NAMI Ask the Expert: Help, Not Handcuffs
Part 4: Implementing a New System
Thursday, May 20, 2021, 4:00 - 5:30pm EST

Featuring Panelists:

- **Mary Burckell**, Director, Safe Haven
- **Nick Richard**, Executive Director, NAMI St. Tammany
- **Tom Rowan**, Project Director and Peer Support Specialist Supervisor, NAMI St. Tammany
- **Judge Alan Zaunbrecher**, 22nd Judicial District Court, Louisiana

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Dan Gillison, Chief Executive Officer, NAMI (00:00:01):

Good afternoon and good early day to those of you that may be in the west. We're really appreciative of you being here, and on behalf of our board, our board president, Shirley Holloway, our staff, and our field leaders and alliance, we'd like to welcome you. Thank you for being here for this part four of our series on Help, Not Handcuffs.

What I'd like to do is to now hand it off to our chief medical officer and the moderator for today's Ask the Expert, our CMO, chief medical officer, Dr. Ken Duckworth. Ken?

Ken Duckworth, Chief Medical Officer, NAMI (00:00:36):

Thank you, Dan. Hello everybody. I think you're going to love today's presentation. This represents the culmination of what we've been trying to do in offering the best models in crisis care, alternatives to some of the outcomes that we've seen in the country. So we've seen Steve Leifman's work and his whole team for jail diversion in Miami-Dade county, the leaders from CAHOOTS, the now nationally famous program from Eugene, Oregon.

Last month, we had leaders from Arizona and Georgia who have worked for years to put together a creative program of crisis diversion, one-stop shop for finding help. Today we're very fortunate to be traveling to St. Tammany Parish in Louisiana, where the food and music are optimal, and so is the community collaboration in creativity. One of the things that's important about this is this has a how-to dimension to it, and how they created it is remarkable.

The four speakers today from this project are Nick Richard, who's been the executive director at NAMI St. Tammany since 2008. Then he'll be followed by his colleague, Tom Rowan, who's the project director and peer support specialist supervisor, who also came in 2008. I'm sure there's a story there. Judge Alan Zaunbrecher, the 22nd judicial district court judge for this program. He both does the mental health court and the assisted outpatient treatment court. And Mary Burckell, who's the director of the Safe Haven Project, who has a lot of community engagement experience that she brings to this project.

So you'll see me again for the Q&A. We encourage your questions. We have an all-star team assembled from St. Tammany, and we welcome your input and questions. So Nick, you're going to lead off and then hand it to your colleagues. Again, I want to thank you for joining us today and teaching us about your work.

Nick Richard (00:02:55):

Thanks, Doc. As mentioned, my name's Nick Rich, I'm the executive director of NAMI in St. Tammany. We're honored to take part in this series. When I saw the rest of the lineup, I was a little bit more than honored. I was a little shocked. So when I see the work that... We all hear about the wonderful work that's going on in Miami and the work that's going on in Oregon. I was shocked because the scope and size of these well-functioning systems is just really tremendous. I wasn't shocked that we were included because I don't believe we have the skill there, but the scope and size is just so different.

So again, I got to thinking, "Well, that's precisely the reason that we're here, St. Tammany Parish." We've all heard of Miami and Eugene, Oregon, but not many people have heard of St. Tammany Parish. We are, in fact, a small bedroom community of New Orleans located just north of New Orleans. Again, we're a parish. You guys call them counties, we're the only state that has parishes. We are a very large geographical area. We have no public transportation, but the size and population of our community brings with it both difficulties and opportunities that larger communities do not have.

There are many things that led to our crisis system, and no, I'm not going to go through each one of these, but as our presentation goes on, we're going to touch on but a few of these things. My role here, especially in the beginning along with my colleague Tom, is to talk about some of the key issues that led to the change and formation of our system.

One of the first ones that happened was Hurricane Katrina. In 2005, Hurricane Katrina devastated Southeast Louisiana, taking lives and homes. While we're still accustomed to dealing with hurricanes in this particular part of the country, where we were not accustomed to and we were not prepared for was the disaster that came a year and a half to two years after that. What happened was, a massive community trauma resulting in sharp rising rates of completed suicides throughout our region. With that broad, it forced elected leaders to come together with community agencies, thrusting mental health into the spotlight into our community. This was one of the key jumping-off points for mental health being a topic in St. Tammany Parish. Now, I'm going to turn it over to Tom Rowan to talk about one of the second aspects. Tom?

Tom Rowan (00:05:33):

See, my camera’s not working, but I have been told I have a good face for radio, so maybe it's a blessing. I am Tom Rowan. I have been with NAMI since August of 2008. Since Dr. Duckworth said there was a story behind that, I'll say I came on board with NAMI four months before Nick Richard, our executive director. He always asked me to say that so that you will know that he is not responsible for me.

Talking about Southeast Louisiana State Hospital, however, is something that I have so looked forward to being able to do. I spent four years at Southeast Louisiana State Hospital working for NAMI St. Tammany. It was literally four of the most enjoyable and rewarding years of my life. Southeast Louisiana Hospital was a very, very special place and had some very, very special people. But the thing about Southeast Hospital that is more special than anything else is how they embraced early on the SAMHSA recovery model and the Behavioral Health Model of recoveries. Behavioral Health Model, of course, states that an understanding of the fact that most people with brain chemistry issues or co-occurring individuals, meaning that they probably have what were viewed as classic mental health issues, as well as substance abuse issues at the same time. That if you don't treat them both, you're not effectively treating either one.

Tom Rowan:

Southeast Hospital was probably the only mental health facility in the state of Louisiana that fully embraced that, and really did a wonderful job. I view the acute unit of Southeast Louisiana Hospital for adults as the primary behavioral health unit in the state of Louisiana, the first one that's fully embraced that concept. As far as the SAMHSA recovery model, that's stated very simply. In the old days, if I walked into an acute unit as a client or what they used to call patients, that if I was the client in an acute unit in a hospital under the old medical model, there would have been somebody in that hospital whose first name was Doctor. That man whose first name was Doctor would have known what was best for me, what I wanted, what my goal should be, what my treatment should be. He would tell me, and my job would be listen.

The SAMHSA recovery model turned that on its head. It said, indeed, that if I walked in as a client in an acute unit or in a hospital setting, that in the treatment team, the most important member of that treatment team would be me, not the doctor. It's not that the doctor wouldn't be important, but it recognize that I am the one who knows the most about me. I know my history, I know my wants and my needs. I pretty well can tell people what has worked for me in the past and what has not worked, and as such, that makes me the most valuable member of that team.

Southeast Louisiana State Hospital fully embraced that. As a matter of fact, along with that, they embraced NAMI principles and the principles of peer support. Again, I've been with NAMI for 13 years. My very first job with NAMI was on an acute unit of a psychiatric facility that was Southeast Louisiana Hospital. I was actually the first person in the state of Louisiana to serve as a peer support specialist in an adult acute unit. We didn't call them peer support specialists at that time because the peer support movement was just getting started. We were actually called client and family liaison. What we were charged with when we were hired was to offer education, support, resources, and advocacy to the clients and in the hospital.

I know those words ring with every member of NAMI; education, support, resources, and advocacy. If that isn't familiar, then you haven't been around NAMI very long. Southeast was a remarkable place, very, very complete campus in terms of what they offered in behavioral health treatments. There were adult acute units, adolescent acute units, residential housing. Southeast Hospital served more than 200 individuals on site at various levels of care, from acute care to intermediate care. Intermediate care, I might add, I'm proud of that term.

Prior to the SAMHSA recovery model coming in play, and the idea of recovery language being important, those units, which we renamed immediate units, were known as long-term units. Wouldn't it be a terrible thing to be a client going into a hospital and being told that you were going into a long-term unit? Talk about take the hope away from people immediately. The idea of intermediate unit is so much more positive. It suggests that there's something else at the end of the tunnel.

The embrace of peer support services by Southeast was extraordinarily important. As far as peer support services at Southeast and in Louisiana, and their history, and how they coincide, both NAMI St. Tammany and Southeast Louisiana Hospital developed peer support services when they were in their infancy in the state of Louisiana. NAMI itself, when you talk about peer support and the peer support model, NAMI should recognize that very well, because when you think about it, all of the NAMI signature programs are based on the idea of peer support. Whether it's peer to peer stuff or family to family stuff, it's peers helping peers and modeling different stages of recovery and answers in their lives.

Tom Rowan:

That of course, though, is a volunteer-based organization and a volunteer-based protocol. What Southeast wanted to see, what NAMI St. Tammany wanted to see, and what the state of Louisiana wanted to see was professional peer support services. Of course, moving into the idea away from volunteerism into professionalism, where you have paid peer support services, that requires certain things, and it all starts with specialized training.

The state of Louisiana, when they finally decided to certify peer support services, engaged the services of Recovery Opportunity Center, also known as RI Consulting out of Arizona. They provided a 72 hour or two-week long training for peer support specialists, which serves, still today, as the training that most peer supports specialists in Louisiana receive. There is another outfit that provides training as well, but I have to say that Recovery Opportunity Center's training, in my view, is far superior.

NAMI St. Tammany also recognized, however, that the state of Louisiana, even to this day, doesn't have a well-defined organization on a state level that licenses and regulates peer support specialists. So we, on our own, developed some important things, because I think one of the things that designates a professional or a profession is that that profession will have a code of ethics.

NAMI St. Tammany has developed a code of ethics, principles of practice, and a statement of core functions, I think, would rival any professional organization that you could name. I might add that we owe a great deal in our principles of practice development to NAPS, the National Association of Peer Supporters, which was formally known as iNAPS, interNational Association of Peer Support Specialists. But we do have those three documents, and certainly, anybody who's interested in receiving copies of those, we do share. Our contact information is available at the end of this presentation. We will be glad to furnish those to anyone who's interested.

NAMI St. Tammany has been a significant employer of peer support specialists. We typically average in any time between nine and 13 full-time peer support specialists employed in various modalities. Right now, we employ 10, and within the next couple of months, we envision employing as many as 14. We've always been if not the largest employer of peer support specialists in the state of Louisiana, certainly right up there close to the top.

In the court system, which of course we're dealing with significantly in today's presentation, our peer support specialists deliver things that are very, very important to defendants or court clients as we view them. That would be mutuality and confidentiality. It is real important we think for the peers to go into the court system and let the defendants know that anything that they say to us is confidential and won't be passed on to judges or probation officers, or even clinicians, unless of course, it's something that involves them being a danger to themselves or others. At that point, of course, we're mandated reporters. But it's very important, in the court system, for that confidentiality and mutuality to take place. Frankly, that's a difficult thing for certain segments of the court system to accept initially. But the 22nd Judicial District Courts have been very, very successful in accepting that.

Talking again about Southeast Hospital, if I may, unfortunately, in 2012, we had a very common experience at that time that we share with a lot of people throughout the country, because Southeast Louisiana Hospital was closed. I know at that time, 2012, throughout the country, hospitals and residential programs were closed. Unfortunately, in many cases, for political reasons. It was a big move to cut costs in state government and lower taxes. That's what was really important and, certainly, was paramount in Louisiana at the time.

Tom Rowan:

Of course, when hospitals and other resources are closed down, we're always promised that community resources are going to appear as replacements, and they're going to be better than what was left. Nothing is really going to be lost. No beds will be lost. No housing will be lost. No resources will be lost.

But unfortunately, as most of us know, those promises are very rarely delivered. In Louisiana, I can tell you that, unfortunately, they weren't delivered. The closing of Southeast Hospital was a tragic event that I still mourn. Literally, right before the closing of the hospital, the hospital had received an audit by the Joint Commission, which referred to Southeast Louisiana Hospital as a beacon of light in the darkness of mental health care. And within months of receiving that audit from an agency whose business was not praising hospitals, it was finding what was wrong with them.

So after being called a beacon of light in the darkness of mental health care, the hospital was closed for political reasons. It is, unfortunately, something I know that a lot of folks... or an experience shared by a lot of folks listening to this presentation. The political reason was, of course, was that privates are supposed to be better than publics in providing services. What we all know is that private hospitals and other private agencies are not better or worse than state-run agencies. They're just different. This isn't a knock on private hospitals that perform a great service, but public hospitals like Southeast Hospital perform services that private hospitals can't because they're beholding to their stockholders and they're there to make a profit. That's why often people are discharged from units when they still need extra time in those units to recover and can't be afforded.

So again, that's just one of those things I mourn for Southeast Hospital, and I mourn for the loss of resources throughout the country. Both St. Tammany Parish and the 22nd Judicial District Courts stepped up and really helped when Southeast closed. One of the things that has been traditional in this area, the 22nd Judicial District Courts have always had specialty courts which have assisted people with behavioral health issues, whether it's behavioral health court, AOT, or the drug courts.

You see a picture there of the late Judge Peter Garcia. It was my privilege to work four years with Judge Garcia when I was behavioral health court case manager for that period of time. He died last year. That's a loss that I still feel when I mourn. He was one of the most brilliant men I've ever met, and he was dedicated to the field of behavioral health and mental health. His loss was felt not only in the court system, but in the behavioral health system, in our state and throughout the country. Judge Garcia was well-known.

Judge Garcia started behavioral health court and started drug courts in our area. We're very happy that in his stead in behavioral health court, Judge Alan Zaunbrecher has taken over. Judge Zaunbrecher not only has taken over behavioral health court, but also AOT court. Both of those are very, very important modalities. Judge Zaunbrecher is more capable than I am of talking, but before he speaks, I just want to say this about the judges in the 22nd Judicial District Court. These men and women deserve our thanks day and night. The judges who serve in these specialty courts serve on their own time. They volunteer their time. All of them have very, very busy dockets, and they don't have to do this, but they do it because they recognize the need. Judge Garcia did that, and Judge Zaunbrecher continues in that tradition. I am very, very pleased to turn the presentation over at this time to Judge Zaunbrecher.

Judge Alan Zaunbrecher (00:22:04):

All right. Thank you, Tom. I appreciate it very much. So what is our solution? We're not saying that how we do it is the only way to do it. We're not saying it's the best way to do it, but we're saying that this is how we do it and this is a method that has, frankly, met with some success. It starts basically, of course, with two things, hard work and money. By hard work, it's not just for the hands-on providers to the participants in our specialty courts, it's building relationships, building partnerships with every stakeholder, even those that may only be peripheral. But when you need them and you need their help in your particular court, behavioral health, or AOT, or drug court, or whatever it is, they're there.

I'm going to list a few of those that maybe you haven't thought of. Some of them, of course, you have. The prosecution, the district attorney, we call it. You may call it the prosecuting attorney. Public defenders, court administration. We have a specialty court coordinator that oversees all our specialty courts. We have case managers, program managers for the individual specialty courts. Probation and behavioral health court, they're probably more important than the district attorneys. All aspects of treatment, anyone that provides the services, some of them specialized, some of them general that we need in this area, you need to establish a relationship with them.

Transportation services. Transportation is so often a problem with people. They can't get to their screen, they can't get to their counseling session. Communications experts. Today with email and Zoom, everything is instant. Everything is instant communication. You need a specialist in communication, a tech person. Housing assistance. At this level, one of the first things we've got to make sure is they've got a place to lay their head at night because that isn't always the case. You have to have somebody on hand. Obviously, local, regional mental health advocates, assistance programs. Then also on the financial end that I'm going to get to, a grant specialist, someone who can help you seek money. And of course, the judiciary.

As Tom said, when you get elected judge of 22nd, there's not a question about whether you're going to handle a specialty court, you're going to handle a specialty court. That's how we operate, and we embrace them. We'll swap them occasionally every three or four years. You may take reentry court or drug court, or a family preservation court, or a veterans court, but you're going to stay involved.

We also have what's called a Crisis Intervention Unit with the St. Tammany Parish sheriff's office. These are specially trained officers who were called when it is apparent that there is a mental health issue involved. Initially, there were four or five officers that received a training, and then the rank of those officers went for additional training and became instructors in crisis intervention for the officers. Now, they can instruct and certify officers. All officers receive some crisis intervention training, but for the crisis intervention team, they receive an enhanced level of training. Now we have two instructors who can certify people as being trained in crisis intervention. They train not only the St. Tammany Parish sheriff's office, but other law enforcement agencies around our district.

You need to have a relationship with someone who can perform medical assessments, because so often, there's an underlying medical problem that, because of their mental illness or because of their addiction, they're not taking care of themselves and things that can be taken care of. Diabetes, for example. We have a person in AOT, which is assisted outpatient treatment that I'm going to get to in some detail, who has treatable, controllable diabetes, but because of the mental illness, doesn't take care of himself. Sometimes that's as big a problem as his underlying mental condition.

Judge Alan Zaunbrecher:

The clerk of court, you have to have a relationship with the clerk of court because so many things you need served and delivered, and so forth, to satisfy the legal process. You need to have a relationship with a public benefits specialist, who can direct the participants in your court with regard to social security, social security disability, Medicare, Medicaid. Any other form of public assistance for which they might be eligible, that can help their overall status, you need somebody.

Local and state legislators. I was telling Nick earlier, we have a situation where they're trying to amend one of the bills that pertains to our specialty courts. You have to have a relationship with your local and state legislators to be able to call them and say, "Hey, we've got a problem with this, and we need your help on this." Another public official that we have a relationship with that's very important to us is the coroner. Now, I know in many states, probably every other state, the coroner doesn't have anything to do with mental health issues, but in Louisiana, they're critical. I'm sure wherever you are, they have some public official that serves that function.

I'm talking about for temporary restraining and things, but for AOT court, again, which I'm going to get to, the coroner is instrumental in concurring that this person is someone who needs the services of assisted outpatient treatment. So establish long-term relationship, get them invested in your program. So when you call, they're happy to, and they're proud to say, "Hey, we help the behavioral health court."

All right. The second thing is money. By money, I mean, it can be money, it can be services, volunteer services or donated services. Tom mentioned earlier, no-lunch Wednesdays. This was a phrase that Judge Garcia coined. We have people that come in, they give up their lunch hour on Wednesdays at 12 o'clock. We staff every participant in behavioral health court, and at one o'clock, they come in and stand in front of the court. I ask them, "How are you doing? Did you make work this week? You missed your screen on Tuesday," and so on and so forth. So volunteer services are important, but you need to identify any funding source or services that are available. That's why I mentioned a grant specialist. Someone who has experience in filing these grant applications can help fund these courts.

I can tell you that SAMHSA gave us a sizeable grant to start our AOT court. Without it, we couldn't do it. But there are other sources available. Our Supreme Court has a fund that supports many of our specialty courts. We have a Northshore... because that's the area that we're called, Northshore of New Orleans... Court Foundation. They do tremendous work to help support a number of causes, but particularly our specialty courts. If you have somebody in your jurisdiction that's a real go-getter and wants to make a difference, and wants to change things, get them to start a court foundation. People often are willing to give to a foundation when they know it's going to be for good things. They may not know what a particular court does or understand it, but they say, look, they're supporting these specialty courts, they're supporting this cause or that cause. If it's done right, it can be very, very beneficial.

So what are our models? What do we do? I'm going to start with BHC, and I'm going to have to go pretty quickly because time's going to get short on me. We, of course, have a specialty court coordinator to oversee all our specialty courts. I think we actually have nine because we have multiple divisions of some, and we have a case manager for every specialty court who handles the day-to-day operations, the contact with the participants and the service providers. They put out fires. We have 50 people in behavioral health court, and that's the maximum we're allowed to have. The case manager helps perform evaluations and assessments to see if they're appropriate.

Judge Alan Zaunbrecher:

Where do we get our referrals? Well, of course, we get them from a number of sources. Other judges who have people coming to their courtroom that they believe might be appropriate for behavioral health court, they send them for assessment. Probation is a source. Pretrial services. We have a program where we try to identify, shortly after arrest, those that may benefit from pretrial services. They may be eligible for a specialty court. They may be eligible for diversion, they may be eligible for something that gets them treatment, gives them a chance, keeps them out of jail.

Then, of course, attorneys. Not only the district attorney, but private attorneys see individuals and say, "Hey, I believe this person would be appropriate for one of the specialty courts." They're assessed. They cannot have committed a crime of violence or a sex crime. We've fudged a little bit on the crime of violence because there's a couple of crimes that are technically called crimes of violence but aren't. Aggravated obstruction of a highway or something like that is a crime of violence. But if it's not a terrible crime and they're appropriate otherwise for our specialty court, we will admit them.

For the behavioral health court, of course, they must have a history of mental illness. They must be competent to stand trial and to understand what they're doing, but they must have a history of mental illness. Now, what is a history? Well, it could be treatment. It could be medication, it could a diagnosis, it could be hospitalization. It could be a temporary commitment, or it could be something in medical records. Sometimes an internist or a GP will note something that provides a history of mental illness, but there has to be something. They can't just say, "Oh, by the way, I've been depressed since I was 14, that's why I robbed the bank, or that's why I was drunk while I was driving." They can't do that.

Now, once accepted into behavioral health court, we run them in phases; phase one, phase two, phase three, and phase four. After phase three, it's what's called graduation. Phase four is really completion, where we just monitor them for a month. Phase one, it usually lasts two to three months. They come in every week before the court at one o'clock on Wednesdays, where we give up our lunch, and I ask them the questions. I could tell you, during COVID, it was tough because everything was Zoom, a lot of technological issues, a lot of communication problems. We really felt the difference. But when they're face-to-face and they come into the courtroom, the bailiff says, "Arise," and you walk out in the robe, and they stand in front of you alone with all their peers.

It's a closed courtroom, except for the people in the program. You say, "Why did you miss your screen last Tuesday? Or why were you 10 minutes late for your individual session last Thursday?" There's a reward system. If they do something good, you reward them. We have a funny little thing called a cookie jar, and there's a bunch of slips of paper in there. If they do something good... It didn't have to be necessarily in the program, but let's say they're observed with some random act of kindness... We've had things like, "I saw Jimbo changing the tire in the parking lot when he left for this lady," or something like that, they do something. We like to reward them because they like that. It's little things. It can be as little as, "Well, you get to go first and leave early next week." You get to skip a week if they're doing really well.

On the other end, we have a sanctions spectrum, as you see on the board. If you're on regular parole and you commit some of these violations, you get revoked and you go to jail. That's the very last thing we want to do in behavioral health court. We'll give them community service. We'll give them write an essay on the importance of compliance. We have workbooks that we can give them. If it gets severe, we might give them a weekend in jail, or be even a week in jail. Then as a last resort would be revocation and expulsion from the program.

Judge Alan Zaunbrecher:

The goal with regard to sanctions that we have is consistency. At that, we fail miserably because each individual is different, and you can't look at one little snapshot in time and say, "Well, they really messed up here, I've got to do this." You look at how they've done the whole time. What's their pattern? What's different now than three months ago?" So it's really specialized and difficult sometime a process of sanctioning.

I have to speak briefly... Nick, do I have a couple more minutes?

Nick Richard (00:36:17):

Yes, judge.

Judge Alan Zaunbrecher (00:36:16):

Okay. AOT and assisted outpatient treatment. This was, of course, Judge Garcia's baby. About three years ago, he asked me to take over behavioral health court because he wanted to dedicate his time to assisted outpatient treatment. The big difference between AOT and BHC is that AOT is a purely civil proceeding. It has nothing to do with the criminal process, and it can't. This program is for the more severe mentally ill individuals. Those that just have repeatedly shown that they are unable to comply with treatment recommendations, but the process has no teeth. In other words, they're not going to go to jail. They're not going to be held in contempt.

But what we do is, by court order, we have them examined. We have a written treatment plan developed for them. We meet with them periodically. We haven't reached the point yet where we can get them to come in face to face on a weekly basis, but we're working for that. There are only a few of these courts in the country. Of course, I know San Francisco's got one, New York has one, but for us, the 22nd JDC, which is 100 miles from the northwest corner of one parish to the Southeast corner of the other parish that we serve, we have about 350,000 residents in this.

Sometimes the distance is a little daunting. It's a very diverse district too, close to the lake, close to the south and the east and close to New Orleans. It is truly a bedroom community, but you get 15 miles north. It is as country as it gets, and believe me, implementing programs to that diverse population is difficult. The process basically is a healthcare provider or an individual with the concurrence of the coroner, who believes this person based on their failure to comply with treatment, would be appropriate for AOT, files a petition with the court. The court has... it requires an examination within 10 days of filing of the petition, and a hearing is held within 18 days of the filing.

Again, the person comes, and if the proof is presented, and if the court believes that they're appropriate, he orders a written treatment plan be provided. We'll approve the written treatment plan, and then periodically, that person comes back in and we determine whether or not they're complying with the program, if the program needs to be amended somehow. Oh, there's lawyers involved. When we first started the AOT program, Nick and I made the circuit with the local newspapers and radio shows, and things like that, and the response was, "How can I help? How can I volunteer?" We had social workers, we had attorneys, we had other individuals to say, "How can I help?" So take advantage of all that.

Judge Alan Zaunbrecher:

How are we doing? Well, I can tell you this, that it's too early to tell with AOT because we've only been doing it five months. But we do know now that the sickest person in behavioral health court is healthier than the healthiest person in AOT. These are severely ill individuals that require much more attention at every level of the court. In BHC, you measure success, are they in treatment? Are they taking their medication? Do they have suitable living conditions? Are they employed? Have they avoided any criminal activity? In AOT, the first level of success is, they're still alive, they're still alive. After that, are they compliant with their treatment? Are they compliant with their meds? Are they stable in their home environment? Employment is really not considered unless it's sheltered employment.

We have successes. It's a little difficult to compare completion and graduation rates for BHC or recidivism rates. Recidivism is measured if three years after graduation, if the person hasn't re-offended, then they're... if they do get arrested within three years, they're considered in statistics. We just got the stats last week from the Supreme Court, and the recidivism rate for all our specialty courts is 10.8%. That means nearly 90% of the people who complete our program don't re-offend within three years. I just think that's a remarkable number. Not only if you compare it to the rate of recidivism in the general population, but if you compare it to the rate of recidivism in the general population with mental illness, I think it's even more remarkable.

Another quick effect that I believe these courts have had, for reasons that still escape me, St. Tammany Parish has been a center of suicide. We've had a high suicide rate. Especially for Louisiana, I don't understand. We're a wealthy community. We have good infrastructure, we have good schools. We have good medical treatment, but within the last five years, we've lead the state in the percentage of suicide. Then it started to go down a little bit. The last two years, it's dropped even more, so we're no longer in the top. I think we're still in the top five, but it's still going down. It's clearly pointed in the right direction.

Again, it's impossible to measure with any mathematical certainty how these courts have saved our public health system in terms of dollars. We know it's been substantial and it frees up those dollars more, it makes them more available for the underserved. Now, again, it's impossible to measure our success on the effect that it's had on the families, because these people have dealt with their child, their sibling, their parent who's been mentally ill for years and years. When they're better, the gratitude that the families and the clients, the participants, show us is very gratifying.

For many of our graduates, this is the first time they've been successful at anything, at anything in their whole life, and they come back. They come back months and years later on Wednesday at one o'clock because that's when they came to thank us again, and to tell the people that are there what kind of impact it had. Well, I'm sorry if I went over. I appreciate it very much, and now I will turn it over to Mary.

Mary Burckell (00:44:22):

Thank you so much, Judge Zaunbrecher. I appreciate it. So my name is Mary Burckell, and I am the director of Safe Haven, and I'm a parish government employee. So Safe Haven, a lot of times they have a misconception. A lot of times here in Louisiana, when people see Safe Haven, they think it's an organization, but in reality, it's a campus and it's a parish project.

Mary Burckell:

Really, how this whole project started was the closure of the state hospital Southeast Louisiana Hospital. As Tom mentioned, this hospital had a very rich history here in our region and in our state. It was built in the 1950s. It was the third state mental hospital when it opened. I give many tours of the current site now that we renamed it Safe Haven, and it's amazing to hear the different stories. Everyone has a story about Safe Haven. Whether it's coming to visit a loved one or talking about our former governor who spent some time here while he was governor, everyone has some kind of connection to Safe Haven and its legacy.

I remember that day when that closure was announced. While I would never really had as large of a connection or spend as much time as Tom did, it was devastating for everyone, because of that legacy of service, because of the great services that we provided out there. It really was a beacon for the region. So when we talk about this project, there's a lot of moving parts going on at the same time. So one, we have the creation of the specialty courts. That's a huge part of this overall story, and really the court system going in there and starting to identify and really starting to say, "Hey, we have problems here, and these are some of the things that we're working on to solve them."

Some of the other... with our sheriff's office, them stepping up too with the CIT program that we already mentioned. But another thing that really laid that foundation and that groundwork for the relationships to be built, to make these types of project possible was the suicide prevention task force which was started in 2010, in response to that large suicide rate we had in St. Tammany. When that statistic came out, it was a real wake-up call, I think, for a lot of us here in St. Tammany, who sometimes maybe didn't always know what was going on in the behavioral health system, or people who were living with behavioral health.

When those statistics came out, our then parish president, Kevin Davis, formed this committee and he took people, experts, from all different areas. So from NAMI, of course, was very much involved. Our community foundation, United Way, Volunteers of America, and our crisis line. Really, what this group kind of did is put us on that beginning path of parish government being one of those other partners when we talked to behavioral health. From this came a media campaign to try to de-stigmatize behavioral health, and as well as starting to fund programs to address this issue, because we knew it was so important.

So when that announcement came in 2012, we already had some... some of that education had already been done. So when that announcement came, we knew how badly that would affect us as a parish. So a couple of things went into action. There's a couple of different parts, one being the actual paperwork, the other, finances, and then the relationships. So the relationships, we have already started, starting working together, admitting it's a problem. So as far as the paperwork goes, it took us three years for our local government to actually purchase the property.

So as announced in June of 2012, in the meantime, the parish entered into some agreements with Department of Health and hospitals, as well as a private hospital to take over that acute care. So that gave us time to actually purchase the property and work those little technical parts out with the state. So through that, y'all see it was officially bought in March of 2015.

So while this whole process was going on, and while that official sale was going on, they went back to the idea of a task force, bringing people together from all different types of the parish, from all different organization to really talk about what should our system be like, and how can Safe Haven be a part of that improvement?

Mary Burckell:

So the major contribution was a study that was done, which we call Transforming the St Tammany Behavioral Health System, which was done in partnership between the Louisiana Public Health Institute and the National Council for Behavioral Health.

Really, the purpose was to figure out where we are today, what can be done to improve, and then just start collecting data to start to have a dashboard so we can get further along in this process. There was four recommendations that came out of that. One, enhance existing behavioral services, transform the utilization of emergency services. We were very much overutilizing emergency room services. Enhance the crisis service continuum, and then also the advocacy education and training opportunities. So this was our foundation as we move forward.

So let me tell you about the financial side. So if you look on your screen, you see a map of it. So the parish, in the initial purchase, purchased 293 acres. It was a huge, mammoth-sized property, and it was a total purchase price of $15 million. Then after that, we decided... The parish government really doesn't need 293 acres. So we broke different pieces off. So we broke some pieces off to Pelican Park, which is our neighbor who is one of our recreation districts. We both broke pieces off to a private hospital so that they could continue to take over those acute care services. As you see through those two sales, we actually were able to recoup about half of that original purchase price.

I'm sure as you're thinking, if you're somewhere else, I can't imagine how I'm thinking about going to a local government agency and saying, "We need to find $11 million," or whatever that initial investment ends. So I really wanted to tell you how we made that work. My biggest recommendation is to know your local government's budget, and to really understand it. With local governments, a lot of times, they have their general fund that they can use more relaxed, and it's a little bit more flexible, but then they had dedicated funding sources. So we were able to use both. We did not fully use our general fund for this project. So we used road and drainage money. We also have here a public health millage, and that was great. That's something that else came out from that suicide prevention task force that really gave us the ability to purchase the property.

So as you see, from each of those accounts, we took different amounts of money based on how much that was. Then we have the subsequent sales. What you see is about half of that purchase price. So what did we end up with? What did we actually truly pay at the end of the day when all those sales were done? So we used about $2 million of our public health millage. We did use some building general funds, about $5 million. We used ROW funds because that campus had about nine acres of roads on it. So those became parish roads. So we used about $0.5 million for that.

Here in Louisiana, we have a lot of wetlands, so we created our own wetland mitigation banks. So when we do construction projects, we don't have to pay by credits from other entities. So some of that project bought some of the land as well. Then we also sold some of the land for a project we were doing for an additional bypass road. So as you can see, it's a lot easier to swallow and to make it work, the $5 million investment of the general funds rather than that full $15 million that you saw at the beginning.

We couldn't do this without our partners. While a lot of the financial burden has been on parish government, we are not the experts. We are not a healthcare agency. I say that all the time, because I think it's so important to remind. It takes every one of our partners to make this work, from our sheriff's office, our 22nd JDC, our district attorney, the coroner's office, NAMI is one of our biggest partners.

Mary Burckell:

Florida Parishes Human Service Authority, which is our human service authority for our region in our two hospitals here in St. Tammany. They're the ones that really made us be able to continue, not just to purchase the property, but then develop it into something else.

So after we purchased it, we came and had a vision for it. So all of our partners contributed to this vision, and that's to have a collaborative healing environment. That's really important for us, to keep those relationships at the center of this project. The other thing we focus on is the full continuum of care, from crisis to wrap-around recovery services, all the way through. We want to make it kind of like a one-stop shop.

So there's a couple of things we're going to try to make sure we address, some of our objectives and goals. Making sure it's a healing environment. The state was not really able to upkeep the campus or the facilities. We know that this is important, that the environment you're in really does affect the way you feel about yourself and the way you think others think about you. So that's going to be something that we continually work on, renovating the space, plantings, all that has to be part of it. We want to expand access to care. We want emergency room diversion.

As you see here in St. Tammany, we had over 2000 unnecessary emergency room visits. And also jail diversion, obviously. Working with our court system, working with our sheriff's office and DA, making sure that we're decriminalizing behavioral health. Organizational framework. We already had that informally, but this project helped us to do in a way that no matter who was in these positions in these organizations, we all can continue to work together. Information management, data is so huge these days and will continue to be to help really direct us where to go. Then, obviously, if it's not financially sustainable, then it's not sustainable at all. Our current parish president, Michael Cooper, and our councilmen have really been behind this. I think that's a lot because of our partners. Our partners continue to talk about it. They don't take their foot off that gas pedal as far as making sure that this continues to be a priority with parish government.

So now that we purchased the property, what is parish government's current role? One, we're a property owner. So we actually rent out space to service providers. So we are not providing those services. These entities, such as NAMI, such as our school board, Start Corporation, and Florida Parishes, they all have services there on campus. But we also have relationships beyond that, with our fire departments, with the VA, as we expand those services in the future. But also financial support. So we've gotten through the purchase of a property, but on a daily basis, how do we pay for this campus? So one, I call it the bricks and mortar. How do we make sure the lights turn on and that we can sweep the floor? That's through two sources; one, the rent from the revenues. So those service providers are actually investing back in the campus and in this vision, but also our public health millage.

We're very fortunate to already have that in place and to be able to do that. My goal is to one day, and I think it's realistic, we'll be completely off the public health millage as far as the bricks and mortar of the project. Capital improvement. So getting all those infrastructure, all the facilities back up to snuff, we're looking at grants mostly from state and federal. Last, to fund the services will be through Medicaid and private insurance. So will this really work? Will that philosophy really work? Well, we have one example, which is our NAMI Day Center. This house used to be the former CEOs house on campus. That position lived on campus. So we took the house, the parish invested community development grant money. Then NAMI went out and got startup costs from Baptist Community Ministry, a grant to begin those services, which was all pure support. Then now, they're also getting CDBG money for some operations, but also looking at Medicaid and actually being able to charge for that.

Mary Burckell:

So where are we going in the future? Number one is our crisis line. Our regional crisis line is looking to relocate to the campus. We are soon to be opening a crisis receiving center so we have everyone in one area, but that's mostly for adults. We want to make sure we don't forget about our adolescent and children. We want to make sure we have crisis services, outpatient treatment, and really been talking with our court system, the need for supervised visitation and safe exchange, to try to prevent some of that trauma that has an early childhood. We also have a huge veterans population here in St. Tammany. So we're looking at residential houses and wrap-around treatment programs. Then also, of course, workforce training, transportation, health and wellness. That will be a part of our future as we move forward. Nick, I'm going to throw it back to you.

Nick Richard (00:58:00):

Thanks, Mary. We're rolling into the... The biggest part, as we close this up, is no, you don't need a hospital closed in your community and you don't need parish government necessarily to put forward funds. What you need is you need relationships, and at NAMI, that's what we're here to do. We're here to convene conversations. We're here to help relationships move forward. So I hope that we were able today to show you how a smaller community, an everyday community can take really what was a tragedy in our community and turn that around to try and meet the needs of people living with mental illness throughout our community. Thank you for having us. Duck?

Ken Duckworth (00:58:44):

Well, this was great. We have a lot of questions, and we're going to take them away. The first question relates directly to what you were just saying, Nick, how do I get this going in my community? So you mentioned relationships, but it sounds like it's multi-year, multiparty relationships as well.

Nick Richard (00:59:05):

Doc, I'll tell you, I started this job when I was in my late 20s, and I came in looking at the mental health system. I was actually frustrated with the judiciary and frustrated with law enforcement. In time, over the next couple of years and spending time with them, where I should have been frustrated really was, honestly, with myself as an advocate in the mental health system. What I learned over time is the individuals that I've come in contact with that are on here now, and there's many, many other people that we've worked with throughout the court system, throughout our law enforcement agencies in parish government, it's our role as advocates to bring forward the information necessary and the tools necessary to give them to help them understand not only where the gaps are, but where we can possibly be as a community.

So I would say yes, of course it takes time to build these relationships, but most importantly, as an advocate, you have to be willing to hear other people's concerns before you tell them how they need to do things.

Ken Duckworth (01:00:06):

Thank you. This is a question for Tom. Tom, let's talk a little bit about the training of peer specialists, both how it's funded, I think that was mentioned, but also how much training occurs, and how somebody knows when they're certified. How do you know when you're a peer specialist?

Tom Rowan (01:00:27):

Well, certainly that varies by state. In Louisiana, which is the only one that I can really speak to, again, the model is an intensive 72-hours training, to begin with, for folks who have no background, whatever. It's interesting that they call that a 72-hour training, because the 72 hours actually constitutes in-classroom time. There probably is an additional 20 to 25 hours of extra work that goes to the testing and one month prior to graduation from that, quote-unquote, 72-hour course. I view the trainings very similarly to how I view education. Again, I have two BA degrees. When I got out of college, I was really proud of that. When I hit the world, I found out that those degrees were nice and looked good in the paper, but they pale by comparison to the folks who've had experience in the real world.

Those were the folks who I learned the most from. The reason I say that is, of all the peer support specialists we employ, we've actually more often hired people who have the skills to do the job we need and get them the training after the fact, as opposed to hiring people just because they have the peer supports certification already. I think that that's one of the reasons why we have had success with this, because if you're really going to be a professional organization, you have to hire the best people. In behavioral health, very, very often, the best people have no clue that there even is a peer support certification, much less how to get it.

One of the other things that's critical is once you have somebody go through that training, and you have somebody on staff, continuing education is just vital. State of Louisiana requires peer support specialists to get 10 CEUs a year. St. Tammany requires that they get 12. We do all of ours in person. We offer in-person CEU opportunities once a month, and we used to invite people who were peer support specialists in the area to come in, whether we employed them or not, we had [inaudible 01:03:15] for COVID. I'm happy to say that as of next month, we're reopening that opportunity [inaudible 01:03:19] peer specialists in our area. Continuing education, I think is as important as the initial training, but it really fits the quality of the person hired that makes it a success.

Ken Duckworth (01:03:38):

Well said. Thank you. This is a question for Judge Zaunbrecher. It's a question about AOT, and do people need to have the competency to participate in AOT? How do you experience that? As you know, some people may struggle with awareness or insight. the medical term for that is anosognosia. So a couple of questions about that, Your Honor. How does that play out in the courtroom?

Judge Alan Zaunbrecher (01:04:09):

Well, for AOT, it's all statutorily driven. In other words, you follow the statute in your jurisdiction. The model is called, I believe, Nicola's Law. I can't remember whether it started in San Francisco or in New York, that the Louisiana law was modeled after. Our law is very specific. It says that in order to qualify for a order, the patient must be, of course, 18 years old suffering from a mental illness, unlikely to safely survive in the community without supervision, based on a clinical determination. Then there are some very specific things in our statute, they have to, at least twice in the last 36 months, have been hospitalized for treatment where mental illness is a significant factor or resulting in an emergency certificate. This is a process. It's like a temporary treatment where they go in, or commit one or more acts of serious violence toward another within the last 36 hours as a result of mental illness.

Judge Alan Zaunbrecher:

Here's one of the stoppers, the patient, as a result of mental illness, is unlikely to voluntarily participate in the recommended treatment or the recommended treatment plan. So if they've tried a lot of things before and it hadn't worked, this is at least a court order. We've got a lot of different providers that are... we're developing our treatment plans and how they're going to be documented, and how they're going to be approved. Frankly, it being a simple proceeding and everyone must be represented, they can't represent themselves-

Ken Duckworth (01:06:22):

That's right.

Judge Alan Zaunbrecher (01:06:23):

... mental health advocates, attorneys who represent them and they do represent… So that's who has their back, so to speak, from a legal standpoint. It's very difficult. Every patient in AOT is a real challenge.

Ken Duckworth (01:06:46):

But it sounds like you've come to the conclusion that it can really make a difference for some people in very specific situations.

Judge Alan Zaunbrecher (01:06:54):

It can, and it will, but it's a never ending process, from what I've seen. We're early on in it, but people get better in behavioral health, and they understand that they have to take their medication and they have to get their periodic treatment. In AOT, every day is a struggle, every single time we see them. It can be different today than it was yesterday and different tomorrow than it was today. So it's a real challenge. We've got a lot of dedicated people who really want to help these people, but it's been a tough go so far.

Ken Duckworth (01:07:36):

Thank you, Judge. A different question. I'm going to shift gears. Crisis response. So when it's police officers, I know they're trained, but are they also wearing traditional police uniforms? There was a couple of questions on that issue. How much of that is done by mental health practitioners? Does it vary at all? Nick, it looks like you want to take that one, and thank you.

Nick Richard (01:08:04):

Yup. So a couple of different things. Obviously, every community is different, right? Selling certain things to certain departments is easier and harder depending on where you live. Our crisis intervention team started in 2016, and as the Judge mentioned, what they did was, not only do we do CIT training annually, in addition to that, they have four officers dedicated just to behavioral health calls. Up until recently, it's certainly something that I pushed for and advocated for, was to have them in plain clothes and unmarked units. That is something that will be happening soon. Certainly, the goal while it didn't happen right out of the gate, obviously, there's a process to all of this, right?

Nick Richard:

Just like in the mental health role, we meet people where they are, well, the same thing applies when I'm working with an agency. I have to meet them where they are, and we have to work together. To the next point of other crisis services, there's actually... Again, just like the rest of the country, especially during COVID, there's funding going towards mobile prices services. Of course, we don't want law enforcement interacting with people with serious mental illness any more than law enforcement wants to interact with serious mental illness.

So our goal is to... as Mary mentioned earlier, two of the primary goals of Safe Haven are, in fact, jail diversion and ER diversion. So of all the systems that we build here, we're trying to divert and reach people before crisis. So to answer the question, no, we're not quite there yet with officers. They're still in their uniforms, they are moving to unmarked cars, and we've had conversations with dressing down. The second part is mobile crisis. We'll be rolling. We do have social workers stationed in ERs, and that as well. So hopefully, long term, I always say, I love working with the CIT, but my long-term goal is to eliminate the need for CIT [inaudible 01:10:02]. So I hope that answers your question.

Ken Duckworth (01:10:05):

That's a great answer. It really speaks to the developmental nature of this work. Now I want to go back to Tom's commentary about the hospital, because several comments are in my state, the hospital is not recovery, peer support-oriented. So my question, I'm going to work off that observation, my hospital is in the dark ages is one of the comments. So the question is... Maybe Tom could take this on. Mary, of course, you'd be another great candidate. Was the culture of recovery, putting people first, is that directly related to the outcome and the process you're working on? Because the culture seemed to be pretty well-established and very good direction before the hospital was closed. So is that related? Is it tangential? Is it luck? Tom and Mary.

Tom Rowan (01:11:03):

Well, that's an interesting question, and really, Southeast Louisiana Hospital was an [inaudible 01:11:13] laboratory to watch this process take place. Again, as Nick said earlier, so much of this goes back to relationships. NAMI St. Tammany had established a very, very close relationship with Southeast Louisiana Hospital because the NAMI chapter here was so invested, the families were so invested in attempting to get good treatment processes for their family members. Since Southeast Louisiana Hospital was located smack dab in the middle of St Tammany Parish, it was easy to have that face-to-face relationship.

The CEO of Southeast Louisiana Hospital at this time was a marvelous woman by the name of Pat Gonzales, who was a social worker. As an LCSW, she had a different outlook on operations than possibly a medical doctor director would have. So she was more receptive to the idea of the recovery model and the other SAMHSA information than possibly somebody with MD after their name would have been. Again, that's not a nasty comment on about people whose first name are doctors…

Ken Duckworth (01:12:47):

No offense taken, Tom. We're good.

Tom Rowan (01:12:47):

I just want to make sure there, Dr. Duckworth.

Ken Duckworth (01:12:55):

No, we're good. Tom, you and I are good.

Tom Rowan (01:12:56):

Okay. Actually, because of that, the hospital was essentially told to embrace this model-

Ken Duckworth (01:13:07):

Mm-hmm (affirmative), by the leadership of the hospital, by the social worker.

Tom Rowan (01:13:12):

By the leadership. It was not embraced overnight. Another reason why it's great to watch another strength of Southeast Hospital and why it was so great to work there Southeast is a teaching hospital. Consequently, they had eight, 10 doctors who were on the various units in partnership with Tulane University. Those doctors would bring in each quarter a different resident and a set of interns. Therefore, you had a whole set of new docs coming in being trained who suddenly were being exposed to this recovery model by doctors [inaudible 01:13:57] themselves and had never implemented it on their own. Out of those 10 doctors who were the primary caregivers in the hospital, I would say probably eight of them embraced the recovery model totally by the time my four years there was done and the hospital closed. But two of them, quite frankly, never did. They all continued with the medical model in treatment team, even though in the [inaudible 01:14:28] of their jobs, they would talk about the recovery model and why it was in [inaudible 01:14:34].

Ken Duckworth (01:14:36):

Briefly, Tom, I'm going to make a statement that the medical model, as you're describing it, is the doctor knows best, tells the patient what to do, and expects them to comply. In this conversation, the recovery model puts the person with the illness at the center of the conversation, and they help to create their own recovery plan. Have I described this accurately?

Tom Rowan (01:14:58):

Accurately and succinct.

Ken Duckworth (01:15:00):

Oh, that's an unusual thing. We should all buy lottery tickets perhaps today. That would be a first time. So you see the leadership of the hospital, the closure of the hospital, and the creation of this community collaboration to be really a culture that was evolving over time. That it also involved the young doctors, because every time you have a resident, you have a young doctor who's going to be influenced, right?

Tom Rowan (01:15:25):

Absolutely correct. One of the most rewarding things to me, personally, is to encounter as psychiatrists in the field today, they're working for the coroner in private practice, or back at the hospital, who were trained at the time that I was there. It's just a wonderful thing because those people really do embrace the recovery model and show that this was possible.

Ken Duckworth (01:15:54):

There's a couple of questions about budget. So I'm going to ask Mary this question. There was a state hospital that was closed when I was the commissioner of mental health in Massachusetts, and the suburban neighborhood wanted to turn it into a soccer field. This had no help for anyone, right? This 150-year legacy of service to a very specific group of people. I think the Department of Mental Health attempted to get some percentage of the revenue, and other ones have had some housing on it for people who live with mental health conditions, but it was an abject failure, a soccer field in these wealthy suburban areas. How did you pull this off? You, the community, Mary, the spokesperson, because you're using this same land to create a multi-party collaboration in the service of the same mission.

Mary Burckell (01:16:51):

Absolutely. I'd love to answer that question. So I think a couple of things worked in our favor. Number one is that it was so large, 292 acres. Really, in reality, there's not a whole lot around it. One, there is recreation district that's next to it, and across the street is a state hospital... a state park, excuse me. So in that area, there's not a lot of residential homeowners in that area.

When the state announced that it was going to close, it was going to sell it in the open market. So it could have been a subdivision or a soccer field, or anything else. That's why parish government initially purchased it. Initially, we weren't thinking about bringing it into this evolution. Initially, we were just going to resell it and have restrictions so it only could be healthcare, to try to at least preserve some type of services.

I think my perspective differs a little with Tom. I don't know, I can't speak for them because they're not here anymore, but those who bought it, it was more about just preserving services. It really wasn't about the model. We just knew if we lost services, we're going to lose treatment. That was going to negatively affect people, from our perspective. So when we purchased the property, actually one of our judges, Judge Swartz, came to the administration and said, "I don't know if you know what you have, what this 292 acres can be." So they went to San Antonio and looked at Haven for Hope, which works with homelessness, kind of that one-stop shop kind of idea. So after they came back from it, our leader said, "We're going to do it, but we're going to do it for behavioral health."

Mary Burckell:

So without that intervention and that relationship between parish government administration and the court, this may never have happened. I'll say we are very... other organizations are looking to come on to Safe Haven, who are looking to relocate to the Northshore because of our zoning, and because they're not going to get a fight. We have these 292 acres, the parish owns thousands of wetlands around it. Also, we have that recreation district and state park. So it really helped us in that particular situation. But I guess my thing would be, if you're in that situation, really talk to people, they can put restrictions when it is sold. Government entities can do that. So that is an option to, hopefully, that doesn't happen in the future.

Ken Duckworth (01:19:13):

Well, Mary, it's a great story, and it speaks to the clarity of purpose of a local group of leaders, which is a pretty great message for everyone who's attending this webinar. Because this wasn't magic from above, this was community organization and clarity of purpose. I want to ask the last question, which may not be ready for prime time, but it also anticipates our next webinar on juveniles. Dr. Ross Greene will be talking about the youth to juvenile detention pipeline, how to interrupt that. We're doing that next month.

So how young do your services go? Have you thought about youth and adolescents through this creative lens, or is that in the to-do list?

Mary Burckell (01:20:10):

So currently on campus, we do have services from our public health school system. They actually have four alternative schools right now on our campus, as well as we have Methodist Children's Home, which is a residential program for boys under the age of 12. In the future, we do know the youth is where we need to go. Unfortunately, when we talked about our high suicide rate, that also includes our children and adolescent, and we've unfortunately seen that here in our community. So definitely going to the youth. I think it's important not just having the crisis services, but closer outpatient services.

So right now, we live about an hour across Lake Pontchartrain to New Orleans. So a lot of our community members actually have to travel great distances, sometimes [inaudible 01:20:59] services. So talking about relocating, maybe not the whole treatment, but maybe part of it, maybe an outpatient program can be over here so that our citizens can have access to that same great care, including our adolescents. I think, Nick, you might... I don't know if you want to add [crosstalk 01:21:16].

Ken Duckworth (01:21:15):

Anybody else want to take on that question?

Nick Richard (01:21:20):

I don't think I've ever been scared of jumping on any question. To be honest, when we were building this, yeah, we knew there's certainly a need with youth and adolescents and adults. I think one of the honest decisions was it was just easier to tackle the system with adults. I think the reality is, that's why we went there first, because we've got all the... you've got judges and law enforcement, parish government, all these people. I can tell you as an advocate, we were scared the whole time, because we want this to succeed. We knew it needed to succeed. So going with adults first had to happen.

Nick Richard:

But especially with youth in our community... Mary's right, traveling an hour across the lake to New Orleans is the short distance, since we have people that are hospitalized across the state four and five hours away with no family or whatsoever. That is obviously not the way that we want to see services delivered to youth and adolescents in our community. So I can tell you now that our big focus as the crisis receiving center open, certainly, is working with parish government and the other partners to make sure that we not only address the adolescent crisis services, but the full wraparound services. Because we have them, a lot of states have them. We just [inaudible 01:22:29] to be able to put them together and have them on the same campus and all talking together. That's where our focus will be in the coming years.

Ken Duckworth (01:22:37):

Thank you. So that's an extension of the remarkable community vision that you have arranged. I'm going to thank you all for this extraordinary community engagement, creativity, and outcome. It's really something to marvel at. So I just want to thank each of you, Mary, Your Honor, Nick, and Tom. You know that NAMI community is very grateful for you and your leadership, and you are available for being in touch with people to teach them what you've learned about putting something together. With that, I'm going to turn this back over to our CEO, Dan Gillison.

Dan Gillison (01:23:27):

All right. Thank you very much, Ken, and thank you to Tom. Mary, Judge, and Nick. We appreciate it very much. We want to make sure you save the dates for the upcoming events, the 17th of June, 15th of July, and the 12th of August. Those will all be at the same time, and the first will feature Dr. Ross Greene, the next one will be Dr. Sidney Hankerson, and the third will be Dr. Judith Cook. These are summer sessions.

We want to also remind you of our convention, Bringing People Together for Mental Health: The time is Now. We've heard a lot of people in this space say mental health is having a moment. Well, we want it to become a movement, and this may be that window of opportunity to do it. We'd love you to join us for our convention on the 27th and 28th of July. You can register at nami.org/convention.

Last but not least, we encourage you to donate to NAMI. We are a not-for-profit. We're able to do this work as a result of your contributions. For those that are already doing it, thank you. For those that haven't, we welcome your donations and contributions, and we appreciate all that you do in your communities in terms of mental health and helping loved ones. With that, what I'd like do in closing is to really thank our production team because our production team really makes these series happen. As I do that, let me also say, this is the first time that we decided to do a series. We did a four-part series on Help, Not Handcuffs. This is a wonderful way to close it out with the team from St. Tammany Parish. So wonderful to have them close it out. We started with a judge and we're wrapping up with a judge. So thank you, Judge, for joining us.

Dan Gillison:

With that said, the staff, Jordan Miller, Teri Brister, Jessie Walthall, and Christina Bott, this is not possible... when we pull the curtains back and turn the lights up, and we start, this wouldn't happen without your support and you managing everything in the background and making this happen. So thank you to the staff for what you do. To all of you, we hope you have a wonderful close to your week and a great weekend. Remember, register for the convention, NAMI Convention, NAMICon, July 27th and 28th, and register as soon as you can. We look forward to seeing you there. All the best to everyone, be safe and take care. Bye now.