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<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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<th>Friday</th>
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<tr>
<td>00/00-00/00</td>
<td>Welcome/ Registration</td>
<td>Posttraumatic Stress Disorder/ Consumer Interviews (#8)</td>
<td>Addictive Diseases (#11)</td>
<td>Consumer Perspectives (#16)</td>
<td>Mental Health/ Community Resources (#20)</td>
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<tr>
<td>8:00 AM</td>
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<tr>
<td>8:30 AM</td>
<td>CIT Program Overview</td>
<td>Co-Occurring Disorders (#12)</td>
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<td>Family Perspective (#17)</td>
<td>De-Escalation Techniques Part 3 (#15)</td>
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<tr>
<td>9:00 AM</td>
<td>Signs and Symptoms of Mental Illness (#1)</td>
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<td>9:30 AM</td>
<td>Schizophrenia (#2)</td>
<td>Site Visit @ Local State Psychiatric Hospital (#9)</td>
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<td>10:00 AM</td>
<td>Mood Disorders (#3)</td>
<td>Developmental Disabilities (#13)</td>
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<td>(Note: Site visit will include a working lunch.)</td>
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<td>De-Escalation Techniques Part 1 (#15)</td>
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<td>Understanding and Preventing Suicide (#5)</td>
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<td>De-Escalation Techniques Part 2 (#15)</td>
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<td>Review of CIT Principles</td>
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<td>Cultural Sensitivity (#18)</td>
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<td>2:00 PM</td>
<td>Child and Adolescent Intervention (#6)</td>
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<td>POST Written Examination/ Course Evaluation</td>
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<td>2:30 PM</td>
<td>Treatments of Psychiatric Illnesses (#7)</td>
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<td>3:00 PM</td>
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<td>Legal Issues and Mental Health Law (#19)</td>
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<td>Class Discussion</td>
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<td>4:30 PM</td>
<td>Class Adjournment</td>
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</table>

* Denotes P.O.S.T. Instructors

Students who are absent for more than 10% of the course will not receive course credit.

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Child and Adolescent Intervention
Treatments of Psychiatric Illnesses

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Legal Issues and Mental Health Law

Day 5
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Course Review
Written Examination/Program Evaluation
Graduation Ceremony

© 2006 Georgia Crisis Intervention Team Program
The Crisis Intervention Team (CIT) is a dynamic collaboration of professionals committed to people with mental illnesses and other brain disorders. The CIT program is sponsored by the National Alliance on Mental Illness, Georgia Department of Human Resources Division of Mental Health, Developmental Disabilities, and Addictive Diseases, Georgia Bureau of Investigation, Georgia Association of Chiefs of Police, Georgia Sheriffs’ Association, Inc., and Georgia Public Safety Training Center. The program is successful because of its strong partnership of volunteers that include law enforcement and corrections officers, mental health professionals, advocates, consumers, and family members.

Law enforcement officers who are trained in CIT can effectively assist individuals with mental illnesses and other brain disorders who are in crisis, therefore advancing public safety and reducing the stigma commonly associated with mental illness. One of our major goals is to train 20% of Georgia law enforcement officers in CIT within the next few years. To achieve our mission, we will focus on the following objectives:

1. Ensure that people with mental illnesses and other brain disorders always receive treatment, in lieu of incarceration in most cases

2. Increase the number of local governments with community-based jail diversion programs for adults and children with serious mental illnesses

3. Improve the quality and quantity of mental health services

4. Protect the rights of people with mental illnesses and other brain disorders

5. Promote adequate training for criminal justice system personnel about mental illness, developmental disabilities, Alzheimer’s disease, and substance abuse.

The CIT Advisory Board coordinates and approves the design, scheduling, and implementation of the course. In addition to the sponsoring agencies, the Board is comprised of representatives from the Atlanta Police Department, Behavioral Health Link/Single Point of Entry, Carter Center, Emory University School of Medicine, Georgia Department of Corrections, Georgia Department of Education, Georgia Department of Juvenile Justice, Georgia Department of Public Safety, Grady Memorial Hospital, and State Board of Pardons and Paroles.
Individuals who have an identified brain disorder (e.g., mental illness, developmental disability, or addictive disease) constitute the single most persecuted and least understood group of people in Georgia. The stigma associated with brain disorders remains an oppressive obstacle to employment and community integration, which hampers efforts to enter the workforce, attend schools and contribute their talents and energy to our society. Like other members of the community, those who have a brain disorder may live in houses, apartments, group homes, or on the street without shelter or resources. They may be professionals, office workers, laborers, homemakers, children, elderly, or people who depend on welfare and social services for survival. They may call for police assistance, be a victim or witness of a crime or accident, the subject of a call, attend a community crime prevention program, or be encountered in all the situations in which police personnel encounter other citizens.

The Americans with Disabilities Act (ADA) entitles people with disabilities to the same services and protections that police departments provide to anyone else. They may not be excluded or segregated from services, be denied services, or otherwise be provided with lesser services or protection than are provided to others. The ADA has refocused awareness on police response to people with brain disorders. While many of those with brain disorders control the symptoms of their illness successfully, others who do not have access to proper services fail to receive treatment or take their medications, or do not recognize that they are ill. Officers and other personnel must be prepared to address situations involving a person who has a brain disorder and be equipped to respond to these situations in an appropriate and sensitive manner.

The ADA does not subscribe to a fixed set of rules to be followed in all cases involving a person who has or who exhibits symptoms of a brain disorder. Rather, it mandates that law enforcement agencies and personnel make reasonable adjustments and modifications in their policies, practices or procedures on a case-by-case basis. For example, when a person exhibiting symptoms of a brain disorder presents or expresses that he or she has a specific brain disorder or requests accommodations, officers and caretakers may need to modify routine practices and procedures and dedicate more time or exercise more sensitivity to extend the services or protections that would be extended to someone else in a similar circumstance.

Georgia CIT officers who are experienced in community policing and possess effective problem-solving skills will be well prepared to serve this population. The nature of the interactions between the police and people with mental illnesses is varied. While responses to some calls for service (i.e., those requiring medical assistance or involving criminal activity) are well-defined, others are less clear and may require the application of problem-solving skills to handle the immediate situation or assist the individual and his or her family in identifying and obtaining solutions and appropriate support services.
CIT officers in Georgia understand that they must assume different roles in their encounters with those who have a brain disorder. As first responders, CIT officers may provide immediate aid. As law enforcers, these officers may encounter victims, witnesses or suspects who have a brain disorder. As service personnel, they may assist people in obtaining appropriate medical attention or other needed services. Helping people with brain disorders and their families to obtain the services of other appropriate agencies, organizations, hospitals, clinics, and shelter care facilities is an important component of the CIT mission.

The Georgia CIT model combines the requirements of the ADA and the principles of community policing. It addresses the complexity of the subject and the critical nature of the police role in responding to and assisting individuals with brain disorders. No single policy or procedure can address all the situations in which officers, communications personnel and other law enforcement employees may be required to provide assistance to a person who has a brain disorder and his or her family. Georgia CIT officers are trained to address the most common types of interactions with people who suffer with a brain disorder.

Pursuant to Official Code of Georgia Annotated (O.C.G.A.) 37-2-1, “the State of Georgia recognizes its responsibility for its citizens who are mentally ill or developmentally disabled including individuals with epilepsy, cerebral palsy, autism, and other neurologically disabling conditions or who abuse alcohol, narcotics, or other drugs and recognizes an obligation to such citizens to meet their needs through a coordinated system of community facilities, programs, and services.” State policy serves to ensure that “adequate mental health, developmental disability, addictive disease, and other disability services” are provided to all its citizens. State policy also serves to ensure that the state provides these services through a unified system, which encourages cooperation and sharing of resources among all providers of such services, both governmental and private.

The intended purpose of this code section is as follows: “To enable and encourage the development of comprehensive, preventive, early detection, habilitative, rehabilitative, and treatment disability services; to improve and expand community programs for the disabled; to provide continuity of care through integration of county, area, regional, and state services and facilities for the disabled; to provide for joint disability services and the sharing of manpower and other resources; and to monitor and restructure the system of providing disability services in the State of Georgia to make better use of the combined public and private resources of the state and local communities.” The Georgia Crisis Intervention Team Program is a necessary component of this collaborative and effective system of statewide services delivery.
Georgia Crisis Intervention Team Program
Law Enforcement Agreement

A. Law enforcement agencies are an essential component of the network of local services that provides support for individuals with brain disorders, their families and other community members. The established departmental policies and procedures within a law enforcement agency should ensure that a consistently high level of service is provided to all community members, and afford those who suffer with brain disorders the same rights, dignity and access to police and other government and community services that are provided to all citizens.

B. Law enforcement agency policies and procedures should ensure that all agency employees consider the entire range of services available in the community to serve those with brain disorders, assess their effectiveness, and improve where possible, the linkages between services so that people with brain disorders receive improved care and improved services.

C. Law enforcement agencies should recognize that the public maintains many misconceptions about those with brain disorders. These misconceptions often result in requests for services. Georgia CIT officers must understand the following:
   a. Having a brain disorder is not a crime.
   b. Most people with brain disorders are or can be fully functional community members.
   c. Very little criminal activity in our society is executed by individuals with serious mental illness.
   d. Some people with brain disorders may be more vulnerable to crime, abuse or injury than the general population.
   e. Involvement in infractions (traffic violations, loitering and disorderly conduct) may be a manifestation of a person’s illness or failure to receive proper treatment for the illness, rather than a result of intentional wrongdoing.

D. Many requests for service do not warrant use of police authority. CIT officers are responsible for responding to many types of non-criminal incidents. The authority to arrest a person should be used in situations where probable cause warrants arrest for a crime. Specifically, no individual should be arrested for behavioral manifestations of brain disorders that are not criminal in nature.

E. Individuals with severe brain disorders can experience intense psychotic crises that pose a significant risk to themselves and others. When requested to intervene in such situations, CIT officers have an obligation to protect the person with an illness from harm in addition to protecting others from potential harm that may be caused by the ill person.

F. In many requests for service, individuals with brain disorders and their families may be in need of support and guidance. CIT officers will support and assist them, when possible, in identifying viable solutions and obtaining aid.

G. A State of Georgia Crisis Intervention Team officer is a member of a unique, elite group. They are knowledgeable, strong, compassionate, exemplary and honorable.
Georgia CIT
Crisis Intervention Team

Law Enforcement  NAMI Advocates  Community Providers

Georgia CIT Vision

Vision: A Georgia where people with mental illnesses and other brain disorders are treated, not incarcerated

Law Enforcement  NAMI Advocates  Community Providers

Georgia CIT Mission

Mission: Equip Georgia CIT Officers with the skills to assist people with mental illnesses and other brain disorders in crisis, thereby advancing public safety and reducing stigma

Law Enforcement  NAMI Advocates  Community Providers

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Statewide CIT Goal

**Goal:**
Train 20% of Georgia Law Enforcement in CIT

Community Providers
NAMI Advocates
Law Enforcement

Three-way Partnership

Law Enforcement & Public Safety
CIT
Community MH/DD/AD Providers

CIT Advisory Board

**Law Enforcement**
Lt. Trudy Boyce, APD
Dir. Vernon Keenan, GBI
Harriett Lawrence, GPSTC
Dr. Janet Oliva, GBI
Paul Maharry, Chiefs' Assoc
Tonya Welch, Sheriff's Assoc
Ronne Lane, GA DOJ
Beth Oxford, Paroles/Parole Board

**NAMI & Advocates**
Lei Ellington, Carter Center
Nora Haynes, VP NAMI
Dave Lushbaugh, NAMI
Diane Reed, NAMI GA

**Community**
Dr. Michael Compton, Emory
David Covington, Behavioral Health LUA
Larry Fricks, DMPH/Consumer
Dir. Gwen Skinner, DHS
DMH/DDAD
Dr. Keith Wood, Grady
Bill Kissel, DMH/DDAD
Exec. Dir. Mary Yoder, AADD
Lei Ellingson, Carter Center
Nora Haynes, VP NAMI
Dave Lushbaugh, NAMI
Diane Reed, NAMI GA
Dir. Vernen Keenan, GBI
Harriett Lawrence, GPSTC
Dr. Janet Oliva, GBI
Paul Maharry, Chiefs' Assoc
Tonya Welch, Sheriff's Assoc
Ronne Lane, GA DOJ
Beth Oxford, Paroles/Parole Board

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National Alliance on Mental Illness (NAMI)
Family/Advocates
Crisis Intervention Team

Who/What is NAMI?
- Family-based, grassroots, support and advocacy organization
- We are the family members, treatment professionals and friends of persons with severe mental illness
- We believe in recovery
- We see mental illness and other brain disorders like any other disease, such as heart disease, diabetes or cancer

Police & Persons in Crisis
- People with mental illnesses sometimes discontinue their medications. Other times they have never been to treatment.
- The person may become agitated, experience psychosis or even feel suicidal.
- When a crisis occurs, the police are often called to intervene.
Memphis Model CIT

- In 1987, an unarmed man with a mental illness was shot and killed by Memphis police; a public outcry followed.
- In response, the Memphis PD and the local NAMI affiliate developed CIT (Crisis Intervention Team).

NAMI CIT Objectives

- Whenever possible, ensure consumer receives treatment rather than jail.
- Avoid unnecessary force by ensuring the CIT officer recognizes a mental illness or other brain disorder.
- Ensure CIT officer has skills to de-escalate a person in crisis.

Combating Stigma

Notice the differences in the way the media addresses a person with diabetes versus a person with mental illness.
Reducing Stigma

President’s New Freedom Commission Report on Mental Health

- Stigma motivates us to fear, reject, avoid, and discriminate against people with mental illnesses (common in US and Western nations)
- Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental illness, especially disorders like schizophrenia.
- Stigma leads to low self-esteem, isolation, hopelessness.
- Due to stigma, people with mental health problems may be ashamed, conceal symptoms or fail to seek treatment.

Law Enforcement

Crisis Intervention Team

- CIT are regular patrol officers who volunteered
- Many CIT officers have family or friends with a mental illness or other brain disorders
- This program has to come from the heart

All Volunteer Program
Immediate Response

- 911 dispatch identifies a call where a consumer with a mental illness or other brain disorder is in crisis
- The closest CIT officer is dispatched to the scene along with other law enforcement

Crisis Intervention

De-escalation Training
- The CIT officer attempts from the beginning to use the consumer’s name
- The CIT officer uses compassion, respect, listening skills and knowledge of crisis intervention stages
- They explain the process to consumers and families

Positive CIT Outcomes

- Decreased number of people with mental illness incarcerated
- Decreased officer and consumer injuries
- CIT officers become consumer advocates
- Consumers more willing to call police for HELP
CIT Identification

- Consumers can identify CIT officers by their Georgia Crisis Intervention Team pin
- 24/7 program
- CIT officers are in charge upon arrival of the scene

Community Providers

- Crisis Intervention Team

40-Hour CIT Curriculum

<table>
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<tr>
<th>Monday</th>
<th>Tuesday</th>
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<td>Mental Illnesses and</td>
<td>Site Visits/Consumer Interaction</td>
<td>Mental Illnesses and Other Brain</td>
<td>De-escalation Skills</td>
<td>De-escalation Skills</td>
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<td>De-escalation Skills</td>
<td>Mental Illnesses and Other</td>
<td>Post-Test &amp; Graduation</td>
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© 2006 Georgia Crisis Intervention Team Program
40-Hour CIT Curriculum

- Volunteer experts from the community provide training
- P.O.S.T. approved by the Georgia Peace Officer Standards and Training Council
- Includes pre-test and post-test assessments

Community Services

- "...the expectation that training by itself will resolve the issues of stigma is not realistic. Mere training is not enough to compensate when there is no infrastructure of services and care. To combat the devastating effects and trauma brought about by the stigma of mental illness requires a profound community outcry, joined with linkages to appropriate community service infrastructures" (Major Sam Cochran)

Emergency Receiving Site

- 15 Minutes to Drop Off Consumer for Evaluation

© 2006 Georgia Crisis Intervention Team Program
On April 29, 2002, the President identified three obstacles preventing Americans with mental illnesses from getting the excellent care they deserve:

- Stigma that surrounds mental illnesses,
- Unfair treatment limitations placed on mental health benefits in private health insurance, and
- The fragmented mental health service delivery system.
Presentation Prepared By:

David Covington, NCC, LPC, MBA
Chief Operating Officer
Integrated Health Resources, d/b/a
Behavioral Health Link
SIGNS AND SYMPTOMS OF MENTAL ILLNESSES
Recognizing Signs and Symptoms of Mental Illnesses

State of Georgia Crisis Intervention Team Training Program

Overview

- Part 1: Signs, Symptoms, Syndromes, and Diagnoses
- Part 2: S/S Involving Mood/Affect/Emotion
- Part 3: S/S Involving Thinking
- Part 4: S/S Involving Senses/Perceptions or Beliefs
- Part 5: S/S of Anxiety
- Part 6: Miscellaneous S/S
- Part 7: Case Stories
Recognizing Signs and Symptoms of Mental Illnesses

Part 1.
Signs, Symptoms, Syndromes, and Diagnoses

Signs

“Objective findings observed by the clinician”
- Things that you observe that indicate something is not right
- Example: abnormality on an EKG
- Example: high level of glucose in the blood
- Example: a tight, red eardrum
- Example: flat affect

Symptoms

“Subjective experiences described by the patient”
- Things that the patient reports as problems
- Example: chest pain
- Example: frequent urination
- Example: pain in the ear, difficulty hearing
- Example: hearing voices talking when there is really no one there
Syndromes

- "A group of signs and symptoms that occur together as a recognizable condition, that may be less specific than a clear-cut disorder or disease"
- A cluster of signs and symptoms
- Example: heart attack
- Example: diabetes
- Example: ear infection
- Example: psychosis

Diagnoses

- Formal names for disease states
- A more specific terminology for a syndrome
- Example: acute myocardial infarction
- Example: type II diabetes mellitus
- Example: otitis media
- Example: schizophrenia, paranoid type

<table>
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<tr>
<th>Sign</th>
<th>Symptom</th>
<th>Syndrome</th>
<th>Diagnosis</th>
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<td>Abnormal EKG</td>
<td>Chest pain</td>
<td>Heart attack</td>
<td>Acute Myocardial Infarction</td>
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<tr>
<td>Elevated glucose in the blood</td>
<td>Frequent urination</td>
<td>Diabetes</td>
<td>Type II Diabetes Mellitus</td>
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<td>Tight, red eardrum</td>
<td>Pain in the ear</td>
<td>Ear infection</td>
<td>Otitis Media</td>
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<tr>
<td>Flat affect</td>
<td>Hearing voices</td>
<td>Psychosis</td>
<td>Schizophrenia, Paranoid Type</td>
</tr>
</tbody>
</table>
Part 1. Quiz Question #1

You are called to the home of a woman who is having suicidal thoughts. When you arrive, she states that she has had insomnia for a week and feels nervous. “Insomnia” and “feeling nervous” are

A. Signs
B. Symptoms
C. Syndromes
D. Diagnoses

Part 1. Quiz Question #2

You sit down with her to learn more about how you can help. She says that she has a history of depression and feels like she is going back into another episode. In this example, “depression” is a

A. Sign
B. Symptom
C. Syndrome
D. Diagnosis

Part 1. Quiz Question #3

While you are talking to her, she shows you some paperwork from her outpatient doctor. The paperwork mentions “major depressive disorder, recurrent, severe”. This is an example of a

A. Sign
B. Symptom
C. Syndrome
D. Diagnosis
Part 1. Quiz Question #4

While you help her call her sister who lives down the street (to take her to the ER), you note that her movements and speech are very slow.
- Slow movements and speech are
  - A. Signs
  - B. Symptoms
  - C. Syndromes
  - D. Diagnoses

Signs, Symptoms, Syndromes, and Diagnoses

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<th>Sign</th>
<th>Symptom</th>
<th>Syndrome</th>
<th>Diagnosis</th>
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<tr>
<td>Slow speech</td>
<td>Insomnia</td>
<td></td>
<td>Major Depressive Disorder, Recurrent, Severe</td>
</tr>
<tr>
<td>Slow movements</td>
<td>Poor appetite</td>
<td>Depression</td>
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<tr>
<td>Observed sadness and tearfulness</td>
<td>Feeling nervous, sad, hopeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observed loss of interest in activities</td>
<td>Difficulty with concentration and memory</td>
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Recognizing Signs and Symptoms of Mental Illnesses

Part 2.
Signs and Symptoms That Involve Mood/Affect/Emotions
Mood and Affect
- Inner emotional state
- Mood = subjectively experienced emotion
- Affect = observed expression of emotion
- Problems with mood are often symptoms!
- Problems with affect are often signs!
- Major Depression and Bipolar Disorder are called “mood disorders” or “affective disorders” (disorders of emotional state)

Mood Symptoms
- Sadness / “dysphoric mood”
- Depression
- Grief or mourning (appropriate to real loss)
- Irritability / easily annoyed or provoked
- Mood swings (rapid ups and downs)
- Elevated mood (too happy)
- Euphoria / “high” mood (much too happy)
- Ecstasy (much, much too happy)

Mood Symptoms
- The “normal” mood range:
  - depressed
dysphoric
sad
euthymic
happy
elevated
euphoric

Major Depressive Episode
Manic Episode
Signs Involving Affect

- Inappropriate affect (emotional tone doesn't match up with thoughts)
- Elevated affect
- Depressed affect
- Labile affect (rapidly shifting)
- Restricted affect (reduced feelings)
- Blunted affect (much reduced feelings)
- Flat affect (absence of apparent feelings)

Major Depression  common S/S

- Sadness, depressed mood
- Decreased appetite, difficulty sleeping
- Loss of interest in pleasurable activities
- Feeling worthless, low self-esteem
- Feelings of helplessness, hopelessness
- Fatigue, low energy
- Difficulty concentrating, poor memory
- Excessive guilt feelings
- Thoughts of death or suicidal thoughts

Bipolar Disorder  common S/S

- Irritability, labile affect
- Laughter
- Racing thoughts, easily distracted
- Elevated mood, euphoria
- More talkative than normal, rapid speech
- Excessive happiness
- Decreased need for sleep
- Increased goal-directed activity
- Grandiosity, excessive self-esteem
Recognizing Signs and Symptoms of Mental Illnesses

Part 3.
Signs and Symptoms That Involve Thinking

Signs Involving Thinking

- Normal thought process = linear, logical
- Disorganized thinking (difficult to follow)
- "Tangentiality" (goes off on odd tangent)
- "Circumstantiality" (around in a big circle)
- Thought blocking (can't get thoughts out)
- Loosening of associations
- "Neologisms"
- Word salad

Tangentiality

- Inability to have goal-directed associations of thought; patient never gets from desired point to desired goal
- "I don't want to go to jail. Jail is for the birds. One time I saw birds flying around in the jail. Birds should be out in the air. The air is dirty in Atlanta. All of these big Marta buses. I ride the bus to get my groceries. Kroger is my favorite store."
Loosening of Associations
- Ideas shift from one subject to another in a completely unrelated way.
- "I don't want to go to jail. Wal-Mart ain't open yet. Last time I got hurt in jail. The birds can't fly out of the cage. It's too tight. April fools!"

Neologisms
- New word created by the patient, often by combining syllables of other words
- "Biblification"
- "Curadiosity"
- "Holification"
- "Snitich"

Word Salad
- Incoherent mixture of words and phrases
Schizophrenia common S/S

- Signs involving thinking are often present in schizophrenia and related disorders
- These disorders are sometimes called “primary thought disorders”
- Other common symptoms/signs of schizophrenia include auditory hallucinations and delusions ...

Recognizing Signs and Symptoms of Mental Illnesses

Part 4.
Signs and Symptoms that Involve Senses / Perception or Beliefs

Hallucinations

- 5 senses, 5 abnormalities of senses
- Hearing: auditory hallucinations (commonly referred to as “hearing voices”)
- Seeing: visual hallucinations (rare)
- Smelling: olfactory hallucinations (rare)
- Tasting: gustatory hallucinations (rare)
- Feeling: tactile hallucinations (rare)
Delusions
- A fixed, false belief
- “the FBI is following me”
- “I’m Moses, I’m here to free the people”
- “someone planted wires in my body”
- “cameras have been planted in the walls”
- “the President is in love with me”
- “there are bugs in my skin”
- “Michael Jackson is my boyfriend”

Recognizing Signs and Symptoms of Mental Illnesses

Part 5.
Signs and Symptoms of Anxiety

Symptoms of Anxiety
- Worry
- Fear
- Nervousness
- Tension
- Shakiness / tremor
- Heart racing, elevated blood pressure
- Difficulty breathing
- Headache
Specific Forms of Anxiety

- Panic attack (sudden attack of severe anxiety, with physical symptoms)
- Agoraphobia (fear of open spaces)
- Obsessions (recurring thought)
- Compulsions (repeated behavior)
- Hypervigilance (high startle response)
- Phobias (specific fear)

Recognizing Signs and Symptoms of Mental Illnesses

Part 6.
Miscellaneous
Signs and Symptoms

Common S/S of Delirium

- Syndrome that usually develops fairly suddenly; due to a medical illness, fever, a seizure, a medicine, or a drug (intoxication or withdrawal)
- Confusion
- Disorientation
- Sleepiness
- Poor attention
- Restlessness
Common S/S of Dementia
- Syndrome that usually develops slowly (months to years) in an elderly person (usually >65); most common cause is Alzheimer's Disease
- Confusion
- Disorientation
- Short-term memory problems
- Wandering
- Irritability / agitation

Common S/S of Addiction
- “Abuse” and “Dependence”
- Tolerance (need increased amounts of drug; same amount causes less effect)
- Withdrawal (syndrome of physical and psychological s/s upon stopping the drug)
- Craving
- Denial
- Interference with functioning

S/S Involving Speech
- Mutism
- Slow speech
- Whispering
- Rapid speech
- Hyperverbal speech
- Pressured speech
S/S Involving Movements
- Tics
- Tremors
- Rapid movements / psychomotor agitation
- Slow movements / psychomotor retardation
- Signs of catatonia

Impaired Insight
- Insight is the ability of the patient to understand the true cause and nature of the situation and signs/symptoms
- Insight is commonly impaired in schizophrenia and related disorders, as well as bipolar disorder

Recognizing Signs and Symptoms of Mental Illnesses
Part 7.
Case Stories
Major Depressive Disorder

- You are called to the home of a 65 yo man who called 9-1-1 after an overdose on Tylenol. His wife died 2 months ago. He needs to go to the ER due to the dangerousness of Tylenol overdose.
- Sadness
- Weight loss
- Loss of interest in activities
- Difficulty falling asleep and staying asleep

Bipolar Disorder

- You are called to a local gas station due to complaints about a man preaching. Upon arrival, you find a 28 yo man dressed in a gold robe proclaiming to be Jesus.
- Irritability
- Laughing loudly
- Hyperverbal speech
- Religious delusions
- Tangential thinking

Schizophrenia

- You are called to the home of a 32 yo man after he pulled the lights out of the ceiling. He is talking to himself, looks afraid, and makes threatening statements.
- Paranoia
- Auditory hallucinations
- Disorganized thinking
- Poor hygiene and grooming
- Poor insight
Dementia

- You are called to the home of a 85yoAAm. His family called because of agitated behavior, including throwing dishes.
- Confused
- Disoriented (“1968”)
- Paranoid delusions
- Impaired short-term memory

Alcohol Dependence

- A 35yowm waves you down as you drive down Boulevard. He is shaky and sweaty. He says that he needs to go to the hospital “for detox”. He smells of alcohol.
- Withdrawal
- Excessive intake
- Poor physical health
- Interference with functioning
- At risk for seizures

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Sensation
(hallucinations)
(Schizophrenia)

Thinking
(disorganized thinking)
(Schizophrenia)

Beliefs
(delusions)

Memory
(Alzheimer’s Disease)

Mood/Affect
(Feeling/Emotions)
(sadness, crying, euphoria)
(Major Depression, Bipolar Disorder)

Speech

Movement
(Parkinson’s Disease)

Reward/Pleasure
(addiction, loss of interests)
(Drug Abuse, Schizophrenia)

Sleep
(insomnia)

Anxiety
(worry, tension)
(Angst Disorders)

Insight/
Judgment
SCHIZOPHRENIA
Schizophrenia: Symptoms, Course, and Treatment

State of Georgia
Crisis Intervention Team
Training Program

Schizophrenia

1. Symptoms
2. Course
3. Treatment

**Sam: Initial Presentation**

- 11pm, psychiatric emergency room: Fulton County police bring in a 20yoAAm due to “threatening and violent behavior” at home
- mother reports that he had kicked six holes in the walls, “looking for the cameras”
- Sam is clearly paranoid and agitated in the emergency room, often whispering to himself
**Sam: Initial Presentation**

- he was given a shot of Haldol and Ativan because he became combative with staff due to his marked paranoia
- mom says that he is convinced that the drug dealers are recording his every move, because they have a “plot” against him

**Schizophrenia**

1. Symptoms

**“Positive” Symptoms**

- things that are present, but they shouldn’t be
- auditory hallucinations (hearing voices)
- delusions
- suspiciousness, paranoia
- ideas of reference (TV/radio referring to you)
“Negative” Symptoms
- things that aren’t present, but should be
- blunted affect, flat affect
- emotional withdrawal
- social isolation
- slow or impoverished thinking and speech
- low motivation
- slow movements
- low energy

Disorganized Symptoms
- disorganized thinking (loosening of associations, tangential or circumstantial thinking, neologisms, word salad)
- disorganized speech
- disorganized behavior

Symptoms of Hostility/Aggression
- usually related to positive symptoms such as paranoid delusions
- irritability
- agitation
- threatening behavior
Cognitive Symptoms

- subtle difficulties with attention
- subtle difficulties with memory
- subtle difficulties with planning

Symptoms of Schizophrenia

- different patients have different combinations of symptoms
- some patients have mostly positive symptoms, like delusions and hallucinations
- some patients have mostly negative symptoms, like withdrawal and isolation
- some patients have mostly disorganization

*Sam:* Symptoms

- suspiciousness, paranoia
- delusion that cameras were in the walls
- withdrawal, blunted affect, social isolation
- irritability, hostility, aggression
Psychosis: A Syndrome

- a cluster of signs and symptoms that is commonly present in schizophrenia
- may also be present in major depression, bipolar disorder, delirium, dementia, etc.
- loss of touch with reality (such as delusions and hallucinations)

Diagnosis of Schizophrenia

A. 2 or more for at least 1 month
   - Delusions
   - Hallucinations
   - Disorganized speech
   - Grossly disorganized or catatonic behavior
   - Negative symptoms
B. Social/Interpersonal/Occupational problems (for at least 6 months)

Subtypes of Schizophrenia

- Schizophrenia, paranoid type
- Schizophrenia, disorganized type
- Schizophrenia, catatonic type
- Schizophrenia, undifferentiated type
- Schizophrenia, residual type
- Schizoaffective disorder, bipolar type
- Schizoaffective disorder, depressive type
Schizophrenia

2. Course

Schizophrenia: Onset

- usually first appears in late teens to mid-30s
- usual age at onset for men is 18-25
- usual age at onset for women: 25 to mid-30s
- for women, second peak after 40

Schizophrenia: Cause

- abnormalities in certain circuits/pathways in the brain (e.g., the dopamine pathway)
- this may come from certain genes, as well as from certain problems early in life (such as pregnancy and delivery complications, etc.)
- biological brain disease with psychological symptoms (Parkinson’s is a biological brain disease with movement symptoms)
Schizophrenia: Course

- many patients experience three phases:
  - Prodromal – beginning of deterioration with mild, often non-specific symptoms
  - Active – symptoms become increasingly apparent and psychosis emerges
  - Residual – a return to prodromal levels
- each phase may last days to years
- often relapses of active-phase symptoms

Sam: Course

- dropped out of school in his senior year
- over the past two years, he prefers to stay at home
- has been hospitalized twice (1 week each)
- often refuses to take medicines
- normally stays to himself
- this is a flare-up/relapse

Sam: Relapse Symptoms

- increasingly focused on the plot, stopped usual activities (no longer listening to rap)
- mom often hears him in his room pacing and talking to himself; first started doing this about 4 months ago; now does it everyday
- believes that the TV is talking about him
- occasionally mentions hidden cameras
**Sam: Relapse Symptoms**

- He neglects his hygiene and self-care, and refuses to eat any food unless mom makes it for him; has lost at least 15 pounds
- Doesn't leave home
- Impaired insight

**Psychosocial Impairment**

- Dysfunction in 1 or more major areas of functioning (relationships, work, education, self-care)
- Educational progress often disrupted
- Employment at lower levels than expected (>70% unemployment)
- 60-70% do not marry
- Limited social contacts

**Schizophrenia**

3. Treatment
Antipsychotic Drugs

- discovery of antipsychotic drugs in the mid-1950s revolutionized care for those with schizophrenia
- two types:
  - “conventionals” / neuroleptics / typicals / first generation agents
  - “atypicals” / second generation agents

Conventional Antipsychotics

- chlorpromazine (Thorazine)
- thioridazine (Mellaril)
- mesoridazine (Serentil)
- loxapine (Loxitane)
- molindone (Moban)
- fluphenazine (Prolixin)

Conventional Antipsychotics

- haloperidol (Haldol)
- perphenazine (Trilafon)
- pimozide (Orap)
- thiothixene (Navane)
- trifluoperazine (Stelazine)
- Haldol decanoate / Prolixin decanoate (one shot every 2-4 weeks)
Atypical Antipsychotics

- clozapine (Clozaril)
- risperidone (Risperdal)
- olanzapine (Zyprexa)
- quetiapine (Seroquel)
- ziprasidone (Geodon)
- aripiprazole (Abilify)

Medication Side Effects

- dry mouth
- dizziness
- sleepiness
- weight gain
- "secondary negative symptoms"
- movement abnormalities (stiffness, tremor, chewing movements)

Sam: Pharmacologic Treatment

- initially started on Risperdal, but this caused an acute dystonic reaction and he refused to take it further
- stabilized on Zyprexa, but it was stopped after 4 months due to 40 pound weight gain
- switched to Geodon
- tolerates mild sedation
Effectiveness of Antipsychotics

- research repeatedly has shown that antipsychotic drugs reduce symptoms in the majority of patients with schizophrenia
- although the use of such drugs is now widely accepted, patients sometimes refuse to take them (due to side effects, cost, or impaired insight)

Psychosocial Treatments

- supportive counseling can be very helpful when used in combination with medication
- family therapy and specific forms of individual therapy
- day treatment, vocational rehab, social skills training, supported housing/employment
- these approaches are combined and tailored to the needs of the individual patient

The Community Approach

- the broadest treatment approach
- 1963: Congress passed the Community Mental Health Act, patients should be able to receive care within their own communities, rather than institutions far from home
- the era of “deinstitutionalization”
- community care is often inadequate for the care of such a complex disorder
Effective Community Care

- coordinated services and case management
- medication + psychosocial treatment
- short-term hospitalization/crisis stabilization
- partial hospitalization/day treatment
- transitional residences/supportive housing
- vocational training/supported employment
- supportive and informed law enforcement

Sam: Community Treatment

- after discharge from 2-week hospitalization, he has been attending a day treatment program where he is working with the food services group for job preparation
- still suspicious, but no longer focused on paranoid delusions
- no more talk about the TV talking about him or hidden cameras at home

Sam: Community Treatment

- he saw a psychiatrist every 2 weeks for 2 months, then monthly
- no prominent positive symptoms, but still left with moderate negative symptoms and some cognitive deficits
- hopes to get a job in his uncle’s restaurant
Barriers to Effective Care

- fewer than half of all people who need them receive appropriate community mental health services
- in any given year, 40% of all people with schizophrenia receive no treatment at all
- two factors primarily are responsible:
  - shortage of services
  - poor coordination of services

Consequences of Inadequate Community Treatment

- many people with schizophrenia become homeless or are incarcerated, usually for petty crimes
- illness is often untreated or under-treated in detention facilities
- “criminalization”

The Promise of Community Treatment

- despite these very serious problems, proper community care has shown great potential for assisting the recovery from schizophrenia
- task forces have been created to find more effective ways for all levels of government to meet the needs of people with such disorders
- another important advancement has been the formation of national advocacy groups (e.g., NMHA, NAMI)
Crisis Intervention Team Training

CIT training is another important part of community care for people with severe and persistent mental illnesses such as schizophrenia!

Thank you for being a part of the effort, and for your commitment to improving the lives of our patients!

Schizophrenia

Questions, Comments, Discussion

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SCHIZOPHRENIA

Negative S/S
- Blunted or flat affect
- Emotional withdrawal
- Social isolation
- Slow thinking and speech
- Low motivation
- Slow movements
- Low energy

Positive S/S
- Auditory hallucinations
- Delusions
- Suspiciousness
- Paranoia
- Ideas of reference

Cognitive S/S
- Problems with: attention, memory, planning

Disorganized S/S
- Loose associations
- Tangentiality
- Neologisms
- Disorganized speech
- Disorganized behavior

Hostility/Aggression S/S
- Irritability
- Agitation
- Hostile attitude
- Aggressive behavior

Affective S/S
- Depressive features
- Manic features

Catatonic S/S
- Mutism
- Extreme slowing of movements
MOOD DISORDERS
Learning Objectives:

1. Appreciate the link between feelings, thoughts, and behaviors.
2. Increase your comfort in talking about mood disorders and mental illness in general.
3. Define the terms mood disorder and affective disorder. Understand ways in which mood disorders can affect thoughts and behaviors.
4. Describe symptoms of Major Depressive Disorder, including potential problems with cognition and perceptions.

Learning Objectives, continued

5. Describe characteristics of a person with Bipolar Disorder, including potential impulsivity and erratic behavior.
6. Differentiate between malicious behavior and unusual or aggressive behavior resulting from a mood disorder.
7. Know and be able to apply the “Ten Commandments of De-escalation.”
Stigma Origins

- Greek for "to mark or brand;" "Marks of the wounds of the crucified Christ."
- Prevents open discourse about mental illness, sexuality, some social issues.
- 1 in 5 Americans has some mental illness during a calendar year.
- "There is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder."

Mind – Body Connection

- How one thinks affects one’s physical health. Examples: affirmations, cortisol surge, exam related illnesses.
- How one’s body feels affects one’s mood. Example: increase heart rate with drugs, make environment warm, panic attack occurs even when there is no stress. "Misattribution of Arousal."
- Stress acts as a "trigger" for other problems, including initial mental illnesses, decreased immunocompetence (and correspondingly infectious/autoimmune illnesses), and decreased cortical brain functioning.

Terms: What do we Mean by Mental Health / Illness?

- Mental Health: successful performance of mental function resulting in productive activities, relationships, and ability to cope with change and adversity. NOT based on some idealistic norm.
- Mental Illness: health condition characterized by alterations in mood, thoughts, behaviors associated with distress and/or impaired functioning.
Depressive Disorders

• Major Depressive Disorder (MDD) is a common problem with prevalence of 7% population at any given time; 20% of women and 12% men during lifetime.

• Signs and symptoms of Major Depression:
  – Persistent sadness and despair
  – Sleep pattern changes (+ or -)
  – Change in appetite (+ or -)
  – Decreased concentration
  – Social withdrawal, feeling worthless or guilty
  – Thoughts of harming self
  – Decreased interest in doing things once enjoyed

• 15% people with MDD develop psychotic symptoms along with symptoms above. May appear agitated, paranoid, disorganized which can be mistaken for anger, malice.

Bipolar Disorder ("Manic Depression")

• Prevalence of nearly 1.2 – 1.5% in U.S. population.

• Symptoms include:
  – Periods of depression as described above
  – Alternated with "Mania" feeling as though one is "on top of the world," or even too good
    • Persistently elevated mood, irritable, or expansive mood
    • Inflated self-esteem
    • More talkative than usual
    • "racing" thoughts
    • Dissociality
    • Increased goal-directed activity (extra work, building things, etc.)
    • Excessive involvement in pleasurable activities (hypersexual, impulsive travel, buying sprees)

Bipolar Disorder, continued

• Major Risk factor for Suicide depressed mood coupled with energy to act

• Psychotic thinking common. Energy during manic phase may appear as aggression, irritability

• At increased risk for other problems
  – Co-occurring substance disorders (60%)
  – Criminal activity (42% in Modesto study)
  – Medical problems including STDs, sleep disturbances
Treatment Options

- Types of treatment for mental illnesses include psychotherapy (talk therapy) and pharmacotherapy (medication).
- Control of hypertension – 40%
  Management of mental illnesses – 80%
  Yet most mentally ill people do not seek help. Why?
- Barriers to treatment
  1. Stigma
  2. Access (no parity for insurers)
  3. Fear of breach of confidentiality
  4. Cost
  5. Sense of Doom
- Mental illness responsible for > 40% workforce loss. Second most expensive disability worldwide.

"Ten Commandments" of De-escalation (Fishkind, 2002)

1. You shall respect personal space (2 arm lengths)
2. You shall not be provocative
3. You shall establish verbal contact
4. You shall state things concisely, and repeat them
5. You shall identify wants/needs explicitly and calmly

"Ten Commandments" of De-escalation, continued

6) You shall listen; no retaliation if insulted
7) You shall agree or agree to disagree
8) You shall lay down the law: link behaviors to consequences
9) You shall offer choices to diminish the assumption that the only two choices are fight or flee
10) You shall debrief with others
Scenario

- Mr. Smith is a 40-year-old African-American man on whom the police were called due to his acting "weird." He had crafted a cardboard "temple" on Peachtree Street and was preaching about the end of the world. When one passer-by challenged him, Mr. Smith swore at the stranger, spit at him, and began chanting. When you approach the scene you see Mr. Smith naked except for his underwear kneeling to pray. How should you de-escalate this potential crisis?

Summary

- Mental illnesses like MDD and Bipolar Disorder are illnesses just like diabetes, hypertension, etc.
- How one feels affects how one thinks and behaves
- It is important to know the signs of MDD and Bipolar Disorder in order to be able to know who may be acting strangely due to their illness rather than aggression
- Employing strategies for crisis de-escalation can calm a volatile situation
- People with mental illnesses require psychiatric care to help their symptoms and behavior

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PERSONALITY DISORDERS
PERSONALITY DISORDERS
State of Georgia
Crisis Intervention Team
Training Program

Personality Disorders

Performance Objectives

Terminal Performance Objective
When presented with a case study of an individual exhibiting personality disorder behaviors and in crisis, the participant will be able to identify the personality disorder(s) associated with those behaviors in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) published by the American Psychiatric Association.

Enabling Objectives

Upon completion of this course of instruction, the participant will be able to:
Explain several suggested factors that may contribute to the development of a personality disorder in accordance with the professional literature.

Identify the three most common subtypes or clusters of personality disorders recognized by the Diagnostic and Statistical Manual of Mental Disorder-IV-TR.

Recognize the characteristics of the ten most common types of personality disorders defined by the Diagnostic and Statistical Manual of Mental Disorders-IV-TR.

Discuss treatment options for individuals diagnosed with personality disorders in accordance with the related research.

**Personality**

A distinctive set of traits, behavior styles, and patterns that comprise our character or individuality.
Personality Disorders

Psychological conditions in which the characteristics and behaviors of the individuals who experience these disorders interfere with daily living and personal relationships.

Personality Disorders

- Inflexible pattern of inner experience and maladaptive patterns of behavior
  - Observed in most of the individual’s interactions
  - Continue for years
  - Differ markedly from the experiences and behaviors usually expected of people

Personality Disorders

- Rigid traits often lead to psychological pain and social or occupational difficulties.
- These traits may also bring pain for others.
- The disorders usually become recognizable in adolescence or early adulthood, but some begin during childhood.
- They are among the most difficult psychological disorders to treat.
- Many sufferers are unaware of their personality problems.
Personality Disorders

- The origin of personality disorders is considerably controversial.
- Some experts believe that:
  - People are genetically predisposed to personality disorders.
  - Events occurring in early childhood exert a powerful influence upon behavior later in life and therefore contribute to the development of a personality disorder.
  - Personality disorders may be caused by a combination of parental upbringing, one’s personality and social development, and genetic and biological factors.

Odd or Eccentric Personality Disorders

(Cluster A)

Paranoid Personality Disorder

A pattern of distrust and suspiciousness of others, whereby their motives are interpreted as malevolent.
Paranoid Personality Disorder

Persons with this disorder:
- Generally suspect, without sufficient basis, that others are exploiting, harming, or deceiving them.
- Are typically preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates.
- May be reluctant to confide in others because of unwarranted fear that the information will be used maliciously against them.
- Usually interpret hidden demeaning or threatening meanings from benign remarks or events.
- May persistently bear grudges; i.e., are unforgiving of insults, injuries, or slights.
- Commonly perceive attacks on their character or reputation that are not apparent to others, and are quick to react angrily or to counterattack.
- Are subject to recurrent suspicions without justification regarding fidelity of a spouse or sexual partner.

Schizoid Personality Disorder

A pattern of detachment from social relationships and a restricted range of emotional expression.
Schizoid Personality Disorder

Persons with this disorder:
- Neither desire nor enjoy close relationships, including those that involve family.
- Almost always choose solitary activities.
- Typically exhibit little, if any, interest in having sexual experiences with another person.
- Receive pleasure in few, if any, activities.

Schizoid Personality Disorder

Persons with this disorder:
- Generally lack close friends or confidants other than first-degree relatives.
- Frequently appear indifferent to the praise or criticism of others.
- Usually display emotional coldness, detachment, or flattened affectivity.

Schizotypal Personality Disorder

A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior.
Schizotypal Personality Disorder

Persons with this disorder:
- May experience ideas of reference (excluding delusions of reference).
- Often possess odd beliefs or display magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or “sixth sense”; bizarre fantasies or preoccupations in children).
- Are subject to unusual perceptual experiences, including bodily illusions.
- Commonly exhibit odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).
- Recurrently display signs of suspiciousness or paranoid ideation.
- Typically reveal inappropriate or constricted affect.
- Generally display behavior or appearance that is odd, eccentric, or peculiar.
- Usually experience a lack of close friends or confidants other than first-degree relatives because of their intense fear of intimacy and closeness.
- Frequently exhibit excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about themselves.

Dramatic, Emotional, or Erratic Personality Disorders

(Cluster B)
Antisocial Personality Disorder

A pattern of disregard for, and violation of, the rights of others.

Persons with this disorder:
- Typically fail to conform to social norms with respect to lawful behaviors, repeatedly performing illegal acts.
- Are generally deceitful, thus indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
- Often exhibit a pattern of impulsivity or behavior that reveals a lack of planning.
- May frequently become irritable and aggressive, thus indicated by a history of violence (i.e., repeated physical fights or assaults).

Persons with this disorder:
- May repeatedly express a reckless disregard for the safety of themselves and others.
- Are consistently irresponsible and repeatedly fail to sustain steady employment or honor financial obligations.
- Usually demonstrate a lack of remorse, characterized by their indifference to or rationalization about the hurt, mistreatment, or pain they have caused others (e.g., theft from another).
Borderline Personality Disorder

A pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity.

Persons with this disorder:
- Primarily exhibit frantic efforts to avoid real or imagined abandonment.
- Typically display a pattern of unstable and intense interpersonal relationships characterized by alternating shifts between extremes of idealization and devaluation.
- Often experience identity disturbance: markedly and persistently unstable self-image or sense of self.
- Repeatedly demonstrate impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, and binge eating).
- Commonly engage in recurrent suicidal behavior, gestures, or threats, or in self-mutilating behavior.

Persons with this disorder:
- Generally exhibit affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- Are prone to chronic feelings of emptiness.
- Usually experience inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, and recurrent physical fights).
- May experience transient, stress-related paranoid ideation or severe dissociative symptoms.
Histrionic Personality Disorder

A pattern of excessive emotionality and attention-seeking.

Persons with this disorder:

- Are primarily uncomfortable in situations where they are not the center of attention.
- Often interact with others in an inappropriate, sexually seductive or provocative manner.
- Generally display a rapidly shifting and shallow expression of emotions.
- May consistently use physical appearance to attract attention to themselves.
- May exhibit a style of speech that is excessively impressionistic and lacking in detail.
- Commonly demonstrate self-dramatization, theatricality, and exaggerated expression of emotion.
- Are usually suggestible (i.e., easily influenced by others or circumstances).
- Frequently consider relationships more intimate than they actually are.

Persons with this disorder:

"Often interact with others in an inappropriate, sexually seductive or provocative manner."

"Generally display a rapidly shifting and shallow expression of emotions."

"May consistently use physical appearance to attract attention to themselves."

"May exhibit a style of speech that is excessively impressionistic and lacking in detail."

"Commonly demonstrate self-dramatization, theatricality, and exaggerated expression of emotion."

"Are usually suggestible (i.e., easily influenced by others or circumstances)."

"Frequently consider relationships more intimate than they actually are."
Narcissistic Personality Disorder

A pattern of grandiosity, need for excessive admiration, and lack of empathy.

Narcissistic Personality Disorder

Persons with this disorder:
- Generally possess a grandiose sense of self-importance (e.g., exaggerate achievements and talents or expect to be recognized as superior without commensurate achievements).
- Are commonly preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
- May believe they are "special" and unique, and can only be understood by, or should associate with, other special or high-status people (or institutions).
- Usually require excessive admiration.

Narcissistic Personality Disorder

Persons with this disorder:
- May experience a strong sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with their expectations).
- Are often interpersonally exploitative (i.e., use/take advantage of others to achieve their own ends).
- Basically lack empathy; are unwilling to recognize or identify with the feelings and needs of others.
- Tend to be envious of others or believe that others are envious of them.
- Frequently exhibit arrogant, haughty behaviors or attitudes.
Anxious or Fearful Personality Disorders
(Cluster C)

Avoidant Personality Disorder

A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.

Persons with this disorder:
- Typically avoid occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection.
- Generally are unwilling to become involved with others unless they are certain of being liked.
- Often exhibit restraint within intimate relationships because of fear that they will be shamed or ridiculed.
- Frequently become preoccupied with concerns about receiving criticism or fear rejection in social situations.
Avoidant Personality Disorder

Persons with this disorder:
- Are commonly inhibited in new interpersonal situations because of their feelings of inadequacy.
- Usually view themselves as socially inept, personally unappealing, or inferior to others.
- May be unusually reluctant to assume personal risks or to engage in any new activities because they may prove embarrassing.

Dependent Personality Disorder

A pattern of submissive and clinging behavior related to an excessive reliance on others.

Dependent Personality Disorder

Persons with this disorder:
- Generally experience difficulty in rendering everyday decisions without an excessive amount of advice and reassurance from others.
- Typically need others to assume responsibility for most major areas of their life.
- Frequently experience difficulty expressing disagreement with others because of fear of loss of support or approval (this does not include realistic fears of retribution).
- Can experience difficulty initiating projects or accomplishing tasks independently (because of a lack of self-confidence in judgment or abilities, and not a lack of motivation or energy).
Dependent Personality Disorder

Persons with this disorder:
- Commonly pursue extreme measures to obtain nurturance and support from others, to the extent of volunteering for tasks that are unpleasant.
- Usually feel uncomfortable or helpless when alone because of an exaggerated fear that they will be unable to care for themselves.
- May urgently seek another relationship for a source of care and support when a close relationship ends.
- Are often unrealistically preoccupied with the fear that they will be left alone to care for themselves.

Obsessive-Compulsive Personality Disorder

A pattern of preoccupation with orderliness, perfectionism, and control.

Persons with this disorder:
- Are basically preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major focus of the activity is lost.
- Generally exhibit perfectionism that interferes with task completion (e.g., are unable to complete a project because of the unreasonably high/strict standards that they have established for themselves and cannot achieve).
- May be excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not attributed to obvious economic necessity).
- Typically are overconscientious, scrupulous, and inflexible about issues of morality, ethics, or values (not attributed to cultural or religious identification).
Obsessive-Compulsive Personality Disorder

Persons with this disorder:
- Are frequently unable to discard worn-out or worthless objects although they may have no sentimental value.
- May be reluctant to delegate tasks or work with others unless their preferred method of performing tasks is precisely followed.
- Commonly adopt a miserly spending style with regard to both self and others, believing that money should be hoarded for future catastrophes.
- Tend to exhibit rigidity and stubbornness in their interactions and behavior.

Treatment

Specific treatment for each disorder is determined by a clinical professional based on:
- age, overall health, and medical history
- type and severity of symptoms
- extent of the disease
- tolerance for specific medications, procedures, or therapies
- expectations for the course of the disease
- individual opinions or preference

Personality disorders are often difficult to treat. They require long-term attention to change the inappropriate behavior and thought patterns.

Treatment may include:
- medication (although medication may be abused and has limited effectiveness); and/or
- psychological strategies or management approaches (including individual, group, or family psychotherapy).
References


References


PRESENTATION
PREPARED
BY
Janet R. Oliva, Ph.D.
Inspector
Georgia Bureau of Investigation
PERSONALITY DISORDERS

Reference Information
(Cluster A)

Paranoid
Paranoid personality disorder is characterized by a pattern of distrust and suspiciousness of others. Persons with this disorder are often emotionally cold, distant, and unable to form close, interpersonal relationships because they do not trust anyone. They generally interpret the intentions of others as deliberately demeaning or malicious. These individuals are untrusting, unforgiving, and prone to angry or aggressive outbursts without justification because they perceive others as disloyal, condescending, or deceitful.

Schizoid
Schizoid personality disorder is characterized by a pattern of detachment from social relationships and a restricted range of emotional expression. Persons with this disorder are introverted, withdrawn, solitary, emotionally cold, and distant because they genuinely prefer to be alone. They avoid social contact, and often seek occupations that require little or no contact with others. These individuals may be too absorbed in their own thoughts and daydreams that they exclude themselves from attachment with other persons and reality.

Schizotypal
Schizotypal personality disorder is characterized by a pattern of intense discomfort in close relationships. Persons with this disorder are often cold, distant, introverted, and have an intense fear of intimacy and closeness, which may cause intense feelings of loneliness. They may exhibit odd or eccentric manners of speaking or dressing and display many symptoms that resemble schizophrenia, but these are less mild and intrusive. These individuals may also experience strange beliefs and thoughts that include “magical thinking” (i.e., believing that they can “see into the future”).

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PERSONALITY DISORDERS
Reference Information
(Cluster B)

Antisocial
Antisocial personality disorder is characterized by a pattern of disregard for and violation of the rights of others. Persons with this disorder ignore normal rules of social behavior, and have a history of legal difficulties, belligerent and irresponsible behavior, and aggressive or violent relationships. They are impulsive, irresponsible, manipulative, and deceitful, and experience no remorse or guilt for any of their destructive actions or the effects of their behavior on others. These individuals are at significant risk for substance abuse, especially alcoholism, because it aids in relieving their tension, irritability, and boredom.

Borderline
Borderline personality disorder is characterized by a pattern of instability in interpersonal relationships, behavior, mood, and self-image. Persons with this disorder may exercise frantic efforts to avoid real or imagined abandonment, and these fears may lead to an excessive dependency on others. They often engage in unpredictable and self-destructive behavior, and may also engage in self-mutilation or make recurrent suicidal gestures to gain attention or manipulate others. These individuals may display impulsive actions or experience chronic feelings of boredom or emptiness and bouts of intense inappropriate anger.

Histrionic
Histrionic personality disorder is characterized by a pattern of excessive emotionality and attention-seeking behaviors. Persons with this disorder are overly conscious of their appearance, are constantly seeking attention, and often behave dramatically in situations that do not warrant that type of reaction. They are always "on stage", and tend to be manipulative, often dominating conversations by interrupting others and using grandiose language. These individuals may experience rapid mood shifts and angry outbursts that are usually deemed unnecessary or inappropriate, and are unable to tolerate significant delays in gratification.

Narcissistic
Narcissistic personality disorder is characterized by a pattern of grandiosity, need for admiration, and lack of empathy. Persons with this disorder present an exaggerated sense of self-importance, grandiosity, and superiority over others. They are absorbed by fantasies of unlimited success and seek constant attention, but are overly sensitive to failure, criticism, judgment, and defeat. These individuals are prone to extreme mood swings between self-admiration and insecurity, exploiting interpersonal relationships, and taking advantage of others.
PERSONALITY DISORDERS
Reference Information
(Cluster C)

Avoidant
Avoidant personality disorder is characterized by a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. Persons with this disorder generally fear rejection and are unwilling to become involved with others unless they are certain of being liked. They yearn for social contact, but are unable to function in social situations because of fear of embarrassing themselves. These individuals often feel empty, depressed, and lonely because of their tendency to occasions or activities involving interpersonal contact.

Dependent
Dependent personality disorder is characterized by a pattern of submissive and clinging behavior related to an inability to properly care for oneself. Persons with this disorder fear separation, require excessive reassurance and advice from others, and are easily hurt by criticism or disapproval. They feel uncomfortable and helpless when they are alone, and can be devastated when a close relationship ends. These individuals may urgently seek another relationship as a source of care and support when a close relationship ends.

Obsessive-Compulsive
Obsessive-Compulsive personality disorder is characterized by a pattern of preoccupation with orderliness, perfectionism, and control. Persons with this disorder are reliable, dependable, and methodical, but their inflexibility often results in their inability to adapt to changed circumstances. They are conscientious, have high levels of aspiration, and strive for perfection, but are never satisfied with their own achievements. These individuals assume more responsibilities, and therefore experience anxiety and difficulty in completing tasks and making decisions.

UNDERSTANDING AND PREVENTING SUICIDE
**Scope of the Problem**

- Suicide claims the lives of more than 29,000 people each year.
- From 1980-1996, the rate of suicide among persons of ages 15-19 years tripled.
- Since 1980, firearms-related suicides have accounted for 96% of the increase in the suicide rate among persons ages 15-19 years.
- Males over the age of 65 are at particularly higher risk.

  - Surgeon General’s Call to Action, 1999.

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**Scope of the Problem**

- For every two victims of homicide, three suicides will occur.
- In 2002, 909 suicides occurred in Georgia.
- In 2002, an estimated 22,725 attempted suicides occurred.

  - Surgeon General’s Call to Action, 1999.

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**Scope of the Problem**

- Approximately 5,000 young people between the ages of 15 – 24 years die annually from suicide.
- More girls than boys attempt suicide.
- More boys than girls (4 to 1) complete the act.
- Suicide is the 11th leading cause of death in the United States.
**Scope of the Problem**

- For every completed suicide, six people will be intimately affected.
- 28,000,000 people are survivors of suicide in the United States today.
- Every suicide directly affects family members, co-workers, friends and the community.
- Suicide survivors themselves are at greater risk for suicide.

**Why Suicide?**

- Causes are multidimensional and may involve:
  - Clinical depression
  - Accumulation of problems
  - Feelings of despair, helplessness and hopelessness
- The death may be the result of:
  - An impulsive act
  - A selected means to end pain

**Suicide Prevention**
Risk Factors

- Previous suicide attempt
- History of depression
- Substance abuse
- Family history of suicide (acts as a role model)
- Hopelessness/helplessness
- Impulsive/aggressive tendencies
- Barriers to mental health services
- Losses (relationships, health)
- Stressful life event(s)

Risk Factors

- Accessibility to lethal methods (i.e., guns)
- Unwillingness to seek help
- Exposure to suicide
- Physical, emotional or sexual abuse
- Legal issues
- Sexual identity conflict

High Risk Groups

- White males
- American Indians
- Young adults (15 – 24)
- Older adults (>65)
- Rural area residents
- Rocky Mountain West
- Attorneys, psychiatrists, dentists, law enforcement, fire and rescue and emergency medical services personnel
### Protective Factors
- Social support
- Access to treatment services
- Involvement in the community
- Feelings of reward
- Feeling of being supported
- Problem-solving and coping skills
- Spiritual support
- Cultural/religious beliefs

### Protective Factors
- Effective and appropriate clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help-seeking.
- Restricted access to highly lethal methods of suicide

### Protective Factors
- Family and community support
- Learned skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural/religious beliefs that discourage suicide
Suicide Intervention

Warning Signs
- Verbal cues: "I can’t go on."
- Becoming depressed or withdrawn
- Behaving recklessly
- Getting affairs in order/giving away possessions
- Changes in behavior, attitudes or appearance
- Abusing drugs or alcohol
- Suffering a major loss or life change

Crisis Intervention
- Show interest and support
- Be direct
- Be non-judgmental and accepting
- Offer hope that help is available, not glib reassurance
Crisis Intervention

- Crisis intervention is warranted when:
  - The person cannot commit to not harming self
  - The person has a plan
  - The person is particularly impulsive
  - The person has history of attempts
  - Intuition tells you that person is not safe

- If a person has a plan:
  - The more specific the plan the greater the intention to act
  - Never leave the person alone if you believe they are suicidal and have a plan
  - Act immediately if you believe the person will act on plan
  - Err on the side of caution
  - Know your resources in advance

Assessment and Referral

- Considerations when determining assessment and referral:
  - Who is available to further assess the person?
  - If a minor, what is the procedure for notifying parents?
  - Is hospitalization necessary?
  - What is the procedure for follow-up with the suicidal person?
Standard of Care
for Assessment

- Assessing intention
- Assessing history of suicide and treatment
- Assessing family history of suicide
- Assessing for access to means
- Discussing safety plans
- Documenting all of the above, including follow-up contacts

Suicide Aftercare
(Following a completed suicide)

Survivor Experience

“There are two parties to a death: the person who dies and the survivors who are bereaved.”

Arnold Toynbee
Historian
Survivor Care

- Accept the intensity of the grief
- Listen with your “heart”
- Avoid simplistic explanations and clichés
- Be compassionate
- Respect the need to grieve
- Understand the uniqueness of suicide grief
- Be aware of holidays and anniversaries
- Be aware of support groups
- Respect faith and spirituality
- Work together as “helpers”

FOUR “TASKS” OF GRIEF AFTER SUICIDE

Here are four steps toward surviving:

- **Tell the story:** Talk about what has happened until it becomes real. Talk to caring family and friends, attend a support group. Sing and dance with a mental health professional, so that you can be safe about the person who died and how the death has impacted your life and family. Tell the story until you don’t need to tell it anymore. Change the way you feel...wait a little bit of time and then start over.

- **Express the Emotions:** Grief is filled with conflicting tidal waves of emotion. Just when you think you’ve accepted the death, you may feel intense anger along with equally intense feelings of love and loss. Or, in the midst of crying about the person’s death, you may feel intense feelings of guilt. No matter what the range of emotions, all are to be expected during grief. It is crucial to get the emotions outside of yourself. “Stuffed” feelings can build and build and become overwhelming. Scream, cry, write, draw, punch a punching bag, tell someone who is empathetic, take a walk, do SOMETHING to express what you feel.

- **Make Meaning from the Loss:** Nothing can make what has happened “okay.” Life is turned upside down and changed forever. However, you can determine that something good and reasonable will come out of the unspeakable tragedy that you are experiencing. At some point, you may be able to accept the fact that your loved one’s entire life was not defined by his or her last decision—to die. Nothing can take away the good things the person accomplished. When you are ready, you may reach out to others with similar experiences or set up a scholarship or other appropriate memorial in the person’s name or work in some capacity to better the lives of others. There are many, many ways to make meaning from tragedy.

- **Transition from the Physical Presence of the Person to the New Relationship:** While missing the physical presence of a loved one is normal, it is important to accept the fact that the loved one is no longer physically present. What can that relationship be? For some, it is memories and love carried in the heart. No one can take away our memories and love, and long as we maintain these for the person who has died, they are still together. The new relationship may be spiritual or in some other way, it is keeping with religious beliefs.

Self-Care of First Responders

- Acknowledging the emotional and physical impact of trauma scenes
- Dealing with stress
- Debriefing
- Preventing burnout
- Understanding posttraumatic stress disorder
- Seeking professional consultation
- Creating a support system
First Responders Dealing with Survivors at the Scene

Survivors of Suicide defined as anyone who experiences the suicide death of another. (Family, friends, colleagues and anyone who witnessed the scene)

Survivors become the primary focus for care and support at the scene

At the scene, Officers can help the situation by the following:

- Introduce yourself to survivors
- Reassure them you're there to help
- Be sensitive to their possible traumatic shock, especially if survivor witnessed the death
- Offer to call family or friends
- Offer to make arrangements about the deceased
- Limited to brief conversations (may need to refer to others)
- Survivors may be in psychological or physical shock
- Survivors may want to see the body
- Inside the setting it may help to see and touch
- Keep others away... tell survivor that they are not alone
- Offer to help them, but do not restate (may need to refer) (if there is one)
- Offer your help to see the body or to assist with arrangements
- Offer to help them, but do not restate (may need to refer) (if there is one)
- Survivors may feel anger, guilt, anxiety or shame
- Offer to help them, but do not restate (may need to refer) (if there is one)
- Survivors may feel confused or overwhelmed
- Offer to help them, but do not restate (may need to refer) (if there is one)
- Help calm the survivors with kindness and politeness
- Leave them with resources in their community (ie: brochures, support groups, meetings, etc)

Presentation Prepared By:

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The Link Counseling Center and The
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Chief Operating Officer
Integrated Health Resources, d/b/a
Behavioral Health Link
I Don't Know Why
I don't know why.
I'll never know why.
I don't have to know why.
I don't like it.
I don't have to like it.
What I do have to do
is make a choice about living.
What I want to do
is accept it and go on living.
The choice is mine.
I can go on living,
valuing every moment
in a way I never did before,
or I can be destroyed by it
and, in turn, destroy others.
I thought I was immortal.
That my family
and my children
were immortal too.
That tragedy happened
only to others.
But I know now that
life is tenuous.
So I am choosing to
go on living,
making the most of the time
I have, valuing
my family and friends
in a way never possible before.
-Iris M. Bolton
From My Son My Son
A Guide to Healing
After Death, Loss or Suicide

Know you can survive. You may not think so, but you can.
Struggle with “why” it happened until you no longer need
to know “why” or until you are satisfied with partial answers.
Know you may feel overwhelmed by the intensity of your feelings, but all your feelings are normal.
Anger, guilt, confusion, forgetfulness are common responses. You are not crazy - you are in mourning.
Be aware you may feel appropriate anger at the person, at the world, at God, at yourself. It’s okay to express it.
You may feel guilty for what you think you did or did not do. Guilt can turn into regret through forgiveness.
Having suicidal thoughts is common. It does not mean that you will act on those thoughts.
Remember to take one moment or one day at a time.
Find a good listener with whom to share. Call someone if you need to talk.
Don’t be afraid to cry. Tears are healing.
Remember, the choice was not yours. No one is the sole influence in another’s life.
Expect setbacks. If emotions return like a tidal wave, you may only be experiencing a remnant of grief, an unfinished piece.
Try to put off major decisions.
Give yourself permission to get professional help.
Be aware of the pain of your family and friends.
Be patient with yourself and with others who may not understand.
Set your own limits and learn to say no.
Steer clear of people who want to tell you what or how to feel.
Know that there are support groups that can be helpful, such as Compassionate Friends. If not, ask a professional to help start one.
Call on your personal faith to help you through.
It is common to experience physical reactions to your grief, such as headaches, loss of appetite, inability to sleep.
The willingness to laugh with others and at yourself is healing.
Wear out your questions, anger, guilt or other feelings until you can let them go. Letting go doesn’t mean forgetting.
Know that you will never be the same again, but you can survive and even go beyond just surviving.

-Iris M. Bolton
Reprinted with permission from Suicide and Its Aftermath
(Dunne, McIntosh, Dunne-Maxim, Norton and Co., 1987
Asking the Question Why Suicide?

Asking “why did my loved one do this?” is the question that haunts most survivors of suicide. The outside world demands to know from us, and we don’t know ourselves. For some of us there were definite clues that our loved ones were depressed or that something was wrong. We either knew that they were in pain and did not know the extent of it, or we did know and tried everything we knew to get help for them. For others the suicide was completely out of character. Many people who end their lives are extremely good actors and actresses. They only allow us to see what they want us to see. In either instance, for many, we never thought it could really happen to us, to our loved ones, and to our families. It doesn’t make sense.

So we search, trying to put the pieces of the puzzle together. Hind sight is 20 X20, and sometimes we find bits and pieces, clues to what might have happened to allow our loved ones to lose hope and give up on life. We often want a specific reason, a direct cause and effect. If we can understand exactly why our loved ones ended their lives, maybe we can keep it from happening again to someone else we love.

For years I struggled with this question myself, following the suicide of my boyfriend. The best explanation was described to me by Iris Bolton, the Executive Director of The Link Counseling Center in Atlanta, GA and a survivor of her son’s suicide. Iris went to Emory University and received a Masters in Suicidology in an attempt to answer this question for herself. She did not find it. Later, Iris found as close to an answer as she will have. It did not come from a Doctor, Professor, or a Therapist. It came from another mother who had lost her son by suicide. This is how it was described to me, and I share it with you;

“The Cup Analogy”

There is a cup of water sitting on a table. It is so full, it is rounded at the top. One or two drops of water are added to the cup and it spills over. What caused the water to spill? We want to blame the last one or two drops, but in an empty cup it would not spill. It was not the water in the cup prior to the drops being added; because if left alone, it would not have spilled. It was a combination of all the drops of water in the cup that came before and the last one or two drops that caused the water to spill.

In a person’s life, the water in the cup is symbolic of all the hurt, pain, shame, humiliation, and loss not dealt with along the way. The last couple of drops symbolize the “trigger events”, “the last straw”, the event or situation that preceded the final act of taking one’s own life. Often we want to blame the trigger event, but this does not make sense to us. Like the water, these events all by them selves would not cause someone to end their life. It is the combination of everything in that person’s life not dealt with and the last one or two things that caused our loved ones to lose hope. For us, we must find a way to pour out the water along the way. This may be through talking it out, writing it out, sometimes yelling it out, whatever works for you. We must learn to deal with our pain in a way our loved ones could not.

This analogy does not give us the concrete answer many of us are looking for, but I know it made sense for me and has been helpful for many survivors. It allowed me to let go of the search for “why”, and to find a different way of dealing with my pain.

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GRIEF AND THE MOURNING PROCESS

THE PHASES OF GRIEF
Many people refer to the “stages” or “phases” of grief. It may be helpful to be aware of these identified phases or common aspects of grief. It is also important to know there is no right or wrong way to grieve. You may go back and forth between phases, experience more than one at a time, or even skip one all together. All feelings are normal, even if they seem “crazy”.

♥ **Shock** is the first stage of numbness, disbelief and unreality.
♥ **Denial** is thoughts or words such as, “I don’t believe it -- It can’t be!”
♥ **Bargaining** involves making promises such as, “I’ll be so good if only I can awaken to find this hasn’t happened” or “I’ll do all the right things if only ”
♥ **Guilt** is a hard stage and difficult to deal with alone. This is a normal feeling characterized by statements such as, “If only I had   If only I had not   ” done or said or thought something. Guilt may ultimately be resolved by understanding that all of us are human beings who give the best and worst of ourselves to others. What they do with what we give is their responsibility.
♥ **Anger** is another very difficult phase, but it may seem necessary in order to face reality and get beyond the loss. We all must heal in our own way and anger is a normal stage along the way. However, you may feel guilty because you are angry at the person who died or because your life is continuing while his or hers is not. If you don’t feel anger, don’t manufacture it!
♥ **Depression** may come and go and be different each time in length and/or intensity. Give yourself time to heal.
♥ **Resignation** means you finally believe the reality of the death.
♥ **Acceptance and Hope** come when you finally understand that you will never be the same, but you can go on to have meaning and purpose in your life.

**SUICIDE IS A PERMANENT SOLUTION TO A TEMPORARY PROBLEM!**
RESOURCES FOR SURVIVORS OF SUICIDE

American Association of Suicidology
Suite 310, 4201 Connecticut Avenue, N.W.
Washington, DC 20008
202-237-2280
www.suicidology.org

American Foundation for Suicide Prevention
National Office, 120 Wall St., 22nd Floor
New York City, NY 10005
212-363-3500
www.afsp.org

The Compassionate Friends
National Headquarters for bereaved parents & siblings
P.O. Box 3696
Oak Brook, IL 60521
630-990-0010 www.compassionatefriends.org

The Jason Foundation
116 Maple Row Blvd. Suite C
Hendersonville, TN 37075
1-888-881-2323
www.jasonfoundation.com

The Jed Foundation
583 Broadway
New York, NY 10012
212-343-0016
www.jedfoundation.org

The Link’s National Resource Center for Suicide Prevention and Aftercare
348 Mt. Vernon Highway, NE
Atlanta, GA 30328
404-256-2919
www.thelink.org linknrc@bellsouth.net

Kristin Brooks Hope Center,
National Hopeline Network
Suicide Prevention Crisis Line and Local Referral
Crisis Number: 1-800-SUICIDE (784-2433)
Business Number: 1-800-442-HOPE (4673)
www.livewithdepression.org www.hopeline.com

National Organization for People of Color Against Suicide, Inc. (NOPCAS)
4715 Sargent Rd. NE Washington, DC 20017
202-549-6039 www.nopcas.com

OASSIS
101 King Farm Blvd. #D 401
Rockville, MD 20850
240-632-0335
www.oassis.org

The Samaritans
PO Box 1259 Madison Square State
New York, NY 10159
W: 212-677-3009
www.samaritansnyc.org

SAVE (Suicide Awareness Voices of Education)
www.save.org
9001 E Bloomington Fwy., Ste. 150
Bloomington, MN 55420-3435
952-946-7998 fax: 952-829-0841

SPAN USA (Suicide Prevention Action Network USA)
www.spanusa.org
1025 Vermont Avenue, N.W., Suite 1200
Washington, DC 20005
202-449-3600 Fax: 202-449-3601

Centre for Suicide Prevention
Suite 320
1202 Centre Street S.E.
Calgary, Alberta Canada T2G 5A5
403-245-3900 www.suicideinfo.ca

Yellow Ribbon/Light for Life Foundation
P.O. Box 644
Westminster, CO 80036-0644 USA
303- 429-3530 www.yellowribbon.org

Suicide Prevention Resource Center (SPRC)
www.sprc.org 877-438-7772

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CHILD AND ADOLESCENT INTERVENTION
Interventions with Children and Adolescents

State of Georgia
Crisis Intervention Team
Training Program

Objectives
- Assessments of children and adolescents
- Most common diagnoses
- Treatment modalities
- Community resources
- Practical applications

Assessment
- Components of a complete diagnostic assessment include
  - Clinical history
  - Physical examination & laboratory tests
  - Mental status examination
Assessment – clinical history

- Interview both the child & parent / primary caregiver as well as other family members, teachers, daycare providers, juvenile court officials, DFCS staff
- Goal is to understand the factors contributing to the distress
  - explore current psychiatric symptoms, past psychiatric history, recent stressors, medical history, substance use, home environment, school, peer relationships, abuse / neglect, history of mental illness in relatives
- Keep in mind
  - chronological (true age) & developmental age of the child
  - For younger children, you may want to physically be on their level to facilitate rapport
  - It often helps to begin with non-threatening topics first
  - With adolescents, it is important to assess risk
    - harm to self or others, self injurious behavior, substance use, high risk sexual behavior, abuse / neglect, legal issues
- Review records from previous mental health treatment, pediatrician, schools, agencies (DFCS, DJJ), psychological testing
- Can use standardized evaluation instruments such as behavior checklists to be completed by children, parents, and teachers
Assessment – physical examination

- Many diseases, both medical & psychiatric, can present with psychiatric symptoms.
- It is imperative that children presenting with psychiatric symptoms have a physical exam (and laboratory tests depending on results of the physical exam) to rule out medical causes such as seizure disorder, genetic diseases, & neurodevelopmental disorders.

Assessment – mental status examination

- A complete mental status examination includes:
  - Appearance
  - Attitude / behavior
  - Psychomotor activity
  - Mood and affect
  - Speech
  - Thought processing
  - Thought content – suicidal & homicidal ideation, hallucinations, delusions
  - Insight & judgment
  - Cognitive / sensorium

Assessment – biopsychosocial model

- Biopsychosocial model
  - Biological system = family / genetic history, development, intelligence
  - Psychological system = emotional development, personality style, primary defenses
  - Social system = peers, community, economic status, race / ethnicity / culture, spirituality
Assessment of the family

- It is important to assess the family to understand the child.
- Techniques such as the genogram (family tree) can be used but you can often learn about the family by asking caregivers questions and by observing the family (seating arrangement, attitudes, power).
- Be mindful of existing cultural factors to facilitate engaging the family in this process & better understand the child & the identified problem within a cultural framework.

The power of observation

- Do not underestimate the power of observation.
- Observe the child & others while they interact as this is very important regardless of the setting.
- The old adage, actions speak louder than words, often rings true when working with youth.

Assessment – putting it all together

- Once all the information has been collected, make a diagnosis based on DSM-IV.
- Many people are not aware that youth may suffer from the same mental illnesses as adults but many times the symptoms are manifested differently.
- Youth tend to be diagnosed more frequently with disruptive behavior disorders but more youth are also being diagnosed with depressive & anxiety disorders.
- Often times, youth will have multiple diagnoses.
Common diagnoses

- Disruptive behavior disorders
  - Attention Deficit Hyperactivity Disorder (ADHD)
  - Oppositional defiant disorder (ODD)
  - Conduct disorder (CD)
- Depressive disorders
- Anxiety disorders
- Substance use disorders

Attention Deficit Hyperactivity Disorder

- Inattention, hyperactivity, & impulsivity are the core symptoms of ADHD
- Impairment relative to expected developmental level in learning & following rules & difficulty in inhibiting impulsive responses to their own needs or external factors
- Great difficulty with motivation, sustained attention, organization, & completion of tasks when they are long, complex, difficult, or boring
- Prone to seek immediate gratification
- School problems include delayed learning, poor study skills, incomplete homework & tests with careless mistakes, & disruptive behavior

- Peers often perceive children with ADHD as immature & irritating & often avoid them because of their low frustration tolerance, difficulty following rules, & intrusive, bossy behavior
- Children with ADHD may behave differently in different settings
  - When a child is in a highly structured environment or novel setting, is engaged in a stimulating activity, or is alone with an interested adult, symptoms may not be apparent at all
  - Symptoms typically worsen in situations that are unstructured, boring, & minimally supervised or that required sustained attention or mental effort
### Oppositional Defiant Disorder

- Argumentative, disobedient, defiant behavior without serious violation of rights
- Anger-related symptoms directed at authority figures such as parents, teachers, & police officers
- Critical feature is self-defeating stance that youth take in arguments – may be willing to lose something they want rather than lose the battle or lose face

### Conduct Disorder

- Youth who repeatedly violate societal rules or personal rights of others
- Consequences of truancy & school suspensions combined with attention problems & learning disorders can lead to loss of interest in school, school failure & drop out, & eventual unemployment
- Youth with CD are at increased risk for early pregnancy, STDs, & physical injury from fights

### Depressive Disorders

- A depressed youth may look agitated & irritable rather than lethargic & may fail to make expected weight gains (particularly younger children)
- Childhood-onset depression is more likely to evolve into bipolar disorder
- A child who is depressed & suicidal may show more impulsive behavior like jumping in front of cars
Anxiety disorders

- An anxious child may be generally socially appropriate but quite clingy to his parents
- Generalized anxiety disorder (GAD)
  - shy, self-doubting, self-deprecating
  - pessimistic
  - may have somatic complaints
  - may be excessively compliant with authority
  - habits such as thumb sucking, nail biting, & hair pulling are common

Post-traumatic stress disorder (PTSD)

- Occurs in youth who have experienced traumatic events such as physical / sexual abuse, rape, victim of violence or witness to family violence
- Hallmark symptoms include re-experiencing trauma (nightmares, flashbacks), avoidance & numbing, hypervigilance
- Can include fear of separation from parents or fear of death, may withdraw from new experiences, perceptual distortions, sleep disturbances, somatic symptoms, regression (irritability)

Substance use disorders

- The continuum of adolescent drug users ranges from nonusers, through experimental and casual users, to abuse & dependence
- The line between use & abuse is crossed more easily by young people than by adults
- Almost all adolescents referred for treatment of substance use have additional disorders such as ADHD, ODD, CD, depression, & anxiety disorders
- Psychiatric disorders may predate substance use or be secondary to the substance use itself such as in substance-induced mood & psychotic disorders
Substance use disorders

- Risk factors for adolescent substance use include family history, peer influence (avoidance, initiation, & maintenance), low self-esteem, impulsivity, aggression, history of physical & sexual abuse, family dysfunction
- Substance use interferes with developing cognitive, social, & physical abilities
- Potential morbidity & mortality from substance use are substantial – increased suicidal ideation & behavior, risk of death from intentional or accidental overdose & dangerous behavior while intoxicated, indiscriminate sexual activity

Treatment

- Think biopsychosocial model
- Biological system – medications, hospitalization
- Psychological system – psychotherapy
- Social system – case management, residential treatment

Treatment – biological system

- Mediations
  - Psychiatric symptoms have been shown to improve with medications
  - Sometimes youth are unable to benefit from other forms of treatment until they are assisted with medication
  - BUT psychotropic medications in children are controversial!
  - There are different classes of medication – stimulants, antidepressants, anxiolytics, mood stabilizers, antipsychotics
**Treatment – biological system**

- Hospitalization
  - If a child is an imminent danger to himself or others, hospitalization is appropriate for safety & stabilization.

**Treatment – psychological system**

- There are many types of psychotherapy
  - Individual
    - Cognitive behavioral therapy
    - Psychodynamic psychotherapy & psychoanalysis
    - Play therapy which in young children is useful as they express themselves through play rather than words
  - Family
    - With family therapy you meet with family members to discuss how the youth’s issues are impacting them but also to observe how the youth’s behavior is impacted by the family.
    - Many times the central issue for parents is loss of (or given up) power & the need to help parents regain that power
  - Group

**Treatment – social system**

- Case management – many schools & community mental health agencies have case managers to assist youth & families in getting connected with a variety of helpful resources
- Residential treatment
  - Residential treatment facilities provide a safe environment for children & have treatment staff especially trained to deal with extreme behaviors
  - Psychiatrists, psychologists, licensed therapists, & case managers are often on staff to see youth multiple times a week
- Wrap around services
Community resources

- Youth are provided resources from multiple agencies - outpatient clinics, hospitals, schools, DFCS, recreational facilities, & other agencies
- These services include:
  - individual & family therapy
  - psychiatric monitoring
  - assistance with a child who has been abused / neglected
  - behavioral aide services
  - respite care
  - parenting education
  - mentoring
  - psychoeducational programs,
  - substance abuse treatment

Community Resources

- Due to the increasing numbers of single-parent families, these resources are very important
- Overall goal of many agencies is to keep children in their family although there are still a few residential treatment facilities accepting youth who cannot be managed in their family

So what does this mean for you?
Practical Applications

- Crisis
  - families call because they are in acute distress and in need of an intervention
  - the intervention usually involves a hospital assessment or further interaction with the legal system
- Red flags – suicidal & homicidal ideation, psychosis, substance intoxication
- Safety - assess the child’s risk of harming himself or others
  - self-injurious behaviors, suicide attempts
  - level of aggression
- Psychosis - look for evidence of psychotic symptoms
  - does the child seem confused or out of it
  - are his or her words & actions making sense to you

Practical Applications

- Substance intoxication - look for evidence of substance use
  - does the child look high or intoxicated – pupil size, speech, belligerent or aggressive behavior
- Remember the developmental as well as the chronological age of the child as this colors your perception of the acuity of the situation and thus affects the disposition
- Problematic behaviors
  - truancy, runaway, destruction of property, assault
  - Legal involvement often the intervention of choice

Questions

[Diagram of a brain with a question mark]
Presentation Prepared By: Leesha M. Ellis-Cox, M.D.
Department of Psychiatry
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TREATMENTS OF PSYCHIATRIC ILLNESSES
The Biopsychosocial Model of Health Care

- The Biopsychosocial model of health care
- Biopsychosocial treatment of the major mental illnesses
- How people with mental illness can perceive YOU
- YOUR reactions to people with mental illness
- Medical and psychiatric emergencies

Overview

- Treatment approach used in all areas of medicine
- Considers the biological, psychological and social factors that affect a person’s health
- A multidisciplinary approach that includes medical professionals, social workers, families, communities, YOU
Biological
Genetic or inherited
- Ex: inheriting increased risk for developing depression
Medical or acquired
- Ex: A man with a stroke or cancer may develop depression because of changes in the chemicals in his brain

Psychological
- The way a person views the world
- Based on childhood/development
- Based on adult experiences
- Ex: A victim of child abuse may have increased risk of depression

Social
- A person’s environment
- What is going on in their life
- Ex: A person with many stressors or losses (divorce, death/illness in family) may have more difficulty with the treatment of their depression
Goal

To Intervene in All Three Areas
For Optimal Treatment

Psychotic Disorders
- Characterized by a break from reality
- Schizophrenia
- Bipolar disorder
- Major depression with psychotic features
- Substance-induced
- Medical causes
Symptoms Of Psychosis

- Delusions
- Odd/bizarre behaviors
- Hallucinations
- Social withdrawal
- Suspiciousness
- Poor self-care habits
- Agitation/anxiety
- Insomnia
- Disorganization
- Poor self-care habits
- Inappropriate affect
- Mutism/catatonia

Biological Treatments

Antipsychotics:
- Risperdal
- Zyprexa
- Seroquel
- Geodon
- Abilify
- Haldol

Side Effects of Antipsychotics

Extrapyramidal Side Effects (EPS)
- Dystonia-stiffness, muscle spasms
- Pseudoparkinsonism - slow, shuffled gait, expressionless face
- Akathisia-inner restlessness - frequent pacing, looks like agitation
Adverse Effects of Antipsychotics

- Neuroleptic malignant syndrome (NMS)
  - A medical emergency
  - Patient needs treatment ASAP!!
- Tardive Dyskinesia - chronic

NMS

- Muscle rigidity
- High body temperature
- Altered level of consciousness
- Coma and death can result without treatment
- Risk highest in black males
- Risk increased by dehydration, or muscle trauma (ex: intense exercise or assault)

Psychological Treatments for Psychiatric Disorders

Psychotherapy: Understand how patients and loved ones view themselves and their illness.
- Supportive Psychotherapy: Support coping mechanisms and behaviors that are healthy.
- Family Therapy: Focus on healthy family relationships and how the illness affects the entire family
Psychological Treatments for Psychiatric Disorders (con’d)

- Psychotherapy
  - Cognitive Behavioral Therapy (CBT): understanding the link between thoughts, feelings and behaviors.
  - Supportive Psychotherapy
  - Insight-Oriented Psychotherapy: focus on how past experiences affect current feelings and relationships

Social Treatments for Psychiatric Disorders

- Social Treatments:
  - Minimize life stressors
  - Psychoeducation: Educate patient and family on early warning signs, behaviors, treatments. Bolster family involvement and community support.
  - Social Skills Training: In very severe cases, patients may need to be taught hygiene, appropriate social skills
  - Psychosocial Rehabilitation, Day Programs and Job Training

The Psychotic Patient and You

- May seem hostile - because paranoid, afraid
- May have bizarre beliefs - ex: “the police officer wants to eat me”
- May copy what you say (echolalia) or make repeated gestures (stereotypies)
- May be too disorganized to follow commands or answer questions
- May be mute or immobile from severity of illness
Your Reactions
- Frustration → Anger
- Discomfort
- Fear
- Sympathy
- Disgust
- Helplessness

Mood Disorders
- Characterized by abnormally high or low mood when compared to normal
- Major Depression
- Bipolar Disorder
  - Mania
- Substance-Induced
- Medical Causes

Symptoms of Depression
- Sadness
- Insomnia
- Guilt
- Energy decreased
- Concentration difficulties
- Appetite changes
- Psychomotor retardation
- Sleep disturbance
- *Psychotic symptoms
Biological Treatments for Depression

- SSRIs: newest medication, safe with few side effects
  - Prozac, Paxil, Zoloft, Celexa, Lexapro
- TCAs: older, effective but many side effects and dangerous in overdose
- MAO-I: older, effective but require dietary restriction
- Other
  - Wellbutrin, Effexor, Serzone, Trazodone
- Electroconvulsive Therapy (ECT)

Side Effects of Antidepressants

- SSRIs: stomach upset, constipation or diarrhea, dry mouth, sexual side effects, jitteriness, headache
- TCAs: dry mouth, rapid heartbeat, dizziness, confusion
- MAO-I: dizziness upon standing, difficulty sleeping

Antidepressant Adverse Events

- Priapism: Abnormally rigid and sustained erection that will not resolve. This is a medical emergency!
- TCA Toxicity: Confusion, rapid heartbeat, seizures, coma, death
- Hypertensive Crisis with MAO-I: extremely high blood pressure, red face, confusion, headache, chest pain
The Depressed Patient and You

- May seem to be ignoring you—because poor concentration, too sad to care what happens.
- May be afraid—guilt may make them expect to be punished by you.
- May not make eye contact because feel ashamed.
- May provoke you because suicidal and want you to kill them (suicide by cop).
- May be mute or immobile from severity of illness.

Symptoms of Mania

- Distractibility
- Insomnia: don’t need to sleep
- Grandiose
- Flight of Ideas
- Activity increased
- Speech pressured
- Thoughts: religious delusions

Biological Treatments for Bipolar Disorder

- Lithium
- Depakote
- Lamictal
- Tegretol
- Neurontin
- ECT
Side Effects of Mood Stabilizers

- Lithium
  - Sedation, drowsiness, tremor, weight gain, increased urination, increased thirst
- Depakote
  - Sedation, drowsiness, dizziness, tremor, acne, weight gain

Mood Stabilizer Adverse Events

- Lithium toxicity: confusion, seizure, cardiovascular collapse, coma, death
  - Treatment: Emergent Dialysis
- Depakote toxicity: stumbling, slurred speech, confusion, seizure, coma, death
  - Treatment: Stomach pump, ICU
- These are medical emergencies!!

The Manic Patient and You

- May be excessively happy, laughing, silly
- Hard to control because bursting with energy
- May seem hostile- because paranoid, afraid
- May be too disorganized to follow commands or answer questions
- May be mute or immobile from severity of illness
Your Reaction
- Mania is contagious! Laughing, amused
- Irritated, Frustrated, Angry
- Confused
- Worn out
- Fear

Substance Use Disorders
- Characterized by uncontrollable, excessive use of drugs and/or alcohol despite negative life consequences.

Symptoms of Substance Disorders
- Cocaine
  - Intoxication: confused, agitated, wide-eyed, grandiose, paranoid, chest pain
  - Withdrawal: severe depression, excessive sleepiness, excessive hunger, suicidal thoughts
- Alcohol/Benzodiazepines
  - Intoxication: slurred speech, confused, stumbling, smells of alcohol, agitated, violent
  - Withdrawal: red, fast heartbeat, elevated blood pressure, shaky, nausea, seizures, coma, death
Symptoms of Substance Disorders

- Heroin:
  - Intoxication: very sleepy, confused, slurred speech, pinpoint pupils
  - Withdrawal: pain all over, sweating, wide pupils, nausea/diarrhea, fast heartbeat, elevated blood pressure
- Methamphetamine
  - Intoxication: agitation, paranoia, energy
  - No withdrawal syndrome

Substance Use Medical Emergencies

- Cocaine: CHEST PAIN! Cocaine can make people have heart attacks.
- Alcohol: DTs! Alcohol withdrawal can be deadly.
- Heroin: Overdose. If a person is not responding and has pinpoint pupils, call EMS!

The Substance Abuse Patient and You

- Patients who are intoxicated and/or in withdrawal may be confused, silly, aggressive, sexually suggestive
- May be too intoxicated to follow directions
- May provoke you unknowingly
  - Accidentally spit in your face
  - Falling down
Biopsychosocial Treatment of Substance Use Disorders

- Substance disorders have genetic risk and environmental insults add risk.
- Medications try to prevent relapse.
  - Treat co-morbid psychiatric illness.
  - Naltrexone, naloxone.

Biopsychosocial Treatment of Substance Use Disorders (con’d)

- Psychotherapy
  - 12 step programs
  - Motivational enhancement therapy (MET)
- Social
  - Life stressors worsen substance use
  - Family involvement/community support critical to prevent relapse

Posttraumatic Stress Disorder PTSD

- A person experiences or witnesses an event that threatens death or serious injury to self or others
- Flashbacks: re-experiencing the events while awake
- Nightmares of the events
- Avoidance of associated stimuli
- Hypervigilance
**Treatments:**

**Biopsychosocial approach**

- **Biological:** Antidepressants, Benzodiazepines, antipsychotics
- **Psychological:**
  - Group therapy
  - Individual therapy
  - CBT
- **Social:**
  - Community and family support

**PTSD and You**

- Police Officers are definitely at risk for developing PTSD given increased exposure to violence
- Patients with PTSD caused by violent act may experience interacting with police as traumatic
- Flashbacks can seem like psychosis and patients may act out their flashbacks

**Your Feelings**

- Fear
- Frustration → Anger
- Guilt
- You may identify with them because of your work experiences
CONCLUSION

Why is any of this important?

Impact of Mental Illness

- 1 in 20 people with severe mental illness are homeless
- Roughly 16% of people in jail have mental illness
- The average age of death for the severely mentally ill population is 52.4 years versus 72.8 years for the general population
- Poor quality of life
- You can make a difference!

You Can Make a Difference

- Often patients are very sensitive to your reaction, and can sense how you are feeling and will respond to that
- You may be the first to notice a medical emergency
- You may be the one to convince a person of the necessity of treatment
- All patients need follow-up after release from jail.
IN REVIEW
- Remember the biopsychosocial model of treatment.
- Be a part of the treatment team!
- Recognize medical emergencies.
- Don’t ignore how the patient makes you feel—it influences how you react.

QUESTIONS?

Presentation
Prepared
By:
Nzinga Ajabu Harrison, M.D.
Emory University School of Medicine
# COMMON SIDE EFFECTS OF PSYCHIATRIC MEDICATIONS

<table>
<thead>
<tr>
<th>Class of Medication</th>
<th>Diagnosis Treated</th>
<th>Common Side Effects</th>
<th>Medical Emergencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIDEPRESSANTS</strong></td>
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<tr>
<td>SSRI</td>
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<tr>
<td>Prozac</td>
<td>Mood Disorders</td>
<td>Headache, dry mouth, sexual side effects, constipation, stomach discomfort, sedation</td>
<td>Overdose: sedation, confusion</td>
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<tr>
<td>Paxil</td>
<td>Major Depression</td>
<td>same as SSRIs</td>
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<tr>
<td>Celexa</td>
<td>Bipolar Disorder</td>
<td>Elevated blood pressure</td>
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<tr>
<td>Lexapro</td>
<td>Anxiety Disorders</td>
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<tr>
<td>Other</td>
<td>OCD</td>
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<tr>
<td>Wellbutrin</td>
<td>PTSD</td>
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<tr>
<td>Effexor</td>
<td></td>
<td>Dry Mouth, Constipation, Urinary Retention, Stomach Discomfort, Sedation, Low Blood Pressure when standing</td>
<td>Overdose: confusion, rapid heartbeat, dilated pupils, fever, seizure, coma, death</td>
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<tr>
<td>Cymbalta</td>
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<tr>
<td>Trazodone</td>
<td>Panic Disorder</td>
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<tr>
<td>TCA</td>
<td>Personality Disorders</td>
<td>Weight gain, sedation, dry mouth, low blood pressure when standing</td>
<td>Overdose: Hypertensive Crisis. Blood pressure gets really high and may cause stroke or heart attack</td>
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<tr>
<td>Paroxetine</td>
<td>Borderline Personality</td>
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<td>Nardil</td>
<td>Mood Disorders</td>
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<td>Parnate</td>
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<td><strong>MOOD STABILIZERS</strong></td>
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<td>Lithium</td>
<td>Mood Disorders</td>
<td>Shakiness, sedation, dry mouth, increased urination, acne, weight gain</td>
<td>Overdose: confusion, shakiness seizure, coma, death</td>
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<tr>
<td>Anti-Seizure Medications</td>
<td>Mood Disorders</td>
<td>Sedation, weight gain, acne, shakiness, interaction with other medications</td>
<td>Overdose: confusion, shakiness seizure, coma, death</td>
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<tr>
<td>Depakote</td>
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<td>Tegretol</td>
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<td>Lamictal</td>
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<td>Lamictal: Rash can be deadly</td>
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</tbody>
</table>
# COMMON SIDE EFFECTS OF PSYCHIATRIC MEDICATIONS

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<thead>
<tr>
<th><strong>ANTIPSYCHOTICS</strong></th>
<th><strong>STIMULANTS</strong></th>
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<tr>
<td><strong>Typical (First-Generation)</strong></td>
<td><strong>Psychotic Disorders</strong></td>
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<tr>
<td>Haldo</td>
<td>Schizophrenia</td>
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<tr>
<td>Prolixin</td>
<td>Depression with Psychosis</td>
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<td>Thorazine</td>
<td>Mania with Psychosis</td>
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<tr>
<td>Atypical (Second-Generation)</td>
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<tr>
<td>Zyprexa</td>
<td>Personality Disorders</td>
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<td>Risperdal</td>
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<td>Geodon</td>
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<td>Abilify</td>
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<td>Seroquel</td>
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<tr>
<td><strong>Amphetamine Derivative</strong></td>
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<tr>
<td>Ritalin</td>
<td>Jitteriness, increased heart beat, decreased sleep, addiction, decreased appetite</td>
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<td>Concerta</td>
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<td>Adderall</td>
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<td>Metadate</td>
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<td>Focalin</td>
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<td><strong>Other</strong></td>
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<td><strong>Strattera</strong></td>
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POSTTRAUMATIC STRESS DISORDER
Posttraumatic Stress Disorder

State of Georgia
Crisis Intervention Team
Training Program

History of PTSD
- Da Costa’s Syndrome, Soldier’s Heart
- Combat Fatigue/War Neuroses
- Myers’ “Shell Shock”
- Freud’s Hysteria
- Rape Trauma Syndrome
- Battered Woman Syndrome
- DSM-III Post-Traumatic Stress Disorder

Prevalence
- 61% of men and 51% of women experience at least one traumatic event in their lifetime.
- About 4% of the population, aged 18 - 54, will experience symptoms of PTSD in a given year (5.2 million people).
- Lifetime Prevalence Rates
  - For Women is 10%
  - For Men is 5%
What is PTSD?

Identifying PTSD in adults and children

DSM-IV-TR criteria for PTSD

- The person has been exposed to a traumatic event in which:
  - They experienced, witnessed, or was confronted with an event involving actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others
  - AND, the person's response involved intense fear, helplessness, or horror.

Examples of Traumatic Events

- Sexual Assault
  - Rape or attempted rape, molestation
- Physical Assault
  - being physically attacked, mugged, shot, stabbed, or held at gunpoint, domestic abuse
- Sudden near-Death experiences
  - car, plane, boating, industrial accidents, or terrorist attacks
- Military
  - serving in an active combat theater
- Natural Disaster
  - Tornado, hurricane, flood, or earthquake
Re-experiencing the trauma

- Recurrent and intrusive distressing memories and/or dreams of the event
- Acting or feeling as if the traumatic event were recurring
- Intense Psychological Distress and/or Physiologic Reactivity to cues that resemble the traumatic event

Avoidance and Numbing

- Avoidance of thoughts, feelings, conversations, activities, places, or people reminiscent of trauma
- Feeling detached/estranged from others
- Restricted range of affect
- Diminished interest in activities
- Inability to recall aspects of the trauma
- Sense of foreshortened future

Increased Arousal

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response
Course of PTSD
- Onset can be within 3 months or not until years later
- Duration of the illness varies. Some people recover within 6 months while others may suffer much longer
- Periods of acute symptoms followed by remission
  - Although some individuals may experience symptoms that are unremitting and severe

Associated Disorders
- Major Depressive Episodes
- Alcohol/drug abuse/dependence
- Simple and Social Phobias (in women)
- Conduct Disorders (in men)
- In Children,
  - Anxiety disorders
  - Acting-out disorders

Additional Areas of Concern
- Attention and Memory Problems
- Functional impairment
  - occupational conflicts
  - aggression, anger problems
  - marital discord / divorce
  - legal altercations
  - difficulties in parenting
PTSD Symptoms in Children
- Generalized fears
- Sleep disturbances
- Posttraumatic play and reenactment
- Lose an acquired developmental skill
- Time Skew
- Omen Formation

Risk Factors for PTSD
- Pre-trauma variables: poor coping skills, pre-existing mental-health problems, and poor social support.
- Trauma-related variables: the amount of physical injury, potential life-threat, and loss of significant others.
- Post-trauma variables: the rate of physical recovery, social support, and involvement in work and social activities.

How to respond to PTSD?
Approaching

- Provide a calm environment
  - Minimize distractions
- Evaluate stress and anger levels
- De-escalating the situation
  - Be aware of personal space
  - Speak calmly, slowly, and softly
  - Use active listening skills

Interviewing

- Clarify roles
  - Direct and respectful statements
- Understanding
  - Memory and attention difficulties
- Reassurance of a safe world
  - Offer supportive statements
  - Provide resources

Providing Referrals

- NAMI (National Alliance Mental Illness)
  - (800) 950-NAMI
- Local Mental Health Center
- Local Hospital
- Local Veterans Hospitals or Centers
PTSD and Law Enforcement

- Law enforcement and trauma
- Know thyself and your colleagues
- Seek and provide support

For More Information:
1-877-507-PTSD
www.ncptsd.org

Presentation Prepared By:

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Virginia M. Worley L.C.S.W.
Posttraumatic Stress Disorder Clinical Team
Atlanta VAMC
SITE VISIT:
LOCAL STATE PSYCHIATRIC HOSPITAL
The Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases provides treatment and support services to people with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. Services are provided across the state through community service boards, boards of health and various private providers, and through state-operated regional hospitals. Regional hospitals are located throughout Georgia in Rome, Decatur, Columbus, Milledgeville, Statesboro, and Savannah. Hospital care at one of these locations is accessed through community intake and assessment to ensure that individuals are referred to the hospital only when they need that level of care.

A site visit/orientation to a Georgia Regional Mental Health Hospital is an important component of the Crisis Intervention Team Training Program. The primary objective of the hospital site visit is to increase law enforcement officers’ understanding of the encounters that consumers have generally experienced with emergency personnel, particularly law enforcement, and the manner in which consumers perceive these experiences can be improved. After visiting a Georgia Regional Mental Health Hospital, officers will be able to: (a) describe the hospital, its services and its role in the community; (b) explain the process of referring people to be evaluated for acute psychiatric admissions to this facility; and (c) identify three of the treatment units at the hospital in addition to listing the major types of treatment they provide.

The site visit will include a detailed overview of the Georgia Regional Mental Health Hospital, its vision, mission, admission criteria, admission procedures, assessment process, and treatment process. Officers will also receive information concerning each treatment unit, the average length of stay on each unit and discharge criteria. Tours of the various hospital units are generally included in the site visits, and are an important aspect of orientation.
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<tr>
<td>8:00 AM</td>
<td>Welcome/Registration</td>
<td>Posttraumatic Stress Disorder/Consumer Interviews (#8)</td>
<td>Addictive Diseases (#11)</td>
<td>Consumer Perspectives (#16)</td>
<td>Mental Health/Community Resources (#20)</td>
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<td>8:30 AM</td>
<td>CIT Program Overview</td>
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<td>Co-Occurring Disorders (#12)</td>
<td>Family Perspective (#17)</td>
<td>De-Escalation Techniques Part 3 (#15)</td>
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<td>Signs and Symptoms of Mental Illness (#1)</td>
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<td>10:00 AM</td>
<td>Schizophrenia (#2)</td>
<td>Site Visit @ Local State Psychiatric Hospital (#9) (Note: Site visit will include a working lunch.)</td>
<td>Developmental Disabilities (#13)</td>
<td>De-Escalation Techniques Part 2 (#15)</td>
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<td>Mood Disorders (#3)</td>
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<td>2:00 PM</td>
<td>Understanding and Preventing Suicide (#5)</td>
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<td>Cultural Sensitivity (#18)</td>
<td>POST Written Examination/ Course Evaluation</td>
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<td>3:00 PM</td>
<td>Child and Adolescent Intervention (#6)</td>
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<td>Legal Issues and Mental Health Law (#19)</td>
<td>Graduation (Dress Attire/ Uniform)</td>
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<td>Treatments of Psychiatric Illnesses (#7)</td>
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<td>5:00 PM</td>
<td>Class Discussion</td>
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<td>Class Adjournment</td>
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© 2006 Georgia Crisis Intervention Team Program
1. Northwest Georgia Regional Hospital  
   1305 Redmond Circle, Northwest  
   Rome, Georgia 30161  
   706 295-6011

2. East Central Regional Hospital/Augusta  
   3405 Mike Padgett Highway  
   Augusta, Georgia 30906  
   706 792-7000

3. East Central Regional Hospital/Gracewood  
   100 Myrtle Boulevard  
   Gracewood, Georgia 30812  
   706 790-2011

4. Georgia Regional Hospital/Atlanta  
   3073 Panthersville Road  
   Decatur, Georgia 30034  
   404 243-2100

5. Central State Hospital  
   620 Broad Street  
   Milledgeville, Georgia 31062  
   478 445-4128

6. West Central Regional Hospital  
   3000 Schatulga Road  
   Columbus, Georgia 31907  
   706 568-5000

7. Georgia Regional Hospital/Savannah  
   1915 Eisenhower Drive  
   Savannah, Georgia 31406  
   912 356-2011

8. Southwestern State Hospital  
   400 South Pinetree Boulevard  
   Thomasville, Georgia 31799  
   229 227-3010
Georgia Crisis Intervention Team
Training Program

__________________________ Site Visit
(Name of Hospital)

Date: _____________

I. Hospital and Committee Overview
   A. Referrals/Admission Process
   B. Admissions
   C. Treatment Modalities
   D. Discharge Planning

II. Consumer Experiences with Law Enforcement

III. Hospital Unit Tours

IV. Tour of Admissions/Observation Area
   (Lunch at hospital site visit is optional)
Hospital Unit Tours

Tour Guide(s):

Schedule:

<table>
<thead>
<tr>
<th>Name</th>
<th>Jurisdiction</th>
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Hospital Site Visit Evaluation

Name of Hospital: ________________________________

Date: ____________

1. What was your overall impression of the visit?

2. How well were the proper procedures for bringing someone to the hospital explained?

3. How well was the proper admission procedure explained?

4. What aspect did you like most about the visit?

5. What aspect did you like least about the visit?

6. How can future site visits be improved?
SITE VISIT: LOCAL EMERGENCY RECEIVING FACILITY
GEORGIA CRISIS INTERVENTION TEAM TRAINING PROGRAM

Emergency Receiving Facility Site Visit

__________________________________________ Site Visit
(Name of Hospital)

Date: __________

• Arrival
  o Session I
    ▪ Group A: Team Meeting
    ▪ Group B: Initial Admissions Process
  o Session II
    ▪ Group A: Initial Admissions Process
    ▪ Group B: Team Meeting
• Meet with Selected Patients
• Conclusion
ADDICTIVE DISEASES
Addictive Diseases

State of Georgia
Crisis Intervention Team
Training Program

A LIFE

A LIFE including alcohol and drug use
A LIFE including alcohol and drug abuse

PARTY!
DRINK &
DRUGS

WORK

SCHOOL

HOME CARE

SPRITUAL GROWTH

COMMUNITY

FAMILY

CHURCH

HOBBIES LAUNDRY

SIGNIFICANT OTHER

LEGAL PROBLEMS

FUTURE GOALS

TROUBLE

EATING

$ MANAGEMENT

A LIFE including drug and alcohol addiction

HOPELESSNESS

DRUGS/
ALCOHOL

SICK

JOB PROBLEMS

SCHOOL

LAUNDRY

COMMUNITY

SIGNIFICANT OTHER

SPRITUAL GROWTH

FAMILY

CHURCH

HOBBIES

SICK JOB PROBLEMS

DEPRESSION

Definition of Addiction:

Chronic neglect of SELF in favor of something or someone else.

~Stephanie Covington
Addiction Has Many Faces

- Not all addicted persons are homeless or living in a “crack” house
- Some addicts appear to be functional, but with a closer look substances are still a problem

Addiction

- Addiction is a brain disease
- Addiction is a primary, progressive, fatal illness.
- A chronic disorder requiring multiple strategies and multiple episodes of intervention
- Treatment works in the long-run
- Treatment is cost-effective

Progression of Abuse to Addiction

- Stage One- Experimenting
- Stage Two- Seeking a Mood Swing
- Stage Three- Preoccupation
- Stage Four- Powerlessness/Addiction
4 Cs of Addiction

- Loss of Consistent Control over use
- Compulsivity or Craving
- Constantly thinking about addictive substance or process
- Continued use in the face of adverse consequences

Addiction Is Not What You Think

- Drug use and behavior are reinforcing or rewarding
- Reward pathway permanently altered
- Engaging in compulsive behavior
  - Even when there are negative consequences
- Loss of control in limiting intake
- Craving: conscious and unconscious
- Disease of the brain

Why do people take drugs?

- They change the brain!!!
- For the brain effects of drug use:
  - Reinforcement ("feel good" qualities)
  - Pleasure
  - Avoid negative feelings
  - Stop withdrawal
  - Try to restore normal brain function
Addiction is a Brain Disease

Prolonged Use Changes the Brain in Fundamental and Lasting Ways

“Healthy” Brain

“Cocaine Addict” Brain

How Does the Brain Work?

• Through changes in the cells within the brain
• Changes in brain cell activity and chemistry are produced by:
  – EXTERNAL environmental stimuli (e.g., putting hand on a hot stove)
  – INTERNAL biochemical stimuli (e.g., biological and behavioral changes produced by psychoactive drugs)

Brain Regions and Their Functions

movement
sensations

vision

judgement

reward

memory

coordination
What Is the Relationship Between the Brain and Behavior?

- Alterations of brain chemistry and/or structure can change:
  - Speech
  - Thinking and awareness
  - Emotions
  - Behavior, movement
  - Sensation (the 5 Senses)
  - Memory storage

Brain Reward Pathways

Dopamine Spells REWARD
Activation of Reward

Addiction as a Brain Disease

- The brain of an addicted person is changed and does not function normally
- Major differences between the addicted vs. non-addicted brain
  - metabolic activity
  - receptor availability
  - genetic expression
  - responsiveness to drugs

The Disease of Addiction

- Primary
- Progressive
- Chronic
- Relapsing
- Treatable
- NOT curable, but you can recover
Substance Abuse

- **Is defined as:** Continued use despite negative consequences as a result of use.
- **This stage of drug abuse is voluntary, preventable behavior.**
  - Impacts relationships and obligations
  - Places self in hazardous situations
  - Recurrent legal problems

Substance Dependence

- **Tolerance** (need more or diminished effect)
- **Withdrawal** (psychological and physiological problems from stopping use)
- **Unsuccessful efforts to cut down**
- Significant time and energy spent craving, obtaining or using substances
- **Impacts relationships and obligations**
- **Use even with negative health consequences**

**Substance Dependence is a Brain Disease**

- **Addicts have lost control over their drug use because of how the drugs have changed their brain chemistry**
- **Compulsion to use is psychologically and physiologically driven**
Addiction Risk Factors

- Genetics
- Young Age of Onset
- Childhood Trauma (violent, sexual)
- Learning Disorders (ADD/ADHD)
- Mental Illness
  - Depression
  - Bipolar Disorder
  - Psychosis

Cognitive Deficits

- Impaired attention
- Memory problems – short-term loss
- Impaired abstraction
- Reduced problem-solving abilities
- Loss of impulse control
- Similar performance to those with brain damage

Common Characteristics of Addicts

- Unemployment
- Multiple criminal justice contacts
- Difficulty coping with stress or anger
- Highly influenced by social peer group
- Difficulty handling high-risk relapse situations
Common Characteristics...

- Emotional and psychological immaturity
- Difficulty relating to family
- Difficulty sustaining long-term relationships
- Educational and vocational deficits

Misconceptions about Addiction

What is it?

- The DRUGS are the problem.
- It’s SINFUL or a MORAL weakness
- It shows a lack of WILLPOWER
- It’s a LEARNED behavior
- It’s “just” a STRESS response
- It’s “just” due to an untreated PSYCHOLOGICAL problem

What is a Psychoactive Drug?

- Drugs are Therapeutic chemicals
  - designed to have maximal benefit
  - with minimal risk of side effects or toxicity
- Psychoactive Drugs change:
  - The Functioning of the Brain
  - Thinking
  - Behavior
  - Emotions
  - Sensation
Classification of Psychoactive Drugs

- Stimulants – cocaine, amphetamine, methamphetamine, caffeine
- Nicotine
- Psychotherapeutics – Prozac, Haldol, lithium
- Opiates – morphine, codeine, heroin, methadone
- Depressants – alcohol, barbiturates, inhalants, sleeping pills

Psychotherapeutic Drugs

- Are used to restore mental health
- Developed recently, beginning in the 1950s
- Allow patients to resume normal lives
- Some are potentially addicting and disrupt function
  - E.g., antianxiety drugs (Valium, Xanax and others) and sedatives (Seconal, Soma)
- Most are Non-addicting:
  - antidepressants (Prozac, Zoloft, Paxil, Celexa, Effexor)
  - antipsychotics (Risperdal, Seroquel, Zyprexa, Haldol)
  - anticonvulsants (Depakote, Tegretol, Trileptal, Topamax)
  - and others

Definition of Alcoholism

JAMA, 1992

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations.

The disease is often progressive and fatal.

It is characterized by continuous or periodic:

- impaired control over drinking,
- preoccupation with the drug alcohol,
- use of alcohol despite adverse consequences,
- and distortions in thinking, most notably denial.
Alcohol Use Disorders are Common in U.S.

- 14 million adults currently have an alcohol use disorder (11 million had disorders in the past or are in recovery)
- 1.8 million of those receive treatment
- >50% of adults have immediate family member with AUD (RWJF 2001)

What Drugs are Addicting? Drugs of Abuse and Dependence

- Caffeine
- Nicotine
- Alcohol
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Opioids
- Amphetamines
- Sedative-Hypnotics and Anxiolytics
- PCP

Where Cocaine Has Its Effects in the Brain
Laboratory Rats Will Self-Administer Cocaine Until They Die


TREATMENT WORKS!
Who needs treatment?

13 to 16 million Americans need treatment for alcohol and/or other drug abuse in any year

BUT...

Only 3 million receive care

National Institute on Drug Abuse (NIDA) Principles of Effective Treatment

1. No single treatment is appropriate for all individuals
2. Treatment needs to be readily available
3. Effective treatment attends to multiple needs of the individual, not just the drug use
4. An individual’s treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s needs

NIDA Principles or Effective Tx (cont’d.)

5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness
6. Counseling and other behavioral therapies are critical components of effective treatment
7. Medications are an important element of treatment for many patients, esp. when combined with counseling or behavioral therapies
8. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way
NIDA Principles or Effective Tx (cont’d.)

9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use
10. Treatment does not need to be voluntary to be effective
11. Possible drug use during treatment must be monitored continuously
12. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B&C and other infectious diseases
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment

Medical Detoxification

- Detoxification safely manages the physical symptoms of withdrawal
- Only first stage of addiction treatment
- Alone, does little to change long-term drug use

Medications for Drug Addiction

- Alcohol and Benzodiazepines: Librium, Ativan, Phenobarbital (withdrawal is potentially fatal if left untreated)
- Opiates: Buprenorphine, Methadone, LAAM, Naltrexone (withdrawal is uncomfortable, not life-threatening)
- Nicotine: Patches, gum, bupropion, behavioral modification
**Motivation to Enter/Sustain Treatment**

- Effective treatment need not be voluntary
- Sanctions/enticements (family, employer, criminal justice system) can increase treatment entry/retention
- Treatment outcomes are similar for those who enter treatment under legal pressure vs voluntary

**Effectiveness of Treatment**

- Goal of treatment is to return to productive functioning
- Treatment reduced drug use by 40-60%
- Treatment reduces crime by 40-60%
- Treatment increases employment prospects by 40%
- Drug treatment is as successful as treatment of diabetes, asthma, and hypertension

**Self-Help and Drug Addiction Treatment**

- Complements and extends treatment efforts
- Most commonly used models include 12-Step (AA, NA) and Smart Recovery
- Most treatment programs encourage self-help participation during/after treatment
12-Step Programs

- Alcoholics Anonymous
- Narcotics Anonymous
- Crystal Meth Anonymous
- Gambling Anonymous
- Al-Anon
- Adult Children of Alcoholics (ACOA)
- Double Trouble (dual diagnosis)

Cost-Effectiveness of Drug Treatment

- Treatment is less expensive than not treating or incarceration (1 yr methadone maintenance = $4,700 vs. $18,400 for imprisonment)
- Every $1 invested in treatment yields up to $7 in reduced crime-related costs
- Savings can exceed costs by 12:1 when health care costs are included
- Reduced interpersonal conflicts
- Improved workplace productivity
- Fewer drug-related accidents

If you treat an individual as he is he will stay as he is, but if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.

~ Johann Wolfgang von Goethe
Presentation Prepared By:

Neil Kaltenecker, Director
Office of Addictive Diseases
Division of Mental Health, Developmental Disabilities, and Addictive Diseases
Georgia Department of Human Resources

Barbara D'Orio, MD, MPA
Associate Professor of Psychiatry
Emory University School of Medicine
Director of Adult Outpatient Psychiatric Services
Grady Health System
CO-OCCURRING DISORDERS
Co-Occurring Psychiatric and Substance-Related Disorders

State of Georgia
Crisis Intervention Team
Training Program

Clients with co-occurring disorders have:

- One or more disorders relating to the use of alcohol and/or other drugs of abuse
- One or more mental disorders
- One disorder of each type that can be established INDEPENDENTLY of the other

National Co-Morbidity Study
Lifetime Prevalence

- Any alcohol or drug abuse/dependence = 26.6%
  - Alcohol Dependence=14.1%
  - Drug Dependence=7.5%
- Any Anxiety Disorder=24.9%
- Major Depressive Episode=17.1%
- Dysthymia (mood disorder)=6.4%
- Manic Episode=1.6%
- Noneffective psychosis=0.7%
Epidemiology of Dual Disorders
(Epidemiological Catchment Area Study)

- Community Lifetime Prevalence of Alcoholism=13.8%
- Lifetime Prevalence of Schizophrenia among alcoholics=3.8%
- Lifetime Prevalence of Alcoholism among Schizophrenics=33.7%
- Lifetime Prevalence of any Alcohol or Drug Disorder in Schizophrenics=47%

Epidemiology of Dual Disorders
(Epidemiological Catchment Area Study)

- 29% of people with psychiatric illness have also had a substance use disorder at some time during their lives
- Odds are 3:1 that a person with one substance use disorder will meet lifetime criteria for another psychiatric or substance use disorder

Epidemiology of Dual Disorders
(Other Studies)

- Overall approximately 50% of persons in psychiatric clinical settings will have a substance use disorder
  - 30% depressed patients
  - 50% bipolar patients
  - 50% schizophrenic patients
  - 80% antisocial personality disorder patients
  - 30% anxiety disorder patients
  - 23% phobic disorder patients
Co-Occurring Disorders in the Justice System

- Rates of mental health disorders are 4 times higher among prisoners than in the general population
- Rates of substance use are four to seven times higher than in the general population
- An estimated 3-11% of individuals in correctional settings have co-occurring disorders
- Rates of co-occurring disorders are particularly high among those in the CJ system diagnosed with bipolar disorder and schizophrenia

Individuals at High-Risk of Co-Occurring Disorders

- Males
- Youthful Offenders
- Low Educational Level
- History of unstable housing or homelessness
- History of legal difficulties and/or incarceration
- Suicidality
- History of emergency room or acute care visits
- High rates of relapse to substance abuse
- Peers/associates who are drug users or who have antisocial features
- Poor relationships w/ family
- Family history of substance use and/or mental health disorders
- Poor adherence to treatment
- Disruptive behavior

Diagnosis

- Substance Induced Disorders: Many psychiatric symptoms can be caused by drugs including depression and psychosis. Symptoms occur in/around drug use. (e.g., Substance Induced Mood or Psychotic Disorders)
- Primary Psychiatric Disorder: Symptoms separate from drug use. (e.g. Major Depression, Schizophrenia)
Diagnosis

- Can’t always know if symptoms are due to a primary psychiatric disorder, intoxication, withdrawal or a substance induced disorder at first glance
- Requires further assessment

Diagnosis

- Review of symptoms related to DSM IV mental health and substance use disorders
- Summarize the pattern of current symptoms and their relation to drug use
- Assess via interviewing, testing, review of records, and interviews with significant others
- Diagnosis helps to determine the focus of treatment: mental health, substance abuse, or both

Diagnosis

- Many substance induced symptoms resolve rapidly with detoxification and/or abstinence with no or short-term use of medication
- Primary psychiatric disorders often require extended treatment with medication
Important Signs and Symptoms of Co-Occurring Disorders
- Unusual affect, appearance, thoughts, or speech
- Suicidal thoughts or behavior
- Paranoia
- Impaired judgment and risk-taking behavior
- Agitation and tremors
- Impaired motor skills
- Dilated or constricted pupils
- Elevated or lowered vital signs
- Hyper-arousal or drowsiness
- Muscle rigidity
- Evidence of current intoxication
- Needle track marks/injection sites
- Inflamed or eroded septum
- Burns of the inside of the lips

Alcohol is the most commonly abused substance by the mentally ill, although individuals with mental health disorders are more likely than the general population to be poly-drug users

Relationship between Disorders
- Psychiatric illnesses increase the risk of developing substance abuse & dependence
- Psychiatric symptoms may affect onset, duration, or response to treatment of substance use/dependence (self-medication behavior)
- Psychiatric symptoms may arise as a direct result of chronic substance use or withdrawal
- Psychiatric disorders can mask substance use disorders and vice versa
Mental Illness and Addiction Parallels

- Biological illnesses
- Heredity may be a factor
- Chronic, incurable, but not hopeless
- Cause a loss of control of behavior/emotions
- Affects the whole family
- Disease of denial

- Symptoms respond to treatment
- Disease progresses without treatment
- Often seen as a moral issue or weakness
- Feelings of guilt, failure, shame, stigma
- Physical, mental, and spiritual disease

Stages of Change Model for Persons with Co-Occurring Disorders

- Engagement – identifying potential sources of motivation
- Persuasion – developing commitment to treatment and recovery
- Active treatment – significant changes in behavior and lifestyle
- Relapse prevention – focus on maintaining prolonged abstinence

A Vision for Treatment of Co-Occurring Disorders

- The client participates in one program that provides treatment for both disorders
- The client’s mental and substance use disorders are treated by the same clinician
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both mental and substance disorders
- The clinicians offer substance abuse treatments tailored for clients who have severe mental disorders
- The focus is on preventing anxiety rather than breaking through denial
A Vision for Treatment of Co-Occurring Disorders (cont’d)

- Emphasis is placed on trust, understanding, and learning
- Treatment is characterized by a slow pace and a long-term perspective
- Providers offer stage-wise and motivational counseling
- Supportive clinicians are readily available
- 12-step groups are available
- Medication therapies are indicated according to clients’ psychiatric and other medical needs

Source: Adapted from Drake et al, 1998

Presentation Prepared By:

Neil Kaltenecker, Director
Office of Addictive Diseases
Division of Mental Health, Developmental Disabilities, and Addictive Diseases
Georgia Department of Human Resources

Barbara D’Orio, MD, MPA
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DEVELOPMENTAL DISABILITIES
Developmental Disabilities and Law Enforcement

State of Georgia
Crisis Intervention Team
Training Program

Topic: Developmental Disability and Law Enforcement

Objectives:
- Describe developmental disability
- Explain difference between mental illness and developmental disabilities
- List/describe challenges of a police officer in contact with a person with a developmental disability
- List/describe challenges of a person with developmental disabilities in responding to a police officer

Objectives (Cont.)
- Describe common encounters a police officer might have with a person with developmental disabilities
- Describe methods to use in communicating with a person with a developmental disability
- Discuss possible ways of determining the appropriate placement/setting for a person with a developmental disability
What is a Developmental Disability?

A disability that is manifested before the person reaches 22 years of age. This disability results in a significant impairment to a person’s daily functioning. This disability can be the result of conditions such as mental retardation, autism, and other associated conditions such as cerebral palsy and seizure disorders.

What is a Developmental Disability?

Results in significant deficits in 3 or more of the following areas:

- Self care
- Economic Self-sufficiency
- Self-direction
- Learning
- Mobility
- Language
- Capacity for Independent Living

What is a Developmental Disability?

Reflects the need for a combination and sequence of special supports and services

Is life long - once it occurs (usually from birth)

Calls for individualized planning, coordination, and supports - making it difficult to generalize
Major Types of Developmental Disability

- Mental Retardation
- Autism
- Behavior Disorders
- Fetal Alcohol Syndrome or Effect
- Learning Disabilities
- Epilepsy
- Cerebral Palsy

NOTE: 11% of students have developmental disabilities - can probably generalize to adult populations

Mental Retardation
Intellectual Disabilities / Cognitive Disabilities

- Intellectual and adaptive functioning that is significantly lower than the normal individual
- This diagnosis is based upon IQ and degree of impairment in adaptive functioning
- Levels range from mild, moderate, severe, to profound.
- Level of IQ can be misleading - so much depends on life experiences

Autism

Lifelong disability that appears during the first three years of life
It is characterized by:
- Lack of social responsiveness
- Lack of communication abilities
- Persistent compulsive behaviors
- Resistance to change in routines, schedules, and familiar environment
Fetal Alcohol Syndrome
- Difficulty with memory, attention, and judgement
- Poor impulse control
- Sensitivity to pressure, sound, and bright lights
- Poor motor skills
- Facial characteristics include but are not always present
  - Small head
  - Flat midface
  - Narrow eye slits
  - Low nasal ridge

General information about Developmental Disabilities
- Not all developmental disabilities involve cognitive limitations
- Persons with cerebral palsy may also have mental retardation, but they are two different disabilities; the same is true of autism
- Not everyone with a cognitive disability has mental retardation

Some common myths about Developmental Disabilities
- Cannot remember facts - happenings
- Cannot be credible witnesses or reporters of information
- Have high rates as offenders
Disability and Victimization

- Persons with developmental disabilities are more typically the victims of crime
- Rates of victimization are extremely high: they are 5-10 times more likely to be victims of crime than the general public
- When properly supported, people can make very reliable witnesses

Disability and Victimization

- Being assaulted, raped or starved by a caregiver is treated as a human resource issue rather than a crime - it is a crime.
- Assault or rape by community members is often dismissed or ignored, with few arrests and little prosecution occurring.
- Being assigned responsibility for actions beyond their capacity.

Differences Between Mental Retardation and Mental Illness

Mental Retardation:
- Intellectual Functioning that is lower than the normal person’s intellectual functioning
- Occurs before age 22
- Degree of impairment is virtually permanent/lifelong
- Person with mental retardation can be expected to behave rationally at his/her functional level.
- People with mental retardation can have an additional diagnosis of mental illness.
Differences (Cont.)

Mental Illness:
- Has nothing to do with intelligence
- May be improved/controlled with therapy and/or medication
- May recover completely from mental illness. Not necessarily permanent.
- May occur at any age
- Person with mental illness may vacillate between normal and irrational behavior
- Mental illness covers a wide variety of symptoms affecting perception, emotions, impulse control, hostility, etc.

Co-Occurrence of Disability

An individual can often be diagnosed with many disabilities
- Mental Retardation
- Autism
- Mental Illness
- Behavioral disorders
- Cerebral palsy
- Vision/hearing disabilities
- Personality disorders
- Seizure disorders

Challenges for a Police Officer

- People with developmental disabilities may not be able to communicate effectively or talk at all.
- People with developmental disabilities may engage in behaviors that are strange, annoying, confusing, or offensive to the officer.
- People with developmental disabilities may not understand Miranda Rights.
- Situations involving people with developmental disabilities may require more time and effort.
- People with developmental disabilities may have co-occurring disorders.
Information for Police Officers

- Developmental disabilities are present in about 10-11% of the population.
- Persons with developmental disabilities do not typically tell others that they have a disability; and
- Most disabilities are not readily visibly evident, but interaction and observation often provide clues that a developmental disability is present and needs to be considered.
- Federal laws require reasonable accommodation.
- Wherever / whenever a crime is committed, police are responsible for investigating and enforcing the law.

Information for Police Officers

- Knowledgeable, aware police officers significantly improve the chances of good, fair prosecution of crimes committed against people with developmental disabilities: taking a good report is critical.
- Knowing when to involve other professionals can take the pressure off - access people with information on disabilities to make your job easier.

Information for Police Officers

- Observant, proactive police officers can help reduce the rates of victimization by:
  - Keeping an active watchful eye out for vulnerable persons and providing extra protection to them;
  - Assuring that crimes against persons with disabilities are recognized as real crimes against real people; and
  - Taking time to get the story from victims with developmental disabilities. It will take longer, but they can and do tell their stories accurately, when we listen well.
Challenges for a Person with Developmental Disabilities

- May not understand the officer or be able to process information or instructions fast enough to respond.
- May not be able to cooperate with law enforcement to:
  - place happenings in sequence or time;
  - read something or sign a document;
  - speak, or
  - move in a particular way.

- May not understand potential for harm if she/he engages in suspicious/aggressive behavior.
- May become frightened or frustrated due to lack of understanding.
- May have been taught not to talk to strangers.
- May interpret attempts to be helpful as alarming.
- Because he/she is under pressure, may not be able to process information, answer questions, follow directions.

Additional Challenges

- People with developmental disabilities may not understand appropriate social rules when in contact with community.
- Taught that police are friends and helpful, may not be able to recognize or adjust to the role change of an officer who is an interrogator.
- Incomplete or immature concepts of blameworthiness or culpability.
- May feel compelled to answer a question even if the question exceeds her/his ability to answer. “I don’t know/understand” is too hard to admit.
- If offered the opportunity to make a phone call, may not know how.
Common Encounters with Person with a Developmental Disability

- A person with developmental disabilities who is disruptive and violent in a group home
- Family/agency reports a person missing
- Person with developmental disabilities who is a victim of assault or rape
- Individual disruptive or stealing in a store
- Individual engaging in inappropriate behavior in public place, etc.

Communicating with a Person with Developmental Disabilities

- Use simple language.
- Use concrete terms/ideas.
- Avoid leading questions.
- Phrase questions for a yes/no answer.
- Rephrase Miranda Warning and ask for explanation.
- Go slow and provide praise for cooperation.
- Never make fun of person.
- Avoid vague, complex questions and asking reasons for behavior.

Managing Crises Involving Persons with Developmental Disabilities

- Speak calmly, quietly, and as firmly as possible.
- Use non-threatening body language.
- Use firm, ONE-STEP commands.
- Minimize distractions.
- Keep animals away (DOGS).
- Look for personal identification information (ID).
- Identify support network (family, caregivers, providers).
- Prepare for time-consuming encounter.
- Calmly repeat short, clear directives.
- Maintain eye contact, observe for signs of understanding.
Managing Crises (Cont.)

- Be attentive to motor/sensory impairment
- Do not use physical intervention unless absolutely necessary
- Be aware of different forms of communication
- Keep safe distance
- Don’t take odd/bizarre behaviors personally.
- Look for signs of agitation, weapons, anger, mental illness
- Use family/caregivers, agency providers as a resource.
- Consider alternatives to arrest (hospital, alternative placements, de-escalation with psychiatric followup, etc.)

Presentation Prepared By:

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ALZHEIMER’S DISEASE
The Problem

- Man w/ dementia left his home by car at 9:00am to go to the store in his local neighborhood. 7 hours later he ran over a curb in a Good Samaritan’s yard 4 counties away.
- Elderly woman w/ Alzheimer’s got on greyhound bus in NYC to Atlanta (with many stops in between) 7 days later she was found by Good Samaritan back in NYC.
- A 77 y/o man with Alzheimer’s drove his car on the wrong side of the road and hit a tractor trailer head on killing himself and the other driver (a 40 y/o man).
- Elderly woman w/ Alzheimer’s wandered out of her home while husband was in the other room in April 2004 her remains were found on Christmas Eve 2004 only 500 yards from her house.

After completing the training, you should be able to:

- Demonstrate an awareness of the risks associated with wandering behavior
- Identify benefits of the Alzheimer’s Association Safe Return Program
- List techniques for effectively interacting with a person who has Alzheimer’s disease
- Describe ways to recognize a person who may be affected by Alzheimer’s disease
After completing the training (Cont.)

- Demonstrate knowledge of situations you may frequently encounter involving a person with Alzheimer’s disease
- Identify local resources, including the Alzheimer’s Association, available to help the individual with Alzheimer’s disease and their families and caregivers

Alzheimer’s disease

- Alzheimer’s disease is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking, and behavior.
- Common symptoms:
  - memory loss
  - problems with reasoning & judgment
  - disorientation to time and place
  - difficulty in learning
  - loss of language skills
  - a decline in the ability to perform familiar tasks

Alzheimer’s disease (cont.)

- The rate of progression varies for each individual
- The time from onset of symptoms until death averages 8 years
  - Lifespan ranges 3-20 years
- Eventually individual becomes incapable of caring for themselves and must rely on help of others
- Every person with AD is different
A Visual of Alzheimer’s Disease

A. The brain of a normal elderly person

B. The brain of a person with Alzheimer’s disease

Alzheimer’s disease Statistics

- Over 4.5 million persons diagnosed in the United States, will triple by 2050
- 1 in 10 people age 65 and over will develop Alzheimer’s disease
- 1 in 2 people age 85 and older will develop Alzheimer’s disease
- 161,000 Georgians diagnosed
- 2-3 times the diagnosed # are impacted

Diagnosis

- Process takes more than one day by more than one doctor
- Comprehensive evaluation includes:
  - Health History
  - Physical Examination
  - Neurological and Mental Status Assessments
  - Analysis of blood and urine
  - Electrocardiogram (EKG)
  - Chest X-ray
  - CT, MRI or PET (Positron Emission Tomography) Scan
**Treatment**
- No cure
- Good planning, medical and social management can ease burden on the person with Alzheimer’s disease and their family
- Physical exercise and social activities
- Proper nutrition
- Calm and well structured environment
- Medications available
  - Aricept, Exelon, Reminyl
  - Memantine (Namenda)

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**Who gets dementia?**

- Most common behavior
- 67% at risk of wandering
- Life-threatening
- Cannot be predicted – it can occur anytime, anyplace by foot, car, public transportation
- If not located within 24 hours, 46 percent of wandering individuals may die
- Average distance is .5 mile
Why people wander

- Restlessness
- Confusion about time
- Change in physical environment (i.e. trying to find “home”)
- Over-stimulation from crowds, noise
- Argument with a caregiver
- Fear caused by a delusion or hallucination

Why people wander? (Continued)

- An inability to communicate basic needs
- Went to the mailbox and could not find way home.
- Looking for a spouse or child because they no longer look familiar
- Medication side effects
- A desire to meet former obligations that no longer exist

Sundowning

- A behavior that occurs in the late afternoon through early evening
- Leads to unsafe wandering due to:
  - Inability to see well in dim light, causing confusion
  - Inability to cope with stress of the day
  - Restlessness from inactivity in the late afternoon
  - Caregiver experiences fatigue and stress, which person senses, causing them to be anxious
Video

- 13-minute video on Safe Return and Law Enforcement Saving Lives Together

Safe Return Program

- National Identification System that operates 24 hours a day, 7 days a week
- Assists in the safe and timely return of individuals with Alzheimer’s disease and related dementias who wander and become lost
- Over 95% success rate with Safe Return
- 43% recovery rate without implementing Safe Return
- Program costs a one-time $40.00 (may have grant money available)
  - An additional $5.00 for caregiver

Safe Return Benefits

- Identification Products
  - Medical alert bracelet or necklace that states the individual is “Memory-Impaired” with ID # and Safe Return #
- 24-hour toll-free crisis line
- National Database
  - Caregiver Information, Medical Conditions, Profile
- Fax Notification
- Chapter support
- Information & training
How Safe Return Responds

- Discovery Incident
  - If you find someone in the field on SR
- Missing Incident
  - A person is reported missing to you on SR
- Non-Registered Person
  - Discovery or Missing person not on SR

Safe Return Crisis Line

- Toll free number available 24/7
  - 1-800-572-1122

Recognizing Alzheimer's disease

- Identification clues
  - Identification jewelry, clothing tags, driver's license (usually very few if any)
- Physical clues
  - Blank facial expressions, Inappropriate Clothing, Age, Unsteady Gait
- Psychological clues
  - Short-term memory loss, confusion, communication problems, Delusions & hallucinations, Agitation, catastrophic reaction
Frequently Encountered Situations

- Wandering
- Driving
- False Reports
- Victimization
- Shoplifting
- Indecent Exposure
- Homicide and Suicide
- Appearance of Intoxication
- Abuse and Neglect

How to interact with a person with Alzheimer’s disease

1. Remember to treat the person with respect and dignity.
2. Avoid restraints if possible
3. Approach from the front and introduce yourself
4. Speak slowly and calmly
5. Keep the “climate” calm and supportive

6. Ask only one question at a time
7. Keep instructions positive
8. Substitute non-verbal for verbal communication
9. Avoid shouting
10. Keep explanations simple
Responding to incidents involving Missing Persons

1. Take Action immediately
   - Person is considered “Endangered Missing”
   - Emergency Situation (persons with AD do not cry out for help or respond to shouts)

2. Initiate Search
   - Check immediate area
   - Check familiar places

3. Enter a report to NCIC

4. Use Search Techniques
   - SAR dogs
   - Search heavy briars or bushes

Responding to incidents involving Missing Persons (cont)

5. Issue a radio report to local community

6. Notify those in change of shifts at your department

7. Ask nearby police depts. to include a report in all shift briefings

8. Inform Media Outlets
   - weather is severe
   - life-threatening health problem
   - dark out and person missing 2 hours

Mattie’s Call

- A formal protocol notifying Metro Atlanta Law Enforcement Agencies, Emergency Management and the Media to issue an urgent bulletin regarding a Missing Person with Alzheimer’s, Dementia or any other mental disabling conditions.
- City of Atlanta ONLY
- Coordinated through the Atlanta Police Department Homicide Unit 404-853-4235
- Support future legislation to go statewide
Alpha Team K9 Search & Rescue

- All-volunteer 501©3 non-profit organization
- Provides resources & personnel to the search & rescue & emergency response community
- Air scent, trailing, cadaver dogs available
- Urban, building and water searches
- Must be coordinated through the police
- Available 24/7 at no cost

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Alpha Team K9 SAR (Cont.)

- Team members trained year round in all types of weather, day and night (demonstrations available)
- National Association of Search and Rescue Team Member
- GEMA certified
- Contact Stuart Samples 404-314-7248 (cell) or 404-701-1515 (pager)
- Visit the website at www.ATSAR.org

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Call to Action

- Look for Identification
- Call number on Identification
- Inform Others
- Sponsor Registration Day
- Publish information in newsletter
- Display information in office
- Join a Triad (S.A.L.T.)
- Train new employees
Alzheimer’s Association
Core Services
- Safe Return
- Support Groups
- Information and Referral
  - 24/7 helpline 1-800-272-3900
- Education
- Care Consultation
- Vision: a world without Alzheimer’s disease
- Mission: to eliminate AD through the advancement of research and promotion of brain health, and to enhance care and support for all individuals, their families & caregivers.

Questions??
Please feel free to call at 1-800-272-3900 or 404-728-1181, ext: 244.

***Please fill out evaluations***

Presentation Prepared By:
Alice Hoffmann
Safe Return Coordinator
Alzheimer’s Association
DE-ESCALATION TECHNIQUES
De-Escalation Techniques

Basic Communication Skills

State of Georgia
Crisis Intervention Team
Training Program

Safety! Safety! Safety!

- As with everything we do, we never jeopardize our personal safety.
- You escalate and de-escalate depending on the situation as dictated by your departmental policy and procedures.

Force Continuum

- Officer presence
- Verbal commands
- Soft empty hands
- Hard empty hands
- Impact weapons
- Lethal force
Memphis Model

- Model developed following the shooting of an unarmed consumer and subsequent community outcry
- Partnership of law enforcement, NAMI, and mental health professionals traveled to Memphis, Tennessee for two-day orientation and then returned for forty-hour course

Why C.I.T.?

- Sixteen percent (16%) of the population in jail and in prison are mentally ill.
- A large number of calls for service involve mental illness issues.
- The training leads to a reduction in officer and consumer injuries.
- Repeated calls are reduced due to the problem-solving skills that are used by C.I.T. officers.

Breakdown of CIT

- Crisis – A crucial or decisive point; a traumatic change in a person's life
- Intervention – To compel or prevent an action
- Team – A number of persons associated in work or activity
Requirements for an Effective CIT Officer

- Ability to be a team player
- Good listening skills
- Empathic understanding
- Effective problem-solving skills
- Assertiveness
- Capacity to remain calm and in control

Effective Communication

- It is defined as the passing of information between one person and another that is mutually understood and results in the other person behaving in a manner that demonstrates understanding.
- CIT officers must be given sufficient time to accomplish the mission – Don't Rush!

Communication

- 7% of communication is verbal
- 93% of communication is not communicated by spoken words
Body Language - Kinesics

- Eye contact
- Body gestures (e.g., holding one’s fist)
- Posture
- Body positioning in space
- Facial expressions
- Arm-crossing

Effective Listening

- Listen for the total meaning
- Respond and focus on what the consumer is telling you – block out distractions
- Reflecting statements show that you are listening
- Being sincere and real will convey understanding

Active Listening

- Minimal encouters – Brief responses (sounds) that indicate your presence and that you are listening
  - Best used when consumers are talking and attempting to expressing themselves.
- For these to be effective, you must be sincere
Active Listening Techniques

- Introduction
- "I" Statements
- Restating
- Mirroring and Reflecting
- Paraphrasing and Summarizing

Officer Introduction

- Introduce yourself
  - "Good Morning"/"Good Afternoon; I’m Officer ________, and I’m a CIT officer with the ________ Police Department." “What’s your name?”
  - Introduction promotes communication
- Be prepared to explain the reason that you are there

Role-Playing

- Role-playing is a practical learning technique used in mastering the various de-escalation skill/techniques
- Everyone is initially uncomfortable when beginning the role-play exercises
- Don’t forget this exercise is a learning experience
- Scenarios are derived from real life experiences
- Feedback is constructive
“I” Statements

- These statements reflect “what” you are seeing and hearing
  - “I can see that you are upset/angry.”
  - “I hear in your voice that you are _______."
  - “I’m here to help you.”/I want to help you.”
  - “I will keep you safe.”
  - “I care . . . I have time . . . I’m listening . . .”
  - “I appreciate your help and cooperation.”
- They convey that you are listening and understanding, and that you care.

Restating Statements

- Projects understanding and that you are listening
  - Consumer: “I don’t know what I’m going to do. My family doesn’t want me here.”
  - C.I.T. Officer: “You’re not sure where you can stay for awhile, but home doesn’t seem to be the best place right now.”

Reflecting/Mirroring Statements

- Reflecting the consumer’s feelings
- Accomplished by repeating the last few words
  - Consumer: “I’m tired of everyone not listening to me and it makes me angry.”
  - C.I.T. Officer: “It makes you angry.”
Summarizing/Paraphrasing Statements

- Restating the information or previous statements in your own words
- These statements should include the main points of the previous content
  - C.I.T. Officer: "Okay, so what you have told me is that . . ., and you feel . . .. Do I understand you correctly?"

Open-Ended Questions

- These questions cannot be answered by a simple "yes" or "no"
- Avoid using "Why?" questions – They can lead to defensiveness
- These types of questions can assist the officer in acquiring additional information, and can also assist the officer in determining whether the consumer is in touch with reality
  - "Tell me more about . . .." "What else . . .?" "When did this happen?"

Closed-Ended Questions

- Helps the officer to obtain a commitment
  - Begin with the question, "Are you . . .?" or "Do you . . .?" or "Will you . . .?"
- Can also help the officer to request specific information
  - "Are you thinking of hurting yourself?"
  - "Will you let me take you to get some help?"
Don’t argue with the consumer!

- The consumer has a right to feel or say whatever they want to say/feel
- Don’t “buy into” delusions – Defer the issue in the best possible manner
- Be courteous, using such words as “please” and “thank you”
- Don’t take the consumer’s words/actions personally
- Be flexible and use your listening skills

Behaviors to Avoid

- Avoid using “Why?” questions
- Do not allow your feelings to interfere with your professionalism, and always focus on the behavior you want from the consumer
- Avoid speaking loudly when it is not necessary
- Do not lose sight of officer safety skills
- Do not rush – you have time
- Avoid allowing yourself to be intimidated by other officers who you may think know better than you – Use them to support you

Training

- “If you don’t use it, you’ll lose it!”
- Keep updated and refreshed about your training
- Safety First – De-escalation will not work 100% of the time
- Always remember the reason that you entered law enforcement
Summary

- Introduction
- “I” Statements
- Restating Statements
- Mirroring and Reflecting Statements
- Paraphrasing and Summarizing Statements

Questions

“There are no stupid questions!”

Presentation Prepared By:

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Clinical Psychologist
CONSUMER PERSPECTIVES
The Consumer’s Perspective
and Recovery

State of Georgia
Crisis Intervention Team
Training Program

Objectives

- Better understand the concept of mental health recovery from the MH consumer’s perspective.
- Define recovery as stated in the President’s New Freedom Commission Report on Mental Health as well as some alternative definitions.
- Explain the differences between “treatment” and “rehabilitation” services, the 5-stage recovery process and the role that hope plays in recovery.

My Life
My Experience of Mental Illness

Everyone’s experience of life and mental illness is different.

Medication can...
- be very helpful, but isn’t always a cure.
- cause or exacerbate other symptoms.
- take weeks or months to work.
- lose effectiveness over time.
- cause unhealthy side effects.
- be cost-prohibitive.
When I am sick or in crisis, please...

VISION STATEMENT of the President's New Freedom Commission on Mental Health

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports — essentials for living, working, learning, and participating fully in the community.
Recommendation 2.2
The President’s New Freedom Commission on Mental Health

“Involve consumers and families fully in orienting the mental health system toward recovery.”

Strengthening the Consumer Voice: The Georgia Peer Specialist Project

“Peer support is the act of people who have had similar experiences with mental illnesses giving each other encouragement, hope, assistance, guidance, and understanding that aids in recovery.”

From S.H.A.R.E. Project in northwest GA. S.H.A.R.E. is a consumer run mutual support program designed to enhance the recovery process. Written in the mid-’90’s

Recovery as defined in the President’s New Freedom Commission on Mental Health

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery.
A Vision of Recovery...

What does this change?

“The Impact of Diagnosis on One’s Self-Image”

A story told by Patricia Deegan, PhD

Five Stages of Recovery

<table>
<thead>
<tr>
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<th>Change is Possible</th>
<th>Commitment to Change</th>
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<td>The person is disabled by the symptoms of the illness.</td>
<td>The task is to decrease the emotional distress by reducing the symptoms.</td>
<td>The person is beginning to believe that his/her life can be different.</td>
<td>The person is willing to explore what it will take to make some changes.</td>
<td>The task is to help the person identify his/her strengths and needs in terms of skills, resources, and supports.</td>
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<td>The task is to restructure his/her thinking to develop a positive self-image.</td>
<td>The task is to instill hope, a sense of possibility, and to rebuild a positive self-image.</td>
<td>The task is to empower the person to participate in his/her recovery by beginning to take small steps.</td>
<td>The person is willing to take responsibility for his/her actions.</td>
<td>The task is to help the person use his/her strengths and to get the necessary skills, resources, and supports.</td>
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Objective Review

- Better understand the concept of mental health recovery from the MH consumer’s perspective.
- Define recovery as stated in the President’s New Freedom Commission Report on Mental Health as well as some alternative definitions.
- Explain the differences between “treatment” and “rehabilitation” services, the 5-stage recovery process and the role that hope plays in recovery.

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National Alliance on Mental Illness
NAMI Georgia
### Five Stages in the Recovery Process

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<td>The person is disabled by the symptoms of the illness. The task is to decrease the emotional distress by reducing the symptoms.</td>
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### The Role of Services in the Recovery Process
The Impact of Diagnosis on One’s Self-Image
Story Told by Patricia Deegan

1. At a recent conference that brought together persons with diverse disabilities, I had the pleasure of talking with a man who was paraplegic. We shared our stories of recovery.

2. At a young age we had both experienced a catastrophic shattering of our world, hopes and dreams. He had broken his neck and was paralyzed, and I was diagnosed as being schizophrenic. We recalled the impact of those first days following the onset of our disabilities. He was an athlete and dreamed of becoming a professional in the sports world. I was a high school athlete and had applied to college to become a gym teacher. Just days earlier we knew ourselves as young people with exciting futures, and then everything collapsed around us. As teenager, we were told that we had an incurable malady and that we would be “sick” or “disabled” for the rest of our lives. We were told if we continued with recommended treatments and therapies, we could learn to “adjust” and “cope” from day to day.

3. Needless to say, we didn’t believe our doctors and social workers. In fact, we adamantly denied and raged against these bleak prophesies for our lives. We felt it was all just a mistake, a bad dream, a temporary setback in our lives. We just knew that in a week or two, things would get back to normal again. We felt our teenage world was still there, just waiting for us to return to it. Our denial was an important stage in our recovery. It was a normal reaction to an overwhelming situation. It was our way of surviving those first awful months.
4. The weeks passed us by, but we did not get better. It became harder and harder to believe we would ever be the same again. What initially had seemed like a fleeting bad dream transformed into a deepening nightmare from which we could not awake. We felt like ships floating on a black sea with no course or bearings. We found ourselves drifting farther and farther away from the young, carefree people we had been. He lay horizontal and in traction while his friends selected to play ball at very prestigious colleges. I stood drugged and still in the hallways of a mental hospital while my classmates went off to their first year of college.

5. We experienced time as a betrayer. Time did not heal us. Our pasts deserted us, and we could not return to who we had been. Our futures appeared to be barren, lifeless places in which no dream could be planted and grow into a reality. As for the present, it was a numbing succession of meaningless days and nights in a world in which we had no place, no use, and no reason to be. Boredom and wishfulness became our only refuge.

6. Our denial gave way to despair and anguish. We both gave up. Giving up was a solution for us. It numbed the pain of our despair because we stopped asking “why and how will I go on?” Giving up meant that for 14 years he sat in rooms of institutions gazing at soap operas, watching others live their lives. For months I sat in a chair in my family’s living room, smoking cigarettes and waiting until it was 8:00 PM so I could go back to bed. At this time even the simplest tasks were overwhelming. I remember being asked to come into the kitchen to help knead some bread dough. I got up, went into the kitchen, and looked at the dough for what seemed an eternity. Then I walked back to my chair and wept. The task seemed overwhelming to me. Later I learned the reason for this: when one lives without hope (when one has given up) the willingness to “do” is paralyzed as well.
7. All of us who have experienced catastrophic illness and disability know this experience of anguish and despair. It is living in darkness without hope, without a past or a future. It is self-pity. It is hatred of everything that is good and life giving. It is rage turned inward. It is a wound with no mouth, a wound that is so deep that no cry can emanate from it. Anguish is a death from which there appears to be no resurrection. It is inertia, which paralyzes the will to do and to accomplish because there is no hope. It is being truly disabled, not by disease or injury, but by despair. This part of the recovery process is a dark night in which even God was felt to have abandoned us. For some of us this dark night lasts moments, days, or months. For others of us it lasts for years. For others, the despair and anguish may never go away.

8. Neither the paralyzed man nor I could remember a specific moment when the small and fragile flame of hope and courage illuminated the darkness of our despair. We do remember that even when we had given up, there were those who loved us and did not give up. They did not abandon us. They were powerless to change us, and they could not make us better. They could not climb this mountain for us, but they were willing to suffer with us. They did not overwhelm us with optimistic plans for our futures, but they remained hopeful despite the odds. Their love for us was like a constant invitation, calling us forth to be something more than all of this self-pity and despair. The miracle was that gradually the paralyzed man and I began to hear and respond to this loving invitation.
9. For 14 years the paralyzed man slouched in front of the television in the hell of his own despair and anguish. For months I sat and smoked cigarettes until it was time to collapse back into a drugged and dreamless sleep. But one day something changed for us. A tiny, fragile spark of hope appeared and promised that there could be something more than all of this darkness. This is the third phase of recovery. This is the mystery. This is the grace. This is the birth of hope called forth by the possibility of being loved. All of the polemic (attack on a belief) and technology of psychiatry, psychology, social work and science cannot account for this phenomenon of hope. But those of us who have recovered know that this grace is real. We lived it. It is our shared secret.

10. It is important to understand that for most of us recovery is not a sudden conversion experience. Hope does not come to us as a sudden bolt of lightening that jolts us into a whole new way of being. Hope is the turning point that must quickly be followed by the willingness to act. The paralyzed man and I began in little ways with small triumphs and simple acts of courage: He shaved, he attempted to read a book, and he talked to a counselor; I rode in the car, I shopped on Wednesdays, and I talked to a friend a few minutes. He applied for benefits, he got a van and learned to drive; I took responsibility for my medications, took a part-time job, and had my own money. He went to college so he could work professionally with other disabled people; I went to school to become a psychologist so I could work with disabled people. One day at a time, with multiple setbacks, we rebuilt our lives. We rebuilt our lives on three corner stones of recovery - hope, willingness and responsible action.
Recommended Websites for Recovery-Based Information

http://akmhcweb.org/  Alaska Mental Health Consumer Web; tools for recovery

www.adscenter.org  Resource Center to Address discrimination and stigma.

www.bazelon.org  The Bazelon Center for Mental Health Law; a national legal advocate for people with mental disabilities; information on psychiatric advance directives.

http://www.bu.edu/cpr/  Boston University’s Center for Psychiatric Rehabilitation; free Psychiatric Rehabilitation Journal articles and other information.

www.dbsalliance.org  Depression & Bipolar Support Alliance; information, resources and directory of local support groups across the nation.

www.emotionsanonymous.org  Emotions Anonymous 12-Step Support Group; search for a support group in your neighborhood.

www.gacps.org  - Georgia’s Certified Peer Specialist website

www.gmhc.org  - The Georgia Mental Health Consumer Network

www.mcg.edu/resources/mh/index.html  Medical College of Georgia’s “Georgia Mental Health Network”.

http://www.mentalhealth.org/consumersurvivor/selfhelp  Knowledge Exchange network, a spin-off of the SAMHSA website.
Recommended Websites for Recovery-Based Information

www.mentalhealthcommission.gov President’s New Freedom Commission on Mental Health

http://www.mhselfhelp.org Mental Health Self Help Clearinghouse. Excellent consumer advocacy web sites; downloadable training materials.

www.mentalhealthrecovery.org Mary Ellen Copeland’s website with resources related to Wellness Recovery Action Plan (WRAP)

www.nmhaq.org National Mental Health Association of Georgia

www.nami.org The National Alliance for the Mentally Ill

http://www.power2u.org National Empowerment Center - Excellent consumer empowerment web site. Many resources on advocacy, empowerment & recovery as well as good links to other sites.

www.psych.uic.edu/uicnrtc/ University of Illinois at Chicago (UC) National Research and Training Center (NRTC) on Psychiatric Disability; great resources on self-determination.

www.samhsa.gov The Substance Abuse and Mental Health Services Administration.

http://www.healthyplace.com/Communities/Thought_Disorders/index.asp Healthy Places.com Thought Disorders Community. Information and self-help recovery for people living with schizophrenia and schizoaffective disorders and those they love.
Recovery as defined in the President’s New Freedom Commission Report on Mental Health

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.
Involving Consumers and Families in Planning, Evaluation, and Services

Through consumer and family member public testimony, comments, and letters, the Commission is convinced of the need to increase opportunities for consumers and family members to share their knowledge, skills, and experiences of recovery. Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings, such as peer-support and psychosocial rehabilitation programs.

Consumers who work as providers help expand the range and availability of services and supports that professionals offer. Studies show that consumer-run services and consumer-providers can broaden access to peer support, engage more individuals in traditional mental health services, and serve as a resource in the recovery of people with a psychiatric diagnosis.18 Because of their experiences, consumer-providers bring different attitudes, motivations, insights, and behavioral qualities to the treatment encounter.87; 88
In the past decade, mental health consumers have become involved in planning and evaluating the quality of mental health care and in conducting sophisticated research to affect system reform. Consumers have created and operated satisfaction assessment teams, used concept-mapping technologies, and carried out research on self-help, recovery, and empowerment.89; 90

Local, State, and Federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services. The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority.

Consumers and families with children with serious emotional disturbances have a key role in expanding the mental health care delivery workforce and creating a system that focuses on recovery. Consequently, consumers should be involved in a variety of appropriate service and support settings. In particular, consumer-operated services for which an evidence base is emerging should be promoted.
FAMILY PERSPECTIVE
FAMILY PERSPECTIVE

State of Georgia
Crisis Intervention Team
Training Program

National Alliance on Mental Illness (NAMI)

- Dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these illnesses through:
  - Advocacy
  - Education
  - Research
  - Support

National Alliance on Mental Illness (NAMI)

- 240,000 members nationwide
- 120 state and local affiliates
- The nation’s largest grassroots organization dedicated to improving the lives of people with severe mental illnesses
- The American Institute of Philanthropy (AIP), the nation’s leading charity watchdog, awarded NAMI an A+ for its cost-effective charitable spending and fund-raising practices.
NAMI Georgia

- A family-based, grassroots, support and advocacy organization
- Comprised of parents, children, spouses, siblings, treatment professionals, and friends of persons with several mental illnesses
- Believe in recovery and work together to build a better life for their loved ones

NAMI Georgia

- Provides education about mental illness and other brain disorders
  - These diseases are like any other disease such as heart disease, diabetes, or cancer.
  - These diseases are common and widespread.
  - An estimated 54 million Americans suffer from some form of a mental illness or other brain disorder in a given year.

NAMI Georgia

- Advocates for certain standards of care that include access to:
  - Appropriate medication
  - Inpatient care
  - ACT programs
  - General medical care
  - Integrated services for dual diagnosis
  - Family psycho-education and support
NAMI Georgia

• Advocates for certain standards of care that include access to: (cont’d)
  – Peer provided services and supports
  – Supported employment services
  – Affordable housing and supports
  – Jail diversion programs
  – A non-stigmatizing and non-discriminating environment

Crisis Intervention Team (CIT) Program

• Involves collaboration among consumers, family members, treatment professionals, educators, law enforcement, and private citizens
• Provides community-based training for law enforcement officers, resulting in improved morale, professional development, and skill efficiencies
• Addresses the No. 1 reason cited by the Surgeon General’s Report on Mental Illness that people do not accept or receive treatment, which is the stigma associated with mental illness

Stigma

• Stigmatization of people with mental illness and other brain disorders is manifested by:
  – Bias
  – Distrust
  – Stereotyping
  – Fear
  – Embarrassment
  – Anger
  – Avoidance
Stigma

- Contributes to:
  - Low self-esteem
  - Isolation
  - Hopelessness
- Reduces access to resources and opportunities:
  - Schools
  - Housing
  - Jobs

Stigma

- Leads the public to avoid living, socializing, or working with, renting to, or employing people with mental illness and other brain disorders
- Deters many from seeking and wanting to pay for the care of those with mental illness and other brain disorders
- Results in discrimination and abuse of those with mental illness and other brain disorders
- Deprives these individuals of their dignity
- Interferes with their full participation in society

Family Experiences

- Families who have a loved one with a mental illness or other brain disorder often share similar experiences and may:
  - deny warning signs.
  - worry about what other people think.
  - wonder what caused the illness.
  - blame themselves.
Family Experiences

- The person with the illness or disability often becomes the focus of family life.
- Other family members may feel ignored or resentful, and experience difficulty pursuing their own interests.
- Whenever possible, families should:
  - seek support from friends or other family members.
  - find a support group or self-help channel.
  - consider therapy as a possible option.

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CULTURAL SENSITIVITY
Objectives

- Provide participants with a description of the general mental health profile for ethnic cultures, sexual minorities, and religious groups.
- Understand your own ethnic and cultural background and how it helps shape your identity, communication style, values, beliefs, and behaviors.
- Discuss the application of cultural competence skills in crisis situations.
What is Cultural Diversity?

- Cultural differences distinguish societies from one another.
- **Culture** - the integrated system of socially acquired values, beliefs, and rules of conduct which delimit the range of accepted behaviors in any given society.
- **Diversity** - the condition of being diverse. **Variety**.
- **Diverse** is defined as being differing from one another; composed of distinct or unlike elements or qualities.

Different cultures

- Age (elders, youth)
- Gender (male, female, transgender)
- Blue collar/White collar
- Gay/Straight
- Race
- Ethnicity
- Country of Origin
CULTURAL COMPETENCE

Cultural Competence

- Cultural Awareness
- Cultural Sensitivity
- Cultural Knowledge
- Cultural Competence (Skills)

- Developing sensitivity and understanding of another group. This usually involves internal changes in terms of attitudes and values.

- Knowing that cultural differences as well as similarities exist without assigning values, i.e., better or worst, right or wrong, to those cultural differences.
Cultural Competence

- Cultural Knowledge
  - Familiarization with selected cultural characteristics, history, values, belief systems and behaviors of the members of another ethnic group
- Cultural Competence (Skills)
  - as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.

What makes us different from each other?

Biology: Determines gender, body size, skin, hair and eye color.

Ethnicity and cultures: customs, language and sense of identity often shared by people with similar roots.
What makes us different from each other?

**Family life:** Family size, values, traditions and social class.

**Beliefs:** One’s religion or philosophy of life

**Geography:** How one feels about being from a certain neighborhood, city or region.

**Experience:** School, work, travel, recreation and with other people

What makes us different from each other?

**Personality characteristics:**

- Emotions
- Will
- Intellect and
- Feelings.
- Other areas addressed include verbal and non-verbal communication styles.

People Differ in Many Ways

- Body Language
- Listening
- Speaking
- Expressing Opinions
- Working Styles
Cultural Identity

- Country Of Origin
- Language
- Acculturation
- Gender
- Age
- Class
- Religious/Spiritual Beliefs
- Sexual Orientation
- Physical Disabilities

CULTURAL COMPETENCIES

- Involve understanding & respecting the person’s cultural values, beliefs & practices
  - Views about law enforcement
  - Views about health & health care
  - Family & community relationships
  - Language & communication styles
  - Ties to another country or part of the US
  - Food preferences
  - Religion * views about death
  - Other factors that may affect care needs

- It can help to have some basic knowledge about the major cultural & religious groups.
- It’s important to know your own culture.
- This can help you remember that a patient may hold different views.
- For example:
  - You may value certain communication styles. For example, you may have views about whether it’s polite or rude to make eye contact or touch someone during conversations
By being open-minded and respectful toward their beliefs, values, & practices, you can help people feel more comfortable.

Factors that may differ from person to person include ethnic, religious, and occupational factors. Some people belong to more than one ethnic group, as well as cultural groups. Other people have fewer group identities.

Others keep traditions only on special occasions, or not at all. Different cultures have different ideas about how to express & respond to pain. Some cultures value bearing pain silently, while others expect expressiveness. Different cultures have different views about when to seek professional medical help, treat oneself, or be treated by a family member or traditional healer.

Language

The degree to which a patient or staff member is fluent in English, or any other language you speak, will have a bearing on your interactions. A prime factor affecting this communication is your attitude toward people who speak limited English. How open are you to working with people who speak with accents?
How do you feel when people speak with family members or co-workers in their native language while you are working with them?

If you are irritated in these situations, consider what it feels like for them.

Do you know a second language?

How easy is it for you to use, and how confident are you about your effectiveness when using it?

Those whose English is limited often say that they speak their native language when possible because both their explanations and their understandings can be more accurate, and because it is more comfortable.

Cultural Influences

- Are complex and multifaceted
- It is impossible to know all the rules about each specific group.
- Cultural generalizations categorize areas of similarity in preferences, norms, & values, which should not be applied with certainty to each individual.
- When dealing with a person who is from a different background, it is more effective to investigate & check out your assumptions than to operate on incorrect predictions.
A number of aspects of interacting & sharing information, besides language, are significantly influenced by culture, including:

- Directness
- Gestures & facial expressions
- Distance
- Touch
- Degree of formality
- Forms of address
- Pace & pitch

Directness

- "Spit it out" and "Say what's on your mind" are popular American expressions of the value of getting to the point.
- In languages that depend on subtle contextual cues & that leave it to the listener to infer meaning, as would be the preference in Arabic or Japanese, information is implied rather than stated.

- Facial expressions, body language, & tone of voice play a much greater role in cultures where people prefer indirect communication & talking around the issue.
- For example, rather than pointing out that part of a form has missing or incorrect information, indirect communicators might praise the sections that were correctly completed, implying that the incomplete section is a problem.
- In another variation, among Hispanics directness in expressing negative feelings or information is discouraged.
This taboo may result in a person not following directions. Differences regarding directness can be particularly frustrating, especially when specific information & answers are needed. "Do you understand?" & the response is a nod or a yes. Individuals from Mexico & much of Asia find it nearly impossible to say no directly because it signals disrespect, can cause loss of face, & makes them feel inadequate.

A response such as "Maybe" or "That would be difficult" is probably a polite no. Avoiding yes/no questions by phrasing the inquiry as a multiple choice question is one way around this impasse. For example, you might ask, "Which of these medications have you taken?" rather than "Did you take this one?"

Another culturally influenced aspect of communication is the demonstration of emotion, such as joy, affection, anger, or upset. While Americans widen their eyes to show anger, Chinese people narrow theirs. Vietnamese, conversely, consider anger a personal thing, not to be demonstrated publicly.
• Smiling & laughter may be signs of embarrassment & confusion on the part of some Asians.
• Talking with one’s hands is more common in southern Europe than in northern Europe.
• A direct stare by an African American or Arab is not meant as a challenge to your authority, while dropped eyes may be a sign of respect from Latino or Asian patients & co-workers.

• Use gestures with care, as they can have negative meanings in other cultures.
• Thumbs-up and the OK sign are obscene gestures in parts of South America & the Mediterranean.
• Pointing with the index finger and beckoning with the hand as a “come here” sign are seen as rude in some cultures much as snapping one’s fingers at someone would be viewed in the United States.

• Distance
  • American culture generally expects people to stand about an arm’s length apart when talking in a business situation.
  • Any closer is reserved for more intimate contact or seen as aggression.
  • In the Middle East, however, it is normal for people to stand close enough to feel each other’s breath on their faces.
  • Latinos typically favor closer proximity than to non-Hispanic whites.
Thus, moving away & keeping greater distance might be perceived by Latinos as aloofness & coldness.
In much of Asia, where cities are crowded & space is at a premium, jostling & bumping in public places aren't seen as intrusive or inconsiderate, & do not require an “excuse me.”
Think about individuals & colleagues, and their use of space.

To touch or not to touch is only part of the question.
Cultures also have different rules about who can be touched & where.
A handshake is generally accepted as a standard greeting in business, yet the kind of handshake differs.
In North America, it is a hearty grasp; in Mexico it is often a softer hold, and in Asia a soft handshake with the second hand brought up under the first is a sign of friendship & warmth.

Religious rules may also apply.
For devout Muslims & Orthodox Jews, touching between men & women in public is not permitted, so a handshake would not be appropriate.
Touching the head, even tousling a child’s hair as an affectionate gesture, would be considered offensive by many Asians.
Individuals will usually let you know their preferences through their behavior.
Following the other person’s lead is generally a good guideline.
If you need to touch someone for purposes of a pad down or search, explain the purpose & procedure before you begin.
An aspect related to self disclosure is loss of face, important in some manner in all cultures. In Asia, the Middle East, & to some extent Latin America, one’s dignity must be preserved at all costs. In fact, death is preferred to loss of face in traditional Japanese culture, hence the suicide ritual, hara-kiri, as a final way to restore honor.

Other Important Factors

- Any embarrassment can lead to loss of face, even in the dominant American culture.
- To be criticized in front of others, publicly snubbed, or fired would be humiliating in most any culture.
- However, behaviors that we see as harmless can be demeaning to others.
- Inadvertent slights or unconscious faux pas can cause serious repercussions in intercultural relationships.

Understanding the role of culture and ethnicity in the development and expression of mental illness is important for appropriate diagnosis and treatment.

Joint effects of socio economic status and minority status on mental health
Income

- In 1994, minority families were at least three times as likely as White families to have incomes placing them below the Federally established poverty line.
- Asian Americans are more than one and a half times more likely than whites to live in poverty. 
  (Mental Health: A Report of the Surgeon General, 2000)

Socioeconomic Status and Mental Illness

- People in the lowest SES strata are about 2 1/2 times more likely than those in the highest strata to have a psychiatric disorder. (Regier, et al., 1993)
  - Greater stress? And, greater vulnerability to stressors contributes to some mental illnesses

Access to Adequate Mental Health Services

- Racial and ethnic minority groups are generally underserved by the mental health services system 
  (Takeuchi & Uehara, 1996; Center for Mental Health, 1998)
MENTAL HEALTH, RACE AND ETHNICITY

African Americans

- African Americans have made great strides in education, income, and other indicators of social well-being.
- African Americans living in the community appear to have overall rates of distress symptoms and mental illness similar to those of whites.

African Americans

- The mental health of African Americans cannot be evaluated without considering the many African Americans found in high-need populations whose members have high levels of mental illness and are significantly in need of treatment.
  Proportionally, 3.5 times as many African Americans as white Americans are homeless. None of them are included in community surveys.
African Americans

- The mental health problems of persons in high-need populations are especially likely to occur jointly with substance abuse problems, as well as with HIV infection or AIDS (Lewin & Altman, 2000).

American Indians and Alaska Natives

- Although relatively little evidence is available, the existing data suggest that American Indian and Alaska Native youth and adults suffer a disproportionate burden of mental health problems compared with other Americans.

- Given the high rates of suicide documented among some segments of this population, they are likely to experience increased need for mental health care as compared with white Americans.

- Despite the mental health problems that plague Indian and Native people, the majority, though at risk, are free of mental illness.
Asian Americans and Pacific Islanders

- When symptom scales are used, Asian Americans do show an elevated level of depressive symptoms compared to white Americans.
- Research is limited to one Asian ethnic group and focuses primarily on mood disorders. No study has addressed the rates of mental disorders for Pacific Islander American ethnic groups.

Asian Americans and Pacific Islanders

- Types of mental health problems appear to depend on level of acculturation.
- AA/PIs have the lowest rates of utilization of mental health services among ethnic populations.

Hispanic Americans

- The system of mental health services currently in place fails to provide for the vast majority of Latinos in need of care.
- Latino youth are at a significantly high risk for poor mental health outcomes. Evidence suggests that they are more likely to drop out of school, to report depression and anxiety, and to consider suicide than white youth.
Hispanic Americans

- There is some evidence that Central Americans do have greater problems than other Latino subgroups, especially with post-traumatic stress disorder. However, there is little evidence of Cuban Americans having lower rates of disorder than other Latino subgroups.

Hispanic Americans

- Mental disorders and distress can be interpreted on many levels, from the molecular aspects of neuroscience to the social world of consumers and families.
- Psychosis can be understood as the result of dysfunctions in neurotransmitters as well as the result of a deeply felt personal loss.

Barriers to Receiving Treatment

- Stigma over mental health problems
  - Limited English proficiency
  - Different cultural explanations for the problems
  - Inability to find culturally competent services
  - Mistrust
  - Cost
  - Clinical Bias
Cultural Competence
Action Steps

- Avoid making judgments about their beliefs and practices
- Respect others' culture/beliefs
- Understand others' view of your culture
- Be aware of your own biases
- Know your limits in dealing with other cultures
- Understand your personal style's effect on others in light of their culture

Following is a list of tips when dealing with people from other cultures:

- Consider analogous beliefs or practices in which you have engaged (for example, although you may not have gone to a shaman or faith healer, you may have prayed for the health or safety of a loved one)
- Ask questions that help you to learn about the patient's view of his/her condition.

THE END
LEGAL ISSUES AND MENTAL HEALTH LAW
Legal Aspects of Mental Health Law
State of Georgia
Crisis Intervention Team
Training Program

Why CIT?

Canton v. Harris (1989)
In 1989, the U.S. Supreme Court ruled in that the inadequacy of police training may serve as a basis for municipal liability where to not to train amounts to deliberate indifference for the rights of persons with whom the police come into contact.

City of Long Beach, California, Defendant; Angela and Titus Byrd, Plaintiffs; Civil case filed in Los Angeles Superior Court
Marcella Byrd, 57 years old
Diagnosis - presumed schizophrenia
Officer Rodriguez called for backup
Backup officer shot beanbag and hit her leg; then again hitting her thigh
Ms. Byrd then used a knife
Officers shot her 5 times, suspect killed
Recovery from schizophrenia could have been an option. That decision was removed as a choice.


Verdict - March 3, 2004
City of Long Beach found to be 80% comparatively negligent as officers did not attempt to de-escalate the situation
Marcella Byrd - 20%
Plaintiffs awarded $210,000

CIT Training and Liability

Reduces liability – For example, CIT leaders in Ohio have reported no lawsuits since CIT established. Reality is that CIT should reduce the risk of successful lawsuits.
Less injury and deaths to individuals with mental disabilities and to officers involved.
Treatment for those individuals in need.
Probate Court Lay Affidavit

Any interested person or persons may institute guardianship proceedings for an incapacitated adult;

Adult guardianship provisions provide for lay affidavit;

Court can order an examination, evaluation, or admit to a treatment facility via involuntary treatment.

- O.C.G.A. §29-5-6(a); Code section will change when new guardianship law becomes effective July 1, 2005.

Probate

- Guardianship
  - Limited, unless otherwise ordered
  - Voting, unless judge finds mental incompetence

- Mental Illness Intervention
  - All rights retained; due process must be afforded before any denial
Types/Stages of Intersection

- Guardianship
  - Emergency, blending into...
  - Permanent

- Mental Illness Interventions
  - Examination
  - Evaluation
  - Admit to Treatment Facility
  - Involuntary Treatment

Legal Aspects Regarding the Role of Law Enforcement in Civil Commitment

Laws and Regulations
Mental Illness Defined

"Mentally ill" means having a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

O.C.G.A. § 37-3-1(11)

"Mentally ill person requiring involuntary treatment" means a person who is an inpatient or an outpatient.

O.C.G.A. § 37-3-1(12)

Inpatient defined

A person who is mentally ill and:

- Who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or
- Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis; AND
- Who is in need of involuntary inpatient treatment.

Civil Involuntary Commitment

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;
- Court Order; or
- Request from facility to pick up because person left without permission during involuntary hospitalization.
**Physician’s Certificate**  
**O.C.G.A. § 37-3-41(a)**

A physician has executed a certificate stating that he has personally examined a person within the preceding 48 hours and found that, based upon observations set forth in the certificate, the person appears to be a mentally ill person requiring involuntary treatment.

**Emergency Receiving Facility (ERF) - 1013**

- Physician issues certificate
  - Person examined in last 48 hours
  - Appears to be mentally ill requiring involuntary treatment
  - Acting on physician’s certificate, law enforcement officer may take to nearest ERF for examination
  - Court can order law enforcement to take patient to either physician or ERF
    - O.C.G.A. §37-3-41(a)

**Court Order**  
**O.C.G.A. § 37-3-41(b)**

Court order from the county in which a person may be found commanding any peace officer to take such person into custody and deliver him forthwith for examination, either to the nearest available emergency receiving facility serving the county in which the patient is found or to a physician who has agreed to examine such patient and who will provide, where appropriate, a certificate pursuant to subsection (a) of this Code section to permit delivery of such patient to an emergency receiving facility pursuant to subsection (a) of this Code section.
Court Order (cont’d)

Such order may only be issued if based either upon an unexpired physician’s certificate, as provided in subsection (a) of this Code section, or upon the affidavits of at least two persons who attest that, within the preceding 48 hours, they have seen the person to be taken into custody and that, based upon observations contained in their affidavit, they have reason to believe such person is a mentally ill person requiring involuntary treatment. The court order shall expire seven days after it is executed.

Left without permission

O.C.G.A. § 37-3-5

If, during the period of involuntary hospitalization pursuant to any valid physician’s certificate, court order, or order by the hearing examiner authorized by this chapter, a patient escapes or otherwise leaves a facility without permission, the facility may advise any peace officer that the patient has escaped or otherwise left the facility without permission; and the peace officer shall be authorized to take the patient into custody and return him to such facility.

Petition for Court-Ordered Evaluation

Any person may file application with a community mental health center under oath saying person is mentally ill requiring involuntary treatment.

Mental Health Center must perform preliminary investigation; If it establishes probable cause to believe true, the Mental Health Center files petition with the Court.

Any person may file a Petition with the Court under oath alleging a person within the county is mentally ill requiring involuntary treatment, if petition is accompanied by a physician’s certificate that the person was examined within the last 5 days, that person may be mentally ill and that full evaluation is necessary.

O.C.G.A. §37-3-61(1)
Emergency admission by law enforcement

- Law enforcement may act on their own if:
  - Person is committing a penal offense AND
  - Police officer has reason to believe the person is mentally ill requiring involuntary treatment, then police may take to physician or an ERF
    - O.C.G.A. §37-3-42

Civil Involuntary Commitment

- Outpatient civil detention is an alternative to inpatient detention under certain circumstances:
  - The person must be deemed safe for the community.
  - Still requires a commitment order to assure compliance with mental health treatment.
  - Law enforcement may be requested to assist, in cases of noncompliance, with transport to a mental health facility.

Outpatient Commitment

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

- O.C.G.A. 37-3-101 - Governing authority for the county of individual's residence arranges;
- Type of vehicle in discretion of county governing authority – provided that
  - Whenever possible, marked vehicles normally used for transportation of criminals/accused shall not be used for patients
  - Court shall order the sheriff to transport the patient in such manner as the patient's condition demands
  - If Community health center is satisfied that patient can be transported safely by family members and friends, private transportation is encouraged;
  - In nonemergency situations, no female patient transported without another female in attendance who is not patient, unless husband, adult brother, or adult son accompanies said female patient.

Liability

Act or Fail to Act

False Imprisonment

- False imprisonment is the unlawful detention of the person of another, for any length of time, whereby such person is deprived of his personal liberty.
- O.C.G.A. § 51-7-20
False Imprisonment Claims

“When the detention is predicated upon a procedurally valid process, false imprisonment is not an available remedy regardless of the motives upon which the process was secured, because detention effectuated pursuant to procedurally valid process, such as an arrest warrant, is not unlawful.”


False Arrest Claims

An arrest under process of law, without probable cause, when made maliciously, shall give a right of action to the party arrested. O.C.G.A. § 51-7-1

Malice consists in personal spite or in a general disregard of the right consideration of mankind, directed by chance against the individual injured. O.C.G.A. § 51-7-2

Immunity

O.C.G.A. §37-3-4 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...”
**Discretionary function**

- When officer was performing a discretionary duty at the time of the arrest and no showing was made that the officer acted maliciously or with an intent to injure, the officer was entitled to official immunity from liability.

**Failure to protect**

- Public duty doctrine:
  "Liability does not attach where the duty owed by the governmental unit runs to the public in general and not to any particular member of the public, except where there is a special relationship between the governmental unit and the individual giving rise to a particular duty owed to that individual."

**Special Relationship**

- Sometimes a special relationship between the individual and the municipality is created which sets the individual apart from the general public and engenders a special duty owed to that individual.
Requirements for the Creation of a Special Relationship

- An explicit assurance by municipality, through promises or actions, that it would act on behalf of the injured party;
- Knowledge on the part of the municipality that inaction could lead to harm; and
- Justifiable and detrimental reliance by the injured party on the municipality's affirmative undertaking.

Legal Aspects of Mental Health Law

Consumers’ Rights
Georgia's Consumers

- Georgia Consumer Network is a national leader
- Cemetery Project at Central State Hospital
- Unmarked, unkempt graves transformed into a place of honor
- "From Silence, to a Whisper, to a Voice"

Rights of Individuals with Mental Illness

- Courts and legislatures have recognized that the persons with mental illness have such rights as:
  - Community integration
  - Treatment or refusal of treatment
  - Legal representation in certain proceedings
  - Freedom from discrimination

Rights of Individuals with Mental Illness

- Primary component of the ADA is "reasonable" accommodations and modifications for disabled persons.
- Law Enforcement Officers must make reasonable adjustments and modifications of policies, practices or procedures, on a case-by-case basis.
- If mental illness or a request for modification due to mental illness is expressed, LEO may need to modify routine practices.
The Americans With Disabilities Act

- The ADA was signed into law on July 26, 1990 by President George Bush
- Olmstead v. L.C. is a landmark U.S. Supreme Court case from Georgia on the ADA (1999).

1990—Americans with Disabilities (ADA) act passed.

- ADA requires fair and equal treatment for all people with disabilities, whether physical or mental
- ADA entitles the mentally ill to same services and protections from law enforcement agencies as other citizens.
- They may not be excluded or segregated, denied or otherwise provided with lesser services

ADA protects qualified individuals with disabilities.

- An individual with a disability is one who has a physical or mental impairment that substantially limits major life activities, has a record of such an impairment, or is regarded as having such an impairment
The Americans With Disabilities Act

Under the ADA, physical or mental impairments include, but are not limited to:

Visual, speech, hearing impairments, mental retardation, emotional illness, Specific learning disabilities, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, orthopedic conditions, cancer, heart disease, diabetes, and contagious and noncontagious diseases, such as TB and HIV.

Americans with Disabilities Act (ADA) & Section 504, Rehabilitation Act of 1973

Prohibit covered entities from discriminating against persons with disabilities in the provision of benefits or services or the conduct of programs or activities on the basis of their disability.

Section 504 applies to programs that receive federal assistance

ADA covers all of the services, programs, and activities conducted by public entities (state and local governments), including licensing.

The Americans With Disabilities Act

Effective communications requirements

Reasonable accommodations or modifications in policies, practices and/or procedures on a case-by-case basis.

– Title II
Limited English Proficiency (LEP) Examples of Discrimination

- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons;
- Subjecting LEP persons to unreasonable delays in the delivery of services;
- Limiting participation in a program or activity on the basis of English proficiency;
- Providing services to LEP persons that are not as effective as those provided to those who are proficient in English; or
- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter.

Olmstead v. L.C.

In June 1999, the U.S. Supreme Court ruled in Olmstead that states must develop a "comprehensive, effectively working plan" to provide medically appropriate community-based care to eligible populations within given budget restraints.

Georgia and Other Laws Protecting Rights

- O.C.G.A. Title 37
- O.C.G.A. Title 31
- Criminal Statutes
- DHR Rules and Regulations for Clients’ Rights, Chapter 290-4-9
- DHR Rules and Regulations for Patients’ Rights, Chapter 290-4-8
- Federal Laws and Regulations
- Hospital Conditions of Participation
- ICF-MR Interpretive Guidelines
- HIPAA Privacy Regulations
Additional Issues

- Co-occurring Disorders
- Limited English Proficiency/Sensory Impairment
- Older adults with Mental Illness
- Dementia
- Chronic physical disability and Mental Illness

Importance of Self-Protection and Self-Advocacy

- Self-Protection is at the foundation of a quality consumer protection system;
- Individuals in services must know boundaries for care providers.
- Individuals in services must be knowledgeable about their condition, medications and other aspects of their care to fully participate in treatment, recovery or habilitation.

Purpose of Consumer Rights

- To protect individuals in service from behavior and consequences that threaten their health, safety or well-being;
- To safeguard the rights of persons treated pursuant to the Official Code of Georgia Annotated (O.C.G.A.) Chapters 37-3, 37-4 and 37-7;
- To establish boundaries for staff and the provider organization, volunteers, contractors, and others in services;
Notice of Consumer Rights

Notice to consumer, parent or guardian at beginning of treatment/habilitation of rights and remedies in regulations;
Notice given in manner commensurate with individual’s abilities and capabilities of understanding;
Prior to restriction of right, staff person shall again inform consumer or his/her parent or legal guardian of administrative complaint or judicial review, except as condition makes impractical — however, to advise as soon as condition permits.

Right to Participate in Treatment Decisions

- Persons in services have the right to participate in their treatment;
  - condition
  - legal status
- Includes the right to refuse treatment
- Individual Services Planning (ISP);
- Discharge Planning;
- Legal representatives can be substituted

Right to Freedom of Choice

- A guiding principle of consumers’ rights is that consumers and their families member should have choice regarding services and input into planning and treatment or habilitation issues;
- Federal Medicaid law incorporates consumer choice.
Right to Confidentiality of Consumer Information

- Records and treatment are confidential;
- Certain information told to certain professionals are privileged information;
- Clients’ Rights Rules and Regulations;
- Patients’ Rights Rules and Regulations;
- State and federal laws;
- Health Information Portability Accountability Act (HIPAA) new privacy regulations.
  - See Office of Civil Right guidance for law enforcement

HIPAA and Law Enforcement

- U.S. Department of Health and Human Services, Office of Civil Rights - enforcement
- www.hhs.gov/ocr/hipaa (Click on New FAQ on Disclosing PHI to Law Enforcement 7/26/04 to the left of page)
- Generally, HIPAA permits a covered entity to release certain Protected Health Information (PHI) when investigating criminal activity
- However, if state privacy law is more stringent, state law will prevail.

Right to be Free from Seclusion and Restraint

- An individual in services is to be free from seclusion and restraints.
- Crisis stabilization
- Federal regulations
  - Hospital Conditions of Participation for Medicaid
  - Seclusion and Restraint regulations
**Right to be Free from Abuse, Neglect and Exploitation**

- Consumers should be free from abuse, neglect and exploitation;
- State and federal laws and regulations against abuse, neglect and exploitation;
- Training in prevention of abuse, neglect and exploitation is key;
- Clients' Rights Rules and Regulations;
- Disabled Adults and Elder Rights laws or Long Term Care Act;
- DHR Uniform Guide for Adult Abuse Reporting

**Vulnerable Consumers**

- Severe Disability;
- Non-Verbal;
- Significant Behavioral Issues;
- Medically Fragile;
- No family or outside person who advocates for the consumer (unpaid);
- Changes in Behavior; and
- Past allegations of abuse;
- Prescribed several medications.

**Keeping An Eye Out For Additional Issues**

- Co-occurring disorders
- Cultural Competency
- Family/Caregiver
- Domestic Disputes
- Incapacitated vs. Overmedicated
- Behavioral vs. Clinical
- Language Barriers
- Aging Issues
- Dementia
- Sensory Impairment
Additional Resources

- Consumer Rights
  - Office of Investigations
  - DHR/MHDDAD
    - (404) 657-5964

Additional Resources

- Adult Protective Services (APS)
  - Disabled Adults and Elder Persons Protection Act, O.C.G.A. §30-5-1, et seq.
  - Centralized Intake
    - DHR Division of Aging Services
    - 1-888-774-0152
    - In Metro Atlanta Call:
      - (404) 657-5250
    - Community Elder Rights Teams
      - include law enforcement

Conclusion

- Over the years, mental health laws and consumer's rights have significantly changed the way law enforcement and mentally ill persons interact.
- The Official Code of Georgia Annotated provides specific guidance, but any questions on the legality of a situation should be addressed to the individual officer's legal counsel.
Legal Aspects of Mental Health Law
Consumer Rights, Civil Commitment & Probate Lay Affidavit Process

Thank you for your leadership on Georgia Crisis Intervention Team Training.

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37-3-1. Definitions.

Statute text

As used in this chapter, the term:

"Available outpatient treatment" means outpatient treatment, either public or private, available in the patient's community, including but not limited to supervision and support of the patient by family, friends, or other responsible persons in that community. Outpatient treatment at state expense shall be available only within the limits of state funds specifically appropriated therefore.

"Chief medical officer" means the physician with overall responsibility for patient treatment at any facility receiving patients under this chapter or a physician appointed in writing as the designee of such chief medical officer.

(2) "Clinical record" means a written record pertaining to an individual patient and shall include all medical records, progress notes, charts, admission and discharge data, and all other information which is recorded by a facility or other entities responsible for a patient's care and treatment under this chapter and which pertains to the patient's hospitalization and treatment. Such other information as may be required by rules and regulations of the board shall also be included.

(3) "Community mental health center" means an organized program for the care and treatment of the mentally ill operated by a community service board or other appropriate public provider.

(4) "Court" means:

In the case of an individual who is 17 years of age or older, the probate court of the county of residence of the patient or the county in which such patient is found. Notwithstanding Code Section 15-9-13, in any case in which the judge of such court is unable to hear a case brought under this chapter within the time required for such hearing or is unavailable to issue the order specified in subsection (b) of Code Section 37-41, such judge shall appoint a person to serve and exercise all the jurisdiction of the probate court in such case. Any person so appointed shall be a member of the State Bar of Georgia and shall be otherwise qualified for his duties by training and experience. Such appointment may be made on a case-by-case basis or by making a standing appointment of one or more persons. Any person receiving such standing appointment shall serve at the pleasure of the judge making the appointment or his successor in office to hear such cases if and when necessary. The compensation of a person so appointed shall be as agreed upon by the judge who makes the appointment and the person appointed and shall be paid from the county funds of said county. All fees collected for the services of such appointed person shall be paid into the general funds of the county served; or

(B) In the case of an individual who is under the age of 17 years, the juvenile court of the county of residence of the patient or the county in which such patient is found.

(5) "Emergency receiving facility" means a facility designated by the department to receive patients under emergency conditions as provided in Part 1 of Article 3 of this chapter.

(6) "Evaluating facility" means a facility designated by the department to receive patients for psychiatric evaluation as provided in Part 2 of Article 3 of this chapter.

(7) "Facility" means any state owned or state operated hospital, community mental health center, or other facility utilized for the diagnosis, care, treatment, or hospitalization of persons who are mentally ill; any facility operated or utilized for such purpose by the United States Department of Veterans Affairs or other federal agency; and any other hospital or facility within the State of Georgia approved for such purpose by the department.
(8) "Full and fair hearing" or "hearing" means a proceeding before a hearing examiner under Code Section 37-3-83 or Code Section 37-3-93 or before a court as defined in paragraph (4) of this Code section. The hearing may be held in a regular courtroom or in an informal setting, in the discretion of the hearing examiner or the court, but the hearing shall be recorded electronically or by a qualified court reporter. The patient shall be provided with effective assistance of counsel. If the patient cannot afford counsel, the court shall appoint counsel for him or the hearing examiner shall have the court appoint such counsel; provided, however, that the patient shall have the right to refuse in writing the appointment of counsel, in the discretion of the hearing examiner or the court. The patient shall have the right to confront and cross-examine witnesses and to offer evidence. The patient shall have the right to subpoena witnesses and to require testimony before the hearing examiner or in court in person or by deposition from any physician upon whose evaluation the decision of the hearing examiner or the court may rest. The patient shall have the right to obtain a continuance for any reasonable time for good cause shown. The hearing examiner and the court shall apply the rules of evidence applicable in civil cases. The burden of proof shall be upon the party seeking treatment of the patient. The standard of proof shall be by clear and convincing evidence. At the request of the patient, the public may be excluded from the hearing. The patient may waive his right to be present at the hearing, in the discretion of the hearing examiner or the court. The reason for the action of the court or hearing examiner in excluding the public or permitting the hearing to proceed in the patient's absence shall be reflected in the record.

(9) "Individualized service plan" means a proposal developed during a patient's stay in a facility and which is specifically tailored to the individual patient's treatment needs. Each plan shall clearly include the following:

(A) A statement of treatment goals or objectives, based upon and related to a proper evaluation, which can be reasonably achieved within a designated time interval;

(B) Treatment methods and procedures to be used to obtain these goals, which methods and procedures are related to these goals and which include a specific prognosis for achieving these goals;

(C) Identification of the types of professional personnel who will carry out the treatment and procedures, including appropriate medical or other professional involvement by a physician or other health professional properly qualified to fulfill legal requirements mandated under state and federal law;

(D) Documentation of patient involvement and, if applicable, the patient's accordance with the service plan; and

(E) A statement attesting that the chief medical officer has made a reasonable effort to meet the plan's individualized treatment goals in the least restrictive environment possible closest to the patient's home community.

(9.1) "Inpatient" means a person who is mentally ill and:

(A)(i) Who presents a substantial risk of imminent harm to that person or others, as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to that person or other persons; or

(ii) Who is so unable to care for that person's own physical health and safety as to create an imminently life-endangering crisis; and

(B) Who is in need of involuntary inpatient treatment.

(9.2) "Inpatient treatment" or "hospitalization" means a program of treatment for mental illness within a hospital facility setting.

(9.3) "Involuntary treatment" means inpatient or outpatient treatment which a patient is required to obtain pursuant to this chapter. (10) "Least restrictive alternative," "least restrictive environment," or "least restrictive appropriate care and treatment" means that which is the least restrictive available alternative, environment, or care and treatment, respectively, within the limits of state funds specifically appropriated therefore.
Official Code of Georgia Annotated – Statutes

(11) "Mentally ill" means having a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.
(12) "Mentally ill person requiring involuntary treatment" means a person who is an inpatient or an outpatient.
(12.1) "Outpatient" means a person who is mentally ill and:
(A) Who is not an inpatient but who, based on the person's treatment history or current mental status, will require outpatient treatment in order to avoid predictably and imminently becoming an inpatient;
(B) Who because of the person's current mental status, mental history, or nature of the person's mental illness is unable voluntarily to seek or comply with outpatient treatment; and
(C) Who is in need of involuntary treatment.
(12.2) "Outpatient treatment" means a program of treatment for mental illness outside a hospital facility setting which includes, without being limited to, medication and prescription monitoring, individual or group therapy, day or partial programming activities, case management services, and other services to alleviate or treat the patient's mental illness so as to maintain the patient's semi-independent functioning and to prevent the patient's becoming an inpatient.
(13) "Patient" means any mentally ill person who seeks treatment under this chapter or any person for whom such treatment is sought.
(14) "Private facility" means any hospital facility that is a proprietary hospital or a hospital operated by a nonprofit corporation or association approved for the purposes of this chapter, as provided herein, or any hospital facility operated by a hospital authority created pursuant to the "Hospital Authorities Law," Article 4 of Chapter 7 of Title 31.
(14.1) "Psychologist" means a licensed psychologist who meets the criteria of training and experience as a health service provider psychologist as provided in Code Section 31-7-162.
(14.2) "Regional state hospital administrator" means the chief administrative officer of a state owned or state operated hospital and the state owned or operated community programs in a region. The regional state hospital administrator, under the supervision of the regional coordinator, has overall management responsibility for the regional state hospital and manages services provided by employees of the regional state hospital and employees of state owned or operated community programs within a mental health, developmental disabilities, and addictive diseases region established in accordance with Code Section 37-2-3.
(15) "Representatives" means the persons appointed as provided in Code Section 37-3-147 to receive notice of the proceedings for voluntary or involuntary treatment.
(16) "Superintendent" means the chief administrative officer who has overall management responsibility at any facility receiving patients under this chapter, other than a regional state hospital or state owned or operated community program, or an individual appointed as the designee of such superintendent.
(16.1) "Traumatic brain injury" means a traumatic insult to the brain and its related parts resulting in organic damage thereto which may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but for the purposes of this chapter, traumatic brain injury shall not be considered mental illness as defined in paragraph (11) of this Code section.
(17) "Treatment" means care, diagnostic and therapeutic services, including the administration of drugs, and any other service for the treatment of an individual.
(18) "Treatment facility" means a facility designated by the department to receive patients for psychiatric treatment as provided in Code Sections 37-3-80 through 37-3-84.
Official Code of Georgia Annotated – Statutes

37-3-4. Immunity of physicians, peace officers, or other private or public hospital employees from liability for actions taken in good faith compliance with admission and discharge provisions of chapter.

Statute text
Any physician, psychologist, peace officer, attorney, or health official, or any hospital official, agent, or other person employed by a private hospital or at a facility operated by the state, by a political subdivision of the state, or by a hospital authority created pursuant to Article 4 of Chapter 7 of Title 31, who acts in good faith in compliance with the admission and discharge provisions of this chapter shall be immune from civil or criminal liability for his actions in connection with the admission of a patient to a facility or the discharge of a patient from a facility.

37-3-5. Apprehension by peace officer of patient who leaves facility without permission.

Statute text
If, during the period of involuntary hospitalization pursuant to any valid physician's certificate, court order, or order by the hearing examiner authorized by this chapter, a patient escapes or otherwise leaves a facility without permission, the facility may advise any peace officer that the patient has escaped or otherwise left the facility without permission; and the peace officer shall be authorized to take the patient into custody and return him to such facility.
Official Code of Georgia Annotated – Statutes

37-3-41. Emergency admission based on physician's certification or court order; report by apprehending officer; entry of treatment order into patient's clinical record; authority of other personnel to act under statute.

Statute text
(a) Any physician within this state may execute a certificate stating that he has personally examined a person within the preceding 48 hours and found that, based upon observations set forth in the certificate, the person appears to be a mentally ill person requiring involuntary treatment. A physician's certificate shall expire seven days after it is executed. Any peace officer, within 72 hours after receiving such certificate, shall make diligent efforts to take into custody the person named in the certificate and to deliver him forthwith to the nearest available emergency receiving facility serving the county in which the patient is found, where he shall be received for examination.

(b) The appropriate court of the county in which a person may be found may issue an order commanding any peace officer to take such person into custody and deliver him forthwith for examination, either to the nearest available emergency receiving facility serving the county in which the patient is found, where such person shall be received for examination, or to a physician who has agreed to examine such patient and who will provide, where appropriate, a certificate pursuant to subsection (a) of this Code section to permit delivery of such patient to an emergency receiving facility pursuant to subsection (a) of this Code section. Such order may only be issued if based either upon an unexpired physician's certificate, as provided in subsection (a) of this Code section, or upon the affidavits of at least two persons who attest that, within the preceding 48 hours, they have seen the person to be taken into custody and that, based upon observations contained in their affidavit, they have reason to believe such person is a mentally ill person requiring involuntary treatment. The court order shall expire seven days after it is executed.

(c) Any peace officer taking into custody and delivering for examination a person, as authorized by subsection (a) or (b) of this Code section, shall execute a written report detailing the circumstances under which such person was taken into custody. The report and either the physician's certificate or court order authorizing such taking into custody shall be made a part of the patient's clinical record.

(d) Any psychologist, clinical social worker, or clinical nurse specialist in psychiatric/mental health may perform any act specified by this Code section to be performed by a physician. Any reference in any part of this chapter to a physician acting under this Code section shall be deemed to refer equally to a psychologist, a clinical social worker, or a clinical nurse specialist in psychiatric/mental health acting under this Code section. For purposes of this subsection, the term "psychologist" means any person authorized under the laws of this state to practice as a licensed psychologist, the term "clinical social worker" means any person authorized under the laws of this state to practice as a licensed clinical social worker, and the term "clinical nurse specialist in psychiatric/mental health" means any person authorized under the laws of this state to practice as a registered professional nurse and who is recognized by the Georgia Board of Nursing to be engaged in advanced nursing practice as a clinical nurse specialist in psychiatric/mental health.
Official Code of Georgia Annotated – Statutes

37-3-42. Emergency admission of persons arrested for penal offenses; report by officer; entry of report into clinical record.

Statute text
(a) A peace officer may take any person to a physician within the county or an adjoining county for emergency examination by the physician, as provided in Code Section 37-3-41, or directly to an emergency receiving facility if (1) the person is committing a penal offense, and (2) the peace officer has probable cause for believing that the person is a mentally ill person requiring involuntary treatment. The peace officer need not formally tender charges against the individual prior to taking the individual to a physician or an emergency receiving facility under this Code section. The peace officer shall execute a written report detailing the circumstances under which the person was taken into custody; and this report shall be made a part of the patient's clinical record.

(b) Any psychologist may perform any act specified by this Code section to be performed by a physician. Any reference in any part of this chapter to a physician acting under this Code section shall be deemed to refer equally to a psychologist acting under this Code section. For purposes of this subsection, the term "psychologist" means any person authorized under the laws of this state to practice as a licensed psychologist.

37-3-61. Initiation of proceedings for court ordered evaluation.

Statute text
Proceedings for a court ordered evaluation may be initiated in the following manner:
(1) Any person may file an application executed under oath with the community mental health center for a court ordered evaluation of a person located within that county who is alleged by such application to be a mentally ill person requiring involuntary treatment. Upon the filing of such application, the community mental health center shall make a preliminary investigation and, if the investigation shows that there is probable cause to believe that such allegation is true, it shall file a petition with the court in the county where the patient is located seeking an involuntary admission for evaluation; and

(2) Any person may file with the court a petition executed under oath alleging that a person within the county is a mentally ill person requiring involuntary treatment. The petition must be accompanied by the certificate of a physician or psychologist stating that he has examined the patient within the preceding five days and has found that the patient may be a mentally ill person requiring involuntary treatment and that a full evaluation of the patient is necessary.
Official Code of Georgia Annotated – Statutes

37-3-101. Transportation of patients generally.
Statute text
(a) The governing authority of the county where the patient is found or located shall arrange for initial emergency transport of a patient to an emergency receiving facility. Except as otherwise authorized under subsection (b) of this Code section, the governing authority of the county of the patient's residence shall arrange for all required transportation for mental health purposes subsequent to the initial transport. The type of vehicle employed shall be in the discretion of the governing authority of the county, provided that, whenever possible, marked vehicles normally used for the transportation of criminals or those accused of crimes shall not be used for the transportation of patients. The court shall, upon the request of the community mental health center, order the sheriff to transport the patient in such manner as the patient's condition demands. At any time the community mental health center is satisfied that the patient can be transported safely by family members or friends, such private transportation shall be encouraged and authorized. In non-emergency situations, no female patient shall be transported at any time without another female in attendance who is not a patient, unless such female patient is accompanied by her husband, father, adult brother, or adult son.

(b) Notwithstanding the provisions of subsection (a) of this Code section, when a patient is under the care of a facility, the facility shall have the discretion to determine the type of vehicle to safely transport the patient and to arrange for such transportation without the need to obtain the prior approval of the governing authority of the county of the patient's residence, the court, or the community mental health center. This subsection shall not prevent the facility from requesting and receiving transportation services from the governing authority of the county of the patient's residence and shall not relieve the county sheriff of the duty of providing transportation. Persons providing transportation are authorized to transport a patient from a sending facility to a receiving facility but shall not release the patient under any circumstances except into the custody of the receiving facility. The use of physical restraints to ensure the safe transport of the patient shall comply with the requirements of Code Section 37-3-165.

When transportation is not provided by the county sheriff, the expense of such transportation shall not be billed to the county governing authority but may be billed to the patient and, unless agreed to in writing by the facility, shall not be billed to or considered an obligation of the facility.

37-3-166. Treatment of clinical records; when release permitted; scope of privileged communications; liability for disclosure; notice to sheriff of discharge. Statute text
(a) A clinical record for each patient shall be maintained. Authorized release of the record shall include but not be limited to examination of the original record, copies of all or any portion of the record, or disclosure of information from the record, except for matters privileged under the laws of this state. Such examination shall be conducted on hospital premises at reasonable times determined by the facility. The clinical record shall not be a public record and no part of it shall be released except:
(1) When the chief medical officer of the facility where the record is kept deems it essential for continued treatment, a copy of the record or parts thereof may be released to physicians or psychologists when and as necessary for the treatment of the patient;
(2) A copy of the record may be released to any person or entity designated in writing by the patient or, if appropriate, the parent of a minor, the legal guardian of an adult or minor, or a person to whom legal custody of a minor patient has been given by order of a court;
(2.1) A copy of the record of a deceased patient or deceased former patient may be released to or in response to a valid subpoena of a coroner or medical examiner under Chapter 16 of Title 45, except for matters privileged under the laws of this state;
Official Code of Georgia Annotated – Statutes

(3) When a patient is admitted to a facility, a copy of the record or information contained in the record from another facility, community mental health center, or private practitioner may be released to the admitting facility. When the service plan of a patient involves transfer of that patient to another facility, community mental health center, or private practitioner, a copy of the record or information contained in the record may be released to that facility, community mental health center, or private practitioner; (4) A copy of the record or any part thereof may be disclosed to any employee or staff member of the facility when it is necessary for the proper treatment of the patient;

(5) A copy of the record shall be released to the patient's attorney if the attorney so requests and the patient, or the patient's legal guardian, consents to the release;

(6) In a bona fide medical emergency, as determined by a physician treating the patient, the chief medical officer may release a copy of the record to the treating physician or to the patient's psychologist;

(7) At the request of the patient, the patient's legal guardian, or the patient's attorney, the record shall be produced by the entity having custody thereof at any hearing held under this chapter;

(8) A copy of the record shall be produced in response to a valid subpoena or order of any court of competent jurisdiction, except for matters privileged under the laws of this state;

(8.1) A copy of the record may be released to the legal representative of a deceased patient's estate, except for matters privileged under the laws of this state;

(9) Notwithstanding any other provision of law to the contrary, a law enforcement officer in the course of a criminal investigation may be informed as to whether a person is or has been a patient in a state facility, as well as the patient's current address, if known; and

(10) Notwithstanding any other provision of law to the contrary, a law enforcement officer in the course of investigating the commission of a crime on the premises of a facility covered by this chapter or against facility personnel or a threat to commit such a crime may be informed as to the circumstances of the incident, including whether the individual allegedly committing or threatening to commit a crime is or has been a patient in the facility, and the name, address, and last known whereabouts of any alleged patient perpetrator.

(b) In connection with any hearing held under this chapter, any physician, including any psychiatrist, or any psychologist who is treating or who has treated the patient shall be authorized to give evidence as to any matter concerning the patient, including evidence as to communications otherwise privileged under Code Section 24-9-21, 24-9-40, or 43-39-16.

(c) Any disclosure authorized by this Code section or any unauthorized disclosure of confidential or privileged patient information or communications shall not in any way abridge or destroy the confidential or privileged character thereof, except for the purpose for which such authorized disclosure is made. Any person making a disclosure authorized by this Code section shall not be liable to the patient or any other person, notwithstanding any contrary provision of Code Section 24-9-21, 24-9-40, or 43-39-16.

(d) When a sheriff transports an adult involuntary patient to a facility, that sheriff may request in writing that a notice of such patient's discharge be given to the sheriff; and such notice shall be provided if such patient or the patient's guardian consents in writing to the disclosure or if, in its discretion, the court ordering the involuntary treatment provides for such notice in the order issued pursuant to Code Section 37-3-81.1.
51-7-1. Right of action for false arrest.
Statute text
An arrest under process of law, without probable cause, when made maliciously, shall give a right of action to the party arrested.

51-7-2. Malice defined.
Statute text
Malice consists in personal spite or in a general disregard of the right consideration of mankind, directed by chance against the individual injured.

51-7-20. False imprisonment defined.
Statute text
False imprisonment is the unlawful detention of the person of another, for any length of time, whereby such person is deprived
30-5-1. Short title. Statute text This chapter shall be known and may be cited as the "Disabled Adults and Elder Persons Protection Act."

30-5-2. Legislative purpose. Statute text The purpose of this chapter is to provide protective services for abused, neglected, or exploited disabled adults and elder persons. It is not the purpose of this chapter to place restrictions upon the personal liberty of disabled adults or elder persons, but this chapter should be liberally construed to assure the availability of protective services to all disabled adults and elder persons in need of them.

30-5-3. Definitions. Statute text As used in this chapter, the term:

1. "Abuse" means the willful infliction of physical pain, physical injury, mental anguish, unreasonable confinement, or the willful deprivation of essential services to a disabled adult or elder person.

2. "Caretaker" means a person who has the responsibility for the care of a disabled adult or elder person as a result of family relationship, contract, voluntary assumption of that responsibility, or by operation of law.

3. "Court" means the probate court for the county of residence of the disabled adult or elder person or the county in which such person is found. In any case in which the judge of the probate court is unable to hear a case brought under this chapter within the time required for such hearing, such judge shall appoint a person to serve and exercise all the jurisdiction of the probate court in such case. Any person so appointed shall be a member of the State Bar of Georgia and be otherwise qualified for his or her duties by training and experience. Such appointment may be made on a case-by-case basis or by making a standing appointment of one or more persons. Any person receiving such standing appointment shall serve at the pleasure of the judge making the appointment or said judge's successor in office to hear such cases if and when necessary. The compensation of a person so appointed shall be as agreed upon by the judge who makes the appointment and the person appointed, with the approval of the governing authority of the county for which such person is appointed, and shall be paid from the county funds of such county. All fees collected for the services of such appointed person shall be paid into the general funds of the county served.

4. "Department" means the Department of Human Resources.

5. "Director" means the director of the county department of family and children services, or the director's designee, in the county in which the disabled adult or elder person resides or is present.

6. "Disabled adult" means a person 18 years of age or older who is not a resident of a long-term care facility, as defined in Article 4 of Chapter 8 of Title 31, but who is mentally or physically incapacitated.

7. "Disabled adult in need of protective services" means a disabled adult who is subject to abuse, neglect, or exploitation as a result of that adult's mental or physical incapacity.

7.1 "Elder person" means a person 65 years of age or older who is not a resident of a long-term care facility as defined in Article 4 of Chapter 8 of Title 31.

8. "Essential services" means social, medical, psychiatric, or legal services necessary to safeguard the disabled adult's or elder person's rights and resources and to maintain the physical and mental well-being of such person. These services shall include, but not be limited to, the provision of medical care for physical and mental health needs, assistance in personal hygiene, food, clothing, adequately heated and ventilated shelter, and protection from health and safety hazards but shall not include the taking into physical custody of a disabled adult or elder person without that person's consent.

9. "Exploitation" means the illegal or improper use of a disabled adult or elder person or that person's resources for another's profit or advantage.

10. "Neglect" means the absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a disabled adult or elder person.

11. "Protective services" means services necessary to protect a disabled adult or elder person from abuse, neglect, or exploitation. Such services shall include, but not be limited to, evaluation of the need for services and mobilization of essential services on behalf of a disabled adult or elder person.
MENTAL HEALTH AND COMMUNITY RESOURCES
State Mental Health System/Local Community Resources

State of Georgia
Crisis Intervention Team Training Program

Georgia Department of Human Resources
Division of Mental Health, Developmental Disabilities and Addictive Diseases

- Provides treatment and support services to individuals with mental illnesses and addictive diseases
- Provides support to individuals with mental retardation and related developmental disabilities
- Services are provided across the state through:
  - Community service boards
  - Boards of health and various private providers
  - State-operated regional hospitals

Community Health Resources

- Community Service Boards
  - Provide community mental health services and referrals
  - Located regionally throughout the state and are available to all 159 counties
- Single Points of Entry
  - Telephone support available 24 hours a day, seven days a week (for certain areas of the state)
- Mobile Crisis Teams
  - Comprised of licensed social workers and psychiatric nurses
  - Accompanied by law enforcement, who respond to crisis situations onsite
Community Health Resources

- Crisis Stabilization Programs
  - An alternative to hospitalization
  - Provides brief psychiatric intervention primarily to low-income persons with acute psychiatric conditions

- Emergency Receiving Facilities
  - Onsite assessments conducted by clinical staff who can assist in referral services

- Georgia Regional Hospitals
  - Receive referrals from an emergency receiving facility
  - Provide stabilization for acute psychiatric crises

Georgia Regional Mental Health Hospital System

- Regional hospitals are located at various sites throughout Georgia
- Hospital care is accessed through community intake and assessment
- Individuals are referred to the hospital only when they need that level of care

Georgia Regional Hospitals

Northwest Georgia Regional Hospital
6000 Redmond Circle, Northwest
Rome, Georgia 30161
706 295-6011

East Central Regional Hospital/Gracewood
100 Myrtle Boulevard
Gracewood, Georgia 30812
706 790-2011

Central State Hospital
620 Broad Street
Milledgeville, Georgia 31062
761-945-6128

Georgia Regional Hospital/Savannah
11915 Eisenhower Drive
Savannah, Georgia 31406
912 356-2011

East Central Regional Hospital/Augusta
3405 Mike Padgett Highway
Augusta, Georgia 30906
706 792-7000

Georgia Regional Hospital/Atlanta
3025 Peachtree Road
Dekalb, Georgia 30309
404 243-2100

West Central Regional Hospital
3000 Schulte Road
Columbus, Georgia 31907
706 568-5000

Southwestern State Hospital
500 South Western Boulevard
Thomasville, Georgia 31792
229 227-3123
### Georgia Community Service Boards (CSBs)

<table>
<thead>
<tr>
<th>COUNTY IN SERVICE AREA</th>
<th>CSB NAME</th>
<th>CHM DIRECTOR NAME</th>
<th>CHM PHONE NUMBER</th>
<th>CHAIRPERSON NAME</th>
<th>ASSOCIATION OFFICER NAME</th>
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<tbody>
<tr>
<td>Bartow, Floyd, Gordon, Murray, Pickens, Whitfield, Cherokee, Fannin, Gilmer, Franklin, Habersham, Hall, Schley, Sumter, Taylor, Webster</td>
<td>Gateway BHS</td>
<td>Sarah C. Roach</td>
<td>706-858-3232</td>
<td>James G. Hightower</td>
<td>Chairperson</td>
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<tr>
<td>Baldwin, Hancock, Jasper, Muscogee, Quitman, Randolph, Baldwin, Hancock, Jasper, Muscogee, Quitman, Randolph, Baldwin, Hancock, Jasper, Muscogee, Quitman, Randolph, Baldwin, Hancock, Jasper, Muscogee, Quitman, Randolph</td>
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<th>Region</th>
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<tr>
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<td>Middle Georgia Alliance of Community Boards</td>
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<td>South Georgia</td>
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<td>Southeast GA</td>
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Presentation Prepared By:

David Covington, NCC, LPC, MBA
Chief Operating Officer
Integrated Health Resources, d/b/a Behavioral Health Link

Janet Oliva, Ph.D.
Inspector
Georgia Bureau of Investigation
<table>
<thead>
<tr>
<th>COUNTIES IN SERVICE AREA</th>
<th>CSB NAME</th>
<th>CSB DIRECTOR ADDRESS</th>
<th>CHAIRPERSON ADDRESS</th>
<th>ASSOCIATION REP (if not Chair) ADDRESS</th>
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<tbody>
<tr>
<td>Baker, Calhoun, Dougherty, Early, Lee, Miller, Terrell, Worth</td>
<td>Albany Area CSB</td>
<td>Faye Holt 1120 W. Broad Ave. P. O. Box 1988 Albany, GA 31707/31702-1988 229-430-4042</td>
<td>Honorable Dan Miller Chair, Worth Cty. Commission P.O. Box 337 Sylvester, GA 31791</td>
<td>Faye Holt</td>
</tr>
<tr>
<td>Clayton</td>
<td>Clayton County CSB</td>
<td>Jade Benefield 112 Broad Street Jonesboro, GA 30236 Ph. 770-478-2280</td>
<td>Bob Reynolds 1400 Mundy’s Mill Rd Jonesboro, GA 30238</td>
<td>Bob Reynolds</td>
</tr>
<tr>
<td>Cobb</td>
<td>Cobb CSB</td>
<td>Tod W. Citron 3830 S. Cobb Drive Smyrna, GA 30080 Ph. 770-429-3000</td>
<td>Dan B. Stephens, M.D. 3830 S. Cobb Drive Smyrna, GA 30080</td>
<td>Tod W. Citron</td>
</tr>
<tr>
<td>Columbia, Lincoln, McDuffie, Richmond, Taliaferro, Warren, Wilkes</td>
<td>CSB of East Central Georgia (Serenity)</td>
<td>Charles D. Williamson 3421 Mike Padgett Hwy Augusta, GA 30906 706-432-4891</td>
<td>Mrs. Stella Nunnally 1050 Phillips St. Augusta, GA 30901</td>
<td>Mrs. Stella Nunnally</td>
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### Georgia Community Service Boards (CSBs)

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<tr>
<th>DeKalb</th>
<th>DeKalb CSB</th>
<th>Gary Richey</th>
<th>P. O. Box 1648</th>
<th>Decatur, GA 30031</th>
<th>Ph. 404-508-7807</th>
<th>Leroy Tanker</th>
<th>2130 Mountain Ln.</th>
<th>Stone Mountain, GA 30087</th>
<th>William Hogan (Pres.)</th>
<th>1479 Kahanna Drive</th>
<th>Decatur, GA 30033</th>
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<tr>
<td>Douglas</td>
<td>Douglas CSB</td>
<td>Ted Citron</td>
<td>3830 S. Cobb Drive</td>
<td>Smyrna, GA 30080</td>
<td>Ph. 770-429-5000</td>
<td>Don Remillard</td>
<td>3830 S. Cobb Drive</td>
<td>Smyrna, GA 30080</td>
<td>Todd Citron</td>
<td></td>
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<tr>
<td>Fulton</td>
<td>Fulton County</td>
<td>Barbara Lattimore</td>
<td>115 MLK, Jr. Drive, Ste. 277</td>
<td>Atlanta, GA 30303</td>
<td>Ph. 404-730-0220</td>
<td>N/A</td>
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<tr>
<td>Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh,</td>
<td>Gateway BHS</td>
<td>Frank Bonati, DPH</td>
<td>1000 Commissioners Drive</td>
<td>Darien, GA 31305</td>
<td>912-437-9300</td>
<td>Tim Hutchens</td>
<td>3901 Darien Hwy., 3-A</td>
<td>Brunswick, GA 31525</td>
<td>Frank Bonati</td>
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<tr>
<td>Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White</td>
<td>Georgia Mountains</td>
<td>Laura Tyler, Ph. D</td>
<td>4331 Thurmond Tanner Rd.</td>
<td>Flowery Branch, GA 30542</td>
<td>Ph. 678-513-5701</td>
<td>Sharon Underwood</td>
<td>Brenau University</td>
<td>Center for Teaching Excellence</td>
<td></td>
<td>Alice Worthan</td>
<td>1844 Jones Road</td>
</tr>
<tr>
<td>Colquitt, Decatur, Grady, Mitchell, Seminole, Thomas</td>
<td>Georgia Pines</td>
<td>Robert H. Jones, Jr.</td>
<td>1102 Smith Avenue, Ste. K</td>
<td>P. O. Box 1659</td>
<td>Thomasville, GA 31792</td>
<td>229-225-4370</td>
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<td>Bob Jones</td>
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<tr>
<td>Gwinnett, Newton, Rockdale</td>
<td>GRN CSB</td>
<td>Bobby Robbins</td>
<td>P. O. Box 687</td>
<td>Lawrenceville, GA 30046</td>
<td>Ph. 770-339-5019</td>
<td>Charles Knight</td>
<td>(Past Pres.)</td>
<td>P. O. Box 465869</td>
<td>Liburn, GA 30044</td>
<td>Charles Knight</td>
<td>(Past Pres.)</td>
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<tr>
<td>Cherokee, Fannin, Gilmer, Murray, Pickens, Whitfield, Bartow, Floyd, Gordon, Haralson, Paulding, Polk</td>
<td>Highland Rivers</td>
<td>Klay Weaver</td>
<td>1710 Whitehouse Dr.</td>
<td>Dalton, GA 30720</td>
<td>Ph. 706-270-5000</td>
<td>Fax 706-270-5124</td>
<td></td>
<td></td>
<td></td>
<td>Klay Weaver</td>
<td></td>
</tr>
</tbody>
</table>

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## Georgia Community Service Boards (CSBs)

<table>
<thead>
<tr>
<th>CSB Name</th>
<th>Address Details</th>
</tr>
</thead>
</table>
| Catoosa, Chattooga, Dade, Walker              | **Lookout Mountain CSB**  
Tom Ford, Ph.D.  
501 Mize Street  
P. O. Box 1027  
LaFayette, GA 30728  
706-638-5584  
  
Jon Payne  
P. O. Box 467  
Summerville, GA 30747  
  
Sarah C. Roach  
(Vice Pres.)  
P.O. Box 2101  
McDonough, GA 30253 |
| Butts, Fayette, Henry, Lamar, Pike, Spalding, Upson | **McIntosh Trail CSB**  
Cathy Johnson, Ed.S., LPC  
1501-A Kalamazoo Drive  
Griffin, GA 30224  
770-358-8250  
  
Susan Craig  
140 Henry Parkway  
McDonough, Georgia 30253  
  
Bobby Gosnell  
P.O. Box 2101  
McDonough, GA 30253 |
| Crisp, Dooly, Macon, Marion, Schley, Sumter, Taylor, Webster | **Middle Flint BHC**  
Pam Davis  
415 N. Jackson Street  
P. O. Drawer 1348  
Americus, GA 31709  
229-831-2470  
  
David Fallin  
120 Cedar Lake Drive  
Cordele, GA 31015  
  
David Fallin |
| Chattahoochee, Clay, Harris, Muscogee, Quitman, Randolph, Stewart, Talbot | **New Horizons CSB**  
Perry Alexander  
P. O. Box 5328  
Columbus, GA 31906  
706-596-5542  
  
Mr. Gary Brown  
P.O. Box 491  
Hamilton, GA 31811  
  
Perry Alexander |
| Baldwin, Hancock, Jasper, Putnam, Washington, Wilkinson | **Oconee CSB**  
Angela Hicks-Hill  
131 N. Jefferson St.  
P. O. Box 1827  
Milledgeville, GA 31061  
478-445-4817  
  
Honorable W. R. Blizzard  
Baldwin County Commission  
225 Deepstep Road, NE  
Milledgeville, GA 31061  
  
Angela Hicks-Hill |
| Burke, Emanuel, Glascock, Jefferson, Jenkins, Screven | **Ogeechee CSB**  
Frank Brantley  
223 N. Anderson Street  
P. O. Box 1259  
Swainsboro, GA 30401  
478-289-2522  
  
Aggie Blalock  
P. O. Box 1259  
Swainsboro, GA 30401  
  
Frank Brantley |
| Carroll, Coweta, Heard, Troup, Meriwether | **Pathways CSB**  
Joan Turner  
122 Gordon Commercial Dr., Suite C  
LaGrange, GA 30240  
706-845-4045  
  
Bob Ziifle  
P.O. Box 1308  
Newnan, GA 30264  
  
Arlena Alford  
(Treasurer)  
P.O. Box 1576  
Newnan, GA 30265 |
<table>
<thead>
<tr>
<th>Georgia Community Service Boards (CSBs)</th>
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</thead>
<tbody>
<tr>
<td><strong>Crawford, Houston, Peach</strong></td>
</tr>
<tr>
<td><strong>Phoenix Center CSB</strong></td>
</tr>
<tr>
<td>Don Blair</td>
</tr>
<tr>
<td>202 North Davis Dr.</td>
</tr>
<tr>
<td>P. O. Box 2886</td>
</tr>
<tr>
<td>Warner Robins, GA 31093/31099</td>
</tr>
<tr>
<td>478-464-5259</td>
</tr>
<tr>
<td>Dr. Ruth O’Dell</td>
</tr>
<tr>
<td>800 Green St.</td>
</tr>
<tr>
<td>Warner Robins, GA 31093</td>
</tr>
<tr>
<td>Ms. Linda Curry</td>
</tr>
<tr>
<td>105 Shannon Glen Ct.</td>
</tr>
<tr>
<td>Warner Robins, GA 31088</td>
</tr>
<tr>
<td><strong>Appling, Bulloch, Candler, Evans, Jeff Davis, Tattnall, Toombs, Wayne</strong></td>
</tr>
<tr>
<td><strong>Pineland CSB</strong></td>
</tr>
<tr>
<td>June A. DiPolito</td>
</tr>
<tr>
<td>9 Allen Cail Dr.</td>
</tr>
<tr>
<td>P. O. Box 745</td>
</tr>
<tr>
<td>Statesboro, GA 30459/30459</td>
</tr>
<tr>
<td>912-764-6906</td>
</tr>
<tr>
<td>Ms. Susan Radovich</td>
</tr>
<tr>
<td>121 Lakewood Drive</td>
</tr>
<tr>
<td>Statesboro, Ga. 30458</td>
</tr>
<tr>
<td>June A. DiPolito</td>
</tr>
<tr>
<td><strong>Bibb, Jones, Monroe, Twiggs</strong></td>
</tr>
<tr>
<td><strong>River Edge CSB</strong></td>
</tr>
<tr>
<td>Frank Fields</td>
</tr>
<tr>
<td>175 Emery Highway</td>
</tr>
<tr>
<td>Macon, GA 31217</td>
</tr>
<tr>
<td>478-751-4515</td>
</tr>
<tr>
<td>Ray A. Bennett</td>
</tr>
<tr>
<td>175 Emery Highway</td>
</tr>
<tr>
<td>Macon, GA 31217</td>
</tr>
<tr>
<td>Bill Willingham (Secretary)</td>
</tr>
<tr>
<td>3593 Jones Road</td>
</tr>
<tr>
<td>Macon, GA 31216</td>
</tr>
<tr>
<td><strong>Atkinson, Bacon, Brantley, Charlton, Clinch, Coffee, Pierce, Ware</strong></td>
</tr>
<tr>
<td><strong>Satilla CSB</strong></td>
</tr>
<tr>
<td>Glyn Thomas, Ph.D</td>
</tr>
<tr>
<td>P. O. Box 1397</td>
</tr>
<tr>
<td>Waycross, GA 31502</td>
</tr>
<tr>
<td>912-284-2543</td>
</tr>
<tr>
<td>Dr. Ellice Martin</td>
</tr>
<tr>
<td>PO Box 296</td>
</tr>
<tr>
<td>Homerville, GA 31634</td>
</tr>
<tr>
<td>Dr. Ellice Martin</td>
</tr>
<tr>
<td>PO Box 296</td>
</tr>
<tr>
<td>Homerville, GA 31634</td>
</tr>
<tr>
<td><strong>Ben Hill, Berrien, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift, Turner</strong></td>
</tr>
<tr>
<td><strong>South Georgia CSB</strong></td>
</tr>
<tr>
<td>Sue Gauton</td>
</tr>
<tr>
<td>3120 N. Oak St Ext, Ste C</td>
</tr>
<tr>
<td>Valdosta, GA 31602-1007</td>
</tr>
<tr>
<td>239-333-7095</td>
</tr>
<tr>
<td>Frank O’Quinn</td>
</tr>
<tr>
<td>Route 2, Box 143</td>
</tr>
<tr>
<td>Adel, GA 31620</td>
</tr>
<tr>
<td>C.H. Majeski</td>
</tr>
<tr>
<td>601 Bowen Marchant Rd.</td>
</tr>
<tr>
<td>Tifton, GA 31793</td>
</tr>
<tr>
<td><strong>Haralson</strong></td>
</tr>
<tr>
<td><strong>Haralson HBS</strong></td>
</tr>
<tr>
<td>(Associate Member)</td>
</tr>
<tr>
<td>Holly Orwell</td>
</tr>
<tr>
<td>217 Tennessee Ave.</td>
</tr>
<tr>
<td>Bremen, GA 30110</td>
</tr>
<tr>
<td>770-537-2367 Ext. 123</td>
</tr>
<tr>
<td>Faye Ward</td>
</tr>
<tr>
<td>513 Alabama Ave.</td>
</tr>
<tr>
<td>Bremen, GA 30110</td>
</tr>
<tr>
<td>TBD</td>
</tr>
</tbody>
</table>

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When encountering negative situations regarding treatment centers, emergency rooms, halfway houses, shelters, group homes or other sites where consumers or patients receive care/treatment, please contact Bill Kissel. On the other hand, should you have a positive experience, please let Bill know as well so appreciation can be communicated.

William P. Kissel, MS
Georgia Department of Human Resources
MH/DD/AD Division 23.392
Director, Quality & Evaluation Unit
2 Peachtree St., NW
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State of Georgia Crisis Intervention Team
Law Enforcement Training Program

The Georgia Crisis Intervention Team Advisory Board would like to acknowledge the dedication and contributions of the following:

- AirTran
- Alzheimer’s Association
- Atlanta Alliance for Developmental Disabilities
- Atlanta Police Academy
- Autism Society of Georgia
- Behavioral Health Link
- Carter Center
- Georgia Bureau of Investigation
- Georgia Coalition for the Prevention of Suicide
- Georgia Department of Education
- Georgia Department of Human Resources
- Georgia-Pacific Corporation
- Georgia Psychiatric Association
- Georgia Public Safety Training Center
- Georgia Regional Hospital at Atlanta
- Grady Memorial Hospital
- Houston, Texas Crisis Intervention Team Program
- Jannsen Pharmaceuticals
- Kansas City, Missouri Crisis Intervention Team Program
- Memphis, Tennessee Police Department
- National Alliance on Mental Illness, NAMI Georgia
- Skyland Trail
- Veterans Administration Hospital

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