Sequential Intercept Model Mapping Report for New Orleans, Louisiana

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October 5 – 6, 2022

Delmar, NY

POLICY RESEARCH, INC.

SAFETY+JUSTICE CHALLENGE

Supported by the John D. and Catherine T. MacArthur Foundation

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Final Report
November 2022

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ACKNOWLEDGEMENTS

This report was prepared by Lisa Maye and Kathleen Kemp of Policy Research, Inc. Policy Research wishes to thank Office of Mayor LaToya Cantrell, City of New Orleans for hosting the workshop and to Adrienne S. Tobler, Interagency Coordination Specialist for offering opening remarks. Support for the workshop was provided to Orleans Parish, New Orleans by the John D. and Catherine T. MacArthur Foundation through the Safety and Justice Challenge.

RECOMMENDED CITATION

Policy Research. (2022). *Sequential intercept model mapping report for New Orleans, Louisiana.* Delmar, NY: Policy Research, Inc.

CONTENTS

BACKGROUND

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available opportunities, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

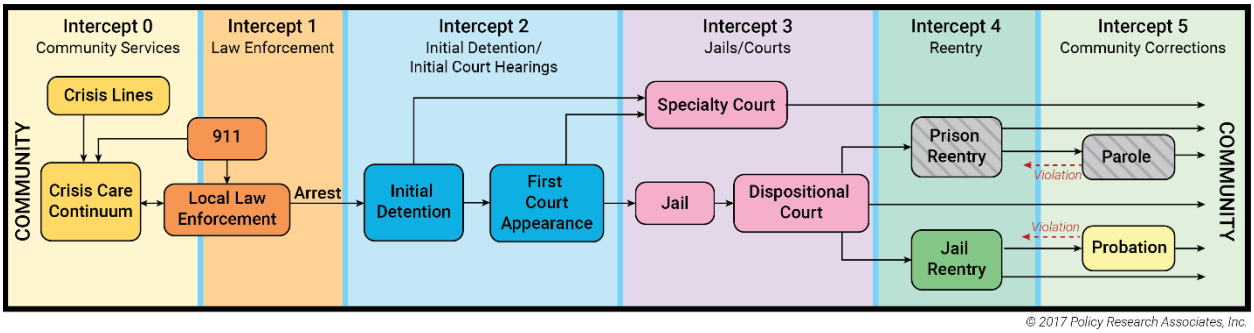
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with, and flow through, the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

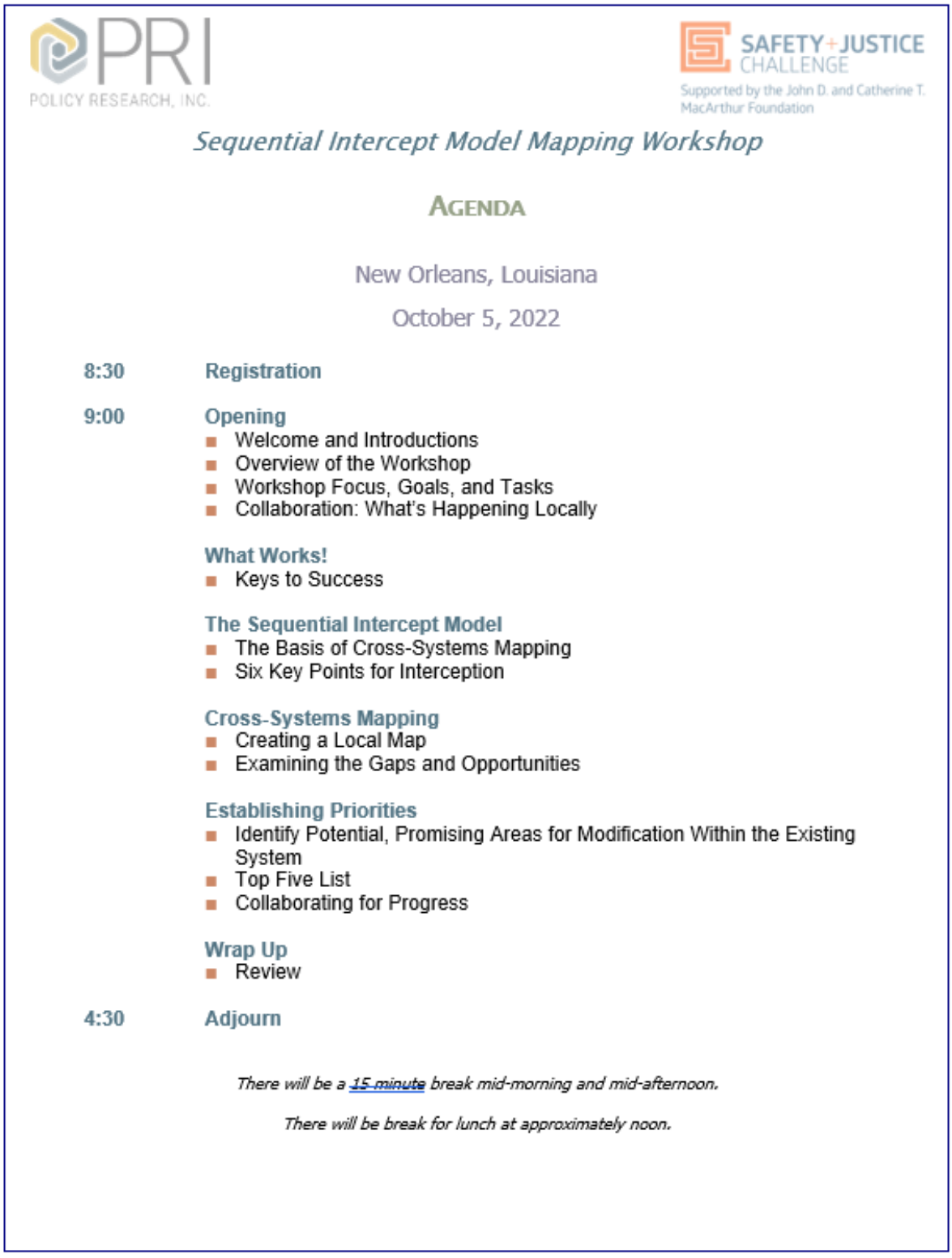
2. Identification of gaps, opportunities, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

AGENDA



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Sequential Intercept Model Mapping Workshop

AGENDA

New Orleans, Louisiana

October 5, 2022

8:30 **Registration**

9:00 **Opening**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review

4:30 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

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Sequential Intercept Model Mapping Workshop

AGENDA

New Orleans, Louisiana

October 6, 2022

8:30 **Registration and Networking**

9:00 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

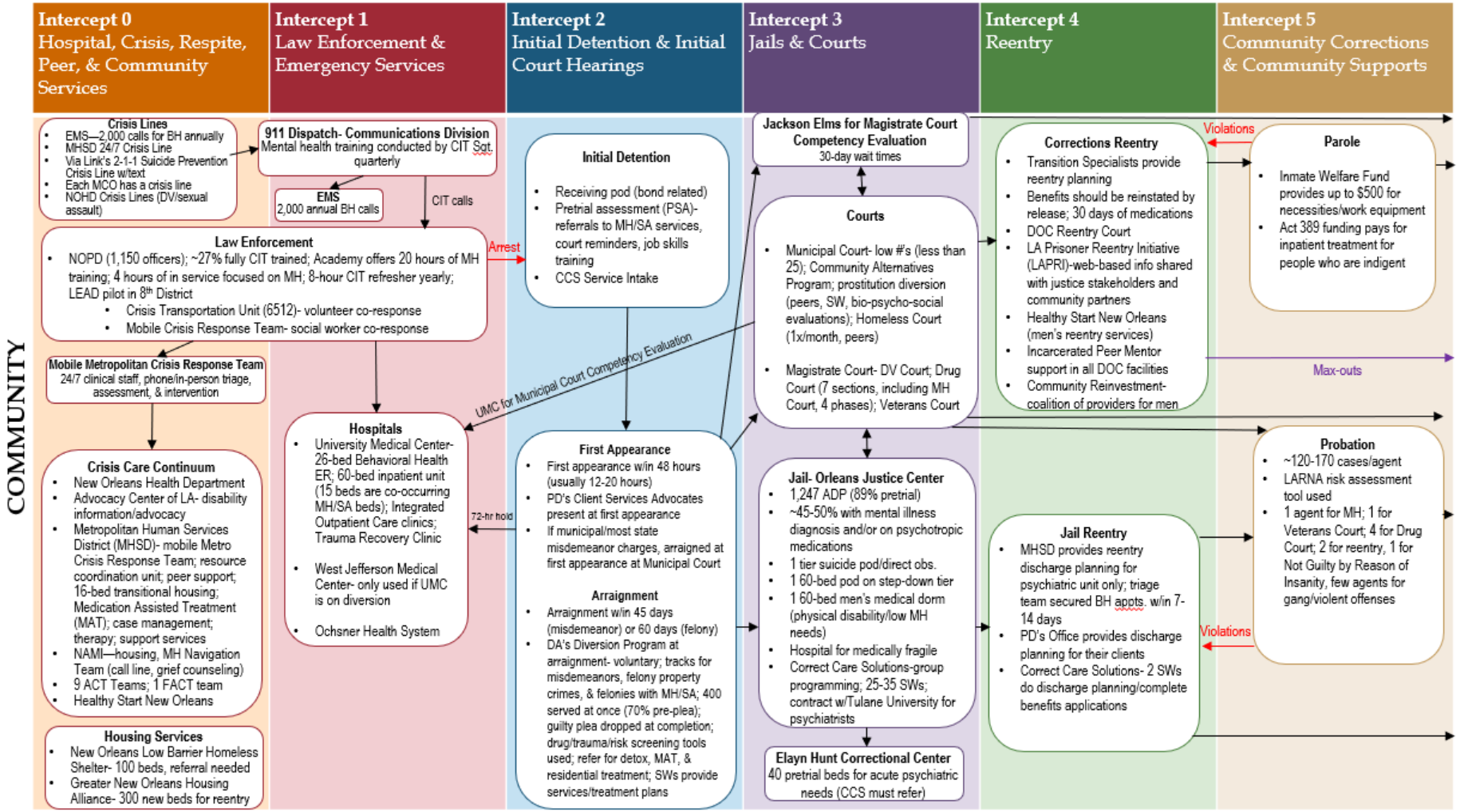
Next Steps

Summary and Closing

12:30 **Adjourn**

There will be a ~~15 minute~~ break mid-morning.

SEQUENTIAL INTERCEPT MODEL MAP FOR NEW ORLEANS, LOUISIANA



The New Orleans Sequential Intercept Model (SIM) Workshop was focused on mapping Intercepts 2 through 4, encompassing initial detention through reentry, which is different than the 2018 iteration as illustrated in Appendix# 4 which covered all 5 intercepts.

The focus allowed the site to spend more time discussing programming and treatment while individuals are detained in terms of case processing, diversion and specialty courts, competency hearings and restoration, and reentry planning.

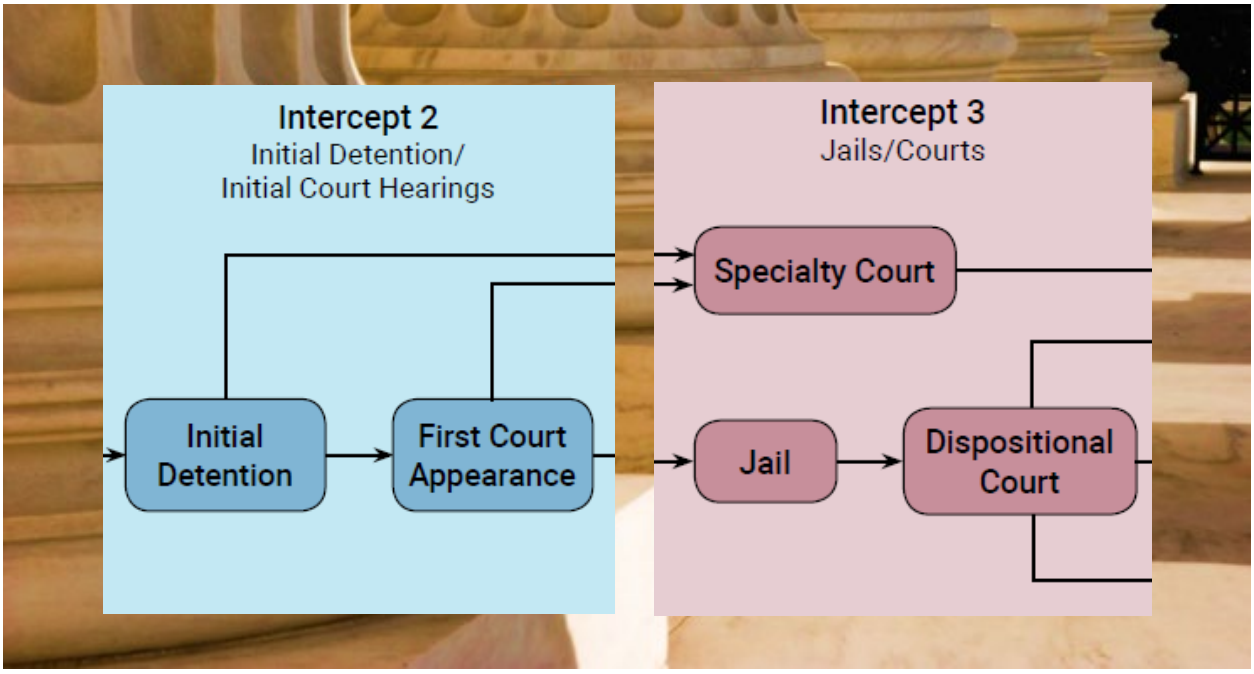
On September 15, 2022, a Criminal Justice System Stress Test was conducted on New Orleans, functioning much like an in-depth case review. It included a brief high level data analysis of the jail population and criminal district court case processing as well as an in-depth review of a sample of 25 cases selected by the technical assistance providers that was based on the data analysis. The stress test that was conducted had an intentional focus on the processing of cases where mental health concerns and substance use disorders were identified. This was the second stress test conducted through NOLA's Safety and Justice Challenge (SJC) effort.

The first stress test was instrumental in identifying policies, practices, and initiatives that lead to NOLA's significant jail population reduction throughout the SJC.

Technical assistance for both initiatives was provided by the JFA Institute, the Justice Management Institute, and Policy Research Associates, Inc.

Opportunities and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model (SIM) map. As part of the mapping activity, the facilitators work with the workshop participants to identify opportunities and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the opportunities and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing opportunities.



INTERCEPT 2 AND INTERCEPT 3

OPPORTUNITIES

INTERCEPT 2

Booking/Initial Detention

Orleans Justice Center (OJC) Intake and Processing Center

Entry to the OJC and into the Intake and Processing Center (IPC) is via the sally port as an arresting agency brings the individual to the jail and correctional staff book the person into the OJC (herein after "jail").

The following are the top Law Enforcement agencies that book into the OJC:

- New Orleans Police Department – *approximately 85% of entire bookings*
- Leviboard
- Harbor
- State Police
- University Police – Tulane, Xavier and Dillard
- Hano

Well Path is the current medical and behavioral health provider within the jail. Tulane University are sub-contracted by Wellpath to provide psychological, physical and nursing services to those

individuals in the jail. A Wellpath nurse conducts an initial Intake Screening to medically clear the individual to enter the jail. This screening asks questions associated with the individual's medical history, and inclusive of, but not exclusive to, whether or not they have been tazed before, if they were involved in a car accident from the arrest, and Well Path intake forms which include a 3-page of intake screening and 1-page medical clearance as illustrated in Appendix #5.

If the individual is not medically cleared to enter the facility, they are transported to the University Medical Center.

After the individual is cleared to enter the facility through this Intake Screening, a pat-down search is performed by correctional staff, the individual's personal items are itemized, and the arrest paperwork is entered into the jail data base.

Following these procedures, correctional staff conduct an electronic body scan on the individual to check for any contraband they may have brought into the facility.

A Wellpath Nurse then conducts a second screening, called the Receiving Intake. This intake gathers information from the individual on their mental health history, asks further medical questions, verifies current medications, and for females, questions are asked on their menses history.

If an individual discloses that they are prescribed psychotropic medications, the Wellpath nurse verifies this prescription with the community provider. In the event that the medication is not on Wellpath's formulary, a provider appointment is set for the individual to be evaluated to be prescribed a comparable medication.

If the arrested individual reports that they receive Medication-Assisted Treatment (MAT) in the community, a Detox Protocol is initiated by Wellpath that includes detox within the jail in a two-week isolation period. A determination is then made quickly after detox to admit this individual into the sub-acute or acute units within the jail. However, MAT is not currently commenced if not prescribed prior to the arrest. Wellpath and the OJC are working on adopting national standards for MAT by the end of 2022.

Meanwhile, warrants and holds are run on the individual by correctional staff.

Once the Receiving Intake is completed, the individual is referred to a Wellpath behavioral health provider (licensed, qualified, mental health professional), who then completes an assessment, and if the individual is deemed to need medication management, the behavioral health provider contacts the nurse, who then either contacts the on-call psychiatrist or sets a "provider appointment."

Initial Court Appearances

Pre-Trial Services

NOLA Pretrial Services handle convictions and open cases.

NOLA Pretrial Services is an independent agency under the jurisdiction of the court (housed inside the court building) and funded by the City. It was initially a pilot program designed by the Vera Institute.

The Intake Specialist or Pretrial Intake Specialist conducts a Needs Assessment. They have access to the "Booking Sheet" and "GIST" as well as warrants an individual may have; the same access to information as the IPC staff have. If the individual is booked into Orleans Parish Jail before 11 AM, the risk assessment will be conducted the same day and if it is after 11 AM, it is completed the next day by 3 PM.

The Needs Assessment or Pretrial Services Assessment (PSA) determines the individual's history and current status regarding behavioral health issues and what responses, services and support are centered around their imminent needs. NOLA Pretrial Services attempt to "support" their clients without penalizing them for established behavioral health issues and emphasize the goal of assisting them in remaining arrest-free, if recommended for release, and returning to court without obstacles.

The release recommendation by the Pretrial Intake Specialist is not applicable for all Murders, Armed Robbery and Rape charges. The risk score is reported no matter the charge, with the PSA used as a tool in the Judges' "toolbox," with the latter maintaining the decision to release or detain the accused.

If the court agrees, the accused is enrolled into a Pretrial Supervision Program with conditions. NOLA Pretrial Services provide a Status Report to the court within 30 days of enrollment in the Pretrial Supervision Program. These Status Reports provide facts about the client and their progress or lack thereof in supervision. Recommendations are included when needed and those recommendations can include an order for additional conditions of release or a decrease in conditions of release when warranted. If there is an imminent risk need that jeopardizes a client remaining arrest-free, they notify the court immediately.

GAPS

Booking/Initial Detention

Jail bookings are remaining flat or declining slightly while the jail population has been increasing. This means that length of stay (LOS) is increasing.[i]

The search for warrants/holds are not necessarily conducted upon booking which means that the charges may not be addressed at the First Appearance.

Pre-trial Services

Risk scores are not used to set bond amounts. There is no behavioral screening at pretrial services to help inform eligibility for diversion programming.

Relative to processing times, it takes an average of one day for a booked defendant to have an initial bond appearance. If the defendant is not released at the initial court appearance, it takes an average of 28 days to have a second court appearance. This delay between the first and second appearance shows the importance of gaining release at the First Appearance and the subsequent impact on the pretrial jail population. [ii]

INTERCEPT 3

OPPORTUNITIES

Jail Structure, Personnel and Services

Current Staffing Pattern for Correction Officers:

- Allotted **154** positions for Day and Night shifts
    - At the time of the workshop, there were **52** officers employed
- Allotted **25** transport Correctional Officers
    - At the time of the workshop, there were **5** transport officers employed

After Correction Officers are recruited and hired, they receive 92 hours of training, 40 of which is civilian training, and Well Path (Dr. Chambliss) provides mental health training to all Correction Officers.

Correction Officers receive de-escalation and Medication-Assisted Treatment (MAT) Training by Well Path staff.

Current Staffing Pattern for Well Path Nursing/Assistant/Technician:

- 5 Registered Nurse openings
- 6 Licensed Practical Nurse openings
- 2 Medical Assistant openings
- 2 Mental Health Technician openings)

Once the **Receiving Intake** is completed, the individual is referred to a Wellpath behavioral health provider (licensed, qualified, mental health professional such as Social Worker (LMSW and LCSW), Licensed Professional Counselor, and Psychologists), who then completes an **Initial Evaluation**, within two hours of the **Receiving Intake**. If the individual is deemed to need medication management, the behavioral health provider contacts the nurse, who then either contacts the on-call psychiatrist or sets a "provider appointment."

There are three categories in which an individual is triaged to receive subsequent mental health services after the **Initial Evaluation:**

1. **Emergent** (subsequent mental health services are delivered within 2 hours)
2. **Urgent** (subsequent mental health services are delivered within 4 hours)– is when the individual is expressing suicidal thoughts and/or ideations, he/she is exhibiting bizarre behavior, or is actively psychotic.
3. **Routine** (subsequent mental health services are delivered within 6 hours).

OJC Housing

Once the screening assessments have been completed, the individual is placed in one of the pods on Level 1 where further Wellpath assessments are conducted and future housing is determined by the Classification Unit.

There are several options for housing for persons with behavioral health issues at the jail.

Individuals that exhibit suicidal behaviors or thoughts are placed on suicide watch (2A), and direct observation is utilized for persons whom staff have psychiatric concerns on.

At the OJC there is a:

- Unit 2A- an acute male mental health unit, including those expressing suicidal thoughts who require direct observation
- Unit 2B- a male mental health step down unit
- The Temporary Mental Health (TMH) unit for males and females.

All individuals placed on the Mental Health caseload are provided with an Individual Treatment Plan.

Dispositional Courts and Problem-Solving Courts

Initial Court Hearing

- 100% of First Appearances are held virtually.
- At First Appearance, the arrest register is viewed by and provided to the Public Defender, the District Attorney, Pretrial Services and the defendant.
- The NOPD Face Sheet and the Affidavit is viewed by the presiding Judge.
- Local Raps or III
- The PSA is provided at First Appearance summarizing the defendant's criminal history, risk assessment and recommended bond setting

Municipal Court handles city misdemeanor charges only with approximately 10,000-20,000 cases annually. Informal processes allow cases to be flagged and referred to the Office of the Public Defender Client Services for support. The Municipal Court has one social worker who recently returned to in-person after a period of primarily virtual services; this person's primary task is to find housing. Municipal Court houses the Community Court (previously Homeless Court) which has a docket 1 time per month with approximately 2 individuals on the last docket. The current caseload for Community Court is between 5-10 cases, and court is held on the third Wednesday of the month. Clients are referred to Community Court from the local Law Enforcement Assisted Diversion (LEAD) program, and the goal is to dismiss all charges.

The District Attorney's Office has a diversion program after First Appearance if the individual is released from jail. Criteria is initially based on the current offense as well as have no prior crimes of violence and no convictions within New Orleans Parish. There are 73 individuals who have

completed the program successfully in 2022 and 177 individuals in 2021. The District Attorney's Office expressed interest in enhancing diversion at First Appearance through a referral form that the OPD or other court personnel can complete. In January 2022, the District Attorney's Office began sending the OPD a list of eligible clients once per week to enhance enrollment in the program. There are 4 case managers to screen and refer individuals to services, which includes about 8 to 13 weeks of individual therapy and other services.

Court Intervention Services (CIS) makes the determination of which defendants are eligible for Specialty Courts, who? conduct their own Intakes. All Specialty Courts are SMI (Serious Mental Illness) eligible.

Drug Court - the mission of the Drug Court Program is to promote public safety and reduce recidivism, with Mental Health Court being a track of Drug Court.

- Referral Process: The Court section contacts the CIS Office by phone. The assigned Case Manager meets with the defendant (via Zoom) and informs the Court of the Court Screening which determines program eligibility.
- Eligibility: The defendant cannot have any prior felony conviction for any offense defined as a homicide in R.S. 14:29. The crime before the court cannot be a crime of violence as defined in R.S. 14:2(B), except a first conviction of an offense with a maximum prison sentence of ten years or less that was not committed against a family member or household member as defined by R.S. 14:35.3, or against a dating partner as defined by R.S. 46:2151, or an offense of domestic abuse battery that is punishable by imprisonment at hard labor as provided in R.S. 14:35.3.

Other criminal proceedings alleging commission of a crime of violence as defined in R.S. 14:2(B) cannot be pending against the defendant. The crime before the court cannot be a charge of driving under the influence of alcohol or any other drug or drugs that resulted in the death of a person. A defendant previously convicted or adjudicated a delinquent for the offense of simple battery shall not be deemed ineligible for the drug division probation program on the sole basis of such status.

- Sentencing: A Case Manager will report on the record the results of the screening. The defendant will be assigned to one of the five Treatment Tracks listed below. Track 1 cases will be transferred to Sections D, E or F. Track 2 cases will be transferred only to Section C. Track 3 cases will be transferred to Section B. Track 4 cases will remain in the sentencing section, and Track 5 cases will be transferred to Section I. Upon conclusion of the screening, the Case Manager will advise the Court if the case should be transferred or remain in that section.

Drug Court Track System

- Track 1: High Risk/High Need (Sections D, E and F)
- Track 2: High Risk/Low Need (Section C)
- Track 3: Low Risk/High Need (Section B)
- Track 4: Low Risk/Low Need (Sentencing Section)

- Track 5: Co-occurring Disorders (Substance Abuse/ Use and Mental Health Disorders (Section I)

Supervision: Assigned Drug Court Section- Drug Court Case Managers and Treatment Counselors provide updated reports during staffing meetings and Drug Court Status Hearings to the Supervising Judge and all other parties, including defense counsel and Probation Officers. Defendants will be referred by a Case Manager to appropriate community programs (mental health, substance abuse treatment, employment, housing etc.) if necessary.

Veterans Treatment Court (VTC)- the VTC is a court-supervised program coupled with intensive treatment and supervision for veterans of the United States Armed Forces who are non-violent criminal offenders and is designed specifically for persons with a felony or misdemeanor drug/alcohol charges or other criminal charges, which are closely related to their substance abuse or mental illness.

- Referral Process: All Judges may make referrals. The Court section contacts the Veterans Justice Outreach Volunteer by phone. The Outreach Volunteer screens the defendant for eligibility. The results of the screening may take 24-72 hours as it needs to be verified if the Veteran was honorably discharged from the Armed Forces. Upon receipt of the Armed Forces discharge information, Outreach Volunteer notifies the referring Judge that the defendant has been honorably discharged. The referring Judge sentences the defendant to complete VTC as a condition of probation, and order the case transferred to Section C to be supervised by the VTC. The program is a minimum of 18 months.

- Eligibility:
  The defendant must be a veteran of the United States Armed Forces with an honorable discharge.
  1. The defendant cannot have a prior felony conviction for an offense defined as a homicide in R.S. 14:29 or as a sex offense in R.S. 15:541, or any pending criminal proceeding alleging commission of an offense defined as a homicide in R.S. 14:29 or as a sex offense in R.S. 15:541.
  2. The crime before the court cannot be a charge of driving under the influence of alcohol or any other drug or drugs that resulted in the death of a person.
  3. If the crime before the court is domestic abuse battery as defined in R.S. 14:35.3 or domestic abuse aggravated assault as defined in R.S. 14:37.7, the defendant shall comply with the following additional requirements as conditions of eligibility in the Veterans Court program:

Completion of a court-monitored domestic abuse intervention program as defined by R.S. 14:35.3.

- Sentencing: The Section Judge who refers the defendant is responsible for sentencing. After sentencing the case is transferred to Section C to be supervised by the VTC Program.
- Supervision: Veteran's Court Section- A Probation Agent monitors defendants assigned to the program and provides reports to the Court concerning the defendant's compliance or noncompliance with the VTC Program. Defendant's will also receive assistance from the Veteran's Administration Justice Outreach Volunteer. Assistance will include connecting

defendants to resources provided by the Veterans Administration. Defendants will be referred by a Probation Agent to appropriate programs (mental health, substance abuse treatment, employment, housing etc.) if necessary.

Misdemeanor Monitoring Court Program - the Misdemeanor Monitoring Court Program is responsible for the supervision of misdemeanor probationers.

- Referral Process: All Judges may make referrals. The Court section should contact the CIS Office by phone. The CIS Administrative Assistant notifies the Misdemeanor Program Case Manager. The Case Manager meets with the defendant and informs the Court of the results of the Court Screening.

The defendant must plead guilty to a misdemeanor offense, present with mental health needs or have been diagnosed with a mental illness.

- Eligibility: The defendant must plead guilty to a misdemeanor offense, present with mental health needs or have been diagnosed with a mental illness. A battery of assessments is administered upon sentencing to determine the most appropriate program.
- Sentencing: The Section Judge who refers the defendant is responsible for sentencing. If the defendant reports a mental health diagnosis or presents with mental health needs, the case shall be transferred to Section I. All other cases will be supervised by the sentencing Judge.
- Supervision: Sentencing Court Section- The Misdemeanor Monitoring Court Case Manager provides reports to the Court regarding compliance or noncompliance with conditions of probation. Defendants are referred by a Case Manager to appropriate programs (mental health, substance abuse treatment, employment, housing etc.) if necessary.

Domestic Violence Court (DVC)- is being mentored by the Tulsa Domestic Violence Court, with the goal to apply for OVW funding that will help to create and sustain a Domestic Violence Court with a singular Judge presiding along with in-house programs, including, but not limited to, Batterer's Intervention, Anger Management and other programs that will assist in holding the participants accountable.

The DCV is also working on a domestic violence technical assistance project made possible by the Center for Court Innovation with partners from the DA'S Office, Public Defender, New Orleans Department of Health and the New Orleans Family Justice Center.

Reentry Court

Current New Orleans' Specialty Court Judges

Drug Court Judges:

- Judge Tracey Flemings-Davillier
- Judge Benedict Willard
- Judge Kimya Holmes
- Judge Rhonda Goode-Douglas
- Judge Robin Pittman
- Judge Karen Herman

Reentry Court Program Judge

- Judge Marcus O. DeLarge

Veterans Court Judge

- Judge Benedict Willard

These Specialty Courts do not have any capacity restrictions, however, continued funding and sustainability is always a challenge. Earlier this year (April 2022) information was presented about Orleans Parish's Specialty Court Programs to staff at the District Attorney's Office.

Competency to Stand Trial

At any time, competency can be raised during a defendant's court proceedings and hearings. This process is governed by the LA Code of Criminal Procedure. The Judge presiding over the case oversees the mental competency process. Such hearings are set on certain days of the week per the section Judge. The defendant's mental capacity to proceed may be raised at any time by the defense, district attorney or the Court. After this issue is raised, the Court orders the defendant to undergo a forensic evaluation by doctors appointed by the Court via the Sanity Commission.

After meeting with the defendant, a report is provided to the Court and counsel for the State of Louisiana, District Attorney's Office and Defense Counsel.

The report addresses the following:

(a) The defendant's capacity to understand the proceedings against him/her.

(b) The defendant's ability to assist in their defense.

(c) The defendant's need for inpatient hospitalization in the event he/she is found incompetent.

A hearing will take place regarding restoration of mental competency. If the defendant is found to be incompetent to proceed, the defendant may be committed by Court order to either inpatient treatment at the Eastern Feliciana Mental Health Forensic Facility (ELMHS) or to an outpatient treatment facility for competency restoration services. Jail-based competency restoration is also an option.

If the defendant is unable to be restored, i.e., "unrestorable," he/she may be subject to civil commitment, as per the Code of Criminal Procedure.

When a person is restored to mental competency, the doctors from the same appointed Sanity Commission will re-evaluate the defendant to determine if they agree with the determination that a defendant's mental capacity has been restored. They will provide a report to the Court and counsel as well. Another hearing will take place regarding restoration of mental competency. The State and Defense counsel then has an opportunity to again question the doctor about the evaluation and recommendation. The Court then makes a ruling based on what is presented, and decisions are controlled by the current law. Hearings generally take place 1 – 2 weeks after a competed evaluation.

If the Court deems that the person has in fact been restored to metal competency, the Court will rule that the defendant has the mental capacity to proceed in the case to trial. If the Court deems that the person lacks the mental capacity to proceed, the Judge will issue its ruling to that effect and may order that the defendant receive further restoration services.

Counsel on each side has the right to challenge or object to the findings/recommendations of the Sanity Commission doctors and/or the treatment facility that provided restoration services. Counsel may also hire independent doctors to further evaluate the defendant. Defense Counsel may also provide academic or medical records that may be helpful in this process.

New Orleans offers jail-based competency restoration and out-patient competency restoration, with hospitalization being provided for at ELMHS.

Cross-system Collaboration

The New Orleans Public Defender's office conducts training to stakeholders to identify mental health concerns.

GAPS

Jail Structure, Personnel and Services

Due to high correctional staff vacancies, a continuous challenge is obtaining deputies to escort health professionals to deliver psychiatric, psychological and nursing services to residents, resulting in services not being provided consistently.. Prior to Covid, residents were escorted to the Wellpath medical clinic but since that time, most services are provided within the pods or the interlock rooms by the pods.

The medication/formulary pharmacy care system is different for Metropolitan Human Services Division (MHSD) and Wellpath. It was noted that if Wellpath used Genoa, individuals would be ensured efficiency and accuracy of medication continuity of care upon booking and discharge, especially for those individuals currently on the MHSD caseload upon booking or upon release. There is no substance use or alcohol screening conducted at any time during a person's stay at the jail.

Women who are booked into jail that are receiving MAT and who are pregnant, are transported outside of the facility to receive methadone, and do not have the opportunity to receive MAT services while in jail.

There is no formal education provided to individuals by Wellpath when they need to be prescribed a comparable medication due to the medication that they are prescribed in the community is not on the formulary at Wellpath.

Group therapy programming for this targeted population is only held at the TDC.

Dispositional Courts

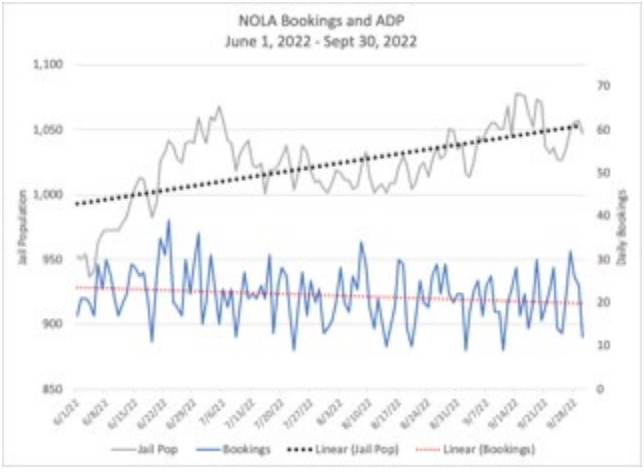
The information collected at booking and thereafter, is not shared with any of the stakeholders (Public Defender, State Attorney, Pretrial Services, etc.) or provided at the attendance at the initial court hearing – First Appearance.

- The Public Defender's office can wait up until two-weeks before they are aware that their client is receiving mental health services inside the jail.
- The Public Defender's office does not have access to the booking queue that is within the jail.
- There is only one First Appearance opportunity per day (down from three, pre-COVID) and there are no in-person interviews with the Public Defender prior to the First Appearance, preventing any information regarding mental health issues to be gained.
    - All First Appearance court hearings are virtual as there are not enough transport deputies to transport individuals to the court.
    - Due to these hearings being virtual, HIPPA forms are unable to be completed, lengthening the time for individuals to be considered for potential diversion services (Pretrial, Specialty Courts, etc.).
- There are no diversion opportunities for individuals with mental health at First Appearance.

Police Departments generally provide their reports within 10 days.

Prior to COVID, defense counsel was assigned to all individuals at First Appearance in New Orleans. The defense counsel was allowed to meet with the individuals about 2 hours before court. The defense counsel also received copies of all arrest registers and PSAs detailing criminal history prior to court.

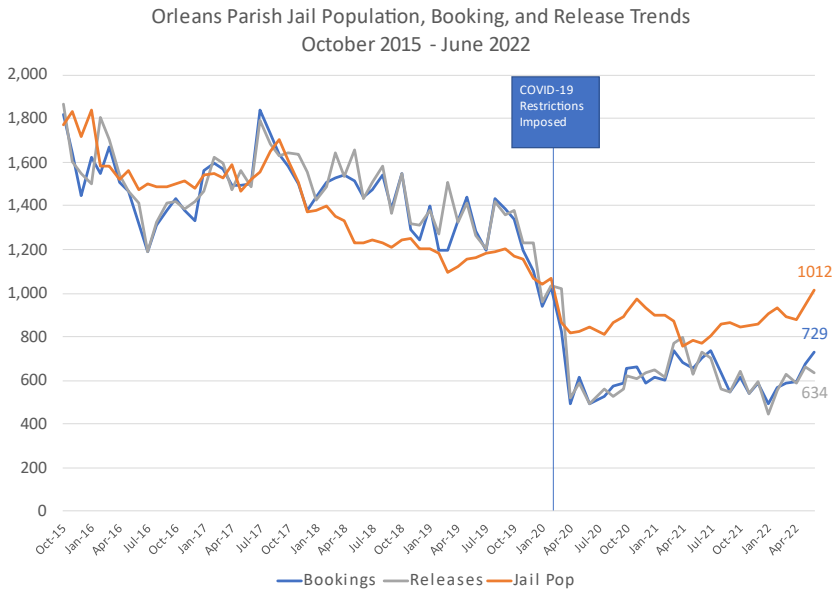
Jail bookings are remaining flat or declining slightly while the jail population has been increasing.[iii] In the chart below you can see that bookings are remaining flat or declining slightly while the jail population has been increasing. This means that length of stay (LOS) is increasing. This can be attributed to case processing by the courts. [iv]



Due to the City Attorney consistently not showing up at **Community Court**, hearings are repeatedly "Set for Status."

The District Attorney's Office in New Orleans has experienced staffing retention issues since YEAR.

1. There is an opportunity for District Attorney diversion (based on offense) for this population after the First Appearance hearing, however, the District Attorney is not provided with:
    - Information regarding a defendant's mental health
    - Any initial screenings or intakes documenting behavioral health concerns.



v

The Public Defender's Mental Health Unit (MHU) lost their funding in June 2021. 2021 MHU quarterly reports are included in appendix #6.

> We screened 197 defendants, 68 qualified for follow up. Based on the number of people admitted post-follow up in previous quarters, we can estimate seven of those 68 clients would have become MHU clients. Variability in docket size and inconsistent transport by OPSO, makes screening difficult and hinders identifying potential MHU clients. Additionally, docket size has risen steadily since October 2020 (when data on screening first began), with sharper rises occurring at the end of March and end of April/beginning of May 2021. This plateaus in mid-May and stays relatively stable through mid-August. The catastrophic damage from Hurricane Ida halted Municipal Court proceedings from August 27 to September 26. First Appearances resumed September 27.[vi]

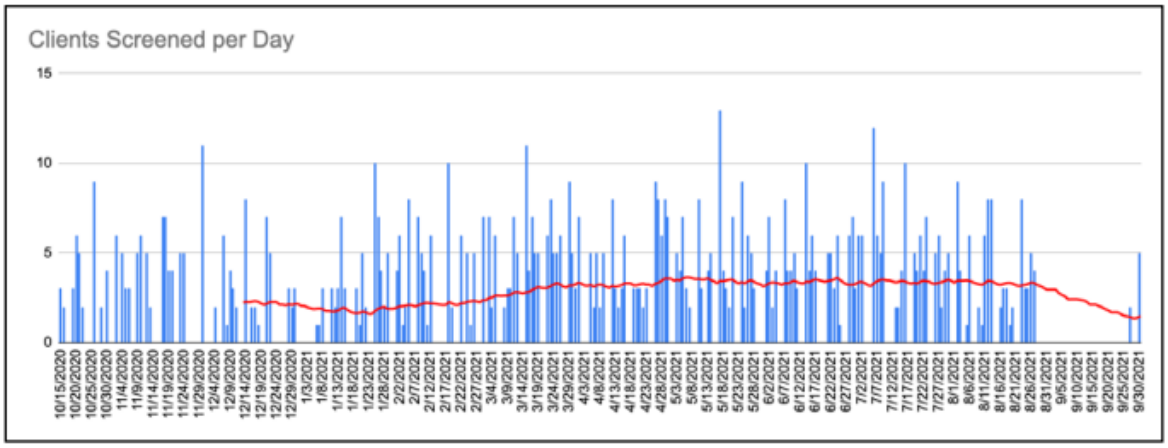


Fig.1 - Municipal Clients Screened Per Day (weekdays only)
[vii]

The one social worker that **Municipal Court** has is very limited in what he/she can do.

Problem-Solving Courts

For Specialty Courts, funding continues to be a challenge, and these courts lack space and funding for behavioral health programming.

- The Veterans Treatment Court (VTC) is active, but there currently is no funding.
- As Mental Health Court is a track of Drug Court, it is not a stand-alone program, and it is offered as post-plea. Additionally, the requirements of the Mental Health Court are more consistent with a Drug Court program than a Mental Health Court.

Mental Competency

It is difficult to get individuals admitted to Competency Restoration (in Criminal District Court) if the case did not originate from Municipal Court. Many stakeholders at the workshop contended and acknowledged that it is appropriate for this population to be diverted at this step.

The issue of Competency is rarely raised at the First Appearance hearing unless a Physician Emergency Ticket (PET) is issued; this is when an individual is presented to be booked into the facility and the jail provider is unable/not equipped to safely monitor the individual.

There is a waiting list for individuals to go to the ELMHS for **competency evaluation**. Participants noted that the average wait for admission was approximately 8 months and once admitted, the average length of stay was 6-18 months. At the time of the workshop, there were fifteen individuals waiting, and it was reported that 6 months prior, there was approximately ninety individuals waiting to be evaluated.

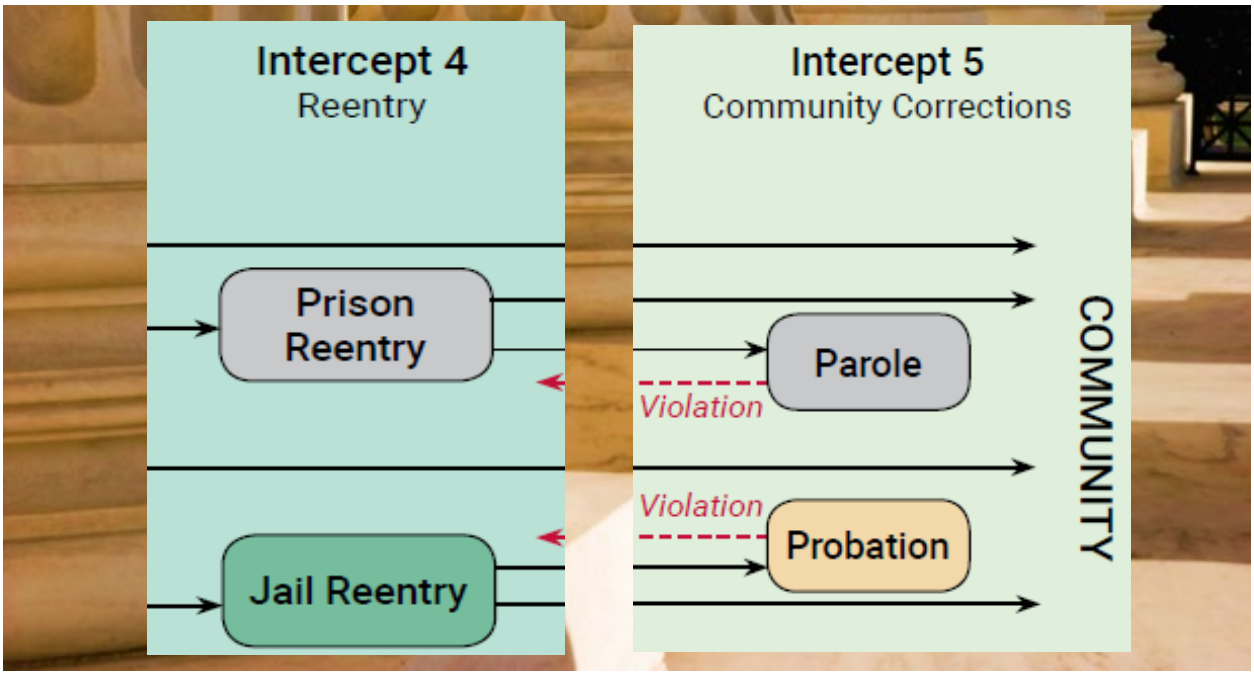
- There is no formal tracking system of the competency restoration or evaluation processes. Stakeholders shared that these processes can be tracked, however, it is a workforce capacity issue.

- A significant portion of individuals going to ELMHS are returning not competent – it is estimated that this number is 15-20%, however, no formal tracking is taking place.
- ELMHS and Wellpath have different medication formularies which may impact individuals being able to maintain competency in the jail once restored to competency at ELMHS.
- Outpatient Competency Restoration is an option that is not frequently utilized.

Data Collection and Sharing

The initial screening completed by Wellpath is not shared with any stakeholder(s) that share the same client.

- No information that can help inform subsequent intakes at the Parish level for these clients is shared by Wellpath, nor is their information documented in the jail record management system- AS-400.
- Although Wellpath "tags" a person for needing additional mental health assessment and/or evaluation in their electronic health record during their initial screening process, this information is inaccessible to any interested stakeholder who may share the client for services.



INTERCEPT 4

OPPORTUNITIES

Jail Services

Upon release from the OJC into the community, individuals on the mental health caseload are provided with a prescription for psychotropic medication 7 – 30 days. Wellpath reports that there is a 90 per cent pickup rate of these prescriptions by the individual.

Community Reentry

There are currently two hired Jail Release Navigators identifying eligible high-utilizer (booked three times or more in a 24-month period) caseload clients that have a mental health or substance use history, via a JRN Data Dashboard that was created by OCJC.

The NOLA Public Defenders Office completes discharge planning on their clients with mental illness and presents this information to the respective judges.

GAPS

Jail Services

On a frequent basis, warrants and/or holds from other jurisdictions tend to “pop” up at the time of a defendant’s release; this does not give the public defender the opportunity to address these charges during the First Appearance or subsequent court dates.

- For Municipal Court cases, warrants/holds are not being searched for until a defendant's release from the jail. As a result, the defendant who has had housing and treatment arranged post-release, tend to lose these opportunities.

Medication Management

Prescriptions are not being filled by the pharmacies that the jail behavioral health provider lists as being a vendor.

- There were several doubts expressed from stakeholders that were present of the 90 per cent post-release fill rate that was reported by Wellpath.
- Prescription lengths vary from 7-30 days depending on the medication.

Peer Support

The Metropolitan Human Services Division (MHSD) peers that are in the jail are there specifically through the COMPREHENSIVE OPIOID, STIMULANT, AND SUBSTANCE ABUSE PROGRAM. Stakeholders in attendance were not necessarily aware of this; several stakeholders shared that there are "blurred" roles of these peers as they are providing services to populations that they are not charged with servicing. In addition, at times making it difficult to properly advocate for some clients in judicial settings.

Metropolitan Human Services Division, at the time of the workshop, was at capacity for accepting any new clients for services.

Pretrial Services

Pretrial Supervision does not conduct a screening for this population; they only assess new clients for imminent needs.

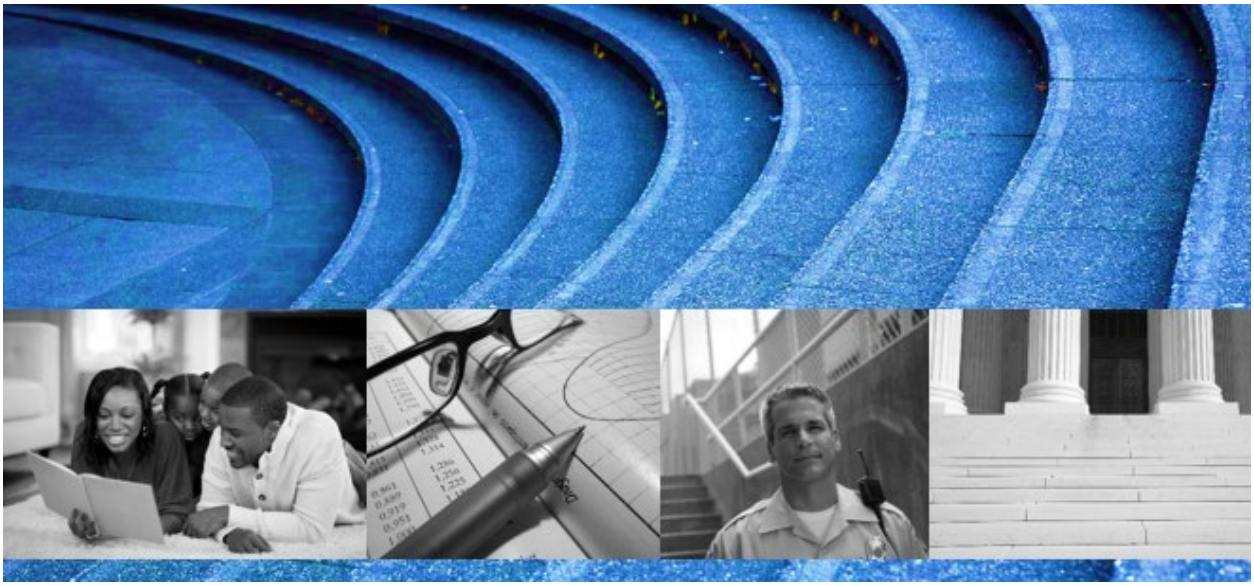
Community Reentry

The Jail Release Navigators are not identifying eligible (booked three times or more in a 24-month period) caseload clients at the time of booking because?.

- There is no dedicated workspace for these positions at the jail.

Housing

Stable, affordable, clean housing for this population remains the biggest barrier for sustained reentry.



PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants were asked to identify a set of priorities followed by a vote where each participant had three votes. The voting took place on October 5, 2022. The top three priorities are highlighted in bold text.

1. **Improve information sharing between District Attorney, Public Defenders, Pretrial Services, Mental Health Services District and WellPath (16 votes)**
2. **Enable public defender's office to meet with client in-person prior to First Appearance and connect with DA Diversion Program (9 votes)**
3. **Improve medication management across system including formularies between EMHS and jail to prevent decompensation, prevent additional symptoms, and improve medication education (7 votes)**
4. Address warrants/holds to be researched and processed as part of protocol from point of entry (6 votes)
1. Mental health diversion track: include pretrial services sharing information and getting information from District Attorney Diversion (6 votes)
    a. Add mental health and substance use screening
    b. Add criteria and communication system for DA Diversion and Public Defender's Office

4. Housing first (6 votes)
5. Create community-based treatment alternatives to increase crisis bed capacity (5 votes)
6. Convene Mental Health summit with Judges and Magistrates regarding how to utilize risk assessment and address mental health needs (4 votes)
7. Behavioral health programming in jail to address monitor's report (2 votes)
8. Community based education as relates to criminal justice system (1 vote)
8. Revalidation of public safety assessment (last completed in 2020) (1 vote)

ACTION PLANS

Priority Area: MOVING FORWARD, where will the SIM Action Plans live moving forward			
Objective	**Action Step**	**Who**	**When**
Create a New Orleans SIM report and map	Write New Orleans Sim Report with Priorities and Action Plans	PRA	November 10th
Determine where SIM work will sit and who will champion this cause going forward	Use SIM Report to present in front of Mayor's Office, District Attorney, City Council	Adrianne PRA	
Consider whether existing or new committee/task force needed to work on quick wins	Consider the following committees as options: Behavioral Health Council in Health Department - Previously had subcommittee SKNOCJC -includes leadership across the system -has a Criminal Justice Population Management Subcommittee and Criminal Justice Information Steering Committee Develop advocacy plan to address state legislature, develop marketing plan		

Priority Area #1: Improve information sharing between District Attorney, Public Defenders, Pretrial Services, Mental Health Services District, and WellPath Participants: Theresa McKinney, Keisha Bouie, Maria Alexander, De'Anna Lawson, Patrick Kemmerly, Max Lunge, Andre' Goudin, Renee Hugle			
Objective	**Action Step**	**Who**	**When**
How to use information obtained on clients - Basic demographics - Mental Health Services Division - WellPath	Need HIPAA (for use) all agencies What every agency is comfortable sharing: Courts, DA, OPD, MHSD, WellPath, Jail	District Attorney Office of Public Defender, CJIS Subcommittee	
What do we want as users of information:			
- District Attorney o At 1st appearance to advocate for treatment/follow-up; o Mental health information to get client treatment services needed	- Determine where information is preserved/stored - Identify system for sharing - What information is stored - Initial conversation with DA/OPD information sharing - Meeting with OPD & Jail Case Managers - Work on MOU to determine what information can be shared - Information being presented at First Appearance		
- Office of Public Defender o Formal process of communication with jail o Accountability, coordination, continuation of care			
- LEAD o Gain access to clients while incarcerated			

Priority Area #2: Enable public defender's office to meet with client in-person prior to First Appearance and connect with DA Diversion Program Participants: Alexis Chernow, Michelle Vines, Swayne Yakkor, Tanya Smith, Debra Hammond, Lindsay Jeffrey			
Objective	**Action Step**	**Who**	**When**
Increase OPSO transportation staff	Continue to recruit/hire deputies	Ask Sherriff Thomas	Ongoing
Clearly defined roles for court transport/CDC from OPSO	Training/policy/accountability	Captain Lawson, OPSO /Dr. Astrid	
Go back to multiple Frist Appearance settings per day	Get Enbanc to agree to multiple First Appearance s a day/get OPSO to agree to transport Get OPDA and OPD to staff	Enbanc/OPSO/OPD/OPDA	
Clearly defined policy on what/when inmates are transported to court settings (days? 6 at time?)	Document/memorialize policy/procedure and shape with Enbanc/OPDA/OPD	OPSO	
Improve WIFI capabilities in jail if going to take place at jail court for extenuating circumstances	OPSO work with IT	A.S. Morales	3 month timeline given
Get all jail list inmates transported to court for every setting unless documented reason for no transport	See how many jail list inmate are not being transported to court daily. Are they being transported to docks? Why not brought?	CourtWatch NOLA OPSO/Court	
Flag inmates for substance use/mental health issues and share with District Attorney for diversion recommendation at First Appearance	Train ADA/staff to ID mental health/substance use in cases Sharing information once identified	OPDA/Magistrate	

Priority Area #3: Improve medication management across system including formularies between Elms and jail to prevent decompensation, prevent additional symptoms, improve medication education Participants: P. Williams, S. Johnson, A. Birgden, T. Perryman, D. Winfield, M. Trudeau, B. Hortenstine, G. Carroll			
Objective	Action Step	Who	When
Establish a database inclusive of all local pharmacies	Convince other pharmacies to contribute to the database that is already in place	Legislative	Immediately
Establish a release routine for BH/MH residents	Discharge planning Create release hours Medication cards/transportation Dressed underneath jumpsuits	OPP Case Manager Judge Sherriff	Upon release
Ensure there are follow up mental health appointments	Schedule follow up appointments	JRN/case managers	Prior to release

PARKING LOT

Some gaps identified during the Sequential Intercept Mapping are too large or in-depth to address during the workshop. These issues are listed below.

INTERCEPT 1 – there is a new electronic data sharing program between the District Attorney's Office and Police Department to get information from each other's respective databases.

EPIC - Ethical Policing Is Courageous is a peer intervention program developed by the NOPD, in collaboration with community partners, to promote a culture of high-quality and ethical policing. EPIC educates, empowers, and supports the officers on the streets to play a meaningful role in "policing" one another. EPIC is a peer intervention program that teaches officers how to intervene to stop a wrongful action before it occurs.

At its core, EPIC is an officer survival program, a community safety program, and a job satisfaction program. EPIC represents a cultural change in policing that equips, encourages, and supports officers to intervene to prevent misconduct and ensure high-quality policing. Everyone benefits when potential misconduct is not perpetrated or when a potential mistake is not made.

All peers utilized in this program have been released from custody.

RECOMMENDATIONS

The Orleans Parish mapping exercise identified areas where programs may need expansion or where new resources and programming must be developed.

Building on solid community commitment and foundation, Orleans Parish has a wealth of resources yet is still a system dealing with gaps.

Continue to shape efforts by formalizing a County-wide Criminal Justice/Behavioral Health Planning Body to address the needs of justice-involved persons with mental health and substance use disorders.

There is a need for on-going dialogue, joint planning, and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state-, county-, and municipal-level change.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

Also, the following national initiatives can inform planning efforts and provide technical assistance to enhance community collaboration:

- The International Association of Chiefs of Police's One Mind Campaign http://www.theiacp.org/onemindcampaign/
- The Stepping Up Initiative https://stepuptogether.org/

Designate an individual on your task force to serve as a State Liaison or invite state office personnel to local meetings so the local concerns on key issues can be addressed at the highest levels.

Address the Incompetent to Stand Trial (IST) population.

Participants discussed the IST population who are retained in jail while waiting transfer to a state forensic hospital. The IST issue is a challenge for states across the country, but strategies have emerged to reduce the number of individuals found IST, provide outpatient restoration alternatives and reduce IST inpatient length of stay. In addition, coordinating strategies within the state forensic leadership will be a critical pathway toward reducing this challenge. This may include coordinating formularies between state hospitals and local jails, as well as coordinating across other activities as well, including thinking through how an IST patient may be eligible for AOT services, or able to be diverted through crisis services and then longer term supports. For cases in which charges are minor, legal standards, such as the American Bar Association standards from 2016, point to consideration of diversion strategies for the misdemeanant who is incompetent to stand trial (see standard 7.4-8(e)).

Stakeholder meetings from the local jurisdiction and the state to focus on this population can be helpful. Outpatient competency-related programs can also be considered. Also see the SAMHSA's GAINS Center's *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial* (2007).

Consider the development of a Local Crisis Center

The development of a crisis center in New Orleans would provide individuals experiencing a mental health crisis with access to short-term stabilization and triage to other services to assist with engagement in the appropriate behavioral health services. See the Crisis Now website for a community self-assessment and bed calculator to assist in determining the recommended service capacities in Potter and Randall counties.

A 23-hour crisis stabilization unit can serve as the hub which connects a community's crisis care continuum between front-end responses on one side and higher levels of care on the other (e.g., crisis residential programs, psychiatric inpatient settings). Crisis stabilization units provide 23-hour observation and stabilization with an opportunity to triage, monitor, and refer individuals to a follow-up level of care. These units may be a standalone service or co-located with other services such as sobering units, crisis residential programs, or on hospital campuses.

Some of the major questions in designing a crisis service, apart from the various types of care and levels of care, are as follows:

- How can the crisis service serve as an integrated hub for other crisis care components?
- What mental health and substance use crisis care gaps exist in the community that a crisis service could help ameliorate?
- Where can a crisis service be located so that it is positioned for equitable access to all residents?
- What are the pathways into the crisis center? Can people be diverted from the emergency department to the crisis center?
- How can the crisis center assist individuals? Become connected with treatment? Access support services and housing? Obtain health coverage and entitlements?

- Moving forward, it is essential to design the crisis diversion center with the user in mind. A 2016 paper by mental health crisis professionals established the Crisis Reliability Indicators Supporting Emergency Services (CRISES) performance measurement framework for ensuring high-quality services responsive to the needs of people experiencing crises (Appendix A). The CRISES framework for excellence in crisis services set forth seven principles with the understanding that a person in crisis should receive services that are…

Enhance the existing criminal justice council's jail population management subcommittee

1. Improve the jail pre-trial population review process to look at anyone who is eligible for bond and release but who is still detained after 3 - 5 or more days.
    a. Revise the regular review process; identify strategies to release or divert individuals to treatment and services, especially those who have been detained more than 3 times in a year.
    b. Develop strategies to address system issues where competence to stand trial can be or has been raised.
    c. Continue to work with JRNs to develop a comprehensive reentry process for those released quickly (within hours of booking), and other lengths of stay including community-based service coordination.
2. Develop a cross-system and cross-population review process of individuals frequently known to Orleans Parish Jail, local and state hospitals, and especially those "boarded" in any of the facilities for extended periods of time. Use data and cost measures. Identify opportunities to build system efficiency and client effectiveness.

In Lucas County, Ohio Lucas County, Ohio. Weekly meetings are held with the prosecutor, public defender, jail representatives, mental health professionals, and others when appropriate. The

team reviews a list of individuals in pre-trial custody to determine why a person is being detained and if he or she can be safely released before trial or have his/her case resolved quickly. For example, some individuals are released to mental health services as part of pre-trial conditions. In other cases, if the case during the normal course of action would result in a plea, the plea offers expedited rather than waiting to set a trial date.

Develop more formal and coordinated screening to enhance current and future diversion strategies at arraignment (Intercept 2) and pre-plea diversion (Intercept 3).

Formalizing screening protocols at arraignment and at the jail is the first step in expanding and implementing diversion strategies. Many screens, such as the Brief Jail Mental Health Screen, are in the public domain.

Additional brief mental health screens include the:

Correctional Mental Health Screen

Mental Health Screening Form III

Brief alcohol and drug screens include the:

Texas Christian University Drug Screen V

Simple Screening Instrument for Substance Abuse

Alcohol, Smoking and Substance Involvement Screening Test

Defendants with mental health disorders who are remanded to pretrial detention often have worse public safety outcomes than defendants who are released to the community pending disposition of their criminal cases. Consider proportional responses based on the severity of a defendant's criminal risk and behavioral health treatment needs.

Defendants with pending cases who are released to pre-trial services as an alternative to detention. These may be cases with moderate criminal risk, but where the individuals would benefit from community-based services that are not available while in pretrial detention and pretrial failure can be avoided.

A deferred prosecution approach where a low-risk defendant is directed to participate in a short-term community-based treatment program. Successful completion of the program results in dismissal of the charges while failure results in remand to custody and continuation of the criminal case.

Consider a competency court docket, such as was established by the Seattle Municipal Court, to reduce time spent in jail during the competency process. Refer to the journal article by Finkle and colleagues (2009) and the 2013 report on the Seattle Municipal Court Mental Health Court, which houses the competency court docket.

Essential elements of Intercept 2 diversion can be found in the SAMHSA Monograph, "Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders in the Criminal Justice System." The monograph identifies four essential elements of arraignment

diversion programs. Improving screening, clinical assessment, and behavioral health disorders who are released without referral or follow-up. The CASES Transitional Case Management and the Manhattan Arraignment Diversion Program are two examples.

See also the *Screening and Assessment* section of the Resources below.

IMPROVE COMMUNICATIONS BETWEEN STAKEHOLDERS

Improving communication between stakeholders was a key theme that came across during the workshop. Consider having communications (public information officers), newsletter publication staff, etc. attend some of the existing stakeholder meetings. Have them identify a way to help communicate the work taking place within and across the stakeholders.

Consider convening and rotating location of cross-system and discipline meetings, resulting in an increase of expectations of agencies to understand the scope and practice of criminal justice and behavioral health partners/stakeholders.

UPDATE THE PSA WITH A VALIDATION STUDY

A preliminary validation study was completed by JFA of the PSA in 2020. It would be useful to update this report based on some of the issues that were raised in the study and during the SIM Workshop.

RESOURCES

Competence Evaluation and Restoration

- Policy Research Associates. Competence to Stand Trial Microsite.
- Policy Research Associates. (2007, re-released 2020). Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- National Council for Behavioral Health. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.
- National Association of State Mental Health Program Directors. Crisis Now: Transforming Services is Within our Reach.
- National Association of Counties. (2010). Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- Abt Associates. (2020). A Guidebook to Reimagining America's Crisis Response Systems.
- Urban Institute. (2020). Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices.
- Open Society Foundations. (2018). Police and Harm Reduction.
- Center for American Progress. (2020). The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call.
- Vera Institute of Justice. (2020). Behavioral Health Crisis Alternatives: Shifting from Policy to Community Responses.
- National Association of State Mental Health Program Directors. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.
- National Association of State Mental Health Program Directors and Treatment Advocacy Center. (2017). Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care.
- R Street. (2019). Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response.
- Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.
- Substance Abuse and Mental Health Services Administration. (2019). Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities.
- Substance Abuse and Mental Health Services Administration. (2020). Crisis Services: Meeting Needs, Saving Lives.

    - Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.
- Crisis Intervention Team International. (2019). Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises.
- Suicide Prevention Resource Center. (2013). The Role of Law Enforcement Officers in Preventing Suicide.
- Bureau of Justice Assistance. (2014). Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.
- International Association of Chiefs of Police. One Mind Campaign: Enhancing Law Enforcement Engagement with People in Crisis, with Mental Health Disorders and/or Developmental Disabilities.
- Bureau of Justice Assistance. Police-Mental Health Collaboration Toolkit.
- Policy Research Associates and the National League of Cities. (2020). Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers.
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- Optum. (2015). In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program (CAMP) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.

Brain Injury

- National Association of State Head Injury Administrators. (2020). Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
- National Association of State Head Injury Administrators. Supporting Materials including Screening Tools and Sample Consent Forms.

Housing

- The Council of State Governments Justice Center. (2021). Reducing Homelessness for People with Behavioral Health Needs Leaving Prisons and Jails: Recommendations to California's Council on Criminal Justice and Behavioral Health.
- Alliance for Health Reform. (2015). The Connection Between Health and Housing: The Evidence and Policy Landscape.
- Economic Roundtable. (2013). Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.
- 100,000 Homes. Housing First Self-Assessment.
- Community Solutions. Built for Zero.
- Urban Institute. (2012). Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.
- Corporation for Supportive Housing. Guide to the Frequent Users Systems Engagement (FUSE) Model.
    - Corporation for Supportive Housing. NYC Frequent User Services Enhancement – Evaluation Findings.

- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Substance Abuse and Mental Health Services Administration. (2015). TIP 55: Behavioral Health Services for People Who Are Homeless.
- National Homelessness Law Center. (2019). Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities.
- Council of State Governments Justice Center. (2021). Reducing Homelessness for People with Behavioral Health Needs Leaving Prison and Jails.

Information Sharing/Data Analysis and Matching

- Center for Policing Equity. (2020). Toolkit for Equitable Public Safety.
- Legal Action Center. (2020). Sample Consent Forms for Release of Substance Use Disorder Patient Records.
- Council of State Governments Justice Center. (2010). Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.
- American Probation and Parole Association. (2014). Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.
- The Council of State Governments Justice Center. (2011). Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.
- Substance Abuse and Mental Health Services Administration. (2019). Data Collection Across the Sequential Intercept Model: Essential Measures.
- Substance Abuse and Mental Health Services Administration. (2018). Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide.
- Data-Driven Justice Initiative. (2016). Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. (2013). Justice Reinvestment at the Local Level: Planning and Implementation Guide.
- Vera Institute of Justice. (2012). Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.
- New Orleans Health Department. (2016). New Orleans Mental Health Dashboard.
- The Cook County, Illinois Jail Data Linkage Project: A Data Matching Initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the Cook County Jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of the enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

Jail Inmate Information/Services

- NAMI California. Arrested Guides and Medication Forms.
- NAMI California. Inmate Mental Health Information Forms.
- Urban Institute. (2018). Strategies for Connecting Justice-Involved Populations to Health Coverage and Care.
- R Street. (2020). How Technology Can Strengthen Family Connections During Incarceration.

Medication-Assisted Treatment (MAT)/Opioids/Substance Use

- American Society of Addiction Medicine. Advancing Access to Addiction Medications.

- American Society of Addiction Medicine. (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
    - ASAM 2020 Focused Update.
    - Journal of Addiction Medicine. (2020). Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.
- National Commission on Correctional Health Care and the National Sheriffs' Association. (2018). Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.
- National Council for Behavioral Health. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit.
- Substance Abuse and Mental Health Services Administration. (2019). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings.
- Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion.
- Substance Abuse and Mental Health Services Administration. (2015). Federal Guidelines for Opioid Treatment Programs.
- Substance Abuse and Mental Health Services Administration. (2020). Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder.
- Substance Abuse and Mental Health Services Administration. (2014). Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide.
- Substance Abuse and Mental Health Services Administration. (2015). Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.
- U.S. Department of Health and Human Services. (2018). Facing Addiction in America: The Surgeon General's Spotlight on Opioids.

Mental Health First Aid

- Mental Health First Aid. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
- Illinois General Assembly. (2013). Public Act 098-0195: Illinois Mental Health First Aid Training Act.
- Pennsylvania Mental Health and Justice Center of Excellence. City of Philadelphia Mental Health First Aid Initiative.

Peer Support/Peer Specialists

- Policy Research Associates. (2020). Peer Support Roles Across the Sequential Intercept Model.
- Department of Behavioral Health and Intellectual disability Services. Peer Support Toolkit.
- University of Colorado Anschutz Medical Campus, Behavioral Health and Wellness Program (2015). DIMENSIONS: Peer Support Program Toolkit.
- Local Program Examples:
    - People USA. Rose Houses are short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. They are 100% operated by peers.
    - Mental Health Association of Nebraska. Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with Peer Specialists.
    - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
    - MHA NE/Lincoln Police Department REAL Referral Program. The REAL referral program works closely with law enforcement officials, community corrections officers

and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained Peer Specialists.

Pretrial/Arraignment Diversion

- Substance Abuse and Mental Health Services Administration. (2015). Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System.
- CSG Justice Center. (2015). Improving Responses to People with Mental Illness at the Pretrial Stage: Essential Elements.
- National Resource Center on Justice Involved Women. (2016). Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. (2013). The Hidden Costs of Pretrial Diversion.

Procedural Justice

- Center for Court Innovation. (2019). Procedural Justice at the Manhattan Criminal Court.
- Chintakrindi, S., Upton, A., Louison A.M., Case, B., & Steadman, H. (2013). Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors.
- American Bar Association. (2016). Criminal Justice Standards on Mental Health.
- Hawaii Opportunity Probation with Enforcement (HOPE) Program Profile. (2011). HOPE is a community supervision strategy for probationers with substance use disorders, particularly those who have long histories of drug use and involvement with the criminal justice system and are considered at high risk of failing probation or returning to prison.

Racial Equity and Disparities

- Mathematica. (2021). Using a Culturally Responsive and Equitable Evaluation Approach to Guide Research and Evaluation.
- Law360. (2021). Data Collection Is Crucial For Equity In Diversion Programs.
- Chicago Beyond. (2018). Why Am I Always Being Researched? A Guidebook for Community Organizations, Researchers, and Funders.
- National Academies of Sciences, Engineering, and Medicine. (2021). Addressing the Drivers of Criminal Justice Involvement to Advance Racial Equity: Proceedings of a Workshop—in Brief.
- Substance Abuse and Mental Health Services Administration. (2015) TIP 59: Improving Cultural Competence.
- SAMHSA's Program to Achieve Wellness. Modifying Evidence-Based Practices to Increase Cultural Competence: An Overview.
- Actionable Intelligence for Social Policy. (2020). A Toolkit for Centering Racial Equity Throughout Data Integration.
- The W. Haywood Burns Institute. Reducing Racial and Ethnic Disparities: A NON-COMPREHENSIVE Checklist.
- National Institute of Corrections. (2014). Incorporating Racial Equality Into Criminal Justice Reform.
- Vera Institute of Justice. (2015). A Prosecutor's Guide for Advancing Racial Equity.

Reentry

- Substance Abuse and Mental Health Services Administration. (2017). Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.
- Substance Abuse and Mental Health Services Administration. (2016). Reentry Resources for Individuals, Providers, Communities, and States.
- Substance Abuse and Mental Health Services Administration. (2020). After Incarceration: A Guide to Helping Women Reenter the Community.
- National Institute of Corrections and Center for Effective Public Policy. (2015). Behavior Management of Justice-Involved Individuals: Contemporary Research and State-of-the-Art Policy and Practice.
- The Council of State Governments Justice Center. (2009). National Reentry Resource Center
- Community Oriented Correctional Health Services. Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies.
- Washington State Institute of Public Policy. (2014). Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.

Screening and Assessment

- Substance Abuse and Mental Health Services Administration. (2019). Screening and Assessment of Co-occurring Disorders in the Justice System.
- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.
- Center for Court Innovation. Digest of Evidence-Based Assessment Tools.
- Urban Institute. (2012). The Role of Screening and Assessment in Jail Reentry.
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822.

Sequential Intercept Model

- Policy Research Associates. The Sequential Intercept Model Microsite.
- Munetz, M.R., and Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services*, 57, 544-549.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). The Sequential Intercept Model and Criminal Justice. New York: Oxford University Press.
- Urban Institute. (2018). Using the Sequential Intercept Model to Guide Local Reform.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

- The online SOAR training portal.
- Information regarding FAQs for SOAR for justice-involved persons.
- Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. Psychiatric Services, 65, 1081-1083.

Telehealth

- Remington, A.A. (2016). 24/7 Connecting with Counselors Anytime, Anywhere. National Council Magazine. Issue 1, page 51.

Transition-Aged Youth

- National Institute of Justice. (2016). Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults.
- Harvard Kennedy School Malcolm Weiner Center for Social Policy. (2016). Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21.
- Roca, Inc. Intervention Program for Young Adults.
- University of Massachusetts Medical School. Transitions to Adulthood Center for Research.

Trauma and Trauma-Informed Care

- SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.
- SAMHSA. (2014). TIP 57: Trauma-Informed Care in Behavioral Health Services.
- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. (2011). Essential Components of Trauma Informed Judicial Practice.
- SAMHSA's GAINS Center. (2011). Trauma-Specific Interventions for Justice-Involved Individuals.
- National Resource Center on Justice-Involved Women. (2015). Jail Tip Sheets on Justice-Involved Women.
- Bureau of Justice Assistance. VALOR Officer Safety and Wellness Program.

Veterans

- SAMHSA's GAINS Center. (2008). Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions.
- Justice for Vets. (2017). Ten Key Components of Veterans Treatment Courts.

APPENDIX

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[i] JFA Institute, 2022. NOLA Bookings and ADP (June 1, 2022 – September 30, 2022)

[ii] JFA Institute, February 18, 2020. Preliminary Evaluation of New Orleans Pretrial Risk Assessment System

[iii] JFA Institute, 2022. NOLA Bookings and ADP (June 1, 2022 – September 30, 2022)

[iv] JFA Institute, 2022. NOLA Bookings and ADP (June 1, 2022 – September 30, 2022)

[v] JFA Institute, James Austin, Ph.D., 2022 Orleans Parish Stress Test

[vi] Orleans Public Defenders; Municipal Mental Health Unit, July – September 2021, Q3 Barksdale Hortenstine, Jr. Director, Mental Health Unit.

[vii] Orleans Public Defenders; Municipal Mental Health Unit, July – September 2021, Q3 Barksdale Hortenstine, Jr. Director, Mental Health Unit.

Appendix 1

New Orleans SIM Workshop Sign-in

Day 1: Wednesday, October 5th, 2022

First Name	Last Name	Organization	Initials or signature
Abby	FREMIN	OPDA	
Adrienne	TOBLER	OCJC	
Alexis	CHERNOW	OPD	
Andre	GAUDIN	OPDA	
Astrid	BIRGDEN	Orleans Justice Center	
Barksdale	HORTENSTINE	OPD	
Carroll	GREGORY	Orleans Justice Center	
Chad	SANDERS	First 72+	
Chauntay	ESTEEN	Orleans Justice Center	
Danny	ENGELBERG	OPD	
Darlene	WINFIELD	Criminal District Court	
De'Anna	LAWSON	Criminal District Court	
Deborah	CHAPMAN	Orleans Justice Center	
Debra	HAMMONS	Orleans Justice Center	
Djuana	BIERRA	Orleans Justice Center	
Duane	PARKER	MHSD	
Ginger	PARSONS	OPD	
Glenn	POWELL	Orleans Justice Center	
Jonathan	FRIEDMAN	Criminal District Court	
Jonathon	GRIFFIN	Orleans Justice Center	
Joseph	HAINES	Criminal District Court	
Juana	LOMBARD	Criminal District Court	
Keisha	BOUIE	Criminal District Court	
Keyon	ALEXANDER-CHAPMAN	Orleans Justice Center	
Lindsay	JEFFREY	Criminal District Court	
Maria	ALEXANDER	MHSD	
Marie	KERRIN	LEAD	
Melvin	JOSEPH	Orleans Justice Center	
Micah	INCE	OPDA	
Michelle	JONES	OPDA	
Natalie	SHARP	NOVAS	
GREGORY	CARROLL	OPSO	

First Name	Last Name	Organization	Initials or signature
Ned	McGowan	OPDA	
Patrick	Kimmerly	LEAD	
Priscilla	Williams	Goodwill	
Sarah	DeLand	Tulane University School of Medicine	
Shaloni	Johnson	Goodwill	
Tangy	Verrett	Orleans Justice Center	
Tanya	Smith	Orleans Justice Center	
Terry	Perryman	MHSD	
Theresa	McKinney	OCJC	
Trenell	Hugle	OPDA	
Tuere	Burns	NOVAS	
Renee'	Gill Pratt	Goodwill	

New Orleans SIM Workshop Sign-in

Day 2: Thursday, October 6th, 2022

First Name	Last Name	Organization	Initials or signature
Abby	FREMIN	OPDA	
Adrienne	TOBLER	OCJC	
Alexis	CHERNOW	OPD	
Andre	GAUDIN	OPDA	
Astrid	BIRGDEN	Orleans Justice Center	
Barksdale	HORTENSTINE	OPD	
Carroll	GREGORY	Orleans Justice Center	
Chad	SANDERS	First 72+	
Chauntay	ESTEEN	Orleans Justice Center	
Danny	ENGELBERG	OPD	
Darlene	WINFIELD	Criminal District Court	
De'Anna	LAWSON	Criminal District Court	
Deborah	CHAPMAN	Orleans Justice Center	
Debra	HAMMONS	Orleans Justice Center	
Djuana	BIERRA	Orleans Justice Center	
Duane	PARKER	MHSD	
Ginger	PARSONS	OPD	
Glenn	POWELL	Orleans Justice Center	
Jonathan	FRIEDMAN	Criminal District Court	
Jonathon	GRIFFIN	Orleans Justice Center	
Joseph	HAINES	Criminal District Court	
Juana	LOMBARD	Criminal District Court	
Keisha	BOUIE	Criminal District Court	
Keyon	ALEXANDER-CHAPMAN	Orleans Justice Center	
Lindsay	JEFFREY	Criminal District Court	
Maria	ALEXANDER	MHSD	
Marie	KERRIN	LEAD	
Melvin	JOSEPH	Orleans Justice Center	
Micah	INCE	OPDA	
Michelle	JONES	OPDA	
Natalie	SHARP	NOVAS	

First Name	Last Name	Organization	Initials or signature
Ned	MCGOWAN	OPDA	
Patrick	KIMMERLY	LEAD	
Priscilla	WILLIAMS	Goodwill	
Sarah	DELAND	Tulane University School of Medicine	
Shaloni	JOHNSON	Goodwill	
Tangy	VERRETT	Orleans Justice Center	
Tanya	SMITH	Orleans Justice Center	
Terry	PERRYMAN	MHSD	
Theresa	MCKINNEY	OCJC	
Trenell	HUGLE	OPDA	
Tuere		NOVAS	
Max	Tredeau	Wellpath	
Max	Lurye	OPD	

Appendix 2

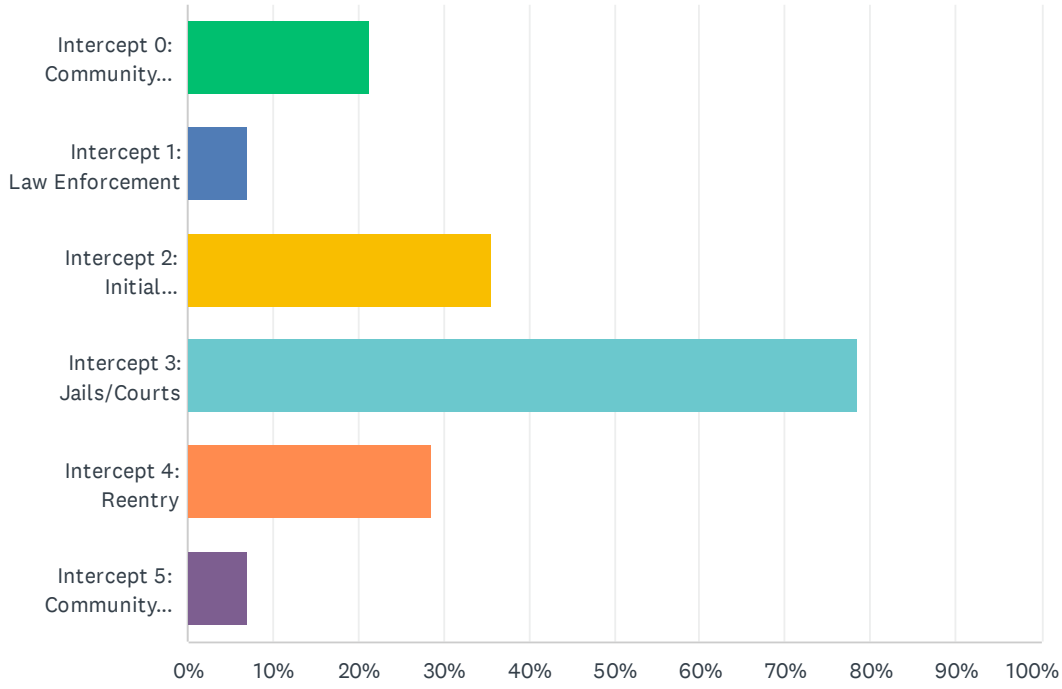
Q3 What professional field do you represent? (e.g., Behavioral Health, Corrections, Family, Peer Services, Law Enforcement)

Answered: 14 Skipped: 0

#	RESPONSES	DATE
1	Court Public defender	10/5/2022 10:04 AM
2	Corrections Corrections	10/4/2022 7:54 PM
3	Law Enforcement Law Enforcement	10/4/2022 5:27 PM
4	Court Reentry Specialty Reentry Court	10/4/2022 4:58 PM
5	Corrections Corrections	10/4/2022 12:05 PM
6	Behavioral Health Community Services Behavioral health	9/29/2022 10:32 AM
7	Court Court	9/28/2022 1:34 PM
8	Corrections Corrections (Jail)	9/28/2022 12:36 PM
9	Court Public Defense	9/27/2022 5:46 PM
10	Community Services Community oversight/community engagement	9/27/2022 5:42 PM
11	Reentry Reentry	9/23/2022 11:01 AM
12	Court Courts	9/23/2022 9:02 AM
13	Behavioral Health Reentry Behavioral Health/Re-entry	9/23/2022 8:58 AM
14	City Government City Government	9/22/2022 5:05 PM

Q4 Where on the Sequential Intercept Model is your role in the community most related?

Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Intercept 0: Community Services (1)	21.43%	3
Intercept 1: Law Enforcement (2)	7.14%	1
Intercept 2: Initial Detention/Initial Court Hearings (3)	35.71%	5
Intercept 3: Jails/Courts (4)	78.57%	11
Intercept 4: Reentry (5)	28.57%	4
Intercept 5: Community Corrections (6)	7.14%	1
Total Respondents: 14		

BASIC STATISTICS				
Minimum	Maximum	Median	Mean	Standard Deviation
1.00	6.00	4.00	3.60	1.26

Q5 Please indicate the accuracy of the following statements about your community.

Answered: 12 Skipped: 2

	TRUE	FALSE	I DON'T KNOW	TOTAL
There is cross-system recognition that many adults involved with the criminal justice system are experiencing mental disorders and substance use disorders.	91.67% 11	0.00% 0	8.33% 1	12
There is cross-system recognition that all systems are responsible for responding to these adults with mental and substance use disorders.	66.67% 8	25.00% 3	8.33% 1	12
Stakeholders have established a shared mission and goals to facilitate collaboration in criminal justice and behavioral health.	58.33% 7	33.33% 4	8.33% 1	12
Stakeholders engage in frequent communication on criminal justice and behavioral health issues, including opportunities, challenges, and oversight of existing initiatives.	58.33% 7	33.33% 4	8.33% 1	12
Based on research evidence and guidance on best practices, stakeholders are willing to change beliefs, behaviors, practices, and policies relating to justice-involved adults with mental disorders and substance use disorders.	58.33% 7	8.33% 1	33.33% 4	12
Stakeholders focus on overcoming barriers to implementing effective programs and policies for justice-involved adults with mental disorders or substance use disorders.	50.00% 6	41.67% 5	8.33% 1	12
The criminal justice and behavioral health systems are engaged in collaborative and comprehensive efforts to foster a shared understanding of gaps at each point in the justice system.	33.33% 4	41.67% 5	25.00% 3	12
Family members of people with mental disorders or substance use disorders are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards.	33.33% 4	33.33% 4	33.33% 4	12
People with lived experience of mental disorders, substance use disorders, and the justice system are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards.	33.33% 4	33.33% 4	33.33% 4	12
In the justice system, criminal justice and behavioral health agencies share resources and staff to support initiatives focused on adults with mental disorders or substance use disorders.	33.33% 4	41.67% 5	25.00% 3	12
Criminal justice and behavioral health agencies share data on a routine basis for program planning, program evaluation, and performance measurement.	25.00% 3	50.00% 6	25.00% 3	12
Criminal justice and behavioral health agencies engage in cross-system education and training to improve collaboration and understanding of different agency priorities, philosophies, and mandates.	25.00% 3	33.33% 4	41.67% 5	12

Q6 Please indicate the accuracy of the following statements about your community

Answered: 12 Skipped: 2

	TRUE	FALSE	I DON'T KNOW	TOTAL
There are procedures to access crisis behavioral health services for adults in contact with the criminal justice system.	58.33% 7	16.67% 2	25.00% 3	12
Adults in contact with the criminal justice system are screened for suicide risk by standardized instruments with demonstrated reliability and validity.	50.00% 6	0.00% 0	50.00% 6	12
Information obtained through screening and assessments is never used in a manner that jeopardizes an individual's legal interests.	41.67% 5	8.33% 1	50.00% 6	12
Adults in contact with the criminal justice system are screened for mental disorders by standardized instruments with demonstrated reliability and validity.	33.33% 4	33.33% 4	33.33% 4	12
Substance use assessments are conducted regularly whenever a screening instrument indicates any such need for adults in contact with the criminal justice system.	33.33% 4	8.33% 1	58.33% 7	12
Risk assessments are performed in conjunction with screening and assessments to inform treatment and programming recommendations that balance public safety and behavioral health treatment needs.	33.33% 4	25.00% 3	41.67% 5	12
Adults in contact with the criminal justice system are screened for substance use disorders by standardized instruments with demonstrated reliability and validity.	25.00% 3	25.00% 3	50.00% 6	12
Mental health assessments are conducted routinely whenever a screening instrument indicates any such need for adults in contact with the criminal justice system.	25.00% 3	0.00% 0	75.00% 9	12
Adults in contact with the criminal justice system are screened for violence and trauma-related symptoms by standardized instruments with demonstrated reliability and validity.	16.67% 2	41.67% 5	41.67% 5	12
Screens and assessments are administered on a routine basis as adults move from one point in the criminal justice system to another.	16.67% 2	25.00% 3	58.33% 7	12
Regular data-matching between criminal justice agencies and behavioral health identifies active and former consumers who have entered the criminal justice system.	16.67% 2	33.33% 4	50.00% 6	12

Q7 Please indicate the accuracy of the following statements about your community.

Answered: 10 Skipped: 4

	TRUE	FALSE	I DON'T KNOW	TOTAL
Pre-trial strategies are in place to reduce detention of low-risk defendants and failure to appear rates for people with mental and substance use disorders.	60.00% 6	30.00% 3	10.00% 1	10
Justice-involved people with mental and substance use disorders have access to comprehensive community-based services.	50.00% 5	50.00% 5	0.00% 0	10
Treatment courts are aligned with best-practice standards and serve high-risk/high-need individuals.	40.00% 4	20.00% 2	40.00% 4	10
Psychotropic medication or prescriptions are provided to inmates with mental disorders to bridge the gaps from the day of jail release to their first appointment with a community-based prescriber.	40.00% 4	20.00% 2	40.00% 4	10
Jail transition planning is provided to inmates with mental disorders to improve post-release recidivism and health care outcomes.	30.00% 3	30.00% 3	40.00% 4	10
Emergency communications call-takers and dispatchers can effectively identify and communicate details about crisis calls to law enforcement and other first responders.	20.00% 2	0.00% 0	80.00% 8	10
Law enforcement and other first responders are trained to respond to adults experiencing mental health crises effectively.	20.00% 2	30.00% 3	50.00% 5	10
Pre-adjudication diversion strategies are as equally available as post-adjudication diversion strategies for individuals with mental disorders and substance use disorders.	20.00% 2	40.00% 4	40.00% 4	10
Evaluation results are reviewed by representatives from the behavioral health and criminal justice systems	20.00% 2	40.00% 4	40.00% 4	10
There are adequate crisis services to meet the needs of people experiencing mental health crises.	10.00% 1	90.00% 9	0.00% 0	10
Jail-based programming and health care meet the complex needs of individuals with mental disorders and substance use disorders, including behavioral health care and chronic health conditions (e.g., diabetes, HIV/AIDS).	10.00% 1	40.00% 4	50.00% 5	10
Medication-assisted treatment is provided to inmates with substance use disorders to reduce relapse episodes and risk for opioid overdoses following release from incarceration.	10.00% 1	30.00% 3	60.00% 6	10
Community supervision agencies (probation and parole) field specialized caseloads for individuals with mental disorders to improve public safety outcomes, including reduced rates of technical violations.	10.00% 1	0.00% 0	90.00% 9	10
Strategies to intervene with justice-involved adults with mental disorders and substance use disorders are evaluated regularly to determine whether they are achieving the intended outcomes.	10.00% 1	30.00% 3	60.00% 6	10

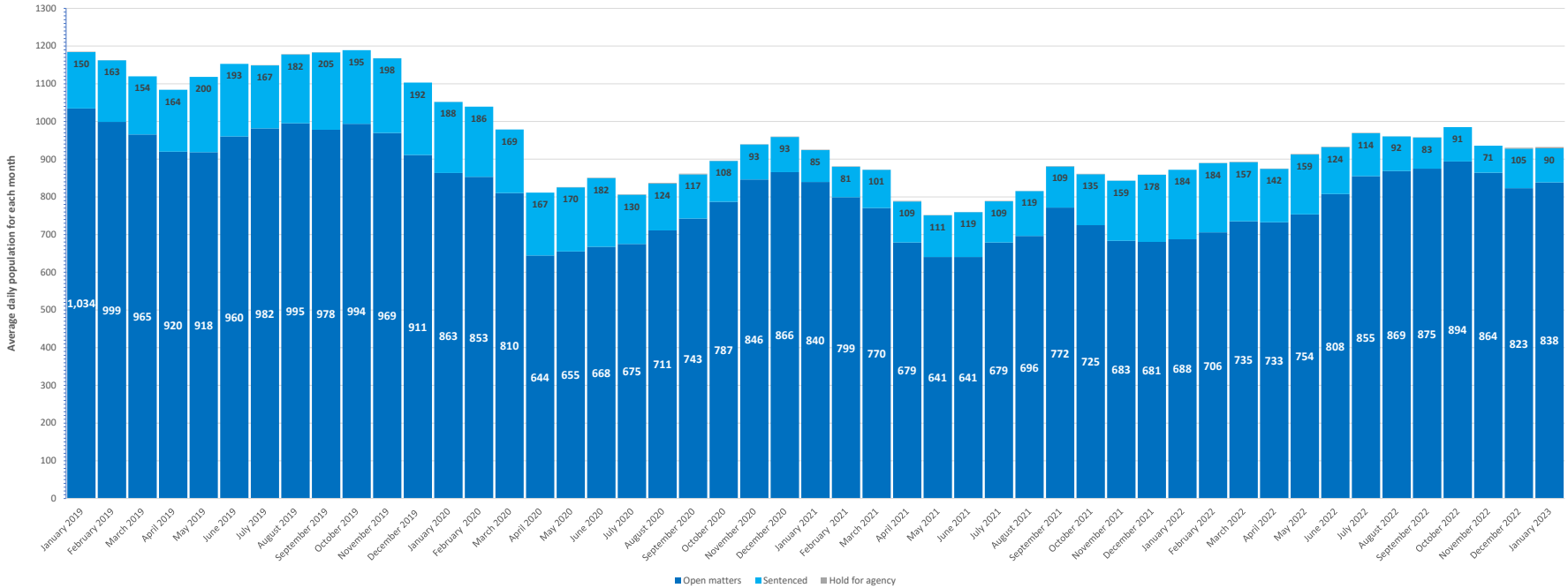
Q8 Please indicate the accuracy of the following statements about your community.

Answered: 10 Skipped: 4

	TRUE	FALSE	I DON'T NOW	TOTAL
Adults with mental disorders and substance use disorders in contact with the criminal justice system have access to a continuum of comprehensive and effective community-based behavioral health care services.	40.00% 4	50.00% 5	10.00% 1	10
Access to housing, peer, employment, transportation, family, and other recovery supports for justice-involved adults with mental and substance use disorders are significant priorities for behavioral health providers.	40.00% 4	20.00% 2	40.00% 4	10
Behavioral health service providers understand how to put the risk-need-responsivity framework into practice with justice-involved adults with mental disorders or substance use disorders.	30.00% 3	10.00% 1	60.00% 6	10
Justice-involved adults with mental disorders or substance use disorders receive legal forms of identification and benefits assistance (e.g., Medicaid/Medicare and Social Security disability benefits).	30.00% 3	30.00% 3	40.00% 4	10
There are gender-specific services and programs for women with mental disorders and substance use disorders involved with the criminal justice system.	30.00% 3	10.00% 1	60.00% 6	10
Behavioral health providers, criminal justice agencies, and community providers share information on individuals with mental disorders or substance use disorders to the extent permitted by law to assist the effective delivery of services and programs.	30.00% 3	30.00% 3	40.00% 4	10
Regardless of the setting, all behavioral health services provided to justice-involved adults are evidence-based practices. Evidence-based practices are manual-based interventions with positive outcomes based on repeated rigorous evaluation studies.	10.00% 1	30.00% 3	60.00% 6	10
Justice-involved adults are fully engaged with behavioral health providers to develop their treatment plans.	10.00% 1	40.00% 4	50.00% 5	10
The services and programs provided to justice-involved adults by the behavioral health and criminal justice systems are culturally sensitive and designed to meet the needs of people of color.	10.00% 1	20.00% 2	70.00% 7	10

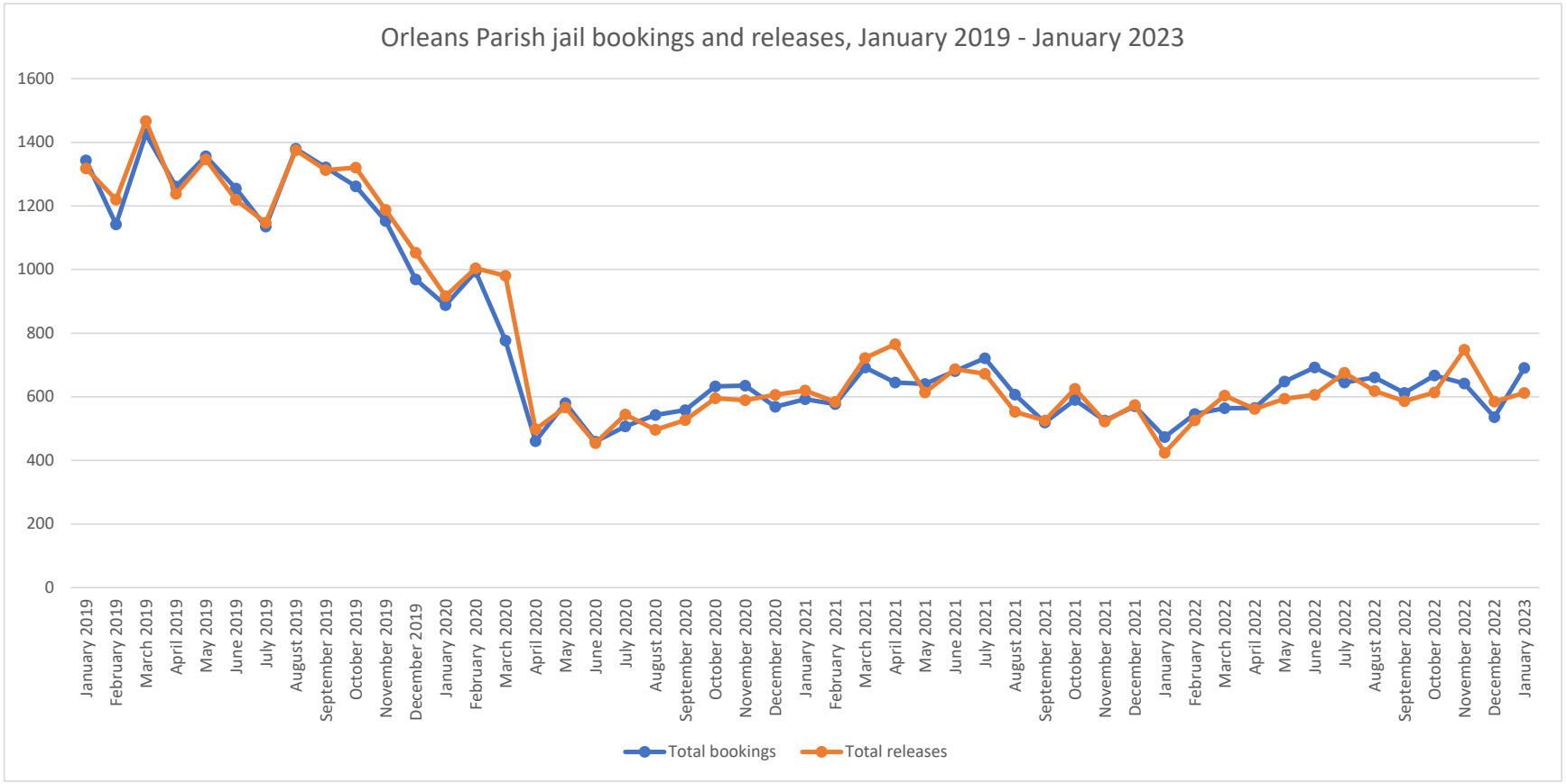
Appendix 3

Month	Open matters	Sentenced	Hold for agency	Total ADIC	ADIC_2	TotalRec	TotalOpen	TotalSent	TotalHold	Check1	Check2	Check3
January 2019	1034	150	1	1185	1185	36742	32068	4638	36	36742	TRUE	TRUE
February 2019	999	163	0	1162	1162	32547	27972	4574	1	32547	TRUE	TRUE
March 2019	965	154	0	1120	1120	34713	29930	4783	0	34713	TRUE	TRUE
April 2019	920	164	0	1084	1084	32523	27596	4927	0	32523	TRUE	TRUE
May 2019	918	200	0	1118	1118	34666	28473	6193	0	34666	TRUE	TRUE
June 2019	960	193	0	1153	1153	34585	28807	5778	0	34585	TRUE	TRUE
July 2019	982	167	0	1149	1149	35628	30430	5185	13	35628	TRUE	TRUE
August 2019	995	182	1	1179	1179	36538	30853	5655	30	36538	TRUE	TRUE
September 2019	978	205	1	1184	1184	35513	29334	6161	18	35513	TRUE	TRUE
October 2019	994	195	0	1189	1189	36859	30811	6048	0	36859	TRUE	TRUE
November 2019	969	198	0	1168	1168	35026	29084	5940	2	35026	TRUE	TRUE
December 2019	911	192	0	1103	1103	34196	28244	5952	0	34196	TRUE	TRUE
January 2020	863	188	0	1052	1052	32611	26767	5836	8	32611	TRUE	TRUE
February 2020	853	186	0	1039	1039	30138	24745	5393	0	30138	TRUE	TRUE
March 2020	810	169	0	979	979	30344	25115	5229	0	30344	TRUE	TRUE
April 2020	644	167	0	811	811	24342	19332	5010	0	24342	TRUE	TRUE
May 2020	655	170	1	826	826	25605	20307	5276	22	25605	TRUE	TRUE
June 2020	668	182	1	851	851	25528	20036	5463	29	25528	TRUE	TRUE
July 2020	675	130	1	807	807	25012	20930	4045	37	25012	TRUE	TRUE
August 2020	711	124	2	837	837	25944	22038	3846	60	25944	TRUE	TRUE
September 2020	743	117	2	862	862	25852	22278	3517	57	25852	TRUE	TRUE
October 2020	787	108	1	896	896	27782	24402	3350	30	27782	TRUE	TRUE
November 2020	846	93	1	940	940	28198	25379	2790	29	28198	TRUE	TRUE
December 2020	866	93	1	960	960	29755	26834	2891	30	29755	TRUE	TRUE
January 2021	840	85	1	925	925	28676	26025	2621	30	28676	TRUE	TRUE
February 2021	799	81	1	881	881	24669	22381	2261	27	24669	TRUE	TRUE
March 2021	770	101	0	872	872	27035	23883	3141	11	27035	TRUE	TRUE
April 2021	679	109	1	789	789	23673	20371	3262	40	23673	TRUE	TRUE
May 2021	641	111	1	752	752	23304	19857	3429	18	23304	TRUE	TRUE
June 2021	641	119	1	760	760	22797	19215	3565	17	22797	TRUE	TRUE
July 2021	679	109	1	789	789	24464	21055	3381	28	24464	TRUE	TRUE
August 2021	696	119	0	816	816	25285	21584	3694	7	25285	TRUE	TRUE
September 2021	772	109	1	882	882	26454	23146	3279	29	26454	TRUE	TRUE
October 2021	725	135	1	861	861	26694	22469	4198	27	26694	TRUE	TRUE
November 2021	683	159	0	843	843	25287	20504	4780	3	25287	TRUE	TRUE
December 2021	681	178	0	859	859	26617	21102	5512	3	26617	TRUE	TRUE
January 2022	688	184	0	872	872	27030	21317	5713	0	27030	TRUE	TRUE
February 2022	706	184	1	890	890	24928	19764	5141	23	24928	TRUE	TRUE
March 2022	735	157	1	893	893	27689	22790	4868	31	27689	TRUE	TRUE
April 2022	733	142	1	875	875	26258	21981	4248	29	26258	TRUE	TRUE
May 2022	754	159	1	914	914	28323	23361	4917	45	28323	TRUE	TRUE
June 2022	808	124	1	933	933	27992	24229	3734	29	27992	TRUE	TRUE
July 2022	855	114	1	970	1002	30066	26504	3532	30	30066	TRUE	FALSE
August 2022	869	92	0	961	961	29786	26927	2845	14	29786	TRUE	TRUE
September 2022	875	83	1	958	990	29698	27116	2564	18	29698	TRUE	FALSE
October 2022	894	91	0	985	985	30529	27711	2818		30529	TRUE	TRUE
November 2022	864	71	0	936	936	29005	26791	2214		29005	TRUE	TRUE
December 2022	823	105	2	930	930	28838	25513	3250	75	28838	TRUE	TRUE
January 2023	838	90	3	932	932	28892	25991	2803	98	28892	TRUE	TRUE


Average daily population for each month
1300
1200
1100
1000
900
800
700
600
500
400
300
200
100
0
January 2019 1,034 150
February 2019 999 163
March 2019 965 154
April 2019 920 164
May 2019 918 200
June 2019 960 193
July 2019 982 167
August 2019 995 182
September 2019 978 205
October 2019 994 195
November 2019 969 198
December 2019 911 192
January 2020 863 188
February 2020 853 186
March 2020 810 169
April 2020 644 167
May 2020 655 170
June 2020 668 182
July 2020 675 130
August 2020 711 124
September 2020 743 117
October 2020 787 108
November 2020 846 93
December 2020 866 93
January 2021 840 85
February 2021 799 81
March 2021 770 101
April 2021 679 109
May 2021 641 111
June 2021 641 119
July 2021 679 109
August 2021 696 119
September 2021 772 109
October 2021 725 135
November 2021 683 159
December 2021 681 178
January 2022 688 184
February 2022 706 184
March 2022 735 157
April 2022 733 142
May 2022 754 159
June 2022 808 124
July 2022 855 114
August 2022 869 92
September 2022 875 83
October 2022 894 91
November 2022 864 71
December 2022 823 105
January 2023 838 90
Open matters
Sentenced
Hold for agency

Month	Total bookings	Total releases
January 2019	1343	1318
February 2019	1142	1220
March 2019	1426	1467
April 2019	1261	1238
May 2019	1356	1346
June 2019	1255	1219
July 2019	1135	1147
August 2019	1380	1375
September 2019	1321	1313
October 2019	1262	1320
November 2019	1153	1188
December 2019	969	1053
January 2020	888	916
February 2020	993	1004
March 2020	777	980
April 2020	460	498
May 2020	580	566
June 2020	459	454
July 2020	507	544
August 2020	543	496
September 2020	558	527
October 2020	633	595
November 2020	635	589
December 2020	569	606
January 2021	592	620
February 2021	577	584
March 2021	692	722
April 2021	645	765
May 2021	640	614
June 2021	681	687
July 2021	721	672
August 2021	607	553
September 2021	519	525
October 2021	590	625
November 2021	525	522
December 2021	570	574
January 2022	473	424
February 2022	546	526
March 2022	564	604
April 2022	565	562

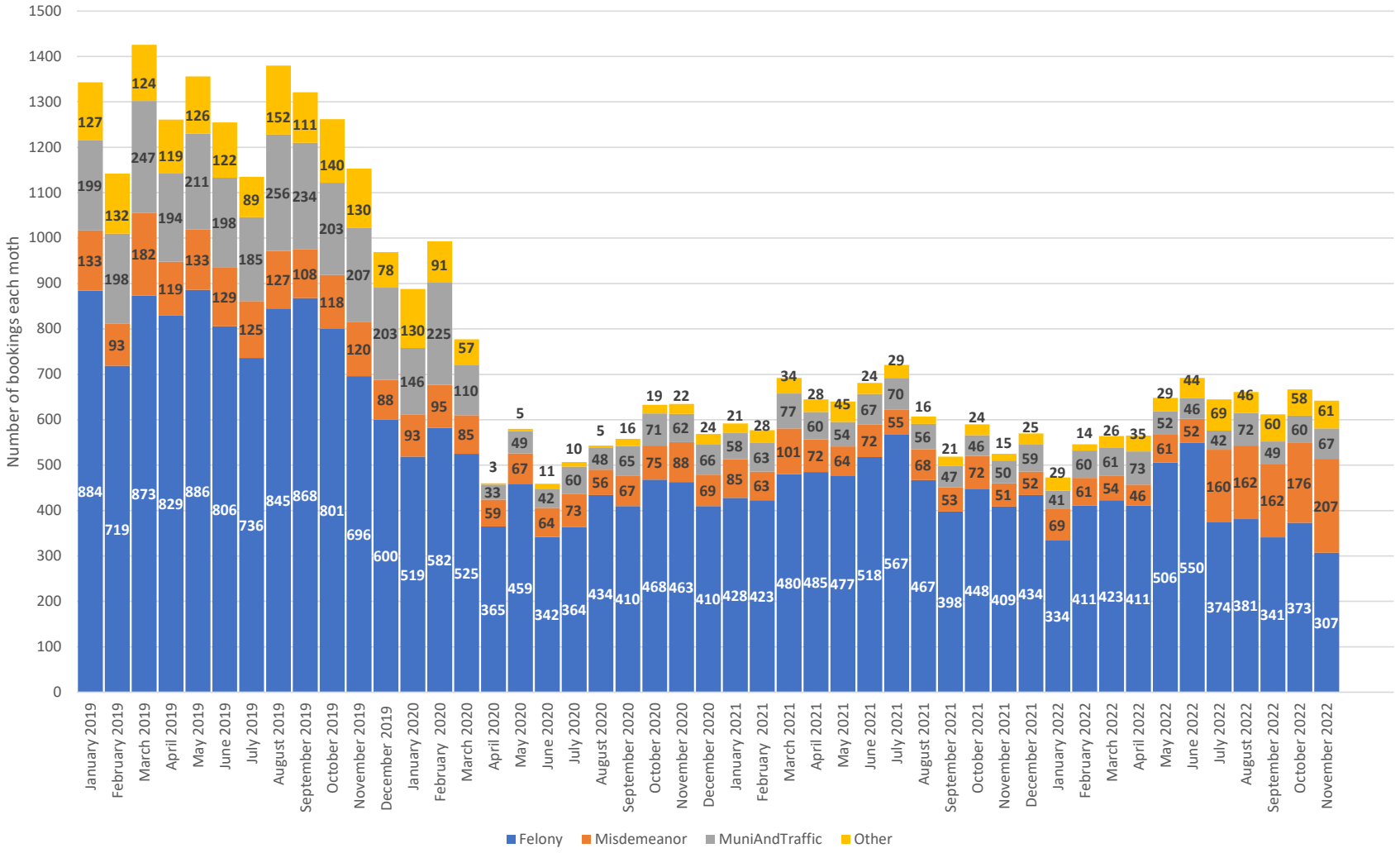
May 2022	648	594
June 2022	692	606
July 2022	645	675
August 2022	661	618
September 2022	612	586
October 2022	667	614
November 2022	642	748
December 2022	536	585
January 2023	691	612



Month	Felony	Misdemear	MuniAndTr	Other	Total	Check1	Check2
January 2019	884	133	199	127	1343	1343	TRUE
February 2019	719	93	198	132	1142	1142	TRUE
March 2019	873	182	247	124	1426	1426	TRUE
April 2019	829	119	194	119	1261	1261	TRUE
May 2019	886	133	211	126	1356	1356	TRUE
June 2019	806	129	198	122	1255	1255	TRUE
July 2019	736	125	185	89	1135	1135	TRUE
August 2019	845	127	256	152	1380	1380	TRUE
September 2019	868	108	234	111	1321	1321	TRUE
October 2019	801	118	203	140	1262	1262	TRUE
November 2019	696	120	207	130	1153	1153	TRUE
December 2019	600	88	203	78	969	969	TRUE
January 2020	519	93	146	130	888	888	TRUE
February 2020	582	95	225	91	993	993	TRUE
March 2020	525	85	110	57	777	777	TRUE
April 2020	365	59	33	3	460	460	TRUE
May 2020	459	67	49	5	580	580	TRUE
June 2020	342	64	42	11	459	459	TRUE
July 2020	364	73	60	10	507	507	TRUE
August 2020	434	56	48	5	543	543	TRUE
September 2020	410	67	65	16	558	558	TRUE
October 2020	468	75	71	19	633	633	TRUE
November 2020	463	88	62	22	635	635	TRUE
December 2020	410	69	66	24	569	569	TRUE
January 2021	428	85	58	21	592	592	TRUE
February 2021	423	63	63	28	577	577	TRUE
March 2021	480	101	77	34	692	692	TRUE
April 2021	485	72	60	28	645	645	TRUE
May 2021	477	64	54	45	640	640	TRUE
June 2021	518	72	67	24	681	681	TRUE
July 2021	567	55	70	29	721	721	TRUE
August 2021	467	68	56	16	607	607	TRUE
September 2021	398	53	47	21	519	519	TRUE
October 2021	448	72	46	24	590	590	TRUE
November 2021	409	51	50	15	525	525	TRUE
December 2021	434	52	59	25	570	570	TRUE
January 2022	334	69	41	29	473	473	TRUE
February 2022	411	61	60	14	546	546	TRUE
March 2022	423	54	61	26	564	564	TRUE
April 2022	411	46	73	35	565	565	TRUE
May 2022	506	61	52	29	648	648	TRUE

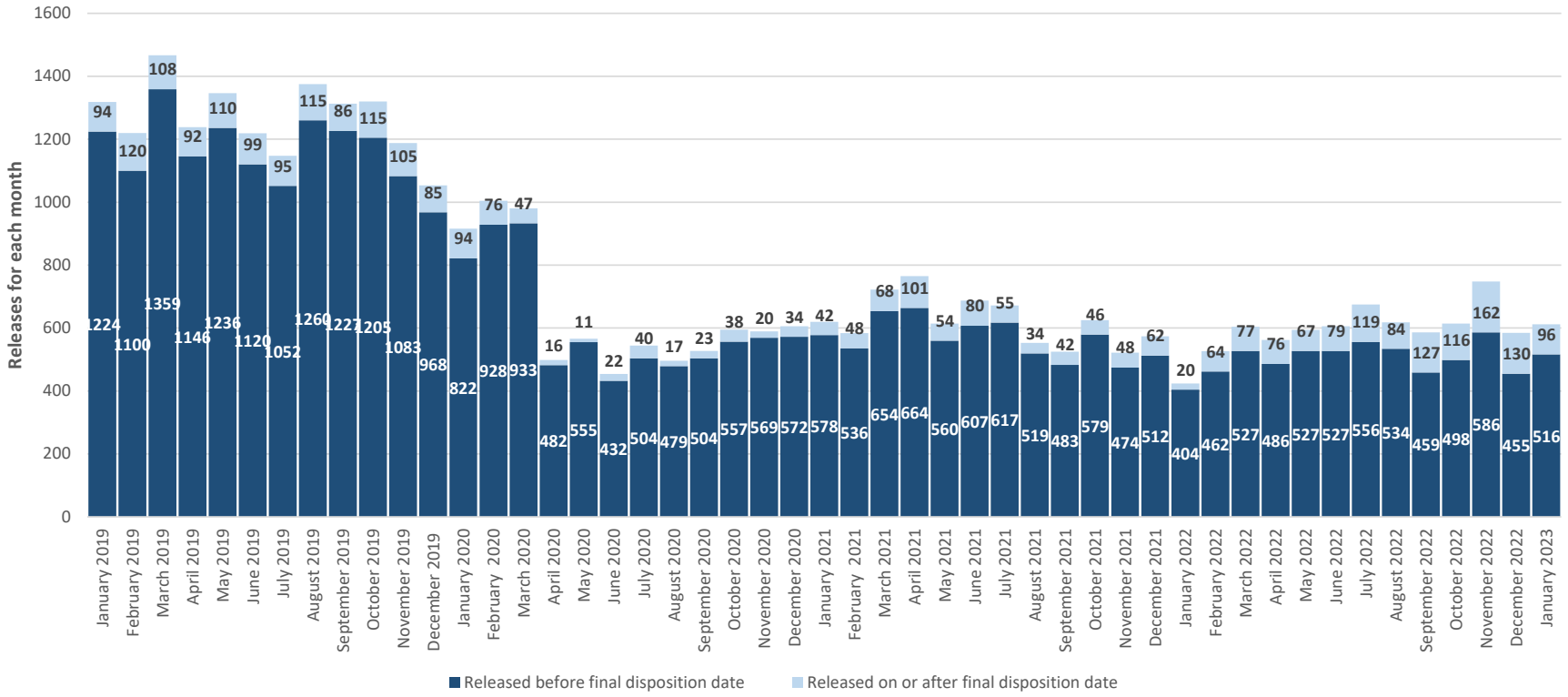
June 2022	550	52	46	44	692	692	TRUE
July 2022	374	160	42	69	645	645	TRUE
August 2022	381	162	72	46	661	661	TRUE
September 2022	341	162	49	60	612	612	TRUE
October 2022	373	176	60	58	667	667	TRUE
November 2022	307	207	67	61	642	642	TRUE

SOMETHING IS OFF WITH JULY 2022



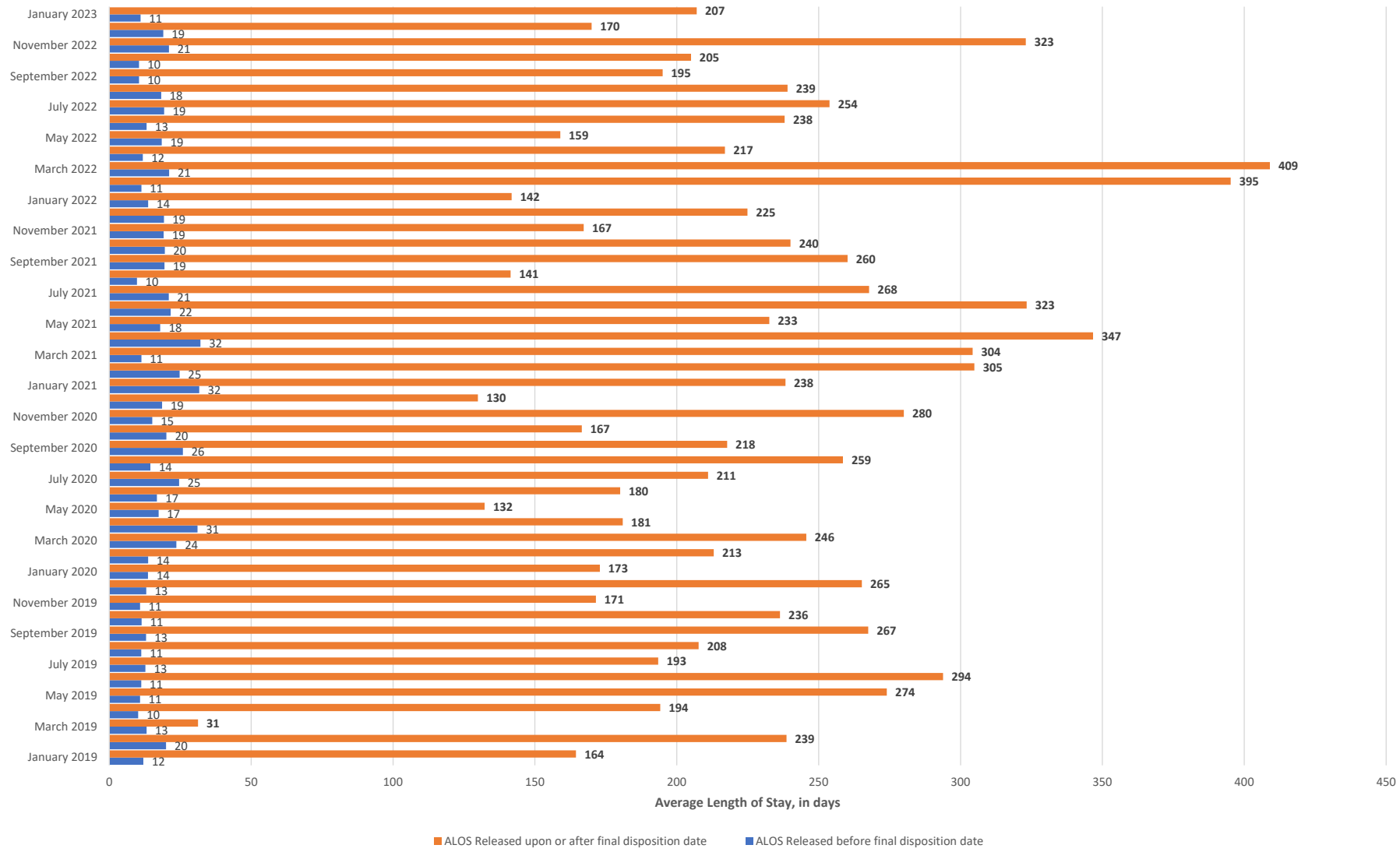
Month and year	Released before final disposition date	Released on or after final disposition date	Total	CHECK1	CHECK2
January 2019	1224	94	1318	1318	TRUE
February 2019	1100	120	1220	1220	TRUE
March 2019	1359	108	1467	1467	TRUE
April 2019	1146	92	1238	1238	TRUE
May 2019	1236	110	1346	1346	TRUE
June 2019	1120	99	1219	1219	TRUE
July 2019	1052	95	1147	1147	TRUE
August 2019	1260	115	1375	1375	TRUE
September 2019	1227	86	1313	1313	TRUE
October 2019	1205	115	1320	1320	TRUE
November 2019	1083	105	1188	1188	TRUE
December 2019	968	85	1053	1053	TRUE
January 2020	822	94	916	916	TRUE
February 2020	928	76	1004	1004	TRUE
March 2020	933	47	980	980	TRUE
April 2020	482	16	498	498	TRUE
May 2020	555	11	566	566	TRUE
June 2020	432	22	454	454	TRUE
July 2020	504	40	544	544	TRUE
August 2020	479	17	496	496	TRUE
September 2020	504	23	527	527	TRUE
October 2020	557	38	595	595	TRUE
November 2020	569	20	589	589	TRUE
December 2020	572	34	606	606	TRUE
January 2021	578	42	620	620	TRUE
February 2021	536	48	584	584	TRUE
March 2021	654	68	722	722	TRUE
April 2021	664	101	765	765	TRUE
May 2021	560	54	614	614	TRUE
June 2021	607	80	687	687	TRUE
July 2021	617	55	672	672	TRUE
August 2021	519	34	553	553	TRUE
September 2021	483	42	525	525	TRUE
October 2021	579	46	625	625	TRUE
November 2021	474	48	522	522	TRUE
December 2021	512	62	574	574	TRUE
January 2022	404	20	424	424	TRUE

February 2022	462	64	526	526	TRUE
March 2022	527	77	604	604	TRUE
April 2022	486	76	562	562	TRUE
May 2022	527	67	594	594	TRUE
June 2022	527	79	606	606	TRUE
July 2022	556	119	675	675	TRUE
August 2022	534	84	618	618	TRUE
September 2022	459	127	586	586	TRUE
October 2022	498	116	614	614	TRUE
November 2022	586	162	748	748	TRUE
December 2022	455	130	585	585	TRUE
January 2023	516	96	612	612	TRUE

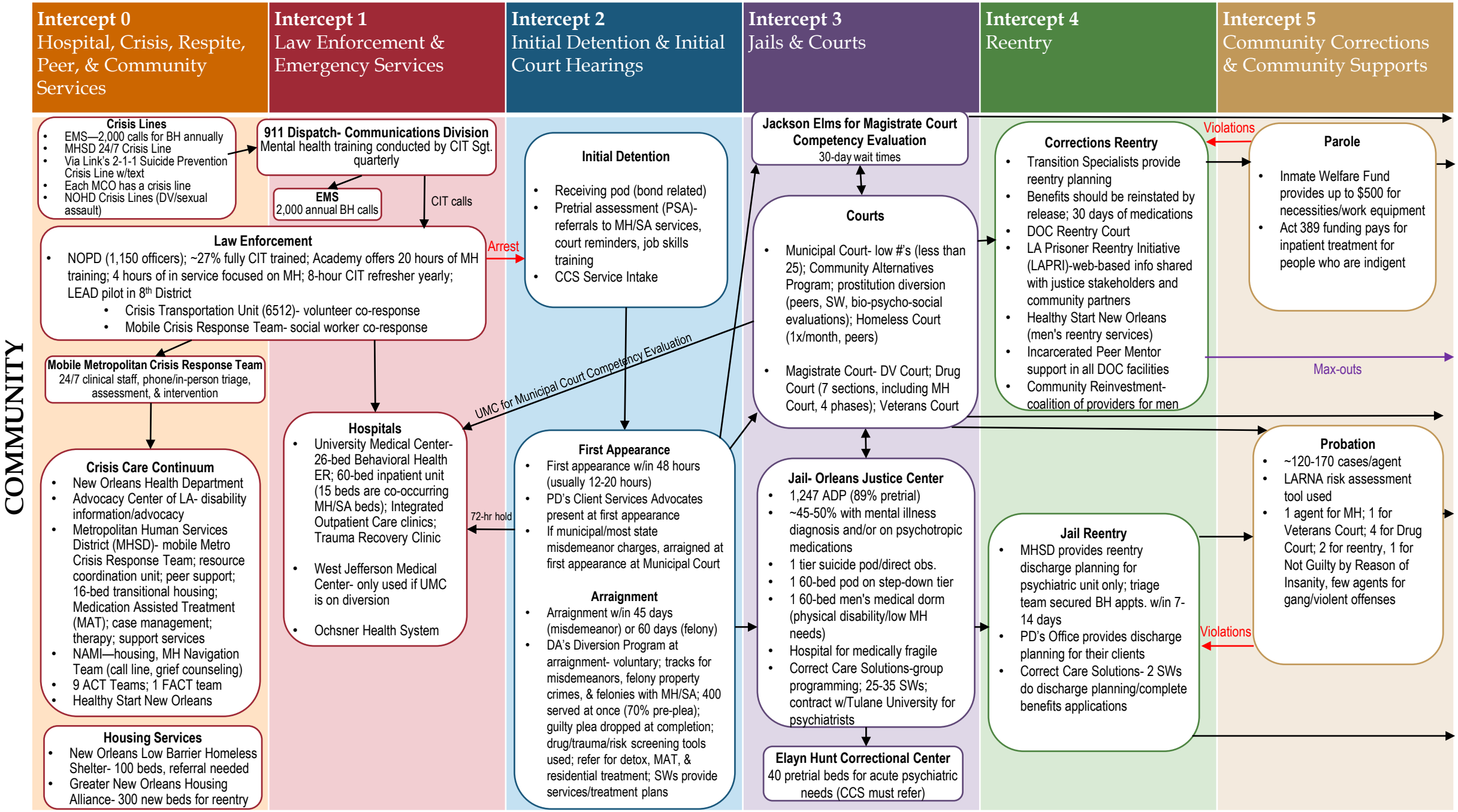


Month	ALOS Released before final disposition date	ALOS Released upon or after final disposition date
January 2019	12	164
February 2019	20	239
March 2019	13	31
April 2019	10	194
May 2019	11	274
June 2019	11	294
July 2019	13	193
August 2019	11	208
September 2019	13	267
October 2019	11	236
November 2019	11	171
December 2019	13	265
January 2020	14	173
February 2020	14	213
March 2020	24	246
April 2020	31	181
May 2020	17	132
June 2020	17	180
July 2020	25	211
August 2020	14	259
September 2020	26	218
October 2020	20	167
November 2020	15	280
December 2020	19	130
January 2021	32	238
February 2021	25	305
March 2021	11	304
April 2021	32	347
May 2021	18	233
June 2021	22	323
July 2021	21	268
August 2021	10	141
September 2021	19	260
October 2021	20	240
November 2021	19	167
December 2021	19	225
January 2022	14	142
February 2022	11	395
March 2022	21	409
April 2022	12	217
May 2022	19	159
June 2022	13	238
July 2022	19	254

August 2022	18	239
September 2022	10	195
October 2022	10	205
November 2022	21	323
December 2022	19	170
January 2023	11	207



Appendix 4


Intercept 0
Hospital, Crisis, Respite, Peer, & Community Services
Intercept 1
Law Enforcement & Emergency Services
Intercept 2
Initial Detention & Initial Court Hearings
Intercept 3
Jails & Courts
Intercept 4
Reentry
Intercept 5
Community Corrections & Community Supports
COMMUNITY
COMMUNITY
Crisis Lines
EMS—2,000 calls for BH annually
MHSD 24/7 Crisis Line
Via Link's 2-1-1 Suicide Prevention Crisis Line w/text
Each MCO has a crisis line
NOHD Crisis Lines (DV/sexual assault)
911 Dispatch- Communications Division
Mental health training conducted by CIT Sgt. quarterly
EMS
2,000 annual BH calls
CIT calls
Law Enforcement
NOPD (1,150 officers); ~27% fully CIT trained; Academy offers 20 hours of MH training; 4 hours of in service focused on MH; 8-hour CIT refresher yearly; LEAD pilot in 8th District
Crisis Transportation Unit (6512)- volunteer co-response
Mobile Crisis Response Team- social worker co-response
Arrest
Initial Detention
Receiving pod (bond related)
Pretrial assessment (PSA)- referrals to MH/SA services, court reminders, job skills training
CCS Service Intake
Jackson Elms for Magistrate Court Competency Evaluation
30-day wait times
Courts
Municipal Court- low #'s (less than 25); Community Alternatives Program; prostitution diversion (peers, SW, bio-psycho-social evaluations); Homeless Court (1x/month, peers)
Magistrate Court- DV Court; Drug Court (7 sections, including MH Court, 4 phases); Veterans Court
Corrections Reentry
Transition Specialists provide reentry planning
Benefits should be reinstated by release; 30 days of medications
DOC Reentry Court
LA Prisoner Reentry Initiative (LAPRI)-web-based info shared with justice stakeholders and community partners
Healthy Start New Orleans (men's reentry services)
Incarcerated Peer Mentor support in all DOC facilities
Community Reinvestment- coalition of providers for men
Violations
Parole
Inmate Welfare Fund provides up to $500 for necessities/work equipment
Act 389 funding pays for inpatient treatment for people who are indigent
Max-outs
Mobile Metropolitan Crisis Response Team
24/7 clinical staff, phone/in-person triage, assessment, & intervention
UMC for Municipal Court Competency Evaluation
Hospitals
University Medical Center- 26-bed Behavioral Health ER; 60-bed inpatient unit (15 beds are co-occurring MH/SA beds); Integrated Outpatient Care clinics; Trauma Recovery Clinic
West Jefferson Medical Center- only used if UMC is on diversion
Ochsner Health System
72-hr hold
First Appearance
First appearance w/in 48 hours (usually 12-20 hours)
PD's Client Services Advocates present at first appearance
If municipal/most state misdemeanor charges, arraigned at first appearance at Municipal Court
Arraignment
Arraignment w/in 45 days (misdemeanor) or 60 days (felony)
DA's Diversion Program at arraignment- voluntary; tracks for misdemeanors, felony property crimes, & felonies with MH/SA; 400 served at once (70% pre-plea); guilty plea dropped at completion; drug/trauma/risk screening tools used; refer for detox, MAT, & residential treatment; SWs provide services/treatment plans
Jail- Orleans Justice Center
1,247 ADP (89% pretrial)
~45-50% with mental illness diagnosis and/or on psychotropic medications
1 tier suicide pod/direct obs.
1 60-bed pod on step-down tier
1 60-bed men's medical dorm (physical disability/low MH needs)
Hospital for medically fragile
Correct Care Solutions-group programming; 25-35 SWs; contract w/Tulane University for psychiatrists
Elayn Hunt Correctional Center
40 pretrial beds for acute psychiatric needs (CCS must refer)
Jail Reentry
MHSD provides reentry discharge planning for psychiatric unit only; triage team secured BH appts. w/in 7-14 days
PD's Office provides discharge planning for their clients
Correct Care Solutions- 2 SWs do discharge planning/complete benefits applications
Violations
Probation
~120-170 cases/agent
LARNA risk assessment tool used
1 agent for MH; 1 for Veterans Court; 4 for Drug Court; 2 for reentry, 1 for Not Guilty by Reason of Insanity, few agents for gang/violent offenses
Crisis Care Continuum
New Orleans Health Department
Advocacy Center of LA- disability information/advocacy
Metropolitan Human Services District (MHSD)- mobile Metro Crisis Response Team; resource coordination unit; peer support; 16-bed transitional housing; Medication Assisted Treatment (MAT); case management; therapy; support services
NAMI—housing, MH Navigation Team (call line, grief counseling)
9 ACT Teams; 1 FACT team
Healthy Start New Orleans
Housing Services
New Orleans Low Barrier Homeless Shelter- 100 beds, referral needed
Greater New Orleans Housing Alliance- 300 new beds for reentry

Appendix 5

Orleans Justice Center
2800 Perdido St
New Orleans, LA 70119
504-202-9374

CORRECT CARE SOLUTIONS

Behavioral Health Initial Evaluation

Status: ☐ Adult ☐ Juvenile

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date: 7/27/2022
[redacted]	[redacted]	[redacted]	[redacted]	

Mental Health Treatment:

Mental Health Outpatient Treatment? ☐Yes ☐No	**Psychiatric Hospitalizations?** ☐Yes ☐No	**Current psychotropic medications:** ☐Yes ☐No
Date medication last taken_____ Pharmacy? ☐N/A ☐Yes ☐Unknown	**Prior Psychotropic Medications?** ☐Yes ☐No	**Prior Diagnosis?** ☐Yes ☐No ☐Unknown
Prior Mental Health Court Services? ☐Yes ☐No	**Prior SSDI?** ☐Yes ☐No	**Prior Guardianship?** ☐Yes ☐No
Past Self Harm/Suicide Attempts? ☐Yes ☐No ☐Refuses to Answer	**Current Self Harm Thoughts?** ☐Yes ☐No ☐Refuses to Answer	**Concerns about ability to cope while incarcerated?** ☐Yes ☐No ☐Refuses to Answer

Substance Use History

Substance Use? ☐Yes ☐No		**History of Inpatient Treatment?** ☐Yes ☐No
Substance	**Substance**	
Type	Type	
Last Used:	Last Used:	
Type:	Type:	
Last Used	Last Used	
Substance	**Substance**	**History of Outpatient Treatment?** ☐Yes ☐No
Type	Type	
Last Used:	Last Used:	
Type:	Type:	
Last Used	Last Used	

SO

D176404DI6600426IC13117704CP30718PNXN

Orleans Justice Center
2800 Perdido St
New Orleans, LA 70119
504-202-9374

CORRECT CARE SOLUTIONS

Behavioral Health Initial Evaluation

Status: ☐ Adult ☐ Juvenile

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date:
[redacted]	[redacted]	[redacted]	[redacted]	7/27/2022

History:

Educational History (including special education)	Employment History:	Military History:

Legal History:	Housing status prior to arrest:	Family/Social Support:

History of Violent Behavior	History of Sexual Offense (perpetrating)?	History of Victimization? ☐Yes ☐No
☐Yes ☐No	☐Yes ☐No	Physical ☐Yes ☐No Sexual ☐Yes ☐No
		Ind Therapy Accepted ☐Yes ☐No

History of Head Injury? ☐Yes ☐No	Patients strength:

Current Status

Medication Complaint? ☐N/A ☐Yes ☐No	Suicidal Ideations noted? ☐Yes ☐No ☐Refuses to Answer	Homicidal Ideations noted? ☐Yes ☐No ☐Refuses to Answer

Risk Level:

☐Hopelessness, feelings of guilt or worthlessness	☐Impulsive	☐Major Depressive/manic episode	☐1st incarceration or arrest	☐Prior suicide attempts or suicide note found
☐New legal issues (new charges, newly sentenced, lengthy sentence, denied parole)	☐Bad news (loss of loved one, visit cancelled or no show, privileges revoked, serious illness, recent rejection or loss)	☐Placement in segregation / isolation	☐Family history of suicide attempts	
☐Intoxicated or detoxing from alcohol / other drugs	☐Humiliating events / rejection (sexual assault)	☐High profile crime (media attention)	☐Anniversary of important loss	
☐Prior suicide watch placement in jail	☐Recent release from psychiatric hospital	☐Reports of giving items away	☐Other (describe):	

Protective Factors

☐Identifies reason for living	☐Fear of death or dying due to pain and suffering	☐Responsibility to family or others; living with family	☐Belief that suicide is immoral; high spirituality.
☐Supportive social network of family	☐Engaged in work or school	☐Other (describe:	

Mental Health Special Needs Flags (Please be sure to select the corresponding flags in the "Problem" section of this patient's chart)

☐First Incarceration ☐Treatment Accepted	☐Victim of Sexual Abuse ☐Treatment Accepted	☐Substance Abuse ☐Treatment Accepted	☐Domestic Violence ☐Treatment Accepted	☐Gender Dysphoria ☐Treatment Accepted

D176404DI66004261C131177704CP30718PNXN

Orleans Justice Center
2800 Perdido St
New Orleans, LA 70119
504-202-9374

CCS CORRECT CARE SOLUTIONS

Behavioral Health Initial Evaluation

Status: ☐ Adult ☐ Juvenile

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date:
[redacted]	[redacted]	[redacted]	[redacted]	7/27/2022

☐Intellectual Disability ☐Treatment Accepted	☐Juvenile ☐Treatment Accepted	☐Pregnant ☐Treatment Accepted	☐Self-Harm Treatment Accepted	☐Suicide Risk ☐Treatment Accepted

Additional Information:

Mental Status Exam:

Appearance:	Speech:	Mood:	Affect:	Thought Form:	Thought Content:
☐ Appropriate ☐ Meticulous ☐ Unclean ☐ Disheveled ☐ Bizarre ☐ Other _____	☐ Appropriate ☐ Expressive ☐ Loud ☐ Slowed ☐ Pressured ☐ Slurred ☐ Other _____	☐ Appropriate ☐ Depressed ☐ Euphoric ☐ Anxious ☐ Angry ☐ Irritable ☐ Other _____	☐ Appropriate ☐ Tearful ☐ Blunted ☐ Flat ☐ Labile ☐ Hostile ☐ Other _____	☐ Coherent ☐ Circumstantial ☐ Tangential ☐ Loose Assoc. ☐ Poverty of Thought ☐ Flight of Ideas ☐ Other_____	☐ Appropriate ☐ Hallucinations ☐ Comp/obsess. ☐ Thought insertion ☐ Broadcasting ☐ Delusional ☐ Suicidal ☐ Homicidal ☐ Other_____

Orientation:	Intelligence:	Memory:	Insight:	Judgment:	Behavior:
☐Person ☐Place ☐Purpose ☐Time	☐ Above Average ☐ Average ☐ Below Average ☐ Developmentally Disabled	☐ Intact ☐ Immediate Impaired ☐ Recent Impaired ☐ Remote Impaired	☐ Intact ☐ Good ☐ Fair ☐ Poor	☐ Intact ☐ Good ☐ Fair ☐ Poor	☐ Appropriate ☐ Belligerent ☐ Agitated ☐ Withdrawn

Comments:

Plan: (please check all that apply)

☐Treatment not indicated at this time, educated on how to further access services. Behavioral Health to follow up PRN	☐Complete Suicide Watch Initial Assessment and start suicide precautions
☐Behavioral Health will follow up within _____days/ date	☐Consult with: _____
☐Homework given on: _____	☐Other_____

☐Refer to:
☐Psychiatric Provider ☐Medical ☐Special Needs ☐Discharge Planner ☐Other _____

Evaluator Signature	Title	Time

SO

wellpath
To hope and healing.

Folder # _____

INTAKE AND RECEIVING PRE-ACCEPTANCE QUESTIONNAIRE (MEDICAL CLEARANCE)

Intake Name: _____ DOB: _____

Screening Date/Time: _____

[Definition: Quick clinical assessment of physical and mental health prior to admission into jail. May require sending patient to hospital ER to be cleared especially if facility does not have resources or ability to care for patients immediate or long-term health needs.]

Screening Questions	Yes	No	Comments
Have you recently had any drugs or alcohol? If yes, when? What drugs?			CIWA/COWS? circle
Did you swallow any drugs or place any drugs in a body cavity?			
Are you homicidal or suicidal?			
Have you been bitten by a dog or person? Have you been tasered?			
Do you take any medication or have any medical problems?			
Do you have a mental health problem or under the care of a mental health professional?			
Do you have open cuts, wounds, sores, or injuries that need immediate emergency room care or that occurred during the arrest?			
Are you on dialysis? If yes, when did you most recently receive scheduled treatment?			
Are you on oxygen to sleep at night or having difficulty breathing now?			
Do you have any disabilities or known illnesses that may be deemed contagious to others (i.e. COVID or TB)?			
Are you pregnant? If yes, which trimester? Any abnormal bleeding, cramping, discharge, or a recent sexual assault?			
Have you recently been exposed to COVID or the flu and have any symptoms? Are you currently vaccinated against either?			

Accepted? Yes ☐ No ☐ Discussed with Provider: _____

Patient's Signature: _____

Screener Signature: _____

Witness Name/Signature: _____

Appendix 6

ORLEANS PUBLIC DEFENDERS

2601 TULANE AVENUE – SUITE 700 • NEW ORLEANS, LA 70119
TELEPHONE: (504) 821-8101 • FAX: (504) 821-5285 • www.opdla.org

DERWYN D. BUNTON, CHIEF PUBLIC DEFENDER

April 10, 2021

Municipal Mental Health Unit, January – March 2021, Q1
Barksdale Hortenstine, Jr. Director, Mental Health Unit, Orleans Public Defenders

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This is a report of the work and outcomes of the Municipal Mental Health Unit (MHU-Muni) 2021 first quarter. To date, there are four MHU-Muni staff: Director, Barksdale Hortenstine; Social Worker, Kyla Burke; Mental Health Attorney, Jack Bohannan; and Paralegal, Gerhardt Weiss. All staff work exclusively with Municipal Court clients to improve mental health services and outcomes, aligned with the goals of MHU-Muni.

The MHU-Muni team has made significant progress in building our unit to provide high quality mental health and trauma-informed legal representation alongside personalized wraparound services despite significant setbacks due to the ongoing COVID19 pandemic. These included barriers to in-person service provision, lack of a confidential screening environment, inability to provide appropriate and adequate wraparound services with direct delivery to services (warm handoff), and mostly, an inability to communicate and work with clients in-person both by the Mental Health Attorney and Social Worker. This lack of direct connection precludes the development of a client-team relationship, thus diminishing the capacity to engage the client in a meaningful partnership.[1] Still, despite this and the additional challenges, we have seen significant outcomes for our clients. Remaining nimble has been imperative and this *new* reality has forced us to build the unit with a dual focus - providing assistance under current conditions, as well as building systems and infrastructure to provide assistance in a post-pandemic community.

MHU-Muni has established an active client roster and actively represents 29 clients with serious mental illness (SMI) in Municipal Court. Of these, 7 were added in this first quarter.[2] We have already realized several significant successes in our goal to reduce recidivism and improve legal outcomes for our clients with SMI. Specifically, we honed in on issues leading to excessive attachments and inadequate wraparound services for mentally ill people charged in Municipal Court and are providing individualized and in-depth attention to our clients by securing appropriate and available wraparound services to meet their needs. The focus remains toward assisting clients with the greatest needs, namely those with high arrest frequency and the most serious forms of SMI, Schizophrenia and Bipolar Disorder. Our data shows we have successfully screened and recruited from this population; our clients' average arrest rate was nearly double that of a representative sample

[1] This may be the most significant challenge as it is the primary theory supporting the direct benefits present in related projects this project is based.

[2] While it is the design and intent of MHU-Muni to serve a low number of high-utilizing clients, this # of clients is about half of what we anticipated for our quarterly docket. We believe this *lower than anticipated* number of clients matching our criteria correlates with the diminished arrests and minimized court functions of Municipal and Traffic Court during COV ID-19.

of Municipal Court clients,[3] and they face rates of Schizophrenia and Bipolar Disorder 1.3 and 2.6 times higher (respectively) than clients receiving mental illness services from OPD's Client Services Division[4] (CSD).

SCREENING AND ADMISSION

Despite launching during unprecedented public health and economic crises, as well as racial and social justice reckonings across the country, MHU-Muni has pushed forward to establish the necessary structure for client identification and referral, as well as solidify the methodology and client-centered approach of the program. In order to be most effective, reduce the frequency of arrest, and meet client's individual and complex needs, we must meet clients where they are, properly assess their needs, and connect them to appropriate and available services.

Current Screening Process

There are currently two main pathways to MHU-Muni representation.

Primarily, clients are identified is through First Appearances[5] (FA). During the final quarter of 2020, our unit began implementing a three-step process for identifying clients who fit our criteria and desire our services. First, prior to FAs, the Paralegal reviews the arrest history of everyone on the docket to ascertain the volume and density of their previous involvement in the legal system. These results are sent to the MHU-Muni team prior to pre-FA Interviews. Second, the Social Worker meets with each client where she administers the screening tool[6] and assesses the prospective clients' presentation for likely SMI. (During COVID, this takes place via Zoom. Ideally, this would happen in person.) Third, all clients flagged as possibly having a mental illness receive a follow-up visit from the Social Worker for an in-depth personal history, HIPAA forms for records requests are signed, and a more informed determination of fitness for our unit is made. If the client does not fit the criteria for our unit, they may (*and often do*) still receive certain benefits including referral for services, text reminders for court dates, or referral to CSD. Additionally, all flagged persons receive the benefit of the Mental Health Attorney, regardless of their involvement in the unit.

Additionally, clients can also be brought to our unit by referral. Any Municipal Court judge or OPD Staff Attorney may refer a client to MHU-Muni for representation.[7] So long as the client meets the criteria for the MHU-Muni program, they will be accepted.

Improvements in 2021 Q1

During this quarter we made four primary improvements to our screening process:

First, we worked with OPSO deputies to get potential clients into the OJC courtroom and onto Zoom sooner for FAs, allowing more time to administer screenings, discuss mental and emotional health challenges, and better prepare for bond advocacy and potential treatment plans for release.

Second, we revised our screening tool to be both quicker and more accurate in determining the presence of SMI. We now use the Brief Jail Mental Health Screen (BJMHS), developed by Policy Research Associates, Inc., and adapted to our specific needs.

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[3] We derived a random sample using a random number generator and selecting clients from that population. Specifics are laid out below.

[4] CSD provides wraparound social services, mitigation and client support in a variety of means, but very often the population served has high mental health needs.

[5] This is the initial hearing during which a Municipal Court judge determines probable cause and sets condition of bond for every arrested detainee facing municipal and/or traffic charges. As of this report, the MHU-Muni unit interviews and represents every client at this proceeding.

[6] Initially we administered a hybrid screening tool of our own design but switched to the Brief Jail Mental Health Screen due to time-constraints and to streamline the screening process, make it more uniform and based on an already validated tool.

[7] This has not been as significant a stream of referral as anticipated, largely due to COVID-19 related restrictions.

Third, in an effort to improve our ability to recognize the signs of mental illness, we have done in-depth academic research into mental illness identification and treatment, participated in trainings led by forensic psychiatrists, and spoken with mental health public defenders from various states and programs to ensure our adherence to best practices, as well as effective client-centered approach.

Fourth, we integrated the screening process with our attorney's initial client interviews in order to provide more immediate information regarding client's mental state. This can be used to more effectively assist in their bond and mitigation advocacy.

The Data

This quarter we have screened 259 individual defendants, of whom 7 became full-time MHU-Muni clients. As indicated below, there is a large variability in docket size, which makes preparing for and conducting the screening more difficult. Docket size has risen steadily since last October (when data on screening first began), with a sharper rise occurring throughout March 2021. Regardless of the increase in Municipal Court defendants, our unit will continue to focus on the highest utilizing and most mentally ill clients, while ensuring our unit remains small enough that all clients continue receiving personalized wrap-around assistance.

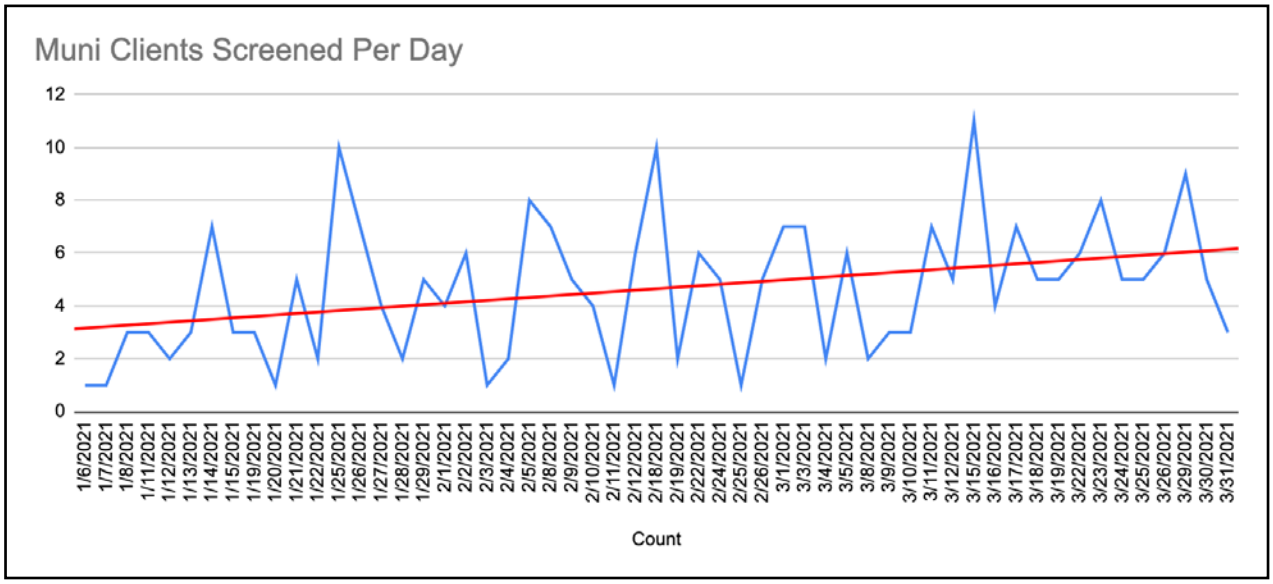

Fig.1 - Municipal Clients Screened Per Day

CLIENT DEMOGRAPHICS AND INITIAL NEEDS

In the section below, MHU-Muni client demographics as well as their identified needs upon entering our program are presented. This information is compared with three other groups to demonstrate how MHU-Muni clients compare to similarly situated populations. The groups examined include:

A. MHU-Muni Clients
B. Municipal Court clients determined to fit our unit's criteria, but declined our services
C. Random selection of Municipal Court clients[8]
D. OPD clients in CSD, screened during 2021-Q1, who indicated a mental illness diagnosis[9]

[8] This group was obtained by applying a random sampling technique to our database of detainees screened during FAs since October, 2020.

[9] Demographic information was obtained through the court's AS400 program while initial needs were documented in Needs Assessment Forms by social workers and client advocates using self-reported information.

Demographics

Fig. 2 shows the racial breakdown of our clients closely matches that of other similarly situated populations. We do have a slightly higher proportion of Black clients compared to the two control populations which do not fit our program's criteria. Considering that CSD clients with a mental health diagnosis had a similar racial makeup as the random sample of Municipal Court clients, it is possible that the cause of this disparity lies in our screening tool and not in differential rates of diagnosis, however with sample sizes this small, no conclusions can yet be drawn with much confidence.

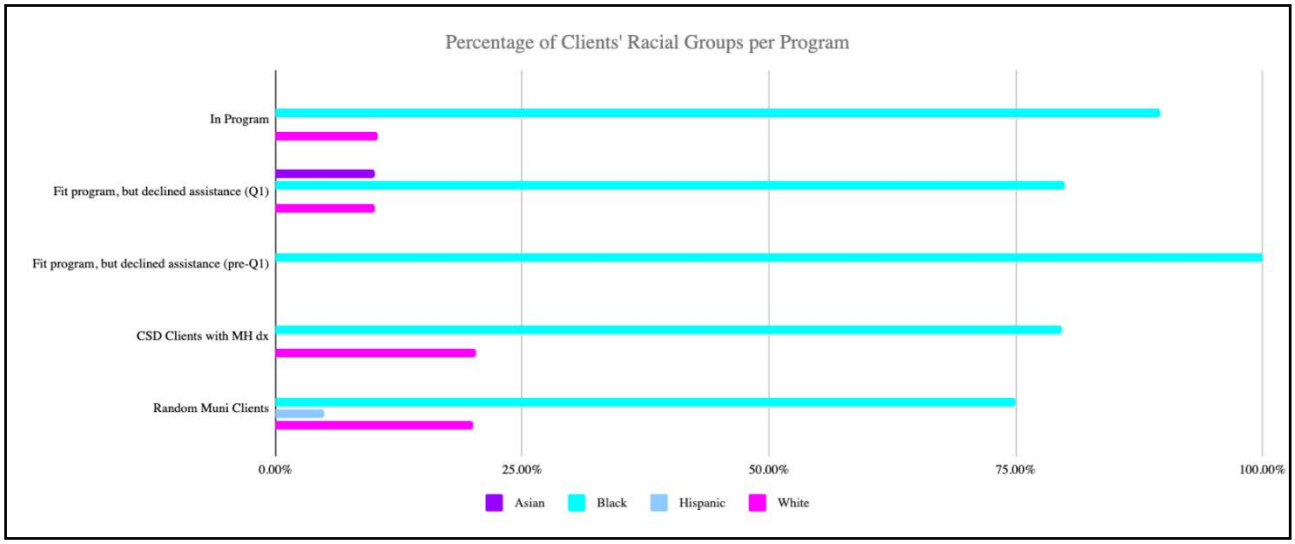

Fig. 2 - Racial Breakdown by Program

Fig. 3 shows how the gender breakdown of our clients differs quite drastically from our control populations. In our random sample of Municipal Court clients, we see a ratio of 95% male to 5% female. This ratio is smaller among CSD clients with a diagnosis of mental illness, which conforms with the sociological and psychological literature which has consistently shown higher rates of diagnosis for common mental illnesses among women.[10] That being noted, our percentage of female clients is still well above that of the CSD control group. When taken in combination with the fact that the group that fits our program but declined service has a smaller percentage of female clients, it is likely that our overrepresentation of women is due to self-selection and not a feature of our screening process. This could be attributed to the greater stigma associated with mental illness for men.[11] In the upcoming quarter we will work to address this disparity. It is very likely that once the pandemic no longer creates barriers to in-person representation, we will be able to more privately screen potential clients and thus reduce the barriers created by stigma.

[10] Klose M, Jacobi F. Can gender differences in the prevalence of mental disorders be explained by sociodemographic factors? Arch Womens Ment Health. 2004 Apr;7(2):133-48. doi: 10.1007/s00737-004-0047-7. Epub 2004 Mar 22. PMID: 15083348.

[11] Farina, A. (1981). Are women nicer people than men? Sex and the stigma of mental disorders. *Clinical Psychology Review, 1*(2), 223-243. doi:10.1016/0272-7358(81)90005-2

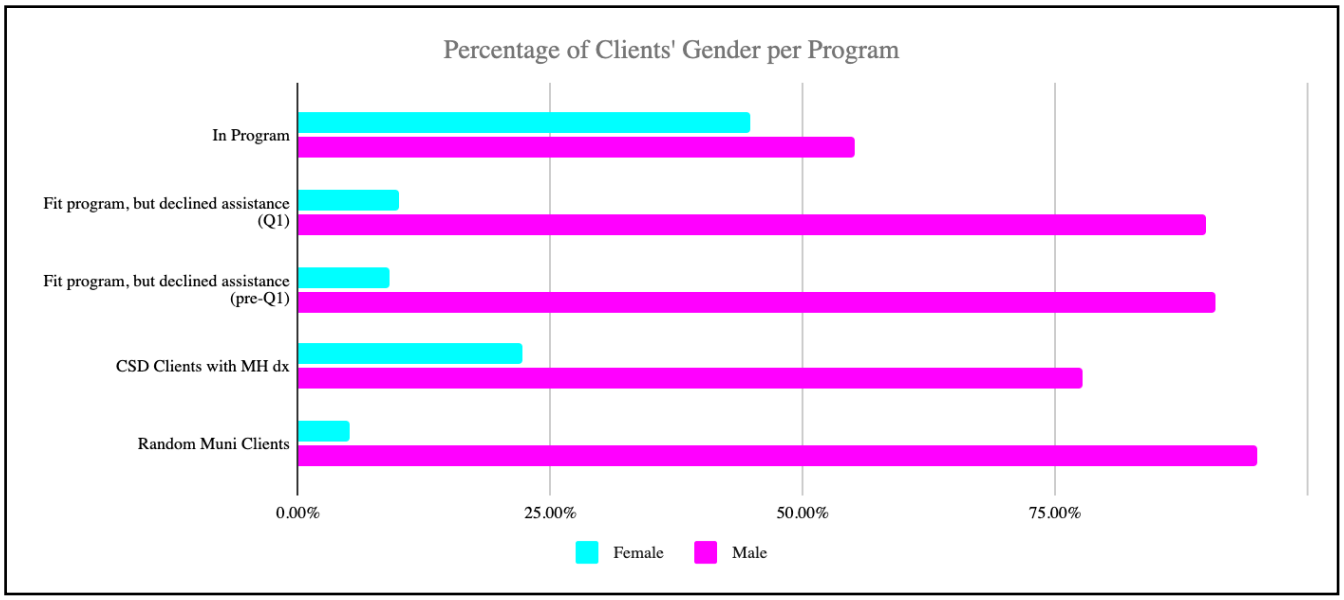

Fig. 3 - Gender Breakdown by Program

Table 1 shows the rates of Serious Mental Illness (SMI) among our three populations. Because all of these populations are OPD clients flagged for having a mental illness, the percentage of each population with SMI is well above the national average (which is around 5.3% for schizophrenia[12] and 4.4% for bipolar disorder[13]). Despite this, our clients still had rates of SMI well above our other control populations, showing that even when compared with other at risk populations, the clients served by our unit are especially in need of individualized mental health-focused services.

Table 1 - Rates of SMI by Program

Program	Schizophrenia	Bipolar Disorder
MHU-Muni Clients	41%	38%
Fit program but declined service	10%	20%
CSD Clients with MH dx	31%	15%

Initial Needs

In analyzing the initial needs of the individuals who fit our program's criteria and desire our services, two trends become clear.

The first noticeable trend is that our clients are often in dire need of the assistance our unit provides. Forty-two percent of our clients were homeless at the time of screening, and of those with housing, more than one in six had their housing status put at risk as a result of their arrest. More than half (61%) of our clients receive

[12] Wu EQ, Shi L, Birnbaum H, Hudson T, Kessler R. Annual prevalence of diagnosed schizophrenia in the USA: a claims data analysis approach. Psychol Med. 2006 Nov;36(11):1535-40. doi: 10.1017/S0033291706008191. Epub 2006 Aug 15. PMID: 16907994.

[13] Harvard Medical School, 2007. National Comorbidity Survey (NSC). (2017, August 21). Retrieved from https://www.hcp.med.harvard.edu/ncs/index.php. Data Table 1: Lifetime prevalence DSM-IV/WMH-CIDI disorders by sex and cohort.

government benefits, while 21% of our clients face barriers to accessing said benefits. Our clients were also the least educated of all groups sampled, and the most likely of all groups to suffer from the most serious forms of mental illness, bipolar disorder and schizophrenia. Lastly, while our clients were similarly likely to suffer from a co-occurring substance use disorder compared with our control groups, they were the least likely to have received treatment for their disorder.

The second trend that becomes clear when analyzing Figures 4-14, is that clients who fit our program's criteria but declined our services faced less dire circumstances than those that accepted our services. This demonstrates the benefits of self-selection and the importance of maintaining client autonomy, as this has allowed clients who do not necessitate our services due to more stable life circumstances to avoid our unit, thus saving us resources which can be directed towards those that show a greater need for personalized assistance.

Figures Showing Initial Needs of Clients, Separated by Program[14]

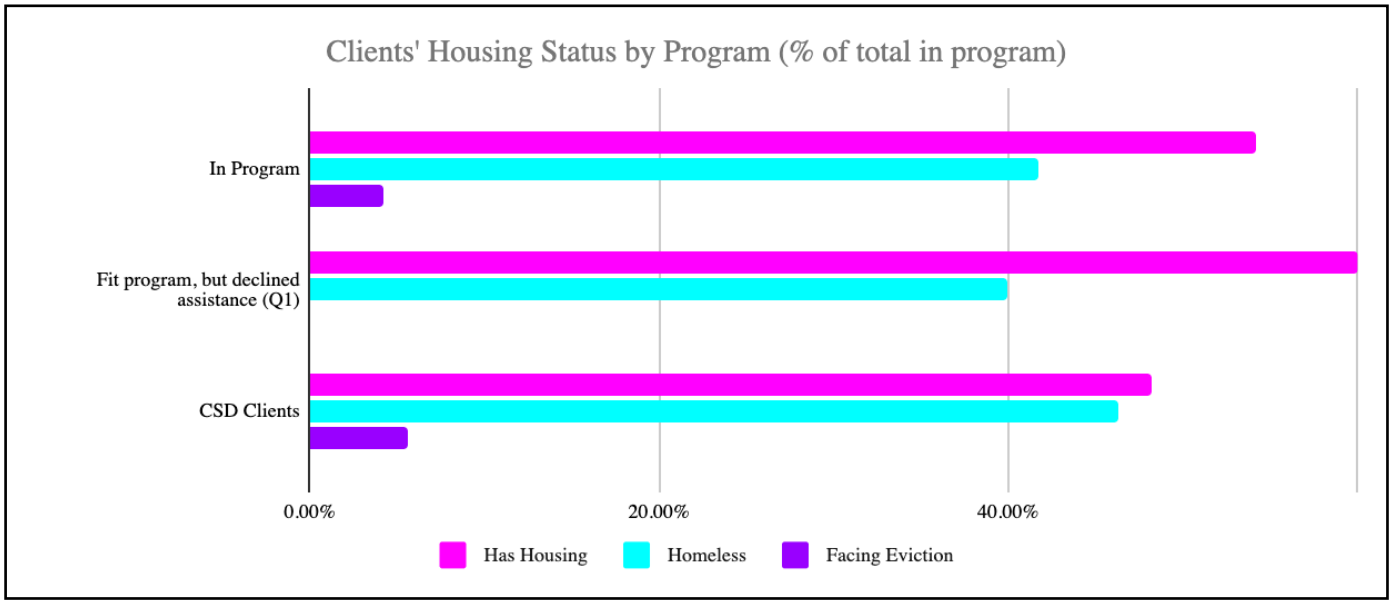

Fig. 4 - Housing Status by Program

[14] Note for interpreting the graphs below: while it is useful to compare the data gathered for the three groups, none of these groups should be considered a "control" in the sense of mirroring the general population of the city, of our clients, or of the jail. All of these groups are composed of individuals who have been diagnosed with a mental illness and who were flagged by OPD as needing personalized assistance, and thus they all likely face higher levels of instability than a representative sample of the city, our clients, or the jail.

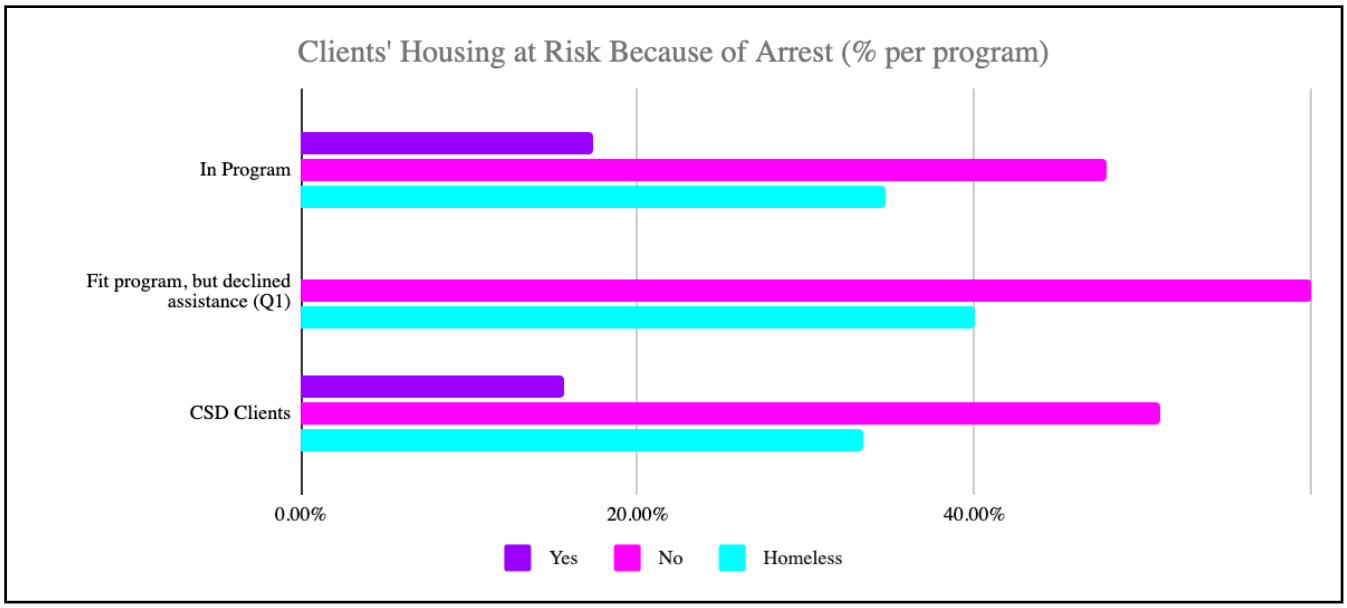

Fig. 5 - Risk Posed to Housing Status by Program

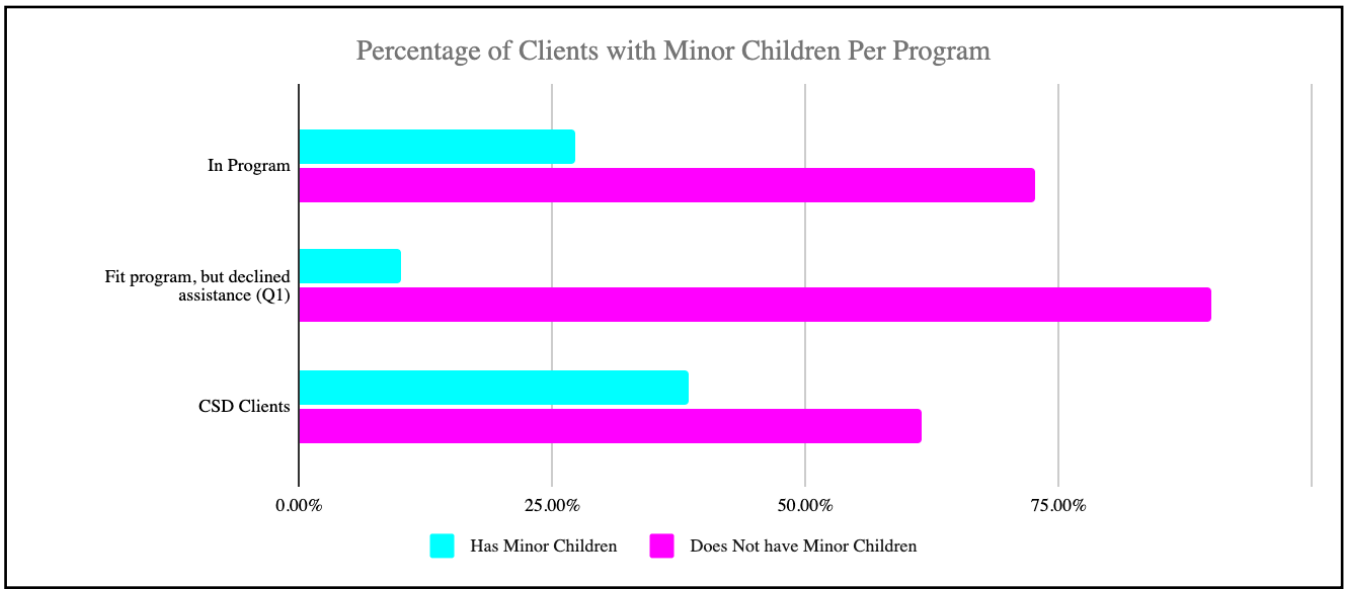

Fig. 6 - Percent of Parents of Minor Children by Program

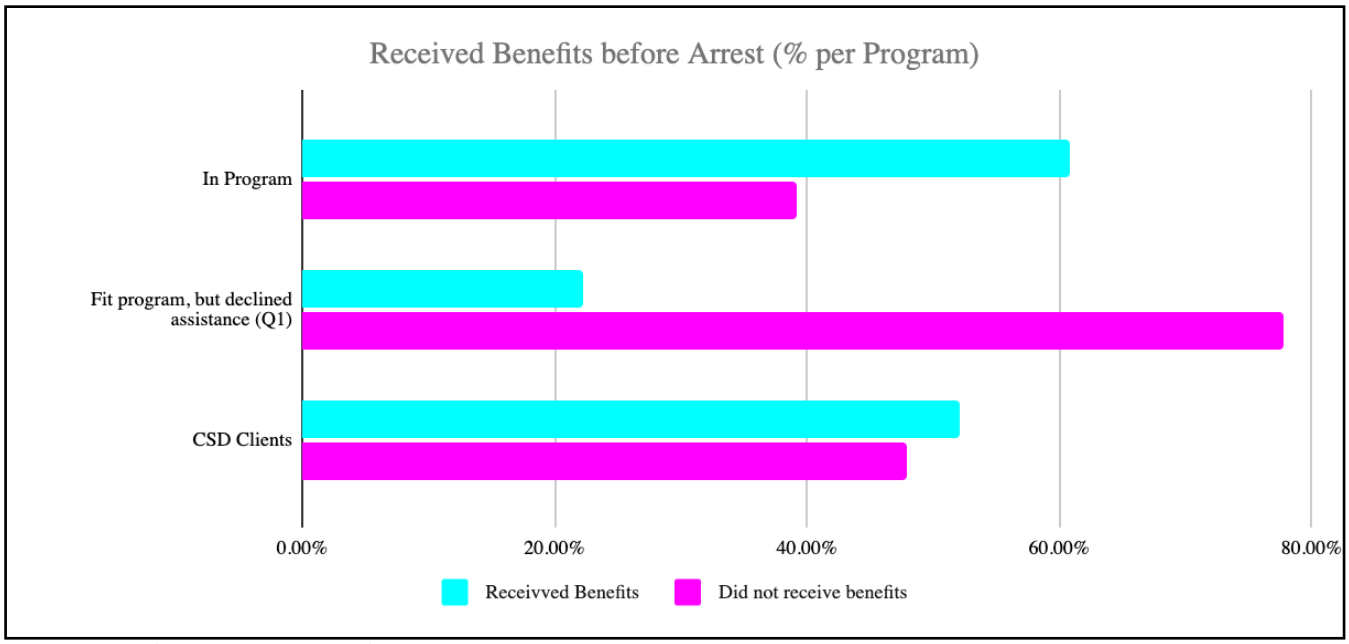

Fig. 7 - Percent of Clients Receiving Benefits by Program

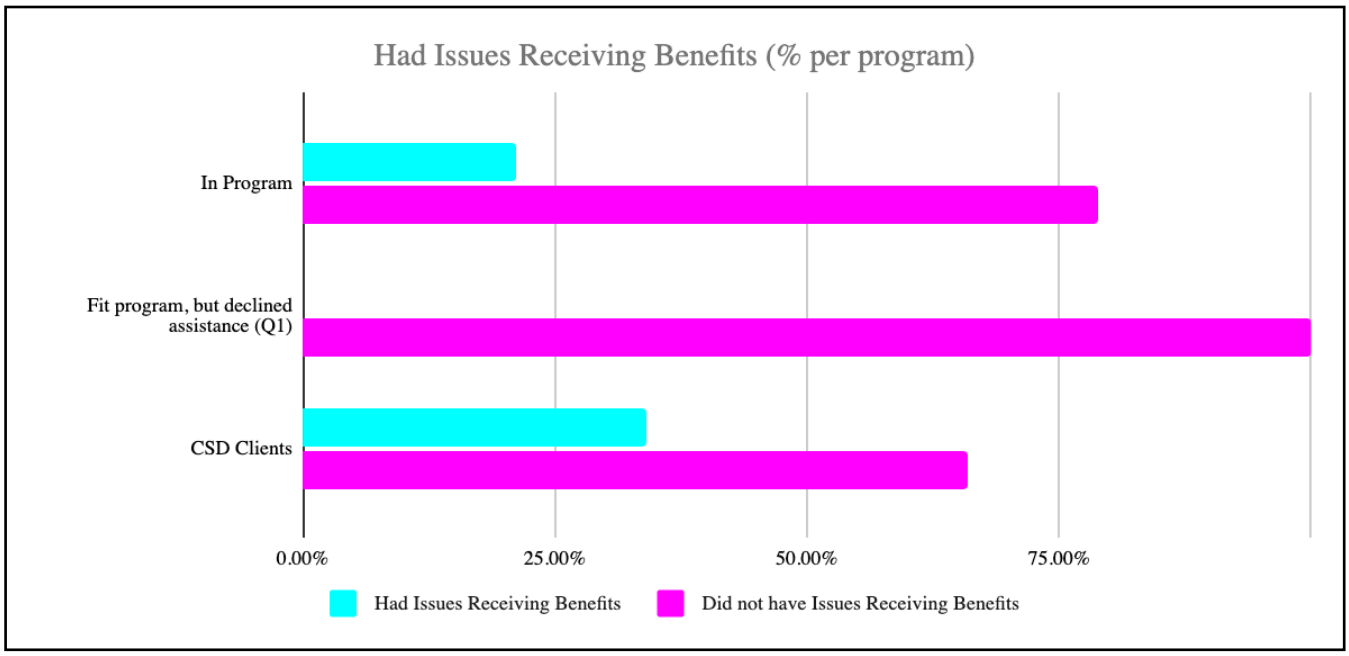

Fig. 8 - Percent of Clients Having Issues Receiving Benefits by Program

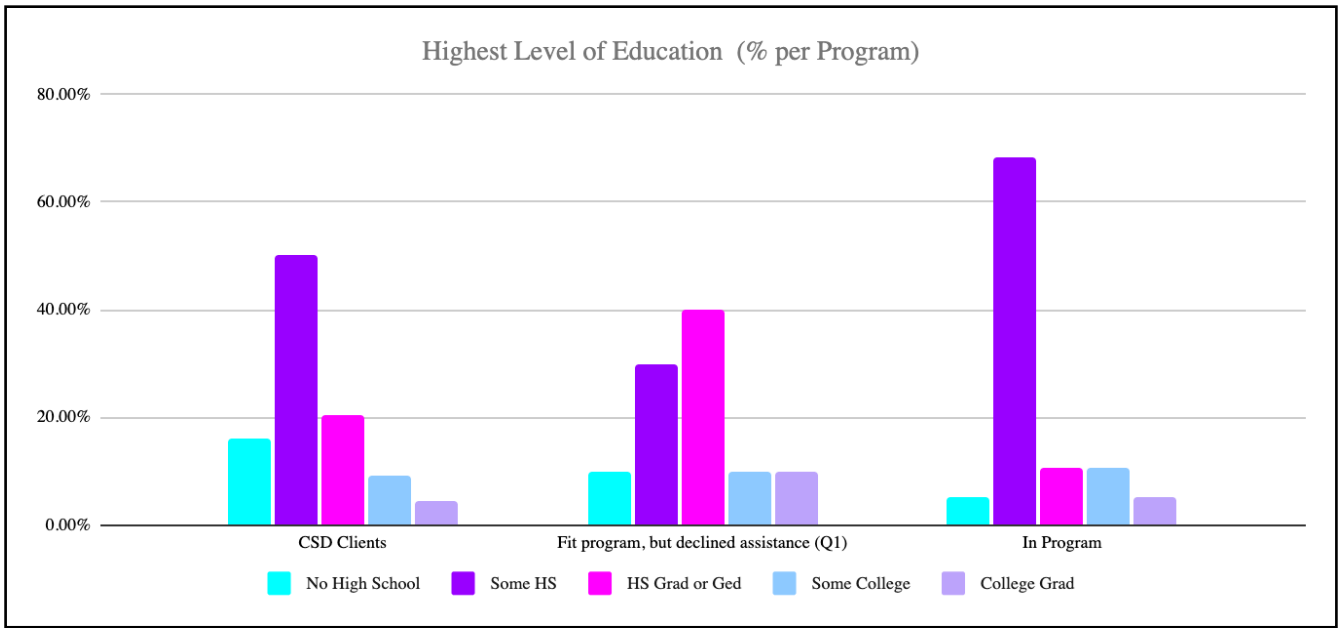

Fig. 9 - Education Attainment by Program

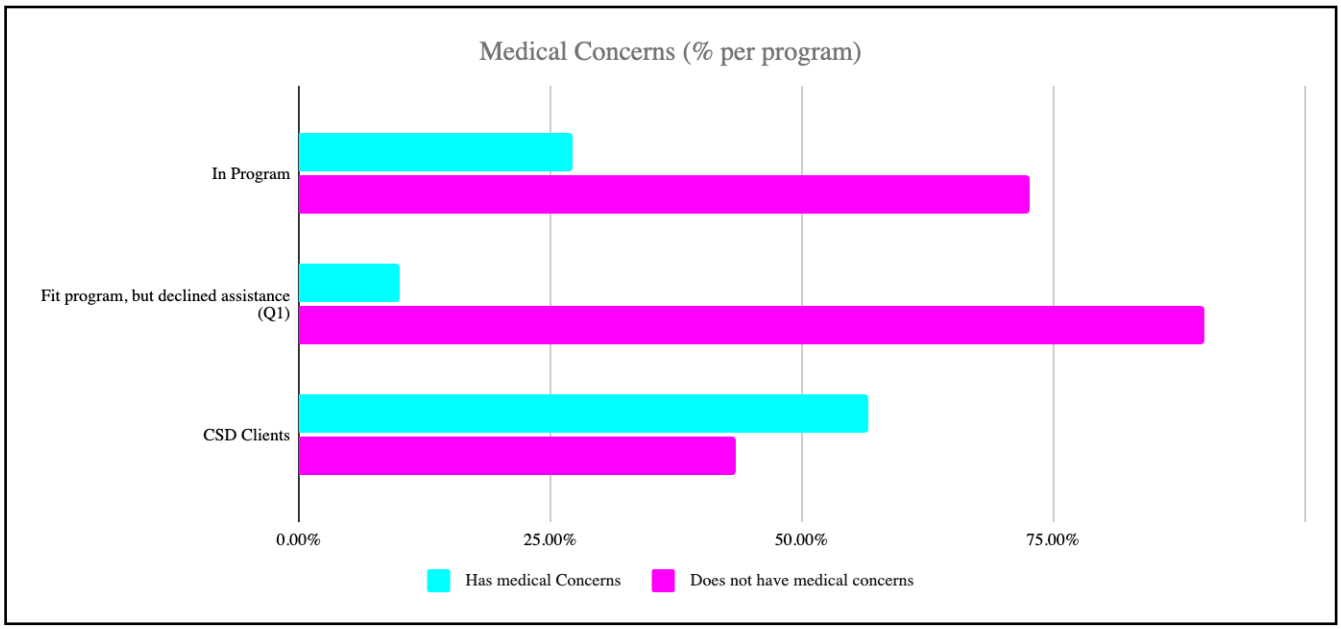

Fig. 10 - Percent of Clients with non-Mental Health (MH) Medical Concerns by Program

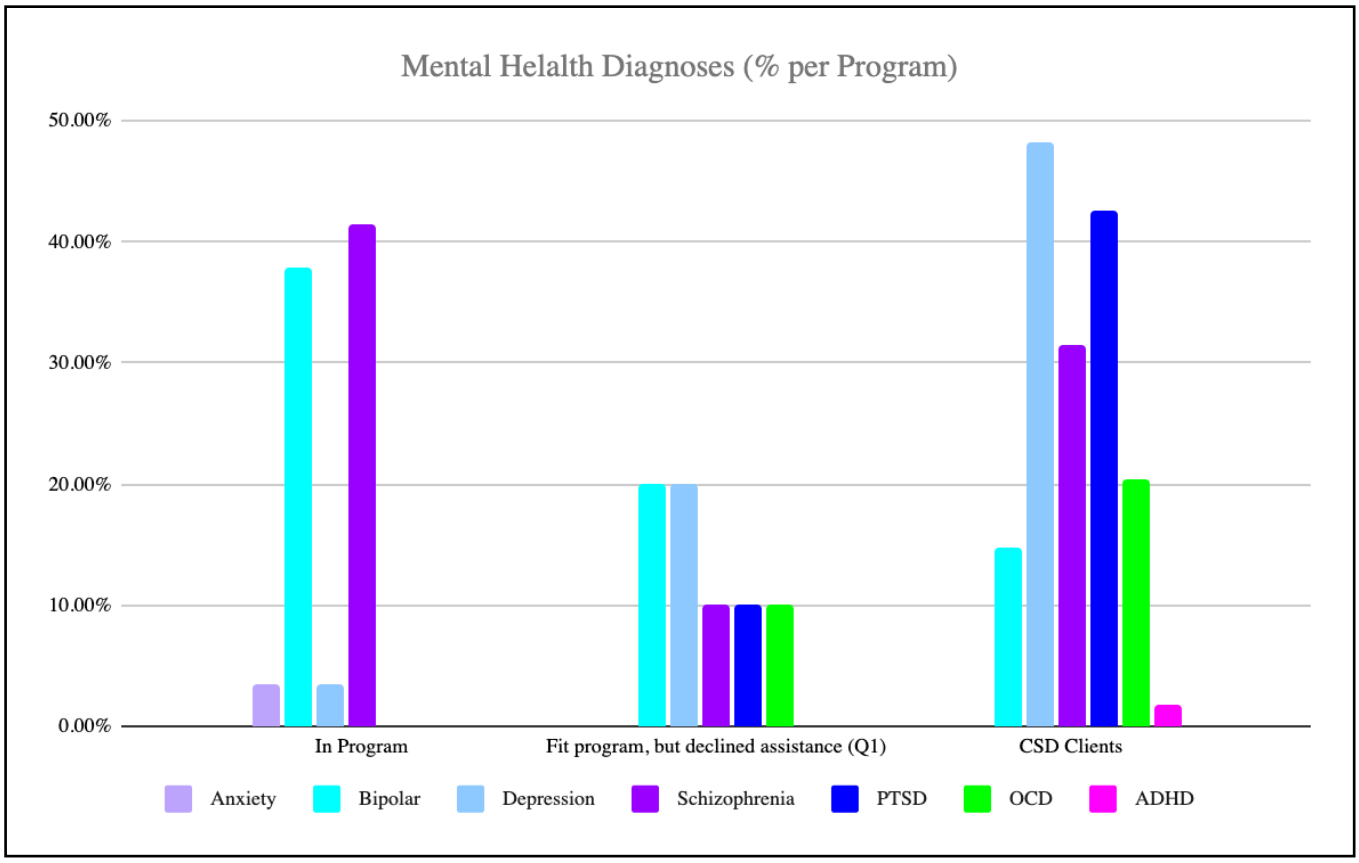

Fig. 11 - Mental Health Diagnoses (MH dx) by Program (measured as a percent of all mental health diagnoses)

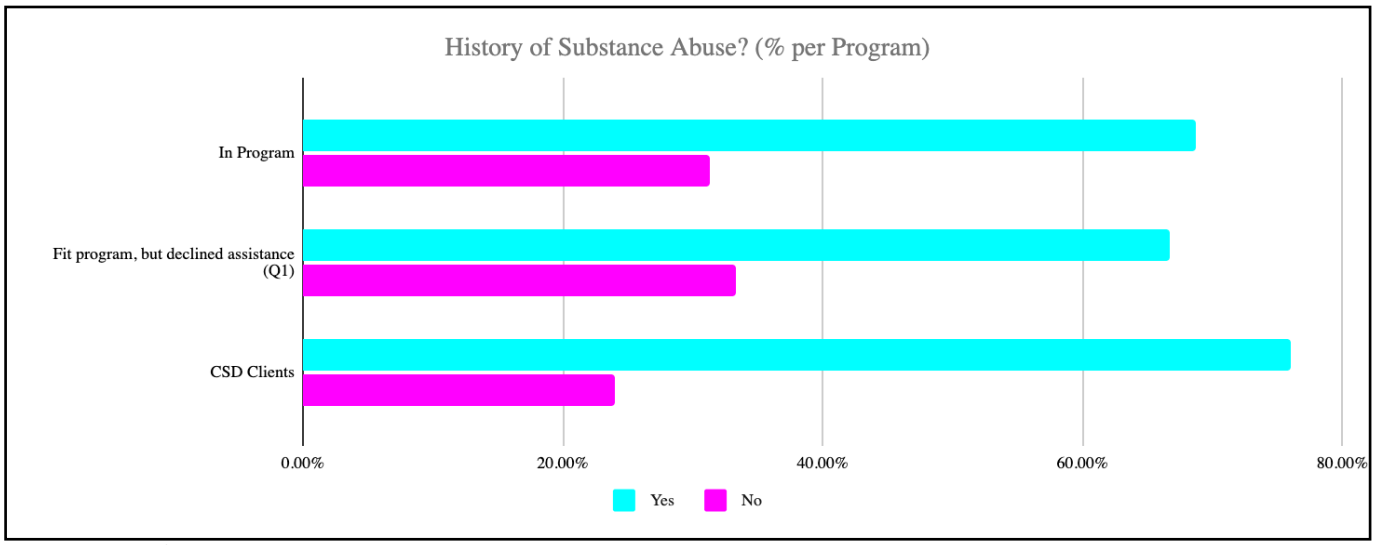

Fig. 12 - History of Substance Abuse by Program

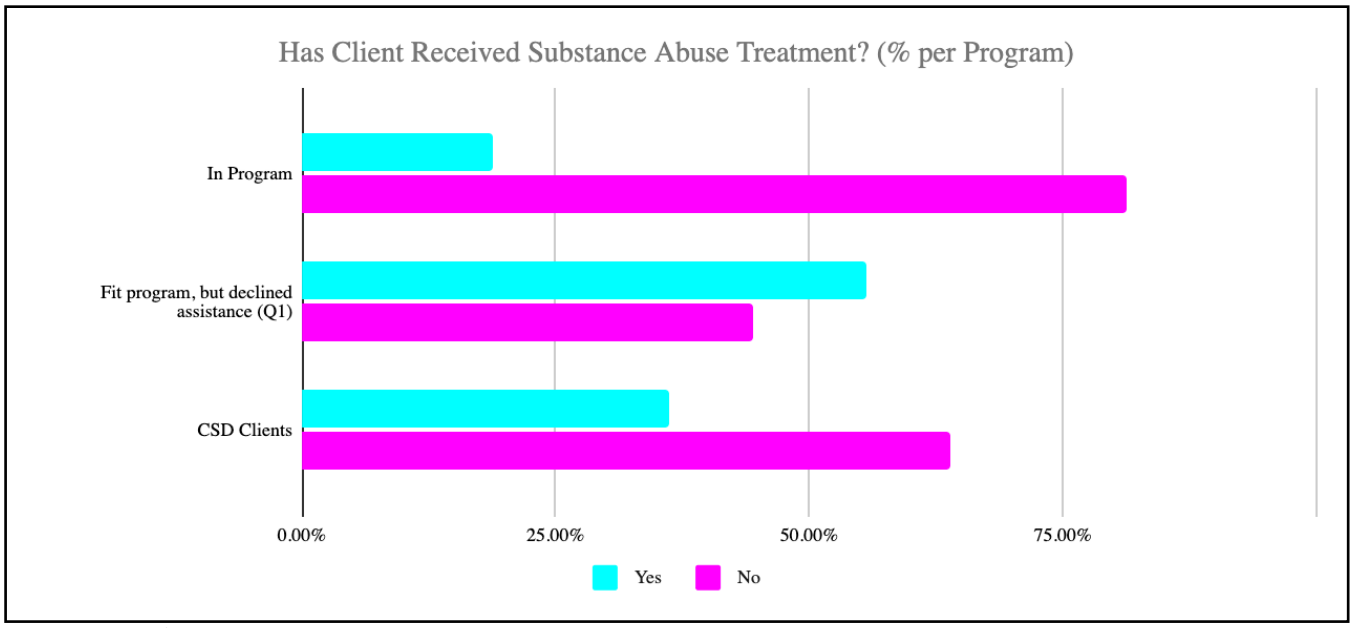

Fig. 13 - History of Substance Abuse Treatment by Program

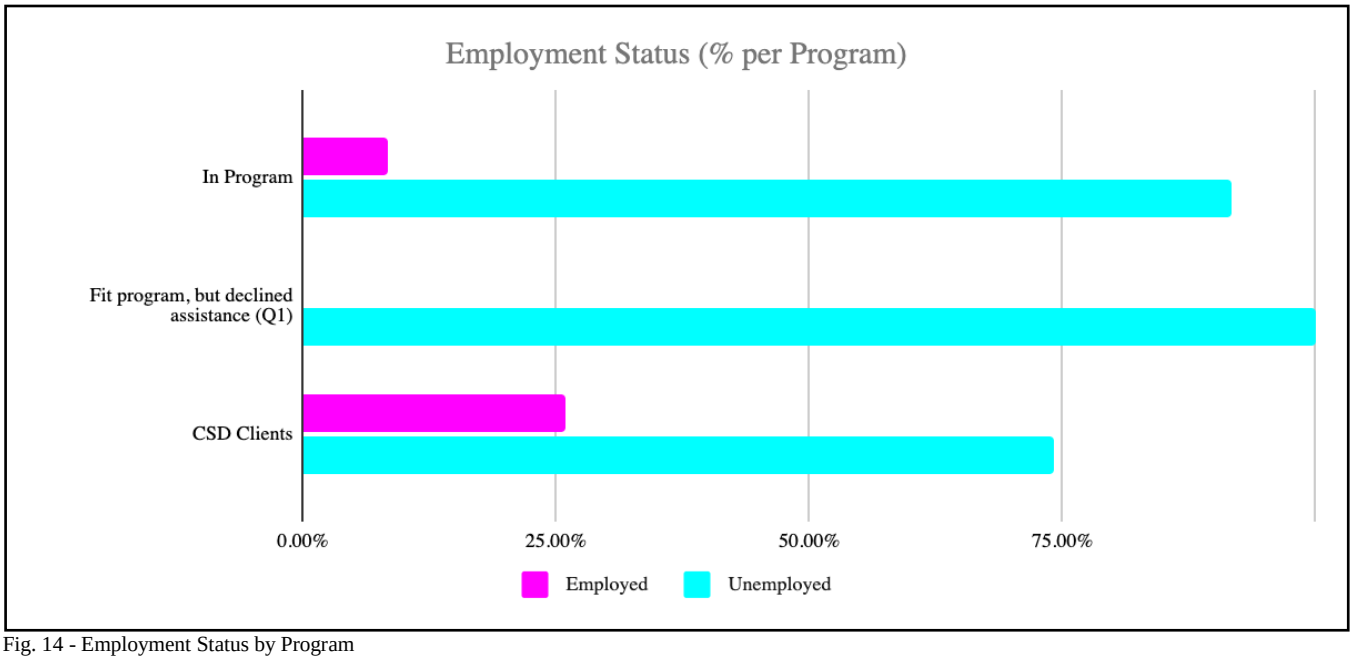

Fig. 14 - Employment Status by Program

As the data clearly demonstrates, when compared with those that did not receive MHU-Muni services, our clients were:

- More likely to be homeless
- More likely to have their housing status impacted by their arrest
- More likely to have minor children
- More likely to receive public benefits
- More likely to face obstacles in obtaining these benefits
- More likely to have compounding medical concerns
- Less likely to graduate from high school or college
- Less likely to have received substance use treatment, *despite* a near identical rate of substance use disorders

The only metric where this pattern did not hold was for employment, where those that fit our program but declined our services were the least likely to be employed. However, when taken within the context of the other data, it would appear that this higher rate of unemployment has not negatively affected their overall level of stability in relation to our clients and the CSD control.

SERVICE PROVISION AND OUTCOMES

Since the founding of MHU-Muni, our Social Worker has done tremendous work to alleviate the instability and marginalization faced by our clients. As soon as a client is accepted into our unit, a personalized treatment plan is created which addresses their specific needs, while maintaining compliance with court orders. For clients who are incarcerated at the time of their acceptance, a personalized release plan is created and submitted to Municipal Court and/or Criminal District Court. To date, 12 release plans have been submitted.

A large part of the Social Worker's work is referring clients to services which are either ordered by the Court or are agreed upon by both the MHU-Muni team and client. So far, we have had a 62.5% success rate for FACT referrals and a 25% success rate for housing referrals. This low success rate for housing referrals exemplifies New Orleans' dire need for more affordable housing, temporary shelters and a long-term solution to the well-noted housing crisis.

Table 2 - Service Referrals Made by Mental Health Social Worker

Referral Made	**Total Referred**
FACT	8
AOT	2
Housing	12
Substance Abuse Treatment	8
Group Home	2
Other Services/Education Programs	18

In order to make these referrals, keep abreast of clients' medical history and treatment, and understand their carceral history, the Social Worker must make numerous records requests. As of this report, she has requested records for 12 of our current clients, totaling 53 requests.

In addition to helping clients access services through referrals, our Social Worker is also tasked with providing necessary goods and services to clients directly. These services include providing transportation for clients to court, treatment, services, etc., as well as accompanying them to Court.[15] Some necessary goods our clients require include phones and IDs.

[15] Obviously this has been significantly decreased by COVID-19, as indicated above.

Table 3 - Goods and Services Provided by Mental Health Social Worker

Goods and Services	**Total Provided**
Rides	21
Cell Phones/IDs bought	7
Accompanied Client to Court	17

Building trust and relationships with clients is paramount to the success of this work. Much of that is reflected in the commitment and effort of the Social Worker, including the amount of regular contact had with each client. For some clients, the Social Worker spends months in daily or weekly communication, making sure their needs are addressed and they are remaining compliant with all court mandated treatment plans. Our Social Worker contacted clients roughly 159 times this past quarter. The 47.6% response rate is indicative of the fact that the population we work with is often especially difficult to reach due to their lack of access to housing and communication infrastructure, as well as due to their symptoms of mental illness. While contact by phone and email is common, so are more difficult forms of relationship building and communication, indicated by the 27 field visits she has made to speak directly with our clients or their families.

Qualitative Case Study of Client Success

Olivia[16] suffers from SMI and upon entering the MHU-Muni program had been experiencing housing instability. The vast majority of Olivia's arrests are for misdemeanors and attachments, almost all of which are directly connected to her lack of housing and/or symptoms of her mental illness. Olivia was interviewed by members of the MHU-Muni team and consented to a treatment plan derived from and consistent with the MHU-Muni model.

As part of that agreement, we arranged for Olivia to be interviewed by an ACT Team and set up multiple interviews with an on-staff Social Worker. Together, Olivia, the ACT Team, the Mental Health Social Worker and Mental Health Attorney agreed upon a treatment plan that involved 1) reconnecting lapsed social services, 2) monthly medication management services, and 3) possible housing solutions. Today, Olivia is still working with the MHU-Muni team and her treatment plan. Since her release in November, she has received monthly medication injection for 5 consecutive months, attended all 7 of her court dates, moved into a group home, and stayed compliant with the court system and probation office. Olivia has transitioned from daily to weekly communication with our Mental Health Social Worker, and is in bi-weekly contact with her ACT Team. More recently Olivia has reconnected with her estranged family and has begun looking for her own apartment.

Since working with the MHU-Muni program, Olivia has been arrested 0 times. This is a substantial milestone. Previously, since 2017, Olivia's longest periods of time outside of jail was 209 days. Prior to working with our program, Olivia had been arrested 6 times in 2019 alone.

LEGAL OUTCOMES

MHU-Muni has handled 69 cases in Q1. It is our guiding principle that by intertwining individualized service provision with mental health-informed legal representation, we can produce better outcomes for high-utilizing clients with SMI. In doing so, we improve their quality of life while saving the city money wasted on

[16] All client names are pseudonyms to ensure client confidentiality.

unnecessary arrests, detention, and court costs. So far, this principle has proved successful, as indicated above and outlined in detail below.

A simple metric for determining recidivism is frequency of arrest. We found the number of arrests per year for each of our clients from January 1, 2017 until they joined our program. Our clients averaged 1.54 arrests per year for this 5 year period, nearly twice the average for the random sample of Municipal Court clients. We then compared this with the number of arrests per year after client's initial contact with MHU-Muni and found their frequency of arrest fell by nearly 60%. While some of this decline may be attributable to the changing arrest protocols during the pandemic, this is only part of the story. The random sample of Municipal Clients only saw a reduction in arrest frequency of just 30%. Therefore, it is likely that this additional 30% decrease seen exclusively by our clients is *at least* partially attributable to the services provided by MHU-Muni. Some of these decreases were especially dramatic. Our three clients with the highest pre-program arrest rates had 17, 15, and 14 arrests each in the 5 months preceding their involvement in our unit and only 1, 0, and 0 arrests after involvement in our program (respectively).

In addition to this reduction in recidivism, our clients saw increased positive outcomes for their cases, when compared to those who were not part of the program. While the other groups received a higher rate of dismissal than our clients prior to this quarter, by the end of Q1 it is clear that our unit is able to produce better case results. This improvement in outcomes is a direct result of the changes made, including the addition of a trained Mental Health Attorney, more efficient team processes, and increased team synergy. By the end of this quarter, our clients received a greater percentage of dismissals than any comparison group. Additionally, our high rate of open/pending cases reflects the time our unit takes to ensure the legal representation our clients receive is accompanied by quality service provision at every step of their journey through this legal system.

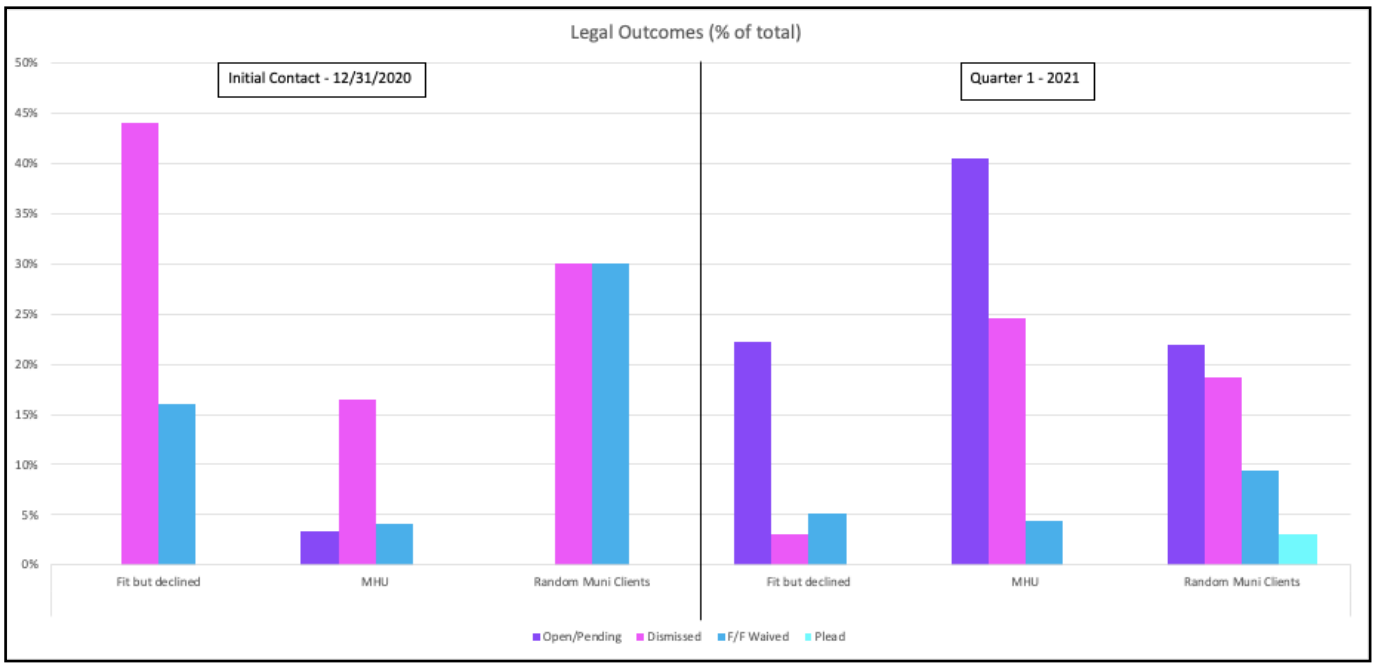

Fig. 15 - Legal Outcomes as a Percentage of Cases Processed

COMMUNITY PARTNERS

Our capacity to provide clients with individualized treatment plans and wrap-around services is only through strong relationships with community partners. Current and upcoming projects include:

- Partnering with Judge Kern Reese and Assisted Outpatient Treatment (AOT) Court for alternative solutions to assist clients with a history of medication non-compliance.

- Partnering with Tulane Forensic Department through Drs. McConville and Vyas to improve competency evaluation efficiency.
- Working with Tulane Medical School to establish a role at Municipal Court for their Forensic Fellowship program.
- Working with First 72+ to connect clients with housing.
- Developing internship opportunities at local university, law school and social work graduate programs.

NEXT STEPS

MHU-Muni will continue to hone and improve its methodology and approach to both identify qualifying and in-need clients, and meet their individual needs as they align with the goals of the program.

Hiring for the remaining positions (Part-time Peer Support Specialist and a dedicated Client and Court Support Administrator for Municipal Court) should be complete in the coming weeks and the program fully operational shortly thereafter. We expect to have all six positions in place by June.

Additionally, we are working to create and schedule trainings for the Municipal Court judges and staff so as to have a full understanding of the program's goals, methodology and processes. This will help create a seamless partnership between the MHU-Muni team and Municipal Court. This program will only be as successful as the partnership and coordination between the two entities.

Having hired the paralegal, we immediately began working on data collection, the results are demonstrated by this report. This collected data will be crucial to understanding and demonstrating the success in this unique approach. We believe in the model, but understand it will be imperative to show stakeholders and decision makers the value in a dedicated mental health team. Already, as laid out above, we have seen the validity of this approach borne out. The data includes prior interactions with court, unmet needs, and results of the new strategies including arrest, jail stay, success in programming, etc. This data collection will continue and evolve where necessary.

MHU-Muni will regularly communicate with Municipal Court judges and staff to evaluate the success of the program, make adjustments when and where necessary to meet the program's overall goals of reducing system interaction for people experiencing and suffering from SMI and other mental health concerns.

Additional Needs

To continue growth of the program and advance the successes already realized, we have identified the following additional staff and needs:

- **Two (2) tablets for in-court needs assessment and data collection - $3,500**
  - $1,750 per unit, onetime cost
- **Part-Time Peer Support Specialist - $20,000 salary**
  - salary only, no benefits
- **Client and Court Support Administrator - $43,000 salary/benefits**
  - $34,000 salary and approx. $9,000 in fringe benefits

ORLEANS PUBLIC DEFENDERS

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DERWYN D. BUNTON, CHIEF PUBLIC DEFENDER

July 12, 2021

Municipal Mental Health Unit, April – June 2021, Q2
Barksdale Hortenstine, Jr. Director, Mental Health Unit, Orleans Public Defenders

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This is a report of the work and outcomes of the Municipal Mental Health Unit (MHU-Muni) 2021 second quarter. Currently, there are only two MHU-Muni staff: Director, Barksdale Hortenstine and Paralegal, Gerhardt Weiss. Both staff work exclusively with Municipal Court clients to improve mental health services and outcomes, aligned with the goals of MHU-Muni.

The MHU-Muni team has made significant progress in building our unit to provide high quality mental health and trauma-informed legal representation alongside personalized wraparound services despite significant setbacks due to the ongoing COVID-19 pandemic, and more recently, the departure of our mental health-informed Attorney (position currently being temporarily filled by Director Hortenstine) and our mental health-informed Social Worker. As outlined in the Q1 report, the pandemic's health regulations continue to create barriers to in-person service provision, lack of a confidential screening environment, inability to provide appropriate and adequate wraparound services with direct delivery to services (warm handoff), and mostly, an inability to communicate and work with clients in-person. This lack of direct connection precludes the development of a client-team relationship, thus diminishing the capacity to engage the client in a meaningful partnership.[1]

Remaining nimble has been imperative and this *new* reality has forced us to build the unit with a dual focus: providing assistance under current conditions, as well as building systems and infrastructure to provide assistance in a post-pandemic world. The loss of half of our team presents an existential threat to the continued effective function of our unit. The entire theory behind this unit's effectiveness relies on the synergized function of a specialized Attorney and Social Worker in providing both mental health-informed legal counsel and wrap around service provision, neither of which are possible without our Social Worker and Attorney. Both left to pursue other similar positions, but outside of the criminal legal system. However, it is important to note the unsustainability of this model in its current skeleton structure. For this program be most effective for both clients and staff, the need to expand the unit is imperative. These positions remain vacant due to lack of financial resources at OPD and uncertain future of City funding. Despite this reality looming in Q3, we have retained our Social Worker through the end of Q2 and thus have continued to see significant outcomes for our clients.

MHU-Muni has established an active client roster, serving 34 clients with serious mental illness (SMI), 11 of whom are also receiving wrap-around service provision and support from our Social Worker. Of these 34, six

[1] This may be the most significant challenge as it is the primary theory supporting the direct benefits present in related projects this project is based.

were added in this second quarter.[2] After establishing separate criteria for closing cases on the legal and social work side, our Social Worker has successfully closed 23 cases (this criterion is discussed in more depth in the Treatment Outcomes page #16). We honed in on issues leading to excessive attachments and inadequate wraparound services and are providing individualized and in-depth attention to our clients by securing appropriate and available services that meet their identified needs. The focus remains toward assisting clients with the greatest needs, namely those with high arrest frequency and the most serious forms of SMI-Schizophrenia and Bipolar Disorder. Our data shows we have successfully screened and recruited from this population; our clients' average arrest rate was nearly triple that of a representative sample of Municipal Court clients,[3] and they face rates of Schizophrenia and Bipolar Disorder 62 and 22.5 times higher (respectively) than the general population.

SCREENING AND ADMISSION

Despite launching during unprecedented public health and economic crises, as well as racial and social justice reckonings across the country, MHU-Muni has pushed forward to establish the necessary structure for client identification and referral, as well as solidify the methodology and client-centered approach of the program. In order to be most effective, reduce the frequency of arrest, and meet client's individual and complex needs, we must meet clients where they are, properly assess their needs, and connect them to appropriate and available services.

Current Screening Process

There are two main pathways to MHU-Muni representation.

Primarily, clients are identified through First Appearances[4] (FA). During the final quarter of 2020, our unit began implementing a three-step process for identifying clients who fit our criteria and desire our services. First, prior to FAs, the Paralegal reviews the arrest history of everyone on the docket to ascertain the volume and density of their previous involvement in the legal system. Second, the Social Worker meets with each client where she administers the screening tool[5] and assesses the prospective clients' presentation for likely SMI. (During COVID-19, this takes place via Zoom. Ideally, this would happen in person.) Third, all clients flagged as possibly having a mental illness receive a follow-up visit from the Social Worker for an in-depth personal history, HIPAA forms for records are signed, and a more informed determination of fitness for our unit is made. If the client does not fit the criteria for our unit, they may (*and often do*) still receive certain benefits including referral for services, text reminders for court dates, or referral to CSD. Additionally, all flagged persons receive the benefit of the Mental Health Attorney, regardless of their involvement in the unit.

Secondarily, clients can also be sent to our unit by referral. Any Municipal Court judge or OPD Staff Attorney may refer a client to MHU-Muni for representation.[6] So long as the client meets the criteria for the MHU-Muni program, they will be accepted.

Improvements in 2021 Q2

During Q2 we made four primary improvements to our screening process.

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[2] While it is the design and intent of MHU-Muni to serve a low number of high-utilizing clients, this # of clients is about half of what we anticipated for our quarterly docket. We believe this *lower than anticipated* number of clients matching our criteria correlates with the diminished arrests and minimized court functions of Municipal and Traffic Court during COV ID-19.

[3] We derived a random sample using a random number generator and selecting clients from that population. Specifics are laid out below.

[4] This is the initial hearing during which a Municipal Court judge determines probable cause and sets condition of bond for every arrested detainee facing municipal and/or traffic charges. As of this report, the MHU-Muni unit interviews and represents every client at this proceeding.

[5] Initially we administered a hybrid screening tool of our own design but switched to the Brief Jail Mental Health Screen due to time-constraints and to streamline the screening process, make it more uniform and based on an already validated tool.

[6] This has not been as significant a stream of referral as anticipated, largely due to COVID-19 related restrictions.

First, we worked with OPSO deputies to get potential clients into the OJC courtroom and onto Zoom sooner for FAs, allowing more time to administer screenings, discuss mental and emotional health challenges, and better prepare for bond advocacy and potential treatment plans for release. Due to the high turnover of our team and of deputies throughout Q2, we have noticed a decrease in our social capital and a corresponding decrease in our ability to ensure adequate time with clients prior to FAs to complete screenings and interviews. Without the stability required to utilize social capital, we will need to rely on structural changes going forward in order to ensure adequate time to screen prospective clients.

Second, we revised our screening tool to be both quicker and more accurate in determining the presence of SMI. We now use the Brief Jail Mental Health Screen (BJMHS), developed by Policy Research Associates, Inc., and adapted to our specific needs.

Third, in an effort to improve our ability to recognize the signs of mental illness, we have done in-depth academic research into mental illness identification and treatment, participated in trainings led by forensic psychiatrists, and spoken with mental health public defenders from various states and programs to ensure our adherence to best practices, as well as effective client-centered approach.

Fourth, we integrated the screening process with our Attorney's initial client interviews in order to provide more immediate information regarding client's mental state. This more effectively assists in their bond and mitigation advocacy.

Additionally, in an effort to understand differing rates of participation, we began collaborating with a professor of sociology to both hone our screening and reduce stigma around mental health issues, with the hope of increasing buy-in and participation to our unit among prospective clients. While the departure of our Social Worker will cause an immediate pause in our ability to perform follow up screening and provide full services, we will continue administering and improving our screening process to a) identify clients with SMI and get them access to whatever services we can, b) keep track of eligible clients for whom we can begin to provide wrap-around services once a new Social Worker is onboarded, and c) improve our screening process both for our own use once fully staffed and for the overall betterment of mental health public defense, as our methods are shared with other units within our office and across the country.

The Data

This quarter we screened 220 individual defendants, of whom six became full-time MHU-Muni clients. Additionally, at least four new clients were provided with services from our MHU Social Worker and at least two people who fit MHU criteria but declined full participation still received the representation of the MHU Attorney. As indicated below, there is a large variability in docket size, which makes preparing for and conducting the screening more difficult. Docket size has risen steadily since last October (when data on screening first began), with sharper rises occurring at the end of March and end of April/beginning of May 2021. Regardless of the increase in Municipal Court defendants, our unit will continue to focus on the highest utilizing and most mentally ill clients, while ensuring our unit remains small enough that all clients continue receiving personalized wrap-around assistance.

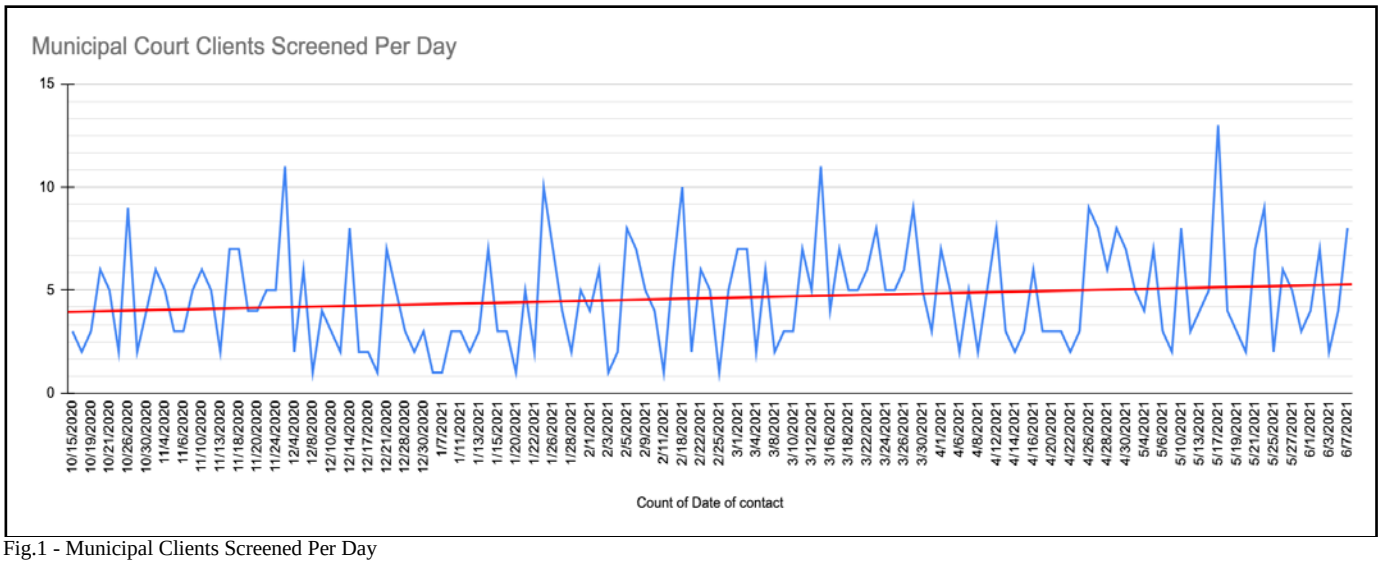


Fig.1 - Municipal Clients Screened Per Day

CLIENT DEMOGRAPHICS AND INITIAL NEEDS

In the section below, MHU-Muni client demographics as well as their identified needs upon entering our program are presented. This information is compared with three other groups to demonstrate how MHU-Muni clients compare to similarly situated populations. The groups examined include:

A. MHU-Muni Clients
B. Municipal Court clients determined to fit our unit's criteria, but declined our services
C. Random selection of Municipal Court clients[7]

Demographics

Fig. 2 shows the racial breakdown of our clients closely matches that of other similarly situated populations. We do have a slightly higher proportion of Black clients compared to the random sample of municipal court clients, which is surprising given the higher prevalence of SMI among white populations. This is very possibly a statistical anomaly arising from our extremely small sample sizes; however, we will continue to investigate the possible causes of this disparity with the sociology professor helping us improve our screening tool. An interesting data point we see emerging is a higher percentage of Black people with SMI face disproportionately low levels of access to services compared to white people with SMI. As of now, we can only speculate as to the causes.

[7] This group was obtained by applying a random sampling technique to our database of detainees screened during FAs since October, 2020.

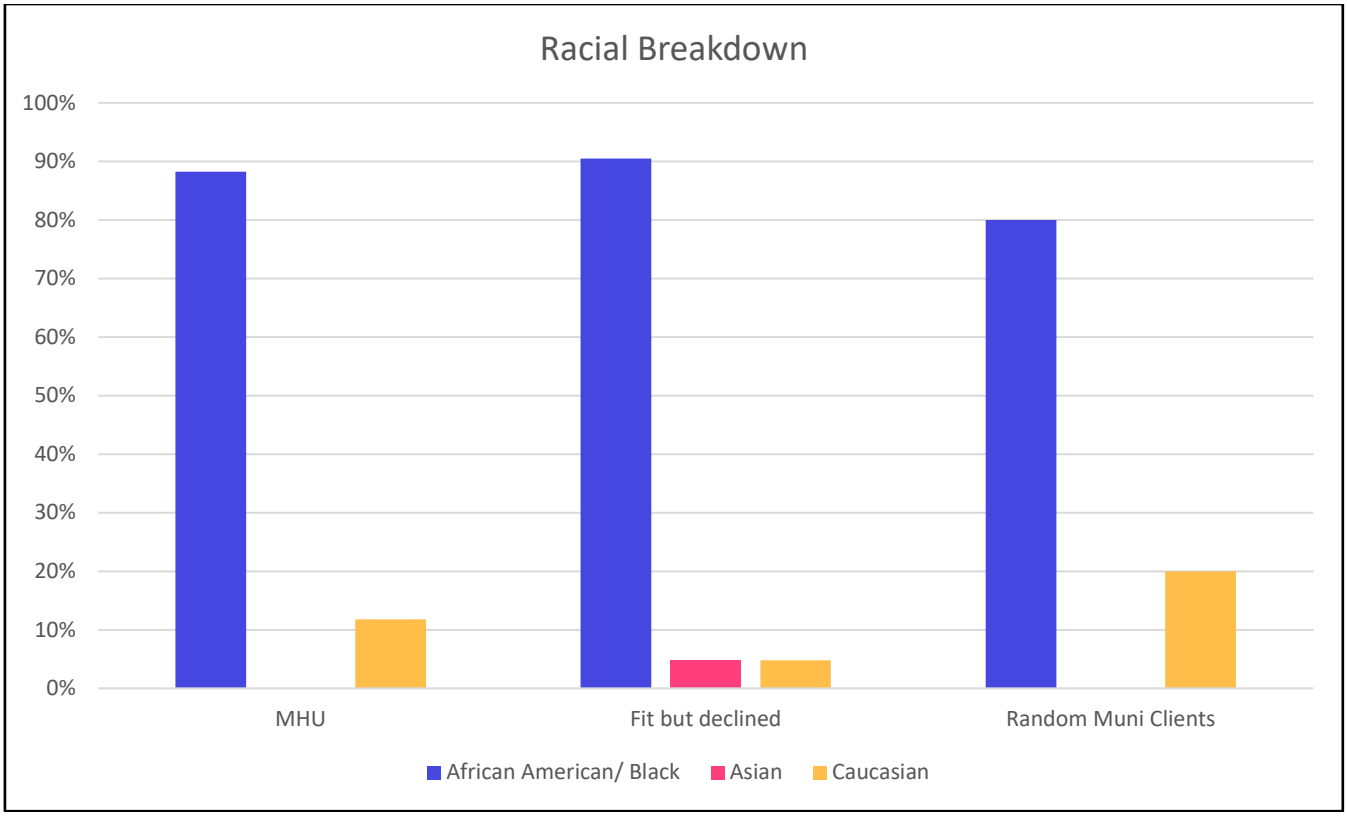


Fig. 2 - Racial Breakdown by Population

Fig. 3 shows how the gender breakdown of our clients differs quite drastically from our control populations. In our random sample of Municipal Court clients, we see a ratio of 80% male to 20% female. While some of this discrepancy is likely a result of the higher rates of SMI among women, the literature does not support this large of a discrepancy[8]. When taken in combination with the fact that the group that fits our program but declined service has a smaller percentage of female clients, it is likely that our overrepresentation of women is due to self-selection and not a feature of our screening process. This could be attributed to the greater stigma associated with mental illness for men.[9] This was noted in our Q1 report where we indicated our commitment to studying and addressing the cause of this disparity. Since then, we have introduced techniques, including motivated interviewing, and allowing for more discreet client responses indicating the need for further screening. As shown in Fig. 4, this has resulted in those clients added in Q2 being more representative of the overall municipal court population's gender ratio.

Continuing to improve the representativeness of our unit and decrease demographic disparities will be a key goal moving forward. We remain hopeful that once the pandemic no longer creates barriers to in-person representation, we will be able to more privately screen potential clients and thus reduce the barriers created by stigma.

[8] Klose M, Jacobi F. Can gender differences in the prevalence of mental disorders be explained by sociodemographic factors? Arch Womens Ment Health. 2004 Apr;7(2):133-48. doi: 10.1007/s00737-004-0047-7. Epub 2004 Mar 22. PMID: 15083348.

[9] Farina, A. (1981). Are women nicer people than men? Sex and the stigma of mental disorders. *Clinical Psychology Review, 1*(2), 223-243. doi:10.1016/0272-7358(81)90005-2

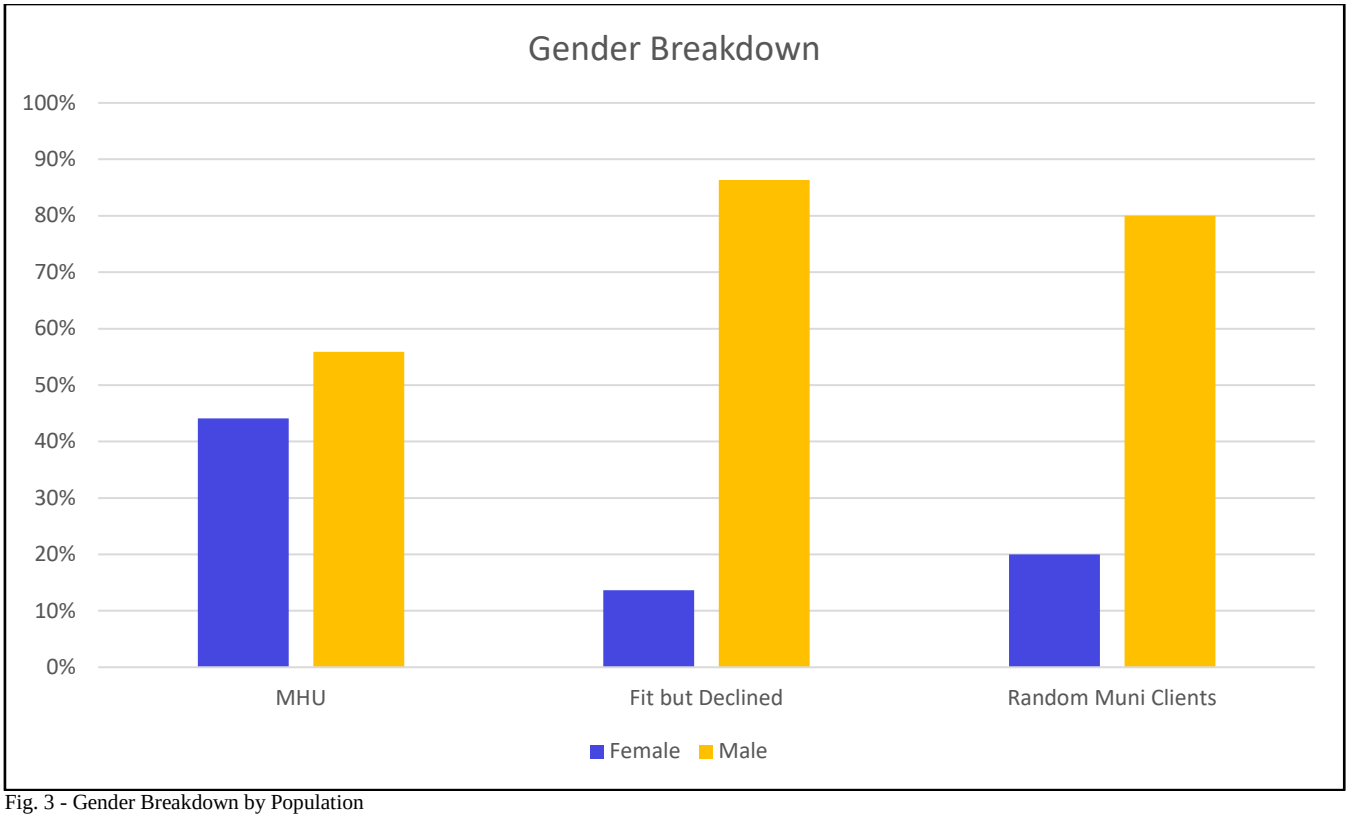


Fig. 3 - Gender Breakdown by Population

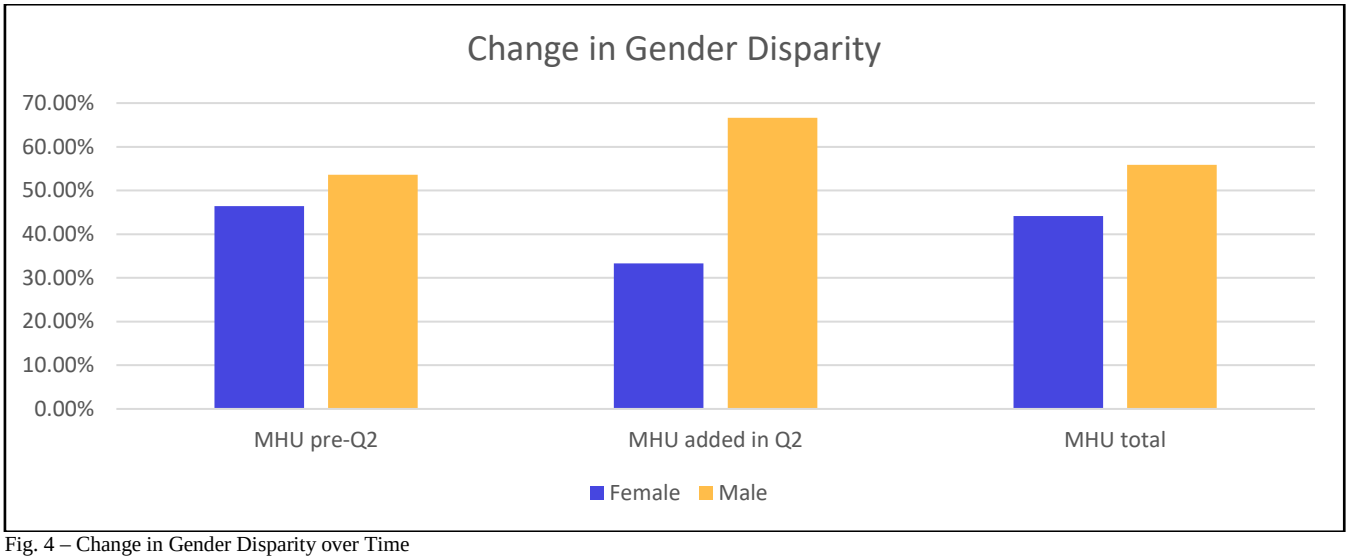


Fig. 4 – Change in Gender Disparity over Time

Table 1 shows the rates of Serious Mental Illness (SMI) among our three populations. The rates of SMI among MHU-Muni clients is higher than it is for those that fit our program but declined our services, and it is radically higher than it is for the general population, based on the currently accepted literature[10].

Table 1 - Rates of SMI by Population

Population	Schizophrenia	Bipolar
MHU	62.07%	58.62%
Fit but Declined	42.86%	42.86%
General Population	1.00%	2.60%

Initial Needs

In analyzing the initial needs of the individuals who fit our program's criteria and desire our services, two trends become clear.

The first is that our clients are often in dire need of the assistance our unit provides. Thirty-five (35%) percent of our clients were homeless at the time of screening, compared to .3% of the general population. Of those with housing, more than one in three had their housing status put at risk as a result of their arrest. The rate at which arrests risked our clients housing status has doubled since the last quarter, likely due to changing eviction protections. More than half (61%) of our clients receive government benefits, while 21% of our clients face barriers to accessing said benefits. Our clients were also the least educated of all groups sampled, and the most likely of all groups to suffer from the most serious forms of mental illness, bipolar disorder and schizophrenia. Lastly, while our clients were similarly likely to suffer from a co-occurring substance use disorder compared with those that declined admission to our unit, they were the least likely to have received treatment for their disorder. When the situation of our clients is compared with the city's general population, the dire need of our clients is evident.

The second trend that becomes clear when analyzing Figures 5-16, is that clients who fit our program's criteria but declined admission to our program faced less dire circumstances than those that accepted our services. This demonstrates the benefits of self-selection and the importance of maintaining client autonomy, as this has allowed clients who do not necessitate our services due to more stable life circumstances to avoid our unit, thus saving resources which can be directed towards those with a greater need for individualized assistance.

[10] *Mental Health Disorder Statistics*. Johns Hopkins Medicine. (n.d.). https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics.; U.S. Department of Health and Human Services. (2021, January). *Mental Illness*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; U.S. Department of Health and Human Services. (2021, January). *Any Anxiety Disorder*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; U.S. Department of Health and Human Services. (2021, January). *Major Depression*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; U.S. Department of Health and Human Services. (2021, January). *Post-Traumatic Stress Disorder (PTSD)*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; U.S. Department of Health and Human Services. (2021, January). *Schizophrenia*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; U.S. Department of Health and Human Services. (2021, January). *Bipolar Disorder*. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness.; *Mental Health By the Numbers*. National Alliance on Mental Illness. (2021, March). https://www.nami.org/mhstats.

The following show the initial needs of MHU-Muni clients, those who fit our programs criteria but declined admission, and, when possible, the general population of New Orleans.

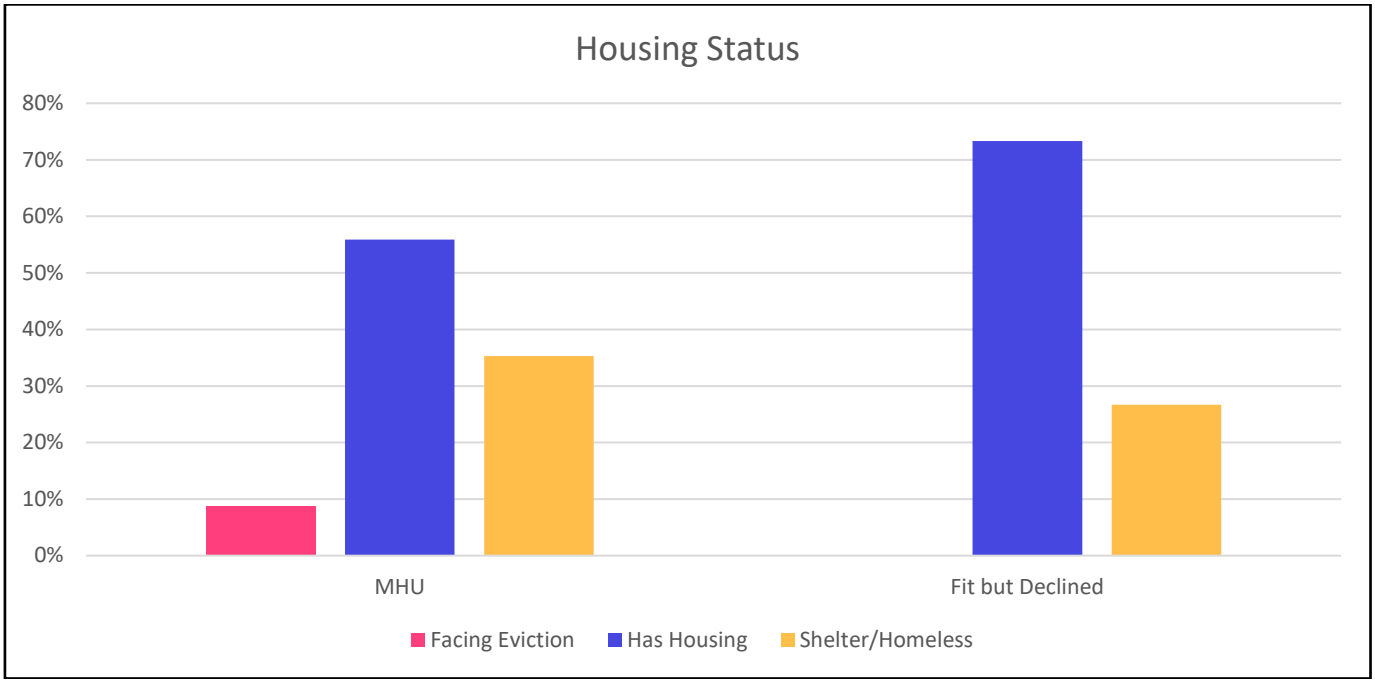


Fig. 5 - Housing Status by Population

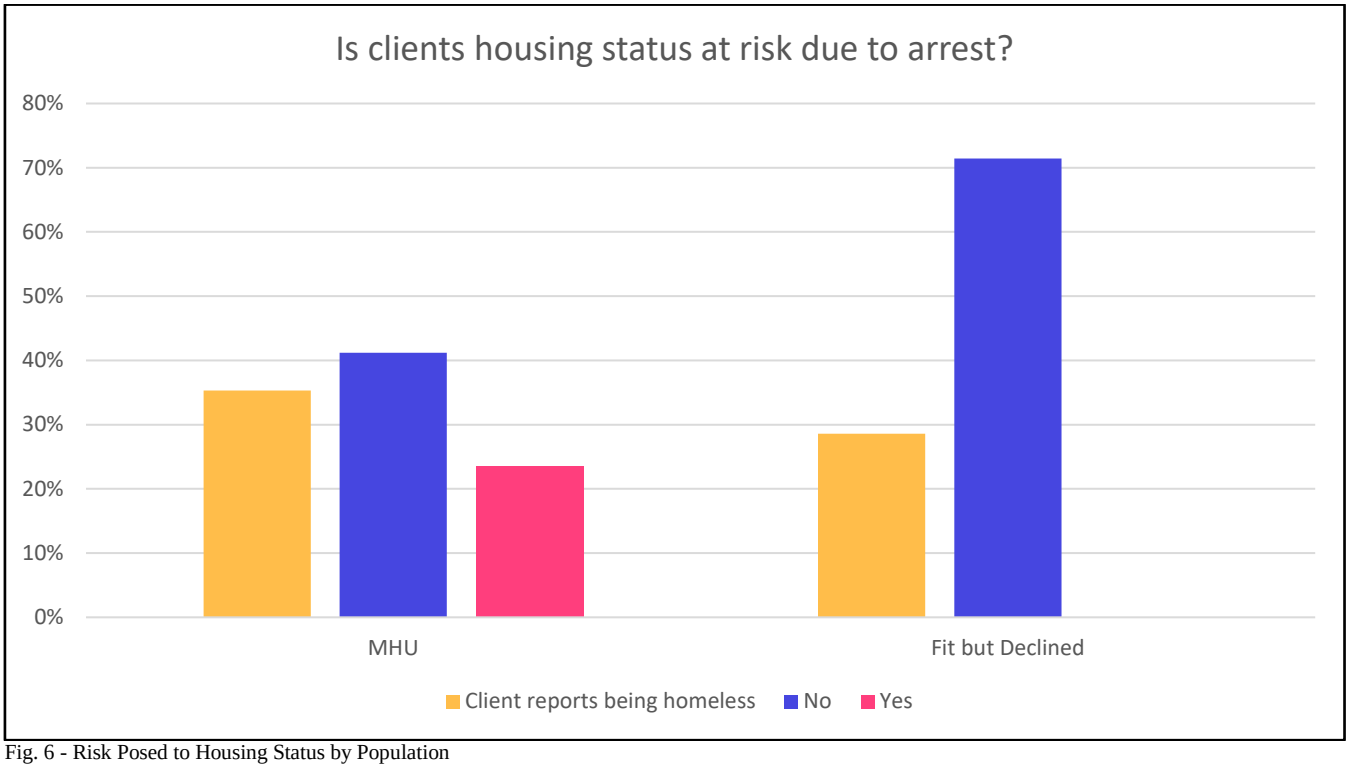


Fig. 6 - Risk Posed to Housing Status by Population

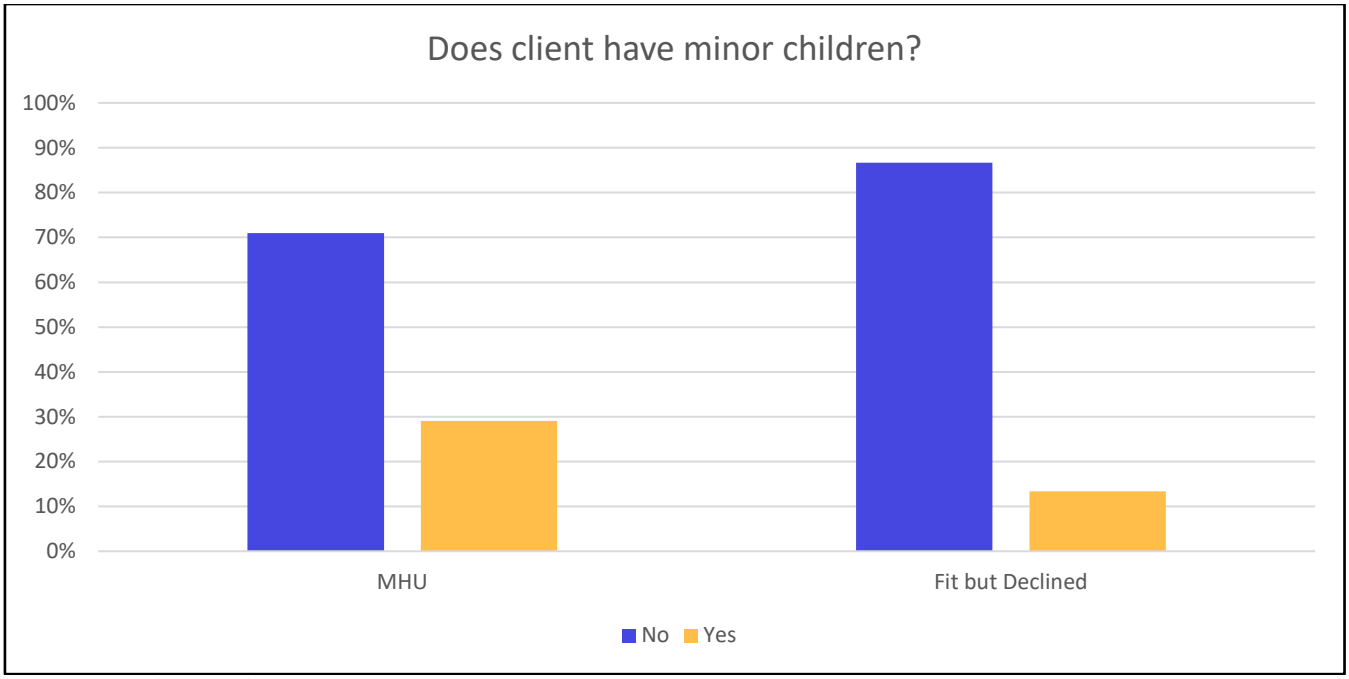


Fig. 7 - Percent of Parents of Minor Children by Population

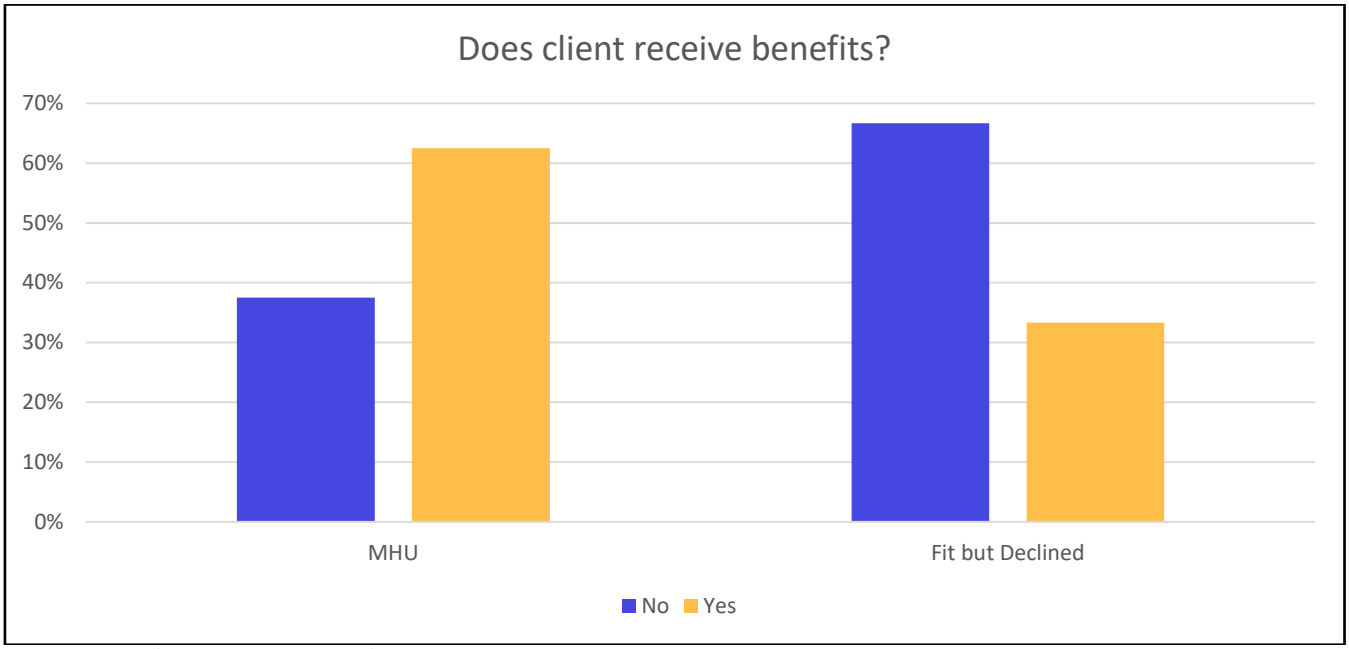


Fig. 8 - Percent of Clients Receiving Benefits by Population

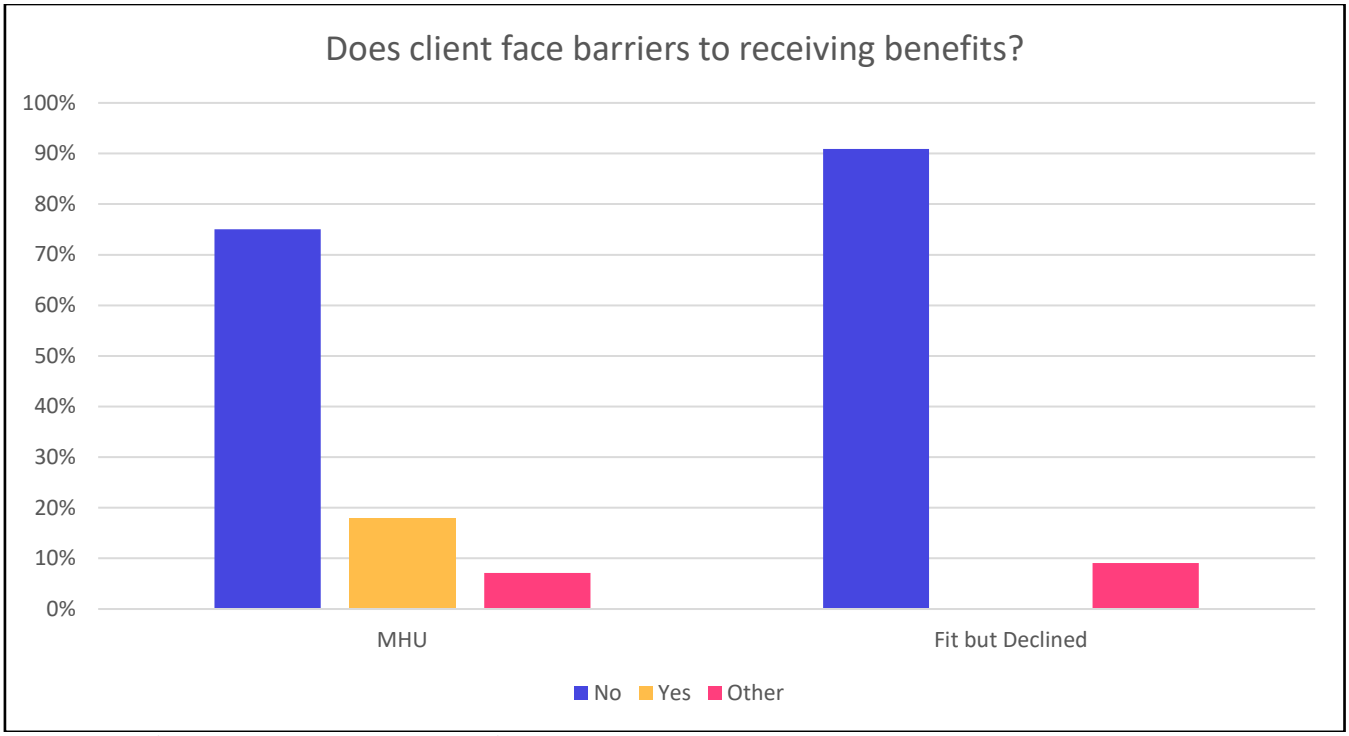


Fig. 9 - Percent of Clients Having Issues Receiving Benefits by Population

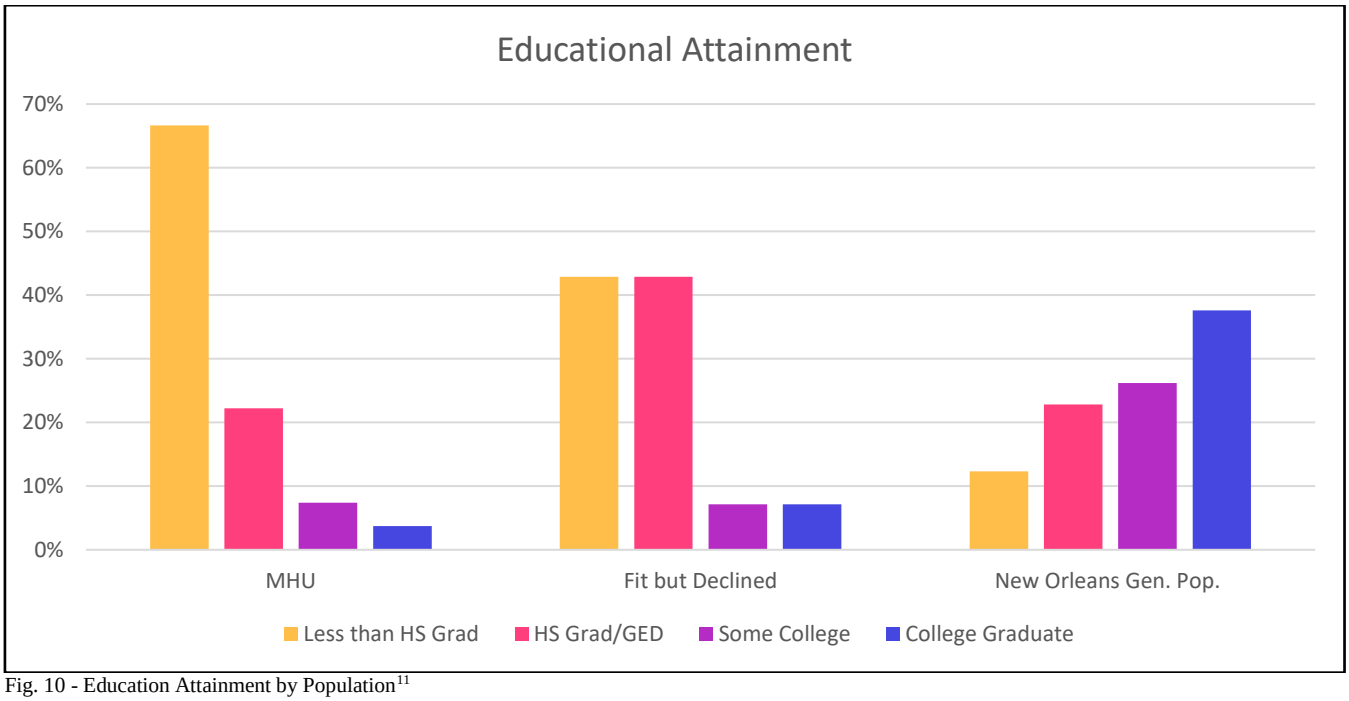


Fig. 10 - Education Attainment by Population[11]

[11] *New Orleans Louisiana Education data*. Towncharts Education data. (n.d.). https://www.towncharts.com/Louisiana/Education/New-Orleans-city-LA-Education-data.html#Figure1. Data from 2020 American Community Survey census data and the survey from Common Core Data

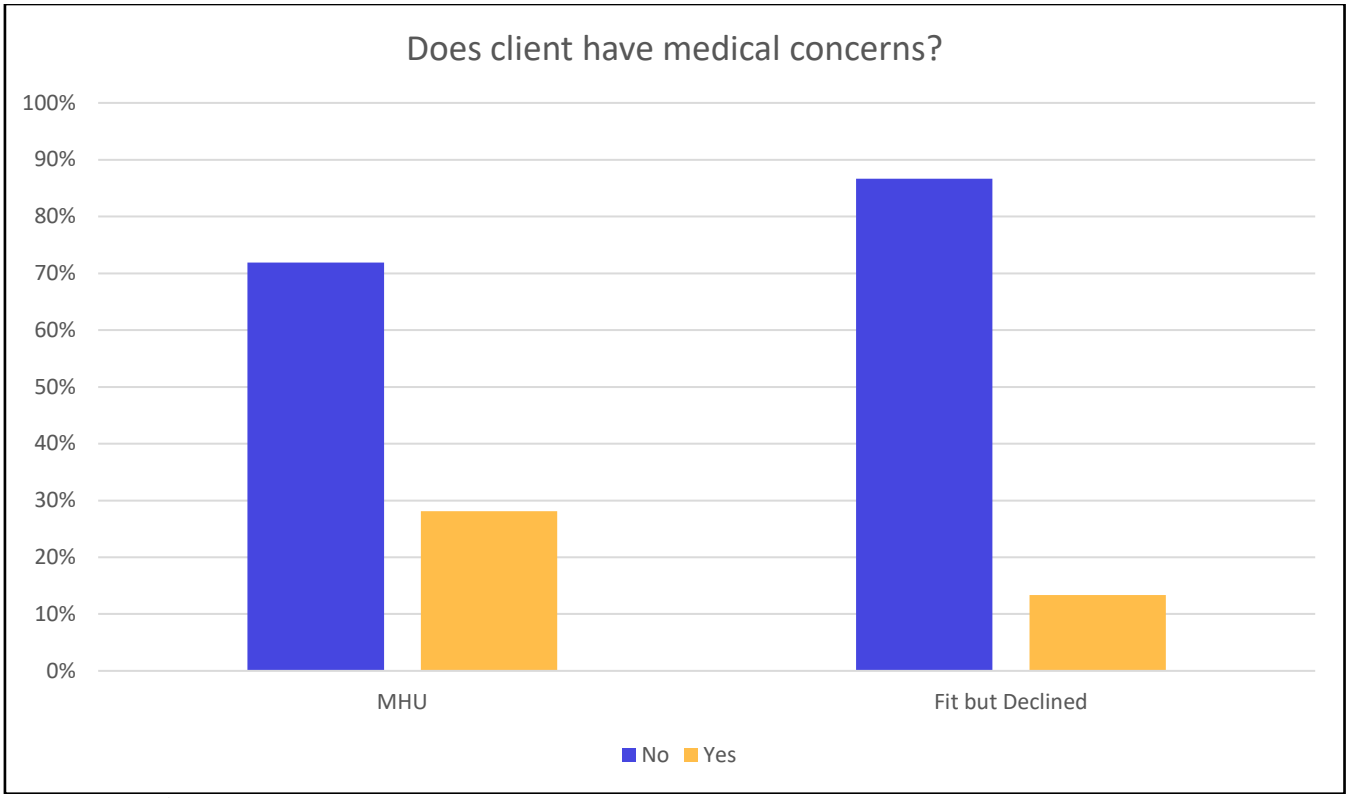


Fig. 11 - Percent of Clients with non-Mental Health (MH) Medical Concerns by Population

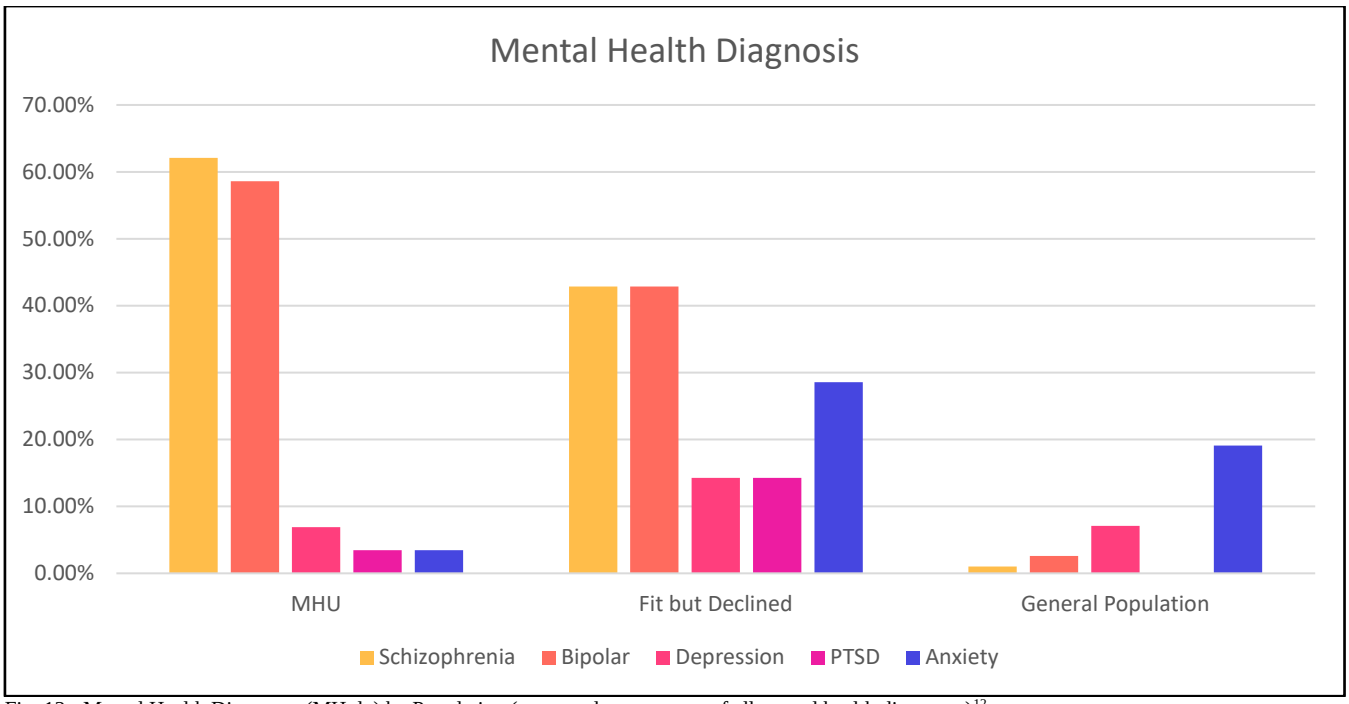


Fig. 12 - Mental Health Diagnoses (MH dx) by Population (measured as a percent of all mental health diagnoses)[12]

[12] *Mental Health Disorder Statistics*. JHMU; U.S. DHHS. *Mental Illness*; U.S. DHHS. *Any Anxiety Disorder*; U.S. DHHS. *Major Depression*; U.S. DHHS. *Post-Traumatic Stress Disorder (PTSD)*; U.S. DHHS. *Schizophrenia*; U.S. DHHS. *Bipolar Disorder*; *Mental Health By the Numbers*. NAMI.

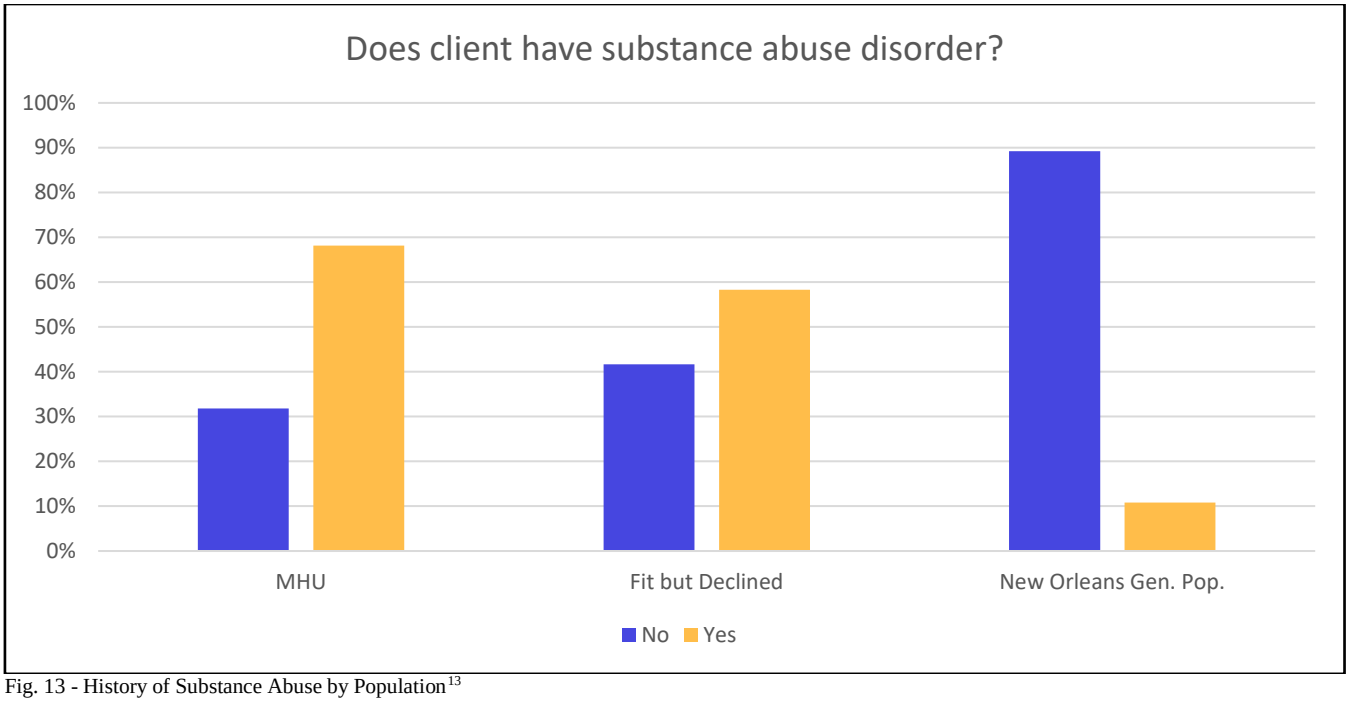


Fig. 13 - History of Substance Abuse by Population[13]

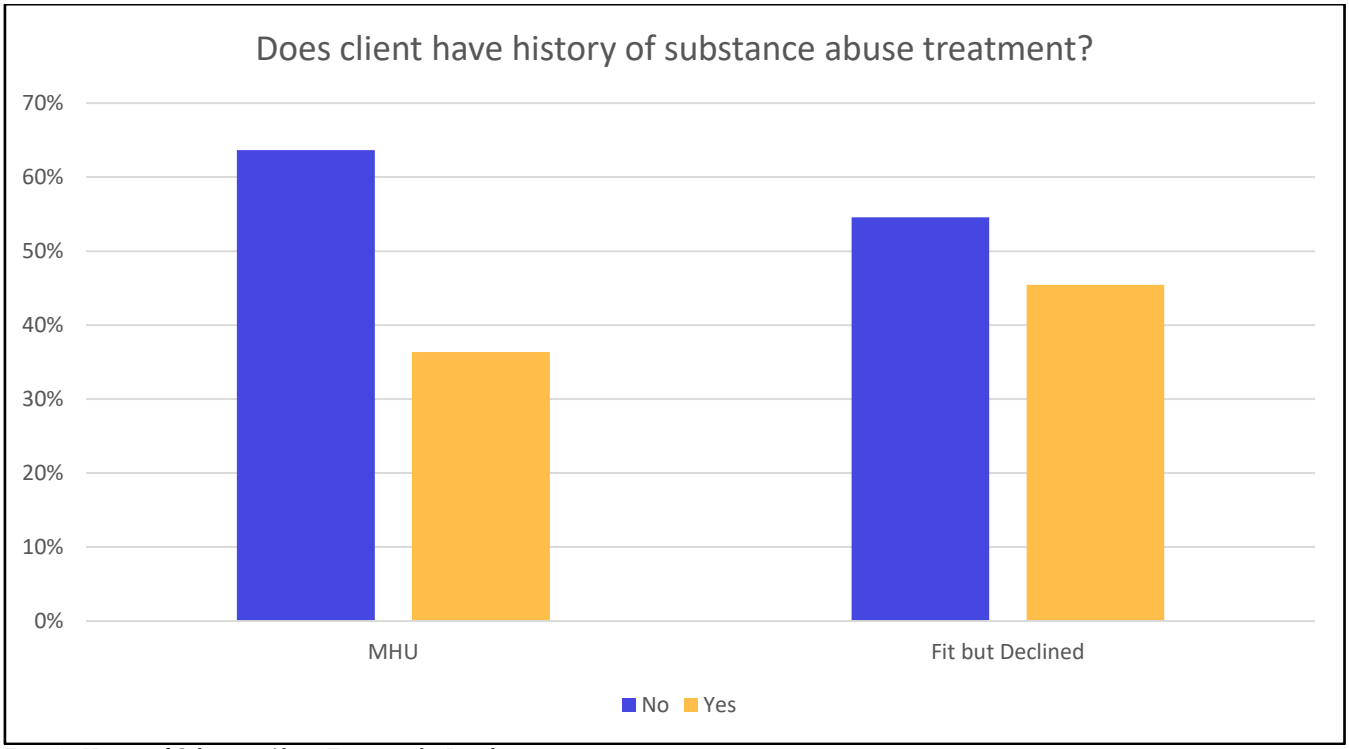


Fig. 14 - History of Substance Abuse Treatment by Population

[13] (2013). (publication). *The NSDUH Report Metro Brief: Substance Use and Mental Disorders in the New Orleans-Metairie-Kenner MSA.* Washington, D.C.

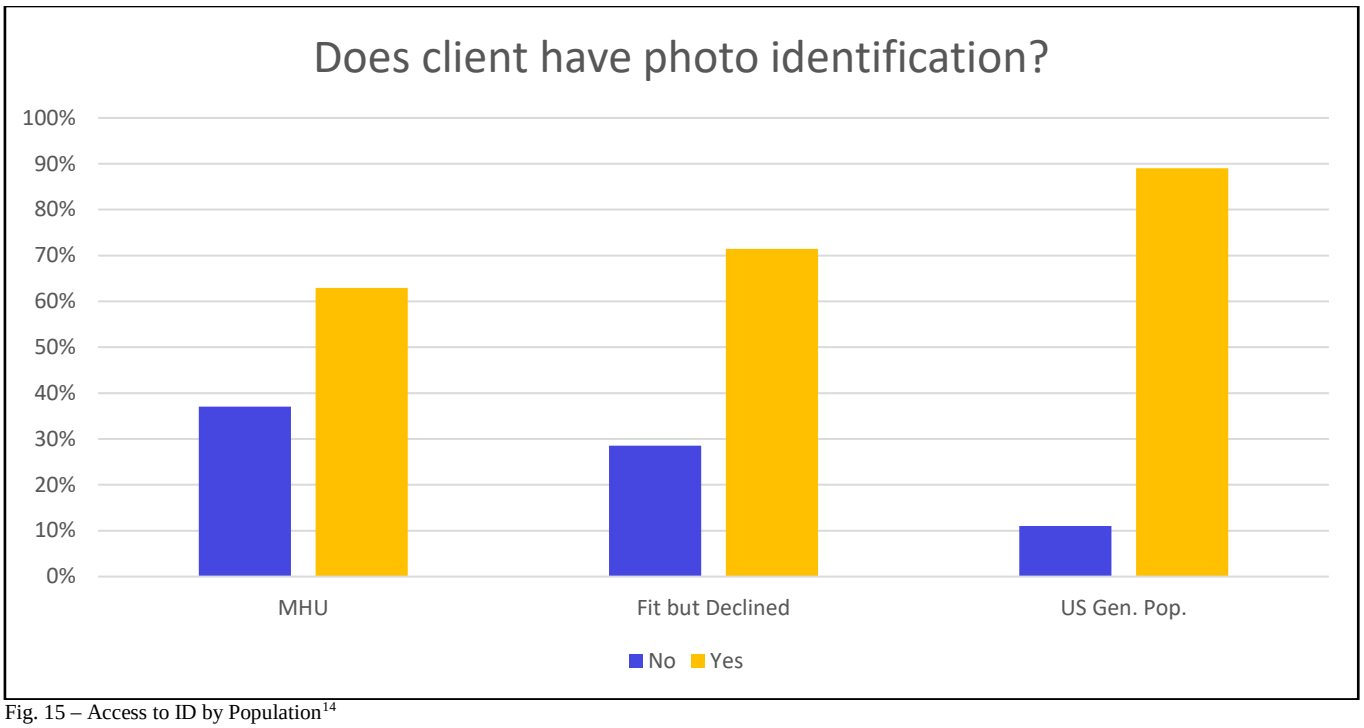
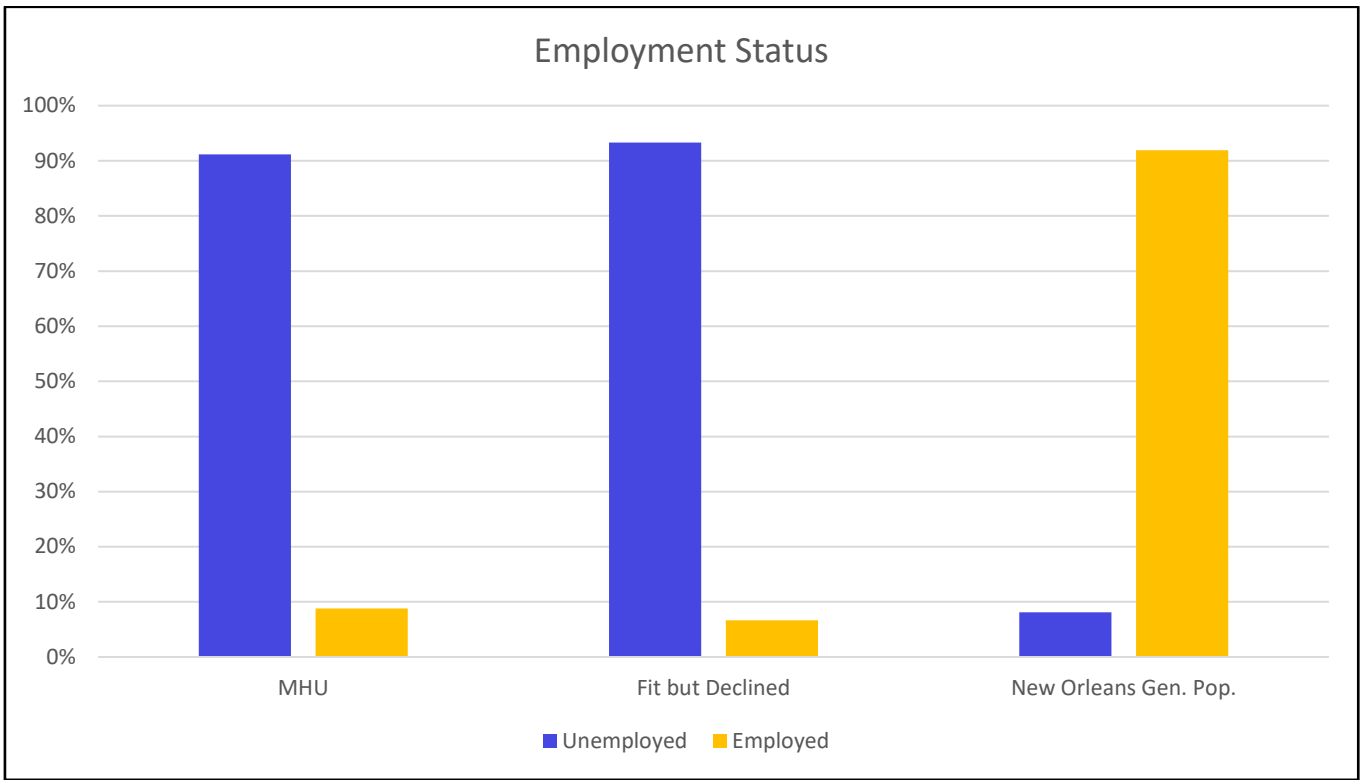


Fig. 15 – Access to ID by Population[14]



[14] Horwitz, S. (2016, May 23). Getting a photo Id so you can vote is easy. Unless you're poor, black, Latino or elderly. *Washington Post.* https://www.washingtonpost.com/politics/courts_law/getting-a-photo-id-so-you-can-vote-is-easy-unless-youre-poor-black-latino-or-elderly/2016/05/23/8d5474ec-20f0-11e6-8690-f14ca9de2972_story.html.

Fig. 16 - Employment Status by Population[15]

As the data clearly demonstrates, when compared with those that did not receive MHU-Muni services, our clients were:

- More likely to be homeless
- More likely to have their housing status impacted by their arrest
- More likely to have minor children
- More likely to receive public benefits
- More likely to face obstacles in obtaining these benefits
- More likely to have compounding medical concerns
- Less likely to graduate from high school or college
- Less likely to have a government ID
- Less likely to have received substance use treatment, *despite* a near identical rate of substance use disorders

The only metric where this pattern did not hold was for employment, where those that fit our program but declined our services were the least likely to be employed. However, when taken within the context of the other data, it would appear that this higher rate of unemployment has not negatively affected their overall level of stability in relation to our clients and the CSD control.

All of this data is nearly identical to the data collected on incoming clients reflected in our Q1 report, showing we have created a system which can reliably identify and onboard those clients most in need of the assistance provided by our unit.

SERVICE PROVISION AND OUTCOMES

Since the founding of MHU-Muni, our Social Worker has done tremendous work to alleviate the instability and marginalization faced by our clients. As soon as a client is accepted into our unit, an individualized treatment plan is created which addresses their specific needs, while maintaining compliance with court orders. For clients incarcerated at the time of their acceptance, a personalized release plan is created and submitted to Municipal Court and/or Criminal District Court. To date, 16 release plans have been submitted, 4 in this past quarter.

Following the models in Texas, and in our attempt to comply with accepted best practices, we worked this quarter to systematize separate case closure criteria for our Attorney and our Social Worker. While a case is closed for a lawyer based on full resolution of legal cases, a case is closed by the Social Worker when a client reaches a point of stable stasis for 30+ days. If direct contact and service provision are not required for 30+ days because a client is staying compliant with court orders and avoiding recidivism, then their case is closed. This allows for a more efficient use of available time and resources and gives both clients and the Social Worker a marker of success. If this client later becomes non-compliant, requests additional assistance, or recidivates, their case is reopened, and service provision is resumed. Based on this criterion, our Social Worker has closed 27 cases.

[15] United States Bureau of Labor Statistics, Economy at a Glance: New Orleans-Metairie-Kenner, LA (2021). Washington, DC. https://www.bls.gov/eag/eag.la_neworleans_msa.htm#eag_la_neworleans_msa.f.p.

A large part of the Social Worker's work is referring clients to services either ordered by the Court or are agreed upon by both the MHU-Muni team and client. This quarter we had a 60% success rate for FACT referrals and a 50% success rate for housing referrals. This represents a 50% increase in our success rate for housing referrals.

Table 2 - Service Referrals Made by Mental Health Social Worker

Referral Made	**Total Referred (% increase over previous quarters)**
FACT	5 (up 150%)
Housing	4 (up 33%)
Substance Abuse Treatment	6 (up 200%)
Other Services/Education Programs	6 (up 33%)

In order to make these referrals, keep abreast of clients' medical history and treatment, and understand their carceral history, the Social Worker must make numerous records requests. This quarter our Social Worker has requested records for 10 clients, totaling 22 requests – an increase of 166%.

In addition to helping clients access services through referrals, our Social Worker is also tasked with providing necessary goods and services to clients directly. These services include providing transportation for clients to court, treatment, services, etc., as well as accompanying them to Court.[16] Some necessary goods our clients require include phones and IDs.

Table 3 - Goods and Services Provided by Mental Health Social Worker

Goods and Services	**Total Provided**
Rides	5 (down 4.8%)
Cell Phones/IDs bought	4 (up 129%)
Accompanied Client to Court	11 (up 212%)

Building trust and relationships with clients is paramount to the success of this work. Much of that is reflected in the commitment and effort of the Social Worker, including the amount of regular contact had with each client. For some clients, the Social Worker spends months in daily or weekly communication, making sure their needs are addressed and they are remaining compliant with all court mandated treatment plans. Our Social Worker contacted clients roughly 64 times this past quarter. There was a 53.1% response rate, indicative of the difficulty in contacting this population due to their lack of access to housing and communication infrastructure, as well as their symptoms of mental illness. However, this response rate is 11.6% above what it was last quarter possibly due to strides made to increase buy-in and reduce barriers to communication. While

[16] Obviously this has been significantly decreased by COVID-19, as indicated above.

contact by phone and email is common, so are more demanding forms of relationship building and communication, indicated by the 10 field visits and 35 jail visits she has made to speak directly with our clients or their families.

Qualitative Case Study of Client Success

Nikita[17]

Nikita has had recurring arrests in Municipal and Traffic Court over many years. Nikita suffers from SMI and was facing eviction. The vast majority of her arrests are for misdemeanors and attachments, almost all of which are directly connected to her lack of financial support or symptoms of her mental illness. Nikita was interviewed by members of the MHU-Muni team and assented to a treatment plan derived from and consistent with the MHU-Muni model. As part of that agreement, we referred her to a daily outpatient treatment program. Together, Nikita, the Social Worker and lawyer agreed upon a treatment plan that involved 1) applying for SSDI, 2) continued medication management, and 3) emergency housing referral. Today, Nikita is working with our pre-MHU-Muni team and treatment plan and is working with UNITY/ Traveler's Aid to move into a new apartment with her family within the month.

Althea

Althea is a new OPD client.[18] Althea suffers from SMI but has not previously had any significant involvement with the justice system. In 2020, Althea was charged with assault, directly related to symptoms of her mental illness. She had recently lost her long-term therapist due to a change in Medicaid. Althea was assigned a Social Worker. We worked with Althea to refer her to a weekly therapist that took Medicaid. She has continued with her weekly therapy and sees her previous psychiatrist every three months. Althea has been working towards significant steady improvement and has not been arrested this year.

LEGAL OUTCOMES

MHU-Muni handled 74 cases in Q2. It is our guiding principle that by intertwining individualized service provision with mental health-informed legal representation, we can produce better outcomes for high-utilizing clients with SMI. In doing so, we improve their quality of life while saving the city money wasted on unnecessary arrests, detention, and court costs. So far, this principle has proved successful, as indicated above and outlined in detail below.

A simple metric for determining recidivism is frequency of arrest. We found the number of arrests per year for each of our clients from January 1, 2017 until they joined our program. Our clients averaged 1.92 arrests per year for this 5 year period, nearly 3 times the average for the random sample of Municipal Court clients. This disparity has increased since our last quarter, showing that we are continuing to improve our ability to identify and work with the highest utilizing clients. We then compared this with the number of arrests per year after client's initial contact with MHU-Muni and found their frequency of arrest fell by 46.3%. During this same period, our random sample of municipal court clients saw their frequency of arrest drop by 41.5%, while those that fit our programs criteria but declined admission to our unit saw their frequency of arrest fall by a mere 28.0%. This shows changing conditions and policies can be effective at reducing arrest frequency overall, however these benefits are not automatically distributed equitably. Without an effective way to provide individualized mental-health informed care to our citizens with SMI and high recidivism, such as is offered by our unit, they will be left behind from this progress. This will likely continue the trend, whereby the overall population of OJC is reduced while the percent of the population with SMI is increased, creating a high

[17] All client names have been changed to protect their anonymity.
[18] Althea was referred to the MHU-Muni team.

concentration of our city's most vulnerable citizens in our jail.[19] When combined with structural reforms to the criminal legal system and policing, we can continue to see an equitable reduction in this jail population, a decrease in tax dollars spent on unnecessary incarceration, greater quality of life for our city's vulnerable citizens, and an increase in public safety.

In addition to reducing arrests, our unit has also proved successful in reducing the time our clients spend in OJC once incarcerated. Prior to their enrolling in our program, our clients spent an average of 34.1 days in jail per arrest. After enrolling in our unit, they spent only 28.56 days in jail per arrest – a reduction of over 16%. Over the course of our program this avoided jail time alone has saved our city $14,631, with $7,601 of that savings coming in this quarter alone. Arrest costs bring even greater savings; during this past quarter alone, the reduction in arrest frequency of our clients has saved the city $6,675 in police costs alone (this does not include costs incurred by OPCD, NOFD, OPSO, or other entities often involved in arrests). Over the course of our program this amounts to over $58,000 in avoided jail and arrest costs. While these are impressive numbers, we believe them to be a very low estimation, as they only take into account two sources of costs for the city. Over the next quarter we will work with academics and with organizations across the city to understand and account for a greater variety of costs incurred by the arrest and incarceration of our clients, and thus understand where even greater savings can be incurred and calculated.[20]

In addition to this reduction in recidivism, our clients saw increased positive outcomes for their cases, when compared to those who did not have the MHU Attorney[21]. Specifically, as shown in Fig. 17, clients represented by the MHU Attorney saw a higher percentage of their cases dismissed and didn't plead to a single charge. MHU-Muni clients also saw the lowest rate of attachments (as calculated by total attachments per client). Additionally, with respect to attachments, while both non-MHU sample populations acquired most of their attachments prior to this quarter, MHU-Muni clients acquired 100% of their attachments during this past quarter – the first quarter since data collection began where we did not have a dedicated mental health Attorney. Looking at the longitudinal data in Fig. 18 shows how when we first onboarded our mental health Attorney at the beginning of Q1 our clients saw a large increase in dismissals, and when they left, they saw a slight reduction in dismissals and a large increase in attachments. This clearly shows the massive importance of retaining a mental health informed and MHU dedicated Attorney.

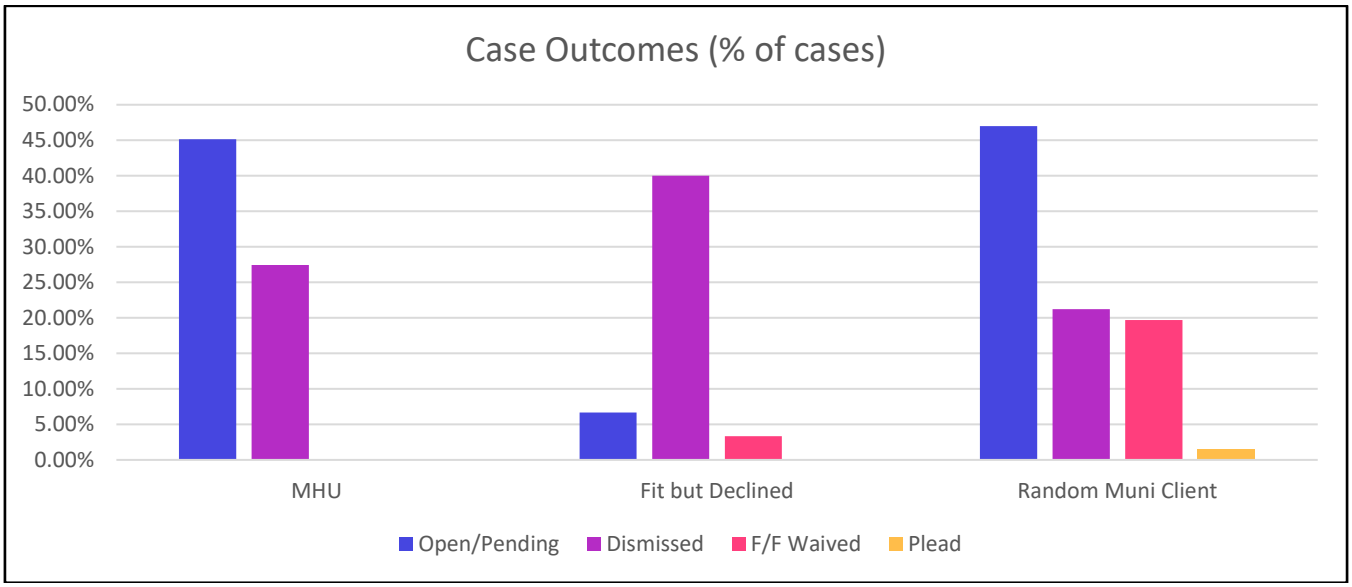


Fig. 17 – Case outcomes by population

[19] Chrastil, N. (2021, February 9). After improvements, monitors warn that conditions at the New Orleans jail may be backsliding. *The Lens Nola*. https://thelensnola.org/2021/02/09/after-improvements-monitors-warn-that-conditions-at-the-new-orleans-jail-may-be-backsliding/.
[20] See last page for all equations used in this section.
[21] Reminder, those that decline admission to our unit do not receive the full services of the Social Worker; however, they do still receive representation by our mental-health-informed attorney.

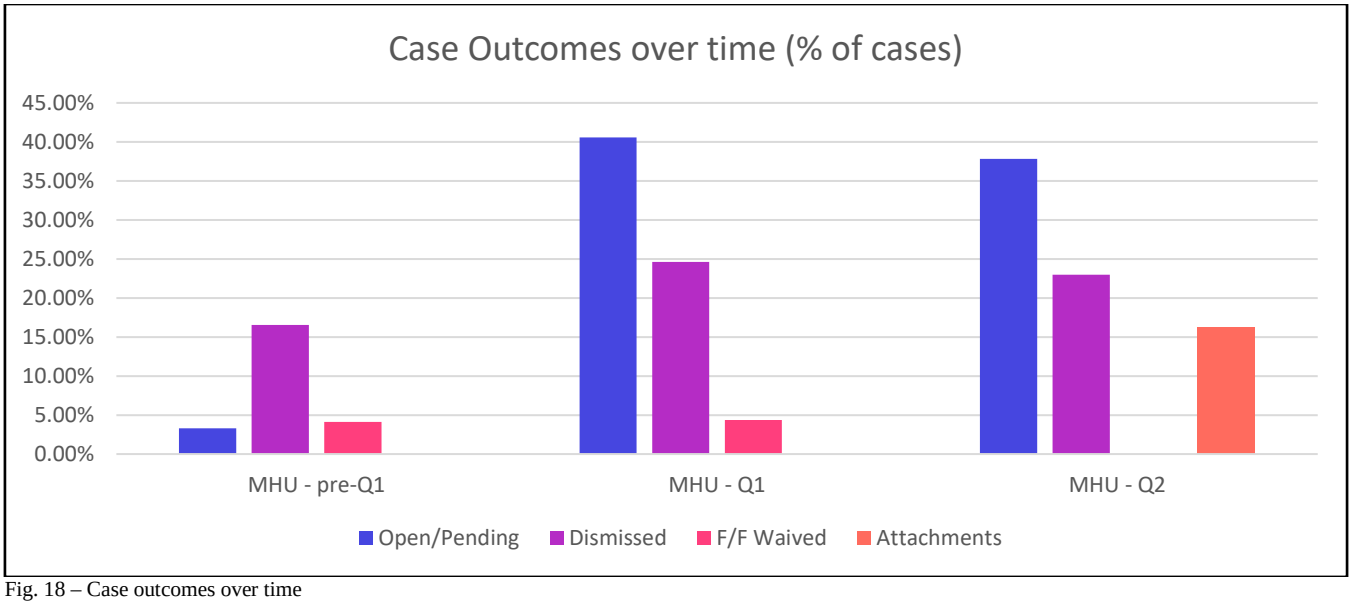


Fig. 18 – Case outcomes over time

COMMUNITY PARTNERS

Our capacity to provide clients with individualized treatment plans and wrap-around services is only through strong relationships with community partners. Current and upcoming projects include:

- Partnering with Judge Kern Reese and Assisted Outpatient Treatment (AOT) Court for alternative solutions to assist clients with a history of medication non-compliance outside the criminal legal system.
- Partnering with Tulane Forensic Department through Drs. McConville and Vyas to improve competency evaluation efficiency.
- Working with Tulane Medical School through Dr. Janet Johnson to establish a role at Municipal Court for their Forensic Fellowship program.
- Working with First 72+ to connect clients with housing.
- Developing internship opportunities at local university, law school and social work graduate programs.

NEXT STEPS

MHU-Muni will continue to hone and improve its methodology and approach to both identify qualifying and in-need clients, and meet their individual needs as they align with the goals of the program.

The pandemic continues to create barriers to the full implementation of the program. We have been unable to hire the remaining positions we had hoped to fill at the end of the last quarter due to ongoing funding issues. Due to the lack of full staffing and outside complications, we have been unable to create and schedule trainings with Municipal Court judges and staff. With the anticipated easing of COVID protocols and as we become fully staffed, we hope to prioritize this need. As previously noted, this program will only be as successful as the partnership and coordination between the two entities.

We will continue to build on the existing data further demonstrating the need for targeted mental services in the criminal legal system, in particular, in municipal court. We will continue to expand partnerships with community organizations, experts and service providers. Additionally, we will remain nimble where possible guided by the needs of both the clients and the program.

MHU-Muni will regularly communicate with Municipal Court judges and staff to evaluate the success of the program, make adjustments when and where necessary to meet the program's overall goals of reducing system interaction for people experiencing and suffering from SMI and other mental health concerns.

While the operation of the program is dependent on dedicated revenue, it will be critical to immediately fill the attorney and social worker positions. No aspect of the MHU program can continue with those positions unfilled. This will rely on funding.

Equations utilized for data analysis

J_0 – Jail days between 01/01/2017 and client's acceptance to program
J_1 – Jail days since acceptance to our program
J_{Q1} – Jail days in Q1
J_{Q2} – Jail days in Q2
D_0 – Days between 01/01/2017 and client's acceptance to program
D_1 – Days since acceptance to our program
D_{Q1} – Days in Q1
D_{Q2} – Days in Q2
C_{JD} – Marginal Cost of 1 Jail Day[22]
A_0 – Arrests between 01/01/2017 and client's acceptance to program
A_1 – Arrests since acceptance to our program
A_{Q1} – Arrests in Q1
A_{Q2} – Arrests in Q2
B_{NOPD} – Average budget of NOPD over the past 5 years[23]
E_{FT} – Average number of full-time employees at NOPD over the past 5 years[24]
H_Y – Hours in a full-time year = 2080
H_A – Average number of hours per arrest of our clients over the past 3 years[25]
P – Average number of police officers per arrest of our clients over the past 3 years[26]

$$\left\{\left[\frac{J_0}{D_0}(D_1)\right] - J_1\right\} C_{JD} = marginal\ jail\ costs\ avoided\ since\ acceptance\ to\ unit$$

$$\left\{\left[\frac{J_0}{D_0}(D_{Q2})\right] - J_{Q2}\right\} C_{JD} = marginal\ jail\ costs\ avoided\ during\ Q2$$

$$\left\{\left[\frac{J_0}{D_0}(D_{Q1})\right] - J_{Q1}\right\} C_{JD} = marginal\ jail\ costs\ avoided\ during\ Q1$$

$$\left\{\left[\frac{J_0}{D_0}(D_1)\right] - J_1\right\} C_{JD} = marginal\ jail\ costs\ avoided\ since\ acceptance\ to\ unit$$

$$\left\{\left[\frac{A_0}{D_0}(D_1)\right] - A_1\right\} \times \left[\left(\frac{B_{NOPD}}{E_{FT} \times H_Y}\right) \times H_A \times P\right] = marginal\ arrest\ costs\ avoided\ since\ acceptance\ to\ unit$$

$$\left\{\left[\frac{A_0}{D_0}(D_{Q2})\right] - A_{Q2}\right\} \times \left[\left(\frac{B_{NOPD}}{E_{FT} \times H_Y}\right) \times H_A \times P\right] = marginal\ arrest\ costs\ avoided\ during\ Q2$$

[22] Wool, J., Shih, A., & Chang, M. G. (2019). (publication). *Paid in Full: A Plan to End Money Injustice in New Orleans.* New Orleans, LA: Vera Institute of Justice.
[23] Office of the Mayor, 2021 Proposed Annual Operating Budget in Brief. New Orleans, LA.; Office of the Mayor, 2020 Annual Operating Budget in Brief. New Orleans, LA.; Office of the Mayor, 2019 Annual Operating Budget. New Orleans, LA.; Office of the Mayor, 2018 Annual Operating Budget. New Orleans, LA.; Office of the Mayor, 2017 Annual Operating Budget. New Orleans, LA.
[24] Ibid.
[25] Orleans Parish Communication District. (2021). 911 calls resulting in the arrest of MHU-Muni clients, 2018 - present. New Orleans. Obtained via PRA request.
[26] Ibid.

ORLEANS PUBLIC DEFENDERS

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DERWYN D. BUNTON, CHIEF PUBLIC DEFENDER

October 5, 2021

Municipal Mental Health Unit, July – September 2021, Q3
Barksdale Hortenstine, Jr. Director, Mental Health Unit, Orleans Public Defenders

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MHU-Muni has faced multiple challenges since its inception, including the citywide cyberattack that affected Municipal Court during our unit's initial months of operation, ongoing COVID-19 pandemic, the lack of guaranteed funding and related staffing shortages, but none as dire as this quarter – the loss of all case-related staff.

Thus, going into Q3 we had none of the team members necessary to enact our theory of change. This complete inability to offer our current clients services and specialized representation has resulted in their jail days increasing to near pre-program involvement levels. Specifically, our clients saw a 17.51% increase in jail days and a 38% reduction in case dismissals over previous quarters[1]. Additionally, we were unable to offer any services to 68 clients flagged as possible SMI by our screener. Based on previous quarters, these clients could likely have seen decreased recidivism, decreased jail days, and better case outcomes. This reversal of the many gains made in previous quarters should indicate the value and impact of this specialized approach.

The entire theory behind MHU's effectiveness relies on the synergized function of a specialized Attorney and Social Worker and the ability to provide mental health-informed legal counsel and wraparound service provision. Neither of these are possible without those two positions. The model is unsustainable in its current skeleton structure. Currently, there are only two MHU-Muni staff: Director, Barksdale Hortenstine and Paralegal, Gerhardt Weiss. For this program to work effectively for both clients and staff, it is imperative to fill the vacant positions and expand the unit.

SCREENING AND ADMISSION

MHU clients are 62 times more likely to have Schizophrenia than the general population, 117 times more likely to be homeless than the average New Orleanian, and prior to entering our unit, had an arrest rate nearly 3 times higher than an average Municipal Court client. Once accepted to our unit, our clients saw their frequency of arrest reduced by 46%, their average jail stay per arrest reduced by more than 16%, and their total jail days reduced by 68.64%. Clients represented by the MHU-Muni Attorney saw better outcomes than Municipal Court clients not represented by the MHU-Muni Attorney, including a higher rate of dismissals, and lower rates of both attachments and plead cases.

[1] Calculated as a percent of total MHU-Muni cases seen per quarter.

Even with limited staffing, MHU-Muni continues to improve the necessary structure for client identification and referral, as well as solidify the methodology and client-centered approach of the program. In order to be most effective, reduce the frequency of arrest, and meet client's individual and complex needs, we must meet clients where they are, properly assess those needs, and connect them to appropriate and available services. During Q3, though we have continued with our goals of identifying possible candidates for our unit, we have been unable to assess their needs or connect them with available services.

We screened 197 defendants, 68 qualified for follow up. Based on the number of people admitted post-follow up in previous quarters, we can estimate seven of those 68 clients would have become MHU clients. Variability in docket size and inconsistent transport by OPSO, makes screening difficult and hinders identifying potential MHU clients. Additionally, docket size has risen steadily since October 2020 (when data on screening first began), with sharper rises occurring at the end of March and end of April/beginning of May 2021. This plateaus in mid-May and stays relatively stable through mid-August. The catastrophic damage from Hurricane Ida halted Municipal Court proceedings from August 27 to September 26. First Appearances resumed September 27.

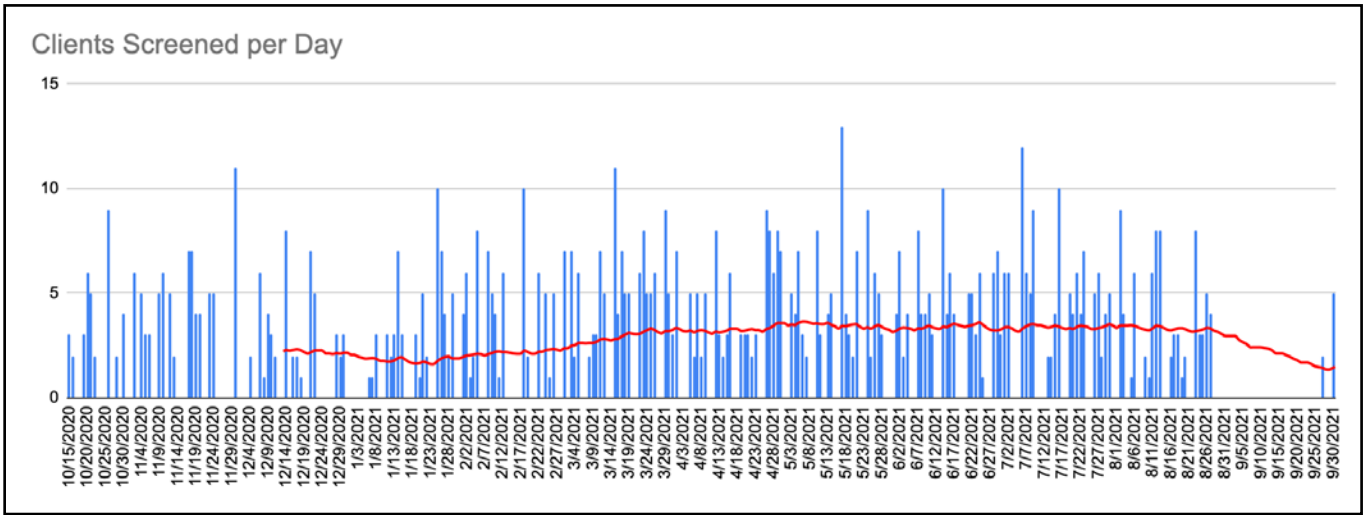
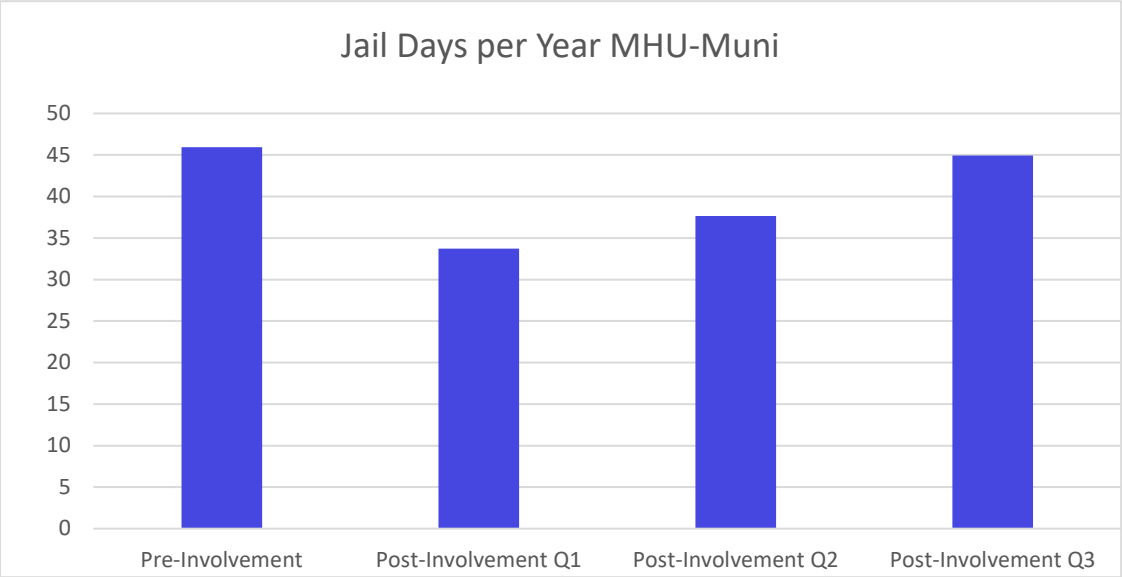


Fig.1 - Municipal Clients Screened Per Day (weekdays only)

LEGAL OUTCOMES

MHU-Muni, via OPD's regular Municipal Court Attorney, handled 52 cases in Q3, with an additional 4 cases still open. Since the beginning of our unit, we have tracked arrest frequency and jail days as a means for measuring the effect on recidivism and incarceration. MHU clients averaged 1.92 arrests per year for the 5-year period between January 1, 2017 and entrance to MHU. This is an arrest rate nearly 3 times the average random sample of Municipal Court clients from Q2. In our Q2 report we compared this pre-involvement arrest frequency with the number of arrests per year after client's initial contact with MHU-Muni and found clients' frequency of arrest fell by 46.3%. During this same period, the random sample of Municipal Court clients dropped by only 41.5%, while those that fit the program criteria but declined participation fell by just 28%. In Q3, we saw similar results: MHU clients' arrest frequency reduced from pre-involvement levels by 58.8%, while the random sample of Municipal Court clients from Q2 reduced just 56.63%, and those that fit criteria but declined inclusion saw a reduction of 45.8%. While some of the Q3 data can be attributed to the disruption of Hurricane Ida, it is clear that innovative approaches can in fact be effective at reducing arrest frequency overall, although they are not automatically distributed equitably.

Q2 data also showed that MHU participation resulted in a reduction in jail days. However, due to limited resources in Q3, these gains have all but reversed. By the end of Q1, the last full quarter with both a Social Worker and Attorney, our clients had seen a 26.65% reduction in jail days from pre-involvement levels, an average of 46 jail days per year to just over 33 days. By the end of Q2, in which we lost our Attorney halfway, we saw a reduction of only 18.08% (an average of 37.64 jail days per year) from pre-involvement levels, an 11.67% increase from Q1. By the end of this quarter, where we operated entirely without an Attorney, our clients reached an average of 44.22 jail days per year, a mere 3.75% reduction from pre-involvement levels.



This simultaneous reduction in arrests and increase in jail days squares with the data collected by other mental health units. Data shows that services provided by an MHU Social Worker can reduce recidivism for up to 18 months.[2] However, if someone with SMI is incarcerated, it is most critical to have a mental health-informed attorney active in that moment in order to realize a reduction in jail time. Having a mental health-informed attorney represent someone in the past does nothing for their ability to get out of jail now, and thus unlike an MHU Social Worker's impact which can last beyond their tenure, the MHU Attorney's impact can only be realized while actively representing clients.

At the end of Q2, our clients saw increased positive outcomes for their cases when compared to those who did not have the MHU Attorney.[3] Specifically, clients represented by the MHU Attorney saw a higher percentage of their cases dismissed and did not plead to a single charge. MHU clients also saw the lowest rate of attachments (as calculated by total attachments per client). While both non-MHU sample populations acquired most of their attachments prior to this quarter, MHU clients acquired 100% of their attachments during Q3. Looking at the longitudinal data in Fig. 18 shows the impact of the Mental Health Attorney. At the beginning of Q1, our clients saw a large increase in dismissals. Comparatively, following the exit of the Attorney, we saw a slight reduction in dismissals and a large increase in attachments. This clearly shows the critical importance of retaining a mental health-informed and MHU-dedicated Attorney. In Q3, our clients saw no benefit relative to a random sample of Municipal Court clients as the same OPD Municipal Court Attorneys represented them all. As a result, we saw a 38% reduction in dismissals from previous quarters (calculated as a percent of total cases seen per quarter).

[2] Texas Indigent Defense Commission. (2018). (rep.). *Texas Mental Health Defender Programs* (pp. 7&12).
[3] Reminder, those that decline admission to our unit do not receive the full services of the Social Worker; however, they do still receive representation by our mental health attorney.

As noted in our Q2 report, *all* rates of recidivism are dropping due to exogenous factors. However, the greater reduction in recidivism enjoyed by MHU clients and the random sample of Municipal Court clients relative to those that fit our program's criteria but declined participation, shows that without an effective way to provide individualized mental-health informed care, clients with SMI will be left behind. This will likely continue a recognized trend, where the overall population of OJC is reduced while the percent of the population with SMI is increased, creating a high concentration of our city's most vulnerable citizens detained in OJC and in the Sheriff's care.[4]If our unit is able to expand our reach, when combined with structural criminal legal system and policing reforms, we will continue to realize an equitable and just reduction in our jail population, a decrease in tax dollars spent on unnecessary incarceration, a greater quality of life for our city's vulnerable citizens, and an overall increase in public safety.

NEXT STEPS

Restaffing the MHU team is our first priority. We have had positive conversations with members of the City Council and City Hall about securing funding. We remain optimistic as to the program's continuation.

As many of the ongoing operational barriers with Municipal Court resolve, we will prioritize creating meaningful trainings with Municipal Court judges and staff to ensure an optimal and effective program. We will also continue efforts to expand partnerships with community organizations, experts and service providers.

Additionally, we will bolster the now existing foundation to preserve the forward-thinking mental health focus by many of the system stakeholders and collaborate toward innovative and appropriate solutions to this ongoing mental health crisis. By building on existing data, we will further demonstrate the effectiveness of specialized and holistic legal representation for clients with significant mental health needs.

[4] Chrastil, N. (2021, February 9). After improvements, monitors warn that conditions at the New Orleans jail may be backsliding. *The Lens Nola*. https://thelensnola.org/2021/02/09/after-improvements-monitors-warn-that-conditions-at-the-new-orleans-jail-may-be-backsliding/.