The Problem with Mental Health in a Nutshell

We are both

Over-Medicated and Under-Medicated

They say the definition of insanity is to do the same thing over and over again, and expect a different result. With mental health, we are refueling the same fire we claim to be fighting.

Purpose of this document:

Individuals, families, law-enforcement, crisis medical, and our communities are being put at risk with the current community based mental healthcare system: individuals that meet the same collateral evidence as ones that used to receive (extended) institutional care, have been moved out into our communities with their rights and opinion (on their mental state and needs) being completely out of balance in the credence that is given to their families, crisis medical, probate judges, law-enforcement, jails, the court system and the communities they are in. We are medicating the masses with psychotropic drugs without true safeguards in place to screen for and help the ones that cannot handle their own medications, and as a result go into temporary psychosis and further erosion of their mental health condition. We will not be able to gain traction in community based mental health unless we address these 2 systemic issues…

1. **Repeat mental health evaluations:** Orders to Apprehend (OTA's), 1013's, Involuntary Commitments, (mental health evaluations/treatments) and repeated arrests linked to mental health, spell out the need for **Assisted Outpatient Treatment** through our CSB's for these high need individuals to coexist in our communities. Please see the President's executive order July 24, 25 "Ending Crime and Disorder on America's Streets". These individuals red flag themselves and if they are expected to remain in our communities and out of our jails, they need **monitoring** and **tracking** for a continuum of care and medication stabilization.

   These individuals are a danger to themselves and others.

2. **We are fueling our mental health crisis by psychotropic drug overuse:** this has grown the mental health industry, and is endangering individuals, and our society with events of temporary psychosis (by the sporadic on-off use and mixed ways of using psychotropic drugs). With the massive increase in the number of suicides in our communities and homicides (that sound psychotic in nature), we should investigate what has changed that might be contributing to this.

   Approximately 1/5 (66 million) of our population are now on psychotropic drugs.

To our Georgia Legislators:

I**n 2023, something happened that never has before:** all 159 counties in Georgia signed a resolution out of concern for mental health. This showed the level of concern across the state to our Governor's office and State Legislature, but until we get surgical in the approach at a federal, state and local level, the problem will not shrink, it will continue to grow. This should concern local governments, as this continues to put a heavy toll on crisis medical, law enforcement, jail, judicial system resources, along with the continued shift of costs to a local level.

Dual county Mental Health Collaborative: in 2018 we started a mental health task force in Peach County, to address issues in our jail and community. This led to a Peach/Crawford County Accountability Court and a consolidated mental health collaborative for the 2 counties. In 2024 we completed the U.G.A. Carl Vincent Institute's Sequential Intercept Model training.
What we are working on now: Between Peach and Crawford County we have a population of around 42,000 and have approximately 25 severe cases that keep recycling through our probate office's, crisis medical and and our jails. To try to fix this, we are trying to narrow the focus to the primary points of contact: crisis medical, law-enforcement, jail and jail medical, Probate Court (orders to apprehend), Magistrate Court (bond release conditions), and Accountability Court.

Primary concern: 1. To bring attention to the ones who used to receive state institutional care, (the difficult ones) these are the ones the community mental healthcare model has overlooked. 2. To bring attention to what is causing episodes of non-retractable behavior and harm from individuals in temporary psychosis.

The information in the following pages have been the findings in our area, and I hope it sheds light on systemic issues that may be hindering the success of community-based mental healthcare in our communities.

Wade L Yoder

Wade Yoder
Peach County BOC At-Large
CSB Board Member
Coordinator for Peach/Crawford
Mental Health Collaborative

Included in document: Legislation request, Timelines, Probate Judge letter, July 24, 2025 Executive Order

Legislation Requests for consideration:

- **Repeat OTA's, 1013s, crisis stabilization unit visits, and arrests (linked to mental health), should be used as a filter for high-need individuals and Assisted Outpatient Treatment:** using this collateral evidence is the way to screen for high-need individuals that are unable to regulate their own psychotropic medications and keep appointments. Implementing Assisted Outpatient Treatment (AOT) statewide for these individuals will shrink pressure on the state beds from a local level. GA DBHDD and our CSB's should collect this information to identify high-need individuals in our communities (that meet the same collateral evidence as ones that used to receive state institutional care). Our 22 state contracted CSB's should be requesting Assisted Outpatient Treatment (AOT) for these high-need individuals in our communities. There should not be 159 interpretations of the law throughout the state of Georgia for what is ethical in the care of a high-need mental health individual. Georgia contracted with the CSB's to fill the gap for high-need individuals when state institutions were closed, but these individuals are getting served in our jails instead of by our CSB's. The stabilization of these high-need individuals within the jails and their reentry, back into the community should have a standard of care and coordination, but instead its a broken path for erosion and recidivism.

- **Mandate that all mental health orders for evaluation (including OTA's from our Probate Judges), are entered into the DBHDD database:** without this, these individuals (sometimes transient and hard to keep up with) are going to continue to slip through the cracks along with exasperated families that give up on a system that is not working for them.
  Please see attached letter: from Peach County Probate Judge Kim Wilson. She echos the voice of probate judges across our state that see the disrespect in the lack of credence families (and the probate judges) get after issuing an Order to Apprehend (OTA) for mental health evaluation. The system is disrespected in that an entire OTA process, (family, probate judge, sheriff deputy's apprehend/transport) can be discarded by a short evaluation at the medical facility, where the individual puts on a short facade, refuses treatment and gets released. It is often said by sheriff departments and probate judges "after an individual is picked up and taken to a facility for evaluation, they beat the deputy back to the community."
  The Order to Apprehend (OTA) process in Georgia is extremely broken and operates in a separate silo that should be, (but is not) connected in with the DBHDD database.

- **Tracking and monitoring of high-need individuals:** if an individual is hard to keep up with, and has a history of being transient between communities, the responsible thing to do is to utilize ankle or wrist tracking devices. Leaving high-need individuals unmonitored along with the effects of an on/off cycle of psychotropic drugs (and still expecting them to make responsible decisions well, in psychosis) is dangerous for themselves and others. Cycling on, and off of psychotropic drugs has been proven to be mentally corrosive, and we shouldn't be surprised when it yields self-harm as well as psychopathic actions from these individuals who are in psychosis.

- **Cost sharing through a psychotropic drug tax:** pharmaceutical companies that are benefitting from the psychotropic drug industry should pay a psychotropic drug tax that would help cover tracking costs for these high-need individuals. With approximately 1/5 of our population (66 million) on psychotropic drugs it seems a reasonable ask.

- **Mandate Jail Medical Providers to provide the same standard of care for identified high-need individuals and collaborate with their local CSB:** individuals that are identified as high need individuals within the jail should fall under a uniform standard of medication stabilization care while in the jail and upon release (including bond release conditions that are coordinated with the local CSB). This is a good time to screen for high-need individuals and when an individual is identified as a high-need individual, the state should absorb at least a portion of the medication cost in the jail. Currently the continuum of care is simply not there throughout our jail system (among jail medical providers).

  For continuum of care after jail based restoration, there needs to be stabilization rails out into our communities (AOT gives stabilization rails out into the community and helps avoid medication and mental health erosion after re-entry).

  Without jail based restoration and a strong community AOT program, community-based mental healthcare will not succeed.

  *From what we have found in Peach and Crawford Counties: there would be a lot of value in our CSB providing a jail-in-reach service, (especially for the ones that are in their care, prior to incarceration). Without this there is a broken path back into the community for these high-need individuals because of the lack of communication currently between providers.

- **Sheriff Department resources are stretched thin and doing mental health transports often pulls deputies out of our communities:** our sheriff departments are not trained in the field of mental health, yet are tasked with care and transport of high-need individuals between facilities. These high-need individuals should be transported by mental health professionals through our local CSB's, not a transport that tends to escalate tension. This would keep the CSB engaged during the transport, stabilization, and then back into the community.

- **Community Service Board (CSB) CEOs direct supervisory authority should be Georgia DBHDD.**

  CSBs were originally contracted to fill the gap created by the closure of Georgia's state institutions. However, with 22 separate CSBs, there are now 22 different interpretations of what "community-based mental health" should look like in the areas they serve. When it comes to best practices for high-need individuals, we cannot have 22 different models. This lack of uniformity is the reason why individuals who once received structured care in state institutions fall through the cracks—often becoming homeless, cycling through crisis centers, or ending up in jails. Most states, centralize policies and procedures for mental and behavioral health standards of care, (even when service delivery is local or regional).

  Without all 22 CSB CEOs following a unified standard of best practice for high-need individuals (that meet the same collateral evidence of severe mental illness of ones that used to receive institutional care), community-based, mental healthcare will not succeed.

- **The need for a Mental Health Blueprint:** Communities want to do the right things, but they don't have the training that executives and staffing do in mental health institutions, or with DBHDD. If communities (especially ones with limited resources) are going to take care of these individuals, there is a need for a blueprint from DBHDD that gives a baseline standard of care so communities can easily identify where the systemic issues are coming from. It is not hard to identify the primary local intercepts that come in contact with high-need individuals; quite often this is the individual's family, the CSB, probate judge, law-enforcement, jail, and magistrate judge. When these primary intercepts are not working properly, there should be something that clearly identifies it.

Example Blueprint

- **In the community:** a probate judge should work with a family and the CSB on an Assisted Outpatient Treatment (AOT), request/order for a high-need family member, (when the collateral evidence is there to justify a high level of care and monitoring).

- **From the community into the jail:** the jail mental health service provider, the CSB, and magistrate judge should be in communication on high-need individuals that have been in the CSB's care in the community to ensure a continuity of care in the jail. At release, set bond conditions (such as a medication mandate and appointments being kept) with the local CSB after stabilization in the jail or refer to Accountability Court (if a community has one). The local CSB should be providing an in-reach service in the jail, to care for the individual in the jail and to ensure a high need, individual does not slip through the cracks after reentry.

- **Release from the jail back into the community:** communication needs to happen between the Public Defender, District Attorney, Magistrate Court (in coordinating bond release conditions) and the CSB, for a continuity of care for these high-need individuals when they re-enter the community. If the bond conditions are not met, the CSB needs to report this to the Magistrate Court/arresting agency, (preference is that the same officer or deputy picks individual up when bond conditions are not met).
  Magistrate Court/Accountability Court: if a community has an Accountability Court, the Accountability Court Director, District Attorney's office, and the Magistrate Judge should work together for referrals into the accountability court program and oversight by the treatment team.

- **Continuum of care in the community:** Monitoring technology (tracking and medical monitoring) implemented for ones that have a history of becoming medically destabilized and becoming a potential harm to themselves, and (or) others.

Part 2. Over Prescribing of Psychotropic drugs

This is a federal issue but its effects are happening at a local level.

1. The qualifying bar needs to be set higher to be a prescriber of psychotropic drugs: the current model is set up for massive psychotropic drug distribution through ones not licensed in psychiatry.

2. Psychotropic drug use history should become public record for investigations when there is a homicide, homicide attempt, or suicide: the current medical privacy model serves to protect the psychotropic drug industry and seems to be covering causation of death and public risk on a broad scale.

- **General population is over-medicated with psychotropics:** prescribers that are prescribing powerful psychotropics do not have to be licensed in psychiatry (but yet they can prescribe medications that can psychologically alter chemical processes in the brain). Approximately 1/5 of our population (66 million) are on psychotropic drugs (see attached chart and timeline for antidepressants).

    - **Potential link:** there appears to be a link between increased psychotropic drug usage, rising suicides and homicides that seem psychotic in nature (a temporary psychopath). Is this another public health failure similar to the opioid epidemic? Should we feel confident that practitioners, (not licensed in psychiatry) being the primary distribution point for psychotropic drugs, are not fueling a psychiatric crisis?

      Variable usage: there are many variables of usage with 66 million individuals being on psychotropic drugs, (such as suddenly discontinuing, or mixing other drugs, and alcohol with psychotropics). When someone does the most harm they can do, it is usually inward directed (suicide) or outward directed (mass homicide) and it seems we have laced our country, states, communities, and schools, with additional risk (much like powder kegs that occasionally get lit). It's hard to go 3 days without seeing a local or national headline of a murder, mass murder, or attempt that appeared psychotic in nature.

- **Usable data:** usable applicable data seems available with our rising suicide rates, and increased jail populations (where mental instability is or was a factor). For years the CDC and FDA seemed to the damage caused by the pharmaceutical industries broad usage and application of opiate painkillers while addiction and death rates were skyrocketing in plain sight. Are we doing this again? Is mass usage of psychotropic drugs and temporary psychosis our new "unpredictable public safety risk?"
  At what point do city, county and state officials have a responsibility to recognize failure in federal policy at a local level (where the problems are occurring at)?

Suicide and Our Community

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. Timelines appear to closely correlate with widespread psychotropic drug usage (see attached 30 year timelines for suicide and antidepressant usage), they almost mirror each other and shouldn't be ignored.

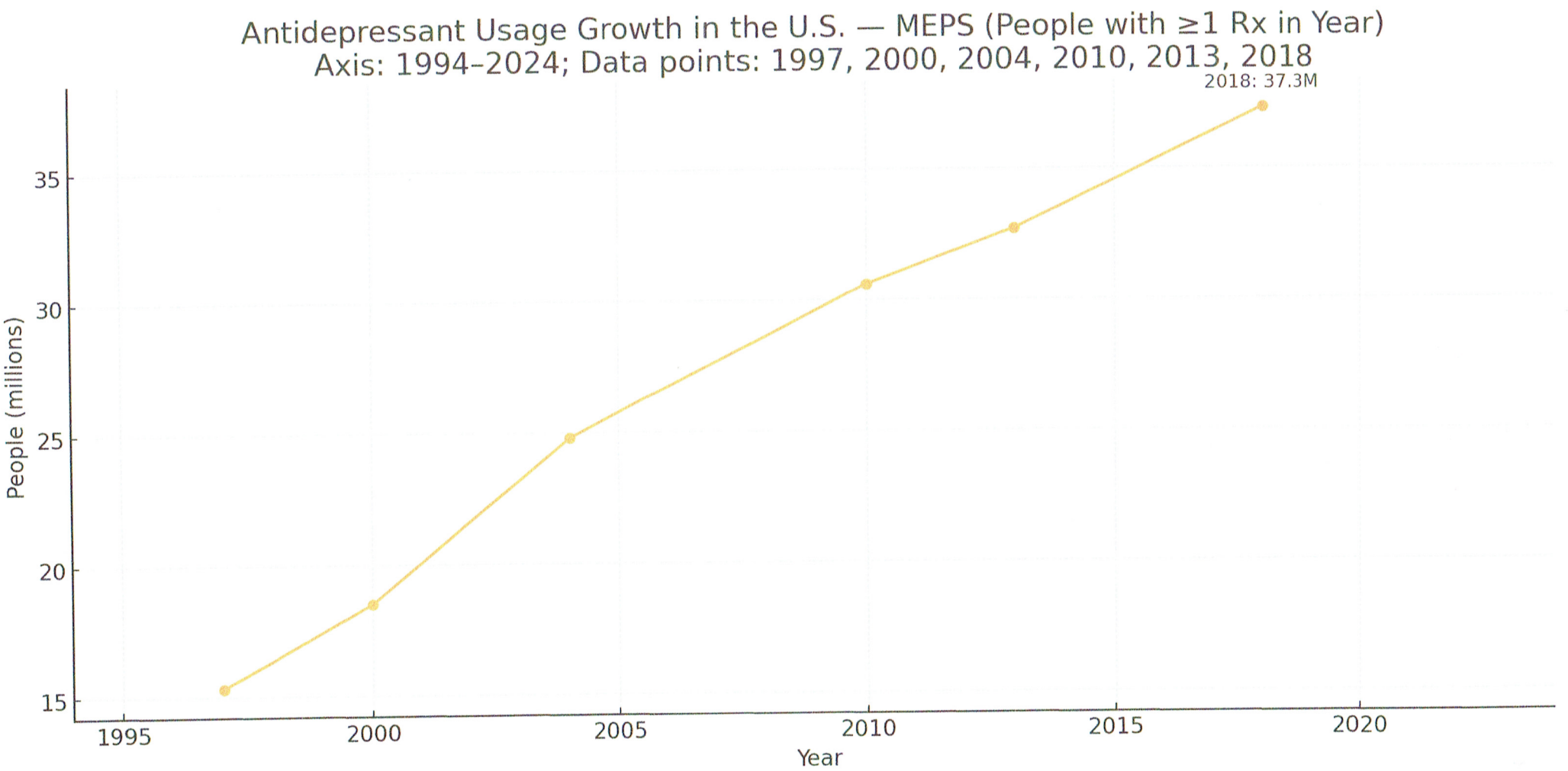
Here in our area of Peach and Crawford Counties, there were 3 individuals I personally knew who ended their lives in the past several years. One was a friend and member of my health club who came in to renew his membership on a Monday after a month-long absence, and on Tuesday morning, he ended his life.

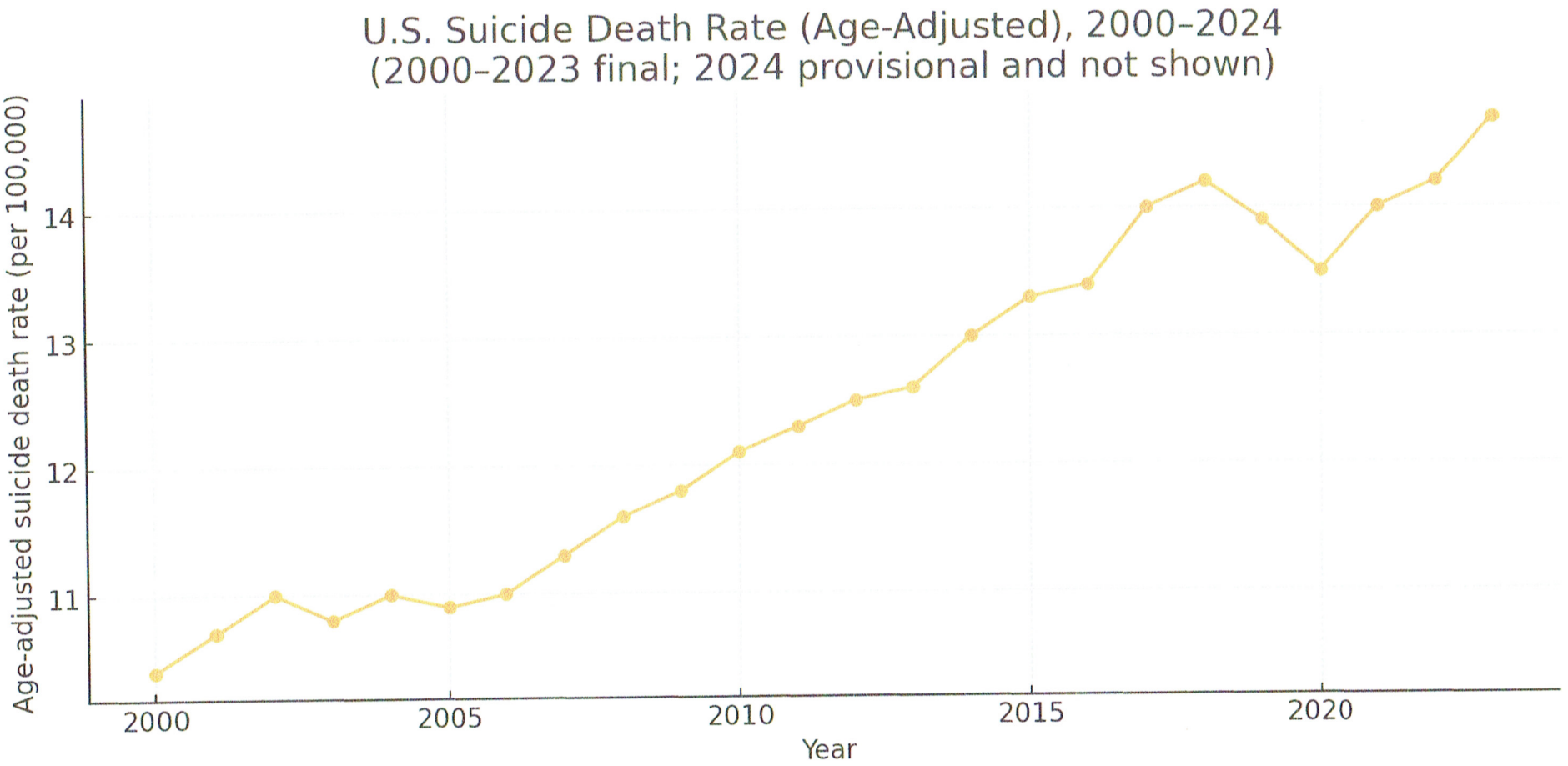
A community member that I had been working with on a project; stopped by my office to thank me for the progress we had made, I will never get to see or speak with her again. A very prominent farmer, one I also considered a friend—took his own life in his pecan orchard. A mother of two teenagers—her son served as a chaplain in our local high school FFA program and she tragically ended her life. Years ago (on a more personal level), my first cousin left work on

his lunch break and ended his life. My business neighbor's son did the same. While I was attending his visitation, I spoke with a friend and mother of one of my young health club members; within a week, he also took his life.

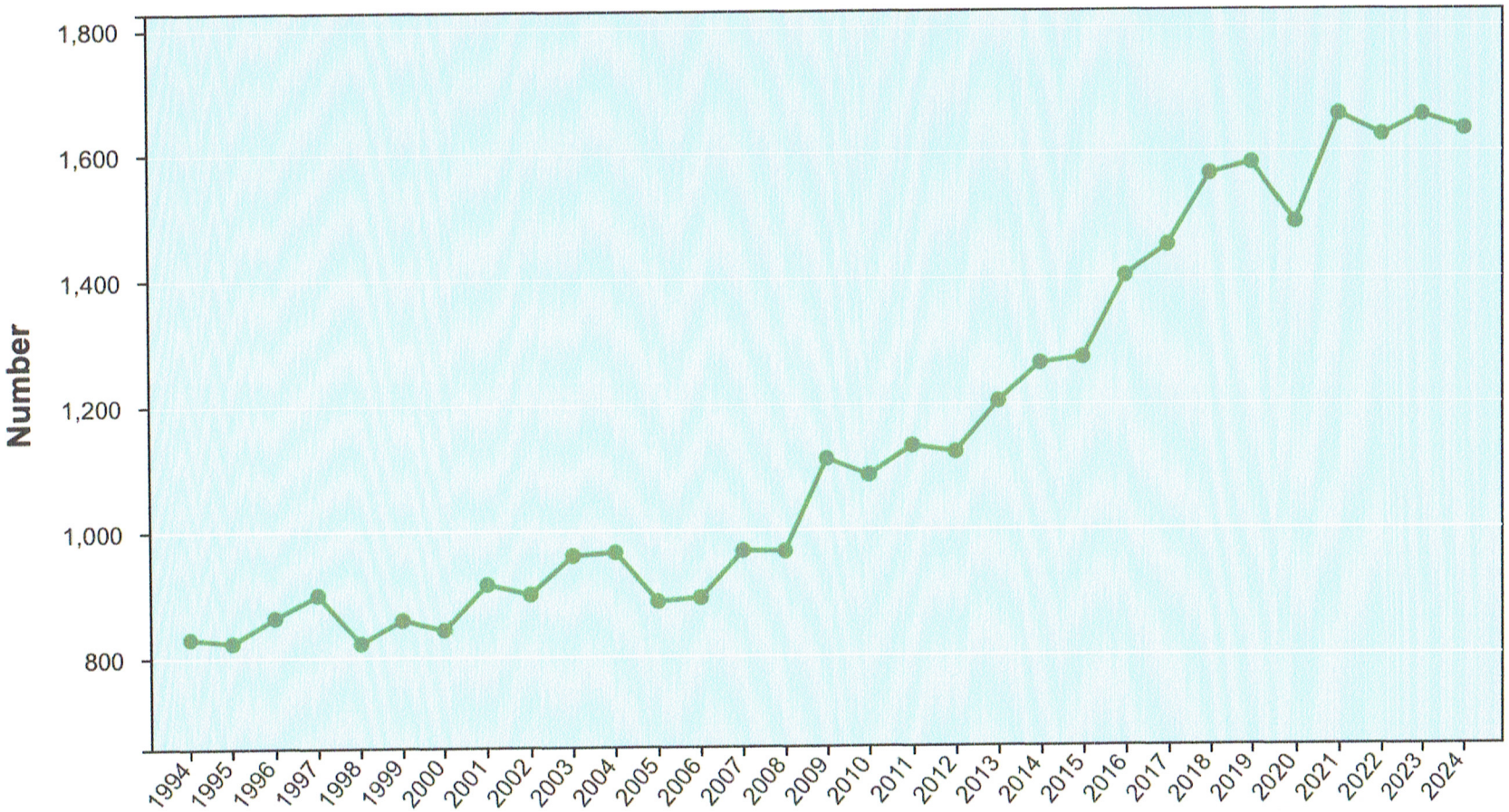
I share these stories not only as a memorial to them, but to urge you to reflect on how often similar tragedies have occurred in your own life and community over the past 10-15 years.

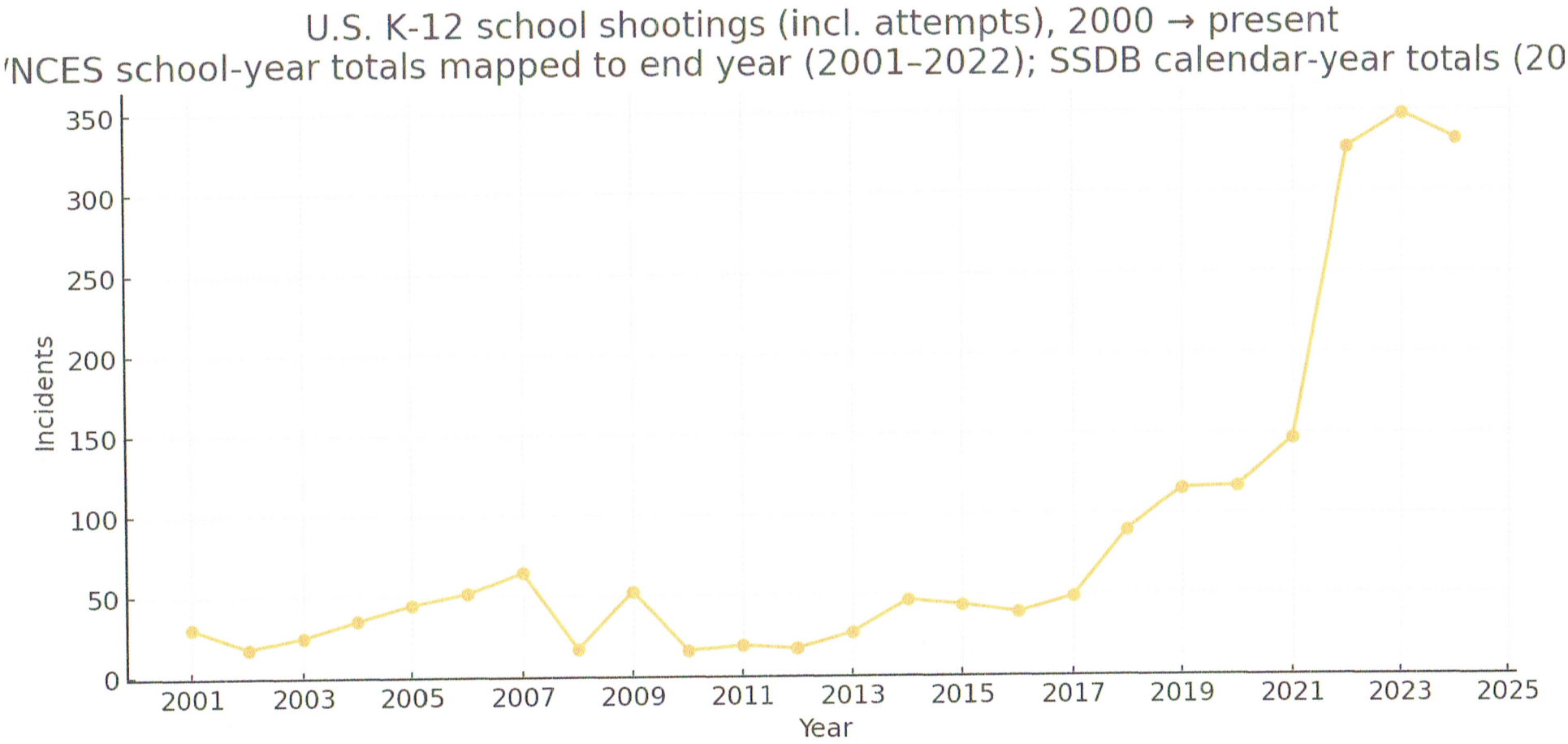
Please see attached 30 year timeline of antidepressants and suicides.


Antidepressant Usage Growth in the U.S. — MEPS (People with ≥1 Rx in Year)
Axis: 1994–2024; Data points: 1997, 2000, 2004, 2010, 2013, 2018
2018: 37.3M
People (millions)
35
30
25
20
15
1995
2000
2005
2010
2015
2020
Year


U.S. Suicide Death Rate (Age-Adjusted), 2000–2024
(2000–2023 final; 2024 provisional and not shown)
Age-adjusted suicide death rate (per 100,000)
11
12
13
14
2000
2005
2010
2015
2020
Year

Number of Deaths, Intentional Self-Harm (Suicide), Georgia, 1994-2024




U.S. K-12 school shootings (incl. attempts), 2000 → present
'NCES school-year totals mapped to end year (2001–2022); SSDB calendar-year totals (20
Incidents
0
50
100
150
200
250
300
350
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021
2023
2025
Year

Homicides and attempted homicides that appear psychotic in nature

When was the last time you went for more than 3 days without a news event that sounded psychotic in nature? Line-up the past several years headlines, school shootings, church shootings, mass-vehicular homicide, stabbings, and we should know there's a problem.

Here are few that happened over the past 18 months:

September 2024, a Kentucky sheriff walked in and shot and killed a local judge.z
December 2024, a Georgia judge killed himself on the bench in his courtroom.
June 2025, Major Travis Decker, 32-year-old ex-Army Ranger accused of suffocating his 3 daughters, and ditching their bodies at a Washington state campground.
June 2025, Warner Robins, GA 88 year old kills his wife and himself in murder suicide.
July 2025, Traverse City, Michigan Walmart mass stabbing.
July 2025, 17 year old kills mother and stepfather in family's Carrollton home.
July 2025, Taylor County, GA man with known mental health issues kills aunt.
August 2025, 5 soldiers injured in Fort Stewart, shooting by a fellow army sergeant.
August 2025, CDC shooting resulting in death of officer.
Aug 2025, Huntsville, AL. Father and 1-year old son found dead in home after murder suicide.
August 2025, semi truck driver has standoff with law enforcement at Galleria Mall in Centerville, GA. Shots were fired, resulting in officer wounded and truck driver's death.
August 2025, Minnesota Catholic school attack.
August 2025, Iryna Zarutska stabbed to death in front of onlookers on train.
August 2025, Teen girl, dentist among 3 dead in Johns Creek murder-suicide.
August 2025, A man killed his mother and himself after conversing with ChatGPT.
September 2025, gunman opens fire at Michigan church and sets it ablaze, killing at least 4 and wounding 8.
October 2025, Angleton, TX mom shot her four children, drove to gas station and called 911.
October 2025, shooting at pet South Carolina bar kills for an injures at least 20 others.
November 2025, Wrightsville, GA fire fighter has arm cut off by assailant with a sword.
December 2025, Warner Robins man receives 20 year sentence for murdering his brother during fight over woman. He said he loved his brother and he was sorry.
December 2025, millionaire mental health entrepreneur, 41, has huge meltdown at upscale bay area winery before going on rampage in his Tesla.
December 2025, woman suffer severe burns after man allegedly throws acid on her while walking at Park in Savannah.
December 2025, former police captain shoots and kills mother and then dies by suicide during traffic stop on I-75.

These decisions whether homicide or suicide (on a scale of 1-10), are as messed up as you can get it, however…

Good and bad decisions on a scale of 1-10: we have seen mental health crisis prevail itself tragically through suicide, and 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). Crisis, medical and law-enforcement are seeing this constantly unfold around them. Should any law-enforcement officer feel at all secure with their life or their family's future, when we are growing this crisis by putting more and more individuals on psychotropic drugs?

It seems we are fueling our mental health crisis, by both lack of monitoring and medication stabilization (for the severely ill) and over-usage of psychotropic drugs (for general population). As a commissioner, I cannot fail to do what I can to bring attention to these 2 issues. I do not take your time for granted, and thank you in advance for your time and consideration in a matter that all the counties in Georgia signed a resolution to resolve. We can make community based mental healthcare succeed at a county level, but need your help.

Sincerely, Wade L. Yoder
Peach County Commissioner At-Large

Cont. Probate Judge Letter, President's Executive Order

PEACH COUNTY PROBATE COURT
STATE OF GEORGIA

PROBATE COURTS AND THE MENTAL HEALTH WORLD

In Georgia, an Order to Apprehend, often associated with the Probate Court, is a legal document used to authorize the apprehension and evaluation of individuals believed to be mentally ill and in need of involuntary treatment. It directs law enforcement to take someone into custody for evaluation at an Emergency Receiving Facility. The Court does not issue orders for persons who are currently incarcerated or in the hospital, as there are other remedies available. An Order to Apprehend is for an evaluation only and it is not a guarantee of treatment or admittance into any hospital facility. Upon evaluation, the medical professionals determine if further involuntary treatment is necessary.

For a Probate Judge to issue an Order to Apprehend the person experiencing a mental health crisis must be at least 17 years of age or older. Also, two individuals must come to the court to complete an affidavit. Those individual must swear or affirm in an affidavit that they have seen the person in the preceding 48 hours and based upon the observations contained in the affidavits, the Affiants must explain what they have observed that gives them reason to believe such person is a mentally ill person and is an imminent danger to themselves, or is unable to care for their own safety.

When families, friends, and loved ones come to the Probate Court for an OTA they are desperate for help. They have turned to this resource or that resource to no avail and they don't know where else to turn. Unfortunately, our hands are tied to an extent, and there's only so much we can do to help them. Collectively, that is one of the biggest frustrations among Probate Judges across the state. For me, it's the repeated cycle of OTA's on certain individuals that are not receiving the treatment they desperately need. The individual is often released after a few days, and the cycle continues. Many times, the individual will evolve into criminal behavior resulting in incarceration. The individual has assaulted their loved ones, destroyed their property, threatened their lives, etc. Most times they are afraid in their own homes, but they don't want to put their loved ones out on the streets or press charges because they don't want to make things worse.

I truly hope that with a collaborative effort we can find better solutions for these ongoing issues within the mental health world. We owe it to the individual, the families, and the communities that we serve.

Sincerely,

Judge Kim Wilson

Peach County Probate Court

Executive Order "Ending Crime and Disorder on America's Streets" (July 24, 2025)
Key Provisions

- Declares rising vagrancy, disorderly behavior, violent street encounters, and homelessness a federal public-safety priority, noting that most individuals living unsheltered have serious mental illness or addiction.
- Directs the Attorney General (with HHS and HUD) to seek reversal of federal and state court rulings and consent decrees that restrict civil commitment of individuals with serious mental illness or addiction who are living on the streets and pose risks to themselves or others.
- Prioritizes federal funding for states and municipalities that:
    - - Enforce laws against open illicit drug use,
    - - Ban street camping, loitering, and urban squatting,
    - - Maintain accurate sex-offender tracking, including for those with no fixed address.
- Redirects federal grants toward:
    - - Institutions,
    - - Treatment centers,
    - - Assisted Outpatient Treatment (AOT) programs, and
    - - Civil commitment pathways

for individuals with serious mental illness or addiction who are experiencing homelessness.

The order also prohibits directing federal funding toward drug injection / safe consumption sites or programs permitting illicit drug use.

- Orders HHS and HUD to increase accountability in federal homelessness programs by:
    - - Requiring participants with serious mental illness or substance use disorder to engage in treatment as a condition of receiving federally funded housing or services.
    - - Preventing sex offenders in federally funded homelessness programs from being housed with children.
    - - Allowing the creation of women-only facilities.

- Requires coordination across DOJ, HHS, HUD, and Transportation to evaluate discretionary grants and give preference to jurisdictions using AOT, treatment-linked housing models, and civil commitment tools to reduce street disorder.