These are the core mental health issues I have found in the work we have done in Peach and Crawford Counties that will continue to plague us, if the root cause is not addressed.

- **Critically ill are under-medicated**
- **General population is over-medicated with psychotropics**
- Current approach has lead to rising suicide rates, jail populations, and repeated psychiatric crises
- **State CSBs (Community Service Boards)** were intended to fill the gap state mental health institutions used to fill and they are not focused enough on high-need individuals
- No clear policy for identifying & treating people who would've been institutionalized in the past
- Lack of coordinated action between CSBs, Probate Judges, jails, Magistrate Judges (and not setting mental health related bond conditions)
- Individuals with repeated mental health crises often go untreated or mismanaged
- A fragmented system leads to repeated OTAs (Orders to Apprehend), incarceration, and hospitalizations
- SSRIs and other psychotropic drugs widely prescribed by general practitioners (not psychiatrists). Why are non-psychiatrists allowed to prescribe powerful psychotropics?
- Potential link between increased psychotropic drug usage and rising suicide/homicide rates. Is this another public health failure similar to the opioid epidemic?

Proposed Solutions:

- CSB's work closely with Crisis Medical, Law Enforcement, Jail and Probate Judge
- **Implement Assisted Outpatient Treatment (AOT)** as standard practice in all counties
- CSBs should actively track individuals with chronic mental health needs
- Stabilizing this small group would reduce crisis costs significantly
- Improves quality of life for individuals and their families
- AOT would reduce law enforcement, jail, and healthcare burden
- Enact scope-of-practice restrictions in Georgia and at a federal level that only psychiatrists should be allowed to prescribe psychotropics. At a minimum require **mandatory informed consent** with risk education before prescriptions.

The Problem with Mental Health in a Nutshell

Under-Medicated and Over-Medicated

This letter is an attempt to bring awareness to what seems to continue fueling the growth of mental health issues (paid for by the taxpayers of our state). It appears we are fueling this through over-medication of psychotropic drugs of the masses (*see over-medication at end*), while leaving the critically ill, under-medicated and vulnerable. We have seen a massive increase of suicide in our respective communities, as well as an influx of individuals with severe mental health illness in our crisis medical centers, our jails, as well as exasperating repeated Orders to Apprehend (OTA's) made by family's to our probate judges for medical evaluations (the dots seem easily connected).

As a county commissioner, CSB board member, and recent Peach County BOC appointee to the GA DBHDD Region 6 Advisory council, as well as being a part of the Sequential Intercept Model (Mental Health mapping) process by the UGA Carl Vinson Institute, the below has been my findings.

Part 1. Under-Medicated

State contracted mental health service providers: Our 22 State Community Service Boards (CSB's), from their state contracted beginnings, should have been given a very

narrow scope of practice (in their contracts) to make sure the individuals (that would have been institutionalized under prior definitions) were still getting served after our state institutions were closed. If we understand the void that the CSB's were supposed to fill in our communities, (after state institutions were shut down) and who these individuals are that would have met the criteria for institutionalization care, we can then tune out much of the noise and fluff surrounding the issues of community based mental health.

The CSB's were supposed to bridge the gap, when state institutions closed, what happened?

- If the 22 CSB's that were contracted by the state to fill the gap in services (when the state institutions were closed), why has their focus not been on these individuals?
- Who are these individuals and where are they today?
- If the CSB's were required to be plugged into their local community's jail/prison/bond release and probation system, (or simply be contracted for the mental health component) would it possibly help ensure success for ones that are released back into the community that suffer from mental illness?
- Why is there not a set of policies and procedure in place for the definition of care (and medication administration such as AOT) for ones that meet the same collateral evidence of ones that used to be in state institutions, and not left wide open for interpretation?
- If these individuals used to be long-term inpatients, are they considered community outpatients? Or have they completely lost any definition since they have been pushed out of institutional care and into the streets, crisis medical centers, and our jails?
- If someone has repeat orders to apprehend for mental health evaluations, arrests, and mental health crisis center visits for stabilization (all in relation to cycling on and off psychotropic drugs), should this not be a the evidence needed that an individual is needing help with their medication regulation?
- If Probate Judges, CSB's (crisis centers), and jail (probation release), would work in lockstep, using collateral evidence that constitutes a higher level of care, to issue Assisted Outpatient Treatment for these individuals -is it possible that we would see a rapid shrinking of repeat offenders and familiar faces? Why do we not use ankle

monitoring, (for severe cases) and digital tracking/monitoring phone apps (for less severe cases), for medical tracking for continued stabilization when out on their own?

- What value does mental health restoration in jail have, when the community and CSB does not have a strong, AOT program in place to keep this individual on track after being released or released on bond?
- Would it help protect individuals that have a track record of collateral evidence, (multiple orders to apprehend for medical evaluation) showing they need assisted, or involuntary outpatient mental health treatment, prior to committing a mentally induced criminal activity?

The case for a statewide push for AOT as standard best practice:

In years past, after criteria (collateral evidence) was met for severe mental illness, an individual was given admission into a state institution for specialized care and treatment. After the closure of approximately 33,000 state hospital beds, these individuals are now in our streets, homeless shelters and homeless encampments, jails, medical crisis centers, judicial systems, disrupting families, and last but not least the individual's mental health pathway to stabilization and recovery has become a very fragmented and broken one.

Assisted Outpatient Treatment (AOT): this form of treatment is the only one that comes close to matching the inpatient care these individuals used to be able to receive. The percentage of individuals who do not have the mental capacity to administer their own psychotropic drugs is very small and the percentage that occasionally refuses their medications (after stabilization), even smaller.

Once a criteria has been met, for a higher level of care, our CSB's should monitor, track and treat these individuals, even if they have to wear an ankle monitor, (not doing this is very unfair and costly to everyone involved). These are the individuals (when off their meds) that disrupt group home and homeless shelter settings, they are the problematic individuals among the homeless population, they take up many resources in our crisis medical systems, law enforcement, jails, judicial systems, cause problems for their families, our streets and our businesses. For individuals that have a cell phone

and have basic mental acuity, a less invasive mobile gps monitoring technology (such as www.vcheck24.com) could be utilized for tracking, welfare checks and to ensure scheduled check-ins with the CSB.

The cost savings should easily justify the expenditure of getting these individuals the care needed. These individuals with severe mental illness create an illusion of a huge mental health problem, when in actuality by simply affording these individuals a higher level of regulated stabilizing care, would remedy most of the issues plaguing community-based, mental healthcare.

Legislative wish: the state should not have to take on all the costs, but could implement a way to incentivize the use of AOT through our CSB's that would also encourage county and municipal governments to participate. Doing this would make a statement by the state of Georgia that adopting AOT is considered a standard best practice of care for these individuals that are suffering from severe mental illness within our communities. **Example:** in Peach County we have a population around 29,000, the ones suffering from critical mental illness that could benefit the most from AOT would be approximately 10-15 individuals. If the focus of state AOT funding would be very narrowly focused on these individuals (as a baseline), the results should show cost savings to easily justify the expenditure, and the quality of life for these individuals that have medication regulation and stabilization, has a value much higher.

If we do not take action at a state and local level, we are doing the ones with critical mental illness a grave injustice, and are costing them quality of life they could have as well as that of their families and communities.

Opinion: Peach and Crawford just went through a very intensive process with the UGA Carl Vincent Institute that helps counties and municipalities develop best practice for handling mental health crisis, mental health in the jail, judicial system, and stabilization and care in the community. However, if we do not quit putting the masses on psychotropic drugs, and side-stepping the responsibility of doing what it takes to keep individuals on psychotropic medication's that have severe mental health difficulties, (that would have received an elevated level of care in state

institutions), we are going to continue living in a powder keg society, where occasionally one gets lit.

Part 2. **Over-Medicated**

We have opened up the floodgates of SSRI (antidepressant) drug prescriptions through general practitioners who are not licensed in psychiatry but can distribute and administer psychotropic drugs. If a degree in psychiatry, holds any value and professional weight, then why does the distribution and administration of psychotropic drugs not hold the same? When did this become okay at this level of psychotropic drug distribution and what methods were used by the FDA and CDC to justify doing this? When there is a massive increase in death there is usually a culprit or origin. Even though this is something we can punt to the federal level and say it is not our responsibility, it is happening in our state, in our counties, and in our communities.

Suicide: we would be hard pressed to find anyone, who has not been closely touched by the epidemic of death by suicide over the past 10-15 years. The dots are there to

easily connect, but unfortunately, consumer protection agencies such as the FDA and CDC, for some reason have either not seen or have avoided a timeline that should closely correlate with mass psychotropic drug usage. Here, in our area of Peach and Crawford Counties, there have been 4 individuals that I personally know of that ended their life in the past year. One was a friend and member of my health club and came in to renew his membership on a Monday after being gone for a month and the next day (Tuesday), ended his life. Another was a mother of 2 teenagers (her son was a chaplain in our local high school FFA program) Another was a member of our community that I had been working on a project for, she stop by my office to thank me for the progress we had made, and about 5 weeks later she took her own life. More recently, a very prominent farmer, and one I considered a friend just took his own life. Others that were personal; my first cousin left his job on lunch break and took his life, another was my business, neighbor's young son. While I was at the visitation I got into a conversation with one of my young members mother, (within the next week) her son and member of my health club took his life. I bring out these stories, not only as a memorial to them, but for a specific purpose to get you to think about how often this has happened in your life over the past 5–10 years.

In 2024 a Kentucky Sheriff walked in and shot and killed a local judge and in Dec. 2024 a Georgia Judge killed himself on the bench in his courtroom. These are only a few of many examples of what seems to be rash but final and fatal decisions made by individuals.

Good and bad behavioral decisions on a scale of 1-10: we have seen mental health prevail itself tragically through suicide, and even mass homicide, but there are many decisions an individual can make, that are not nearly as tragic, (none-the-less can be very tragic and costly to the individual and/or ones around them). Letting psychotropic drugs be distributed so easily throughout our population, seems to mirror the same blindness when the medical industry was allowed to flood our country with opioids. Is this happening once again but in the shape of psychotropic drugs?

Legislation request: though this should be a federal scope of practice law, it is happening in our state, and our local communities, so please push for scope of practice legislation in the state of Georgia (and on a federal level) that only allows doctors licensed in psychiatry to distribute psychotropic drugs **for any new patients**. Or at least require detailed explanation of the psychotropic being prescribed along with a patient (or guardian's) signature acknowledging that they have received and understand the information. "The gravity and seriousness of what a patient is being prescribed, how they regulate it, the danger of suddenly discontinuing it, and warnings about consumption of alcohol and mixing other drugs, and what they should do if they begin to have suicidal or homicidal thoughts" should be impressed on an individual, before being prescribed a psychotropic drug.

There will be reasons, given, such as there are simply not enough psychiatrists to prescribe psychotropic drugs to the public, but if we do not figure out a way to slow down the psychotropic drug prescriptions, we are going to continue having powder kegs ignite throughout our population whether in our schools or society in general. We are being hit by a scourge of suicides and mass homicides that are happening in our local communities, and we need to bring state and federal attention to what the FDA and CDC are once again (as in the opioid epidemic) turning a blind eye to.

We have a psychotropic drug prescription epidemic.

Thank you for being interested in mental healthcare for your community! Wade Yoder

Wade Yoder
Peach County BOC At-Large
478.955.1999
wade-yoder@peachcounty.gov