Georgia Department of Behavioral Health & Developmental Disabilities

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Center for Justice Innovation

GEORGIA COMPETENCY TO STAND TRIAL TOOLKIT

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How This Toolkit Was Developed

From April 2024 to April 2025, the Honorable Kathlene F. Gosselin (retired) and Dr. Julie Oliver, State Forensic Director at the Georgia Department of Behavioral Health and Developmental Disabilities partnered with the Center for Justice Innovation (the Center) to support the development of a toolkit to help criminal legal system stakeholders understand Georgia's competency evaluation process, and to highlight available mental health services in Georgia. The decision to create the toolkit was driven by the work of the Georgia Behavioral Health Reform and Innovation Commission's Forensic Competency Advisory Committee. The development process involved several key steps:

- conducting one-on-one preparatory interviews with select members of the Georgia Behavioral Health Reform and Innovation Commission's Forensic Competency Advisory Committee members to gather preliminary insights and information regarding the intersection between mental health and the criminal legal system, competency, and competency evaluations,
- attending a Forensic Competency Advisory Committee meeting to understand the issues and knowledge gaps this toolkit should address,
- collaboratively developing a framework for the information included within the toolkit, and
- engaging in an iterative process to edit and finetune the toolkit to ensure that the toolkit accurately met the goals of its development.

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Note, Grant No. 15PDJA-22-GK-01567-JAGJ was terminated by the Department of Justice effective April 22, 2025. Thereafter, Center staff did not perform any additional work on the toolkit.

Objectives of This Toolkit

This toolkit provides Georgia lawyers with the tools and strategies needed to advocate for and implement meaningful changes in the competency hearing process. It includes practical recommendations, best practices, and a framework for collaboration aimed at achieving a system where competency determinations are handled with greater efficiency and fairness.

Throughout this document, it is important for readers to note that mental capacity, which is the basis for competency, is dynamic and fluid; individuals may have periods of higher or lower capacity to make decisions or understand situations. For this reason, relying on the guidelines established by practitioners and mental health professionals is imperative.

By addressing these critical issues and adopting a forward-thinking approach, we can work together to ensure that the competency hearing process in Georgia is just, effective, and aligned with our commitment to upholding the highest standards of legal and ethical practice.

Introduction

The competency hearing process is a critical yet imperfect component of our judicial system. Ensuring that defendants receive timely and fair evaluations of their mental competency is not just a procedural formality - it is a fundamental right. However, delays and inefficiencies in this process can undermine the very essence of legal fairness and due process. Issues related to the competency hearing process are not relegated to the peach state. Nationwide, jurisdictions battle case delays associated with requests for competency evaluation and determinations of incompetency to stand trial.[1]

This toolkit aims to address the pressing need for reform in Georgia's competency hearing procedures. This toolkit proposes a series of actionable steps to streamline and improve the current system. Focused, systemic changes can significantly reduce delays and enhance the overall efficiency of competency evaluations and hearings.

Key Issues with the Current Competency Hearing Process

1. **Delays in Evaluations and Placements**: Long wait times for competency evaluations and post-evaluation placements can impede timely justice and exacerbate the strain on both defendants and the legal system.
2. **Resource Constraints**: Limited resources and funding often contribute to bottlenecks and inefficiencies in managing the competency to stand trial evaluation process, i.e. court-ordered evaluations or court orders to restoration services.
3. **Inconsistent Utilization**: Competency evaluations may be mistakenly requested as a mechanism to explore community-based treatment options or to identify mitigating factors in pending cases prolonging the evaluation wait time for those who fit the criteria for competency evaluation.
4. **Communication Gaps**: Poor coordination between various stakeholders—defense attorneys, prosecutors, and mental health professionals—can further delay the process.

[1] See National Center for State Courts, https://www.ncsc.org/__data/assets/pdf_file/0019/66304/Leading_Reform-Competence_to_Stand_Trial.pdf

Summary of Competency Hearing Procedures in Georgia

In Georgia, when someone involved in a legal case is suspected of not being mentally competent to stand trial, a competency hearing is held to determine whether they are fit to proceed. Here's a basic rundown of how this process works:

1. **Request for Evaluation**: The defense attorney or the judge can request a mental competency evaluation if there is a warranted concern that the defendant might not fully understand the court proceedings or be able to participate in their defense. Given the limited scope of a competency evaluation, a request would be improper if it is made for purposes of diagnosing the defendant's mental health condition or to obtain access to services or treatment for the defendant.
2. **Competency Evaluation**: The court then reviews the request at an initial hearing, including supporting materials, to determine whether there is sufficient information to indicate an evaluation should be conducted. Based on the review, the court will order a physician or licensed psychologist from the Department of Behavior Health and Developmental Disabilities Office of Forensic Services to evaluate the defendant. Supporting materials should be included with the order, including a summary of prior mental health treatment, summary of the defendant's criminal history, a copy of the arrest report, and the referral form that indicated why competency to stand trial is being raised, i.e. what symptoms or problems the attorney observed prompting the request. A court order allowing for pertinent records (e.g. school, mental health, medical, erc) to be released to the Department of Behavioral Health and Developmental Disabilities in lieu of a signed release of information form is beneficial and could reduce wait time for necessary documentation to complete the evaluation. The evaluation report will detail whether the defendant is capable of understanding the nature and object of the proceedings, including the filed charges, and whether the defendant can assist in providing a proper defense. Note, competency evaluations should not be ordered to obtain a diagnosis for access to services or access to emergency treatment.
3. **Hearing**: Based on the evaluation report, if the defense counsel files a special plea, a competency hearing is scheduled. This procedure is a civil trial, with the presumption that the defendant is competent at the outset of the hearing. A bench trial is customary, but the defendant may request a jury trial. During the hearing, the judge reviews the evaluation report and any other relevant information. The hearing determines if the defendant is competent to stand trial or if the defendant would benefit from interventions aimed to restore them to competency (e.g. medication, education about court process) before the trial can proceed.
4. **Possible Outcomes**:
    - **Competent**: If the defendant is found competent, the case, including a trial, proceeds as planned.
    - **Incompetent**: If the defendant is deemed incompetent, the court may order an evaluation by a department physician or licensed psychologist to determine whether there is a substantial probability that the defendant will attain mental competency to stand trial in the foreseeable future. This evaluation shall be

conducted within 90 days of DBHDD taking custody of the individual. For nonviolent misdemeanors, excluding family violence and DUI offenses, the evaluation is conducted within 45 days of DBHDD taking custody of the individual.

5. **Review and Follow-up**: If found incompetent to stand trial but with a substantial probability of attaining competency within the foreseeable future or by the end of the 45 or 90-day period, the defendant's competency shall be monitored for an additional period not to exceed 120 days for applicable nonviolent misdemeanors or nine months for all other charges. If the defendant regains competency, the case resumes. If not, at the end of the allotted restoration period, or at any point during the 120-day or 9-month period, if there is sufficient evidence that the accused is not restorable to competency, the Department of Behavioral Health and Developmental Disabilities shall report that finding and the reasons therefor to the court.

   For qualifying misdemeanor offenses, if by the end of the 120 day restoration period or when the accused's condition warrants, if the accused is still determined by the department physician or licensed psychologist to be mentally incompetent to stand trial, irrespective of the probability of recovery in the foreseeable future, the charges against the accused shall be dismissed as a matter of law by the court and the accused shall be referred to a community service board unless otherwise ordered by the court for cause shown upon the hearing of a motion by the prosecuting attorney.

Other Legal Implications

Criminal Responsibility v. Competency to Stand Trial

Not Guilty by Reason of Insanity is not the same as competency to stand trial. Degree of criminal responsibility (insanity) is related to mental/psychiatric functioning at the time of the act, while competency to stand trial (current mental competency) is a separate legal consideration; therefore, these are two necessarily distinct evaluations. An order for mental evaluation regarding the degree of criminal responsibility or sanity at the time of the act should only be requested when considering a not guilty by reason of insanity defense.

Georgia law recognizes two insanity defenses based on mental incapacity or delusional compulsion.[2] A defendant shall not be found guilty of a crime if, *at the time of the act*, the defendant lacked the mental capacity to distinguish between right and wrong or acted because of a delusional compulsion in relation to such act. Not guilty by reason of insanity is an affirmative defense under Georgia law, meaning the defense has the burden of proof and must introduce evidence as to the defendant's insanity at the time of the act.

[2] *See* OCGA §§ 16-3-2 and OCGA §§ 16-3-3.

For felony cases, the DBHDD practice is for the case to be indicted before completing an evaluation for an insanity defense. An indictment is necessary because the insanity defense requires considering the facts of the case, including questioning the defendant as to whether they committed the crime, which would be shared with both sides as a part of the procedure. Once ordered, DBHDD will conduct an evaluative examination of said defendant, and provide the court a report of diagnosis, prognosis, and findings.

A defendant who successfully pleads not guilty by reason of insanity is subject to detention in a state mental health facility for a period of up to 30 days following the trial. During this time, clinicians will evaluate the defendant's mental health and provide an opinion to the court regarding whether the individual meets inpatient/outpatient civil commitment criteria or can be fully released. Following the DBHDD evaluation, the judge will determine the defendant's next steps, which may lead to the defendant's involuntary inpatient civil commitment or a conditional (outpatient civil commitment) or full release.

For misdemeanor cases, parties may want to consider whether proceeding with the insanity defense is in the best interest of the individual and the case. Evaluation and placement delays may result in extended hospitalization for individuals when diversion or outpatient services may be a more suitable option for case disposition.

Competency to stand trial as outlined in Georgia law is a distinct legal consideration from criminal responsibility. As explained in depth in this document, an order for a mental evaluation regarding a defendant's competence to stand trial would assess whether a defendant understands the proceedings against them and whether they are capable of helping their attorney prepare their defense. A defendant can be found competent to stand trial but still found not guilty by reason of insanity.

Excluded Conditions & Competency

Dementia, traumatic brain injury (TBI), and intellectual and developmental disabilities (I/DD) do not meet the criteria for civil commitment. Although they may be a specific factor in a finding of incompetence to stand trial, they are not mental illnesses, and therefore cannot directly lead to civil commitment, as the statute is silent about these diagnoses, defining inpatient treatment as "a program of treatment for mental illness."[3] Individuals with dementia, TBI, and I/DD should be judicially referred through the same competency to stand trial process and follow the same outlined evaluation process; however, there is a statutory gap as to where individuals with these diagnoses should reside if they are found incompetent to stand trial and unable to be restored to competency due to their disability.

[3] *See* OCGA §§ 37-3-1.

The conditions mentioned above are not likely to improve with psychiatric interventions; consequently, the Court may wish to consider longer-term case resolution/community placement options. DBHDD evaluations should provide potential treatment options for the court to consider.

Due Process & Competency Delays

Statutory timelines may not always align with the practical realities of competency evaluation assessments and admission for restoration services. Forensic court orders expire 165 days (for qualifying misdemeanor offenses) and 365 days (for all other charges) after an individual arrives at a hospital facility. However, for defendants accused of misdemeanor offenses, the wait time for transfer and evaluation may exceed the maximum sentence they would have served if convicted. This delay raises due process concerns, as defendants may remain in jail awaiting assessment and/or admission.[4]

Options Available at the Intersection of a Criminal Case & Mental Health Concerns

In Georgia, there are several options available to individuals facing criminal charges while experiencing mental health concerns aside from a competency evaluation. These alternatives may offer individuals mental health services to support them as they navigate the criminal legal system and may avoid case delays associated with the competency evaluation process. System actors should consider the following:

- Community-based Mental Health Services
- Pretrial Diversion Programs
- Jail-based Mental Health Services

These options may alleviate the need for a competency evaluation by connecting individuals to service options.

Community-based Mental Health Services

For individuals not incarcerated or for whom release into the community is feasible, system actors may consider the following community-based services:[5]

[4] For misdemeanor cases, Senate Bill 132 passed and changed the law to require that competency evaluations for nonviolent misdemeanors occur within 45 days of DBHDD taking custody of the individual. Following DBHDD findings, the court would retain custody over the accused for the purpose of continued treatment for an additional period not to exceed 120 days, rather than the 9 months previously allowed under statute. Following the 120 days, should the individual still be deemed incompetent to stand trial, the case would be dismissed, and the accused referred to a community service board for services. *See* SB 132.

[5] See Appendix A for the 2025 DBHDD Division of Behavioral Health Community Behavioral Health Diversion document.

Georgia Crisis and Access Line (GCAL).The Georgia Crisis and Access Line is a nationally accredited crisis center and partner to the National Suicide Prevention Lifeline (NSPL).

- Service availability: 24 hours a day, seven days a week, 365 days a year.[6]
- Services provided:
    - telephonic intervention services
    - dispatching mobile crisis teams
    - assisting in finding an open crisis or detox bed in the state
    - linking individuals with urgent appointment services.[7]

The crisis and access line can be reached at 1-800-715-4225.

For more information about the Georgia Crisis and Access Line, visit https://www.georgiacollaborative.com/providers/georgia-crisis-and-access-line-gcal/.

988. 988 is a crisis line available to anyone via call or text. Users are connected with a crisis counselor, and conversations are free and confidential.

Anyone experiencing a suicidal crisis or emotional distress should call or text 988. It is available 24 hours a day, 7 days a week and 365 days a year.

For more information about 988, visit https://dbhdd.georgia.gov/be-dbhdd/988-georgia

Mobile Crisis Response Service Teams (MCR). Mobile Crisis Response Service Teams provide immediate, in-person support for individuals facing a mental health crisis or those with intellectual or developmental disabilities.

- Service availability: 24 hours a day, seven days a week, 365 days a year.[8]
- Services provided:
    - Immediate on-site crisis management, including assessment, de-escalation, short-term intervention, consultation, and referrals.
    - Post-crisis follow-up to ensure connection to recommended services.

MCR services can be requested via the Georgia Crisis and Access Line at 1-800-715-4225.

For more information about the Mobile Crisis Response Service Teams, visit https://dbhdd.georgia.gov/mobile-crisis-services.

[6] https://dbhdd.georgia.gov/be-dbhdd/crisis-system-georgia
[7] Ibid.
[8] Ibid.

The Forensic Peer Mentor (FPM) Project. The Peer Mentor Project provides support, linkage, and care coordination to promote the successful community reintegration of adults with behavioral health diagnoses returning to the community following incarceration.[9]

- Service availability: Within 3-18 months of their release date/tentative parole month.
- Services provided:
    - Linking individuals to services
    - Coordinating post-release care

For more information about the Peer Mentor Project, visit https://www.gmhcn.org/peer-mentoring-forensic-peer-mentor.

iHope, Inc. Forensic Peer Mentor Project (FPM). The iHope Peer Mentor Project provides certified peer support to returning citizens in middle Georgia.[10]

- Service availability: At any point after release.
- Services provided:
    - Support to obtain stable housing
    - Support to find employment
    - Support to claim benefits
    - Connection to recovery services

For more information about the iHope Forensic Peer Mentor Project, visit https://www.ihopeinc.org/services/forensic-services/, or call 478-225-2895.

Wellness and Respite Centers. Georgia Wellness and Respite Centers are a free, peer-run alternative to traditional mental health day programs and psychiatric hospitalization.[11] To be eligible to use the respite centers, individuals must have had a "Proactive Conversation," a proactive interview with a peer staff member while the individual is well. As such, stakeholders may want to consider this option after someone is stabilized or restored to competency as a future option should support be needed. Eligible individuals must also be at least 18 years of age, self-identify as a consumer of mental health services, have a house tour, and sign Participation Guidelines.[12] While Respite Centers do not have doctors, nurses, case managers, or clinical staff, all peer staff are Certified Peer Specialists.[13]

- Service availability: 24 hours a day, seven days a week, 365 days a year.
- Service provided:
    - Respite rooms
    - Round-the-clock peer support for up to seven nights every 30 days

[9] https://www.gmhcn.org/peer-mentoring-forensic-peer-mentor
[10] https://www.ihopeinc.org/services/forensic-services/
[11] https://www.gmhcn.org/peer-support-wellness-respite
[12] Ibid.
[13] Ibid.

For more information on Wellness and Respite Centers, visit https://www.gmhcn.org/peer-support-wellness-respite.

Mental Health/Substance Use Warmlines. Mental Health/Substance Use Warmlines provide peer support over the phone using specially trained Certified Peer Specialists with lived experience recovering from behavioral health concerns.

- Service availability: 24 hours a day.
- Services provided:[14]
    - Hope and encouragement
    - Sharing lived experience
    - Understanding what it is like to experience mental health concerns
    - Linkage to support for legal issues, social support services, housing assistance, and other barriers to wellness

Warmline services can be accessed by calling 1-888-945-1414.

For more information on Mental Health/Substance Use Warmlines, visit https://www.gmhcn.org/peer2peer-warm-line.

Assertive Community Treatment (ACT). Assertive Community Treatment is an alternative, community-based service for individuals experiencing severe and persistent mental illness and/or co-occurring substance-related disorders. It also supports individuals for whom mental illness seriously impairs their ability to live in the community, i.e. those who may have frequent experiences of psychiatric admission, homelessness, incarceration, and/or legal involvement as a result of their mental illness.[15] ACT is an option for individuals who have not been successful using traditional outpatient services. ACT teams provide service where people are rather than in an office.[16] To locate an ACT Team call the Georgia Crisis and Access Line.

- Service availability: 24 hours a day, seven days a week
- Service provided[17]:
    - mental health counseling
    - psychoeducation
    - medication management
    - rehabilitation
    - substance abuse treatment
    - housing assistance
    - transportation
    - vocational assistance
    - social skills acquisition

[14] https://www.gmhcn.org/peer2peer-warm-line
[15] https://dbhdd.georgia.gov/document/publication/dbhdd-act-team-overview/download
[16] https://dbhdd.org/blog/wp-content/uploads/2015/03/act_one_pager.pdf
[17] Ibid.

    - symptom self-management
    - crisis and safety planning
    - 24/7 crisis intervention and response
    - service and resource coordination
    - support with activities of daily living

Community Service Boards. Community Service Boards (CSB) provide mental health, developmental disabilities, and addictive disease services to children and adults. These services are available to people with no insurance and limited means to pay for treatment and those with Medicaid or Medicare. There are 22 CSBs providing services for the entirety of the state.

- Service availability: 24 hours a day, seven days a week, 365 days a year.
- Service provided[18]:
    - intensive crisis stabilization
    - acute detoxification
    - outpatient counseling
    - peer support services
    - residential substance use treatment
    - community-based services
    - supported employment
    - day programs
    - supportive housing

For more information on Community Service Boards, visit https://dbhdd.georgia.gov/locations/community-service-board.

Regional Services Contacts. The Department of Behavioral Health and Developmental Disabilities system of services is administered through 6 Field Offices that serve Georgia. These offices administer the hospital and community resources assigned to the region. The regional field offices are your first point of contact for any questions about services in your area. In addition, the field offices do the following:

- Locate and coordinate services and support
- Monitor the services being received by consumers to ensure quality and access
- Develop new services and expand existing services as needed
- Investigate and resolve complaints
- Conduct special investigations and reviews when warranted

[18] https://www.georgiapines.net/community-service-boards-a-critical-part-of-georgias-healthcare-system/

- *Oversee statewide initiatives*

To access local Regional Field Office information, please visit the website below, which offers an interactive map.

https://dbhdd.maps.arcgis.com/apps/instant/lookup/index.html?appid=66e57defda7a442597357d9be5ec00bc

Pretrial Diversion Programs

Georgia Code § 15-18-80 authorizes prosecuting attorney's offices from each judicial circuit to create and administer Pretrial Diversion and Intervention Programs. These programs may be an option for individuals who meet the eligibility criteria and could benefit from supportive services, such as mental health counseling.

There are statutory restrictions to participation in pretrial diversion and intervention programs. Prosecuting attorneys consider the nature of the crime an individual is charged with, their prior arrest record, and the alleged victim's notification and response in determining participant eligibility.[19] Individuals charged with an serious offense with a mandatory minimum of incarceration that cannot be suspended, probated, or deferred are ineligible for diversion programs.[20] Pretrial diversion and intervention programs may have program administration fees up to $1000, and participants may be required to pay restitution to victims.[21]

Jail-based Mental Health Services

Jail medical staff may provide support for incarcerated individuals with mental health needs. Through timely identification, appropriate mental health care, and collaboration with legal stakeholders, jail-based medical staff may be able to offer the care or make the referrals necessary to support an individual's stabilization.

Mental health screenings during intake and subsequent behavioral observations can help identify those needing further evaluation. From there, medical staff may be able to gather historical mental health information and document behavioral observations for stakeholders exploring competency issues. Jail-based medical staff may also provide interim mental health care, such as medication management and therapeutic interventions, to stabilize the individual. They may also be able to implement crisis intervention strategies to address acute mental distress and connect individuals with more in-depth care.

Some facilities have a jail in-reach program. These programs consist of a forensic peer specialist and a counselor.[22] They typically support individuals with mental health and other social service

[19] *See* OCGA § 15-18-80
[20] Ibid.
[21] Ibid.
[22] Jail in-reach programs are run by Community Service Boards. Visit https://dbhdd.georgia.gov/locations/community-service-board, to find local Community Service Boards for more information on available jail in-reach programs.

needs as they prepare to reintegrate into the community following incarceration. In some instances, in-reach staff may be an added support for individuals not yet being released. In those cases, peer specialists may utilize their personal experience and training to encourage individuals to engage with jail-based medical staff and/or consider mental health medication or other treatments, which may lead to the individual's eventual stabilization.

Setting up regular meetings with jail staff can support jurisdictions in understanding the services available and provided. These meetings may also foster collaboration between stakeholders, allowing jail staff and system actors to troubleshoot issues affecting individuals who are experiencing mental health concerns and incarcerated.

Competency Dockets

Competency dockets are a calendaring option used by some judicial circuits to manage cases related to competency and criminal responsibility. Cases where a motion for evaluation is being considered or has been filed are consolidated into one recurring docket. These dockets ensure that competency cases are fully accounted for. The dockets also support relationship-building between system actors (judges, prosecutors and defense attorneys), jail staff, and staff at the Department of Behavioral Health and Developmental Disabilities and allow judges and system actors to develop expertise in the law and procedure and maintain familiarity with pending cases. This expertise can be deepened by having dedicated system actors for that docket who can handle the cases while pending on that docket.

Once a competency docket is established, the judge(s) presiding over the docket may take actions to support more docket efficiency and to mitigate delays associated with wait times for unnecessary competency evaluations or placements for restoration services. Judges may consider the following actions:

1. **Conduct an Initial Hearing.** Judges, even without a competency docket, are required to conduct a brief initial hearing following a defense motion for evaluation.[23] This hearing should be used to determine if the full competency process is necessary and should include the defendant, if possible. Judges may inquire of defense counsel the reason they initially filed a motion for evaluation, whether the defendant is currently receiving mental health care, either while incarcerated or in the community, and whether the defendant is prescribed, and currently, taking medication for mental illness. If the defendant is present, the judge may ask, with defense counsel agreement, initial questions that go to the heart of the issue of competency, such as: 1) who is the person beside you and what is their role? 2) who is the person at the other counsel table? 3) who am I and what is my role? The judge may also ask questions related to mental health care such as: 1) are you currently, or have you ever taken medications for mental illness? and 2) if not currently taking medications, would you be willing to do so? All of these questions may result in the

[23] Georgia Senate Bill 132, titled *Insanity and Mental Incapacity; hearing before a court orders an evaluation of the mental competency of an accused person to stand trial;* has passed and went into effect 7/1/25, following a motion for evaluation, a judge *shall* conduct a competency hearing.

judge determining that a competency evaluation is not needed, or that other alternatives should be explored first, including looking at criminal responsibility.

2. **Monitor Defendant Progress.** Competency dockets should be calendared consistently, i.e. once a month. Judges should monitor defendant progress by 1) checking in on defendant compliance with taking medication, 2) asking what services the defendant is receiving, whether incarcerated or in the community, 3) requesting re-evaluation of defendants who are medication compliant and/or receiving and compliant with services, 4) calendaring cases in a timely fashion when competency is restored, 5) working with DBHDD to advance people to evaluation and/or treatment if they are decompensating to avoid further damage. All of these steps may support defendants in moving through the system more quickly once competent, or in getting services more quickly when decompensating.

Competency dockets should be understood as a temporary docket placement for cases. Once an individual is deemed competent to stand trial, or restored to competency, their case should be removed to a regular trial calendar for resolution. In cases where an individual is found incompetent to stand trial and is not restorable, the competency docket may be the appropriate forum to determine the best course of action for the case.

Mental Health Courts

Mental health courts are a type of Accountability Court offered in some jurisdictions.[24] They serve individuals with severe and persistent mental illness, or who have co-occurring substance use disorder, whose felony or misdemeanor charges may be related to their diagnosis.

Mental health courts are different from competency dockets in that mental health court is an option used to resolve cases whereas competency dockets are dedicated calendars to track cases where there is a question of whether an individual is competent to stand trial in their case. Nevertheless, if an attorney has questions regarding the competency of their client, which are subsequently resolved following an evaluation and restoration to competency, mental health court may be a viable option to resolve the defendant's case once restored. This may serve as a mechanism to ensure continuation of services and provide additional resources as an individual reintegrates into the community.

Mental health courts may admit eligible participants pre-plea, post-plea, or operate under a hybrid model, though most individuals are admitted as a result of a guilty plea, with very limited exceptions. Participants typically engage in mental health court for 18 to 24 months. One does not need a competency evaluation to be eligible for mental health court, although they must be competent to enter an accountability court.

Requirements for participation:

[24] Accountability Court is an umbrella term that includes mental health court, veterans court, drug courts, DUI courts, and family courts.

- Needs assessment
- Regular court appearances
- Treatment and case plans
- Drug screening
- Individual and group counseling
- Medication management

Not every case is eligible for resolution in mental health court. Pursuant to O.C.G.A. §15-1-16, defendants charged with murder, armed robbery, rape, aggravated sodomy, aggravated sexual battery, aggravated child molestation, or child molestation shall not be eligible for entry into the mental health court division, except in the case of a separate court supervised reentry program designed to more closely monitor mentally ill offenders returning to the community after having served a term of incarceration.[25]

Questions for Stakeholders to Consider

When examining cases where mental health concerns are at play, stakeholders, namely prosecutors, defense attorneys and judges, may want to consider the following questions to help identify the best course of action to be taken.

The questions are organized by stakeholder type, but all explore: 1) whether the individual facing charges is exhibiting signs of mental illness, 2) whether delays in evaluation and restoration a factor in the case are, 3) whether prolonged detention is impacting the individual, and 4) whether outpatient services are a viable option.

Questions for DEFENSE ATTORNEYS to consider:

- Does the client exhibit signs of mental illness, cognitive disability, or other impairments that raise competency concerns?
    - Do the signs/symptoms exhibited appear to be treatable, to the best of your knowledge, i.e. not the result of intellectual disability, dementia, traumatic brain injury, or other conditions that are not treatable?
- Is the client able to effectively communicate, understand court proceedings, and assist in their own defense?
- Has a formal competency evaluation been requested for the present matter? If not, should a motion for evaluation be filed?
- Has the client ever been found incompetent to stand trial in the past? If so, when?
    - Were they ever restored to competency?
    - How was the previous case/were the previous cases resolved?
- What is the current timeline for competency evaluation and potential restoration services?

[25] See Standards for GA Accountability Courts, https://cacj.georgia.gov/document/document/standardsamhc7121/download

    - Based on the client's current charge(s) and the current timeline for competency evaluation and restoration, will they wait in jail longer than they would potentially serve if convicted or plead out?
- How long has the client already been detained?
- Is the client's mental health deteriorating due to prolonged incarceration?
    - Is the client receiving adequate mental health care while detained? If so, what treatment is being provided? If not, what treatment is needed? Has that treatment been advocated for?
    - Could continued detention exacerbate their condition, making restoration less likely or more prolonged?
    - Is diversion, dismissal, or a negotiated plea a more appropriate resolution than continued detention?
- Would outpatient evaluation, community-based restoration, or supervised release with services be appropriate and feasible for this client?
    - Is the client currently prescribed a medicine for mental illness?
    - Is the client currently taking any medication for mental illness?
    - Has the client been connected with community-based mental health services in the past? If so, what services? Was the client successful?
    - Is the client willing to connect with community-based mental health services now?
- Is the delay in competency services violating the client's constitutional rights to due process under Jackson v. Indiana or other precedent?
- Would it be appropriate to file a motion for release, dismissal, or a stay of proceedings based on excessive delay?
- Are there legal grounds for habeas corpus relief due to unconstitutional conditions of confinement?

Questions for PROSECUTING ATTORNEYS to consider:

- Is there credible evidence raising concerns about the defendant's competency to stand trial?
- Has a formal competency evaluation been requested for the present matter? If not, should one be initiated?
- Has the defendant ever been found incompetent to stand trial in the past? If so, when?
    - Were they ever restored to competency?
    - How was the previous case/were the previous cases resolved?
- What is the current timeline for competency evaluation and potential restoration services?
    - Based on the defendant's current charge(s) and the current timeline for competency evaluation and restoration, will they wait in jail longer than they would potentially serve if convicted or plead out?
- How long has the defendant already been detained while awaiting competency services?
    - What impact is prolonged detention having on the defendant's mental health and overall well-being?
    - Could prolonged detention worsen the defendant's competency or mental health condition?

    - Is the defendant receiving adequate mental health care while detained? If not, is defense advocating for adequate care?
- Does the nature of the offense necessitate prosecuting this case to the full extent of the law?
    - Could dismissal, diversion, or other alternatives be more appropriate given the delays in competency services and/or nature of the offense?
- Could the defendant be safely supervised or monitored in the community while awaiting treatment or evaluation?
    - Is the defendant currently prescribed a medicine for mental illness?
    - Is the defendant currently taking any medication for mental illness?
    - Has the defendant been connected with community-based mental health services in the past? If so, what services? Was the defendant successful?
    - Is the defendant willing to connect with community-based mental health services now?

Questions for JUDGES to consider:

- Is there credible evidence raising concerns about the defendant's competency to stand trial?
- Does the client exhibit signs of mental illness, cognitive disability, or other impairments that raise competency concerns?
- Has a formal competency evaluation been requested for the present matter? If not, should one be initiated?
- How long has the defendant been detained while awaiting competency services?
- Does the length of detention already exceed the maximum sentence or expected sentence for the charged offense?
- What is the current timeline for competency evaluation and potential restoration services?
- Should the court consider alternatives to incarceration such as outpatient competency restoration services, conditional release with mental health supervision, immediate removal to a treatment facility rather than jail, unconditional release?
    - Is the defendant currently prescribed a medicine for mental illness?
    - Is the defendant currently taking any medication for mental illness?
    - Has the defendant been connected with community-based mental health services in the past? If so, what services? Was the defendant successful?
    - Is the defendant willing to connect with community-based mental health services now?
- *Questions for Prosecuting Attorney:*
    - Given the delays in competency services, is continued prosecution in the interest of justice for this case?
    - Are there alternatives to continued prosecution, such as diversion, case dismissal, or reduced charges, that could resolve the matter?

    - Have the People considered the possibility of outpatient restoration or community-based services as an option in this case?
- *Questions for Defense:*
    - Do you have evidence of the defendant's inability to effectively communicate, understand court proceedings, and assist in their own defense?
    - Is the client's mental health deteriorating due to prolonged incarceration?
    - Could continued detention exacerbate their condition, making restoration less likely or more prolonged?

If a competency evaluation is determined to be the appropriate step, attorneys and judge should consider the least restrictive paths to conducting this evaluation.

NOTE: Once the competency order starts, some of the previously available options (see prior section) are no longer available.

Procedure for Determination of Mental Competency to Stand Trial:

1. Request for Competency Evaluation

- **Initiation**: The defense or the court may raise the issue of the defendant's competency to stand trial. The concern must be supported by specific evidence or observations that the defendant may be unable to understand the proceedings or assist in their own defense.
- **Motion**: The defense or prosecution may file a formal motion for a competency evaluation, or if information becomes known to the court sufficient to raise a genuine doubt about the defendant's competency to stand trial, the court has a duty to begin an inquiry of its own accord and may order an evaluation.
- **Timing**: If there is a genuine concern about the defendant's mental competency to stand trial, the issue can be raised at any point in the criminal process – during pretrial proceedings and even after a trial has started.

2. Appointment of Mental Health Experts

- **Selection**: Once the court grants the motion for a competency evaluation, the court may order the Department of Behavioral Health and Developmental Disabilities (DBHDD) to conduct an evaluation by a physician or licensed psychologist. DBHDD's Office of Forensic Services completes evaluations on the legal issues of competency to stand trial. Court orders should be sent to courtservices@dbhdd.ga.gov for adult cases or juvenilecourtservices@dbhdd.ga.gov for youths.
- **State vs. Private Expert**: In some cases, the defendant may seek a court order for a non-DBHDD/private mental competency evaluation, with the cost to be incurred by the defendant.

3. Competency Evaluation Process

- **Evaluation Setting**: The evaluation may take place in a correctional facility, a state forensic institution, or on an outpatient basis, depending on the circumstances and the defendant's location.
- **Scope of Evaluation**: The mental health expert(s) will assess:
    1. **Capacity to Understand**: Whether the defendant understands the nature of the charges, the legal process, and potential consequences.
    2. **Ability to Assist Counsel**: Whether the defendant can communicate effectively with their attorney and participate in their defense.
- **Evaluation Report**: The physician or licensed psychologist prepares a written report summarizing their findings and conclusions. This report will include whether the defendant is competent to stand trial and, if found incompetent, whether the defendant can regain competency with treatment. The report also provides information about potential treatment setting recommended based on the individual's presentation. The competency evaluations may come in different formats at the discretion of the evaluator (e.g. long or short-form versions), and the court has the option to request a truncated report.
- **Criminal Responsibility (Mental state at the time of the alleged act)**:
    1. Criminal responsibility is a separate determination from competency. In most cases this should only be requested when considering a not guilty by reason of insanity special plea.
        - GA Code § 16-3-2 (2020)

4. Competency Hearing

- **Scheduling**: If the evaluation report suggests that the defendant may be incompetent, and the defense counsel files a special plea, the evaluation report will be sent to the prosecutor and a bench trial, generally referred to as a competency hearing, will be scheduled. This is a separate civil legal proceeding from the criminal trial. Defense counsel may, in lieu of a bench trial, request a special jury trial.
- **Presentation of Evidence**: During the hearing, the court will consider the evaluation report and allow both the defense and the prosecution to present evidence or call witnesses. The physician or licensed psychologist may testify, and their findings can be challenged through cross-examination.
- **Burden of Proof**: In Georgia, the burden is on the party raising the competency issue (typically the defense) to prove by a preponderance of the evidence that the defendant is not competent to stand trial.

5. Court's Determination

- **Finding of Competency**: If the court finds that the defendant is competent to stand trial, the criminal proceedings will resume.

- **Finding of Incompetency**: If the court finds the defendant incompetent to stand trial, the court may order a DBHDD physician or licensed psychologist to re-evaluate to determine whether there is a substantial probability of the defendant attaining mental competency to stand trial in the foreseeable future. The results of this evaluation may include possible options for treatment. For inpatient or in-custody defendants, this evaluation is required to occur within 45 or 90 days after DBHDD has received actual custody of the defendant, depending on the nature of the charges. For outpatient defendants, the evaluation would be required to be completed within 45 or 90 days of the court ordered evaluation, again depending on the nature of the charges.
    - If DBHDD finds the defendant is incompetent to stand trial but has potential for restoration, the court will request that DBHDD attempt competency restoration.
    - If DBHDD finds the defendant incompetent to stand trial with no substantial probability to attain restoration in the foreseeable future, the court has 45 days to determine next steps for the defendant.

6. Treatment to Restore Competency

- **Commitment to a Facility**: The court may order the defendant to be committed to a DBHDD forensic facility for treatment. DBHDD has the discretion to use a psychiatric hospital or a jail-based restoration program for treatment.
- **Outpatient Treatment**: For defendants accused of non-violent crimes, the court may order outpatient treatment if it is deemed sufficient to restore the defendant's competency.
- **Periodic Re-Evaluations**: The defendant's competency will be periodically re-evaluated over an additional period not to exceed 120 days (qualifying misdemeanors) or nine months (all other charges). During this time, the court will receive reports from a department physician or licensed psychologist regarding the defendant's progress toward restored competency. If after the allotted restoration time allowed by law, the defendant is still determined mentally incompetent to stand trial, the court will follow the same steps as it would for a defendant without a substantial probability to attain competency.

7. Restoration of Competency

- **Review of Treatment**: Once the department physician or licensed psychologist believes the defendant's competency has been restored, DBHDD will notify the court.
- **Hearing**: Within 45 days of receiving the DBHDD's competency evaluation, the court will hold another hearing to determine if the defendant is now competent to stand trial.

- **Resumption of Criminal Proceedings**: If the defendant is found competent, the criminal proceedings will resume.

8. Extended or Permanent Incompetency

- **Civil Commitment**: If it is unlikely that the defendant will ever be restored to competency, the court may order inpatient civil commitment proceedings to ensure the defendant is hospitalized or placed in a mental health facility. The court may also order outpatient civil commitment. Inpatient and outpatient civil commitment can be accomplished through the criminal court if there is an interest in following the case. It can also be accomplished through probate court if the charges are dismissed.
    - Certain diagnoses may lead to a determination of incompetence to stand trial without substantial likelihood of restoration but may not allow the defendant to be eligible for civil commitment under the law. Such diagnoses may include, but are not limited to, dementia and intellectual or developmental disability.
- **Dismissal of Charges**: If the defendant remains incompetent for an extended period, and there is no substantial likelihood of restoration, the charges may be dismissed without prejudice.

    - For qualifying misdemeanor offenses, if by the end of the 120 day restoration period or when the accused's condition warrants, if the accused is still determined by the department physician or licensed psychologist to be mentally incompetent to stand trial, irrespective of the probability of recovery in the foreseeable future, the charges against the accused shall be dismissed as a matter of law by the court and the accused shall be referred to a community service board unless otherwise ordered by the court for cause shown upon the hearing of a motion by the prosecuting attorney.

9. Appeals

- The determination of competency can be appealed. An appeal is typically initiated by the defense if the defendant is found competent to stand trial. The appeal would follow Georgia's general appellate procedures for criminal matters.

Relevant Statutes related to Competency to Stand Trial

- **O.C.G.A. § 37-3-1** (Mental Health Definitions)
- **O.C.G.A. § 16-3-2** (Mental Capacity; Insanity)
- **O.C.G.A. § 16-3-2** (Delusional Compulsion)
- **O.C.G.A. § 17-7-129** (Mental capacity to stand trial; release of competency evaluation to prosecuting attorney)
- **O.C.G.A. § 17-7-130** (Proceedings upon plea of mental incompetency to stand trial)

- **O.C.G.A. § 17-7-170** (Demand for Speedy Trial)

Conclusion

In Georgia and across the nation, delays associated with the competency evaluation process threaten the due process rights of individuals at the intersection of mental health and the criminal legal system. Protecting those rights will require a multi-stakeholder response that utilizes sound legal practices, innovation, and community-based services to meet the challenge. This toolkit summarizes current issues and procedures and identifies services and court-based alternatives to equip stakeholders with the tools to navigate and improve the system. With practical guidance, strategic questions, and a framework for collaborative problem-solving, this toolkit serves as a resource for creating a competency process that is more efficient, equitable, and responsive to the needs of all involved.

Appendix A

DBHDD DIVISION OF BEHAVIORAL HEALTH

Diversion is an intervention approach that redirects individuals away from formal processing in the justice system, while still holding them accountable for their actions.

The goal of diversion is to remove and/or prevent individuals, as early as possible, from entering the justice system. Through diversion related activities/interventions, as defined below, the hope is to avoid negative outcomes associated with formal processing, incarceration, recidivism, stigmatization/labeling, and increased criminal justice costs for those individuals who could have been served in the community via a Behavioral Health provider. This is done through behavioral health supports/programs/activities that are put in place to assist the individual remain in their community. (See list of DBHDD Diversion Activities below).

ACTIVITIES/DEFINITIONS OF DIVERSION:

Behavioral Health Diversion refers to jail diversion, whereby an individual who has a behavioral health need may still be involved with the criminal justice system (such as the courts) but spends little to no time in a jail facility and is instead connected to community-based treatment and support services either with or without court involvement or correctional supervision.

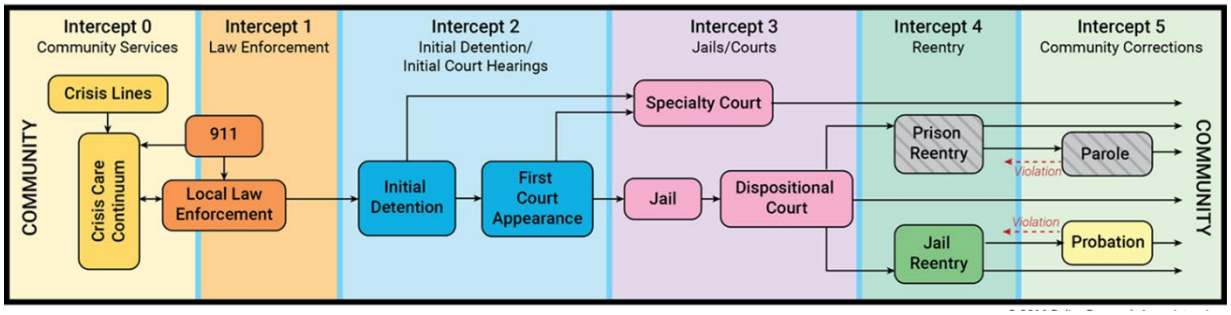
Behavioral health diversion intervention: These programs and practices reduce or eliminate jail time for individuals who have behavioral health needs by connecting them to community-based treatment and support services. This term includes recognizable diversion programs such as mobile crisis teams and Law Enforcement Assisted Diversion (LEAD), as well as local practices that lead to a diversion-related outcome.

Pre-booking diversion: Programs and practices that can occur at any point in the criminal justice system before a person is booked into a facility and relies heavily on effective interactions between police and community mental health and substance use disorder treatment providers.

Post-booking diversion: Programs that are used to identify and divert individuals who have behavioral health needs after they have been booked into jail. Post-booking diversion interventions are typically led by either the courts or jails.

Pretrial diversion: Type of post-booking diversion. It is commonly defined as programs and practices that occur at any level or stage of justice supervision between law enforcement contact and a plea or other disposition of the criminal case. As a result, pretrial diversion may involve multiple agencies, including jail, pretrial release, prosecutors, defense counsel, and even probation departments that operate in a pretrial capacity.

SEQUENTIAL INTERCEPT MODEL:



DBHDD DIVERSION ACTIVITIES:

I. Office of Children, Young Adults and Families (OCYF)

a. **Georgia Apex Program (APEX) - Intercept 0**

Apex is a DBHDD-funded partnership between community-based behavioral health providers and local school districts. The program utilizes a school-based behavioral health framework to increase access to behavioral health services among school-aged youth (Pre-K through 12th grade) throughout the state.

b. **Intensive Customized Care Coordination (IC3) - Intercept 0, 1, 4, 5**

IC3 is Georgia's adaptation of High-Fidelity Wraparound. The model assists youth with complex behavioral health needs and their family by assembling a team of dedicated care coordinators, peer supports with lived experience, and other supportive individuals identified by the family. The goal is to develop an individualized plan of care to meet the family's underlying needs, generate hope, and increase functioning at home, at school, and in the community.

IC3 is differentiated from traditional case management by:

- Coaching and skill building for the child and parent or caregiver to empower self-activation and self-management for personal resiliency, recovery and wellness, and movement toward stability and independence.
- Intensity of the coordination: average of three (3) hours of coordination weekly.
- Frequency of the coordination: average of one (1) face-to-face meeting weekly.
- Caseload: average of ten (10) youth per care coordinator.
- Duration of intended services: 12 to 18 months.
- Partnership includes a high-fidelity wraparound-trained certified parent peer specialist as a part of the Wrap Team.
- Support of a Child and Family Team, minimally comprised of the child, parent or caregiver, care coordinator, certified parent peer specialist, and one natural support.
- Care decisions made in Child and Family Team meetings, held at least every 30 days.

c. **System of Care Coordinators (SOC) - Intercept 0, 2**

The SOC Legacy program provides funding support for Tier 1 providers and community organizations to provide direct services and supports; supplement expansion of youth and family voice; provide training on system of care-related topics; and work collaboratively with other agencies, organizations and community providers to support SOC efforts statewide. The program is supported and administered by DBHDD's OCYF. Services and supports provided for youth aged (4 years old) through age 26.

The goal of the SOC Legacy program is to improve outcomes for children, young adults, and families, managing serious mental health challenges and substance use concerns, by focusing on social determinants such as education, employment, social connectedness, accessing behavioral health services, resiliency, and vocational/independence development.

d. **Youth Mental Health Resiliency Support Clubhouses - Intercept 0, 4, 5**

Mental Health Resiliency Clubhouse is a youth-guided, family-driven intervention that provides creative and non-traditional techniques to build skills, develop leaders, and create relationships among peers. The therapeutic environment of each Clubhouse promotes emotional development and healing in a safe, supportive setting for youth and young adults. The goal is to improve outcomes for youth and young adults with serious mental health conditions in collaboration with families and community partners, and through caring and passionate staff as well as positive skill-building techniques.

The Youth Mental Health Resiliency Clubhouse Program is designed to provide a comprehensive and unique set of services for children, young adults and families coping with the isolation, stigma, and other challenges of mental health disorders. The clubhouse program provides supportive services that include educational supports, employment services, peer support, family engagement, social activities, and other initiatives geared to engage youth as well as assist them in managing behaviors and symptoms. In addition to receiving the unique support of the Clubhouse, youth and their families participate in therapeutic evidence-based interventions. The supports and interventions are all grounded in the 7 Cs of Resiliency* framework, which promotes seven interrelated core components to build resiliency: competence, confidence, character, contribution, coping, control, and connection.

e. **Coordinated Specialty Care for First Episode Psychosis – Intercept 0-5**
Coordinated Specialty Care for the First Episode Psychosis Program (CSC for FEP) is a team-based, time-limited, multi-faceted approach to treating youth and young adults, ages 16-30, experiencing first episode psychosis. The CSC for FEP model's guiding principles include early detection of psychosis; rapid access to specialty care; flexible, accessible, youth-friendly, and welcoming services; recovery-focused interventions; and respect for young adults striving for autonomy and independence. Component interventions include case management, psychotherapy, supported education and employment services, peer support, family education and support, and medication management. CSC for FEP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of the individuals served.

f. **CHRIS 180 Drop-In Center – The Spot – Intercept 0**
Drop-in centers represent a service that is provided by persons who have personal experience with challenges similar to those experienced by program participants, including mental health problems, substance abuse or both. A drop-in center is primarily operated by peers, meaning, the individuals that access the drop-in center are also the people who make the decisions and rules for the drop-in center. This method of service delivery is an important element in the shift to position consumers in the role of a provider. This is a working example of the shift from the medical model to the clubhouse model of community mental health.

g. **GPSN CPS & The Youth Peer Center (TYPC) – Intercept 0**
GPSN is a family-run organization in Atlanta, Ga. that seeks to prioritize the family network to address children's mental and behavioral health issues. The organization has a long-standing commitment to serving Georgia families and transition-age youth. Their peer services include: the Transitional Youth Peer Center (TYPC); homeless youth peer support; youth M.O.V.E. advocacy; and therapeutic foster care services. In addition to

these services, GPSN also facilitates ongoing Certified Peer Support-Parent (CPS-P) and Certified Peer Support-Youth trainings throughout the state.

h. **F.A.V.O.R. – Federation of Families Chapter & CPS – Intercept 0**
Families Advocating for Voices of Resilience, Inc. (FAVOR) is a faith-based non-profit enriching the lives of families in Georgia. F.A.V.O.R provides PEER support services to families with children ages 5 through 21 with a primary mental or behavioral health diagnosis. Their mission is to ensure families have a voice in their treatment by educating, strengthening, and empowering them while in their present circumstances. The organization assists families in maximizing their fullest potential by understanding their unique needs, linking them to community resources, and providing support through various services.

II. Office of Behavioral Health Prevention (OBHP)

a. **Youth Prevention Clubhouses – Intercept 0**
Provide prevention services to high-risk youth, ages 12-17, through evidence-based curriculums, peer mentorship, and interactive programs for building coping, decision-making, and life skills.

1. **Next Generation Youth Development** (Dawson County, GA)
Next Generation operates the V2 Clubhouse and provides youth with structured, evidence-based prevention programming using CSAP strategies such as Education, Alternatives, and Information Dissemination. The program incorporates mentoring, academic support, employment readiness, community service, and supervised recreational activities. Youth and families also participate in monthly engagement events, and individualized case management is provided to address basic needs and ensure access to services.

2. **DR3AM'RS Clubhouse Program** (Norcross, GA)
View Point Health, in collaboration with Mixtura, delivers the DR3AM'RS Clubhouse program. The site serves as a culturally responsive, safe space for youth with a focus on resilience-building and prevention education. Services include evidence-based programming, mentoring, tutoring, career exploration, family engagement activities, and holistic wellness efforts such as nutrition and health education. The clubhouse also features creative arts, gaming, and field trips to promote prosocial behavior.

3. **100 Black Men of West Georgia** (LaGrange, GA)
This Clubhouse engages youth through a culturally affirming prevention approach led by the 100 Black Men of West Georgia. Programming includes evidence-based education, mentoring by trusted community leaders, service learning, and employment development. Youth also benefit from consistent case management, academic support, and enrichment activities designed to promote healthy decision-making and reduce substance misuse risk factors.

III. Office of Adult Mental Health (AMH)

a. **Assisted Outpatient Treatment (AOT) – Intercept 0, 1, 2**
AOT is commonly referred to as the practice of providing court-ordered community-based mental health treatment under a civil commitment to individuals living with serious mental illness if it is determined that they may be a danger to themselves or others. It is a legal procedure which may be employed in the case of a *specific individual* who meets certain criteria.

AOT can facilitate engagement in treatment services and supports that may allow an individual to live independently in the community of their choice while living with a mental health diagnosis. It also helps providers focus their attention to work diligently to keep the enrolled individual engaged in effective treatment, and to support them in reaching their personal recovery goals.

b. **Co-responder Program – Intercept 0 ,1**
Co-responder programs are established through a partnership between Community Service Board (CSB) and one or more law enforcement agencies to utilize the combined expertise of police officers and behavioral health professionals on emergency calls involving behavioral health crises to de-escalate situations and help link individuals with behavioral health issues to appropriate services.

SB 403, the "Georgia Behavioral Health and Peace Officer Co-response Act" provides local law enforcement agencies with the opportunity to partner with behavioral health specialists to assist officers when responding to an emergency mental health crisis.

c. **Forensic Peer Mentors (FPM) – Intercept 3, 4**
The goal of the FPM Program is to assist in re-entry efforts and reducing recidivism of post-incarcerated offenders with serious mental illness and/or co-occurring substance use disorder who are incarcerated in a Facility and within 12-18 months of release and after release to support reentry and connect to resources needed for sustained success.

d. **Mental Health Accountability Courts – Intercept 2, 3**
Mental Health Accountability Courts are designed to assist persons with severe and persistent mental illnesses who have legal troubles. They provide combined mental health and substance use treatment (therapy) along with structure from the court system (sanctions, interactions with the judge, access to a public defender) to change behaviors, thought processes, and promote recovery to reduce recidivism. This is a treatment approach versus incarceration.

e. **Assertive Community Treatment (ACT) - Intercept 0, 1, 4, 5**
ACT is an evidence based, person-centered, recovery-oriented, intensive community-based service that provides a comprehensive approach to service delivery to individuals whose severe and persistent mental illness has significantly impaired their functioning in the community and for whom traditional outpatient treatment has shown minimal effectiveness.

The ACT Team works as one organizational unit providing community-based interventions that are rehabilitative, intensive, integrated, and stage specific. ACT is a unique treatment model in which the majority of mental health services are directly provided internally by the ACT program in the recipient's natural environment.
ACT services supports individuals in transitioning out of institutions and helps to integrate them into community settings successfully. ACT ensures individuals are

afforded opportunities for safe and affordable housing, supported employment, medication education and stabilization to decrease symptomology and linkage to statewide benefits. ACT services hope to reduce re-admission to inpatient settings, involvement with the criminal justice system and homelessness.

f. **Jail In-Reach Pilots – Intercept 2, 3, 4**

Jail In-Reach Pilots utilize a Case Manager (CM) and a Forensic Peer Mentor (FPM) to identify, engage and assist individuals in receiving appropriate community behavioral health services and successful community reentry. A CM and FPM are assigned to each jail, and a screening is completed to identify individuals that meet criteria for the program. The Case Manager provides referral and linkage to services and supports that decrease hospitalization, incarceration, and homelessness and arranges outpatient follow up services at community service board. The case manager is also responsible for working with correctional officers to identify individuals that may meet criteria to receive jail in-reach services.

The FPM will utilize lived experience to engage individuals prior to release, will participate in jail transition/release planning and will provide follow up to link individuals to treatment, medical care, and other community services and supports that are responsive to the needs of the individual.

g. **Georgia Crisis Intervention Team Program (CIT) – Intercept 1**

The CIT Training course prepares law enforcement officers and other public safety personnel with the skills to assist and refer people with mental illness, co-occurring disorders, substance misuse, developmental disorders or other brain disorders who are in crisis, thereby advancing public safety, reducing stigma, and diverting individuals in need of treatment for behavioral health conditions away from the criminal justice system. This course is an intensive 40-hour, five-day curriculum that is comprised of both classroom instruction and practical exercises delivered by mental health professionals, other subject matter experts and CIT law enforcement instructors. This course is approved by the Georgia Peace Officers Standards and Training (POST) Council.

IV. Office of Addictive Diseases (AD)

a. **AD Accountability Courts – Intercept 2,3**

This is a time-limited, multi-faceted treatment model for adults who are enrolled in a Certified Accountability Court Program and require structure and support to achieve and sustain recovery from behavioral health conditions. These services enable individuals served to maintain residence in their community, continue to work and go to school and be part of their family life.

b. **Forensic Peer Mentors (FPM) - Intercept 3,4**

Peer Support is a service intended to promote recovery and wellness, assist with community re-entry/integration efforts, and support a reduction in the likelihood of recidivism among judicially involved individuals with serious mental illnesses and/or co-occurring substance use disorders. FPMs support individuals in preparing for a life free

from judicial involvement and provides ongoing support during and after release from judicial obligations.

c. **Women's Treatment and Recovery Services (WTRS) Residential, Outpatient, and Transitional Housing – Intercept 0**
WTRS provides a continuum of care with services from Intensive residential to After Care programming. Each level of care is individualized based on need and offer clinical services that include individual and group counseling with trauma focus. Residential sites also provide Therapeutic Childcare (TCC), providing assessment for the children on site to ensure each child receives any identified services. An on-site safe and adequate living environment is provided for dependent children ages 13 and younger. WTRS also has priority admission targeted for pregnant women, IV users, and those who meet the definition of Needy Families in Georgia. There are currently 21 providers, and, in each region, there is also an option of Transitional Housing that provides a safe, stable, recovery residence for no more than 6 months to any woman or woman with a child that has successfully completed all recommended treatment/recovery services within the WTRS network.

d. **State Opioid Response Emergency Department – Intercept 0**
Provides Peer Recovery Support Services (PRSS) in the emergency department and hospital system for community members impacted by addiction. Strategy is simple but highly effective. Whenever a hospital has an admission due to an overdose or any other substance challenge, the Recover Connection team is sent a referral to meet with that peer at that moment in the hospital. The relationship continues daily until discharge. Peers then assist them in finding the pathway of their choice through resources to offer as much opportunity to recover as possible.

e. **Medication Assisted Treatment Inpatient/Outpatient Services – Intercept 0, 1, 2**
Comprehensive opioid specific treatment programs that aim to treat/manage opioid use disorders through an approach that utilizes medications, such as methadone, buprenorphine, and naltrexone. The target population for the residential services is adult men and women, age 18 or older and the average length of stay for the inpatient programs are 6-12 weeks. For these programs, a verified substance abuse diagnosis is required and must be from a psychiatrist, licensed professional counselor, LCSW, or a nurse practitioner.

f. **Addiction Recovery Support Centers (ARSC) Outpatient Services – Intercept 0, 1, 2**
An Addiction Recovery Support Center is a peer led environment that offers a set of non-clinical activities that engage, educate and support individuals and families successfully to make life changes necessary to establish, maintain and enhance recovery (health and wellness) from substance use disorders. The recovery activities are community-based services for individuals with a substance use disorder; and consist of activities that promote recovery, self-determination, self-advocacy, well-being, and independence. The target population for these programs are Individuals 18 years or older and their families affected by the disease of addiction. It is important to note, there is no diagnose needed to receive services. These programs provide daily activities that are holistic in nature, support people moving beyond their illness and toward a life of self-directed recovery.

g. **Addiction Recovery Support Centers (ARSC) – Intercept 0**

A peer led program that offers non-clinical activities to support individuals and families on their journey in recovery from substance use disorders. The recovery activities are community-based services for those in or seeking recovery and their allies; consist of activities that promote recovery, self- determination, self-advocacy, well-being, and independence.
Activities are individualized, recovery-focused, and based on a relationship that supports a person's ability to promote their own recovery. The activities include social support, linkage to and coordinating among other service providers, eliminating barriers to independence and continued recovery.

h. **Certified Addiction Recovery Empowerment Specialist Recovery - Intercept 0**
CARES is designed to create a workforce of peers to provide recovery support services to the communities of Georgia. The CARES Academy is the first of its kind in the country to be Medicaid billable. We have a total of 10 Cares Academy each year. Three CARES Academies are specialized, 2 for individuals who use medication to support their recovery and 1 for the deaf and hard of hearing in recovery.

i. **Gambling Addiction Treatment Services - Intercept 0,1**
DBHDD contracts with four community-based treatment providers to deliver ASAM Level One Treatment for individuals with Gambling Addiction and Substance Use Disorders. These programs may collaborate with the drug courts in their region and integrate the educational component into their daily treatment activities.

V. Office of Crisis Coordination

a. **Georgia Crisis and Access Line (GCAL) and 988 – Intercept 0**
GCAL is a 24/7/365 call center that is accessible to anyone in Georgia who needs crisis intervention and/ or access to services. Call center clinicians rapidly assess the individual and their situation, de-escalate whenever possible, and refer the person to the appropriate level of follow up treatment or resources. Call center staff can refer people to outpatient services, dispatch a mobile crisis team, link people to community crisis or inpatient care, or connect the individual to 911 for active rescue. GCAL can be accessed using the 1-800 number (800-415-7225) or by calling, texting, or chatting through 988. 911 Centers can also link people to GCAL using a special phone number that connects them directly to a call center staff member instead of waiting in line with others who have reached out directly to GCAL.

b. **Mobile Crisis Response Service Teams (MCR) – Intercept 0**
MCRS provides community-based face-to-face rapid response to individuals in an active state of crisis. This service operates 24 hours a day, seven days a week. MCRS offers short-term, behavioral health, intellectual/developmental disability, and/or Autism Spectrum Disorder (ASD) crisis response for individuals in need of crisis assessment, intervention, and referral services within their community.

This service is unique in that it provides in-person and/or telemedicine intervention to persons in their community who may be in crisis. MCRS may be provided in community settings including, but not limited to homes, residential settings, other

treatment/support settings, schools, hospital emergency departments, jails, and social service settings. Interventions include a brief, situational assessment; verbal and or behavioral interventions to de-escalate the crisis; assistance in immediate crisis resolution; mobilization of natural support systems; and referral to alternate services at the appropriate level.

VI. Office of Prevention and Federal Grants

a. **State Opioid Adapted Response (SOAR) Training for Law Enforcement - Intercept 1**
This training is a partnership with the Georgia Public Safety Training Center (GPSTC). The purpose of this course is to give the public safety responder the tools necessary to recognize symptoms of an opioid overdose, information on best practices to protect themselves and the victim from further exposure, and instruction on how to properly administer Naloxone. Officers also review Georgia's 9-1-1 Medical Amnesty and Expanded Naloxone Access Law, which provides limited immunity from arrest, charge, and prosecution for possession of certain drugs and drug paraphernalia for individuals who experience a drug overdose and are in need of medical care and SUD treatment and for those who seek medical care in good faith for a person experiencing an overdose. Officers are provided with information on treatment resources that they can provide to individuals in crisis.

VII. Office of Recovery Transformation – Intercept 0, 3,4,5

a. **Certified Peer Specialist – Addiction/Mental Health, CPS-AD/CPS-MH** – Intercept 3,4
Certified Peer Specialists, CPS-AD/MH - CPSs provide support, interventions, help identify goals, increase engagement, and assist with recovery navigation.

Peer support increases:

- Engagement for "Hard-to-reach" individuals
- Individuals' involvement in their services
- Employment
- Housing
- Provider relationships
- Child Welfare Reunification
- Quality of life
- Connection in communities

Peer support decreases:

- Emergency Department visits
- Substance Use
- Inpatient days
- Re-hospitalizations
- Re-incarceration
- Justice and Welfare Involvement
- Cost of services

b. **The Peer Mentor Project – Intercept 0**
Peer Mentors provide mentoring, peer support, and community-resource linkage to promote the successful transition of adults with behavioral health diagnoses returning to communities of their choice following psychiatric in-patient hospitalization.

Peer Mentors work in each of the five Georgia Regional Hospital catchment areas (Central State Hospital in Milledgeville; East Central Regional Hospital in Augusta; Georgia Regional Hospital in Atlanta; Georgia Regional Hospital in Savannah; and West Central Georgia Regional Hospital in Columbus), in Crisis Centers throughout Georgia, with Mobile Crisis Teams, and in the Georgia Mental Health Consumer Network's Peer Support, Wellness, and Respite Centers.

c. **Addiction Recovery Support Centers, ARSC – Intercept 0**
A peer led community-based program that offers non-clinical activities to support individuals and families on their journey in recovery from substance use disorders.

d. **5 Wellness & Respite Centers – Intercept 0**
Georgia's Peer Support, Wellness, and Respite Centers are peer-run alternatives to traditional mental health day programs and psychiatric hospitalization.

Each of the five Peer Support, Wellness, and Respite Centers has respite rooms available to citizens of Georgia, available 24 hours a day, year-round. The three or four respite rooms at each Center are free of charge and can be occupied by a peer overwhelmed by life challenges who feels they would benefit from 24/7 peer support, for up to seven nights, every 30 days. The Respite centers also offer daily peer to peer connections through support groups and activities.

e. **MH/SA Warmlines – Intercept 0**
The Peer 2 Peer Warm Line provides Georgians the opportunity to receive peer support over the phone and online twenty-four hours a day. Each call or chat message is answered by a Certified Peer Specialist, a person with lived experience recovering from behavioral health concerns, who has received special training to be able to listen with empathy, and who can provide assistance and resources to others.

VIII. High Utilization Management (HUM) – Intercept 0

The HUM program provides support to individuals who have experienced challenges or other barriers in accessing and remaining enrolled in community-based services and supports. Using a data-driven process, HUM identifies and provides assertive linkage, referral, and short-term care coordination for individuals with behavioral health and substance abuse challenges who have a demonstrated history of high crisis service utilization.

HUM offers support, education, and navigation to assist at-risk individuals who could benefit from the removal of barriers to access community-based treatment. Utilizing a recovery-oriented approach, HUM services offer care coordination in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental, and other services and supports, regardless of the funding source for the services which access is sought. The HUM program includes assertive engagement and time limited follow up to individuals to support and encourage a consistent and ongoing connection with appropriate community resources.

The target population for HUM includes:

Adults and Children with a primary substance use, mental health, or co-occurring diagnosis who have been admitted to a crisis setting (CSU, BHCC, State contracted Community-Based Inpatient Psychiatric facility, DBHDD State Hospital, or Residential Detox) meeting one of the following frequency rates:

1. A 30-day readmission; or
2. Two (2) admissions within a 12-month period;
   AND/OR
3. Other crisis utilization indicators, as evidenced by the following:
   a. Three (3) mobile crisis dispatches within 90 days or;
   b. Four (4) or more mobile crisis dispatches within nine months; or
   c. Two (2) or more presentations at an Emergency Department within 90 days; and/or
   d. 30 consecutive days or more in a CSU or State Contracted Community-Based Inpatient Psychiatric bed.

IX. Office of Supportive Housing (OSH)

a. **Georgia Housing Voucher Program (GHVP) - Intercept 4,5**

GHVP is a permanent supportive housing program for individuals who have behavioral health and/or mental health barriers, are involved with the justice system and homeless and/or unsheltered. GHVP assists program participants in finding their own living space and signing their own lease for permanent long-term housing. The goal of the program is for GHVP to provide a housing first approach with long term housing support. GHVP assist individuals in obtaining stable, long-term, independent housing and thereby:

- Serve as diversion to incarceration.
- Ensure a successful transition back into the community after release from a correctional faciality.
- Significantly reduces recidivism.
- Reduce costs for the local community and stakeholders.

On-going housing supports include:

- Linkage with local health care providers such as mental health, medical, dental, and vision.
- Addressing current needs as well as preventative measures and anticipating future service needs.
- Linkage with employment and other vocational resources.
- Linkage with substance use resources.
- Focus on increasing independence and activities of daily living.
- Choice in where program participants live.
- Assistance working with local landlords, property management, rental companies, and apartment complexes.
- Assistance completing housing applications and obtaining all. entitlements/benefits.
- Transportation education and support to navigate their local communities.

Bridge Funding provides financial assistance for:

- short term hotel stays
- rental deposits and move in costs
- household goods and furnishings (i.e., bed, mattress, sofa, bed linen, food, pots/pans)

- landlord incentives
- landlord repair costs
- utility assistance

b. **Projects for the Assistance for the Transition from Homelessness (PATH) – Intercept 1, 4, 5**

Stable housing is a critical component of recovery. SAMHSA's homelessness programs and resources work to end homelessness by improving access to treatment and services that support health and wellness. It is well documented that untreated behavioral health conditions can contribute to issues such as unemployment that make it difficult to find and keep stable and affordable housing. As reported by the Office of National Drug Control Policy, approximately 30% of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition. SAMSHA's homelessness programs support many types of behavioral health treatments and recovery-oriented services. These services include:

- Outreach
- Case management
- Treatment for mental and/or substance use disorders
- Enrollment in mainstream benefits such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP)
- Peer support services
- Employment readiness services

Programs primarily target people experiencing homelessness who have been underserved, or who have not received any behavioral health services. Most of these programs support people who experience chronic homelessness.

c. **Comprehensive Continuum for People with Severe Mental Illness & Frequent Police Contact/ Policing Alternatives & Diversion (PAD) Initiative (legal name: Atlanta Fulton Pre-Arrest Diversion Initiative) - Intercept 0,1,4,5**

The PAD Initiative provides law enforcement assisted diversion (pre-arrest) as well as community referrals through the City of Atlanta 311 line to divert individuals from arrest who are suffering from mental illness, substance addiction or extreme poverty. Approximately 95% of the individuals diverted or referred to PAD are homeless; twenty percent of PAD's active participants are living with SPMI. PAD is well-positioned to divert individuals at the point of potential arrest as well as to accept community referrals for settlement eligible individuals. PAD uses a Housing First and Harm Reduction approach and provides immediate (same day) respite housing with hotel partners to diverted individuals.

Fulton County Superior Court's Familiar Faces project is a partnership between the Court, Grady, PAD, and other agencies. This cohort are people identified via analysis and data-matching from the city, county, and state criminal justice systems, health care and forensic service providers, and local Homeless Management Information systems. The proposed activities will serve individuals in the Familiar Faces cohort through street engagement, hotel support, and housing support.

Eligible households include individuals with SPMI who are living on the street, have frequent incarcerations or emergency room visits, and who meet settlement criteria. Individuals will be identified through existing partnerships with the Atlanta Police Department, Grady

Hospital, Office of the Fulton County Public Defender, City of Atlanta and Fulton County Solicitor's Offices, Fulton Superior Court Familiar Faces Initiative, and Fulton DBHDD Screening & Reentry Teams at Fulton County Jail.

X. Certified Community Behavioral Health Clinics (CCBHCs) – Intercepts 0, 1, 2, 3, 4, 5

Certified Community Behavioral Health Clinics (CCBHCs) are an emerging behavioral health provider model that incorporates care coordination and primary healthcare screening and monitoring with enhanced existing behavioral health services including those for children, youth, families, and adults with mental health and/or substance use disorders. As such, a CCBHC could provide interventions at any intercept and facilitate coordination between systems. A CCBHC is expected to develop relationships with stakeholders in their communities and provide person and family-centered, trauma-informed services to anyone seeking help for a mental health or substance use condition.