement

DBHDD reports it is meeting or exceeding DOJ's FY14 targets for behavioral health services. In particular, these services focus on service to adults with severe and persistent mental illness or a co-occurring mental health and substance use disorder, who have experienced

multiple instances of hospitalization, homelessness, and/or incarceration. As of July 1, 2014 DBHDD had contracted with service providers across the State for the following services:

- 22 Assertive Community Treatment (ACT) Teams
- Eight Community Support Teams
- 25 Case Management Service Providers
- Eight Intensive Case Management Teams
- 1450 Supported Housing beds with bridge funding for at least 540
- Supported Employment services to over 930 adults in ADA target population
- Peer Support, Mentoring, Wellness and Respite Services for 1,418 individuals
- Three Walk-in Crisis Service Centers
- Mobile Crisis Teams in 159 counties with an average response time of 48 minutes
- 22 Crisis Stabilization Units for adults experiencing a behavioral health crisis
- 12 Crisis apartments to support stabilization and prevent hospitalization

While the ADA settlement agreement does not address specifically address addiction treatment services, it is important to note that DBHDD's behavioral health services incorporate integrated dual disorders treatment for individuals with a co-occurring mental health and substance use disorder and that many, if not all of the Crisis Stabilization Units offer medically monitored detoxification services.[14]

[14] For more information about DBHDD's Addiction Treatment services go to http://dbhdd.georgia.gov/addictive-diseases. To learn more about DBHDD's Adult Community Mental /Bbehavioral Health services go to http://dbhdd.georgia.gov/adult-mental-health. To identify mental health, behavioral health and addiction treatment providers visit www.mygcal.com. Mental health, behavioral health, addiction treatment, outpatient and crisis services can be accessed 24 hours a day by calling the Georgia Crisis & Access Line at 1-800-715-4225.

DBHDD Developmental Disabilities Services Associated with the ADA Settlement Agreement

A developmental disability is a chronic condition that develops before a person reaches age 22 and limits their ability to function mentally and/or physically. The Department of Behavioral Health and Developmental Disabilities offers community based crisis support for persons with developmental disabilities that serve as an alternative to institutional placement, emergency room care, or incarceration. Law enforcement can accessed this system 24 hours a day by calling the **Georgia Crisis Access Line (GCAL) at 1-800-715-4225.** This system will activate a mobile crisis team to respond to the scene. At a minimum, the mobile crisis team will include a Licensed Clinical Social Worker (LCSW), a behavior specialist, and other direct support staff. The other team members may include a registered nurse, safety officers, and additional social workers. Physicians are available for consultation.

Services for Children, Young Adults and Families (CYF)

DBHDD's Office of Children, Young Adults and Families (CYF) offers children, young adults, and their families a range of treatment and support services to address emotional and behavioral problems. Early treatment of these problems is critical to help a child complete school and develop fundamental developmental skills.

Because of a changing population and recent incidents occurring across the country, DBHDD believes it is necessary to have a specific office responsible for providing training, technical assistance, support and guidance regarding young adults.

While the ADA settlement agreement does not specifically address services for youth, it is important to note that individuals under the age of 18 are no longer admitted to state psychiatric hospitals. To serve youth who are in need of short-term acute stabilization of behavioral health problems, DBHDD operates four Crisis Stabilization Units. DBHDD also operates seven Psychiatric Residential Treatment (PRTF) Service sites which provide comprehensive mental health and substance abuse treatment to children, adolescents, and young adults ages 5-21 who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in an inpatient treatment setting and for whom alternative, less restrictive forms of treatment have been tried and found unsuccessful or are not medically indicated.[15]

Statewide Coordination of Crisis Response Services

Crisis response is a critical element of DBHDD's continuum of care and essential to maintenance of a community-based system of care. Of particular interest to law enforcement officers is DBHDD's increased capacity to provide and coordinate statewide crisis response services for adults and children with mental health, substance use and/or developmental disabilities.

The purpose of the Georgia Crisis and Access Line (GCAL) is to offer community-based crisis support as an alternative to institutional placement, emergency room care, or incarceration. To accomplish this, the Georgia Crisis and Access Line (GCAL) 1-800-715-4225 is designed to:

- Provide telephonic crisis counseling
- Conduct telephonic assessments to determine level of care needed

[15] To learn more about the variety of services offered to youth, young adults and their families go to http://dbhdd.georgia.gov/office-cyf-services. To locate services in a specific location visit www.mygcal.com. All services for youth, young adults and families, including behavioral crisis services can be accessed 24 hours a day by calling the Georgia Crisis and Access Line (GCAL) at 1-800-715-4225.

- Connect individuals to the closest available services appropriate for their needs
- Schedule initial appointments with outpatient providers
- Dispatch mobile crisis response teams
- Monitor and coordinate statewide utilization of mobile crisis teams, crisis stabilization units, crisis respite apartments & homes, and state hospital & contracted inpatient beds

As with the development of any large statewide system, there will be issues to resolve. In order to foster continued development of this program, DBHDD needs law enforcement officers and other stakeholders to use this new system as well as identify areas that need improvement.

DBHDD's service system is administered at the regional level. It is the responsibility of the DBHDD Regional Office staff to support consumers and their families access needed services; Develop relationships with and facilitate productive relationships between DBHDD contracted service providers, DBHDD hospitals and other agencies that serve or interact with DBHDD consumers; and to monitor and address any complaints or concerns about regional provider performance. Therefore, DBHDD encourages local law enforcement agencies to contact and develop a relationship with staff in the nearest regional office.

Additional Resources

DBHDD offers additional resources and training to assist officers when interacting with individuals who are experiencing behavioral health and developmental disabilities:

- Mental Health First Aid is a 6-8 hour class that helps lay persons better identify and understand symptoms of behavioral health

conditions; how to talk to someone that may be experiencing symptoms; and how to assist an individual in getting help.[16]

- DBHDD receives federal and state funding for community support and training related to suicide prevention, intervention and aftercare. Specialized training has been developed specifically for law enforcement officers.[17]

- SAMHSA's GAINS Center is the national nexus of information and resources about mental health and substance abuse services to people with co-occurring disorders in the criminal justice center. It offers training that can help criminal justice professionals increase their understanding and awareness of the impact of trauma; develop trauma informed responses; and provide strategies for developing trauma informed policies. This can help to avoid re-traumatizing individuals, increase safety for all, decrease recidivism, and promote support and recovery. [18]

- DBHDD received funding from SAMHSA GAINS Center to develop a pilot program for and provide training and technical assistance related to jail diversion and trauma resolution with veterans.

- The Georgia Parent Support Network provides information, resources and information about local groups that provide educational and positive peer support for parents of youth with emotional and behavioral disorders.[19]
- The Georgia Aging and Disability Resource Connection is a coordinated system of partnering organizations that are dedicated to:

[16] For more information and listings of Georgia trainers go to www.mhfa.org.
[17] See also http://dbhdd.georgia.gov/suicide-prevention.
[18] See also http://gainscenter.samhsa.gov/.
[19] http://www.gpsn.org/

  - Providing accurate information about publicly and privately financed long-term supports and services.
  - Offering a consumer-oriented approach to learning about the availability of services in the home and community.
  - Alleviating the need for multiple calls and/or visits to receive services.
  - Supporting individuals and family members who are aging or living with a disability.[20]

- See also in the appendix, a protocol to link refugees to mental health services, and a listing of state psychiatric hospitals, private contracted hospitals and DBHDD Community Service Board areas; and a description of a partnership between a DBHDD contract provider of mobile crisis services, EMS and law enforcement.

[20] www.georgiaadrc.com

PART II

Mental Health Issues Among Law Enforcement Officers

Mental Health Issues Among Law Enforcement Officers

Mental health has generally been an overlooked priority in the law enforcement profession for a variety of reasons. Many law enforcement executives do not see a need for proactive measures to provide positive, preventative mental health practices. In addition, leaders often fail to recognize the need to address mental health issues from a reactive standpoint; after the critical incident has already happened. A greater travesty is the leaders who fail to recognize the maladaptive behaviors of troubled officers, often brought on as a result of a work-related incident or personal tragedy.

The problem is compounded when officers refuse help or deny that there is a problem. This is understandable when one recognizes the stigma associated with mental health issues can sometimes destroy an officer's career.

In addition, managing an employee is much more difficult when a mental health issue has been manifested. It is much easier to manage a person who is physically sick as their thinking is not usually impaired. When a person is experiencing a physical illness they generate empathy and concern for their problems from others. A person having mental health issues is seen as someone who does not want to deal with the issue. The problem is magnified by their inappropriate behaviors, emotional swings, and thinking patterns that impair the communications exchange. There are also the concerns associated with the potential liability of allowing the person to continue in a safety sensitive position such as an officer.

Left unchecked, the individual's personal behavior and work performance will deteriorate. Dr. Steve Sampson, who has worked with law enforcement officers for over thirty years and has treated more than 2,000 public safety personnel notes the following issues are most commonly observed:

- Substance Abuse (primarily alcohol);
- Domestic violence within their families;
- High divorce rate;
- Post-Traumatic Stress Disorders;
- Infidelity; and
- High suicide rate (that is under reported).

Facts Relating to Officer Stress and Suicide

Law enforcement officers today are at greater risk of taking their own life than being killed in the line of duty. According to the Law Enforcement Memorial Page[21], there were 105 law enforcement deaths in the line of duty in 2013, compared with 125 deaths in 2012. Regardless of the resource examined, the number of law enforcement suicides is at least equal to the number of line of duty deaths. Some studies indicate the number is much higher,

[21] www.odmp.org

with the suicide rate actually being three to five times the number of deaths in the line of duty. Some of this is anecdotal, as there is speculation that many deaths are not reported as suicides to benefit the other family members of the deceased.

A 2012 study of police suicides by two retired state law enforcement officers showed the 'official' number of law enforcement suicides fell for the first time in 2012 to 126 law enforcement suicides.[22] The following findings are from this same study. The average age at the time of the officer suicide was 42, and the average number of years of service was 16 years. 91% of the suicides were by male officers. 63% of the victims were single, and 11% were veterans. This study believes that the number of officer suicides has fallen as a result of more departments having peer support programs.

Acute and Cumulative Stress

The stressors of law enforcement work can be considered the greatest contributor to these numbers. Acute stress is considered as a reaction to a single traumatic critical incident such as an officer involved shooting, line of duty death of a co-worker, or a crash involving child fatalities. Post-Traumatic Stress Disorder (PTSD) may evolve from acute stress.

Cumulative stress develops from the daily grind in officers' personal and professional lives. One of the major contributors to officers experiencing a high rate of mental/emotional disorders is that they deal constantly with people who have mental/emotional

[22] www.policesuicidestudy.com/id16.html

problems either temporarily or frequently. This chronic exposure can have a "social/emotional contagion effect". When dealing with difficult people in difficult situations individuals will often take on, or mimic, their characteristics.

If not addressed in a healthy way, cumulative stress can be just as devastating as acute stress. In police work, the number one stressor is the internal politics and administration of an officer's given agency. It is important for police executives to recognize they are not immune to these same stressors. In some cases, it is more difficult for the executives who receive pressures from elected officials and city/county managers. At the same time, they receive criticism and pushback from subordinate officers and supervisors who are attempting to undermined efforts to modify the status quo.

When an officer is involved in a traumatic critical incident, the compelling factor in determining how the officer effectively recovers is how the officer (and their family) is supported in the aftermath by the agency and the administration. It should be noted that many agencies within the State of Georgia are fantastic in taking care of their personnel, but the majority of departments fail in this area.

When departments fail to administer "psychological first aid," they are ultimately setting their officers up for failure. Oftentimes, symptoms are manifested when an officer begins drinking alcohol excessively after a critical work related incident. Shortly afterwards, the individual begins consistently calling in sick. Eventually they are fired because of a DUI, or coming to work after drinking. As a result of losing their job, the former officer begins to experience a number of negative consequences of their

behavior including the financial backlash, failed marriage/relationships, or worse. Of the number of police suicides annually, many could have been prevented if the agency was proactive. Of the estimated 18,000 law enforcement agencies nationwide, only about 2% have programs that address law enforcement PTSD or suicide prevention.

From a financial perspective, education, training and generally caring about personnel is more cost effective than a passive response that results in insurance payouts, law suits and broken officers. Agencies must view their staff as an investment, not an expense. When a department hires an officer, the department pays to train and equip them and provides liability insurance. Annual training in the area of officer mental health, stress awareness, coping mechanisms (maladaptive and healthy), physical fitness and resiliency should be mandatory.

Peer Counseling Programs

An evolving practice that is demonstrating great promise for addressing the needs of officers is Peer Counseling Programs. Since the days of Sir Robert Peele, considered to have been the father of modern law enforcement, "informal" peer support has occurred. Getting together after a shift for a beer and talking about anything from the departmental hierarchy to a tragic incident has gone on for more than 200 years. This, in and of itself, is a form of informal peer support and can be therapeutic. Normalizing reactions to stressors is done through conversation. Gaining a level of perspective through another's eyes who shares a similar experience may well be the best form of help in the aftermath of a

critical incident. The credibility offered from someone who has "walked a mile in your shoes" is irreplaceable. As important as psychiatry and counseling is, these types of interventions or services, do not offer what peer support can accomplish. Often times, peer support can serve as a buffer between an impacted individual and counseling or psychotherapy. Many times, the latter is not needed when an effective, formal peer support element is in place.

It has long been known that war veterans returning from combat do not open up to just anyone about their experiences. Whether a combat veteran just returned from a deployment or the veteran was at Pearl Harbor in December of 1941, for the most part, they won't talk about what they saw or experienced to people who don't know what they know. Normalizing the reactions of someone who suffers from combat related Post Traumatic Stress Disorder can often times be accomplished by those who have seen and experienced the horrible images of war themselves. Acceptance as an equal because of shared experiences is the essence of peer support. As with the military, law enforcement has a certain level of bravado and macho attitude associated with it. Although this is not always the case, it still can make it more difficult when attempting to reach out to impacted individuals in the aftermath of a critical incident. This is why shared similar experiences between trained peers and impacted individuals are so important. A critical incident can be defined as an overwhelming, threatening, terrifying, disgusting or unusually challenging event that disrupts normal coping abilities and has the potential to create positive growth, or significant human distress. A critical incident or series of incidents can change beliefs, world views and values. These changes come not from the incidents themselves, but from the

psychological responses to the incidents, both in the immediate and long term aftermath.

When officers are experiencing sustained stress reactions as a result of a critical incident, they have sunk into a psychological crisis. When this occurs, one's normal coping mechanisms have failed. This can usually be seen by family and co-workers. When typical patterns of behavior become distressed, there are usually signs of impairment and dysfunction. Although it would have been optimal to intervene prior to reaching psychological crisis, it becomes critical to take action when a co-worker is showing signs of impairment and dysfunction. There are many studies to conclude that early peer and psychological intervention can greatly reduce the need for more intense counseling or therapy later.

Prior to a critical incident, increased awareness and training plays a major role when someone is faced with a new traumatic experience. Educating individuals of the normal stress reactions that occur immediately after of a critical incident can help ensure the transition to a "new normal" not as disruptive.

When a trained peer support team performs an intervention, the goals are Stabilization, Symptom Reduction, and a Return to Adaptive Functioning. From this, a facilitation of access to continued care from a therapist, social worker or psychiatrist, should be in place.

Peer team interventions include One-on-One meetings, Defusing's, Crisis Management Briefings, Critical Incident Stress Debriefings and Follow up. The first three of these interventions typically occur within twenty-four hours of a critical incident. One-on-One meetings and Defusing's need to occur almost immediately after the incident has occurred. A Crisis Management Briefing (CMB)

involves a large group and is more of a "these are the facts" kind of meeting. A person of authority or who has knowledge of the incident will typically explain the incident, along with other people of relevance such as representative from FEMA, a district attorney, sheriff, fire chief, hospital representative, etc.

It is not uncommon for persons who were involved in the same incident to offer different versions of what took place. A CMB is designed to get attendees on the same page and helps to stop the rumor mill. A CMB also affords attendees an opportunity to learn about normal reactions to stress.

A Critical Incident Stress Debriefing (CISD) normally occurs a few days to a week after a critical incident, but can occur later if circumstances dictate. A CISD involves small, homogenous groups. Participants may have played different roles during an incident, but witnessed and experienced most of the same things. The timing of a CISD can be crucial. For example: In the case of a police officer who is murdered in the line of duty, there is a certain order of events that need to take place. The suspect must be apprehended (or deceased), the funeral must occur, and then the CISD should be held. Putting the CISD before any of the other events will adversely affect it effectiveness, because few people want to be there or are not ready to begin processing what has happened. One of the areas where agencies sometimes fail is during the Follow-up. After a CISD, peer support team members can get lost in their other duties or are already neck deep in another critical incident.

Currently, there are peer support teams in nearly every state that subscribe to the Critical Incident Stress Management model (CISM). This model spells out the above intervention methodologies and facilitates training to peer team members,

counselors, social workers and psychiatrists through the International Critical Incident Stress Foundation (ICISF). The ICISF hosts classes and advanced coursework, to include topics such as Police Suicide, Responding to Mass Casualties, Line of Duty Deaths, Individual Interventions and the Mental Health of Peer Members. In total, there are nearly forty classes.

The Georgia State Patrol's (GSP) Critical Incident Support Team (CIST) became the first state police agency in the nation to become nationally certified in Critical Incident Emergency Response. This endeavor took nearly three years to achieve. It involved members taking a total of seven required classes, the placement of a team administrator, the hiring of a clinical director and a formal policy in place regarding peer support. The GSP CIST has assisted law enforcement officers, firefighters, paramedics and spouses in seven states.

The Post Critical Incident Seminar (PCIS) is an intense, three day seminar in which peer support, professional psychological counseling, teaching and fellowship come together to help get public safety officials past "sticking points" and on the road to a healthier coping environment. It is a perfect form of follow-up to a CISD.

In March 2013, the GSP hosted the State of Georgia's first PCIS in Augusta. Included as participants were officers from Sandy Hook, Columbine and Virginia Tech. These were the sites of the three worst school shootings in our nation's history. Also included were officers from the Augusta, GA – Aiken, SC area who were involved in three line of duty deaths within three months. These three murders all occurred within a twenty five mile radius. In the end, forty seven people left Augusta better than they arrived three days prior. Mission accomplished. In March, 2014, GSP partnered

with the GBI to host its second PCIS on St. Simons Island with more than forty three participants from six states attending.

Legal Issues

House Bill 872, annotated as O.C.G.A. § 24-5-510 was signed into law by Governor Nathan Deal on April 17, 2014, and becomes law on July 1, 2014. This new code creates a privileged communication between law enforcement officers and peer counselors. There are a few exceptions to this new code section including:

- The disclosure is authorized by the client, or if deceased by the executor or next of kin;
- Compelled by a court order;
- The peer counselor was an initial responding officer, witness, or party to the act;
- The communication was made when the peer counselor was not performing official duties; or
- The client is charged with a crime.

The signing of this law should calm the fears of all officers that what they will discuss in the aforementioned meetings will be maintained in confidence as now is required by law. This should lead to open discussions that can assist with healing and coping in the aftermath of extremely stressful incidents.

Conclusions and Recommendations

Many of the problems dealing with mental health issues still exist today, as they did when the original paper was published in 2008. Regardless, progress has been made to improving law enforcement officers' response and the mental health service delivery. A number of recommendations are presented for consideration.

The lack of communication between DBHDD and the law enforcement community regarding the advances made in service delivery must be resolved. GACP should consider partnering with other law enforcement associations, Georgia Public Safety Training Center and DBHDD to sponsor regional seminars regarding the response persons who are mentally ill or developmentally disabled, the services available for these individuals, and how to easily access these services.

To properly prepare officers for these encounters, each department needs to provide specific operational procedures to guide officers responding to persons who with mental illness or experiencing diminished capacity. This policy should provide greater emphasis on de-escalation techniques and require officers to consider less intrusive alternatives before employing force (when applicable). These policies should be reviewed on a regular basis.

Law enforcement executives should provide officers with advanced training in dealing with mental health consumers beyond the level currently provided in the Basic Mandate course prior to being assigned to work in an enforcement position.

Agencies should develop a strategic goal of requiring that all officers attend crisis intervention training after they have two years' experience. While some may not seek to be identified as a CIT officer, each officer

needs to have an understanding of how to interact with individuals in crisis.

On-going refresher training should be provided to include evolving approaches to address persons in crisis. This training should include scenario-based exercises to facilitate officers' decision making skills and abilities when encountering persons in crisis.

Where feasible, agencies should develop a specialized unit of crisis intervention officers who are selected based on their temperament, experience, and desire to interact with individuals with mental illness or in mental health crisis. If an agency does not have the resources to develop this program in-house, consideration should be provided to a multi-agency collaboration.

The Georgia Association of Chiefs of Police should consider developing a model policy to guide agencies with implementing this recommendation.

In the coming years, leaders will likely experience greater strain on their already limited budgets. Because of this, it is imperative that the source of the problem be addressed and eliminate the need for law enforcement officers to deal with the mental health services failures. It is not appropriate for mental illness to be treated as a criminal justice issue. To address this, law enforcement executives must continue to network with mental health service providers to ensure the processes are in place to adequately address consumers' needs. Second, law enforcement must continue to be an advocate at the State level for the expansion and accountability of mental health service programs and providers.

The Georgia Association of Chief of Police should partner with the Georgia State Patrol and Georgia Bureau of Investigation to support the on-going development of the state-wide Peer Counseling Initiative. This

should involve the inclusion officers from city and county agencies to be trained and used as peer counselors.

Many officers' mental and emotional disorders are the result of mental and emotional illiteracy. Officers are not taught how to manage their negative thoughts and emotions and some have difficulty controlling them. Law enforcement executives should strive to ensure officers are exposed to courses such as personal relationship training, emotional intelligence training, substance abuse management, and other psycho-educational courses much as they are required to attend firearms, tactical and self-defense training. The use of employee assistance programs, combined with training and a good peer support program appear to be the best method of reaching these goals at the current time.

Law enforcement executives should work with HR representatives to ensure Employee Assistance Programs have the specific skills and abilities to address the unique issues that are common for public safety officers in crisis. As part of this, greater education needs to be provided to law enforcement executives, city and county managers, and state, county, and municipal elected officials regarding issues faced by law enforcement officers, peer counseling programs, and other services that should be made available.

Appendices

Appendix A **DBHDD Adult CSUs by Region Map**

Appendix B **DBHDD Adult CSUs - List**

Appendix C **DBHDD Youth CSUs - List**

Appendix D **Georgia Crisis Response System - Overview**

Appendix E **DBHDD Regional Map with Hospital Service Areas**

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Appendix G **CSBs – Regions – Hospitals – Address/Phone**

Appendix H **Emergency Receiving Evaluations and Treatment Facilities**

Appendix I **BHL Mobile Crisis Response Team Collaboration with EMS and Law Enforcement**

Appendix J **GBI HIPPA Related Information**

Appendix K **Protocol for Linking Mental Health Services to Refugees**

Appendix L **Outline of Basic Law Enforcement Training Course on Mental Health, Mental Retardation and Substance Abuse**

Appendix M **Tactical Communication Styles for Special Needs Subjects**

Appendix N **GBI Policy on Encounters with the Developmentally Disabled**

Appendix O **Guidelines for Peer Support Program**

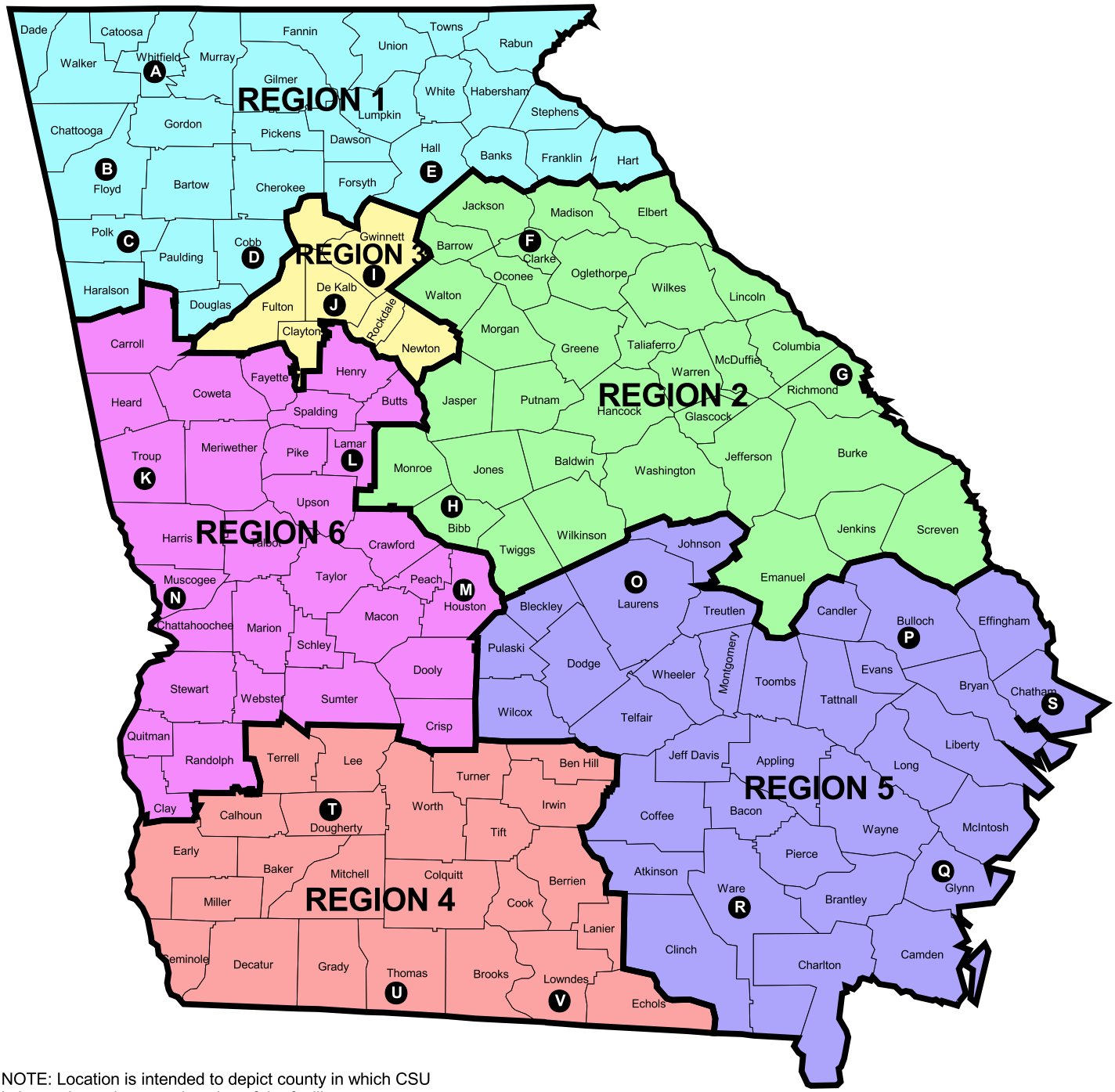
Appendix P **Suicide Prevention Guide for Supervisory Staff**

Appendix Q **SAMSA GAINS Center Trauma Training**

Appendix R **Peer Counseling Legislation House Bill 872 as Passed Version**

APPENDIX A

Georgia Department of Behavioral Health & Developmental Disabilities
Crisis Stabilization Units - Adults
by Region



NOTE: Location is intended to depict county in which CSU is located, not the exact location of the facility.

REGION 1
A - Highland Rivers - Dalton
B - Highland Rivers - Rome
C - Highland Rivers - Cedartown
D - Cobb CSB - Smyrna
E - Avita Community Partners - Flowery Branch

REGION 2
F - Advantage Behavioral Health - Athens
G - Serenity Behavioral Health - Augusta
H - River Edge CSB - Macon

REGION 3
I - View Point Health - Lawrenceville
J - DeKalb CSB - Decatur

REGION 4
T - Aspire BH - Albany
U - Georgia Pines CSB - Thomasville
V - South Georgia CSB - Valdosta

REGION 5
O - CSB of Middle Georgia - Dublin
P - Pineland CSB - Statesboro
Q - Gateway CSB - Brunswick
R - Unison Behavorial Health - Waycross
S - CSU of Savannah - Savannah

REGION 6
K - Pathways CSB - LaGrange
L - McIntosh Trail - Barnesville
M - Phoenix Center - Warner Robins
N - The Bradley Center - Columbus

DBHDD

APPENDIX B

Department of Behavioral Health and Developmental Disabilities
Adult Crisis Stabilization Units

Call the Georgia Crisis and Access Line (GCAL) 1-800-715-4225 to confirm admission.

Region	Map Key	County	City	Crisis Stabilization Unit (CSU)	Community Service Board (CSB) / Parent Organization
1	A	Whitfield	Dalton	**Highland Rivers - Treatment Services** 900 Shugart Road Dalton, GA 30720	Highland Rivers CSB
1	B	Floyd	Rome	**Highland Rivers - Rome CSU** 1 East Woodbine Ave Rome, GA 30165	Highland Rivers CSB
1	C	Polk	Cedartown	**Highland Rivers-Residential Treatment Unit** 180 Water Oak Drive Cedartown, GA 30125	Highland Rivers CSB
1	D	Cobb	Smyrna	**Cobb Stabilization Unit** 5400 South Cobb Drive Smyrna, GA 30080	Cobb/Douglas CSB
1	E	Hall	Flowery Branch	**AVITA CSU** 4331 Thurmond Tanner Parkway Flowery Branch, GA 30542	Avita Community Partners (formerly GA Mountains CSB)
2	F	Clarke	Athens	**The Vantage Point** 195 Miles Street Athens, Georgia 30601	Advantage Behavioral Health Systems
2	G	Richmond	Augusta	**Serenity Behavioral Health Systems Crisis Stabilization Program** 3421 Mike Padgett Highway, Bldg. C Augusta, Georgia 30906	Serenity Behavioral Health Systems (formerly CSB of East Central Georgia)
2	H	Bibb	Macon	**River Edge-The Recovery Center** 3675 Fulton Mill Road Macon, GA 31206	River Edge Behavioral Health Center
3	I	Gwinnett	Lawrenceville	**View Point -Charles L. Knight Adult CSU** 615 Lawrenceville-Sewanee Rd. Lawrenceville, GA 30045	View Point Health (formerly Gwinnett-Rockdale-Newton CSB)
3	J	Dekalb	Decatur	**DeKalb Regional Crisis Center** 450 Winn Way Decatur, GA 30030	DeKalb CSB

Department of Behavioral Health and Developmental Disabilities
Adult Crisis Stabilization Units

Call the Georgia Crisis and Access Line (GCAL) 1-800-715-4225 to confirm admission.

Region	Map Key	County	City	Crisis Stabilization Unit (CSU)	Community Service Board (CSB) / Parent Organization
4	T	Dougherty	Albany	**Albany Area CSB Crisis Stabilization & Residential Detoxification** 601 West 11th Avenue Albany, GA 31702	Aspire Behavioral Health (formerly Albany Area CSB)
4	U	Thomas	Thomasville	**Georgia Pines Community Service Board** 525 Cassidy Road Thomasville, GA 31792	Georgia Pines CSB
4	V	Lowndes	Valdosta	**Behavioral Health Services of S. GA** 3116 North Oak Street Valdosta, GA 31602	South Georgia CSB
5	O	Laurens	Dublin	**Quentin Price MD CSU** 118 Thomas Lane Dublin, GA 31021	CSB of Middle Georgia
5	P	Bulloch	Statesboro	**Pineland-John's Place** 4 West Altman Street Statesboro, GA 30458	Pineland CSB (MH/DD/AD)
5	Q	Glynn	Brunswick	**Gateway BHS CSU** 121 Burgess Street Brunswick, GA 31523	Gateway Behavioral Health Services (formerly CSB)
5	R	Ware	Waycross	**St. Illa CSU** 3455 Harris Road Waycross, GA 31501	Unison Behavioral Health
5	S	Chatham	Savannah	**CSU of Savannah** 1150 Cornell Ave Savannah, GA 31406	UHS of Savannah (aka Coastal Harbor)
6	K	Troup	LaGrange	**Pathways- Second Season** 124 Gordon Commercial Drive LaGrange, GA 30240	Pathways Center for Behavioral and Developmental Growth (CSB)
6	L	Lamar	Barnesville	**McIntosh Trail CSB - Pine Woods** 700 Veterans Parkway Barnesville, GA 30204	McIntosh Trail CSB
6	M	Houston	Warner Robins	**Phoenix Pointe** 940 C. Highway 96 Warner Robins, GA 31088	Phoenix Center CSB
6	N	Muscogee	Columbus	**The Bradley Center of St. Francis Hospital** 2000 16th Avenue Columbus, GA 31901	St. Francis Hospital, Inc.

APPENDIX C

Department of Behavioral Health and Developmental Disabilities
Crisis Stabilization Units for Youth

Call the Georgia Crisis and Access Line (GCAL) 1-800-715-4225 to confirm admission.

DBHDD Region	County	City	Crisis Stabilization Unit (CSU)	Ages Served	Community Service Board (CSB) / Parent Organization
2	Bibb	Macon	**River Edge-C&A CSU** 3575 Fulton Mill Rd Macon, GA 31206	Ages 5-14	River Edge Behavioral Health Center
3	Dekalb	Decatur	**View Point -Adolescent CSU** 2591 Candler Road Decatur, GA 30032	Ages 14-18	View Point Health (formerly Gwinnett-Rockdale-Newton CSB)
5	Chatham	Bloomingdale	**Lakeside Center** 600 DOT Barn Road Bloomingdale, Georgia 31302	Ages 5-18	Georgia Regional Hospital-Savannah Telephone:
6	Meriweather	Greenville	**Pathways-Hope's Corner** 756 Woodbury Road Building B, Suite 101 Greenville, GA 30222	Ages 5-18	Pathways Center for Behavioral and Developmental Growth

APPENDIX D

DBHDD

Georgia Crisis Response System for Individuals with Developmental Disabilities

Division of Developmental Disabilities

The Georgia Crisis Response System for Individuals with Developmental Disabilities (GCRS-DD) is a system of care that is accessed through a single point of entry, which is the Georgia Crisis Access Line (GCAL). The GCRS-DD provides community-based crisis supports as an alternative to institutional placement, emergency room care, or involvement of law enforcement (including incarceration). GCRS-DD serves individuals with developmental disabilities aged 5 years and older in *acute crisis situations* who

- Have documented evidence of an intellectual/developmental disability prior to age 18 or a closely related disability prior to age 22 or
- Have had a screening suggesting a developmental disability.

What Caregivers Should Do in a Crisis Situation

- First attempt to resolve and/or return the individual to a pre-crisis state.
- If the individual has a behavior plan, use the strategies in the plan to resolve the crisis.
- If unable to resolve the situation and the individual or others are at risk of harm, call GCAL (1-800-715-4225).
- If there is a medical emergency or a crime is being committed, call 911.

GCAL intake personnel will assess the sitaution and resolve the crisis by telephone or dispatch a Mobile Crisis Team if a face-to-face intervention is needed.

Mobile Crisis Team

At a minimum, a Mobile Crisis Team includes a licensed clinical social worker (LCSW), a behavior specialist, and direct support staff. Other team members may include a registered nurse, safety officers, additional social workers and support staff. Physicians are available for consultation.

The Mobile Crisis Team arrives at the scene of the crisis within 1½ hours to assess the crisis situation. Following an assessment of the individual in crisis, the LCSW communicates all recommendations for continued interventions and referrals for additional supports within 24 hours to the individuals, families/caregivers, and other stakeholders (i.e., Support Coordinators, State Service Coordinators, Planning List Administrators, and Intake and Evaluation).

Support Services

The Mobile Crisis Team coordinates intensive in-home and out-of-home supports provided on a time-limited basis (not to exceed 7 days) to resolve the crisis. Any extension beyond 7 days has to be approved by the Regional Service Administrator, Developmental Disabilities, in the region of the individual's residence.

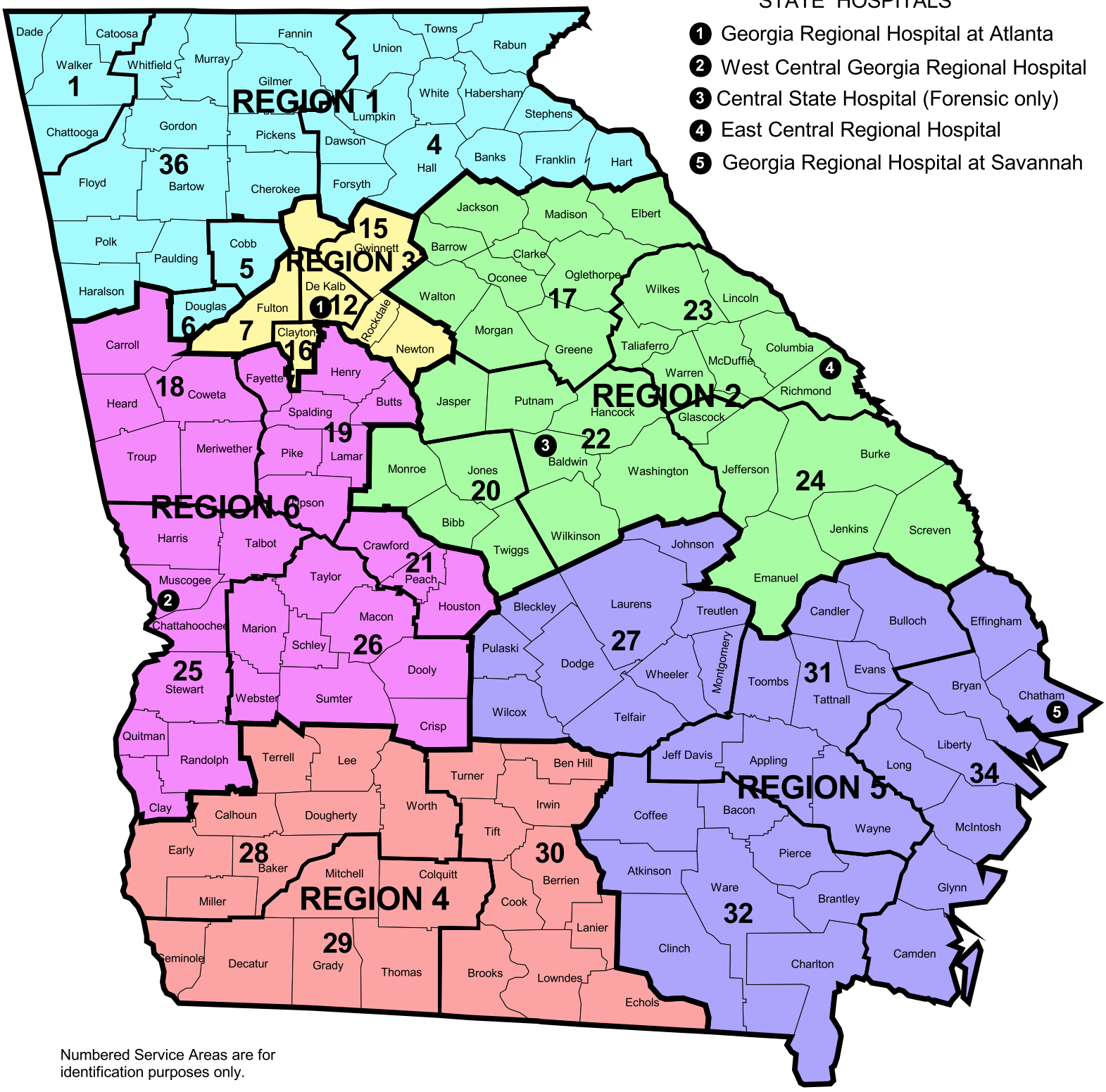
- Out-of-Home Crisis Support Homes are for adults andserve no more than 4 individuals at a time.
- Temporary and Immediate Support (TIS) Homes are for children/youth 10–17 years old and serve no more than 4 individuals at a time.
- Intensive In-Home Supports are provided for children aged 5–9 years old.

For additional information, contact DBHDD, Division of Developmental Disabilities:

(404) 463-8037

APPENDIX E

Georgia Department of Behavioral Health & Developmental Disabilities
Regional Map with Community Service Areas
Effective January 1, 2014



Numbered Service Areas are for identification purposes only.

1 - Lookout Mountain Community Services
4 - Avita Community Partners
5 - Cobb Community Service Board
6 - Douglas Community Service Board
7 - Fulton County
12 - DeKalb Community Service Board
15 - View Point Health
16 - Clayton Community Service Board
17 - Advantage Behavioral Health Systems
18 - Pathways Center for Behavioral & Developmental Growth
19 - McIntosh Trail Community Service Board
20 - River Edge Behavioral Health Center
21 - Phoenix Center Behavioral Health Services
22 - Oconee Community Service Board
23 - CSB of East Central Ga (Serenity Behavioral Health)
24 - Ogeechee Behavorial Health Services
25 - New Horizons Community Service Board
26 - Middle Flint Behavorial Healthcare
27 - Community Service Board of Middle Georgia
28 - Albany Area Community Service Board
29 - Georgia Pines Community MHMRSA Services
30 - Behavioral Health Services of South Georgia
31 - Pineland Area Community Service Board
32 - Unison Behavioral Health (formerly Satilla CSB)
34 - Gateway Community Service Board
36 - Highland Rivers Community Service Board

DBHDD, Office of Decision Support (6/18/2014)

APPENDIX F

March 1, 2014 (revised) | **GEORGIA DBHDD REGIONAL OPERATIONS** | **Michael Link, Regional Operations Director**

REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6
705 North Division St, Bldg 104 Rome, Georgia 30165 Phone: (706) 802-5272 Toll Free: (800) 646-7721 I&E Office (Toll Free (877) 217-4462) 650 Henderson Dr, Suite 430 Cartersville, Georgia 30120 Phone: (770) 387-5440 Fax: (770) 387-5445	3405 Mike Padgett Hwy, Bldg 3 Augusta, Georgia 30906 Phone: (706) 792-7733 Toll Free: (866) 380-4835 Fax: (706) 792-7284	100 Crescent Centre Pkwy Suite 900 Tucker, Georgia 30084 Phone: (770) 414-3052 Fax: (770) 414-3048	400 South Pinetree Boulevard Thomasville, Georgia 31792 Phone: (229) 225-5099 Toll Free: (877) 683-8557 Fax: (229) 227-2918 (Mailing Address) Post office Box 1378 Thomasville, Georgia 31799	1915 Eisenhower Drive Bldg 7 Savannah, Georgia 31406 Phone: (912) 303-1670 Fax: (912) 303-1681 I&E Contact Toll Free: (800) 348-3503 Fax: (912) 351-6309	3000 Schatulga Road Bldg 4 Columbus, Georgia 31907 Phone: (706) 565-7835 Fax: (706) 565-3565
ADMINISTRATION					
Regional Coordinator Charles Fetner (706) 802-5272 Administrative Assistant Pat Robinson (706) 802-5272 Support Svcs. Worker (RPB) Vacant (706) 802-5606 Regional Compliance Officer Marion Gordon (706) 295-6019	Regional Coordinator Audrey Sumner (706) 792-7733 Administrative Assistant Cheryl Bellardino (706) 792-7743 Regional Compliance Officer Dawn Peel (706) 792-7671 Business Financial Manager Eric Loggins (706) 792-7675	Regional Coordinator Lynn Copeland (770) 414-3052 Administrative Assistant Regina Matthews (770) 414-3093 Regional Compliance Officer Lori Hanes (770) 414-3061	Regional Coordinator Kenneth R. Brandon (229) 225-5099 Administrative Assistant Jacqueline Davis (229) 225-3980 Regional Compliance Officer Jenny DeLoach (229) 225-4082 Business Financial Manager Carol J. Williams (229) 225-5508	Regional Coordinator Charles Ringling (912) 303-1670 Executive Secretary Vacant Regional Compliance Officer Vacant (912) 351-6700	Regional Coordinator Leland "Lee" Johnson (706) 565-3478 Administrative Assistant Erika Ball (706) 565-7835 Regional Compliance Officer Emily Gregory (706) 565-3680 Business Financial Manager Dawn Robinson (706) 568-2151
BEHAVIORAL HEALTH					
Regional Services Administrator Debbie Atkins (706) 802-5604 Case Expediters Belinda Pullum (706) 802-5277 Vacant MHAD Program Specialists Nora Hall (706) 802-5278 Vicki Harrison-Beal (706) 802-5602	Regional Services Administrator Keith Edmonds (706) 792-7696 Executive Secretary Jessica Seigler (706) 771-4828 Case Expediters Jennifer Thomas (706) 792-7694 June Stewart (706) 792-7670 Robert Johnson (706) 771-4784 Transition Coordinator Patrick Steele (706) 792-7285 MHAD Program Specialist Vacant	Regional Services Administrator Gwen Craddieth (770) 414-3056 Executive Secretary Dion Cannon (770) 414-2628 Case Expediters Enchante Franklin (770) 414-3063 Terrence Franklin (404) 243-2126 Transition Coordinators Troy McQueen (770) 414-3062 Anna McLaughlin (770) 414-3066 MHAD Program Specialist Vacant	Regional Services Administrator Jennifer Dunn (229) 225-3981 Executive Secretary Judy Barnes (229) 227-3041 Regional Transition C. Humphries – Spec (229)225-3984 Jimmy Bennett - Coor (229) 228-3808 Patty Waters - Coor (229) 227-2518 Case Expediter Sharon Pyles (229) 227-3115 MHAD Program Specialist Vacant	Regional Services Administrator Ted Schiffman (912) 303-1670 Administrative Assistant Sarah Dunbar (912) 303-1670 Regional Transition Jeanette Bacon-Spec (912) 351-6705 Jose Lopez - Coor (912) 356-2403 Nicole Fields - Coor (912) 303-1868 MHAD Program Specialist JaVonna Daniels (912) 351-6414 Vacant (912) 303-1670	Regional Services Administrator Chris Newland (706) 568-2243 Executive Secretary Lawonna Parks (706) 568-2253 Case Expediters Angela Tommey (706) 565-3585 Sandra Vega (706) 565-3619 Transition Coordinator Sam Page (706) 565-3610 Sarah Romero (706) 569-2974 MHAD Program Specialist Jackie Ezell (706) 565-3592
DEVELOPMENTAL DISABILITIES					
Regional Services Administrator Ron Wakefield (770) 387-5440 Executive Secretary Karen Hocker (770) 387-5440 I&E Manager Lesa Hope (770) 387-4022 Planning List Admin Supervisor Trudee Britt (770) 387-4018 LOC Registered Nurse Kelly Sayer (770) 387-5440 Intake Coordinator Witni Jackson (770) 387-5440 Case Expediters Maxine Carlock (770) 387-5440 Karen Cawthon (706) 802-5276 Operations Analysts Cecilia Duval (770) 387-4028 Peggy Prough (770) 387-4021 Sheila Stubbs (770) 387-5440 Tomika Turner (770) 387-4029	Regional Services Administrator Karla Brown (706) 792-7695 I &E Manager Betty Dyches (706) 792-7693 Planning List Admin Supervisor Normand Tremblay (706) 792-7286 LOC Registered Nurse Martha Panter (706) 792-7741 Virginia Williams (706) 792-7206 Intake Coordinator Elise Beumer (706) 792-7741 Case Expediters Eric Marriott (706) 792-7739 Laura Giles (478) 445-5827 Kimberly Dempsey (706) 792-7663 Kimberly Redd (706) 792-7692 Operations Analysts Jessie Watts (706) 792-7737 Lynette Walton (706) 792-7679 Cassandra Ewing (706) 792-7738	Regional Services Administrator Carole Crowley (770) 414-3017 Executive Secretary Kathleen Browne (770) 414-3046 I&E Manager Debora Cook (770) 414-3047 Planning List Admin Supervisor Develyn Stovall (770) 724-6365 LOC Registered Nurse Barbara Goolsby (770) 414-3013 Intake Coordinator Vanessa Pryor (770) 414-3064 Case Expediters Inell Jackson (770) 414-3067 Leah Matthews (770) 414-2614 Rhonda Flint – ER (770) 414 3060 Operations Analysts Arnaca Buggs (770) 414-3197 Brenda Carter (770) 414-3019 Jennifer Bryant (770) 414-3059 Kay D. Fishenden (770) 414-3044 Shandria Davis (770) 414-3058 HQM Darletha Charleston (770) 414-3065	Regional Services Administrator Michael Bee (229) 227-2412 Executive Secretary Marilyn Bryant (229) 227-2898 I &E Manager Marcy Burns (229) 227-2924 Planning List Admin Supervisor Belinda Stephen (229) 227-2912 LOC Registered Nurse Vickie Fountain (229) 225-5099 Intake Coordinator Robyn McQueen (229) 225-5099 Case Expediters Angela Jones (229) 227-2926 Dale Goodman (229) 225-5099 Operations Analysts Kathy Jarosz (229) 227-3220 Sandra Green (229) 227-3114 HQM Debbie Strickland (229) 227-2984	Regional Services Administrator Stephanie Stewart (912) 303-1649 Interim I &E Manager Ramona Pullin (912) 303-1649 Interim Plan List Admin Supervisor William "Tee" Scott (912) 351-6513 Toll Free: (866) 314-0332 LOC Registered Nurse Debra Norman (912) 356-2468 Intake Coordinator Eunice Banks (912) 351-6435 Case Expediters Susan Bradley (404) 831-4057 William "Tee" Scott (912)414-8259 Operations Analysts Augustine Ozobia (912) 303-1916 Earl Stanford (912) 303-1676 Nancy Haysman (912) 351-6798 HQM Kimberly Glenn (912) 303-1997	Regional Services Administrator Valona Baldwin (706) 565-3692 Executive Secretary Vacant I&E Manager Mable Semper (706) 569-2971 Planning List Admin Supervisor Linda Dykes (706) 565-3567 LOC Registered Nurse Rebecca Huggins (706) 565-3611 Intake Coordinator Florence Agbasi (706) 565-3636 Case Expediters Lynn Kirby (CSH) (478) 445-8281 Pamela Byrd (706) 565-2421 Operations Analysts Charmeian Smith (706) 568-5328 Kawanda Duncan (706) 565-7856 Rosa Sanders (706) 565-3620 HQM Deborah Grant (706) 563480

APPENDIX G

DMHDDAD REGIONAL OFFICES, REGIONAL HOSPITALS AND COMMUNITY SERVICE BOARDS (Revised 10.31.2012)

Region	Regional Hospital	Community Service Board	Counties Served	Region
REGION ONE (Page 1 of 1)				
DBHDD Region 1 Office 705 North Division Street Building 104 Rome, Georgia 30165 Phone 706-802-5272 Fax 706-802-5280 1-800-646-7721		***Tom Ford, Director*** **Lookout Mountain Community Services** P.O. Box 1027, Lafayette, GA 30728 Phone:706-638-5584 FAX:706-638-5585 **Georgia Access & Crisis Line - 1-800-715-4225**	Catoosa Chattooga Dade Walker	1 1 1 1
		Jason Bearden, CEO/Executive Director **Highland Rivers Community Service Board** 1401 Applewood Drive, Suite 5 Dalton, Georgia 30720 Telephone: (706) 270-5000 FAX: (706) 270-5124 jasonbearden@highlandrivers.org **S.P.O.E. ACCESS NUMBER: 1-800-923-2305** ***Haralson Behavioral Health Services** (which provides some MHDDAD services to county and is operated by Board of Health) Telephone: (770) 537-2367 FAX: (770) 537-1203 **Georgia Access & Crisis Line - 1-800-715-4225**	Bartow Cherokee Fannin Floyd Gilmer Gordon Haralson* Murray Paulding Pickens Polk Whitfield	1 1 1 1 1 1 1 1 1 1 1 1
		Todd Citron, Director **Cobb-Douglas CSB** 3830 S. Cobb Drive, Suite 300 tcitron@cobbcsb.com Smyrna, GA 30080 Phone: 770-429-5000 Fax: 770-528-9824 **Georgia Access & Crisis Line - 1-800-715-4225**	Cherokee Cobb Douglas	1 1 1 1 1 1
		Cindy McLaughlin, CEO **Avita Community Partners** 4331 Thurmond Tanner Road Flowery Branch, GA 30542 Phone: 678-513-5700 Fax: 678-513-5829 cindy.mclaughlin@avitapartners.org **Georgia Access & Crisis Line - 1-800-715-4225**	Bankx Dawson Forsyth Franklin Habersham Hall, Hart Lumpkin Rabun Stephens Towns Union, White	1 1 1 1 1 1 1 1 1 1 1
		Mary Wise, CEO, Tanya Smith, Director **Georgia H.O.P.E.** (provides Adult MH/AD services) 1622 Hickory Street Dalton, Georgia 30720 **Telephone**: (706)-279-0405 **FAX**: (706) 279-4190 tanyasmith@gahope.org **Georgia Access & Crisis Line - 1-800-715-4225**	Dade Fannin Gilmer Murray Whitfield	1 1 1 1 1

Region	Regional Hospital	Community Service Board	Counties Served	Region
REGION TWO (Page 1 of 1)				
Audrey Sumner Regional Coordinator acsumner@dhr.state.ga.us BB: 404-683-1879 **Karla Brown** DD Regional Services Administrator kbrown@dhr.state.ga.us Direct Line: 706-792-7695 BB: 706-691-6253 **Keith Edmonds** BH Regional Services Administrator kedmonds@dhr.state.ga.us Direct Line: 706-792-7696 BB: 706-831-8516 3405 Mike Padgett Highway Building 3 Augusta, Georgia 30906 Phone 706-792-7733 FAX 706-792-7740 Toll free 1-866-380-4835 **Admin. Asst**: Cheryl Bellardino cmccoy@dhr.state.ga.us	**East Central Regional Hospital (Gracewood)** 100 Myrtle Boulevard Gracewood, Georgia 30812 24 Hour (706) 790-2011 **East Central Regional Hospital (Augusta)** 3405 Mike Padgett Highway Augusta, Georgia 30906 **Nan Lewis** Regional Hospital Administrator nmlewis1@dhr.state.ga.us 100 Myrtle Boulevard Gracewood, Georgia 30812 Phone (706) 790-2030 Fax (706) 790-2025 **Administrative Assistant:** Theresa Crouch tcrouch@dhr.state.ga.us **Vicky Spratlin, M.D.** Clinical Director vespratlin@dhr.state.ga.us 3405 Mike Padgett Highway Augusta, Georgia 30906 Phone (706) 792-7021 or (706) 790-2160 Fax (706) 790-2355	***Charles D. Williamson, CEO*** **Serenity Behavioral Health Systems** 3421 Mike Padgett Highway Augusta, GA 30906-3815 Telephone: (706) 432-7800 FAX: (706) 432-3791 cwilliamson@serenitybhs.com **Georgia Access & Crisis Line - 1-800-715-4225**	Columbia Lincoln McDuffie Richmond Taliaferro Warren Wilkes	2 2 2 2 2 2 2
		Amy Tribble, Director **Ogeechee Behavioral Health Services** P.O. Box 1259 Swainsboro, GA 30401-1259 Telephone: (478) 289-2522 FAX: (478) 289-2544 (Secretary-Donna Almond) atribble@obhs-ga.org **Georgia Access & Crisis Line - 1-800-715-4225**	Burke Emanuel Glascock Jefferson Jenkins Screven	2 2 2 2 2 2
		Cindy A. Darden, Director **Advantage Behavioral Health Systems** 250 North Avenue Athens, GA 30601-2244 Telephone: (706) 389-6739 FAX: (706) 542-9681 cdarden@advantagebhs.org **Georgia Access & Crisis Line - 1-800-715-4225**	Barrow Clarke Elbert Greene Jackson Madison Morgan Oconee Oglethorpe Walton	2 2 2 2 2 2 2 2 2 2
		Angela Hicks-Hill, Director **Oconee Community Service Board** P.O. Box 1827 Milledgeville, GA 31059-1827 Telephone: (478) 445-4817 FAX: (478) 445-4963 oconeejaws@windstream.net **Georgia Access & Crisis Line - 1-800-715-4225**	Baldwin Hancock Jasper Putnam Washington Wilkinson	2 2 2 2 2 2
	Central State Hospital 620 Broad Street Milledgeville, GA 31062 **Dan Howell** Regional Hospital Administrator (Acting) dlhowell1@dhr.state.ga.us 620 Broad Street Milledgeville, GA 31062 Phone (478) 445-4128 Fax (478) 445-6034 **Administrative Assistant:** Jennifer Simmons-Taylor JSTaylor@dhr.state.ga.us **Emile Risby, M.D.** Clinical Director (Acting) edrisby@dhr.state.ga.us 620 Broad Street Milledgeville, GA 31062 Phone (478) 445-4387 Fax (478) 445-6275	***Shannon T. Harvey, CEO*** **River Edge** 175 Emery Highway Macon, GA 31217 Telephone: (478) 751-4515 FAX: (478) 752-1040 sharvey@river-edge.org **Georgia Access & Crisis Line - 1-800-715-4225**	Baldwin Bibb Jones Monroe Putnam Twiggs Wilkinson	2 2 2 2 2 2 2
		Patrick Waters **American Work** 1727 Wrightsboro Rd. Augusta, GA 30904 Telephone: (706) 736-8170 pwaters@americanwork.org **Georgia Access & Crisis Line - 1-800-715-4225**	Burke, Columbia Glascock Hancock Jefferson Jenkins, Lincoln McDuffie Richmond Screven Taliaferro Warren Washington Wilkes	2 2 2 2 2 2 2 2 2 2 2 2

Region	Regional Hospital	Community Service Board	Counties Served	Region
Region Three (Page 1 of 1)				
Michael Link Regional Coordinator milink@dhr.state.ga.us Direct Line: 770-414-3055 BB: 404-353-6342 **Lorraine Brooks** DD Regional Services Administrator lbrooks@dhr.state.ga.us Phone: 770-414-3046 **Lynn Copeland** BH Regional Services Administrator lcopelan@dhr.state.ga.us Phone: 770-414-3056 BB: 404-357-8912 100 Crescent Centre Parkway Suite 900 Tucker, Georgia 30084-7055 Phone 770-414-3052 FAX 770-414-3048 **Admin. Asst**: Regina Matthews rematthews@dhr.state.ga.us	**Georgia Regional Hospital at Atlanta** 3073 Panthersville Road Decatur, Georgia 30037 24 Hour (404) 243-2216 **Rick Gray, Ph.D.** Regional Hospital Administrator rickgray@dhr.state.ga.us Phone (404) 243-2110 Fax (404) 212-4621 **Admin Asst:** Antoinette Short ashort@dhr.state.ga.us **Delquis Mendoza, MD** Clinical Director **(Acting)** dmendoza@dhr.state.ga.us Phone (404) 243-2114 Fax (404) 212-4628	***Gary S. Richey, Director*** **DeKalb Community Service Board** 445 Winn Way, Room 464 **or** *P.O. Box 1648* Decatur, GA 30030-1707 *Decatur, GA 30032* Telephone: (404) 294-3836 FAX: (404) 508-7795 Switchboard: 294-3834 garyr@dekcsb.org **Georgia Access & Crisis Line - 1-800-715-4225**	DeKalb	3
		David Crews, CEO **Viewpoint Health** P.O. Box 687 Lawrenceville, GA 30046-0687 Telephone: (770) 339-5019 FAX: (770) 339-5382 David.Crews@VPHealth.org **Georgia Access & Crisis Line - 1-800-715-4225**	Gwinnett Newton Rockdale	3 3 3
		Aundria Cheever, CEO **Clayton Community MH, AD Developmental Services** 112 Broad Street Jonesboro, GA 30236-1919 Telephone: (770) 478-2280 FAX: (770) 477-9772 Aundria.Cheever@ClaytonCenter.org **Georgia Access & Crisis Line - 1-800-715-4225** **Behavioral Health Services** **853 Battle Creek Road, Jonesboro, GA 30236** **770-478-1099 Hotline, 770-996-4357, FAX 770-478-8722**	Clayton	3

Region	Regional Hospital	Community Service Board	Counties Served	Region
REGION FOUR (Page 1 of 1)				
Ken Brandon Regional Coordinator kbrandon@dhr.state.ga.us Phone: 229-227-5917 **VACANT** DD Regional Services Administrator Phone: **Jennifer W. Dunn** BH Regional Services Administrator jwdunn@dhr.state.ga.us Phone: 229-225-5099 P.O. Box 1378 Thomasville, Georgia 31799 Phone 229-225-5099 FAX 229-227-2918 1-877-683-8557 **Admin. Asst:** Jacqueline Davis jadavis4@dhr.state.ga.us	**Southwestern State Hospital** 400 South Pinetree Boulevard Post Office Box 1378 Thomasville, Georgia 31799 24 Hour (229) 227-2915, 2700 **Eric Carpenter, RHA** gecarpenter@dhr.state.ga.us Phone (229) 227-3020 Fax (229) 227-2883 **Admin Asst: VACANT** **Joseph LeRoy, M.D. ,** Clinical Dir. jbleroy@dhr.state.ga.us Phone (229) 227-2990 Fax (229) 227-2753	***Kay Brooks, Exec. Director*** **Albany Area Community Service Board** P.O. Box 1988 Albany, GA 31702-1988 Telephone: (229) 430-4042 FAX: (229) 430-4047 kbrooks@albanycsb.org **Georgia Access & Crisis Line - 1-800-715-4225**	Baker Calhoun Dougherty Early Lee Miller Terrell Worth	4 4 4 4 4 4 4 4
		Robert Jones, Director **The Georgia Pines Community MHDDAD Services** 1102 Smith Avenue, Suite K Thomasville, GA 31792-1659 Telephone: (229) 225-4370 FAX: (229) 225-4374 bjones@georgiapines.net **Georgia Access & Crisis Line - 1-800-715-4225**	Colquitt Decatur Grady Mitchell Seminole Thomas	4 4 4 4 4 4
		David Sofferin CEO **Behavioral Health Services of South Georgia** 3120 North Oak Street Extension Suite C Valdosta, GA 31602-1007 Telephone: (229) 671-6102 FAX: (229) 671-6755 dsofferin@bhsga.com **Georgia Access & Crisis Line - 1-800-715-4225**	Ben Hill Berrien Brooks Cook Echols Irwin Lanier Lowndes Tift Turner	4 4 4 4 4 4 4 4 4 4

Region	Regional Hospital	Community Service Board	Counties Served	Region
REGION FIVE (Page 1 of 1)				
Charles Ringling Regional Coordinator-Lead CPRINGLING@dhr.state.ga.us BB: 912-704-9059 **VACANT** DD Regional Services Administrator **Ted Schiffman** BH Regional Services Administrator teschiffman@dhr.state.ga.us 1915 Eisenhower Dr., Building 2 Savannah, GA 31406 Phone: 912-303-1670 FAX: 912 303-1681 **Admin. Asst:** Sarah Dunbar sdunbar@dhr.state.ga.us	**Georgia Regional Hospital at Savannah** 1915 Eisenhower Drive Savannah, Georgia 31406 24 Hour (912) 356-2030 **Charles Xiaoshong Li, M.D.** Regional Hospital Administrator CXLI@dhr.state.ga.us Phone (912) 356-2045 Fax (912) 351-3550 **Admin Asst:** Lula Williams lhwilliams@dhr.state.ga.us **Reemon Bishara, M.D.** Clinical Director RBISHARA@dhr.state.ga.us Phone (912) 356-2482 Fax (912) 356-2691	***June DiPolito,* Director** **Pineland Area MH, DD & AD Community Svc. Board** P.O. Box 745 Statesboro, GA 30459-0745 Telephone: (912) 764-6906 FAX: (912) 489-3058 jdipolito@pinelandcsb.org **Georgia Access & Crisis Line - 1-800-715-4225**	Appling Bulloch Candler Evans Jeff Davis Tattnall Toombs Wayne	5 5 5 5 5 5 5 5
		***Frank Bonati,* Dr.PH., Director** **Gateway Behavioral Health Services** 700 Coastal Village Drive Brunswick, GA 31520 Telephone: (912) 554-8500 FAX: (912) 264-0979 bonati@gatewaybhs.org **Georgia Access & Crisis Line - 1-800-715-4225**	Bryan Camden Chatham Effingham Glynn Liberty Long McIntosh	5 5 5 5 5 5 5 5
		Allen Brown, CEO **Satilla Community Services** 1007 Mary Street Waycross, GA 31503 abrown@satillacs.org Telephone: (912) 449-7101 FAX: (912) 287-6660 **Georgia Access & Crisis Line - 1-800-715-4225**	Atkinson Bacon Brantley Charlton Clinch Coffee Pierce Ware	5 5 5 5 5 5 5 5
		Denise Forbes, LCSW, Director **Community Service Board of Middle Georgia** 2121 A Bellevue Road Dublin, GA 31021-2998 Telephone: (478) 272-1190 FAX: (478) 275-6509 dforbes@csbmg.com **Georgia Access & Crisis Line - 1-800-715-4225**	Bleckley Dodge Johnson Laurens Montgomery Pulaski Telfair Treutlen Wheeler Wilcox	5 5 5 5 5 5 5 5 5 5

Region	Regional Hospital	Community Service Board	Counties Served	Region
REGION SIX (Page 1 of 1)				
Leland "Lee" Johnson Regional Coordinator lhjohnson1@dhr.state.ga.us Direct Line: 706-565-3478 BB: 404-326-8626 **Joseph Coleman** DD Regional Services Administrator Jcoleman@dhr.state.ga.us Direct Line: 706-565-3561 BB: 706-987-9871 **Paula Walden** BH Regional Services Administrator pmclemmons@dhr.state.ga.us Direct Line: 706-565-3564 BB: 706-622-1379 3000 Shatulga Rd., Bldg. 4 elbell@dhr.state.ga.us Phone (706)565-7835 FAX (706)565-3565 **Admin. Asst:** Erika Ball elbell@dhr.state.ga.us	**West Central** 3000 Shatulga Rd. Columbus, GA 31907 (706) 568-5207 **John Robertson** Regional Hospital Administrator jlrobertson@dhr.state.ga.us Phone (706) 568-5203 Fax (706) 568-2257 **Admin Asst:** Rebecca Pyke ripike@dhr.state.ga.us **Nicholas Sanchez, M.D.** Clinical Director nisanchez@dhr.state.ga.us Phone (706) 568-5202 **Susan Queen** Assistant Clinical Director squeen@dhr.state.ga.us Phone (706) 568-5202	***Beth Ragan, CEO*** **Middle Flint CSB** P.O. Box 1348 Americus, GA 31709-1348 Telephone: (229) 931-2470 FAX: (229) 931-2474 bethr@sstarga.org	Crisp Dooly Macon Marion Schley Sumter Taylor Webster	6 6 6 6 6 6 6 6
		Sherman Whitfield, CEO **New Horizons CSB** P.O. Box 5328 Columbus, GA 31906 Telephone: (706) 596-5582 FAX: (706) 596-5589 swhitfield@newhorizonscsb.org **S.P.O.E. ACCESS NUMBER: 1-800-715-4225** **Georgia Access & Crisis Line - 1-800-715-4225**	Chattahoochee Clay Harris Muscogee Quitman Randolph Stewart Talbot	6 6 6 6 6 6 6 6
		Mr. Jade Benefield, Director **Pathways Center for Behavioral & Dev.Growth** 120 Gordon Commercial Drive, Suite A LaGrange, GA 30240-5740 Telephone: (706) 845-4045 FAX: (706) 845-4341 jade.benefield@pathwayscsb.org	Carroll Coweta Heard Meriwether Troup	6 6 6 6 6
		Pam McCollum, Director **McIntosh Trail Community Service Board** P. O. Box 1320 1501-A Kalamazoo Drive Griffin, GA 30224 Telephone: (770) 358-8250 FAX: (770) 229-3223 pmccollum@mctrail.org **Georgia Access & Crisis Line - 1-800-715-4225**	Butts Fayette Henry Lamar Pike Spaulding Upson	6 6 6 6 6 6 6
		James Singleton, CEO **Phoenix Center CSB** 940 Highway 96 Warner Robbins, GA 31088 **Telephone:** (478) 988-1002 **FAX:** (478) 988-1106 jamessingleton@phoenixcenterbhs.com	Crawford Houston Peach	6 6 6

APPENDIX H

Department of Behavioral Health and Developmental Disabilities

Emergency Receiving(ER), Evaluation(E), Treatment(T) Facilities

By County

PSYCHIATRIC HOSPITALS	Adult / C&A	County	City	Type
Coastal Behavioral Health	Adult	CHATHAM	Savannah	ERET
Coastal Harbor Treatment Center	C&A	CHATHAM	Savannah	ERET
Riverwoods Behavioral Health System	Adult and C&A	CLAYTON	Riverdale	ERET
Anchor Hospital/Southern Crescent Beh. Health System	Adult	CLAYTON	College Park	ERET
Ridgeview Institute	Adult and C&A	COBB	Smyrna	ERET
Turning Point Care Center	Adult	COLQUITT	Moultrie	ERET
Laurel Heights Hospital	C&A	DEKALB	Atlanta	ERET
Peachford Hospital	Adult and C&A	DEKALB	Atlanta	ERET
Saint Simons by the Sea	Adult and C&A	GLYNN	St. Simons Island	ERET
Lakeview Behavioral Health	Adult and C&A	GWINNETT	Norcross	ERET
SummitRidge Hospital	Adult and C&A	GWINNETT	Lawrenceville	ERET
Crescent Pines Hospital	Adult and C&A	HENRY	Stockbridge	ERET
Greenleaf Center	Adult and C&A	LOWNDES	Valdosta	ERET
Lighthouse Care Center of Augusta	C&A	RICHMOND	Augusta	ERET
ACUTE CARE HOSPITALS	**Adult / C&A**	**County**	**City**	**Type**
Appling Health Care Geriatric Behavioral Health Unit	Adult	APPLING	Baxley	ERET
Coliseum Center for Behavioral Health	Adult	BIBB	Macon	ERET
Medical Center of Central Georgia	Adult	BIBB	Macon	ERET
Willowbrooke at Tanner	Adult and C&A	CARROLL	Villa Rica	ERET
Memorial Health University Medical Center/Center for Behavioral Medicine	Adult	CHATHAM	Savannah	ERET
Wellstar Cobb Hospital	Adult	COBB	Austell	ERET
Wellstar Kennestone Hospital	Adult and C&A	COBB	Marietta	**ERE**
Grady Health System - Dept. of Behavioral Health	Adult	DEKALB/FULTON	Atlanta	ERET
Wesley Woods Geriatric Hospital	Adult	DEKALB	Atlanta	**Evaluation, Treatmemt only**
Dodge County Hospital	Adult and C&A	DODGE	Eastman	**ERE**
Phoebe Putney Memorial Hospital	Adult	DOUGHERTY	Albany	ERET
Atlanta Medical Center	Adult	FULTON	Atlanta	ERET
Northeast Georgia Medical Center	Adult and C&A	HALL	Gainesville	ERET
Houston Medical Center	Adult	HOUSTON	Warner Robins	ERET
Bradley Center/ St. Francis Hospital	Adult and C&A	MUSCOGEE	Columbus	ERET
Trinity Hospital of Augusta	Adult	RICHMOND	Augusta	ERET
Archbold Northside Center for Beh. Health & Psychiatric Care	Adult	THOMAS	Thomasville	**ERE**
Grady Health System - Dept. of Behavioral Health	Adult	FULTON	Atlanta	ERET

DBHDD Behavioral Health Licensing Unit 7/16/2014

Department of Behavioral Health and Developmental Disabilities

Emergency Receiving(ER), Evaluation(E), Treatment(T) Facilities

By County

STATE PSYCHIATRIC HOSPITALS	Adult / C&A	County	City	Type
Georgia Regional Hospital/Savannah	Adult	CHATHAM	Savannah	ERET
Georgia Regional Hospital/Atlanta	Adult	DEKALB	Decatur	ERET
West Central Ga. Regional Hospital	Adult	MUSCOGEE	Columbus	ERET
East Central Regional Hospital	Adult	RICHMOND	Augusta	ERET
ADULT CRISIS STABILIZATION UNITS (CSU)	**Adult / C&A**	**County**	**City**	**Type**
The Recovery Center - River Edge	Adult	BIBB	Macon	ERE
John's Place - Pineland	Adult	BULLOCH	Statesboro	ERE
CSU of Savannah	Adult	CHATHAM	Savannah	ERE
The Vantage Point - Advantage BHS	Adult	CLARKE	Athens	ERE
Cobb Stabilization Unit	Adult	COBB	Smyrna	ERE
DeKalb Reg Crisis Center	Adult	DEKALB	Decatur	ERE
Albany Area CSB CS/Res/Detox	Adult	DOUGHERTY	Albany	ERE
Rome Crisis Stabilization Unit - Highland Rivers	Adult	FLOYD	Rome	ERE
Gateway BHS CSU	Adult	GLYNN	Brunswick	ERE
Charles L. Knight Adult CSU - Viewpoint	Adult	GWINNETT	Lawrenceville	ERE
AVITA CSU - Georgia Mountain Community Services	Adult	HALL	Flowery Branch	ERE
Phoenix Pointe	Adult	HOUSTON	Warner Robins	ERE
Pine Woods - McIntosh Trail CSB	Adult	LAMAR	Barnesville	ERE
The Quentin Price MD CSP - CSB of Middle GA	Adult	LAURENS	Dublin	ERE
Behavioral Health Services of South Georgia	Adult	LOWNDES	Valdosta	ERE
The Bradley Center of St. Francis	Adult	MUSCOGEE	Columbus	ERE
Residential Treatment Unit - Highland CSB	Adult	POLK	Cedartown	ERE
Serenity Behavioral Health Systems CSP - CSB of East Central GA	Adult	RICHMOND	Augusta	ERE
Georgia Pines BHCC	Adult	THOMAS	Thomasville	ERE
Second Season - Pathways	Adult	TROUP	LaGrange	ERE
St ILLA CSU - Satilla CSB	Adult	WARE	Waycross	ERE
Treatment Services - Highland Rivers	Adult	WHITFIELD	Dalton	ERE
CHILD/ADOLESCENT CRISIS STABILIZATION UNITS (CSU)	**Adult / C&A**	**County**	**City**	**Type**
River Edge C&A CSU	C&A	BIBB	Macon	ERE
Lakeside Center	C&A	CHATHAM	Bloomingdale	ERE
Adolescent Crisis Stabilization Unit - View Point	C&A	DEKALB	Decatur	ERE
Hope's Corner - Pathways	C&A	MERIWEATHER	Greenville	ERE

DBHDD Behavioral Health Licensing Unit 7/16/2014

APPENDIX I

Georgia Crisis & Access Line
A crisis has no schedule. Help is available 24/7 for problems with mental health, drugs, or alcohol.
Call 1-800-715-4225 or visit us online at mygcal.com

BHL Mobile Crisis Response Services has partnered with Grady Health Services in an innovative collaboration designed to take some of the services offered in the ED into the community.

Some time ago, Grady Hospital identified that individuals presenting to the emergency department requesting assistance with mental health services were often finding that the emergency department was not the best place for them to receive assistance. Most individuals were discharged from the emergency department with a referral to other services after spending lengthy amounts of time waiting and being evaluated. This was clearly a poor use of available resources.

As a 911 provider, Grady EMS also found that often individuals were calling 911 for assistance with mental health concerns that were not truly emergent. Ambulance crews only had two options for outcomes on these cases: transport the individual to the ED for evaluation or have the individual refuse transport and remain at their location of origin without receiving any kind of mental health evaluation or treatment. With only these two options at their disposal, EMS crews were forced to transport many individuals to the ED despite the likelihood that the ED was not the most appropriate place for them to receive services. At times, some individuals were refusing services when crews felt like they should be transported.

In an effort to address some of these concerns, Grady EMS decided to change their strategy. They partnered with BHL, a provider of crisis services for mental health, to find new ways to respond to community mental health concerns. Grady provided a vehicle (an SUV rather than an ambulance) and a paramedic, and BHL provided a licensed mental health clinician. Together, the paramedic and clinician began responding to some of the 911 dispatches that appeared to be of a mental health nature. They found that they were able to provide an evaluation on scene and make better decisions about what kinds of treatment individuals may need. Essentially, by bringing the assessor to the caller, they saved the trip into the ED, the time the individual waited for evaluation, and the manpower it took to manage that scenario. Via their existing partnerships with multiple mental health providers, the BHL clinician was often able to provide referrals on scene without having to transport the individual to the emergency department. At other times, the clinician was able to determine that an individual was at severe risk of harm due to mental health concerns and execute a 1013 to ensure that the individual received appropriate services without refusing treatment.

The results were dramatic. Grady EMS saw a substantial reduction in the number of individuals they were transporting to the ED with mental health complaints. They found that the amount of sedating medications they used was also reduced dramatically. (The best theory is that with a clinician available to help de-escalate and manage scenes involving mental health concerns, individuals were less likely to become agitated and require such interventions as sedation and restraint.) Grady ED reported a significant decline in the number of individuals presenting with mental health concerns. These reductions translated into substantial monetary savings for the hospital and the EMS service and more appropriate service linkage for individuals in the community.

Not satisfied with excellence, the EMS initiative (now called the Upstream Crisis Intervention Unit) borrowed from the concept of community paramedicine to expand their focus. In addition to responding to 911 calls, the team now receives lists of frequent 911 callers from the EMS lead. Referencing these lists, the team makes frequent visits to these individuals to ensure that they are taking medications, making it to appointments, and are able to maintain basic necessities like housing. With appropriate oversight, the team is doing things no ambulance could: providing courtesy rides to pharmacies to get medications refilled, providing rides to appointments and other resources, setting appointments for individuals who may have missed them, administering individuals' injectable medications in the field

when medical review has determined it to be appropriate, and even helping individuals sign up for benefits such as Medicaid. The team has taken on a life of its own and is constantly looking for new ways to help the community.

So excited by the successes experienced in its collaboration with Grady EMS, BHL is seeking to partner with other community agencies, including other EMS providers as well as law enforcement personnel. Mental health services are often unavailable or difficult to access, particularly in rural communities. One answer may be taking the services to the individual rather than asking the individual to come to the service.

Building on the successes of the Upstream Crisis Intervention Unit BHL is now partnering with Gwinnett County Police to enhance and support their response to 911 calls. The project evolved from discussions with EMS, Gwinnett 911 and other first responders. Through those initial meetings, it became clear that of the agencies involved, the Gwinnett County Police were most interested in enhancing their response to 911 calls involving mental health and substance abuse issues. The County Police are well aware of their limitations. Too often, individuals in behavioral health crisis end up in jail, while many others are transported to ER's where they wait (sometimes days) to be transferred to psychiatric facilities. In some cases, these individuals are discharged home from the ER without ever being connected to care. BHL and Gwinnett County Police leadership have worked together to develop a pilot program scheduled to start June 9th.

The pilot will take place in the West Precinct of Gwinnett County, a very densely populated area. The design of the pilot is simple; Gwinnett County Police are dispatched by 911 and once on scene, if they determine behavioral health intervention is indicated, police or the 911 dispatcher calls GCAL. GCAL staff document the information and contact the individual in crisis to determine whether the situation can be managed telephonically or whether MCRS should be sent. If managed telephonically, the crisis is deescalated and the individual is linked to services. When MCRS is dispatched, the team assesses the individual in crisis face-to-face and determines the necessary level of care. When hospitalization is indicated, all efforts are made to get the individual directly to a psychiatric facility rather than routing them through an ER. If outpatient services are indicated, a crisis safety plan is developed on the scene with the individual and available supports, and an appointment is scheduled with a mental health provider. The individual is also given additional resources (support groups, the GCAL number, etc.) that could help prevent future crises. Once the scene is deemed safe by law enforcement, police are free to move on to other responsibilities and the GCAL clinician or the MCRS team will continue working with the individual until the crisis has passed.

BHL and Gwinnett County Police leadership have developed training for front-line staff for both organizations – the information will be presented in roll calls by GCAL and MCRS supervisory staff to not only allow for questions and answers, but to also provide the face-to-face interactions on which effective relationships are built and maintained. All involved will provide real-time input on the process to allow for adjustments and improvements as the pilot continues.

It's clear both agencies are very committed to helping residents of Gwinnett County with mental illness and substance abuse problems by connecting them more immediately and appropriately to the care and services they need.

APPENDIX J

LEGAL UPDATE

October 12, 2005
Georgia Bureau of Investigation

Dawn M. Diedrich
Deputy Director of Legal Services

Obtaining the Release of Medical Information after the Implementation of the Health Insurance Portability and Accountability Act (HIPAA)

Legal Services has been receiving calls regarding the effect of HIPAA on obtaining medical records in investigations. HIPAA does authorize the release without consent of medical information regarding individuals who are victims of a crime to law enforcement. Additionally medical information may be released without consent to coroners and medical examiners to identify a deceased person, determining a cause of death, or other duties as authorized by law. For your convenience when interacting with medical providers, a copy of these regulations and the website where they may be viewed is attached to this Legal Update and may be given to medical providers.

With regard to medical records of witnesses or suspects, HIPAA makes no provision for their release to law enforcement without consent or a warrant. For those records, you may want to obtain consent of the individual. A copy of a revised consent form is attached. We have learned that some providers are no longer accepting the old form.

Finally, if you are unable to obtain the records with consent or one of the statutory exceptions for victims, you should obtain a search warrant. In King v. State, 276 Ga. 126, 129 (2003), the Georgia Supreme Court held that a search warrant to obtain medical records of a suspect in a criminal investigation was the appropriate mechanism to obtain medical records as it provided adequate protection for a suspect's privacy rights. Similarly, the HIPAA regulations require that providers must disclose protected health information "in compliance with and as limited by the relevant requirements of a court-ordered warrant." 45 C.F.R. 164.512(f)(1)(ii)(A).

GEORGIA BUREAU OF INVESTIGATION
AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION

I hereby authorize Special Agent _____ of the Georgia Bureau of Investigation to receive information from the Medical Records of:

Patient: _____

SS# _____

Date of Birth: _____

I authorize the inspection of the Medical Records by the above named agency/person and/or to the furnishing of a photostat or other copies.

I place no limitations and understand that the information to be released may refer to history of illness, diagnostic and therapeutic information, including any treatment for alcohol or drug abuse/dependency; psychiatric or psychological conditions, mental illness or retardation, sexually transmitted disease, AIDS, or HIV. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by presenting a written revocation to the Georgia Bureau of Investigation or my healthcare providers. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the Georgia Bureau of Investigation agent named above

Date:_____

Signature: _____
(Patient or Authorized Person)

Relationship to Patient: _____
(If other than patient)

This authorization expires _____ (insert applicable date or event or insert "no expiration designated") or in 6 months, whichever is shorter, and no further use/disclosures as described above may be made after the expiration.

104th Congress
PUBLIC LAW 104-191

AUG. 21, 1996

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
http://www.hhs.gov/ocr/regtext.html

Code of Federal Regulations 45

Subpart C-Compliance and Enforcement

164.512 Uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required.

45 CFR 164.512 (f) HIPAA Exception for Law Enforcement
(f) Standard: Disclosures for law enforcement purposes.
(3) A covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime.

45 CFR 164.512 (g) HIPAA Exemption for Medical Examiners and Coroners
(g) Standard: Uses and disclosures about decedents.
(l) Coroners and medical examiners. A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

APPENDIX K

Protocol for Linkage to Mental Health Provider Services for Refugees

Improving access to mental health services for newly arrived refugees in Georgia

Contents

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Suicide Protocol 5

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1. Introduction

Every year Georgia welcomes thousands of refugees arriving from overseas seeking a new and safe life here in the United States. Having gone through the refugee experience, many of them have suffered trauma, torture, displacement, and many calamities that have qualified them for resettlement in our country. The Georgia Department of Public Health (GDPH), through the Refugee Health Program, provides much needed direction for health assistance and services to refugees resettled in Georgia. One of the main components of the program is the mental health and wellness coordination for refugees. Through the Refugee Mental Health Coordinator, newly arrived refugees can be linked to the necessary mental health services and resources around the state.

As new members of our community, refugees have access to the full range of mental health services that are available to residents of the state of Georgia. During the primary health screening conducted by local and county health departments, refugees who are in need of mental health service are identified and channelled through the system to receive the necessary care by mental health care providers. In this regard, the GDPH Refugee Mental Health Coordinator provides linkage services to make sure refugees in need of mental health care are properly linked to the providers who can offer treatment and rehabilitation. The protocol below identifies the ways in which linkage service is conducted.

2. Strategic Objectives of Protocol

2.1 To improve access to mental health services for newly arrived refugees in Georgia

2.2 To adopt a client-centered approach to refugee mental health response and service provision

2.3 To foster collaboration among refugee mental health partners at various levels

2.4 To improve communication and information sharing between partners in the linkage process

2.5 To establish accountability and reduce processing time for refugees in need of mental health services

3. Aims of Protocol

3.1 To adopt a linkage process that ensures newly arrived refugees in Georgia have access to appropriate mental health providers and services

3.2 To identify the various stakeholders in the process and their responsibilities

3.3 To define the linkage steps and provide guidance to referrers

3.4 To create a referral form to speed up the process of linking refugees to providers

4. Mental Health Screening for Newly Arrived Refugees

4.1 As stipulated by the Centers for Disease Control and Prevention in the "Guidelines for Mental Health Screening during the Domestic Medical Examination for Newly arrived Refugees"[1], the goal of the mental health screening is to identify and triage refugees in need of mental health treatment.

4.2 Clinicians conducting the screening are encouraged to familiarize themselves with refugee backgrounds and conditions they may present and to establish a screening process that is sensitive enough to detect the early mental health needs of refugees.

4.3 Once screening has been conducted, it is recommended that screeners provide education to refugees on mental health issues, expected stress responses, and make available mental health resources.

4.4 Refugees may also be counselled on the services available to them and encouraged to seek mental health assistance within the initial period of insurance coverage (first eight months of arrival).

4.5 Once a refugee has expressed desire to seek mental health assistance, the screener should refer them to the State Refugee Mental Health Coordinator (RMHC) for case management and further referral to provider.

5. Linkage Procedure

5.1 **Sources of referral**: Referrals to the RMHC can be made by the following agents:

5.1.1 Health clinicians who conducted the mental health screening
5.1.2 Refugee resettlement agencies
5.1.3 Individual referral by refugee
5.1.4 Community members

5.2 **Refugee Consent**: The refugee must be consulted and notified by the referring agent above that a referral to the RMHC will be done, in an effort to connect them with a mental health provider. Refugee consent for referral

[1] For text of the complete document, please go to:
http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

to mental health services must be established prior to making the referral to the MHC.

5.3 **Referral form**:

5.3.1 To be able to effectively connect refugees to providers, the referring agents mentioned in 5.1.1 & 5.1.2 above will provide *certain biographic and case-related information to the MHC in* the form provided (See Annex 1).

5.3.2 Where the request for linkage is done by a refugee or a member of the community verbally, the RMHC shall fill out the referral form, and initiate case management by updating the local health department with the case information.

5.4 **Referral responsibilities**: The primary responsibility for identification of mental health needs of arriving refugees lies with the clinic conducting the primary health screening. It is the responsibility of the RMHC to make sure that all referrals received are promptly processed, and a connection to the appropriate mental health provider is made within 48 hours of receipt of referral form.

5.5 **Linkage by RMHC to Provider**: Once the RMHC receives a referral, the MHC will contact the mental health provider and will schedule an appointment for the client.

5.5.1 Client information given by the RMHC to the provider will include client name, gender, date of birth, health insurance type and number, client address and telephone number, country of origin, primary language, confirm whether or not interpretation is needed, and a reason for the referral (including current symptoms).

5.5.2 Once the appointment has been set, the RMHC will contact the client and will inform them of the appointment.

5.5.3 The information given to the client about their appointment will including the name of the provider, address and telephone number, date and time of appointment, a brief on the intake process and what to expect on their first appointment.

5.6 **Exclusions**: The RMHC shall accept referrals for newly arrived refugees up to 90 days of arrival. Refugees in need of mental health services outside of the 90 day period shall be linked to mental health services through their screening clinic.

6. **Referrals for Substance Abuse:** During the mental health screening it is essential to access the refugees' history, current intake and consumption of alcohol and/or drugs. A very useful resource for drug and alcohol addiction recovery programs in the metro Atlanta area can be found at: http://www.atlm.edu/downloads/Drug%20and%20Alcohol%20Resources%202012.pdf.

   6.1 If a case needs enrollment into a drug and alcohol recovery program, the screener shall use the referral form mentioned in 5.3.1 to refer the case to the RMHC for linkage to the appropriate program.

   6.2 The same steps for referral mentioned above, including the consent for services provisions shall apply to alcohol and drug recovery clients.

7. **Referrals for Children and Adolescents:** There is a number of services provided to children and adolescents in need of mental health services in Georgia. Services for these two groups differ in that assessments and interventions can be provided at home, close to home, or in an area that reduces a child's apprehension and makes them most responsive.

   7.1 If a refugee child or adolescent requires mental health services, the screener will follow the same process mentioned in point 5 above, with the exception of flagging the referral form by marking the top left-hand corner with the initials **CRC** (child refugee case) in bold.

8. **Suicide Protocol:** In the past few years several refugees have openly expressed suicidal ideation during the mental health screening and subsequent visits to the health screening clinic. In such cases, and following national suicide intervention guidelines, the screener is obliged to respond in the following way:

   8.1 Assess the client's desire to commit suicide by asking them if this is an action they are ready to perform

   8.2 Identify the plan and method of performing the act

   8.3 If the client is exhibiting signs of distress the screener must call 911

   8.4 Otherwise call the **Georgia Access Line at 1.800.715.4225**. The Georgia Access Line provides state wide service. They will connect the screener to the closest Community Service Board or emergency facility. If requested they will also dispatch a mobile crisis team which can come to the client's location. The mobile team is tasked with providing rapid response and assessment, as well as transporting the client to the nearest emergency room or mental health facility. *Important to note that until the mobile team arrives, the client should* ***not*** *be left alone without supervision.*

8.5 Upon notifying the dispatch team the MHC should also be notified at 404.780.0242

8.6 After the emergency intervention has been done, the screener will provide a referral form to the MHC, and flagging the referral form by marking the top left-hand corner with the initials **EMR** (emergency refugee) in bold.

Georgia Department of Public Health

State Refugee Health Program
Mental Health Referral Form

Referral Source Information

Agency: _____ Date: ____/____/____
Name: _____ Title: _____
Phone: _____ Fax: _____ E-mail: _____

Client Information

Name: _____ Age: _____ Gender: ___ F ___ M
Country of Origin): _____ Primary Language: _____
Address: _____ County: _____ Alien #: _____
Telephone(s): _____ Date of Arrival (US): ____/____/____
Medicaid #/ CMO: _____ VOLAG/Sponsor: _____
(Caseworker)

Reason for Referral: Describe the behavior/concerns that led to this referral or symptoms exhibited by the client?

_____
_____
_____
_____
_____
_____

Previous history of mental health problems?	Yes	No	Unsure	(If yes?)_____
Did they come with an overseas mental health diagnosis?	Yes	No	Unsure	
History of psychiatric hospitalization?	Yes	No	Unsure	
Previous suicide attempts?	Yes	No	Unsure	
Are they actively suicidal?	Yes	No	Unsure	
Substance abuse?	Yes	No	Unsure	
Domestic violence?	Yes	No	Unsure	
Physical health conditions?	Yes	No	Unsure	
Evidence of torture?	Yes	No	Unsure	

Service(s) Requested

____ Mental Health Education/Orientation
____ State Program Referral
____ Other: _____
____ Follow-Up Care
____ Non-compliance with Treatment Plan

For Office Use Only: Date Referral Received: ____/____/____ Received By: _____

Assigned To: _____ Approved: Y N

Please Fax to: Refugee Health Program (404) 463-1416 or E-mail to: shsadrazodl@dhr.state.ga.us

Georgia Department of Public Health

State Refugee Health Program
Mental Health Referral Form

Referral Source Information

Agency: _____ Date: ____/____/____
Name: _____ Title: _____
Phone: _____ Fax: _____ E-mail: _____

Client Information

Name: _____ Age: _____ Gender: ___ F ___ M
Country of Origin): _____ Primary Language: _____
Address: _____ County: _____ Alien #: _____
Telephone(s): _____ Date of Arrival (US): ____/____/____
Medicaid #/ CMO: _____ VOLAG/Sponsor: _____
(Caseworker)

Reason for Referral: Describe the behavior/concerns that led to this referral or symptoms exhibited by the client?

_____
_____
_____
_____
_____
_____

Previous history of mental health problems?	Yes	No	Unsure	(If yes?)_____
Did they come with an overseas mental health diagnosis?	Yes	No	Unsure	
History of psychiatric hospitalization?	Yes	No	Unsure	
Previous suicide attempts?	Yes	No	Unsure	
Are they actively suicidal?	Yes	No	Unsure	
Substance abuse?	Yes	No	Unsure	
Domestic violence?	Yes	No	Unsure	
Physical health conditions?	Yes	No	Unsure	
Evidence of torture?	Yes	No	Unsure	

Service(s) Requested

___ Mental Health Education/Orientation
___ State *Program Referral*
___ Other: _____
___ Follow-Up Care
___ Non-compliance with Treatment Plan

For Office Use Only: Date Referral Received: ____/____/____ Received By: _____

Assigned To: _____ Approved: Y N

Please Fax to: Refugee Health Program (404) 463-1416 or E-mail to: shsadrazodi@dhr.state.ga.us

APPENDIX L

MENTAL HEALTH, MENTAL RETARDATION, AND SUBSTANCE ABUSE

4 Instructional Hours

Instructional Goal

3.3 The instructional goal for Mental Health, Mental Retardation, and Substance Abuse is to provide the student with an understanding of terminology, characteristics of mental illness, mental retardation, and substance abuse, procedures, and applicable provisions of the law.

Terminal Performance Objective

Given an assignment as a law enforcement officer, students will utilize proven strategies for effective communication and interaction with people with disabilities, in accordance with the Americans with Disabilities Act and Department of Justice regulations.

Enabling Objectives

3.3.1 Identify the distinctions between mental illness, mental retardation, and substance abuse.

3.3.2 Identify the symptoms of mental illness, mental retardation, and substance abuse.

3.3.3 Identify the legal requirements for voluntary and involuntary admissions to treatment facilities for mental illness and substance abuse.

3.3.4 Identify effective provisions for interacting with a person exhibiting symptoms of mental illness, mental retardation, or substance abuse.

Topical Outline

I. Introduction

- A. Misconceptions about mental illness and mental retardation
- B. Mental illness defined
- C. Mental retardation defined
- D. Substance abuse defined

II. Mental Retardation, Mental Illness, and Substance Abuse

- A. Categories of mental retardation

1. Mild or able to be educated
2. Moderate or trainable
3. Severe or moderately trainable
4. Profound or limited trainable

B. Characteristics of mental retardation

C. Types of mental illness and their symptoms

1. Depression
2. Mania
3. Schizophrenia
4. Panic disorder

D. How to identify the substance abuser

E. Mental and physical complications of substance abuse

1. Delirium tremens
2. Cirrhosis
3. Needle marks

III. Applicable Provisions of the O.C.G.A.

A. O.C.G.A. 37-3-1 Definitions

B. Provisions applicable to peace officers

1. O.C.G.A. 37-3-4Immunity of Physicians and Peace Officers
2. O.C.G.A. 37-3-5Apprehension by a Peace Officer of Patients Who Leave the Facility Without Permission
3. O.C.G.A. 37-3-7Abandoning or Leaving Patients on Grounds of a Psychiatric Hospital Without Permission is Criminal Trespass

C. Voluntary and involuntary commitments

1. O.C.G.A. 37-3-20Voluntary Commitments
2. O.C.G.A. 37-3-22Rights of Voluntary Patients to Discharge

3. O.C.G.A. 37-3-41Emergency Admissions
    a. physician's certificate
    b. court order
    c. peace officer report
4. O.C.G.A. 37-3-42Emergency Admission of Person Arrested for a Penal Offense
5. O.C.G.A. 37-3-43Right to Timely Examination After Emergency Admission

IV. Handling the Mentally Ill, Mentally Retarded and Substance Abuser

A. Signs of potential aggression or violence
    1. Sudden change in behavior
    2. Exaggeration of unusual behavior

B. Behavioral, facial and psychological cues
    1. Behavioral cues
    2. Facial cues
    3. Psychological cues

C. Communicating with a disturbed mentally ill person
    1. Position your body so that the individual knows you are listening. Establish and maintain eye contact
    2. Focus on the individual's external behaviors in addition to what the person is saying. Observe body language and avoid giving value judgments

D. Intervention techniques
    1. Employ reason as a method of intervention
        a. calling the individual's attention to the consequences of his behavior will bring the situation under control
        b. Employing reason is not threatening the individual. Threats only serve to increase the possibility of a violent outburst

2. Divert the individual's attention

   a. Try and turn the person's attention away from what is bothering him

   b. Introduce something that interests him

   c. Individuals in a state of confusion can sometimes be easily distracted and allow you to diffuse a potential incident

3. Talking the person down

   a. You may personally experience some fear or insecurity in a situation that could potentially move to violence

   b. Avoid coming on too strong. Maintain a calm, caring, and secure image

   c. Do not fear being "firm" with the person

   d. Get the person away from others. Avoid an audience before the person feels obligated to act to save face

   e. Work with the person one-on-one but have backup close enough to assist if needed

   f. Maintain an arm's reach distance and observe the person closely

   g. Get the person to sit down if possible. This could have a calming effect

   h. Conduct a calm, quiet conversation. Enable the person to express feelings and feel like he has some control and not feel threatened

   i. Help the person explore various appropriate options. Negotiate as much as possible; don't be inflexible

4. Dealing with aggressive behavior

   a When the paranoid or suspicious person becomes aggressive, they may be reacting to feelings of being cornered or hemmed in

b When aggressive individuals refuse to cooperate and you have tried all other means, you should consider a "show of force"

V. Alzheimer's Disease and Related Dementias

A. Definition

B. Symptoms

C. Diagnosis

D. Treatment

E. Causes and Research

F. Recognizing a Person Who May have Alzheimer's Disease

1. Identification Clues

2. Physical Clues

a. Blank Facial Expressions

b. Inappropriate Clothing

c. Age

d. Unsteady Gait

3. Psychological Clues

a. Short-Term Memory Loss

b. Confusion

c. Communication Problems

d. Delusions and Hallucinations

e. Agitation

f. Catastrophic Reaction

4. Frequently Encountered Situations

a. Wandering

i. Description and Definition

ii. Why people Wander

iii. Findings from Search and Rescue Study

b. Automobile Accidents

c. Indecent Exposure

d. Homicide and Suicide

e. Appearance and Intoxication

f. Abuse and Neglect

g. Poisoning and Choking

h. Falls and Tripping

i. Burns and Electrocution

5. Interacting with a Person with Alzheimer's Disease

a. Treat the Person with Respect and Dignity

b. Avoid Restraints if Possible

c. Approach from the Front and Introduce Yourself

d. Speak Slowly and Calmly

e. Keep the "Climate" Calm and Supportive

f. Ask on One Question at a Time

g. Keep Instructions Positive

h. Substitute Non-Verbal for Verbal for Communication

i. Avoid Shouting

j. Keep Explanations Simple

6. Alzheimer's Association and Safe Return Program

a. Mission

b. How Safe Return Works

i. Registration

ii. When Wandering Occurs

c. Safe Return Benefits

i. Identification Products

ii. National Information/Photo Database

iii. 24-Hour Toll-Free Crisis Line 1-800-572-1122

iv. Fax notification System

v. Chapter Support

vi. Information and Training

VI. Conclusion

A. Summary

B. Final Questions

C. Closing Statements

Instructional Guide

This block of instruction could be enhanced by the use of a practical exercise, role playing, or demonstration.

Course Preparation

Prepare student handouts.

Supplemental Materials and Equipment

Classroom equipment and supplies

Instructor References

Georgia Criminal and Traffic Law Manual

Peace Officer Reference Text

APPENDIX M

Tactical Communications Styles for Special Needs Subjects
(Remember to pause between steps)

Tactical 8-Step® Identifying a Lost Subject

1. "Hello
2. My name is Jim.
3. I am a police officer.
4. I will help you.
5. Give me your ID card please.
6. Good job, thank you.
7. I will call someone to take you home now.
8. Wait here with me. Good job, thank you."

Tactical 8 Step® Inappropriate Behaviors (loitering example)

1. "Hello
2. My name is Jenny.
3. I am a police officer.
4. You have been here too long.
5. I will help you get home.
6. Give me your ID card, please.
7. Go home now, please (if safe or escort).
8. Thank you."

Handcuffing a Compliant Subject

- "The rules say I have to put these handcuffs on you.
- These are handcuffs (Tell-Show-Do*)
- They will keep you safe.
- Sit in the car.
- Good Job, Thank you."

Some Common Commands

Slapping or hitting: "Quiet hands"

Kicking: "Quiet feet" or "Stop kicking"

Biting: "Don't bite" or "Stop biting"

Wandering: "Stay right here"

(Moderate volume, firm tone)

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*Tell-Show-Do

Tell: "I am going to handcuff you." Or "I am going to search you."

Show: ***Show the subject what you are going to do. Model it on yourself or in the air (simulation).***

Do: ***Move in and handcuff, search, etc.***

Tactical 8-Step Initial Contact Model® Developed by Dr. George Thompson, Verbal Judo Institute.
Adapted for special needs by Joel Lashley, Children's Hospital of Wisconsin.
Contact joellashley@chw.org for additional copies, comments, suggestions, or to schedule training for police, corrections, social workers, and juvenile detention officers.

APPENDIX N

POLICY STATEMENT 1035	DATE January 4, 2005
SUBJECT Encounters with the Developmentally Disabled	PAGE 1 of 7

PURPOSE

It is the policy of the Georgia Bureau of Investigation that all developmentally disabled, alcohol dependent, or drug dependent individuals encountered by employees of the GBI shall be treated courteously and humanely. Law enforcement personnel of the GBI will take reasonable and lawful action necessary to assure their safety and the safety of others.

POLICY

Persons afflicted with developmental disabilities are limited in their ability to effectively communicate, interact with others, and make reasoned decisions on their own. This can make interactions with such persons difficult in enforcement and other encounters and may result in inappropriate or counterproductive police actions if personnel are not prepared to recognize and deal with symptomatic behaviors and reactions of such persons. The number of persons afflicted with such disabilities is increasing dramatically in the United States. Therefore, it is the policy of the GBI that personnel understand the symptomatic behavior of such persons and be prepared to deal with them in a manner that will best serve their needs and this agency's law enforcement mission.

I. DEFINITIONS

Developmental Disability: A potentially severe, chronic disability attributable to a physical or mental impairment or combination of impairments, resulting in substantial functional limitations to major life activities such as understanding and expression of language, learning, mobility, self-direction, self-care, capacity for independent living, and economic self-sufficiency.

II. PROCEDURES

A. Common Symptoms

There are numerous forms of developmental disabilities. Although personnel are not in a position to diagnose persons with such disabilities, personnel should be alert to the symptoms that are suggestive of such disorders. These include but are not limited to the following symptoms in various combinations and degrees of severity:

1. Difficulty communicating and expressing oneself
2. Communication by pointing or gestures rather than words
3. Repetition of phrases or words
4. Repetitive body movements which may be harmful to themselves (movements may include, but are not limited to, swaying, spinning, clapping hands, flailing arms, snapping fingers, biting wrists, or banging the head)
5. Little or no eye contact
6. Tendency to show distress, laugh, or cry for no apparent reason
7. Uneven gross or fine motor skills
8. Unresponsiveness to verbal commands; appearance of being deaf even though hearing is normal
9. Aversion to touch, loud noise, bright lights, and commotion
10. No real fear of danger
11. Oversensitivity or undersensitivity to pain
12. Self-injurious behavior

B. Common Encounters

Personnel may encounter persons who have developmental disabilities in a variety of situations. Due to the nature of developmental disabilities, the following are some of the most common situations in which such persons may be encountered:

1. Wandering. Developmentally delayed, autistic, or other developmentally disabled persons sometimes evade their parents, supervisor, caregiver, or institutional setting and may be found wandering aimlessly or engaged in repetitive or bizarre behavior in public places or stores.

2. Seizures. Some developmentally disabled persons, such as those suffering from autism, are more subject to seizures and may be encountered by personnel in response to a medical emergency.

3. Disturbances. Disturbances may develop and a caregiver may be unable to maintain control of the disabled person who is engaging in self-destructive behavior or tantrum.

4. Strange or Bizarre Behavior. Strange or bizarre behavior may take innumerable forms prompting calls for service, such as picking up items in stores (e.g., perceived shoplifting), repetitive and seemingly nonsensical motions and actions in public places, inappropriate laughing or crying, and personal endangerment.

5. Offensive or Suspicious Persons. Socially inappropriate or unacceptable acts, such as ignorance of personal space, annoyance of others, or inappropriate touching of others or oneself, are sometimes associated with the developmentally disabled who often are not conscious of acceptable social behavior.

C. Handling and Deescalating Encounters

Some persons with developmental disabilities can be easily upset and may engage in tantrums or self-destructive behavior or may become aggressive. Fear, frustration, and minor changes in their daily routines and surroundings may trigger such behavior. Therefore, personnel shall take measures to prevent such reactions and deescalate situations

involving such persons in the course of taking enforcement and related actions. These include the following:

1. Speak calmly; use nonthreatening body language. Using a stern, loud, command tone to gain compliance will have either no effect or a negative effect on a developmentally disabled person. Use nonthreatening body language; keep your voice calm and your hands to your sides. Be aware that such persons may not understand the *Miranda* warning even if they say they do.

2. Keep the commotion down. Eliminate to the degree possible, loud sounds, bright lights, and other sources of overstimulation. Turn off sirens and flashers, ask others to move away, or, if possible, move the developmentally disabled person to more peaceful surroundings.

3. Look for personal identification. Look for medical ID tags on wrists, neck, shoes, belt, or other apparel. Some persons carry a card noting that they are developmentally disabled and possibly nonverbal. That card should also provide a contact name and telephone number.

4. Call the contact person or caregiver. The person's caregiver or institutional or group home worker is the best resource for specific advice on calming the person and ensuring the safety of the person and others until the contact person arrives on the scene.

5. Prepare for a potentially long encounter. Dealings with such a person cannot be rushed unless there is an emergency situation. Deescalation of the situation using calming communication techniques can take time.

6. Repeat short, direct phrases in a calm voice. For example, rather than saying "Let's go over to my car where we can talk," simply repeat "Come here," while pointing until the person's attention and compliance is obtained.

7. Be attentive to sensory impairments. Many persons who have autism have sensory impairments that make it difficult for them to process incoming sensory information properly. For example,

some may experience buzzing or humming in their ears that makes it difficult for them to hear. Should personnel identify a sensory impairment, he or she should take precautions to avoid exacerbating the situation:

a. Don't touch the person. Unless the person is in an emergency situation, speak with the person quietly and in a nonthreatening manner to gain compliance.

b. Use soft gestures. When asking the person to do something, such as to look at you, speak and gesture softly. Avoid abrupt movements or actions.

c. Use direct and simple language. Slang and expressions have little or no meaning to such persons. Normally, they will understand only the simplest and most direct language (e.g., come, sit, stand).

d. Don't interpret odd behavior as belligerent. In a tense or even unfamiliar situation, these persons will tend to shut down and close off unwelcome stimuli (e.g., cover ears or eyes, lie down, shake or rock, repeat questions, sing, hum, or make noises). This behavior is a protective mechanism for dealing with troubling or frightening situations. Don't stop the person from repetitive behavior unless it is harmful to him or her or others.

8. Be aware of different forms of communication. Some developmentally disabled persons carry a book of universal communication icons. Pointing to one or more of these icons will allow these persons to communicate where they live, their mother's or father's name, address, or what he or she may want. Those with communication difficulties may also demonstrate limited speaking capabilities, at times incorrectly using words such as "You" when they mean "I."

9. Don't get angry at antisocial behaviors. Many such persons do not understand that this is not appropriate.

10. Maintain a safe distance. Provide the person with a zone of comfort that will also serve as a buffer for personnel safety.

D. Taking Persons into Custody

Taking custody of a developmentally disabled person should be avoided whenever possible as it will invariably initiate a severe anxiety response and escalate the situation. Therefore, in minor offense situations, agents shall explain the circumstances to the complainant and request that alternative means be taken to remedy the situation. This normally will involve release of the person to an authorized caregiver. In more serious offense situations or where alternatives to arrest are not permissible, agents shall observe the following guidelines:

1. Avoid the use of handcuffs and other restraints unless unavoidable. Use of restraints will invariably escalate panic and resistance.

2. Summon the person's caregiver to accompany the person and to assist in the calming and intervention process. If a caregiver is not readily available, summon a mental health crisis intervention worker.

3. Employ calming and reassuring language and de-escalation protocols provided in this policy.

4. Do not incarcerate the person in a lockup or other holding cell if possible. Do not incarcerate the person with others.

5. Until alternative arrangements can be made, put the person in a quiet room with subdued lighting with a caregiver or other responsible individual or another officer who has experience in dealing with such persons.

6. Provide the person with any comfort items that may have been in his or her possession at the time of arrest.

E. Interviews and Interrogations

If possible, agents conducting interviews or interrogations of a person who is, or who is suspected of being, developmentally disabled should

consult with a mental health professional or the prosecuting attorney's office to determine whether the person is competent to understand his or her rights to remain silent and to have an attorney present. If an agent interviews such persons as suspects, victims, or witnesses, the agent should observe the following in order to obtain valid information:

1. Do not interpret lack of eye contact and strange actions or responses as indications of deceit, deception, or evasion of questions.

2. Use simple, straightforward questions.

3. Do not employ common interrogation techniques, suggest answers, attempt to complete thoughts of persons slow to respond, or pose hypothetical conclusions, recognizing that developmentally disabled persons are easily manipulated and may be highly suggestible.

III. AVAILABLE MENTAL HEALTH RESOURCES

In the event a mental health professional is needed in regards to developmentally disabled person(s), refer to the Division of Mental Health, Developmental Disabilities and Addictive Diseases Emergency Contact Numbers (Attachment A) for local contact information or if after business hours, contact the GBI Communications Center. If internet access is readily available, visit www.mhddad.dhr.georgia.gov to search for local service providers.

IV. TRAINING

All entry level personnel will receive initial documented training regarding encounters with the developmentally disabled. Additionally, all personnel will receive documented refresher training at least every three years.

APPENDIX O

GEORGIA BUREAU OF INVESTIGATION
INVESTIGATIVE DIVISION

DIRECTIVE 2-21

TITLE: Guidelines for Peer Support Program

DATE: September 21, 2010 **PAGE 1 OF 3**

REVIEWED:

AUTHORITY: R. E. Andrews
Deputy Director for Investigations

PURPOSE: The following guidelines are established relative to the Peer Support Program (PSP) which provides an opportunity for Investigative Division personnel to speak with a trained Peer Support Group (PSG) member regarding any current or past work related crisis or critical incident.

I. GENERAL

A. The Peer Support Group consists of Investigative Division personnel who are specially trained as skilled listeners. The objective of the PSG is to provide support for Investigative Division personnel who have experienced a work related crisis or critical incident.

B. A list of trained PSG personnel (Attachment A) will be maintained in the Communications Center and is accessible to Investigative Division personnel. Personnel utilizing the services of the PSP may select any member of the group from this list as a resource.

II. PROCEDURES

A. Investigative Division personnel interested in using the PSP may contact a PSG member directly through e-mail, telephone, or in person. After the

request for support has been made, the PSG member will make contact with the employee within 24 hours to schedule a peer support meeting.

B. Peer Support meetings may be conducted via telephone, in person, or by any means that may be preferred by the employee seeking assistance. The PSG member must ensure his or her supervisor is aware each time that PSP assistance is being provided. The PSG member will not disclose the name or other information about the contact.

III. DUTIES AND RESPONSIBILITIES OF PEER SUPPORT GROUP

A. The GBI recognizes that each employee is valuable. The GBI recognizes that issues or problems related to a crisis or critical incident can affect job performance and personal lives of employees. The PSG members are trained in active listening as well as how to relate to employees who have experienced work related stress.

B. It shall be the responsibility of the PSG members to listen to the concerns of the employee. The PSG member will assist the employee by offering the employee additional resources such as EAP if applicable. The training that the PSG members have received will benefit the employee by allowing him or her to express their thoughts and emotions in a non-judgmental environment. The PSG member may be able to help the employee in clarifying or resolving some of the issues, concerns, or emotions the employee is experiencing. It should be noted that the PSG members are not counselors, but individuals who employees may feel more comfortable in speaking with as opposed to someone unknown to the employee.

IV. ADDITIONAL INFORMATION

A. Privacy is crucial to the success of the PSP. To ensure privacy, conversations with a PSG member will not be shared or discussed with other employees of the GBI except in following circumstances.

1. An employee is considered to be a threat to him or herself or others.

2. A criminal offense has occurred.

B. The Peer Support Program is a support initiative provided by the GBI. At the discretion of the Director or his designee, this program may be discontinued at anytime.

V. DISSEMINATION OF INFORMATION

The dissemination of information concerning a Peer support contact will be strictly prohibited unless approved by the Director, Assistant Director, the Deputy Director for Investigations, or the appropriate Inspector, pursuant to the requirements of the Georgia Open Records Act.

PSG members will not be obligated to report any information other than the information previously mentioned in Section IV.

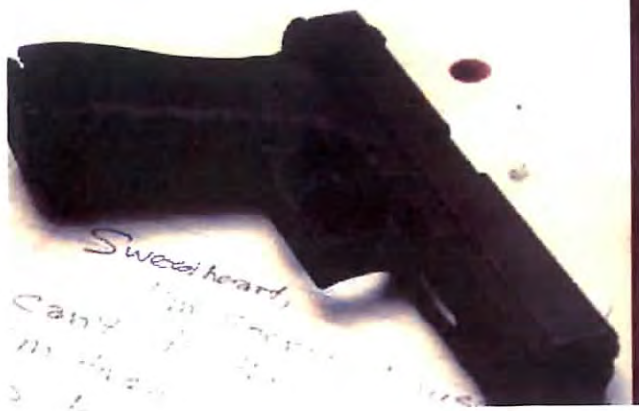
APPENDIX P

Why should I be aware of suicide?

Statistics show that:

- More than twice as many peace officers die because of suicide than are killed in the line of duty.
- All police officers have firearms, and firearms are the most frequently used means of suicide.
- Law enforcement suicide significantly impacts partners, colleagues, supervisors, first responders, family, friends and the community at large.
- Eighty percent of people who attempt suicide tell somebody first via their actions or actual statements.

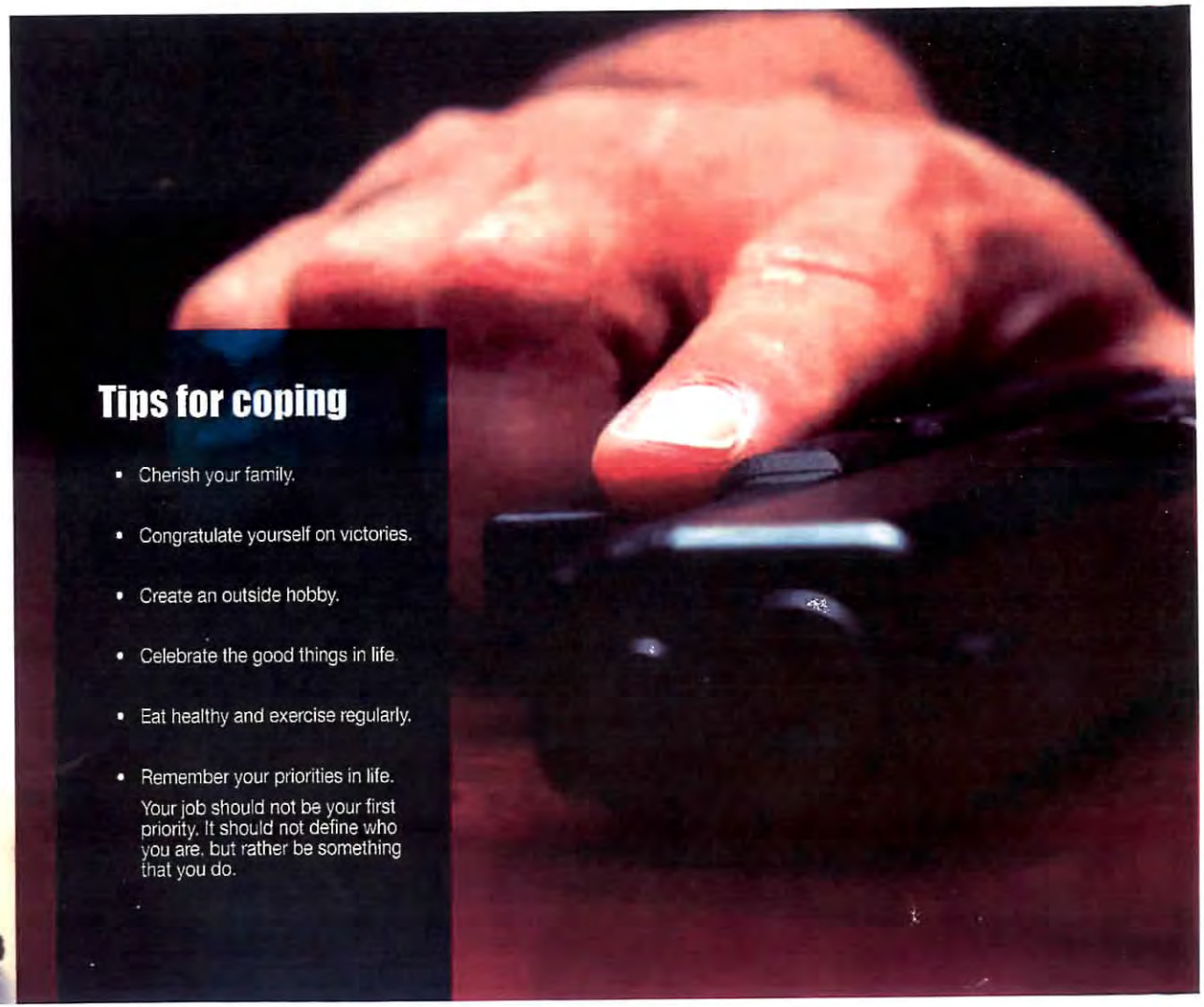
Contact:



Florida Governor's Office of Drug Control

Suicide prevention

A guide for supervisory staff



Tips for coping

- Cherish your family.
- Congratulate yourself on victories.
- Create an outside hobby.
- Celebrate the good things in life.
- Eat healthy and exercise regularly.
- Remember your priorities in life.
  Your job should not be your first priority. It should not define who you are, but rather be something that you do.

Why do people attempt suicide?

Though the reasons may vary, frequently, people attempt suicide because they want others to know they are in psychological pain; they want the pain to end. In addition, depression, anxiety, alcohol, drugs, a relationship loss and being under investigation increase the likelihood a person will attempt suicide. Suicide is a permanent solution to a temporary problem.

Suicide risk factors/ indicators

1. Threats to harm oneself.
2. Prior suicide attempt(s).
3. Disturbance in sleep, appetite or weight.
4. Thinking is constricted – there's an attitude of all or nothing, or issues are black or white.
5. Risk-taking behavior has increased.
6. There is a plan and a means to carry out a suicide.
7. The person is emotionless and/or numb.
8. Anger and/or agitation.
9. Sadness and/or depression.
10. Hopelessness, with no orientation toward the future, or the giving away of valued possessions.
11. Problems at work/home.
12. A recent loss (of status or of a loved one).
13. The person is under investigation.
14. Social isolation and/or withdrawal.
15. Increased consumption of alcohol/drugs.

Supervisor responsibilities

- Obtain suicide prevention training for your agency.
- Make sure that information about suicide prevention is available to line staff.
- Be aware and encourage the use of resources such as chaplains, peer support and Employee Assistance Programs (EAP).
- Ensure that your subordinates feel they will be given assistance and support when they bring a problem forward.

What you can tell your line staff

- When you suspect someone is having suicidal thoughts, reach out as soon as possible.
- Ask the person if he/she is thinking about suicide. Your asking him/her will not make him/her go out and do it.

It is courageous and appropriate to take steps necessary to help a co-worker who is at risk for suicide.

You Can Help

* Take all threats and gestures seriously.
* Assess if your safety is in jeopardy.
* Ask permission to secure weapon(s), including backup(s).
* Immediately request assistance from .
* DO NOT leave the person alone.
* Help delegate necessary duties such as child care or other daily responsibilities, until the crisis has resolved.
* When the crisis is over, get debriefed for your own peace of mind.

AID LIFE

This acronym may help you remember what to do when assisting a person who is suicidal:

A **Ask.** Do not be afraid to ask, "Are you thinking about hurting yourself?" or "Are you thinking about suicide?"

I **Intervene immediately.** Take action. Listen and let the person know he or she is not alone.

D **Don't keep it a secret.**

L **Locate help.** Seek out a professional at , Peer Support Person, Chaplain, friend or family member.

I **Involve Command.** If the person is imminently suicidal, be prepared to involve a supervisor to save his or her life.

F **Find someone to stay with the person now.** Don't leave the person alone.

E **Expedite.** Get help now. An at-risk person needs immediate attention from professionals.

SUICIDE PREVENTION

A Guide For Supervisory Staff

Why Should I Learn About Suicide?

- ✔ It is one of the top ten causes of death.
- ✔ More peace officers die because of suicide than are killed in the line of duty.
- ✔ One half million people are admitted to emergency rooms each year due to suicide attempts.
- ✔ All deputies have firearms, and firearms are the most frequently used means of suicide.
- ✔ Law enforcement suicide significantly impacts partners, colleagues, supervisors, first responders, family, friends and the community at large.
- ✔ 80% of people who attempt suicide tell somebody first via their actions or actual statements.

Why Do People Attempt Suicide?

- ◆ Frequently, it is to let other people know that they are in psychological pain.
- ◆ Depression, anxiety, alcohol, drugs, a relationship loss, and being under investigation increase the likelihood that a person will attempt suicide.

Suicide Risk Factors

(1) Threat to harm oneself
(2) Prior suicide attempt(s)
(3) Disturbance in sleep/appetite/weight
(4) Thinking is constricted, all or nothing, black or white
(5) Risk-taking behavior has increased
(6) There is a plan and means to carry it out
(7) Is emotionless/numb
(8) Is angry/agitated
(9) Is sad/depressed
(10) Is hopeless, with no orientation toward the future or is giving away valued possessions
(11) Problems at work/home
(12) Recent loss (status, loved one)
(13) Under investigation
(14) Socially isolated/withdrawn
(15) Increased consumption of alcohol/drugs

Supervisor Responsibilities

- ☎ To request suicide prevention training call
- ☎ Make sure that information about suicide prevention is available to line staff.
- ☎ Be aware of resources within the Department, such as Chaplains, PSP, counseling and consultations through
- ☎ Ensure that your subordinates feel that they will be given assistance and support when they bring a problem forward.

What You Can Tell Your Line Staff

- ☞ When you suspect someone is having suicidal thoughts, reach out to them as soon as possible.
- ☞ Asking the person if they are thinking about suicide will NOT make them go out and do it.
- ☞ It is courageous and appropriate to take steps necessary to help a co-worker who is at risk for suicide.

APPENDIX Q

TRAINER LOGIN

- eNewsletter
- Join Listserv
- Learning Community
- BHJTC in Your State
- Contact Us
- Home

Trauma Training

Although prevalence estimates vary, there is consensus that high percentages of justice-involved women and men have experienced serious trauma throughout their lifetime. The reverberating effects of trauma experiences can challenge a person's capacity for recovery and pose significant barriers to accessing services, often resulting in an increase risk of coming into contact with the criminal justice system.

To raise awareness about trauma and its effects among criminal justice professionals, SAMHSA's GAINS Center developed a training curriculum, **How Being Trauma-Informed Improves Criminal Justice System Responses.**

How Being Trauma-Informed Improves Criminal Justice System Responses is a half-day training for criminal justice professionals to:

- Increase understanding and awareness of the impact of trauma,
- Develop trauma-informed responses, and
- Provide strategies for developing and implementing trauma-informed policies.

Trauma-informed criminal justice responses can help to avoid re-traumatizing individuals, and thereby increase safety for all, decrease recidivism, and promote and support recovery of justice-involved women and men with serious mental illness. Partnerships across systems can also help to link individuals to trauma-informed services and treatment for trauma.

This highly interactive training is specifically tailored to community-based criminal justice professionals including:

- Police
- Community corrections (probation, parole, and pre-trial services officers)
- Court personnel

For more information about this training, including details about making this training accessible in your community, contact the GAINS Center.

National Database of GAINS Center Trauma-Informed Responses Trainers

To find a GAINS Center trainer in your area, please use our .

For Alternative Access to Web Documents : Email GAINS@prainc.com

APPENDIX R

House Bill 872 (AS PASSED HOUSE AND SENATE)

By: Representatives Rogers of the 10th, Hitchens of the 161st, Lumsden of the 12th, Benton of the 31st, Powell of the 32nd, and others

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 5 of Title 24 of the Official Code of Georgia Annotated, relating to privileges, so as to create a privileged communication between law enforcement officers and peer counselors under certain circumstances; to provide for definitions; to provide for exceptions; to provide for related matters; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 5 of Title 24 of the Official Code of Georgia Annotated, relating to privileges, is amended by adding a new Code section to read as follows:

"24-5-510.

(a) As used in this Code section, the term:

(1) 'Client' means a law enforcement employee or a law enforcement officer's immediate family.

(2) 'Immediate family' means the spouse, child, stepchild, parent, or stepparent.

(3) 'Peer counselor' means an employee of a law enforcement agency who has received training to provide emotional and moral support to a client and was designated by a sheriff, police chief, or other head of a law enforcement agency to counsel clients.

(b) Except as provided in subsection (c) of this Code section, communications between a client and a peer counselor shall be privileged. A peer counselor shall not disclose any such communications made to him or her and shall not be competent or compellable to testify with reference to any such communications in any court.

(c) The privilege created by subsection (b) of this Code section shall not apply when:

(1) The disclosure is authorized by the client, or if the client is deceased, by his or her executor or administrator, and if an executor or administrator is not appointed, by the client's next of kin;

(2) Compelled by court order;

(3) The peer counselor was an initial responding officer, witness, or party to an act that is the subject of the counseling;

(4) The communication was made when the peer counselor was not performing official duties; or

(5) The client is charged with a crime.

(d) The privilege created by this Code section shall not be grounds to fail to comply with mandatory reporting requirements as set forth in Code Section 19-7-5 or Chapter 5 of Title 30, the 'Disabled Adults and Elder Persons Protection Act.'"

SECTION 2.

All laws and parts of laws in conflict with this Act are repealed.