

LOUISIANA

FY 2012

Combined Behavioral Health Assessment and Plan

**Community Mental Health Services
and
Substance Abuse Prevention and Treatment
Block Grants**

September 1, 2011

**Office of Behavioral Health
Department of Health and Hospitals**

**LOUISIANA
FY 2012**

**Community Mental Health Services and Substance Abuse Prevention and Treatment
Block Grants
COMBINED BEHAVIORAL HEALTH ASSESSMENT AND PLAN**

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LOUISIANA

FY 2012 Combined Behavioral Health Assessment and Plan

Part I State Information

**State Information
FACE SHEET**

STATE NAME: Louisiana

DUNS#: 809927064

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

AGENCY: Office of Behavioral Health

ORGANIZATIONAL UNIT: Department of Health and Hospitals

STREET ADDRESS: 628 N. 4th Street, 4th Floor (P.O. Box 4049)

CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049

TELEPHONE: (225) 342-2540 **FAX:** (225) 342-5066

II. CONTACT PERSON FOR THE GRANTEE OF THE BLOCK GRANT

NAME: Anthony Speier, Ph.D. **TITLE:** Interim Assistant Secretary

AGENCY: Office of Behavioral Health

ORGANIZATIONAL UNIT: Department of Health and Hospitals

STREET ADDRESS: 628 N. 4th Street, 4th Floor, (P.O. Box 4049)

CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049

TELEPHONE: (225) 342-2540 **FAX:** (225) 342-5066 **EMAIL:** Anthony.Speier@la.gov

III. STATE EXPENDITURE PERIOD (most recent expenditure period that is closed out)

FROM: July 1, 2010 **TO:** June 30, 2011

IV. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

NAME: Jessica Brown, Ph.D.

TITLE: Director - Division of Policy and Planning

AGENCY: Office of Behavioral Health

ORGANIZATIONAL UNIT: Department of Health and Hospitals

STREET ADDRESS: 628 N. 4th Street, 4th Floor, (P.O. Box 4049)

CITY: Baton Rouge **STATE:** LA **ZIP:** 70821-4049

TELEPHONE: (225) 342-2540 **FAX:** (225) 342-5066 **EMAIL:** Jessica.Brown@la.gov

BOBBY JINDAL
GOVERNOR



Post Office Box 94004
Baton Rouge, LA 70804-9004

August 25, 2011

Barbara Orlando, M.S.
Grants Management Specialist
Office of Program Services, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20850

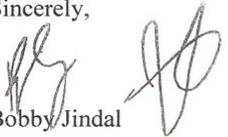
RE: Designation of Authority to Sign CMHS and SAPT Block Grant Application

Dear Ms. Orlando:

As Governor of the State of Louisiana, I delegate authority to Anthony H. Speier, Ph.D., the Interim Assistant Secretary of the Office of Behavioral Health (OBH), to sign the Community Mental Health Services (CMHS) and the Substance Abuse Prevention and Treatment (SAPT) Block Grant Application on behalf of the Louisiana Department of Health and Hospitals. This letter also serves as recognition of Dr. Speier as the appropriate authority to receive the Louisiana CMHS and SAPT Block Grant funds.

This approval is in effect for my term of office.

Sincerely,


Bobby Jindal
Governor

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction sub-agreements.

Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

10. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
11. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
12. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
13. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
14. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
15. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Governor or Governor Designee

Anthony Speier, Ph.D.
Interim Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

Date

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about –
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
- (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-
D Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any

person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Governor or Governor Designee

Anthony Speier, Ph.D.
Interim Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

Date

Community Mental Health Services
Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Louisiana agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.

(C) 24-hour-a-day emergency care services.

(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and

(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act; (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the

Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

- (1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
- (2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the

State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Governor or Governor Designee

Date

Anthony Speier, Ph.D.
Interim Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

**Substance Abuse Prevention and Treatment
Block Grant Funding Agreements
FISCAL YEAR 2012**

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute. SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

- I. Formula Grants to States, Section 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations; Pregnant women and women with dependent children) Section 1922
- III. Intravenous Drug Abuse, Section 1923
- IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals under Age 18, Section 1926
- VII. Treatment Services for Pregnant Women, Section 1927
- VIII. Additional Agreements (Improved Referral Process, Continuing Education, Coordination of Activities and Services), Section 1928
- IX. Submission to Secretary of Statewide Assessment of Needs, Section 1929
- X. Maintenance of Effort Regarding State Expenditures, Section 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. Application for Grant; Approval of State Plan, Section 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. Additional Requirements, Section 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953
- XIX. Services Provided By Nongovernmental Organizations, Section 1955
- XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Louisiana will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Governor or Governor Designee

Date

Anthony Speier, Ph.D.
Interim Assistant Secretary
Office of Behavioral Health
Louisiana Department of Health & Hospitals

For Governor Bobby Jindal

LOUISIANA

FY 2012 Combined Behavioral Health Assessment and Plan

Part II Planning Steps

**PLANNING STEP ONE: ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE
SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS**

Overview of the Louisiana Behavioral Health System

STATE LEVEL

Creation of the Office of Behavioral Health

The Office for Addictive Disorders (OAD) and the Office of Mental Health (OMH) had, until recently, operated as separate state agencies within DHH, predominantly managing and operating their own separate service delivery systems. Although each parallel mental health and addictive disorders service system had a rich history of service delivery, these services were often times redundant and did not utilize shrinking and limited resources in the most effective manner. This, in turn, affected adequate access and capacity for the target populations. In order to un-encumber these parallel systems and develop an integrated behavioral health care system, Louisiana merged the Offices of Addictive Disorders and Mental Health to form the Office of Behavioral Health (OBH) under the authorization of Act 384 from the 2009 Regular Session. The Office of Behavioral Health began operating as one entity on July 1, 2010.

The newly created Office of Behavioral Health is one of five agencies within the Louisiana Department of Health and Hospitals (DHH). The Mission of DHH is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of Louisiana. Included under the DHH umbrella with the newly merged Office of Behavioral Health (OBH) are the Office of Public Health (OPH); Office of Aging and Adult Services (OAAS); Office of Management and Finance (including the State Medicaid agency); and the Office for Citizens with Developmental Disabilities (OCDD). In July 2009, the Mental Health Rehabilitation (MHR) program was moved to the Bureau of Health Services Financing/Medicaid Services within DHH.

The Office of Behavioral Health (OBH) is now the state agency responsible for planning, developing, operating, and evaluating treatment and prevention services for the public behavioral health system. Within these responsibilities, the OBH is charged with the provision of mental health services that target adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, as well as persons experiencing an acute mental illness. Similarly, the OBH is charged with the provision of addictive disorders services for people suffering from addictions to drugs, alcohol or gambling, as well as support for their families, and prevention services. The OBH has a specialized division for the establishment of best practice standards and evidence based practices for children and adolescents in the behavioral health service delivery system.

During its inception, the staff and stakeholders of OBH crafted a new recovery-oriented mission statement and a new vision of the behavioral health system that provided a framework for moving the agency into a period of “Good and Modern” behavioral health service delivery.

Mission

The mission of the Office of Behavioral Health is to promote recovery and resiliency through services and supports in the community that are preventive, accessible, comprehensive and dynamic.

Vision

The Office of Behavioral Health ensures care and support that improves quality of life for those who are impacted by behavioral health challenges.

Guiding Principles

- *We can and will make a difference in the lives of children and adults in the state of Louisiana.*
- *People recover from both mental illness and addiction when given the proper care and a supportive environment.*
- *The services of the system will respond to the needs of individuals, families and communities, including culturally and linguistically diverse services.*
- *Individuals, families and communities will be welcomed into the system of services and supports with a “no wrong door” approach.*
- *We respect the dignity of individuals, families, communities and the workforce that serves them.*
- *Through a cooperative spirit of partnerships and collaborations, the needs of individuals, families and communities will be met by a workforce that is ethical, competent and committed to the welfare of the people it serves.*
- *We will utilize the unique skills of professionals with appropriate competencies, credentials and certifications.*
- *Mental illness and addiction are health care issues and must be seamlessly integrated into a comprehensive physical and behavioral health care system that includes primary care settings.*
- *Many people we serve suffer from both mental illness and addiction. As we provide care, we must understand, identify and treat both illnesses as primary conditions.*
- *The system of care will be easily accessible and comprehensive and will fully integrate a continuum of prevention and treatment services to all age groups. It will be designed to be evidence-based, responsive to changing needs, and built on a foundation of continuous quality improvement.*
- *We will measure our results to demonstrate both improved outcomes for the people we serve and fiscal responsibility to our funders.*
- *We will prioritize de-stigmatizing historical biases and prejudices against those with mental illness and substance use disorders, and those who provide services, through efforts to increase access to treatment. We will do this by reducing financial barriers, addressing provider bias, integrating care and increasing the willingness and ability of individuals to seek and receive treatment.*

It is anticipated that, over time, this merger will allow for increased utilization of best practices in the treatment of individuals with mental illness, addictive disorders, and co-occurring disorders by providing fertile ground to develop real integrated care. In turn Louisiana’s behavioral health system will become less dependent on restrictive inpatient levels of care, particularly psychiatric institutions, and more dependent on community-based care options.

There is no separate statewide division for children’s services. However, with the recent adoption of a multi-agency managed Coordinated System of Care for the child and youth population, a specialized child-specific unit has been incorporated and it complements the OBH organizational structure.

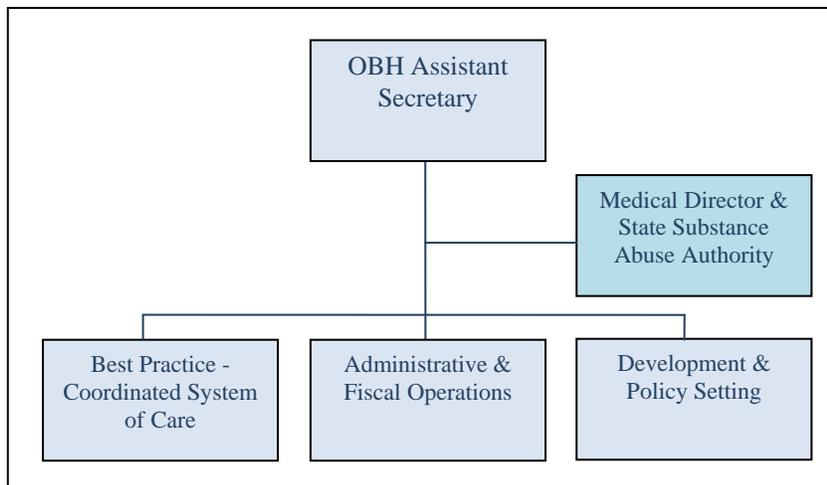
Organizational Restructuring of the Central Office

Act 384 effectively merged the administration and planning functions of the former mental health and addictive disorder offices into one entity on July 1, 2010. In the past, the Offices of Mental Health and Addictive Disorders had been “integrated” and separated in name only by legislative act or directive. However, none of these previous attempts at integration had substantively altered the composition or operations of each distinct office. In accordance with expert consultation, OBH

redesigned the Central Office according to functional areas, which eliminated duplication and supported the development of an integrated administrative office that is able to seamlessly support a service delivery system that caters to individual and shared needs of populations with mental health, substance use, or co-occurring disorders.

The Office of Behavioral Health (OBH) integrated the infrastructure at the level of the central office operations, inclusive of state agency leadership, and OBH is now governed by the Assistant Secretary (Commissioner), who is the appointing authority for the agency and reports to the Secretary of DHH. Three OBH divisions were created and include: 1) the Administrative Division (human resources, fiscal, operational); 2) the System of Care Division, (mental health and addictive disorder prevention and treatment); and 3) the Development Division, (research and design, integrated policy and planning, business intelligence/information technology, quality assurance) (see figure below). Staff with respective addictive disorders and mental health specializations were re-assigned and redistributed throughout the organization. Previously non-integrated addictive disorder and mental health “siloed” organizational tracks were completely merged within the three primary organizational areas. Redundancy was removed and the organizational table was streamlined.

OBH Central Office Administrative Reorganization



A benefit from this re-organization was the cost savings of 20% of the Office’s budget. This included the elimination of eleven positions within the table of organization. Based on the national trends examined, a mistake that other re-organizing states made was the loss of leadership and the minimization of the needs of the addictive disorders population in the overarching structure of a behavioral health agency. Often

times, a State Substance Abuse Authority (SSA) with limited influence was overshadowed by the corresponding mental health authority with the larger budget, stronger Medicaid ties, and perception of greater authority. In Louisiana, the State Substance Abuse Authority was designated to be the overarching chief Medical Director for the Office. In this capacity, the voice and needs associated with substance use disorders would remain strong and intact. Agency integration is a five year process by national standards, but with the progress made in its inaugural year the Louisiana Office of Behavioral Health is confident in its capacity to continue this evolution and in its ability to document significant progress along continuing key priorities.

Office of Behavioral Health Budget

The Office of Behavioral Health FY 2012 budget (initial appropriation) is \$342,993,068. The total appropriation for the OBH Community Budget is \$92,570,391. The mission of the Community Mental Health program budget is to provide comprehensive, integrated, evidence-based programs and support services enabling persons to function at their best possible level, promoting recovery. The Addictive Disorders Community program budget aims to enhance, provide, and ensure best

practices for the prevention and treatment of substance use, gambling and high risk behaviors to the citizens of Louisiana. The following tables provide additional budgetary information, including a breakdown of federal funding for mental health and addictive disorder services.

OFFICE OF BEHAVIORAL HEALTH APPROPRIATION FOR FY 11-12			
BUDGET SUB-ITEM	SUB-ITEM DIVISIONS	TOTAL(S)	% of TOTAL
Community Budget	CMHCs (a)	\$31,476,476	9%
	Acute Units (b)	\$4,495,171	1%
	MH Social Service Contracts	\$23,091,583	7%
	AD Regional Community	\$33,507,161	10%
	Community Total	\$92,570,391	27%
Hospital Budget	Central Louisiana State Hospital	\$24,837,943	7%
	Eastern Louisiana Mental Health System (c)	\$96,177,275	28%
	Southeast Louisiana Hospital (d)	\$57,069,995	17%
	Hospital Total	\$178,085,213	52%
State Office Budget	Central Office Total (e)	\$72,337,464	21%
TOTAL		\$342,993,068	100%
(a) Excludes budgets for Local Governing Entities (LGEs).			
(b) Does not include funds for operation of acute units in MH hospitals.			
(c) East Louisiana Mental Health System is comprised of East Louisiana State Hospital, Feliciana Forensic Facility, and Greenwell Springs Hospital. Budgets are combined.			
(d) Southeast Louisiana Hospital and New Orleans Adolescent Hospital consolidated as of 07/01/2009.			
(e) Includes MH Central Office community (\$18,320,443), AD Central Office community (\$33,896,547) and Administration (\$20,120,474)			

HOSPITAL SYSTEM

	FY2012 (7/1/11)
Total Adult/Child State Hosp. Beds (a)	856
State General Funds (b) (\$)	101,219,506
Federal Funds (\$)	64,673,481

NOTES: (a) Staffed beds. Does not include money for operation of acute units in OMH freestanding psychiatric Hospitals. (b) Additional services for persons with mental illness are provided through the Medicaid agency: Mental Health Rehabilitation Option

COMMUNITY SYSTEM

Acute Units	FY2012 (7/1/11)
Total Number of Acute Beds	114
State General Funds (\$)	0
Federal Funds (\$)	4,495,171

CMHCs	FY 2012 (7/1/11)
Total Number of CMHCs*	45
State General Funds (\$)**	44,194,126
Federal Funds (\$)	5,096,739

*Includes Clinics only – (including LGEs);** Does not include LGEs

Contract Community Programs	FY 2012 (7/1/11)
State General Funds (\$)	13,361,007
Federal Funds (\$)	2,915,777

AD Community	FY 2012 (7/1/11)
State General Funds (\$)	27,476,035
Federal Funds (\$)	24,459,620

*Combines regional and central office budgets for AD services

**Office of Behavioral Health
Authorized Table of Organization (T.O.) Personnel Positions**

Office of Behavioral Health	FY 2011 T.O.	Classified	Un- classified	Reductions	FY 2012 T.O.
Administration					
Mental Health	34	32	2	(8)	26
Addictive Disorders	22	21	1	(3)	19
TOTAL - Administration	56	53	3	(11)	45
MH Community					
Community	53	53	0	0	53
Region 4	134	128	6	(29)	105
Region 5	65	62	3	(6)	59
Region 6	70	66	4	(27)	43
Region 7	68	61	7	(14)	54
Region 8	61	58	3	(6)	55
TOTAL – MH Community	451	428	23	(82)	369
Hospitals					
Central Louisiana State Hospital	257	253	4	0	257
Eastern Louisiana State Hospital	1,130	1,122	8	(76)	1,054
Southeast Louisiana State Hospital	579	572	7	(0)	579
TOTAL - Hospitals	1,966	1,947	19	(76)	1,890
AD Community					
Community	22	18	4	(7)	15
Region 4	36	36	0	(3)	33
Region 5	20	20	0	(1)	19
Region 6	33	33	0	(8)	25
Region 7	39	39	0	(6)	33
Region 8	39	39	0	(5)	34
TOTAL – AD Community	189	185	4	(30)	159
TOTAL - OBH	2,662	2,613	49	(199)	2,463

*FY11 Midyear Reductions – 21

*FY11 Integration – 99

LOCAL AUTHORITIES

Evolution toward Local Governing Entities

Legislation has mandated that the administration of the Louisiana mental health, addictive disorder and developmental disability healthcare system change from a centrally controlled set of Regions to a system of independent healthcare districts or locally controlled authorities. These districts and authorities are referred to as Local Governing Entities (LGEs) and are under the administration of OBH. As of July 2011, there are five LGEs in operation and five state-operated Regions that are in various stages of the transition to becoming LGEs. The LGEs are local umbrella agencies that administer the state-funded mental health, addictive disorder and developmental disability services in an integrated system within their localities. The LGE model affords opportunity for greater accountability and responsiveness to local communities since it is based on local control and local authority. Each LGE is administered by an Executive Director who reports to a local governing board of directors of community and consumer volunteers. All Local Governing Entities remain

part of the DHH departmental organizational structure, but not in a direct reporting line with OBH. The Office of Behavioral Health maintains requirements for uniform data reporting through memoranda of agreement arrangements supported by the Department of Health and Hospitals.

With the emergence of the LGEs, the role of OBH has begun to transition away from direct operational service delivery to one of providing resources and assistance that enable the LGEs to carry out service delivery. OBH is also responsible for providing assistance in setting policy, establishing minimum standards for the operation of the service system, establishing reasonable expectations for service utilization and outcomes, and developing mechanisms statewide for measuring these outcomes. In addition, OBH ensures that the LGE service system is well coordinated with those services that continue to be operated by the State (primarily the State-operated psychiatric hospitals).

The OBH Central Office, under the larger umbrella of DHH, has provided technical assistance and guidance to the remaining state-operated Regions as they prepare to transition to Local Governing Entities. Per ACT 373, passed during the 2008 Louisiana Legislative Session, all Regions that convert to an LGE must successfully complete a readiness criteria process that demonstrates their capability to assume the responsibility for high quality service delivery and good governance. This process includes the establishment of local governing boards that provide ongoing support and advice, while serving as vehicles for community coordination. Members of the Governing Boards are appointed by the Governor, and the bylaws require that membership is reflective of the population of the Region.

OBH retains its responsibility as a recipient of Federal Block Grant funds to ensure that all Regions and LGEs receiving Block Grant funds comply with all Federal Block Grant requirements. LGEs must maintain Mental Health Regional Advisory Councils, officially linked to the State Planning and Advisory Council, in order to qualify to receive Block Grant funding. To assist the reader in understanding the State behavioral health care system, a listing and map of Louisiana that illustrates the geographic Regions or Local Governing Entities (LGEs) and a description of each Region and LGE are below.

DHH Administrative Regions and Local Governmental Entities (LGEs)

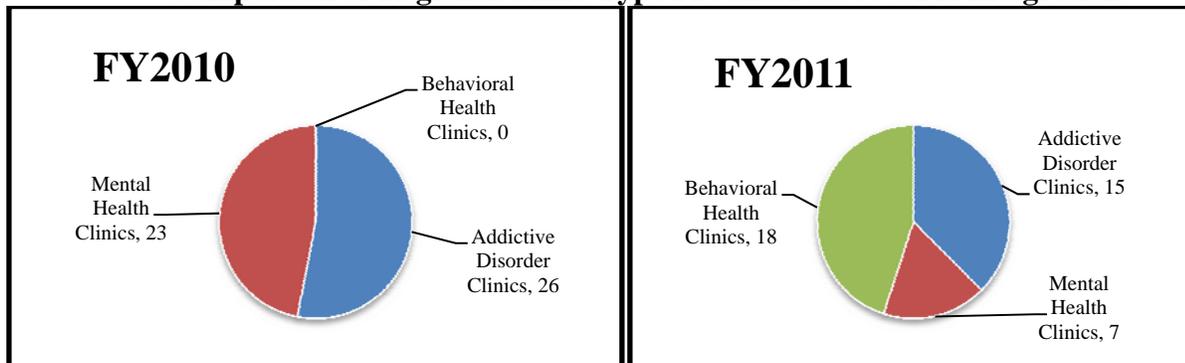
Region or District/Authority	Parishes
Metropolitan Human Services District: MHSD (formerly Region 1 - established July 1, 2004) is comprised of the New Orleans metropolitan area and two civil parishes to the south of Orleans Parish.	Orleans, Plaquemines, St. Bernard
Capital Area Human Services District: CAHSD (formerly Region 2 - established July 1, 1997) encompasses the Baton Rouge metropolitan area and six surrounding parishes.	Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana
South Central Louisiana Human Services Authority: SCLHSA (formerly Region 3 - established July 1, 2010) includes seven parishes in the bayou country of coastal Louisiana with Houma as the regional hub.	Assumption, LaFourche, St. Charles, St. James, St. John the Baptist, St. Mary, Terrebonne
Region 4 is comprised of eight parishes in the Acadiana area with Lafayette serving as the regional hub. <i>(will become Acadiana Area Human Services District)</i>	Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
Region 5 encompasses five southwestern parishes, including coastal Cameron. Lake Charles is the hub of this Region.	Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis

Regions resulted in a consolidated management structure with a single Regional Administrator for overall behavioral health operations in that locale. Fiscal, administrative support, and clinical management functions were redesigned to build in efficiencies and eliminate duplications. Efforts to maintain the needed expertise were instituted in an effort to ensure continuity of operations in the midst of massive system changes and to ensure a balance of representation between mental health and addictive disorders. At this time, all Regional administrative offices have been consolidated and are co-located. Significant fiscal savings were accrued as a result of this integration of the Regions, which provided for the elimination of 178 positions across all five Regions.

Clinic Level Systems Re-Organization

OBH Central Office executive management and regional managerial staff worked strategically to co-locate and physically integrate the largest mental health and addictive disorders outpatient clinics in each Region. In addition, Regional Administrators assessed staff and facility needs for the purpose of integration of facilities wherever possible. Decisions about integrating physical space were based on several factors, such as bus line proximity for consumers, general accessibility, the physical space of the clinics, accommodating increased personnel, operational needs of the clinic, whether the clinic buildings were state owned, distance to other facilities in the region, and cost efficiencies to maintain the physical structures. Currently there are a total of 77 clinics, which are either operated by Regions or the LGEs – 19 are mental health clinics, 33 are addictive disorders clinics, and 25 are integrated clinics providing both mental health and substance use services. The graph below illustrates these substantial changes in clinic type across Louisiana’s five state-managed Regions since the creation of an integrated OBH (FY2011) as compared to the clinic type prior to the integration (FY2010). Not all fellow addictive disorder and mental health clinics could be co-located or merged, as not all mental health clinics could accommodate the integration of an addictive disorders clinic, in terms of physical space and operational needs. In some instances, leases could not be terminated, or because of their rural location and part-time service delivery, the service system could not merge. The goal is that these logistic barriers to co-location will be resolved and all OBH services will ultimately be integrated.

Comparison of Regional Clinic Type Pre and Post to OBH Integration



OBH has achieved critical benchmarks in its consolidation and integration of local mental health and addictive disorders clinics, thereby providing the infrastructure to support a service delivery system that is more holistic and comprehensive. As the initial benefits of co-locating mental health and addictive disorder clinics have been realized, OBH clients are better served. One Regional Manager wrote, “Having experts in both mental health and substance abuse under one roof has already proven to be priceless.” While still early on in the establishment of an integrated behavioral health service delivery system, the preliminary evidence supports that the co-location and merging

of clinics has improved care, particularly related to the provision of co-occurring treatment. However, the first year of these clinic integration activities marks just the beginning of the local systems transformation that needs to take place in order to sustain gains and continue to improve. Fiscal Year 2012 priorities include institutionalizing the unique features of both mental health and addictive disorder services into an integrated service delivery system that is supported by an integrated and efficient administrative structure. Much of the standards for co-occurring or integrated care can be built upon the framework established by the Co-Occurring State Infrastructure Grant (CoSIG) that the state of Louisiana was awarded in 2004. The overarching goal of CoSIG was to move clinic-based services to a “Co-occurring Capable” status. This status was operationalized as being well-coordinated care between mental health and addictive services. The identified fidelity instrument, Dual Diagnosis Capability in Addiction and Mental Health Treatment (DDCAT/DDCMHT) was used to define and measure these practice and programmatic changes that incorporated multiple program dimensions such as program management, milieu, assessment, treatment, staffing patterns, and training. Through these continued efforts, the OBH clinics are in a good position to continue this work and move toward a “Co-Occurring Enhanced” status, which is defined as completely integrated mental health and addictive disorder care that is seamless to the client. Hence, OBH will be pursuing integrated behavioral health licensing standards, integrated behavioral health policies and regulations, and continued behavioral health workforce development.

The table below details the current state-supported operational clinics in the state as well as the clinic’s current capacity to provide mental health services, addictive disorders services or both. This transformational process is anticipated to continue as clinics continue to merge and become providers within the managed care environment under the administrative authorization of the State Management Organization.

MHSD	Algiers-Fischer Behavioral Health Center	4422 General Meyer Avenue, Suite 203	New Orleans
	Central City Behavioral Health Center	2221 Phillip Street	New Orleans
	Chartres-Pontchartrain Behavioral Health Center	719 Elysian Fields Avenue	New Orleans
	New Orleans East Behavioral Health Center	5640 Read Boulevard, Suite 810	New Orleans
	Plaquemines Behavioral Health Center	103 Avenue A, Suite A	Belle Chasse
	St. Bernard Behavioral Health Center	7407 St. Bernard Highway , Suite A	Arabi
CAHSD	Capital Area Center for Adult Behavioral Health Services	4615 Government Street, Bldg. 2	Baton Rouge
	Child/Adolescent Behavioral Health Center	4615 Government Street, Bldg. 1	Baton Rouge
	Donaldsonville Mental Health Center	901 Catalpa Street	Donaldsonville
	East Feliciana Satellite Clinic	12080 Marston Street	Clinton
	Gonzales Mental Health Center	1112 S.E. Ascension Complex Blvd.	Gonzales
	Iberville Parish Satellite Clinic	58311 Plaquemine Street	Plaquemine
	Margaret Dumas Mental Health Center	3843 Harding Boulevard	Baton Rouge
	Parish of Iberville Substance Abuse Center	24705 Plaza Drive, Suite B	Plaquemine
	Pointe Coupee Parish Satellite Clinic	282-A Hospital Road	New Roads
	West Baton Rouge Parish Satellite Clinic	685 Louisiana Avenue	Port Allen
	West Feliciana Satellite Clinic	5154 Burnett Road	St. Francisville
SCLHSA	Assumption Mental Health Clinic	2630 Highway 1	Labadieville
	Lafourche Mental Health Clinic	157 Twin Oaks Drive	Raceland
	River Parishes Addictive Disorders Clinic	421 West Airline Highway, Suite L	LaPlace
	River Parishes Mental Health Clinic	1809 West Airline Highway	LaPlace
	St. Mary Addictive Disorders Clinic	512 Roderick Street, Suite 200	Morgan City

	St. Mary Mental Health Clinic	500 Roderick Street, Suite B	Morgan City
	Terrebonne Addictive Disorders Clinic	521 Legion Avenue	Houma
	Terrebonne Mental Health Clinic	5599 Highway 311	Houma
	Thibodaux Addictive Disorders Clinic	303 Hickory Street	Thibodaux
Region 4	Crowley Behavioral Health Clinic	1822 West 2nd Street	Crowley
	Dr. Joseph Henry Tyler, Jr. Behavioral Health Clinic	302 Dulles Drive	Lafayette
	New Iberia Behavioral Health Clinic	611 West Admiral Doyle Drive	New Iberia
	Opelousas Behavioral Health Clinic	220 South Market Street	Opelousas
	Ville Platte Behavioral Health Clinic	312 Court Street	Ville Platte
Region 5	Allen Parish Behavioral Health Clinic	402 Industrial Drive	Oberlin
	Beauregard Behavioral Health Clinic	106 Port Street	DeRidder
	Jefferson Davis Addictive Disorders Clinic	915 West Shankland	Jennings
	Lake Charles Behavioral Health Clinic	4105 Kirkman Street	Lake Charles
Region 6	Avoyelles Addictive Disorders Clinic	106 East Mark Street	Marksville
	Avoyelles Mental Health Center	694 Government Street	Marksville
	Behavioral Health Clinic of Central Louisiana	242 Shamrock Street	Pineville
	Grant Addictive Disorders Clinic	211 Main Street	Colfax
	Jonesville Addictive Disorders Clinic	308 Nasif Street	Jonesville
	Jonesville Mental Health Clinic	2801 Fourth Street , Suite 2	Jonesville
	LaSalle Addictive Disorders Clinic	7865 Highway 8 West	Jena
	Leesville Mental Health Clinic	105 Belview Road	Leesville
	Vernon Addictive Disorders Clinic	201 South 3rd Street, Old Court House	Leesville
	Winn Addictive Disorders Clinic	301 West Main Street, Suite 202-B	Winnfield
Region 7	Mansfield Behavioral Health Clinic	501 Louisiana Avenue	Mansfield
	Many Behavioral Health Clinic	265 Highland Drive	Many
	Minden Behavioral Health Clinic (9/6/2011)	435 Homer Road	Minden
	Natchitoches Behavioral Health Clinic	210 Medical Drive	Natchitoches
	Northwest Regional Center for Addictive Disorders (Until 11/2011)	8932 Jewella Avenue	Shreveport
	Red River Behavioral Health Clinic	1313 Ringgold Avenue	Coushatta
	Shreveport Behavioral Health Clinic	1310 North Hearne Avenue	Shreveport
	Shreveport Behavioral Health Clinic - Children and Adolescent Services	2924 Knight Street, Building 3, Suite 350	Shreveport
Region 8	Bastrop Behavioral Health Clinic	320 South Franklin	Bastrop
	Columbia Behavioral Health Clinic	5159 Highway 4 East	Columbia
	Jonesboro Behavioral Health Clinic	4134 Highway 4 East	Jonesboro
	Monroe Addictive Disorders Clinic	3200 Concordia Street	Monroe
	Monroe Behavioral Health Clinic	4800 South Grand Street	Monroe
	Northeast Louisiana Substance Abuse/Oak Grove	Oak Grove Courthouse	Oak Grove
	Northeast Louisiana Substance Abuse/Rayville	204 Morgan Street	Rayville
	Northeast Louisiana Substance Abuse/Winnsboro	6564 Main Street	Winnsboro
	Richland Mental Health Clinic	115 Christian Drive	Rayville
	Ruston Behavioral Health Clinic	602 East Georgia Avenue	Ruston
	Tallulah Mental Health Center	1012 Johnson Street	Tallulah
	Winnsboro Behavioral Health Clinic	1301 B Landis Street	Winnsboro
FPHSA	Bogalusa Mental Health Center	619 Willis Avenue	Bogalusa
	Florida Parishes Human Services Authority Denham Springs	1920 Florida Avenue, Suites A & B	Denham Springs
	Hammond Addictive Disorders Clinic	403 Market Street	Hammond
	Lurline Smith Mental Health Center	900 Wilkinson Street	Mandeville
	Rosenblum Mental Health Center (Adult Services)	130 Robin Hood Drive	Hammond

	Rosenblum Mental Health Center (Child Services)	15785 Medical Arts Plaza	Hammond
	Slidell Addictive Disorders Clinic	2331 Carey Street	Slidell
	St. Helena Parish Addictive Disorders Clinic	102 North Second Street	Greensburg
	Washington Parish Addictive Disorders Clinic	2106 Avenue F	Bogalusa
JPHSA	East Jefferson Behavioral Health Center	2400 Edenborn Avenue	Metairie
	West Jefferson Behavioral Health Center	5001 Westbank Expressway	Marrero

Right Sizing Inpatient Care

The OBH has recently completed a critical initiative entitled “Right Sizing” inpatient care. Over the last two decades, Louisiana has remained dependent on psychiatric hospital levels of care through the Disproportionate Share Hospital program. While other states were re-organizing their funding approach and moving to a greater proportion of high intensity community based programs, Louisiana continued to have greater fiscal resources directed toward inpatient care. Efforts are underway to decrease reliance on more restrictive inpatient levels of care. The emphasis for this initiative has been to reduce the number of psychiatric beds at East Louisiana State Hospital (ELSH) by 118. In order to accomplish this task and maintain needed capacity in the state psychiatric hospital system, all of the hospitals including Central Louisiana State Hospital (CLSH) and Southeast Louisiana State Hospital (SELH) participated in a structured and coordinated discharge process in collaboration with community providers to prepare appropriate patients for discharge into the community. As of July 1, 2011, there were 206 persons discharged into the communities from the state psychiatric hospitals, and there were 118 adult civil beds closed. A comprehensive discharge planning process was utilized to support the discharge of these individuals back into the community. Commensurate with this initiative, reinvestment in the communities was needed to develop and implement the necessary supports and evidence based practices (EBPs) that were required for successful reintegration into the community. The reinvestment in communities was used primarily for the implementation of Assertive Community Treatment (ACT) and Intensive Case Management (ICM) teams throughout the state. An additional critical component of this new service capacity was the expansion of the Permanent Supportive Housing (PSH) program and other creative residential housing approaches to support the housing needs of these individuals. The PSH program was made available to residents along the coastal, hurricane-prone areas of the State. Persons being discharged from institutional care were designated as preferred populations for this program and were provided increased access to the available PSH housing units.

A critical component of the OBH Mental Health Redesign and Hospital Discharge Initiative is the intensive follow-up and tracking system to monitor how persons discharged from the state civil psychiatric hospitals are faring in the community. An OBH team has been assembled to conduct at least quarterly contacts with providers who serve the discharged SMI patients in order to determine if the person is stable and doing well or to pick up information that would indicate that there is some risk to that stability. The OBH team provides feedback to community providers and OBH local leadership if concerns are detected. It is anticipated that some persons will require additional assistance during the initial period post discharge, and at times acute hospitalizations will be a part of a person’s recovery. The vast majority of persons experiencing acute exacerbations have been able to return to a residence in the community. Approximately 30% of the discharged persons have been returned to a level of housing that is relatively independent in the community, while another 38% have been able to reintegrate through a more structured housing model with attendant staff and specialized housing supports. Over a third of the persons discharged accessed behavioral health care through newly implemented EBPs such as ACT or ICM. An overview of follow-up data collected thus far is compiled in the tables below.

Right Sizing Care: Hospital Discharges	
Housing Options	% of Discharged Population
Home	20%
Nursing Home	12%
Permanent Housing	9%
Group Home	18%
Supervised Independent Living	20%
Re-Hospitalization	10%
Out-of-State Discharge, Unknown	9%
Other	2%

Right Sizing Care: Hospital Discharges	
Behavioral Health Services	% of Discharged Population
Community-Based Teams (ACT, ICM)	35%
Mental Health Clinic Services	18%
Mental Health Services through Nursing Facility	12%
Partial Hospital Program/ Day Program	17%
Acute Hospital Services	7%
Other	11%

Medicaid Reform for Behavioral Health System

Physical Health/Medicaid Reform: Prior to the development of overall Medicaid transformation within OBH, the Department of Health and Hospitals initiated a sweeping Medicaid reform moving away from fee-for-service (FFS) and working toward effectively coordinating enrollees' health care. Overall, coordinating primary care is expected to lead to better access, more choices, and improved health for patients, with provider rates no less than those in FFS. The DHH is proposing two types of primary care Coordinated Care Networks (CCNs):

1. The CCN Prepaid is a traditional, capitated, managed care model in which entities establish networks of providers. Entities receive a monthly fee for each enrollee covered to provide core benefits and services, with prior authorizations and claims payment handled directly through the entity.
2. The CCN Shared Savings is an Enhanced Primary Care Case Management Plan, in which the network receives a monthly per member fee to provide enhanced care management services, with opportunities for providers in that network to share in cost savings resulting from coordinating care in this model. Medicaid's fiscal intermediary would continue processing claims.

The amount, duration, and scope of services provided by CCNs cannot be less than the State's Medicaid State Plan. The prepaid model does allow the flexibility for CCNs to provide enhanced benefits (or more than the State Plan required). Dental, pharmacy, hospice, behavioral health, nursing home care, personal care, school-based Individualized Educational Plan (IEP), and targeted case management are carved out and scheduled to remain Medicaid FFS treatment.

The selection process for healthcare contractors for the primary care CCN-Prepaid and Shared Savings plans has been completed. Three contractors have been selected for the CCN-Prepaid and two contractors for the Shared Savings Plan. Implementation is targeted to begin in the New Orleans metropolitan area by January 1, 2012. Other geographic areas of the state will begin implementation 90 days after implementation in the New Orleans area.

Behavioral Health/Medicaid Reform/Louisiana Behavioral Health Partnership: On the heels of Medicaid reform for physical health issues, OBH has entered into a new era of Medicaid reform that

better leverages federal Medicaid funding and positions Louisiana to expand Medicaid reimbursement for addictive disorders. Entitled the *Louisiana Behavioral Health Partnership (LBHP)*, this comprehensive Medicaid reform package maximizes federal funding to support mental health and addictive disorder services, making them more accessible and efficient through the 1915(i), 1915(b), and 1915(c) Medicaid waivers, in addition to expansive State Plan Amendments. Conceptually, the LBHP takes behavioral health services paid for by state general funds and makes these services a substantial part of the Medicaid funded integrated service delivery system. With reduced dollars spent, OBH can maintain, and even expand, to some extent, an integrated service menu and still fund a “safety net” of service delivery not funded by insurance.

Under the LBHP umbrella, behavioral health services will be effectively managed through an OBH contract with a private health care entity referred to as a Statewide Management Organization (SMO), which will provide a robust network of expanded providers in behavioral healthcare statewide. The OBH has been delegated by the state Medicaid agency to serve as the purchasing agent for the SMO. This will help to assure that the needs of its recipient populations will be met. OBH will hold the SMO accountable for improving access to and quality of care, and for managing the care in order to maximize efficiencies in the system and ensure strong coordination of all services. The SMO will administer all behavioral health services and implement a Prepaid Inpatient Health Plan (PIHP). Concurrent to the implementation of the PIHP, the following programs are administered through the 1915(b) mandatory enrollment and selective services contracting authority: 1915(c) Children’s CSoC Serious Emotional Disturbance (SED), 1915(c) Home and Community-Based Waiver and the Adult Psychosocial Rehabilitation and Clinic, 1915(i) State Plan Option for Adults with Severe and Persistent Mental Illness (SPMI). The mental health and substance use disorder PIHP is for adult services, including those for at-risk adults with limited mental health and substance use disorder benefits, and is paid on a non-risk basis for children’s services and for any individual with retroactive eligibility and spend-down beneficiaries in the month he/she meets the spend-down.

As the transformation of service delivery brought on by Medicaid and the new era of health care reform bring even greater access, OBH’s role will change to one of purchaser of services and evaluator of outcomes.

The LBHP is inclusive of the Coordinated System of Care (CSoC) provided for through the 1915(c) waiver, which will provide a model of care for children and youths at risk for out-of-home placement that is guided by the Wraparound model of coordinated care. The CSoC concept in Louisiana involves the collaboration and formal agreements from the four critical child-serving agencies: Department of Child and Family Services (DCFS), Office of Juvenile Justice (OJJ), Department of Education (DOE), and the Office of Behavioral Health (OBH). Through the CSoC, each of the child-serving agencies contributes funding that, when summed across all agencies, will be used to better leverage federal Medicaid resources. The fiscal resources will be managed through the SMO, which will not only better manage the care but prevent the duplication in services that had been a rampant problem when each agency maintained siloed provider systems. The primary focus of care for CSoC through the 1915(c) waiver is children and youths at risk for out-of-home placement. The process of building the local systems of care is planned for implementation in a staged process throughout the state. Five geographic areas of the state were chosen to be initial pilot sites for CSoC implementation. These sites have demonstrated a heightened degree of readiness for CSoC, strong commitments from its community partners, and the capacity to build Wraparound Agencies and Family Support Organizations.

As the competitive process unfolds for the Statewide Management Organization (SMO), the successful proposer will operate the Prepaid Inpatient Health Plan (PIHP) to provide the following services:

1. Manage behavioral health services for adults with substance use disorders, as well as adults with functional mental health needs, including: persons with acute Stabilization Needs; Persons with SMI (Federal definition), persons with major mental disorder (MMD), and adults who have previously met the above criteria and need subsequent medically necessary services for stabilization and maintenance on a risk basis, effective on or about March 1, 2012.
2. Manage mental health and substance use care for all eligible children/youth in need of behavioral health care, on a non-risk basis, effective March 1, 2012.
3. Implement a CSoC for a subset of children/youth who are in or at risk of out-of-home placements on a nonrisk basis, effective March 1, 2012. The CSoC will be phased in over the term of the contract through amendments in the State's 1915(c) waiver.

Louisiana Behavioral Health Partnership Workforce Development Initiative: The workforce development process for transitioning OBH behavioral health clinics into competent, qualified LBHP network providers has included identifying necessary training, credentialing, and certification standards for providers and provider agencies. OBH providers in the current system will require orientation and training to these infrastructure and operational requirements in order to assure readiness and a successful transition into the new managed care system as LBHP providers. Training for this level of organizational orientation is currently under development.

Workforce development activities related to the Coordinated System of Care (CSoC) are at a more advanced stage of development. Early on, it was recognized that many of the more progressive strategies and interventions associated with the CSoC initiative would have to be developed and the workforce created. The CSoC workforce development committee then created a comprehensive Workforce Development Plan to assure that providers within the Coordinated System of Care initial implementing communities are competently prepared to meet the needs of youth and their families. The workgroup, made up of multi-agency participants, coordinated their efforts with other CSoC workgroups and utilized national technical assistance to 1) identify a set of pre-service competencies and accompanying e-learning resources, and to 2) design a plan of training for foundational courses including Wraparound Process/Planning, Cultural Linguistic Competency and Family Service Organization planning, to be made available to providers and stakeholders in the development of the local systems of care. National experts providing these trainings will include the Maryland University Innovations Institute and Georgetown University.

In addition to these initial CSoC trainings, OBH has submitted a proposal to collaborate with the Louisiana State University School of Public Health, Institute of Justice to assist in assuring the sustainability of these initial implementing communities by providing technical assistance for the implementation of evidence based practices and the development and implementation of the Family Support Organizations.

Training, credentialing, and certification for LBHP and CSoC will provide the foundation for ongoing OBH workforce development activities statewide, until the implementing communities and existing providers are properly prepared to deliver quality services within the identified service array, inclusive of promising and evidence based practices. OBH will develop and implement the infrastructure, policies and processes necessary to facilitate the successful creation of the LBHP.

Emergency and Disaster Response - Louisiana Spirit Coastal Recovery Counseling Program

After several years of dealing with the event of hurricanes as well as the aftermath of these destructive storms, Louisiana has established a core response effort to disasters in the state. Each year, the state has continued to face disasters of a different sort, and has been able to activate the core of the DHH disaster infrastructure to address these needs. The Special Unit of Disaster Preparedness readies the Office of Behavioral Health (OBH) to respond rapidly and effectively to natural and man-made disasters, whether it be an oil spill, terrorism, or a hurricane. The OBH workforce is alerted in the event of a storm threat or other disaster. Employees are expected to be activated during a crisis and stand willing and able to assist and report to their assigned placement. Communication needs for staff have resulted in extensive uses of technology. Many staff members have been issued cell phones and blackberries and make available 800 Mhz radios for use in disasters. Employees have access to electronic bulletin boards or websites that allow communication between staff, supervisors, and administration.

Trainings are also offered to emergency service providers, as well as behavioral health providers to support efforts to strengthen the state's emergency response capabilities while reducing the psychological impact of a disaster statewide. National Incident Management System training has been made a requirement of employment by OBH, and OBH maintains a registry of credentialed behavioral health professionals who are able to provide assistance in disaster mental health, stress management, and multiple agencies' response to disaster incidents. Emergency preparedness, response and recovery have become a part of every healthcare provider's job function, and employees have learned that every disaster is different, often requiring new learning and flexibility. Through ongoing collaboration with OPH, OBH key emergency response personnel are engaged in activities and trainings to improve workforce readiness and response operations in Medical Special Needs Shelters and state and local Emergency Operations Centers (EOC). Trainings are provided in the following areas of focus.

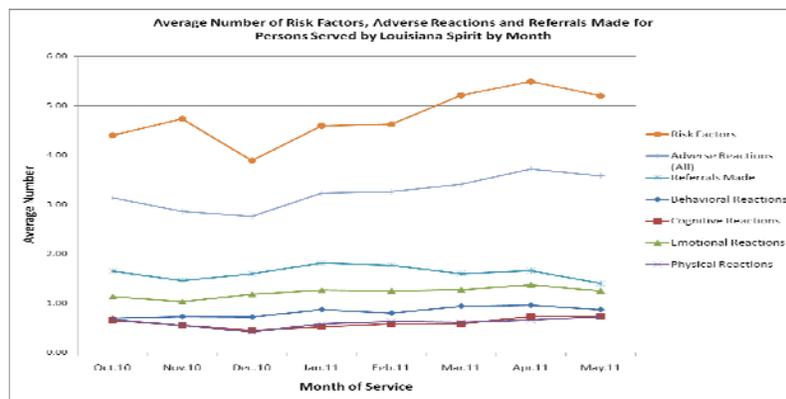
- Hurricane preparedness training and Shelter-in-Place tabletop exercises
- OBH coordinates in-service training for emergency room doctors, nurses and other professional and para-professional staff and trains teachers and school administrators in disaster response procedures.
- OBH/Office of Public Health/Governor's Office of Homeland Security/Emergency Preparedness support training to parish level police/fire/EMS workers including:
 - Crisis intervention techniques to first responders
 - Critical incident management
 - Mental health disaster services
 - Bio-terrorism preparedness
 - Mental health response to mass casualties
 - Coordination of mental health and first responders
 - Stress management for first responders

Deepwater Horizon Oil Spill

In 2010, the Gulf Coast region of Louisiana was confronted with a man-made disaster - the explosion of the Deep Water Horizon/British Petroleum oil rig on April 20th. This resulted in the catastrophic oil spill off the coast of Louisiana. The long-term impact of this spill continues to be assessed as it resulted in the loss of a livelihood for many families living and working along the coast. Repercussions have affected everyone from fishermen, to restaurant owners and the tourism industry, and all of the industries and businesses that support these sectors of the state’s economy. Through funding from British Petroleum, the Louisiana Spirit Coastal Recovery Counseling Program was activated on May 21, 2010 by the State to provide crisis counseling services for residents impacted by the oil spill. Workers reached out where fishermen, individuals, families and others affected by the oil spill were likely to be found. Geographically, this includes the southeast parishes of Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, Terrebonne, Lafourche, and St. Mary.

Following the second funding award by British Petroleum on October 1, 2010, short-term behavioral health prevention and intervention services continued but were restructured utilizing the Local Governing Entities (LGEs) of Jefferson Parish Human Services Authority (JPHSA), Metropolitan Human Services District (MHSD) and South Central Louisiana Human Services Authority (SCLHSA) as administrators of direct service. Subsequently, each entity subcontracted crisis counseling services through local community-based service providers in the parishes of Jefferson, Lafourche, Orleans, Plaquemines, St. Bernard, and Terrebonne. The Louisiana Spirit Coastal Recovery Counseling program design was modeled after the successful Louisiana Spirit Hurricane Recovery program. Crisis counseling services provided include: information/education dissemination, psychological first aid, crisis/trauma counseling, grief and loss counseling, supportive counseling, resiliency support, psychosocial education, and community level education and training. In addition to the crisis counseling and information and referral sources, the program also provided media messaging regarding services available after the oil spill. From May 21, 2010 through May 31, 2011, more than 85,000 direct face-to-face contacts were provided. Services continue to be provided through the LGEs and NGO (non-governmental organization) provider network, with an anticipated end date of January 31, 2012.

The following data refers to individual counseling sessions completed by counselors with the Louisiana Spirit Coastal Recovery Program in all parishes served between October, 2010 and May, 2011.



The Coastal Recovery Program tracked the most common risk factors that impacted the population. At least one in three persons served by the program experienced one or more of the following risk factors:

- Resident in affected community
- A close family member or friend was impacted by the oil spill
- Impacted by the recent hurricanes: Hurricanes Katrina, Rita/ Gustav
- Oil spill related negative impact on savings
- Employed in an industry affected by the oil spill
- Experienced an oil spill related reduction in income
- Suffered other financial losses
- Had a new or expanded need for public financial assistance

As a part of the BP oil explosion, crisis counselors have documented the percentage of adverse (i) Behavioral Reactions (changes in activity level, hyper-vigilance, agitation, isolation), (ii) Cognitive Reactions (concentrating, decision making, memory), (iii) Emotional Reactions (anxious, irritable, despair, sadness) and (iv) Physical Reactions (sleeping, fatigue/exhaustion, headaches, deterioration in health) recently experienced by persons served and disclosed during the session. The majority (82%) of all counseling sessions involved the disclosure of at least one type of adverse reaction, and there was a steady increase in these adverse reactions in more recent months, as the course of the disaster became prolonged with limited resolution. An essential outcome of the crisis counseling sessions is the linkage of persons to resources that may help them address continuing concerns. Referral sources included additional counseling sessions, BP claims services, public assistance and workforce development. The majority (87%) of all counseling sessions resulted in the provision of at least one type of referral to help meet these needs. The most often requested referral was additional counseling services.

Mississippi River Flooding

In the late spring of 2011, OBH participated and supported impacted populations in the Mississippi River Flood event. The entire length of the Mississippi riverbanks in Louisiana was affected either by direct flooding or extensive prevention/preparedness activities. OBH assisted in supporting behavioral health needs precipitated by the event. OBH continues to work with key stakeholders to ensure ongoing implementation of readiness and ensuring continued safety of clients, staff and the at-large community.

Overview of the Louisiana Mental Health Service System

Mental Health Service System Array (CMHS Block Grant Criterion 1 and Criterion 3)

As the Office of Behavioral Health (OBH) directs the integration of behavioral health services and aligns services for implementation of major Medicaid reform, it continues to be responsible for the operation and support of day-to-day clinical service delivery. Thus, the OBH must manage the maintenance of day-to-day operational issues, (i.e. planning, developing, operating, and evaluating public mental health services and addictive disorder services for the citizens of the State) along with readying the system for an overhaul.

By the end of FY2011, the Louisiana behavioral health service delivery system found itself involved in a series of major transformation stages as well as the ongoing continuation of the more historic aspects of the service delivery system that have been the mainstays of care. Mental health services are designated to provide care for the high need populations of the state. State-supported mental health services target adults with a severe mental illness, children and adolescents with a serious emotional/behavioral disorder, and all people experiencing an acute mental illness. There is no separate state-wide division for children's services, but the OBH has targeted specific improvements in the provision of Child /Youth Best Practices.

Clinics

The OBH continues to strive to maintain appropriate access to a wide continuum of mental health services. State-supported Community Mental Health Clinics (CMHCs) or Behavioral Health Clinics continue to exist as a mainstay of the service system. Half of the CMHCs are currently operated by Local Governing Entities (LGEs), while the remainder continues to be operated by OBH-managed Regions. The Clinics have continued historically to be the back bone of the public supported mental health service system, providing lower intensities of care. The CMHCs have been fiscally supported in the past through the Medicaid Clinic Option and continue to provide services to a large portion of the mental health population. Estimates for FY11 show that over 60,000 unique individuals have been provided basic behavioral health care services through the clinic-based delivery system.

AGE GROUP	TOTAL	
	N	%
CHILD (0-12)	5,302	8.60%
ADOLESCENT (13-17)	5,487	8.90%
ADULT (18-64)	48,592	79.30%
SENIOR (65+)	1,861	3.00%
missing/unknown	12	0.00%
TOTAL	61,254	100.00%

The clinic-based services in most Regions and LGEs offer an array of services including crisis services, screening and assessment, individual evaluation and treatment, psychopharmacology, clinical casework, specialized services for children and youth, and in some areas, specialized services for those in the criminal justice system and for persons with co-occurring mental and addictive disorders. The clinics are expected to continue to provide some of the safety net services as the state of Louisiana proceeds through the anticipated Medicaid Reform for its behavioral health services. Although the community clinics operate with somewhat traditional hours, crisis services are available on a 24-hour basis. The clinic-based services are designed to provide an easily

accessible level of care to persons, who are experiencing acute distress. Services include telephone counseling and referrals, face-to-face screening and assessment, community housing for stabilization, crisis respite in some areas, and access to inpatient care. The federal fiscal support through Medicaid will change from the Clinic Option to that of the Home and Community Based Services Option (1915(i) Waivers). Traditionally, Louisiana OBH clinics that provide mental health services have rendered the following clinic based services. The backbone of the clinic-based services consists of the medication management and individual counseling interventions, which will continue to be accessed through the planned Medicaid reform package.

CLINIC BASED SERVICE TYPE	TOTAL	
	N	%
Consult/Adjuvant Services	35,831	7.86%
Counseling/Therapy (Couples, Family or Group)	35,287	7.74%
Specialty Injections	13,506	2.96%
Counseling/Therapy (Individual)	108,679	23.84%
Medical Management	140,317	30.78%
Physical Health Services	10,563	2.32%
Psychiatric/Psychological/Psychosocial Screening & Evaluation	61,015	13.39%
Care Management Services	49,512	10.86%
Missing/Unknown	1,091	0.24%
TOTAL	455,801	100.00%

Transformation of the clinic-based system is well underway and a number of previous mental health only clinics have been integrated and are now able to provide both mental health and addictive disorders services. In FY10, there were 45 distinct Community Mental Health Clinics (CMHCs), and 27 Outreach mental health locations that were operational across the LGEs and the Regions. Through this strategic process of co-location, some of the CMHCs were re-assessed with regard to fiscal viability and downsized, streamlined, or even eliminated.

Contractual Community Based Programs

The OBH has substantially enhanced the array of community-based private providers through contractual relationships generated at the Central Office, Regional and LGE level. Typically, through these contracts, the OBH has been able to seed unique, innovative programs that may not be reimbursable through Medicaid or other third party payers. These innovative programs include Supported Living, Supported Employment, family/consumer support services (e.g., case management, respite, drop-in centers, consumer liaisons), and school-based mental health services.

As Louisiana has struggled fiscally over the last year as a result of the national economic downturn and large state budget deficits, the OBH has made it a priority to direct critically necessary funding to support much needed community-based services that target the severely mentally ill population. For years, the OBH and the associated Regions and LGEs have maintained pockets of evidence-based practices such as Assertive Community Treatment teams, but there has not been a comprehensive statewide, systematic implementation of such services. In spite of the economic downfall, the OBH executive leadership recognized that stronger more comprehensive levels of

high intensity care for persons with serious mental illness would be required to transform the behavioral health system and reduce reliance on expensive more intensive levels of care. By more systemically investing in community-based services, the Louisiana behavioral health system could move away from inpatient care and develop an outpatient system with the necessary supports and service array to manage persons with more complex needs. The investments in community-based services over the last fiscal year were primarily targeted toward the development and implementation of Assertive Community Treatment (ACT) teams and Intensive Case Management (ICM) teams.

A strategic analysis was conducted to determine the best philosophical and treatment approach for each community. For the more populous and urban areas of the state, it was more cost-effective to implement an ACT model and therefore this type of resource for community-based services was preferentially chosen for those areas of the state. In more rural areas of the state with greater geographic spread, Intensive Case Management(ICM) or smaller, half ACT teams were preferentially implemented. The table below documents the current types and capacities of these services throughout the state.

Region/ LGE	Assertive Community Treatment Team Distribution	Total Capacity (persons served)	Intensive Case Management Distribution	Total Capacity (persons served)
MHSD	1 ACT team (NHS) 1 FACT team (NHS) serves both MHSD & JPHSA 1 ACT team (RHD)	300	5 Case Managers (NAMI)	110
CAHSD	1 FACT team (NHS)	100	--	--
SCLHSA	--	--	20 Case Managers	400
Region 4	.5 ACT team (VOA) 1 ACT team (NHS)	150	17 Case Managers (VOA)	200
Region 5	.5 ACT team (NHS)	50	10 Case Managers	200
Region 6	1 ACT team (NHS)	100	--	--
Region 7	1 ACT team (NHS)	100	10 Case Managers (NHS)	200
Region 8	--	--	10 Case Managers (Easter Seals)	200
FPHSA	--	--	15 Case Managers (Options for Independence)	300
JPHSA	2 ACT teams (RHD) 1 ACT team (Family Preservation Services)	300	--	--
TOTAL	11 ACT/FACT teams	1100	85 Case Managers	1625

Evidence Based Practices (EBPs) Implementation in Community-Based Services

The OBH has made a concerted effort to increase the number of EBPs within the behavioral health service delivery system. As described in the contractual services section, the OBH has authorized a statewide expansion of critically needed EBPs including Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), and Intensive Case Management (ICM). By FY 2011, each Region or LGE had implemented either ACT or ICM in their local area. These EBPs support the more severely mentally ill population and persons being discharged from intermediate care psychiatric facilities. In conjunction with the community-based services, OBH Central Office also facilitated the implementation of a Permanent Supportive Housing (PSH) program. The PSH initiative was specifically targeted for approximately half of the state including the coastal hurricane-prone parishes of the state. Within the PSH program, individuals being discharged from

psychiatric institutions were provided a super-preference on the PSH list. As a result of the superpreference criteria, 26 persons from institutions were able to access housing in the community.

As a core service available to the targeted mental health population in the state, medication management (MM) has been in place for decades. Newly enhanced psychopharmacology guidelines provide improved guidance on the use of medications for the mentally ill with particular emphasis on monitoring the use of multiple antipsychotics as well as utilization of second generation antipsychotics. Additionally, each Region and LGE has been afforded the opportunity to have specialized teams of clinicians involved in on-site training for Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT). These trainings offered specialized technical assistance and follow-up supervision in order to meet certification requirements. The OBH has also invested in peer supported interventions including the Wellness Recovery Action Plan (WRAP) and Peer Support Services (PSS). Through trainings and certification procedures, the state of Louisiana has produced a work-ready cohort of certified peer support specialists, who are available statewide.

Through the Co-Occurring State Incentive Grant (COSIG), the framework for the provision of integrated mental health and addictive disorders services was established. In statewide implementation, the service system was, at a minimum, expected to maintain a coordinated and collaborative management of individuals with co-occurring disorders, defined as Co-occurring Capable (COC). The core philosophy of integrated services, as delineated by Minkoff and Cline, was adopted by the state's behavioral health system. Within this framework, clinics achieved a co-occurring capable status through fidelity assessment using Mark McGovern's Dual Diagnosis Capability Assessment Tool (DDCAT).

In small pockets of the state, the evidence-based practices of Supported Employment and Supported Education are available. The OBH-sponsored Supported Education programs provide both individual and group support to students with SMI who are pursuing postsecondary education. The Supported Education advisor serves as a case manager for students with SMI. The program targets students of all ages and referrals come from a variety of sources, including mental health clinics, on-campus mental health services, rehabilitation services, and university staff.

Of the EBPs listed, several are available statewide (Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Wellness Recovery Action Plan, Medication Management and Peer Support Services). The OBH continues to explore its ability and capacity to expand the provision of EBPs. For many of the EBPs, OBH is dependent on State General Funds or Mental Health Block Grant (MHBG) funds for financial support.

Medicaid Mental Health Rehabilitation Services

Historically, the state mental health office, previously known as the OMH, operated as a managed care agent of the state Medicaid agency to authorize and monitor the mental health rehabilitation services provided through private provider network. Beginning in fiscal year 2010, the Mental Health Rehabilitation (MHR) program was transferred in its entirety to the Bureau of Health Services Financing/Medicaid Services within DHH. Efforts had been underway to improve and revamp the Mental Health Rehabilitation Medicaid program for some years prior. In 2006, the private provider MHR network was required to undergo formal accreditation through Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA). Improvements and standardization of the MHR program continued, and in June 2010, the MHR program began

statewide implementation of its new Provider Performance Indicator reviews. The Clinical Documentation/Utilization Management Monitoring module and a newly designed Covered Services Module were implemented. Results will be used for Provider Report Cards, as well as referrals for possible Notices of Deficiencies, provider training and education referrals, and as focused monitoring tools for complaints, grievances, etc. Through the MHR program, clients are able to access a number of community-based rehabilitation practices including Community Support, Counseling, Group and Family Interventions, as well as Psychosocial Skills Training and Parent/Family Interventions. Recently, Multisystemic Therapy (MST) was added to the services offered through MHR, and providers were also certified by Medicaid. Medicaid's MST program now has 25 providers with 36 teams. So far, during the current fiscal year, 1,910 youth have been served in MST throughout the state. During FY2011, there were 98 enrolled MHR providers that served 12,553 unduplicated recipients.

In addition to maintaining the current network of MHR providers, the Medicaid Behavioral Health Section has been a critical lead in the design and development of the Coordinated System of Care (CSoC), in collaboration with the Department of Children and Family Services (DCFS), Office of Juvenile Justice (OJJ), Office of Behavioral Health (OBH), and Department of Education (DOE), as well as family members, advocates, and other invested stakeholders. Similarly, the Medicaid Behavioral Health Section has worked in close partnership with the OBH as the statewide Louisiana Behavioral Health Partnership (LBHP) has unfolded. As the Statewide Management Organization Request for Proposal (RFP) process has been underway, both the OBH and the Medicaid section have worked together collaboratively to foster and plan for this major system overhaul.

The tables below show pertinent facts about the MHR program through FY 2010.

Number Receiving Mental Health Rehabilitation Services

	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Children: Medicaid Funded	4,886	4,201	4,539	5,205	8,106
Adults: Medicaid Funded	2,379	1,605	1,459	2,182	2,471
TOTAL	7,265	5,806	5,998	7,387	9,909*

*Unduplicated: some were treated as children and also as adults when they turned 18.

Mental Health Rehabilitation Providers

	FY 05-06	FY 06-07	FY 07-08	FY 08-09	FY 09-10
Medicaid Mental Health Rehabilitation Agencies Active During FY	114	77	61	68	69

Community-Based Crisis Services

As an adjunct to current services, Mental Health Emergency Room Extension (MHERE) Units have been established in most Regions/LGEs throughout the state. These units provide a specifically designated program within hospital emergency departments to triage for behavioral health

conditions. The services include medical clearance, behavioral health assessment and evaluation, and crisis treatment of a person in crisis to determine the level of service need. The MHERE provides the opportunity for rapid stabilization in a safe, quiet environment and increases the person’s ability to recognize and deal with the situations that may have initiated the crisis while the unit is working to increase and improve the network of community and natural supports.

Hospitals

OBH provides for a continuum of care process to facilitate access to acute and/or intermediate/long-term hospital placements. In keeping with system of care principles and the need for a comprehensive continuum of care, there is an emphasis on a close liaison among the regional service system, the LGEs, State hospitals, community provider agencies, and consumer and family support and advocacy systems. The community and hospital system of care emphasize continuity of care and treatment in the least restrictive environment appropriate to the person’s needs. OBH supports consumer and family involvement in the planning, development, delivery, and evaluation of services.

There are three OBH state-operated psychiatric hospitals providing acute, intermediate, and specialized inpatient care; including one forensic division. These include Southeast Louisiana Hospital (SELH) in Mandeville, Eastern Louisiana Mental Health System (ELMHS) in Jackson and Greenwell Springs, and Central Louisiana State Hospital (CLSH) in Pineville. Collectively, all three hospitals operate 594 intermediate care beds. One hospital (ELMHS) includes a division that is solely designated for the treatment of the forensic population; this setting has a total of 355 adult (intermediate) forensic beds. Of these 355 forensic beds, approximately 235 of the beds are housed in the specialty forensic division known as Feliciana Forensic Facility (FFF). Across all three hospitals, there are 189 civil inpatient beds, most of which are currently at CLSH and SELH. There are also 50 child/adolescent beds currently being managed at SELH.

State Supported Psychiatric Hospitals		City	ICF Beds
Central Louisiana State Hospital (CLSH)		Pineville	60
Eastern Louisiana Mental Health System (ELMHS)	East Division	Jackson	35
	Forensic Division	Jackson	355
Southeast Louisiana Hospital (SELH)		Mandeville	94
TOTAL			594

Acute psychiatric inpatient units are short-term (generally less than 14-day) programs utilized to stabilize persons showing emergency need so as to return them back to community functioning as soon as possible. Within both SELH and the Greenwell Springs division of ELMHS, there are two state operated acute units. Together, both units support 80 adult acute unit beds. There are several facilities in the state operated by the Louisiana State University Medical schools that have acute mental health beds. Statewide, there are 50 beds dedicated to Children/Youth; all of which are currently located at SELH.

Community Forensic Services

The population of persons with both serious mental health problems and forensic involvement often require specialized services, specific to issues of competency and/or diversion. Within the system of care, there is a Community Forensic Services (CFS) division that operates two distinct programs; these programs are described and detailed in the table below.

The Competency Restoration/Jail-Based Services are designed for pretrial detainees, who have been identified or adjudicated as incompetent and ordered to be hospitalized or to receive jail-based (community) treatment. District Forensic Coordinators (DFC), working with contract Psychiatrists and Psychologists, go to the jails and perform competency assessments, treatment and evaluation services. The evaluation report generated by this effort is the procedure by which those regaining competency in the jails are moved from the waiting list for inpatient without the necessity of hospitalization and thus diverting the need for lengthy inpatient stays. (La.C.Crm.Pro. Art. 649).

The Conditional Release Program (ConRep) and Assertive Community Services are designed for forensic patients [Not Guilty By Reason of Insanity (*NGRI*) and Incompetent to Proceed (*ITP*) 648B], who are discharged or diverted from DHH inpatient units. Forensic Service Teams are assigned to provide intensive supervision and consultation to forensic patients utilizing existing OBH mental health clinics as a basic delivery mode for psychiatric aftercare. These teams also provide assertive crisis intervention services together with monitoring for the court. In New Orleans, from which a significant percentage of discharged and potentially dischargeable forensic patients reside, there is a specialized Forensic Aftercare Clinic, administratively and clinically managed by Community Forensic Services(CFS). This program began as a Federal Demonstration Project designed to increase the discharges of forensic clients and to maintain client compliance with ConRep court orders so that public safety (i.e., harm to others) is not jeopardized.

FORENSIC PROGRAM	PURPOSE	NUMBER SERVED
Community Forensic Services 1 Attorney (Program Director), 16 DHH District Forensic Coordinators (DFCs), 1 social services counselor, 1 social worker	Competency restoration (jail-based and community-based) for pretrial detainees identifies as incompetent Intensive supervision and consultation to forensic patients (NGBRI, 648B and ITP) who are discharged or diverted from DHH inpatient units	300 per year on conditional release 200 per year who are ITP in jail/community
Forensic Aftercare Clinic 2 forensic psychiatrists, 1 forensic psychologist, 1 forensic psychology intern, 2 RNs, 2 addictions counselors, 1 sex offender therapist, 1 case monitor, 1 social services counselor, 1 administrative coordinator, 1 social worker/clinic manager	Multidisciplinary team, intensive supervision, case monitoring, mental health and substance abuse treatment and/or sex offender treatment to forensic patients (NGBRI, 648B, and ITPs) who are discharged or diverted from DHH inpatient units	40 clients at any given time – includes diversion and conditional release clients (Con Rep)

On April 12, 2010, the Advocacy Center filed an action against DHH, regarding the length of time taken to accept physical custody of an individual determined to be incompetent to proceed to trial. A Federal Consent Decree was entered on April 12, 2011. The Consent Decree requires that all incompetent detainees be assessed within 5 calendar days of receipt of the court order and a determination made of whether the person meets criteria for Emergency, Major Mental Health needs or Other Mental Health Needs. Based upon this determination, admission standards into DHH custody are established and must be followed. The DHH submitted the first report on August 2010 with a 98% compliance rate. As a result of this legal action and the OBH's general initiative to become less dependent upon more intensive and more restrictive levels of care like long-term hospitalization, additional levels of residential care for persons with forensic involvement have been developed. The table below illustrates several of the programs that have been designed and

implemented, which provide less restrictive options for this special population and allow for a graduated process of discharge and reintegration into community settings.

FORENSIC PROGRAM	DESCRIPTION	BED/CAPACITY
Secure Forensic Facility (SFF)	Supervised residential placement at a 1:15 ratio for court-ordered, conditionally released, and/or other selected, forensic clients in need of individualized services to develop daily living skills and to prepare for vocational adjustment and reentry into the community	82 male beds
Sex Offender Treatment Program at the Forensic Aftercare Clinic in New Orleans	Outpatient sex offender treatment to community based sex offenders receiving services at the FAC	Capacity to serve FAC recipients
Forensic Supervised Transitional Residential and Aftercare Program (FSTRAP) – Baton Rouge	Appropriate, secure supervised residential housing in the community Services as daily living skills, symptoms management, legal rights, medication management and other clinical groups necessitated by the individualized person-centered treatment plan	40 civil beds for individuals determined to be not restorable and are conditionally released 45 beds for conditionally released clients with an NGBRI status
Forensic Supervised Transitional Residential and Aftercare Program New Orleans (STRAP-NO)	Residential facility for pre-trial ITP clients with mild mental health or substance abuse issues (mental health services and competency restoration to be provided by the FAC)	22 male beds
Group Home for Females	Aftercare services to females discharged from FFF	4 beds contracted through private provider

Special Array of Children’s Mental Health Services (CMHS Block Grant Criterion 3)

The OBH has recognized that Louisiana’s children and youth are seriously underserved, and its capacity to serve children from birth to 21 is greatly underfunded and inadequate to meet the continually growing behavioral health needs of the State’s children. Youth in the custody of the child welfare and juvenile justice systems receive mental health and substance use disorder treatment in out-of-home, restrictive settings. The OBH acknowledges that the needs of children with SED and their families are currently being addressed through a fragmented service delivery model that is not well coordinated, frequently does not meet their needs, and is often difficult to navigate. The lack of a sufficient scale for quality, effective, community-based children’s mental health services results in children with the highest level of risk being detained in secure or residential settings.

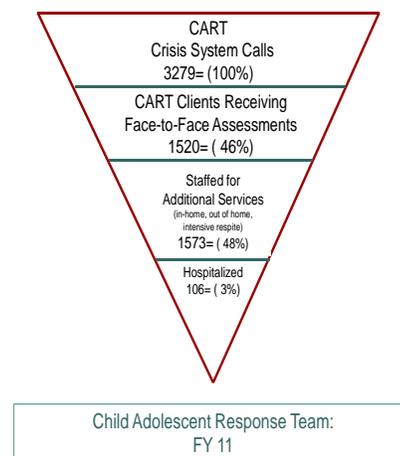
Given these deficits, there have been consistent efforts to improve the capacity and quality of children’s services in Louisiana. In light of these efforts, there has been a steady increase in the number of children served over the last five years. In part, this increase in numbers served has been facilitated through the implementation of increased access with child specialists in the community clinics, implementation of some child EBPs in the communities, the development of a statewide crisis response program for children, and expansion of school-based services. The core children and adolescent services in many ways mirror the adult service array within the state-managed system. Clinic-based services including counseling, psychopharmacologic interventions and comprehensive evaluations are provided for children and adolescents. However, these services are

not easily accessed because of school hours, and parental work hours are not necessarily conducive to clinic operations.

In terms of enhancing children’s services through EBP implementation, OBH has been focused on securing Medicaid funding for evidence-based practices for children and adolescents, including both Functional Family Therapy (FFT) and Multi-systemic Therapy (MST) services. The FFT team can serve children with a variety of behavioral health needs, from conduct disorder to substance abuse. All parishes have developed local FFT teams that can provide proven treatment alternatives to out-of-home placements. MST is an intensive, home-based wraparound model that combines a variety of individual and family interventions within a systemic context. MST has been evaluated with youth at risk for detention/incarceration and at risk for psychiatric or substance use disorder hospitalization and it has shown significant results in reducing out-of-home placement, externalizing problem behaviors, rates of recidivism and lowering costs of treatment. This program is operating in many areas of the state to include MHSD, CAHSD, SCLHSA, Region IV, Region V, Region VI, Region VII and JPHSA. With continued efforts to improve the Mental Health Rehabilitation (MHR) optional Medicaid program, a number of new Multi-Systemic Therapy (MST) providers were certified by Medicaid during the year. As of FY2011, Medicaid’s MST program now has 25 providers with 36 teams. So far, during the current fiscal year, 1,910 youth have been served in MST throughout the state.

In addition to the already cited EBPs that are supported through Medicaid, the Louisiana Children’s Health Insurance Program (LaCHIP) provides behavioral health services to many children eligible for Medicaid. These services include mental health clinic services, psychological tests and therapy, and MHR services and are offered to children up to age 21. Alternatively, services may be provided by another children’s system, primarily child welfare or juvenile justice.

The community-based Child and Adolescent Response Team (CART) program and other community-based supports and services continue to provide a route to assist in the reduction of inpatient hospitalizations and diversion from out-of-home placements. Crisis services for children and youth are provided twenty-four hours a day, seven days a week. These crisis services are referred to as the CART Program and are available in all Regions/LGEs. CART crisis services are available to all children and their families, not just those eligible for mental health clinics and psychiatric hospitals. Services include telephone access at all times with additional crisis services and referrals, face-to-face screening and assessment, crisis respite in some areas, clinical case management, consumer care resources, and access to inpatient care. The infusion of Social Service Block Grant funds allowed for the expansion of respite care, crisis transportation, in-home crisis stabilization, and family preservation at various locations across the state. The CART program provides daily access to parents/teachers, doctor’s offices, emergency room staff or other community persons who identify a child experiencing a crisis. In FY2011, from July to May, statewide implementation indicates that there were 3,279 youths screened. Of those screened, 1,520



(46%) required a face-to-face assessment, and only 106 (3%) resulted in the child or youth's psychiatric hospitalization; thus demonstrating the effectiveness of CART's diversion. Approximately, 48% (1,573) of those served by CART were staffed for additional services. After the maximum seven day period of CART crisis stabilization, youth and their families may still require further in-home intensive services. Intensive in-home services may be provided through any of the available community based services such as FFT, MST, and Psychosocial Rehabilitation services with child providers.

The OBH also has a number of specialty initiatives that have focused on forensically involved youths. The OBH has partnered with the other child-serving agencies to develop and provide specific specialized services for children with SED in the child welfare, juvenile, or criminal justice system. Louisiana has participated as one of the States in the juvenile justice reform initiative funded by the John T. and Catherine D. MacArthur Foundation's Models for Change. This initiative has focused in part on expansion of treatment alternatives to incarceration. This has been a particularly effective collaboration in the Monroe area of Region VIII. In this area of the state, there is a strong collaborative of child and youth serving agencies that have come together to offer creative and effective community-based options for the children and youths served in this area. This is inclusive of an effective District Attorney diversion program and an enhanced system of managing and diverting the extensive referrals from the local schools. The OBH also continues to closely study issues relating to juvenile competency and to review programs in other States. The OBH received a \$40,000 grant in June 2010 to implement a pilot program in Orleans, St. Bernard, Plaquemines, Jefferson, and Caddo Parishes for youth who are found incompetent to stand trial and are in need of a more restrictive environment but do not meet the criteria for hospitalization. The pilot program will provide therapeutic foster homes (mentor homes) for a limited number of youth who are found incompetent to stand trial and need intensive supervision, as well as wraparound services and individual, group, and family therapy.

In spite of the consistent efforts by the OBH, it is acknowledged by the OBH Central Office that children's behavioral health services have been chronically underfunded and fragmented across multiple child serving agencies and departments. Availability of services (particularly effective, quality, culturally responsive services) is not consistent across the State. In response to the substantial gaps and fractured service delivery system, the Coordinated System of Care (CSOC) and Medicaid reform initiatives have been developed to address and eliminate these systems' level deficits. The CSOC is conceptualized upon the national standards of the system of care and should expand practices that support family involvement as a core component. The focus is not on looking to the State to maintain current operations or to expand already available services. Instead, CSOC offers the opportunity to partner with child-serving entities in communities and transform the care delivery system. Through the CSOC waiver, children who are at-risk for out-of-home placement will be able to access wraparound services through a Wraparound Agency (WAA) that will coordinate comprehensive children's behavioral health services and supports inclusive of: wraparound facilitation/child and family teams (CFTs); case conferences; independent living/skills building; short-term respite; youth support and training; parent support and training; and crisis stabilization. A commendable innovation within the Louisiana CSOC model is the Family Support Organizations (FSO) that will provide the services and support of youth and family mentors within the Child-Family teams. The CSOC proposes to fund these local family Peer Support programs by braiding Medicaid, Medicaid Waivers, and non-Medicaid funds. Families are viewed as critical to supporting their child's mental health and wellness. Currently, providers are expected to involve families in their child's treatment and provide linkages to supports and services to address families'

needs. Beginning on March 1, 2012, the CSoc will be phased in by region. Through a formal Request for Application (RFA) process, five geographic areas of the state were selected as the CSoc pilot sites. These sites were selected based on their readiness and the presences of necessary infrastructure such as community collaboratives being in place. A statewide implementation for CSoc is anticipated to be complete by 2013.

For children and youth not eligible for the CSoc (1915c) waiver, these individuals will be able to access many of the same comprehensive services that are managed through intensive care coordination as opposed to wraparound service provider. Like the CSoc waiver services, all children's behavioral health services will be managed through the Statewide Management Organization (SMO) that is scheduled to begin on March 1, 2012. Children and adolescents will be able to access general services such as pharmacy, clinic-based individual and family therapeutic services, community-based rehabilitation services, and school-based behavioral health services. Children and adolescents will also be able to access more intensive levels of care such as child therapeutic group homes (TGH); psychiatric residential treatment facilities (PRTFs); and inpatient hospitalization. All services will be managed with the goal of reducing redundant services for children and reducing the State's reliance on restrictive levels of care.

Management Systems (CMHS Block Grant Criterion 5)

Community Based Resources, Staffing, and Training of Providers

Budget issues, physician shortages and hiring freezes all continue to challenge the State as it moves forward to improve the service delivery system. As the state undertakes the transition toward managed care for service delivery of behavioral health services, workforce development activities have been recognized as essential to success. Each of the components of the overall Medicaid reform package requires extensive focus on workforce development, which should serve to address concerns regarding recruitment and retention of qualified staff as the OBH continues to focus on competency development, enabling staff to maintain the skills necessary to perform job functions.

The Coordinated System of Care (CSoc) will focus on the implementation of Systems of Care in five of the ten administrative regions across the state and workforce development will include at minimum training in Systems of Care Values/Principles, Wraparound approach, Cultural Competence, Family Driven Care, and Individualized Service Planning through Child and Family Teams. The implementation of Medicaid waiver services for Adults and Youth (not served under CSoc) will focus attention on existing and implementation of new Evidence Based Practices including Assertive Community Treatment, Intensive Case Management, Multi-Systemic Therapy, Functional Family Therapy, and Crisis Intervention/Stabilization, among others.

The OBH integration initiative will require training on factors that facilitate the successful integration of clinical and business models into a single, seamless practice model for Behavioral Health. Many of the trainings related to this integration effort have been directed toward helping each practice guild (mental health and addictive disorders) understand the other's philosophy. This includes the practical application of clinical and business practices in order to assess efficiencies and opportunities to synthesize and merge philosophies in the best interest of smooth, efficient clinic operations and to ensure that services are provided within the best possible contemporary milieu. Cultural competency has been identified as a core competency required of direct care across the initiatives outlined above. As OBH moves forward with the implementation of Medicaid reform (i.e., Louisiana Behavioral Health Partnership (LBHP), it will be doing so in a manner that maintains and further develops cultural competency in the workforce. A comprehensive training

plan has been developed, and the need for infusing cultural competency throughout professional and paraprofessional training has been identified. Specific contractual arrangements to provide targeted training from an expert in cultural competency have been detailed in the training plan. Given the exceptional need in this area, the OBH will provide funding and resources to target concerns or problems specific to minority groups.

The Office of Behavioral Health continues to make use of the Learning Management System, Essential Learning and will be incorporating the use of this platform and subsequent E-Commerce site development to ensure wide availability of training statewide. OBH continues to work with Essential Learning to ensure that courses are provided in an efficient manner, saving time and money. To ensure that training knowledge is transferred into practice, OBH will continue to measure outcomes, application of learning objectives and provide follow up review. The system will also allow the tracking of “live” trainings, and this capability will improve ability to consolidate training data and records, as well as report out on training provided and completed. OBH currently has over 3,700 staff enrolled in this EL system.

In spite of the anticipated expansion of the behavioral health workforce through Medicaid transformational activities, the state continues to require management of employee operations for state-operated hospitals, clinics, and facilities. In the several tables provided below, the current workforce is detailed. As already indicated, the state-operated systems have struggled with access to prescribers. In general as a result of budget deficits, the state-supported workforce has been downsized. There has been an insufficient number of direct service providers to address basic treatment and support needs of the community service population. A common complaint expressed in surveys of consumers is not being able to see their therapist or doctor often enough and having to participate in group treatment rather than more individualized treatment. Fortunately, through gubernatorial executive order, direct care workers have been excluded from the state-wide hiring freezes. To further enhance access to skilled prescribers, the OBH has developed a policy that permits local CMHCs to contract with or employ Medical Psychologists and Nurse Practitioners who can prescribe psychotropic medications.

The tables on the following pages detail further information regarding staffing resources.

**State Psychiatric Facilities Statewide Staffed Beds
(6/30/2011)**

Facility		Adult Acute Beds	Adult Civil Intermediate Beds	Adult Forensic Beds	Child and Adolescent Beds	Specialty Child and Adolescent Beds	TOTAL	
OBH HOSPITALS	Central State Hospital	0	60	0	0	0	60	
	Eastern Louisiana Mental Health System	Jackson and Greenwell Springs Campus	48	60	95	0	0	203
		Feliciana Forensic Facility	0	0	235	0	0	235
		Total for ELMHS	48	60	330	0	0	438
	Southeast Louisiana Hospital (Mandeville, LA)	32	94	0	30	20	176	
LSU-New Orleans/ Staffed by OBH	Moss Hospital	14	0	0	0	0	14	
	University Medical Hospital	20	0	0	0	0	20	
TOTAL STAFFED BEDS		114	214	330	30	20	708	

* Data from Daily Census Report - OBH does not get data from the LSU operated/staffed facilities

**Total Number of Hospital Intermediate Care Beds
by facility (6/30/2011)**

	Licensed Beds on 6/30/2011	Staffed Beds on 6/30/2011	% Staffed Average for Fiscal Year	% Occupancy Average for Fiscal Year
Central Louisiana State Hospital	196	128	66.6%	95.9%
East Louisiana State Hospital	362	268	81.8%	97.6%
Southeast Louisiana State Hospital	139	132	47.9%	91.9%
Feliciana Forensic Facility	235	235	100%	100%
TOTAL	932	762	--	--

* Data from Patient Population Movement Report and Daily Census Report

Numbers of Community Professional Staff Members by Discipline on June 30, 2011

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/PharmD
		Region/LGE	Doctoral*	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters		Bachelors
MHSD	12 (11.2)	3 0 MP	0	0	28	0	8	0	1	2	0
CAHSD	11(7 FTE)	3(2 FTE) 0 MP	0	0	71(47 FTE)	2 (1 FTE)	16 (11 FTE)	2 (1 FTE)	15 (10 FTE)	12 (8 FTE)	0
III	15	1 0 MP	0	0	8	0	12	2	16 (11 FTE)	6 (2)	3
IV	5(4.58 FTE)	0 0 MP	6	0	32	0	0	10	2	7	13 (3.6)
V	5(1.8 FTE)	0 1 MP	5	0	10	0	5	0	3 (2.2 FTE)	7	0
VI	4	3 0 MP	5	0	14	0	3	6	0	14	0
VII	6	2 (1 FTE) 0 MP	3	0	10 (9.8)	1	3 (2.8)	2	18	7	0
VIII	6(4.2 FTE)	2(0.5 FTE)/ 2 MP(0.5 FTE)	0	0	16	0	2	6	10	5	2(1.8 FTE)
FPHSA	12(6.4 FTE)	1(.075 FTE) 1 MP	0	1	36 (35.2)	0	3	3	1	2	1(.4 FTE)
JPHSA	12(9.64 FTE)	2 0 MP	0	0	57(54.1FTE)	4	7	2	23 (22.8)	21(20.33FTE)	1
Total By Discipline	88 (9.82 FTE)	16 (13.25FTE) / 4(2.5 FTE) MP	19	1	282 (254.1 FTE)	7 (6 FTE)	59 (53.8 FTE)	33 (32 FTE)	89 (78 FTE)	83 (74.33 FTE)	20 (9.8 FTE)

NOTES: (FTE listed only if not full-time) * MP=Medical Psychologist

Numbers of OBH Hospital Professional Staff Members by Discipline on June 30, 2011

Discipline	Psychiatry	Psychology		Social Work		Registered Nurse			Other		Other Physician/Doctorate
		Hospital	Doctoral & Medical Psych	Masters	DSW	Masters	Masters	Bachelors	Associate	Masters		Bachelors
CLSH	2	3	1	0	6	0	4	42	2	13	1
ELMHS	21	7 (3MP)	5	0	29	8	46	47	11	27	5
SELH	6	13	0	1	20	4	34	42	7	31	0
Total by Discipline	29	23	6	1	55	12	84	131	20	71	6

NOTES: (FTE listed only if not full-time) * MP= Medical Psychologist

OBH Mental Health Community Total Prescribing Workforce on June 30, 2011

Psychiatric Type	Total Number FTE Psychiatrists		Of Total Psychiatry FTE, Number Certified Child Psychiatrists		Total Number FTE Medical Psychologists		Total Number FTE Nurse Practitioners	
	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract	Civil Service	Contract
MHSD	9	3	0	0	0	0	0	0
CAHSD	8	5	18	14	0	0	2	0
3	6	5	0	0	0	0	2	1
4	4.5	1.3	1	.5	0	0.3	0	0
5	1	0.8	0	0	0	1	0	0
6	4	1	1	0	0	0	1	0
7	5.8	.8	0	.4	0	0	0	0
8	2	2.2	0	.2	0	0	0	0
FPHSA	3.2	3.2	1	1	0	0	0	0
JPHSA	8.98	0.86	2.63	0.33	0	0	0	0
TOTAL	52.48	23.16	23.63	16.43	0	1.3	5	1

OBH Hospital Psychiatric Workforce on June 30, 2011

Psychiatric Type	Number FTE Psychiatrists Serving Adults/Children		Number FTE Certified Child Psychiatrists		Hospital FTE Total Psychiatrists
	Civil Service	Contract	Civil Service	Contract	
Hospital					
CLSH	2	4	0	0	6
ELMHS	0	21	0	0	21
SELH	6	16	2	2	22
Totals*	8	41	2	2	49

CLSH = Central Louisiana State Hospital

ELMHS = Eastern Louisiana Mental Health System (ELMHS): Greenwell Springs Hospital, East Division, Forensic Division

SELH = Southeast Louisiana Hospital

OBH Community Staff Liaisons on June 30, 2011

Region/ LGE	FTE Child/Youth Family Liaisons	FTE Adult Consumer Liaisons
MHSD	1	.5
CAHSD	1	1
III	0	0
IV	0	0
V	.6	.8
VI	0	.65
VII	1	0
VIII	0	0
FPHSA	0	.6
JPHSA	2	0

Includes civil service and contract employees

Special Services and Supports

Housing Services and Homelessness (CMHS Block Grant Criterion 4)

The job crisis and lack of sufficient income denies many individuals and families the opportunity to participate in the free market society without supports to bridge the gaps to obtaining and maintaining housing and financial resources to prevent homelessness. The new faces of the homeless are a direct result of the struggling economy created by the housing crisis, record breaking unemployment and inflation that makes housing impossible to afford without subsidized assistance and services. The economy is critical to restoring jobs and housing stability. This is particularly significant since the areas of the state that were the most directly hit by the hurricanes of 2005 and 2008 were the areas that have traditionally had the greatest population, and therefore the highest rates of homelessness, as well as the highest numbers of people with mental illness. State housing recovery efforts for affordable housing continue amidst multiple barriers including changes in real estate development costs at all levels and local resistance to affordable housing development projects. After the devastating hurricanes, many individuals and families experienced homelessness for the first time. It was, ironically, not the last time for many of these individuals, since their housing assistance came to an end again with the closing of FEMA programs in 2009. It is difficult to estimate the number of people who continue to be affected by the hurricanes, because many of them have been in and out of different housing situations since the hurricanes occurred. The metropolitan areas around New Orleans continue to report problems, as do other areas affected by the hurricanes. The housing stock of affordable housing units with a subsidy is limited or in high crime areas that are undesirable.

Individuals with financial concerns, including many people with disabilities, are having an increasingly difficult time in retaining their housing and are at risk for homelessness. Those already homeless are facing significant barriers to obtaining housing they can afford. According to the National Low Income Housing Coalition, in Louisiana the Fair Market Rent for a two bedroom apartment is \$994 per month. In order to afford this level of rent and utilities without paying more than 30% of income on housing, a full time work wage of \$40,000 per year is required while the Supplemental Security Income is \$ 674.00 per month or \$ 8,080.00 per year. It is important to note that there has not been a cost of living raise in two years for the disability income populations by the federal government. In a defined time period following the 2005 hurricanes, the average SSI payment increased 16.4% from \$579 to \$674 per month. During that same time period, the federal minimum wage level increased

27.2% from \$5.15 to \$6.55. In contrast, the fair market rent for a 1-bedroom apartment, including utilities, in the Greater New Orleans area increased 52.4% from \$578 to \$881. As a result, many consumers were unable to maintain independent housing. Many of them lived with family members or friends, often in overcrowded environments. Some of them ended up in homeless shelters or on the streets because they were unable to stay permanently with family or friends.

Homelessness Estimates

The Department of Child and Family Services (DCFS) annual needs assessment/shelter survey is an unduplicated statewide count of the number of homeless individuals served by the homeless shelters in the State for the year. It also includes a point-in-time count that examines the subpopulations represented in the shelter county. In 2008, 199 shelters (78 percent) reported a total of 32,112 homeless individuals served. The survey data indicated the following for the subpopulations: severe mental illness – 3,927 (12.23 percent); chronic homelessness – 6,072 (18.91 percent); dual diagnosis – 4,942 (15.39 percent); substance abuse – 9,309 (28.99 percent); veterans – 3,692 (11.5 percent); and the elderly – 1,441 (4.49 percent). Experience suggests that persons with mental illness are underserved in the general shelter population and, therefore, there may be significant numbers of *unsheltered* homeless who have a mental illness. It is also likely that there are a number of persons *sheltered* who are undisclosed as having a mental illness and, therefore, their mental illness is undetected and not included in the count. In addition, prevalence of substance abuse among adults with serious mental illness is between 50-70%. Taking those factors into consideration, some sources

use the higher percentage of 30% in calculating homelessness for persons with mental illness. This would yield an estimate of the number of persons with mental illness, inclusive of those with co-occurring addictive disorders, who are homeless is approximately 9,634 persons, or 30% of the total 32,112 homeless served by the shelters who reported for the 2008 survey. The Shelter Survey is broken down by sub-population in the adjacent table. This sub-population breakdown relates to the primary reason a person is homeless, although it is recognized that homelessness is multifactorial, and some individuals may fall into more than one category.

Sub-population	Number	Percentage of Total
Severely mentally ill	3,927	12.23%
Chronic homeless	6,072	18.91%
Dual Diagnosed	4,942	15.39%
Substance Abuse	9,309	28.99%
Veterans	3,692	11.50%
Elderly	1,441	4.49%
<i>Other/ Not Reported</i>	2,729	8.50%
TOTAL	32,112	

The recent Point in Time (P-N-T) survey (2009) reported the total number of “literally homeless” persons in all of Louisiana was 5,994. Literally homeless persons are those who live in emergency shelters or transitional housing for some period of time, or who sleep in places not meant for human habitation (streets, parks, abandoned buildings, etc.) and may use shelters on an intermittent basis. The P-N-T survey was a statewide count of homeless persons done during the 24-hour period between noon, January 28th and noon, January 29st. It should be noted that the Point in Time survey is limited in its population coverage; for instance, unsheltered persons are difficult to identify and count, not all identified persons are willing to release information, and/or persons are undocumented because they do not seek services from a participating provider during the survey period. Therefore, by a conservative estimate, on any given day, there may be as many as twice the *reported* count of homeless adults and children living in Louisiana.

**Clients Reporting Being Homeless as of 6/30/2011
Compared to 6/30/2010**

Region/ LGE	Total number reporting homelessness as of 6/30/10	Of total number, how many were displaced by hurricanes/ disaster (6/30/2010)	Total number reporting homelessness as of 6/30/11	Of total number, how many were displaced by hurricanes/ disaster (6/30/2011)	Methodology used to arrive at these figures*
MHSD	8,725	n/a	6,687	n/a	Point in time survey
CAHSD	38,800	unknown	1,022	0	Point in time survey
Region III	397	0	1,014	0	HMIS Data, Point in time survey
Region IV	7,332	unknown	5,840	unknown	HMIS Data
Region V	115	unknown	263	9	Point in time survey
Region VI	46	unknown	38	unknown	HMIS Data
Region VII	3,633	0	764	0	Point in time survey
Region VIII	228	0	55	0	Point in time survey
FPHSA	357	unknown	281	Unknown	HMIS Data, Annual Shelter Survey, Point in time survey
JPHSA	331	0	261	0	HMIS Data

*HMIS: Homeless Management Information System Data

Other more local estimates of homelessness include the annual application from Louisiana Projects to Assist in Transition from Homelessness (PATH); estimates reflect that providers will serve 4,000 to 5,000 homeless persons with mental illness during FY2012 with Federal and matching PATH funds and other sources of funding. Annual data reported by PATH providers for the number of individuals enrolled in PATH in 2010 was approximate 1,400 (unduplicated count). This is less than a statewide estimate as PATH programs are not available in every Region/LGE. UNITY of Greater New Orleans, a non-profit organization for the homeless, estimates that there are approximately 8,725 homeless persons on any given day in the Greater New Orleans area alone who are in need of housing and supportive services, and approximately 40% or 3,490 have a mental illness.

Taken together, the deficits in affordable housing and the drastic increase in the cost of living in many areas of the state have generated a homeless crisis. The homeless crisis disproportionately affects the chronically mentally ill, most of whom are on a fixed budget and lack support systems. Particularly in urban areas, thousands of people inhabit abandoned homes, nearly 500 people fill the emergency shelters every night, and there are countless numbers of individuals living from ‘pillow to post’ and on the street. It is noted that U.S. Department of Housing and Urban Development (HUD) does not consider people who are in shelters, supportive housing and FEMA housing as “homeless” and therefore numbers that include people who are *displaced from their homes* are not technically ‘homeless’ and these numbers are actually much greater than reflected in the HUD counts.

Housing Programs

There are multiple providers of homeless programs in each area of the state. Each Region/LGE has a Continuum of Care for the Homeless that serves as the coordinating body for the development of housing and services to the homeless. The regional Continuums of Care incorporate a complete array of assistance for homeless clients from outreach services to placement in permanent housing. Both

private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance use and mental health disorder services. Services targeted to the elderly, children, youth and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. One of the greatest needs in Louisiana is the creation of housing that is affordable to persons living on an income level that is comparable to that of SSI recipients. That is, housing that is aimed at those individuals at and below 20% of Median Income. Supportive services necessary to assist an individual in remaining housed are also crucial. Efforts to increase available and appropriate housing for persons with mental illness through training and recruitment of housing providers and developers and development and access to support services continues to be a priority. The State is using a Housing First model, where the overall framework is that housing is a necessity and the primary need is to obtain housing first without any preconditions to services. The cause of homelessness should be addressed with a client-centered approach that helps individuals identify why they became homeless and avoid situations that cause homelessness to reoccur. Moreover, housing is a basic right, and should not be denied to anyone, even if they are abusing substances or refusing mental health treatment services. Housing First is endorsed by the HUD and considered to be an EBP and a solution to addressing the chronically homeless. OBH has a strong commitment to keeping families together and to increasing affordable housing stock.

There is much activity around assisting individuals with SMI to obtain and maintain appropriate housing. Many successful programs to assist individuals with housing needs are operating in each Region and LGE as can be seen in the table below:

**Housing Assistance Programs
by Region/Local Governing Entity (LGE) FY 2011**

Region/ LGE	# of Programs	# Referred Unduplicated	# Placed Unduplicated
MHSD	3 programs	unknown	272
CAHSD	2 programs	60	28
Region III	6 programs	472	126
Region IV	6 programs	149	483
Region V	9 programs	393	207
Region VI	5 programs	114	32
Region VII	4 programs	152	114
Region VIII	9 programs	254	144
FPHSA	2 programs	13	9
JPHSA	10 programs	527	262

The American Reinvestment and Recovery Act of 2009 includes about \$13.61 billion for projects and programs that are currently being administered by the Department of Housing and Urban Development. One goal of the Act was to stimulate the economy through access to affordable housing and protecting those in greatest need. The state has continued to pursue housing resources through the HUD McKinney-Vento funding streams such as the Continuum of Care Supportive Housing Program (SHP) for the Homeless populations and other HUD programs. The Section 811 and Section 8 programs are more housing resource programs with specific emphasizes on the Project Base Voucher (PBV) and the Shelter Plus Care (S+C) for the homeless and disability populations. In addition, OBH is developing partnerships with Rural Development housing programs and state Housing Authorities. The American Reinvestment and Recovery ACT of 2009 is a welcome housing resource to stimulate and provide bridge subsidy funds for some of our most vulnerable homeless and/or disability

populations. Specifically the Homeless Prevention and Rapid Re-Housing (HPRP) program has provided widespread relief. Louisiana received over \$26,000,000 in HPRP funding with DCFS Administering \$13.5 million and the other funds going to direct allocation to existing community providers. DCFS reports that approximately 60% of the HPRP funds have been utilized with an anticipated program termination date scheduled for June 30, 2012. The OBH goal is to continue collaboration across departmental agencies and to utilize all available housing funding resources to develop or partner with housing providers to develop a sufficient housing stock of affordable housing. While shifts in HUD policy have created barriers to persons with mental illness qualifying for housing resources through the Continuum of Care, and the Section 811 and Section 8 programs have been severely reduced, the HUD programs continue to be a focus of development activities. OBH Regional Housing Coordinators are active participants in the regional housing/homeless coalitions. In some cases these coordinators are in leadership positions in their local coalitions. Service providers have pursued Section 811 applications and sought to develop fruitful relationships with local Housing Authorities, 202 Elderly Housing programs and The Louisiana Housing Finance Agency to pursue disability required rental unit set-asides. In addition, UNITY, a local homeless continuum in metropolitan New Orleans, has recently responded to an RFP from SAMHSA with a proposal for the New Day Grant and Catholic Charities of Capital Area Baton Rouge has submitted an application for the Section 811 program. It is essential and critical that housing development continue with particular emphasis on strategies to coordinate tax credits, rental vouchers (Section 8 and Shelter + Care) and affordable financing. The Weatherization Programs and Rental Rehabilitation administered through our local Community Developments need continual funding and efficient access to assistance. Federal applications for housing and support services submitted by mental health providers have increased over the years as agencies search for avenues to develop housing and support services for the mental health consumers they serve.

Projects to Assist in Transition from Homelessness (PATH)

The Projects to Assist in Transition from Homelessness (PATH) program of CMHS is targeted specifically towards those homeless persons with severe mental illness and/or severe mental illness with a co-occurring disorder. Louisiana's PATH program provides a significant amount of *outreach* activity as well as other support services. The annual reports from Louisiana PATH providers for FY2011 anticipate that between 4,000 to 5,000 participants will be contacted or served during outreach efforts; however, it is estimated that 1,500 will be enrolled. The PATH expanded services to 8 of the 10 regions demonstrating efforts to provide homeless outreach and housing assistance to individuals with mental health issues and co-occurring disorders. For the federal PATH funding, Louisiana relies on in-kind and contractual contributions as its federal match. For FY11 the match amount is \$350,409.00. Virtually all of the PATH service providers are part of the local Continuum of Care systems for the homeless. As a part of the planning process, these coalitions participate and facilitate public hearings to request comment on the current use of funding to put an end to homelessness, and to provide opportunities for public comment.

Louisiana Road Home Recovery Plan

The Louisiana Road Home Recovery Plan, an initiative of the Louisiana Recovery Authority (LRA) has included the rebuilding of affordable housing in the areas most impacted by Hurricanes Katrina, Rita, Gustav and Ike. This has been accomplished through a system of funding incentives that encourage the creation of mixed income housing developments. This plan targets not only the metropolitan areas impacted by the hurricanes but also several of the rural parishes that were impacted by hurricane Rita. Included in this plan is the use of Permanent Supportive Housing as a model for housing and supports for people with special needs, such as people with disabilities, older people with

support needs, families with children/youth who have disabilities and youth aging out of foster care. It is a model that provides for housing that is fully integrated into the community. The model does this through setting aside a percentage of housing units within each housing development built to be used for persons in special population categories, and includes support services that are delivered in the individual's (or family's) home. Adults with SMI and families of children with emotional/behavioral disorders, and the frail elderly are included within the identified special needs population targeted for the supportive housing set aside units. The services to be delivered to persons/families in the target population will be those services likely to help them maintain housing stability. Effort and dollars have been put into Family Support Services, housing with individualized in-home supports, and other community-based services throughout the State.

The current PSH Initiative within OBH has been largely based upon the housing successes of the 2008 post-Hurricane Katrina era, when Louisiana advocated successfully with the United States Congress to provide 3,000 units of Permanent Supported Housing (PSH) to address the demand for affordable housing with support services in response to hurricanes Katrina and Rita. OBH, in partnership with other offices in DHH, disability advocates, and advocates for people who are homeless, actively pursued the inclusion of people with disabilities in all post-disaster development of affordable housing. These efforts resulted in a Permanent Supportive Housing (PSH) Initiative which successfully gained a set aside of 5% of all units developed through a combination of disaster-related housing development programs (including Low Income Housing Tax Credits) targeted to low income people with disabilities. OBH has been successful in obtaining initial funding sufficient to develop housing support services for 600 adults with mental illness (60 for each of the 10 planning regions) and 24 hour residential care beds to serve 100 people (10 for each of the 10 planning regions) in 2006. This program was successfully continued through FY2009, and program participants were transitioned to the federally funded PSH that had been previously advocated for in the United States Congress. Presently, the Department of Housing and Urban Development administers the PSH program with a subsidy administrator. The program continues to operate with plans to implement Medicaid funding for the support services. In addition, the ten year anniversary of the Olmstead decision of 1999 as well as the FY2011 budget restraints were strong motivators in the OBH's recent decision to decrease intermediate care hospital beds and instead embrace a community model of care using best practices like Housing First and Supported Housing Program (PSH), Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Forensic Assertive Community Treatment (FACT). The current OBH administration opted to increase the stock of permanent supportive housing; and consequently has withstood pressure to fund large residential treatment centers. Through collaboration across the DHH Housing Authority, OBH, and other agencies serving disabled populations, individuals with a disability who were being discharged from institutional levels of care were given a superpreference rating on the waiting list for PSH units. Through this special superpreference option, over 25 persons being discharged from the intermediate care psychiatric facilities were able to access an apartment unit with supportive services. This was the first time in years that some of these individuals resided outside of a restrictive level of care. Through these different PSH initiatives, OBH has recognized the importance of supportive services in combination with permanent housing as an absolute necessity to enhancing the opportunity for community integration, as well as maintaining housing, treatment services, financial benefits, mainstream resources and entitlements. Other items in the plan that further assisted individuals in making the often difficult hurdle of transitioning from institutional to independent living are rental bridge subsidy funding, the utilization of Consumer Care funds, and assistance with Olmstead grant funding. Of particular note has been the OBH pursuit of State General Funds for housing and support services throughout the last fiscal year to supplement therapeutic residential housing for individuals who were discharged to north Louisiana parishes where

PSH was not available. In these cases, housing coordinators creatively developed shared residential settings for a small group (no more than three individuals) into a supported housing model that provided Residential Intensive Service Teams (RIST) – a highly intensive level of support services that can be stepped down over time. In this model, persons recently discharged from a long-term psychiatric hospitalization are able to access the structure and support of care professionals, who are on site 24 hours per day. This model allows for the care professional to slowly transition to lesser and lesser levels of supervision and care that can be less abrupt and can provide a smoother transition for some persons.

Homeless Coalition

Each Region/LGE has a Homeless Coalition, an organization that addresses systems issues and coordinates services for the homeless. The Regional Homeless Coalitions incorporate a complete continuum of care for homeless clients from outreach services to placement in permanent housing. Both private and public agencies are members of these organizations. The programs provide outreach and/or shelter and housing services to the homeless, as well as substance abuse and mental health services. Services targeted to children, youth and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. Each year the state homeless coalitions host a statewide homeless conference to educate and promote homeless services and assistance along with presentations of Evidence Best Practices programs that are successfully implementing homeless services.

Children's Housing Services

Programs and services targeted to children, youth and their families who are homeless have been generally limited in the past; however, there have been strides to identify and improve a number of service gaps for children and youth who are homeless across the state. Many of the child-serving housing programs are specific to the local areas of Louisiana. A local non-profit in Baton Rouge, Church United for Community Development has applied for funding from US DHHS for Administration Children & Families Outreach Program. This will identify homeless youth up to 21 years-old who have been or are at risk of sexual abuse or victimization/exploitation. It will assist in locating shelter space and services. CAHSD has supported the application and will provide mental health/substance use disorder services to those youth meeting eligibility criteria as an in kind match for the grant application. In SCLHSA, the Haven (domestic violence shelter), Beautiful Beginning (homeless shelter for families), and Gulf Coast Teaching Family Services provide outreach to homeless youth through their shelters and work with the families. Runaway children and youth in Region III have been identified who are in need of housing, medical, mental health, and substance use disorder services. The homeless coalition has developed a program (Gulf Coast Teaching Family Services) funded by HUD (Basic Center Grant Program) that provides outreach, respite care, individual and family counseling, and case management to runaway homeless children and youth. The goal is to unite the children and youth with their parents. Another example exists in Region IV, where "Project Matrix" serves homeless families, including homeless children and youth. These and various other projects are funded through the Department of Housing and Urban Development's (HUD) Continuum of Care for the Homeless program. In Region V, there is Education Treatment Council's Harbor House and Transitional Living Program (TLP). Harbor House is a temporary shelter (standard stay is < 45 days) for homeless youth. TLP is an 18 month, independent living program for homeless youth funded through HUD Continuum of Care. There is 24 hour staff but it is considered a minimal supervision program. Although TLP is not solely for youth with a mental health diagnosis, it is an

option for transitional age youth with a mental health diagnosis as long as they meet their program criteria. They provide minimal outreach services as part of this program.

The issue of education for homeless children and youth is directly addressed in the McKinney-Vento State Plan for the education of homeless children and youth as amended by Title X, Part C of the No Child Left Behind Act of 2001, Public Law 107-110. Specific activities for school districts to address the needs of homeless (and highly mobile) families have been established. These activities include such things as: designating a liaison for the school district to act as a contact person, outreach worker and advocate for homeless families and youth; identifying local service providers (shelters, food banks, community agencies) for homeless families; and informing parents and youth of their right to public education, even if they do not have a permanent address. In Louisiana, expanded definitions have helped local school districts understand who may be in need of assistance. Children and Youth living in the following types of situations are eligible for assistance from local homeless educational programs:

- Children and Youth in Transitional or Emergency Shelters
- Children and Youth Living in Trailer Parks, Camping Grounds, Vehicles
- Children and Youth “Doubled-Up” in Housing
- Children and Youth Living in Motels and Weekly-Rates Apartments
- Foster Children and Youth
- Incarcerated Children and Youth
- Migratory Children and Youth
- Unaccompanied Minors: Runaways and Abandoned Youth
- Highly-Mobile Families and Youth

Employment Services

The Office of Behavioral Health (OBH) recognizes that work is a major component in the recovery process and supports consumers who have work as a goal. OBH had utilized Employment Specialist training and other related employment training available through The University of North Texas & the Federal Region VI Community Rehabilitation Continuing Education Program to build a cadre of trained Employment Coordinators in each Region. At this time, however, most Regional Employment Coordinators have additional duties and on average devote less than 25% of their time to employment issues. The merger of offices and subsequent layoff of staff, have left the position vacant in some Regions. Each of these issues has served to hamper efforts to increase employment initiatives. Though several regions have expressed an interest in hiring full time employment coordinators and have been working towards doing so, not many have been able to make this a reality to date.

To expand employment of persons with severe mental illness, OBH has promoted a strategy to actively seek and access opportunities external to OBH at the state and federal level to fund the further development of such services which expand employment opportunities. Such external opportunities may include, but are not limited to monies available for employment, employment services related to housing support, vocational rehabilitation services, and related employment services. Such funds are available through the Social Security Administration, HUD, Workforce Commission (formerly Department of Labor), the Rehabilitation Services Administration, and other Federal and state programs. The passage of the Federal Ticket to Work Program and the Work Incentives Improvement Act of 1999 make a large pool of federal dollars available for development of these employment related services.

OBH has active linkages to, and representatives serving on the advisory body of, the Louisiana Medicaid Infrastructure Grant (which facilitated the organization of the Medicaid Purchase Plan). Additionally, staff coordinates with other programs, and program offices, such as the Disability Navigator initiative through the Louisiana Workforce Commission (formerly Department of Labor), the Work Incentive Planning and Assistance (WIPA) program through both the Advocacy Center and Louisiana State University, Louisiana Rehabilitation Services, and other employment related work groups such as the WORK PAY\$ committee. This committee is comprised of community partners and is intended to further the employment of individuals with disabilities in the state of Louisiana. OBH is also working as a collaborative partner on both a state and regional level in the development and implementation of job fairs for individuals with disabilities throughout the state. This will be the 8th year of the job fairs, which have traditionally been held in October for National Disability Employment Awareness Month.

OBH Employment Liaisons and Consumer Liaisons continue to receive training in Benefits Planning, One-Stop, and Ticket-To-Work topics relevant to mental health consumers through Social Security Benefits Planning and the Workforce Commission (formerly Department of Labor). OBH continues to work with Louisiana Rehabilitation Services, as well as other program offices, seeking opportunities for increased collaboration for training and improvements in program design in order to better serve individuals as they transition to work. Specific areas of training include: issues related to employment, recovery and evidence based practices.

The Louisiana Work Incentive Planning and Assistance (LAWIPA) program helps Social Security beneficiaries work through issues relating to social security benefits and employment. The program is a coalition between the Advocacy Center of Louisiana and the LSU Health Sciences Center's Human Development Center. Many individuals with disabilities who receive SSDI and/or SSI benefits want to work or increase their work activity. One barrier for these individuals is the fear of losing health care and other benefits if they work. Valuable work incentive programs can extend benefits, but are often poorly understood and underutilized. The LAWIPA coalition educates clients and assists them in overcoming work barriers, perceived or real; and also focuses on improved community partnerships. Benefit specialists, called Community Work Incentive Coordinators, provide services to all Louisiana SSDI and SSI beneficiaries age 14 and older who have disabilities. OBH clinic staff and clients are able to work with Coordinators to help navigate the various work related resources (as offered in conjunction with the Ticket to Work program), and identify on an individualized basis the way their benefits will be impacted by going to work. The ultimate goal of the new WIPA coalition is to support the successful employment of beneficiaries with disabilities.

OBH has participated in the development and implementation of Supported Self-Employment (Micro enterprise) pilots in different regions of the state, and in the previous development and establishment of intensive employment placement and support pilots (Employment Recovery Teams) in two regions. OBH has also supported the continued implementation of an employment program through the Jefferson Parish Human Services Authority's community mental health clinic. The program continues with great success as the JPHSA staff collaborates with LRS, DOL and the Career Solution Centers, as well as actively works with their clinician promoting employment as a path to recovery.

Joint OBH-LRS efforts are aimed at offering consumers intensive individualized supports in order to assist them in seeking, finding, obtaining, and keeping employment in community based competitive jobs and/or self-employment. A joint LRS-OBH agreement spells out each party's areas of responsibility and supports regular collaboration between the agencies. OBH has conducted

Employment Needs Assessments with collaborative participation by LRS in each Area, and engages in routine joint regional meetings to: assess each Area's current employment initiatives; determine needs for enhancement/creation of new employment programs/opportunities for consumers; share information on current and planned OBH employment projects; develop/enhance cooperation with LRS and private employment providers; develop a database of employment related resources for each Region/Area.

Act 378 funds for adults can be used in any manner to assist the individual in remaining in the community. Should they need any type of job training or assistance in obtaining a job, or a job coach, these funds can cover those costs.

The overall goal of OBH employment initiatives is to create a system within the Office of Behavioral Health that will encourage and facilitate consumers of mental health services to become employed, thereby achieving greater self-determination and a higher quality of life, while helping consumers transition from being dependent on taxpayer supported programs, to being independent, taxpaying citizens contributing to the economic growth of our state and society. The national economy has made this goal an extremely challenging one at best. Nationwide, a suffering economy can have a spiraling effect as workers are laid off and the need for public assistance increases. However, when resources are not available, the solution-focused alternative is to assist clients in obtaining and maintaining employment through help with resume-writing, job searching, and interviewing skills.

Employment Programs Serving SMI by Region/Local Governing Entity - FY 2011

REGION / LGE	TYPE OF EMPLOYMENT SERVICE	NUMBER SMI SERVED	NUMBER SMI PLACED
MHSD	Employment/Pre-Employment Training Transitional Employment	Average 1,008/yr	unknown
CAHSD	Supported Employment	unknown	unknown
III	Employment Referral, Supported Employment	4	2
IV	Consumer Micro Enterprise, Employment Referral, Employment/Pre-Employment Training , Supported Employment	28	70
V	Employment Referral Employment/Pre-Employment Training	85	31
VI	Employment Referral Employment/Pre-Employment Training, Individual Placement and Support (IPS)	227	10
VII	Employment Referral Employment/ Pre-employment Training Supported Employment Transitional Employment, Individual Placement and Support (IPS)	35	10
VIII	Employment Training/Pre-Employment Individual Placement and Support (IPS)	162	128
FPHSA	Employment Referral	2	0
JPHSA	Supported Employment, Individual Placement and Support (IPS)	170	113
TOTAL		1,721	364

**Profile of Persons Served (CMHC)
Adult Clients by Employment Status
Louisiana OBH Outpatient Data PERSONS SERVED Unduplicated FY2011**

	Age 18-20		Age 21-64		Age 65+		TOTAL		TOTAL
	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	
Employed: Competitively Employed Full or Part-time (includes Supported Employment)	165	116	4,228	2,509	121	54	4,514	2,679	7,193
Unemployed	252	225	3,916	3,292	39	24	4,207	3,541	7,748
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc)	528	539	13,367	8,913	835	300	14,730	9,752	24,482
Employment Status Not Available	243	200	4,564	2,790	100	32	4,907	3,022	7,929
TOTAL	1,188	1,080	26,075	17,504	1,095	410	28,358	18,994	47,352

*Employment status at admission. Data from CMHC data: OBHIS and JPHSA. Unduplicated across Regions/LGE by client.
URS Table 4. URS Table 4 Profile of Persons Served CMHC, Adult Clients by Employment Status*

Employment Services for Youth

There are limited and generally locally developed employment programs for youths in the state. Many of these are disability specific but can be accessed by youths with behavioral health involvement. Some of the Regions/LGEs have highlighted some of these programs.

In the greater New Orleans area, the Workforce Investment Board Youth Council is sponsored by the Office of the Mayor of New Orleans. This group develops services for the city’s youth to prepare, enter, and succeed in the world of work; training and support are provided to youth and employers. The Metropolitan Human Services District has contracts and programs that assist adults, young adults, and families in their efforts to enter the job market and to stay employed. Referrals originate from many sources, including: community behavioral health clinics, Medicaid mental health rehabilitation programs, and case management agencies. MHSD is a Work Experience (WE) Program site for JOB 1, a program of Goodwill Industries of Southeastern Louisiana, Inc. and part of the Mayor of New Orleans’ Economic Development Team. WE provides on-the-job training for persons with limited or no previous work experience in an effort to help them develop basic work readiness skills, as a part of their effort to find permanent employment. In JPHSA the Adolescent Job Shadowing/Apprentice Program serves youth between the ages of 14 and 20. This program offers job readiness curriculum support as well as stipend exposure to the workforce with the assistance of a mentor.

In the greater Baton Rouge area, the Capital Area Human Services District (CAHSD) partners with Instructional Resource Centers and Transition Core Teams in local school systems to provide services to youth, especially as they transition from educational to vocational systems. Through efforts including planning meetings, transition fairs, interagency service coordination and family support coordination, CAHSD provides services for transition-aged clients with developmental disabilities, mental health disorders, and/or addictive disorders. Individuals who become clients of CAHSD mental health services are eligible for services from the La HIRE program that provides team building and intensive employment support. Services include case management, job finding, and other supportive services necessary to help consumers find and maintain employment. Louisiana Rehabilitation

Services serves ages 16-21 with Job Placement Services. The Transitional Core Team serves ages 16-21 with the Job Fair and Placement Services. LSU Youth Employment serves ages 16-21 with on campus employment. In January 2009, CAHSD filled its Employment Coordinator position and developed a new District-wide Employment Program to meet the employment needs of transition age youth and adults with emotional disorders/behavioral disorders, severe mental illnesses, addictive disorders, developmental disabilities, and co-occurring disorders, particularly those who are not served by the LAHIRE program.

SCLHSA serves ages 16-18 through Career Solutions: The Work Connection by assisting youth who are looking for job placement and career enhancement. In Region IV, Louisiana Rehabilitation Services assists individuals with disabilities to obtain job training or education and the National Guard Youth Challenge Program (ages 16-18) assists high school dropouts to obtain job training and a GED. The Lafayette Parish School System/Options Program assists high school students to obtain a certificate in a vocation when a high school diploma will not be obtained. Region V refers transitional age youth to Transition Workshops for training on adult issues, resume building, and networking. Calcasieu Parish Schools Job for Americas also offers a program in Region V to help high school students with job training, mentoring and job placement. Louisiana Rehabilitation Services (LRS) has a transitional age program to assist with job readiness and placement for individuals 17 years of age and older who are graduating from high school. Families Helping Families holds transition fairs and offers resources from area agencies to youth in grades 11 and 12. In Region VII, the Special Education Transition Team helps special education students connect with vocational services, trainings, and sheltered workshops. In the Florida Parishes Human Services Authority, The Youth Career Development Project, funded by a grant from the US Department of Labor, teaches construction skills to youth between the ages of 16 and 24 with little or no work history. Additionally, the public school system in this area offers various on-the-job trainings to students in special education classes. These trainings are provided by local businesses.

Educational Services

Louisiana OBH Supported Education is a program based on a 1997 OMH/Louisiana State University (LSU) joint research project concerning theories and models of Supported Education nationwide, and development of a '*Louisiana Model*' for Supported Education based on that research. The Louisiana Office of Mental Health initially funded the LSU Supported Education Program for students with serious mental illness (SMI). LSU became one of the first four year universities in the nation to have a supported education program in place and operational, with initiation of the program in 1997. Upon LSU's agreement to continue the program, OMH then moved the funding to the University of Louisiana at Lafayette (ULL). The ULL program became operational in the Fall Semester of 2000, with the University being fully able to sustain it internally as of 2006. Both LSU and ULL initially received funding with Block Grant monies to establish a Supported Education Advisor position within each university's existing services for students with disabilities. Each university historically agreed to contribute in-kind resources for the program and to continue the programs funding once the OBH "seed money" ends. To date, though the programs have continued at both LSU and ULL, there has been no expansion to other post-secondary educational settings. The Supported Education Advisor only serves those students identifying themselves as persons with Serious Mental Illness (SMI). The OBH-sponsored supported education programs provide both individual and group support to students with serious mental illness pursuing post-secondary education. Students also receive assistance with needed accommodations under ADA, as well as disability management counseling and information/referral to on and off campus agencies. The Supported Education Advisor serves as a case manager for students with SMI; is a liaison to the student's primary therapist; and serves as an on-

campus advocate. The focus is on attempting to minimize the impact of a student's psychiatric illness by determining what accommodations are needed in order for the student to successfully handle both academics and adaptation to the social milieu of the university. The long-term goal of the program is to see the student with SMI successfully complete a university education and enter the world of work in a career field of the student's choice. The program targets students with SMI of all ages, both those who are older and are (re) entering a secondary educational setting after years of mental health treatment, as well as those who are younger and may be experiencing psychiatric symptomatology for the first time. Thus the goal of the program is achieved through both funneling individuals back into the educational system as well as maintaining them there as they cope with the onset of their mental illness.

Referrals to the program come from a variety of sources, including: OBH Mental Health Clinics, the on-campus Mental Health Services of the universities, Louisiana Rehabilitation Services, and University faculty and staff. The largest referral source, however, continues to be self-referral by SMI students enrolled at each school who have been made aware of the program. Satisfaction surveys administered to students receiving services at LSU and ULL indicate a high level of satisfaction with services received. Both schools continue to do satisfaction surveys with current students, and follow-up with those who have graduated. Grade point averages have consistently been above average, suggesting that the programs are helpful.

Physical Health Integration

Individuals with Serious Mental Illnesses and Addictive Disorders often have co-occurring chronic medical problems. Therefore, it is important to enhance a collaborative network of primary health care providers within the total system of care. Louisiana's extensive system of public general hospitals provides medical care for many of the state's indigent population, most of whom have historically had no primary care physician. Individuals who are clients of State-operated Behavioral Health Clinics or Medicaid funded Behavioral Health Services also benefit from a systematic health screening. Thus, all clients receive a service plan that addresses all health needs including mental health and addictions. The OBH clinics work very closely with private health providers.

In some regions, hospitals began offering onsite medical services at the mental health clinics. Some clinics continue to integrate primary care activities into their main clinics, along with smoking cessation programs, diabetes screenings, and hypertension and cholesterol screenings. Wellness clinics and Medication Management clinics are becoming commonplace in the regions. The State is currently making plans to develop an infrastructure to accommodate the behavioral health needs of the increased number of citizens who will be newly insured. Integrated services already provided in addictive disorder programs include contractual services with primary care physicians 5-10 hours per week at residential facilities and in some outpatient clinics. These physicians provide screenings, interventions, and referrals for medical concerns as a result of laboratory work or patient report. Integration of services for mental illness with primary health occurs at various levels in inpatient and outpatient settings in the State.

The Louisiana Adolescent School Health Initiative Act (R.S. 40:31.3) authorizes the Office of Public Health to facilitate and encourage the development of comprehensive health centers in Louisiana's public schools, School-Based Health Clinics (SBHCs). Mandatory staffing in the SBHC must include a Master's level mental health provider and must include mental health services, including assessment, treatment, referral and crisis intervention, family counseling, and case management. Social services include assistance with Medicaid/LaCHIP and other health insurance enrollment. There were 62

School-Based Health Clinics (SBHCs) in 26 parishes serving 95 public schools and providing access to nearly 55,000 students during the 2008-2009 school year. For FY2010, Louisiana had a decrease in the Maternal and Child Health (MCH) Block Grant from \$480,000 to \$300,000, which is a primary funding source for SBHCs, but increased operation to 65 SBHCs. The SBHCs in Louisiana follow the *Principles, Standards and Guidelines for SBHCs in Louisiana*. These include guidelines for behavioral health care in individual and group settings. The SBHCs receive funding from the United States Health Resources and Services Administration (HRSA), DHH, and a number of charities and foundations, as well as Medicaid, LaCHIP, and private insurance.

In spite of these local and targeted measures to incorporate physical health services into a comprehensive package for behavioral health clients, the impact of these efforts has been limited. The Affordable Care Act offers some unique opportunities to address this concern for persons with behavioral health needs. The options are being considered and are being reviewed by the OBH. The OBH is also interested in continued collaboration with Federally Qualified Health Centers (FQHCs) for placement of behavioral health specialists in their facilities, along with the provision of education and increased clinical collaboration. The State plans to consider a system for coordinating health care for recipients who require case management services to avoid duplication and to ensure that the members' needs are adequately met. The unique parallel service systems transformations that involve Medicaid reform to both the physical health and behavioral health service systems has some potential for improving collaboration and meeting these needs for Medicaid recipients. The OBH is committed to developing and ensuring that the Statewide Management Organization(SMO) provide appropriate primary care referrals and adequate follow-up for the persons being served through the behavioral health system.

Special Populations

Older Persons (CMHS Block Grant Criterion 4)

Even though the Office of Behavioral Health system of care provides statewide access to mental health services for adults with SMI, including the population of older persons, services specific to older adults, aged 65 and older with SMI, are a statewide area of need. The DHH recognized this need in recent years and developed the Office of Aging and Adult Services (OASS). Although this new office is not limited to serving persons with mental illness, there has been increasing and stronger collaboration across the program Offices within DHH. The OBH continues to develop holistic initiatives that offer comprehensive and blended services for vulnerable adults experiencing psychiatric and physical trauma, including those in acute crisis. However, the OBH has no specific treatment programs for older adults. Specific Regions and LGEs report having some programming that targets older citizens; however, the needs are great and services are not consistent across the State for older adults. An older adult initiative was planned by OBH for FY 2010, whereby the OBH identified 1,500 adults aged 65 and older who were being served within the system.

Services provided typically to the general adult population with SMI include psychiatric evaluation, bio-psychosocial assessments, individual therapy and specialized group therapies and other evidence based treatments based on unique individual needs. Some clinics have benefits specialists who work with all populations, but particularly the elderly, to ensure that they receive individualized case management. Some clinics have assigned a registered nurse (RN) to deliver specialized health needs to the elderly population. Informal collaborative agreements exist with Federally Qualified Health Centers (FQHC) regarding persons with SMI who are older than 65. Mobile outreach teams provide therapeutic respite and linkage to community services.

Current fiscal year aggregate data indicates that more than eleven thousand (11,000) behavioral health services have been delivered to Louisiana seniors (aged 65 and over) throughout the OBH Regions and LGEs, with the overwhelming majority (over 10,000) being delivered in-person. The following tables represent the distribution of delivered services to seniors by OBH Region and LGE:

OBH Regions

SERVICE METHOD	REGION										TOTAL	
	Region 4		Region 5		Region 6		Region 7		Region 8			
	N	%	N	%	N	%	N	%	N	%	N	%
IN-PERSON	1,305	100.00%	289	98.20%	758	100.00%	312	99.60%	964	100.00%	3,628	99.80%
TELE-VIDEO	.	.	5	1.70%	.	.	1	0.30%	.	.	6	0.10%
TOTAL	1,305	100.00%	294	100.00%	758	100.00%	313	100.00%	964	100.00%	3,634	100.00%

Local Governing Entity (LGE)

SERVICE METHOD	LOCAL GOVERNING ENTITY (LGE)										TOTAL	
	2-CAHSD		3-SCLHSA		9-FPHSA		JPHSA		1-MHSD			
	N	%	N	%	N	%	N	%	N	%	N	%
IN-PERSON	1,834	100.00%	2,126	99.00%	816	100.00%	.	.	1,821	100.00%	6,597	83.90%
TELE-VIDEO	.	.	20	0.90%	.	.	.	.	.	.	20	0.20%
missing/unknown	.	.	.	.	.	.	1,238	100.00%	.	.	1,238	15.70%
TOTAL	1,834	100.00%	2,146	100.00%	816	100.00%	1,238	100.00%	1,821	100.00%	7,855	100.00%

The overwhelming majority of mental health conditions upon admission to community based services for Louisiana’s senior population are Major Affective Disorders followed closely by Psychotic Disorders. The below tables represent the distribution of primary admitting diagnoses for seniors:

OBH Regions

DIAGNOSIS: PRIMARY at ADMISSION	REGION										TOTAL	
	Region 4		Region 5		Region 6		Region 7		Region 8			
	N	%	N	%	N	%	N	%	N	%	N	%
ADJUSTMENT DISORDER	4	2.20%	.	.	.	.	1	1.90%	.	.	5	1.10%
ANXIETY DISORDER	6	3.30%	.	.	5	5.30%	.	.	3	3.20%	14	3.10%
CONDUCT DISORDER	1	0.50%	.	.	.	.	.	.	.	.	1	0.20%
DEMENTIAS	.	.	.	.	1	1.00%	.	.	.	.	1	0.20%
DEPRESSIVE DISORDER	9	4.90%	1	3.20%	13	13.90%	.	.	3	3.20%	26	5.70%
DIAGNOSIS DEFERRED	13	7.10%	1	3.20%	.	.	2	3.80%	.	.	16	3.50%
MAJOR AFFECTIVE DISORDER	80	44.10%	13	41.90%	32	34.40%	19	36.50%	42	45.60%	186	41.40%
MENTAL RETARDATION	2	1.10%	.	.	.	.	.	.	.	.	2	0.40%
OTHER DISORDERS	9	4.90%	1	3.20%	2	2.10%	.	.	3	3.20%	15	3.30%
PERSONALITY DISORDERS	.	.	1	3.20%	1	1.00%	.	.	.	.	2	0.40%
PSYCHOTIC DISORDER	54	29.80%	14	45.10%	38	40.80%	30	57.60%	41	44.50%	177	39.40%
SUBSTANCE/ETOH ABUSE DISORDER	.	.	.	.	1	1.00%	.	.	.	.	1	0.20%
V CODES	3	1.60%	.	.	.	.	.	.	.	.	3	0.60%
TOTAL	181	100.00%	31	100.00%	93	100.00%	52	100.00%	92	100.00%	449	100.00%

Local Governing Entities (LGE)

DIAGNOSIS: PRIMARY At ADMISSION	LOCAL GOVERNING ENTITY (LGE)										TOTAL	
	2-CAHSD		3-SCLHSA		9-FPHSA		JPHSA		1-MHSD			
	N	%	N	%	N	%	N	%	N	%	N	%
ADJUSTMENT DISORDER	6	2.00%	8	2.60%	2	1.40%	.	.	6	1.50%	22	1.70%
ANXIETY DISORDER	15	5.10%	7	2.30%	.	.	.	.	23	5.70%	45	3.50%
DEMENTIAS	2	0.60%	.	.	.	.	.	.	1	0.20%	3	0.20%
DEPRESSIVE DISORDER	28	9.60%	18	6.00%	9	6.30%	4	2.70%	25	6.20%	84	6.50%
DIAGNOSIS DEFERRED	.	.	6	2.00%	.	.	.	.	19	4.70%	25	1.90%
MAJOR AFFECTIVE DISORDER	116	40.00%	167	55.80%	57	40.40%	37	25.50%	145	36.20%	522	40.90%
MENTAL RETARDATION	1	0.30%	2	0.60%	.	.	.	.	1	0.20%	4	0.30%
OTHER DISORDERS	7	2.40%	10	3.30%	7	4.90%	.	.	15	3.70%	39	3.00%
PERSONALITY DISORDERS	2	0.60%	.	.	.	.	.	.	1	0.20%	3	0.20%
PERVASIVE DEV. DISORDER	.	.	1	0.30%	.	.	.	.	.	.	1	0.00%
PSYCHOTIC DISORDER	85	29.30%	67	22.40%	66	46.80%	15	10.30%	87	21.70%	320	25.00%
SUBSTANCE/ETOH ABUSE DISORDER	3	1.00%	2	0.60%	.	.	1	0.60%	10	2.50%	16	1.20%
V CODES	.	.	.	.	.	.	.	.	5	1.20%	5	0.30%
missing/unknown	25	8.60%	11	3.60%	.	.	88	60.60%	62	15.50%	186	14.50%
TOTAL	290	100.00%	299	100.00%	141	100.00%	145	100.00%	400	100.00%	1,275	100.00%

In addition to community based services for older persons, OBH works collaboratively with Medicaid, the Office of Adult and Aging Services (OAAS), and the Office for Citizens with Developmental Disabilities (OCDD) in identifying seniors with mental disorders who are nursing facility applicants and who may require specialized treatment beyond those traditionally offered in a nursing home setting. The collaboration is part of the federally mandated Pre-Admission Screening and Resident Review (PASRR) process. Presently, the OBH incorporates the use of web-based record filing and faxing to accommodate the transmission, receipt and storage of information obtained from hospitals and nursing facilities throughout the state. Expert psychiatric consultation is used for cases involving complex clinical presentations, and recommendations for nursing home placement and mental health treatment are made based on a comprehensive review of clinical information.

The table below represents the number of seniors evaluated to date by OBH for nursing home placement and mental health treatment in the current fiscal year:

Recommend Nursing Home Placement without Mental Health Treatment	92	37%
Recommend Nursing Home Placement And Mental Health Treatment	158	63%
Total	250	100%

Seniors referred to OBH by the OAAS who have been recommended for mental health care are tracked and monitored to ensure the delivery of services. Services are provided by an array of mental health

care providers including Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP), Community Mental or Behavioral Health Clinics and Psychiatric Nurse Practitioners.

Rural Populations (CMHS Block Grant Criterion 4)

A *Rural Area* has been defined by OMH using the 1990 U.S. Census Bureau definition: A rural area is one in which there is no city in the parish (county) with a population exceeding 50,000. Louisiana is a largely rural state, with 88% (56) of its 64 parishes considered rural by this definition. Estimates from the most recent Census Bureau statistics (7/1/2009) indicate that there are 1,135,163 rural residents and 3,356,913 urban residents in Louisiana. There is an OMH mental health clinic or satellite clinic in 45 of these 56 rural parishes. There is a Mental Health Rehabilitation provider located in most of the rural parishes.

Although OBH has placed many effective programs in rural areas, barriers, especially transportation, continue to restrict the access of consumers to these rural mental health programs. Transportation in the rural areas of the state has long been problematic, not only for OBH consumers, but for the general public living in many of these areas. The lack of transportation resources not only limits access to mental health services, but to employment and educational opportunities. The resulting increased social isolation of many OBH clients with serious mental illness who live in these areas is a primary problem and focus of attention for OBH. Efforts to expand the number of both mental health programs and recruiting of transportation providers in rural areas are an ongoing goal. However, due to fiscal reductions, some of these less productive satellite and outreach sites have been eliminated. In many cases, community-based services such as ACT or ICM have been made available to serve some of these populations. One desired outcome of the transfer of the management of behavioral health services to a State Management Organization is the expectation that such managed care companies will be able to build a robust provider network, even in the more rural areas of the state. The advancement of telemedicine options maintained within the Medicaid reform is also expected to extend services to the less populated areas of the state.

RURAL TRANSPORTATION PROGRAMS FOR SMI/EBD 2010-2011

Region/ LGE	Type of Programs	# of Rural Programs
MHSD	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	4
CAHSD	Medicaid Transportation, City/Parish Transportation; Local Providers	27
III	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	10
IV	Medicaid Transportation, City/Parish Transportation, Local Providers	8
V	Medicaid Transportation; City/Parish Transportation; Local Providers, Other	20
VI	Medicaid Transportation, City/Parish Transportation, Local Providers, Others	16
VII	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
VIII	Medicaid Transportation, City/Parish Transportation, Other	7
FPHSA	Medicaid Transportation, City/Parish Transportation, Local Providers, Other	23
JPHSA	Local Providers, Other	2
TOTAL		140

RURAL MENTAL HEALTH PROGRAMS FOR SMI/EBD 2010-2011

Region/ LGE	Name/Type of Programs	# of Adult Rural Programs	# of C/Y Rural Programs
MHSD	CMHC, Satellite Clinics, ACT Teams, Drop-In Centers, Other	8	1
CAHSD	CMHC, Satellite Clinics, ACT Teams, MHR Agencies, Other	3	2
III	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	11	8
IV	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	18	6
V	Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-in Centers, MHR Agencies, Support Groups, Other	21	13
VI	CMHC, Satellite Clinics, Outreach Sites, ACT Teams, Mobile Outreach, Drop-In Centers, MHR, Support Groups, Other	24	15
VII	CMHC, Satellite Clinics, ACT teams, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	8	5
VIII	CMHC, Satellite Clinics, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	26	23
FPHSA	CMHC, Satellite Clinics, Outreach Sites, Mobile Outreach, Drop-In Centers, MHR Agencies, Support Groups, Other	24	10
JPHSA	Other	0	1
TOTAL		143	84

CMHC= Community Mental Health Clinic
 ACT= Assertive Community Treatment Team
 MHR= Medicaid Mental Health Rehabilitation Program

Overview of the Louisiana Addictive Disorder Service System

Addictive Disorder Service System Array

OBH continues to maintain a full continuum of substance use disorder treatment for all levels of care, even though budgetary restraints have forced significant reductions. Programs statewide, in both urban and rural areas, include residential/inpatient, intensive outpatient, outpatient, detoxification (social, medical, and medically supported), community-based (halfway-houses, therapeutic communities and three quarter homes), and recovery home services. During SFY 2011, OBH admitted a total of 27,572 individuals into its substance use disorder treatment continuum, and a total of 459,892 services were provided, inclusive of all levels of care, as per the Louisiana Addictive Disorder Data System (LADDS). Currently, Block Grant funding is used for intensive outpatient, outpatient, social detoxification, halfway-house, and residential/inpatient levels of care. It is also used for services provided to special populations as required by Block Grant guidelines, as well as funds Recovery Home Outreach Workers.

Since the Office for Addictive Disorders merged with the Office of Mental Health to become the Office of Behavioral Health (OBH), barriers to accessing coordinated care for co-occurring disorders have been greatly reduced. In FY2011 services for both mental health and addictive disorders have been provided by one organization, and in many areas, by the same clinic.

The OBH's implementation of process improvement strategies has also increased access to care, helping providers deliver the "right type of service to the right client, at the right time and at the right intensity." By defining the target population and appropriate service mix, implementing centralized screening and scheduling, and instituting walk-in appointments, wait lists for services have been dramatically reduced. In some cases, clinics maintain no wait lists, and in others wait lists have been reduced from months to weeks or days. These activities have expanded access, improved provider productivity, and have generally moved the behavioral health clinics toward a higher practice standard. OBH continues to utilize outpatient as the single point of entry to access addiction services, with some modifications occurring at the local level due to the recent co-location of many addiction and mental health programs. Some Regions/LGEs have developed an access unit at each clinic while other Regions/LGEs have implemented an access point, such as a single clinic, where all admissions are processed (*SAPT Block Grant Federal Goal 1: Improving Access to Prevention and Treatment Services*).

MOST COMMONLY ABUSED SUBSTANCES		
#	Substance Name	% of Population
1	Alcohol	30.2%
2	Cocaine	22.4%
3	Marijuana	21.7%
4	Opiates	10.7%
5	Heroin	2.6%
6	Methamphetamine	2.3%
7	Methodone	1.9%

The trends of substance abuse reported in Louisiana by individuals admitted in SFY 2011 include alcohol, tobacco, marijuana, cocaine, heroin, opiate medications for pain, and anxiety medications. The table on the left shows the most commonly abused substances. SFY 2011 data of the substance use disorder treatment population indicates that of the individuals engaged in treatment, 15.2% were admitted with an alcohol problem only, 42.3% were admitted for treatment of a drug addiction only,

INDIVIDUALS SERVED (BY AGE)	
Age Group	% Served
18 and Under	8.7%
19 – 30	37.3%
31 – 50	45.1%
51 and Over	8.9%

and 38.7% were admitted for treatment of both alcohol and drug addiction. The table on the right shows the age groups of individuals served in SFY 2011. In addition to those populations previously

mentioned, those individuals admitted for the treatment of gambling addiction represented 1.9% of the population.

There are currently more than 1,200 individuals per day on a waiting list for 24-hour substance abuse treatment in Louisiana.

The Office of Behavioral Health provides access to substance use disorder treatment services through a statewide infrastructure of providers that work together in a seamless system of recovery-oriented care, with a range of services accessed according to the assessment of severity of an individual's substance use disorder. Louisiana's continuum of care is modeled on the American Society of Addiction Medicine (ASAM) levels of care and is designed to place individuals in the least restrictive level of care appropriate to the need and to progress to less intensive levels of care until recovery can be sustained with minimal help (*SAPT Block Grant Federal Goal 10: Process for Referring*). The Office of Behavioral Health and its treatment providers utilize an electronic version of the Addiction Severity Index (ASI) assessment interview for adults and the Comprehensive Adolescent Severity Inventory (CASI) assessment interview for adolescents with a patient placement Decision Support Summary (DSS) component for both adults and adolescents. This Decision Support Summary is a tool that guides patient placement decisions and provides an integrative summary based on six dimensional problem areas used by the American Society of Addiction Medicine (ASAM).

OBH funds a full continuum of substance use disorder services, from prevention to brief screening and intervention, and from detoxification to residential and outpatient levels of care. All Block Grant requirements related to the OBH system of care are communicated through contractual agreements, with language that addresses the details related to termination of the agreement due to lack of compliance.

Prevention

The state's goal is to build, operate and maintain a prevention system that is family-focused, evidence based, outcome driven and cost effective. This mission includes reducing high risk behaviors associated with alcohol, tobacco and other drug (ATOD) use and increasing the availability and effectiveness of a general health promotion and education message (*SAPT Block Grant Federal Goal 2: Primary Prevention Services*). Prevention services are provided across the State of Louisiana to individuals of all ages and their families. Every effort is made to fill gaps and provide services to those populations of the State that data indicates are underserved.

The Office of Behavioral Health continues with the vision that prevention is a process that helps create, reinforce, and support healthy behaviors and lifestyles through the lifespan. As part of the merger of mental health and addictive disorders, prevention planning efforts have expanded in scope and not only consist of educating citizens about addiction, but about mental health issues as well, more specifically about the prevention of suicide. Suicide prevention activities have been rolled into the plan for prevention services statewide and will be delivered through the existing education infrastructure already utilized for substance abuse prevention. The ultimate goal is to create and operate a seamless system of care that includes primary prevention, intervention, and treatment services for both mental health and substance use disorders.

Prevention Strategies

During SFY2011, 52 Community-Based Prevention Providers and 10 Community Synar Projects were funded and provided services in the areas of Information Dissemination, Education,

Alternative Activities, Problem Identification and Referral, Community-Based Process and Environmental. The Community-Based Prevention Providers implemented 20 evidence-based programs. Three of these providers implemented the Children’s Program Kit for children of addicted parents. The Synar Projects and the evidence-based programs funded by the Block Grant were 100% evidence-based. In addition, the Prevention Management Information System (PMIS) documents that the Strategic Prevention Framework State Incentive Grant (SPF-SIG) funded one parish coalition that provided one (1) evidence-based prevention program of the twenty (20).

Information Dissemination: All OBH contract providers provide information specific to their program and ATOD to the communities in which they reside. OBH also maintains at least one (1) Regional Alcohol and Drug Awareness Resource (RADAR) Associate Network in each of the ten (10) Regions/Local Governing Entities (LGEs). OBH, through its PMIS system, confirms that this Information Dissemination strategy impacted 266,784 citizens and delivered 954,664 pieces (704,735 by contractors; 249,929 by agency staff) of ATOD literature during SFY2011. Contract staff dedicated 1% of staff time to the strategy of Information Dissemination. OBH agency staff dedicated 12% of staff time to this strategy. Provider and agency staff provided the following services: ATOD literature, audiovisual materials, clearing house, curriculum materials, attended health fairs, health promotion events, media campaigns, printed material, public service announcements, RADAR, resource directory, speaking engagements and telephone information.

Education: OBH contract providers provide on-going prevention education from evidence-based curriculums to enrollees in their respective program(s). During SFY2011, OBH confirmed through its PMIS system that evidence-based services were provided to 77,171 enrollees exceeding the 25,000 target. This represents a 7% increase over FY2010 (72,095). Also, 597,739 pieces of ATOD prevention literature were distributed. Of the 77,171 individuals enrolled in evidence-based programs, 5,293 were from a SPF-SIG sub-recipient. The SPF-SIG sub-recipients implemented the Staying on Track program. The following table lists the 20 Evidence-Based Educational Programs that were funded during FY2011 designated by Universal, Selective, or Indicated.

Universal Evidence-Based Program	Selective Evidence-Based Program
Life Skills Training	Children Program Kit
Project Northland	Strengthening Families
Staying on Track (SPF-SIG)	Guiding Good Choices
Kids Don't Gamble... Wanna Bet?	Life Skills Parent
Positive Action	Atlas (SPF-SIG)
Too Good for Drugs and Violence	Selective Program Total: 5
Second Step	
Project Alert	Indicated Evidence-Based Program
Coping Skills	Leadership and Resiliency
Al's Pal	Indicated Program Totals
Protecting You-Protecting Me	
Guided Imagery Program	
Project Toward No Tobacco Use	
All Stars	
Universal Program Total: 14	

Five areas of the state exceeded the state average of 7,717 enrollees per Region/LGE - MHSD, Region IV, Region VI, Region VII and Region VIII. These Regions/LGEs registered a total of 53,536 enrollees in their programs, representing 69% of the services delivered. Contractor staff dedicated 97% of services to the strategy of Education, exceeding the 80% target.

Alternatives: Prevention contractors have the option of providing alternative strategies through in-kind contributions to their respective target population(s) as appropriate. OBH, through its PMIS system, confirms contractor staff dedicated 1% of services to the strategy of Alternatives during SFY2011, which is well below the 5% maximum target. Provider staff provided alcohol, tobacco and other drug-free events, community drop-in center activities, community services, and youth and adult leadership functions to 12,546 participants during the target period and distributed 10,847 pieces of ATOD literature. OBH also implemented the evidence-based Leadership and Resiliency Program. These programs served an additional 496 enrollees with program-specific alternative activities and distributed 2,568 pieces of ATOD literature.

Problem Identification and Referral: OBH continues to provide problem identification and referral services to all State employees through the existing Employee Assistance Program (EAP). Currently, EAP is a peer-referral program only and does not provide direct services. OBH tracks the number of referral requests, referral sources, and identified problems. Contract providers are responsible for ensuring access to community resources by referring participants and/or their families for services not provided by the contractor. OBH, through its PMIS system, confirms that less than 1% of provider services were dedicated to the strategy of Problem Identification and Referral, and providers disseminated 1,211 pieces of literature to 689 participants during SFY2011. Providers referred customers to services that included DUI/DWI/MIP services, as well as student and employee assistance programs. Providers delivered these services on an individual basis and in venues such as adult education classes, suicide prevention workshops and teen job fairs.

OBH Prevention Services maintains the EAP, which is available to all State Employees and identifies those experiencing problems that interfere with the normal performance of work duties. OBH maintains the EAP contact information on their website for all regions of the state, and provides technical assistance to agency staff regarding tracking EAP referrals in the PMIS database. According to the Prevention Services SFY 2011 Report, OBH Staff dedicated 2% of staff time to the strategy of Problem Identification and Referral, and EAP services were provided to 92 state employees, with a total of 239 referrals to services being made. Problem Identification and Referral was done chiefly by phone, but also in person at meetings and through presentations. Agency staff disseminated 689 pieces of literature to stakeholders. The following are examples of presenting problems: Abuse, Child Welfare, Elderly Issues, Employment, Family Counseling, Financial, Insurance, Legal, Medical and Mental Health, Retirement, Substance Abuse, Support Groups, Student Assistance and Other Reasons.

Community Based Process: The Office of Behavioral Health (OBH) continues to develop a comprehensive, research-based approach to prevention services. In an effort to mobilize communities, OBH staff and contractors participate in the implementation of the Strategic Prevention Framework. This Framework includes the following steps: 1) Needs and Resources Assessment; 2) Assess and Build Capacity; 3) Select Appropriate Programs, Policies and Practices; 4) Implement Selected Programs, Policies and Practices; and 5) Evaluate Outcomes. OBH, through its PMIS system, confirms that OBH agency staff dedicated 88% of staff time to the strategy of Community-Based Process during SFY2011, exceeding the 40% target. Providers dedicated 2% of

staff time to the strategy of Community-Based Process. Agency and provider staff participated in accessing services and funding, assessing community needs, community volunteer services, community needs assessment, community team activities, contract monitoring, formal community teams, professional development, strategic prevention planning, technical assistance and training. Agency staff provided community-based process services to 26,226 participants and distributed 36,789 pieces of ATOD prevention literature. In addition, provider staff provided community-based process services to 11,592 participants and distributed 14,004 pieces of ATOD prevention literature.

Environmental: OBH continues to fund a Synar Contractor in each region of the State in an effort to maintain no more than a 10% sale rate of tobacco products to minors. OBH staff and contractors actively scan their respective communities and regions to identify and collaborate with other agencies and organizations (i.e. Coalition for Tobacco Free Living, Students Against Destructive Decisions, American Lung Association, etc.) that are engaged in environmental strategies that address substance use disorders and related behaviors.

Provider and agency staff participated in alcohol use restrictions in public places, changing environmental laws, community mobilizing for change on alcohol, social norms campaigns, social marketing campaigns, compliance checks of alcohol and tobacco retailers, environmental consultation to communities, establishing ATOD-Free policies, prevention of underage alcoholic beverage sales, public policy efforts, checking age identification for alcohol and tobacco purchased, minimum age of seller requirements, policies concerning cigarette vending machines and alcohol restrictions at community events. These activities impacted 2,370 participants and distributed 1,099 pieces of ATOD prevention literature. OBH, through its PMIS system, dedicated 2% of agency staff time to Environmental strategies during SFY2011. Synar Provider Staff dedicated 100% of provider staff time to Environmental Strategies and provided merchant education to 4,426 retail outlets.

Louisiana Caring Communities Survey

OBH co-sponsored, along with the Department of Education (DOE), the 2010 Louisiana Caring Communities Survey (CCYS) for 6th, 8th, 10th and 12th graders. The 2010 survey was very successful, with a total of 113,414 participating students. Of all participants, data from 105,814 students were accepted for analysis. The students participating were from 709 schools in 67 Local Education Agencies (LEAs), with 62 parishes participating. Results of the survey are outlined in State, Regional and Parish reports, which are posted on the OBH website for review and use by the general public. School level reports are available only to the Superintendents of each Parish. OBH will provide a community tool for reviewing CCYS Reports. PowerPoint templates for State, Regional and Parish level data is being distributed to OBH and DOE to ensure consistency and accuracy of presentations made utilizing CCYS data. Technical assistance will be provided as needed to the Regions/LGEs as they present the data to their LEAs.

Task Force to Prevent Underage and High Risk Drinking

OBH coordinates and participates in the State's Task Force to Prevent Underage and High Risk Drinking. During SFY2011, the Center for Substance Abuse Prevention's (CSAP) South West Regional expert served as the chair and OBH staff served as members of the Task Force. There were meetings of the Task Force several times during the year, and the Task Force held two Orange Ribbon planning meetings in March of 2011. At the request of the Task Force, Governor Jindal

issued proclamations announcing April as Alcohol Awareness Month and proclaiming the week of April 5th as Orange Ribbon Week.

A Youth Public Policy Institute was held in St. Francisville, Louisiana on April 1-3, 2011 as a training opportunity for young people prior to Orange Ribbon week. This event brought together high school students from across Louisiana to develop policy recommendations to prevent underage drinking. Also, students from this event were selected to speak at the Orange Ribbon rally. The purpose of the institute was to introduce students in grades 10-12 to administrative and legislative policy-making as it relates to underage drinking and the traffic fatalities that result from it. Workshops covered how policy is created, amended and changed at the local and state levels as well as how students as citizens can be involved. Students identified and selected issues of interest related to underage drinking (local ordinances or policies like fairs and festivals or state level issues like the loophole that allows 18 year olds into bars) and created action plans around those issues as part of the institute.

The students that participated in the Youth Public Policy Institute developed three policy recommendations: raise the age to enter a bar in Louisiana from 18 to 21, have alcohol moved to the back of convenience stores and close all bars at the same designated time. The “21 to enter” recommendation was sponsored by State Senator Crowe as a bill in the 2011 legislative session. Although the bill did not pass, the whole experience was an exciting learning opportunity for Louisiana youth leaders. A rally and press conference was held on the front steps of the Louisiana State Capitol on **April 5, 2011** to announce Louisiana's commitment to the prevention of underage drinking. Students and interested parties from across Louisiana attended the rally to show their support of this campaign. Approximately 200 students from around the state were present for the rally. Schools were able to receive Orange Ribbon material kits upon request.

The Task Force to Prevent Underage and High Risk Drinking was disbanded and returned to the umbrella of the Prevention Services Committee which is a part of the Louisiana State Drug Policy Board, late in the first quarter of 2011. This is the body from which the Task Force was originally formed. The Prevention Services Committee's Goal Group 3 continues to work on the mission of reducing the consumption and consequences of alcohol use.

Louisiana Higher Education Coalition to Reduce Alcohol, Tobacco, and Other Drugs

OBH funded the Louisiana Higher Education Coalition to Reduce Alcohol, Tobacco, and Other Drugs (LaHEC) during SFY2011. LaHEC stimulated vision and commitment for the LaHEC mission within/among all institutions through collaboration among higher education staff/faculty as well as key community and state stakeholders. LaHEC facilitated communication within/among all member institutions through monthly emails and telephone communication with liaisons at the thirty-five institutions of higher education. A new LaHEC website was launched to make data from the CORE Alcohol and Drug survey for institutions of higher education and other useful resources available to LaHEC institutions. Additional capacity among Louisiana institutions of higher education was also sought during SFY 2011 as evidenced by extending invitations to nine technical colleges to join the coalition and participate in the 2011 administration of the CORE survey. LaHEC also organized and implemented professional development between/among LaHEC institutions of higher education in the state for the purpose of establishing campus-community coalitions throughout Louisiana that address environmental problems related to substance use through policy education, policy development, policy enhancement, and policy enforcement (using

a public health model). On-site regional and individual institution technical assistance and coalition building took place at four sites in different regions of the state during November, 2010.

OBH sponsors the administration of the bi-annual CORE Alcohol and Drug survey for institutions of higher education across the state of Louisiana. The CORE survey was conducted in spring 2011. Thirty-five institutions of higher education participated in this survey, which produced a sample size of almost 10,000 students. The CORE survey will be administered again in spring 2013. OBH also sponsors an annual LaHEC Summit to assess and address high risk behaviors and plan interventions for institutions of higher education. The 2011 LaHEC Professional Development Summit was held on August 11-12, 2011 with the overall goal of mobilizing institutions of higher education and community stakeholders to address the issue of alcohol, tobacco, and other drugs in collegiate populations by utilizing empirical data to inform interventions, programs, and policy change. There were 128 participants registered for the two-day Professional Development Summit, representing 25 of the 35 institutions of higher education and various state agencies and community stakeholders. A total of six sessions were provided, including presentations on 2011 Core Survey Results; Statewide Trends in High School Students' Substance Use and Antisocial Behavior; Contemporary Issues in Campus Alcohol Enforcement; Substance Abuse Awareness Initiatives in Historically Black Colleges and Universities (HBCU's); Shaping Healthy Collegiate Environments to Reduce the Harms Resulting from College Student Drinking; and The Application of Core Data to Inform Programming and Interventions at LaHEC Institutions. All the Summit presentations as well as educational documents/website links will be made available through the LaHEC website. All Summit participants completed an evaluation of the Summit, and an analysis and report on these evaluations is being prepared by LaHEC staff.

Prevention Workforce Development

OBH Prevention Services (through a contractual agreement with Southern University Baton Rouge) offers web-based courses to meet the educational requirements for employees, contractors, and other interested persons to become certified or licensed prevention professionals and to further develop the prevention workforce in Louisiana. Two courses (Prevention Professional Seminar and Tobacco Seminar) are provided online and two courses are offered onsite (Prevention Ethics and Cultural Competence). Courses provided online utilize a real-time web-based platform called WIMBA. In WIMBA, participants and a facilitator(s) log on at a prescribed time and are able to interact, view the same documents and discuss materials simulating a classroom setting.

The Prevention Professional Seminar provides the fundamentals of prevention as a science and emphasizes the transition of Louisiana's focus from a risk and protective model to the public health model. The public health model incorporates the Strategic Prevention Framework (SPF) as the focus is on environmental strategies to make population level changes rather than only individual changes through programs. Also, SPF project directors and staff persons' engagement in OBH's trainings demonstrate evidence of prevention workforce development. The two onsite courses were offered in two regions of the State during each semester (Fall, Spring, Summer). Exam Preparation Sessions are offered 4 times each year to 4 regions of the State the month prior to the actual exam in an effort to cost-effectively make training accessible across the state.

OBH and partnering agencies (State Cadre of Trainers) also provide a minimum of two (2) Substance Abuse Prevention Specialist Trainings (SAPST) each year. For FY2011, the SAPST training was provided in October 2010 during each Saturday of the month. The SAPST provides no

less than 30 hours of Continuing Education with the following modules being covered: 1) Introduction to Prevention (i.e., History, View Points, Building Blocks); 2) Prevention Research; 3) Prevention Program Planning; 4) Facts about Drugs and Prevention Terms; 5) Cultural Context and Ethics of Prevention; 6) Using Human Development in Prevention; 7) The Media and Prevention; 8) Evaluation; and 9) Prevention Certification. The Southwest Center for the Application of Prevention technologies (SWCAPT) also provides two (2) 6 hour Ethics Trainings and one (1) 3 hour Ethics Trainings.

Through a contractual agreement with Southern University in Baton Rouge beginning fall 2010 through summer 2011, 10 online courses and 2 off campus courses were provided with 217 students completing the courses. The courses are offered to meet the needs of the prevention field throughout the state. Agencies that have participated in the courses include Department of Health and Hospitals, Department of Education, and Governor's Office Staff. Safe and Drug Free School and Communities grantees are also encouraged to participate in the training. Additionally, the field of prevention is an academic option in the Department of Psychology at Southern University; students are recruited into the field through this mechanism.

OBH also hosted and participated in the 4th Annual Suicide prevention and Awareness Conference, 2010 Louisiana Safe and Drug Free Summit, 4th Annual Children's Mental Health Summit, and Strategic Prevention Immersion Training with a total of 77 participants and 39.8 contact hours being provided.

OBH, in partnership with the Governor's Office and Southern University, provided training in the Strategic Planning Framework Curriculum, June 7-10, 2011. Thirty-two individuals were in attendance to include OBH Regional Staff, SPF-SIG staff, and staff from the Louisiana Higher Education Coalition. Follow-up trainings have been scheduled for the remainder of this calendar year to refresh participants on the components outlined in the SPF Curriculum.

Tobacco Regulation and Youth Access Control

Louisiana utilizes environmental, legal, and community-based strategies to reduce the access of tobacco products to minors (*SAPT Block Grant Federal Goal 8: Tobacco Products*). Louisiana has in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco to sell tobacco to persons less than 18 years of age. The State enforces this law by conducting random, annual, and unannounced inspections of tobacco distribution outlets and must achieve an inspection failure rate that is no more than 20 percent. OBH's overall success rate at reducing the availability of tobacco products to minors has been consistently far below 20 percent and Fiscal Year 2011 is no different.

OBH funds ten (10) regional Synar contractors to provide merchant education through unconsummated compliance checks of tobacco retailers. OBH also contracts with the Office of Alcohol and Tobacco Control to conduct the random, unannounced inspections necessary to complete the required Annual Synar Report. The OBH Synar Coordinator is responsible for monitoring contract deliverables as outlined in the contract between OBH and the Louisiana Office of Alcohol and Tobacco Control (OATC). OATC is expected to conduct 2,400 random, unannounced compliance checks of tobacco retailers annually. Of these 2,400 compliance checks, 1,000 are conducted for the Annual Synar Report and 1,400 are conducted routinely throughout the year.

During the Annual Synar Survey, referred to in Louisiana as the Annual Synar Report, three layers of monitoring are employed to ensure accuracy of the data. Each agent, who is employed by the Office of Alcohol and Tobacco Control, reviews the tobacco retailer compliance check form before submitting the form to his/her supervisor. Then, the supervisor reviews the form before sending the form to OATC headquarters. Finally, the State Synar Coordinator reviews each form before sending to the Synar Principal Investigator. Synar Contractors are monitored programmatically on a monthly basis by OBH Regional Prevention Coordinators (RPC's) who conduct monthly Statement of Work compliance and quarterly Facility, Staff and Policy reviews. Synar Contractors submit Tobacco Retailer Unconsummated Compliance Check forms to OBH through the PMIS web-based computer system.

Brief Intervention

OBH has coordinated efforts with the Office of Public Health to improve statewide birth outcomes via ongoing implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative, aimed at enhancing statewide education and screening of pregnant women for addictions, depression, and domestic violence. In SFY 2011, the SBIRT project in Louisiana assumed a new name and an expanded focus. Now called the *Birth Outcomes Initiative*, the project has been elevated to a health care priority under the Louisiana Department of Health and Hospitals (DHH), Office of the Secretary. One of the goals of the newly formed *Birth Outcomes Initiative* is to advance behavioral health screenings for alcohol and tobacco use in prenatal health care. This is in keeping with SAMHSA's long range goal of incorporating substance use screenings as a routine component of primary healthcare. The *Birth Outcomes Initiative* will use state general funds to draw down Medicaid dollars, and provide reimbursement to private physicians for screening pregnant women for alcohol and tobacco use. The instrument that physicians will be required to use is still under consideration, but the project is considering the *Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)* instrument instead of the *4 P's Plus* that has historically been used. This is essentially a cost saving measure since there are no proprietary costs associated with the *ASSIST* instrument.

The Office of Behavioral Health is collaborating with the *Birth Outcomes Initiative* by providing financial and advisory support. OBH will continue to contribute \$233,000 per year to the project's overall budget, as well as provide consultation as needed. Additionally, all OBH offices/contractors are working closely with the *Birth Outcomes Initiative* to assure timely access to services for pregnant women by adhering to priority admission guidelines.

Substance Use Disorder Treatment for Adults

The Office of Behavioral Health maintains a continuum of substance use disorder treatment services throughout the State (*SAPT Block Grant Federal Goal 1: Improving Access to Prevention and Treatment Services*).

Detoxification Services

Detoxification treatment offers a range of intensity of services. This level of care can be provided in an outpatient or the individual's physical status can be severe and acute enough to warrant primary medical and psychiatric care on a twenty-four hour basis. Treatment in this level assures a safe withdrawal and stabilizes the individual. Specific services provided depend on the acuity and severity of the individual's problem and are described below.

Ambulatory Detoxification - This is an outpatient clinic service for non-severe or life-threatening withdrawal, provided the individual’s living environment is stable and contains adequate social supports.

Social Detoxification - This is a twenty-four hour residential service in a non-hospital setting which provides safe withdrawal and transition to ongoing treatment.

Medically Monitored/Supported Detoxification/Non-Hospital setting - Twenty-four hour service provided in a residential, free standing, non-hospital setting with twenty-hour nursing coverage and physician availability. Medication dispensation and monitoring of withdrawal symptoms is also characteristic of this service.

Medical/Medically Managed Detoxification/Hospital setting - Full-service hospital setting with 24-hour availability of nursing and physician care for medication dispensation and monitoring of all medical and withdrawal symptoms.

Programs	# Programs	# Beds
Social Detoxification	4	33
Medically-Supported Detoxification	6	66
Medical Detoxification	2	32

During SFY 2011, the service delivery system for detoxification services consisted of four social, six medically supported and two medical programs with a total capacity of 131 beds provided through state-operated and contract facilities. According to the Louisiana Addictive Disorders Data System (LADDS), there were 5,510 client admissions during SFY 2011 to detoxification programs statewide - 1,324 to social, 2,011 to medically supported, and 2,175 to medical. OBH strives to maintain bed capacity for detoxification services; however, reductions in social detoxification bed capacity have already occurred for SFY 2012 due to budget deficits as well as changes in the service delivery system through privatization efforts.

Outpatient Treatment

Outpatient services represent the least restrictive and lowest intensity of care and are intended for those individuals who need some treatment, but whose problems have a low severity rating. Services are provided as needed, typically once a week, for fewer than nine hours a week for adults and fewer than six hours a week for adolescents. As part of the continuum of care, outpatient treatment can also be a “step down” from more intense levels of care, for those individuals who have progressed and no longer need more intense services. Services can include education and individual, family, or group counseling. Outpatient services remain the single point of entry for addiction treatment. During SFY 2011, OBH had a total of 13,837 outpatient client admissions and provided 383,409 services in the outpatient setting per LADDS. Counselors/Clinicians in OBH treatment programs provided services as clinically indicated and assumed the responsibility of providing case management/care coordination services. These services included but were not limited to referral, discharge planning, and aftercare treatment.

With the merger of the Offices of Addictive Disorders and Mental Health into the Office of Behavioral Health, several Regions elected to implement a combined access unit that screens for both mental and addictive disorders and refers to addiction, mental health, or co-occurring services. Others have designated an access point, such as one clinic, which complete all admissions.

Adaptation of screening, assessment and referral protocol will be continued in the future to accommodate the implementation of the new Statewide Management Organization, as well.

**Number and Location of Substance Abuse, Mental Health
and Behavioral Health Outpatient Clinics (as of 6/30/2011)**

Region / LGE	Total Clinics	MH Clinics	SA Clinics	BH Clinics
MHSD	8	1	2	5
CAHSD	7	3	2	2
SCLHSA	8	4	4	0
Region IV	5	0	0	5
Region V	4	0	1	3
Region VI	11	2	9	0
Region VII	9	0	7	2
Region VIII	11	0	6	5
FPHSA	12	6	6	0
JPHSA	4	0	1	3
Total	79	16	38	25

Intensive Outpatient Treatment

Intensive Outpatient services are offered to individuals who need more intense treatment than is offered in outpatient, but do not require the frequency and intensity of residential or inpatient treatment. Services offered in this level of care are the same as those in outpatient (including compulsive gambling counseling), except that they are offered more frequently. Typically, intensive outpatient services are provided to the individual for at least nine hours per week for adults, and at least six hours per week for adolescents, three or four times a week. During SFY 2011, OBH had a total of 290 intensive outpatient client admissions and provided 9,620 services in the intensive outpatient setting per LADDS.

Residential/Inpatient Treatment

The residential/inpatient level of care provides services for those individuals who need relatively intense treatment in a structured environment. There are four subcategories of intensity within this level of care, ranging from low-intensity treatment to medically-monitored intensive inpatient services. Services provided in this level of care are dependent on the severity of the individual’s disorder, and are available twenty-four hours a day. The Office of Behavioral Health (OBH) funds residential/inpatient programs in every Region/LGE of the state. OBH also funds one inpatient program for compulsive gambling treatment that provides services for the entire state.

Programs	# Programs	# Beds
Adult	19	520
Adolescent	4	135
Women and Dependent Children	7	108

These inpatient facilities utilize standardized treatment services which included assessments, drug testing, individual therapy, group therapy, family therapy, primary educational services, medical services and STD/ TB/HIV services. Services also include treatment for co-occurring disorders as well as recreational therapy and social/life skills training.

In SFY 2011, OBH maintained nineteen adult short-term residential/inpatient programs, located in five Regions and four LGEs throughout the State, having a total bed capacity of 520. There were a total of 4,102 admissions to Inpatient Adult programs and 1,495 admissions to Residential programs. Approximately 18,664 services were provided to individuals receiving inpatient and residential services. These services were delivered by both state-operated and contract providers throughout the state.

Also during SFY 2011, six state-operated inpatient facilities were privatized as part of the statewide plan for privatization of adult inpatient services, as privatization is considered a more efficient means to deliver services. These addictive disorder inpatient facilities were notified of the privatization intent in March of 2010, Requests for Proposals (RFP) were developed and the target date for the change was October of 2010. Efforts were made to assure a continuous delivery of services when transitioning to private contractors. Clinics were opened across a staggered time continuum to avoid service disruptions.

Halfway Houses

Following the completion of primary inpatient treatment, Halfway Houses provide community-based care and treatment. Individuals are provided with transitional arrangements, support, counseling, room and board, social and recreational activities, and vocational opportunities in a moderately structured, substance-free environment. Halfway Houses focus on re-socialization and encourage individuals to resume independent living and functioning in the community.

Three-Quarter Way Houses

This program is less structured than a Halfway House, and continues to provide a support system for the recovering individual. Individuals are able to function independently in a job situation. The Three-Quarter Way House functions as a source of peer support and supportive counseling. This level of service provides a monitored environment designed to promote the maintenance of the individual's level of functioning and prepare him or her for independent living.

Therapeutic Community (TC)

This community-based program provides a highly structured environment designed to treat individuals who have demonstrated a pattern of recidivism or a need for long-term residential treatment. This is a unique program in that it relies on the social environment to foster changes in the individual, while promoting self-reliance and a positive self-image. In general, this program lasts a minimum of 12 months.

Recovery Support Services

Services to support the recovery of an individual are a vital part of successful treatment. Such services help an individual to sustain the positive behavioral and lifestyle changes made during their treatment, and foster relapse prevention. Examples of Recovery Support services are housing, job readiness, transportation and child care.

Access to Recovery

The United States Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) awarded Louisiana its first Access to Recovery grant (ATR-I) in 2004. The Access to Recovery (ATR) program was created as a Presidential initiative to provide client free choice among substance abuse clinical treatment and recovery support providers, expand access to a

comprehensive array of clinical treatment and recovery support options (including faith and community-based organizations), and increase substance abuse treatment capacity. The Louisiana ATR-I program targeted all residents of the State with special emphasis on women and adolescents with substance use disorders. In 2007, Louisiana was one of 19 states and 5 tribal organizations out of 40 applicants that were awarded a second Access to Recovery (ATR-II) grant. This grant provided \$13.4 million over a three year period to assist in closing identified gaps in substance abuse treatment and recovery support services for those adults and adolescents involved in the criminal justice system and methamphetamine users.

Through the ATR grant awards, Louisiana developed a unique and comprehensive electronic voucher and clinical case record system that continues to provide clients with freedom of choice for clinical treatment services and recovery support services. Supported by State general funds, OBH utilizes ATR to expand treatment services and to supplement its continuum of care with the following recovery support services: Alcohol and Drug Free Social Activities, Anger Management, Care Coordination, Childcare, Family Education, Halfway House, Job Readiness, Life Skills, Pastoral Counseling, Recreational Therapy, Spiritual Support, Transitional Housing, and Transportation. Through recruitment and workforce development efforts, the ATR program has expanded the treatment capacity and expertise of the Faith-Based and Community-Based providers; serving as a model for continued provider network development for OBH. ATR is a performance based program, with ongoing participation as a provider determined by each agency's individual performance and outcomes when compared to similar provider agencies in the State. Approximately 4,371 people were engaged in ATR services in SFY2011, of which 69.6% completed treatment. ATR is a treatment model that works with people who may not typically be engaged in traditional treatment models; and it offers a service system of community and faith-based providers that are better able to adjust to the cultural needs of the populations they are serving in their local communities.

The ATR voucher program and web-based voucher management system has served as a prototype for the knowledge and movement of OBH into a managed care environment, and the ATR staff continue to work in collaboration with the Louisiana Behavioral Health Partnership (LBHP) to build strategies for rebalancing funding to include Medicaid and State General Funds. ATR vendors have been included in the dialogue regarding plans to pursue and achieve accreditation standards in order to serve the Medicaid population. As of June 30, 211, the ATR budget has been sustained at \$7.2 million for SFY 2012 with state general funds.

Louisiana Access to Recovery (ATR) Vendors

Region or LGE	ATR Vendors
MHSD	2
CAHSD	8
SCLHSA	2
Region IV	5
Region V	0
Region VI	0
Region VII	3
Region VIII	6
FPHSA	2
JPHSA	5
Total – June 30, 2011	33

Oxford Houses

OBH no longer participates in the SAPT Block Grant option to maintain a revolving loan fund process for the development of recovery group homes (*SAPT Block Grant Federal Goal 7: Development of Group Homes*). Historically, home loans were made available by the State for the development of Oxford homes - democratically run, self-supporting and drug free homes that follow the Oxford House, Inc. model. All of these home loans have been paid in full, and Oxford chapters now make home loans directly through the home office, Oxford House, Inc. During FY 2011, OBH and Oxford House, Inc. maintained a contractual agreement to monitor and promote the development of Oxford homes throughout Louisiana. OBH continues to make referrals to Oxford homes on a statewide basis and Oxford Outreach Workers and Regional/LGE Administrators continue collaborations to locate and lease housing to serve recovering individuals. Oxford homes are currently in all Regions/LGEs of the state with 58 operational homes and a total of 432 beds. Of these homes, 43 are for men with 309 beds, 14 are for women with 114 beds, and 1 is for women and children with 9 beds. The Oxford House Inc. contract provides for two Outreach Workers, one male and one female. The female homes are monitored by the female Outreach Worker, and the male homes are monitored by both Outreach Workers. An OBH Program Manager conducts quarterly teleconferences with Regional Administrators/LGE Executive Directors and Oxford Outreach Workers. The bed utilization rates, home status reports, new home openings, home closures or moves, Oxford Model presentations and future goals are discussed during these teleconferences. Vacancies as well as any problematic issues are discussed as well. Oxford House, Inc. opened its first women and children's home in the Baton Rouge Chapter in 2011. Due to budget restraints, OBH no longer pays for resident attendance at the Oxford National Conference but continues to provide funding for the state conference.

Co-Occurring Disorder Treatment for Adults

Reports published in the Journal of the American Medical Association (JAMA) indicate that approximately half of individuals with severe mental health disorders are also affected by addiction. The same reports reveal that 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness, and that out of all those diagnosed with mental illness, approximately 29% abuse either alcohol or drugs. Current data indicate that out of all individuals treated in Mental Health programs, 49% have a co-occurring addictive disorder. It is also estimated that 46% of consumers treated for addictive disorders have concurrent mental illness.

Evolution of Integrated Treatment

In 2003, the State of Louisiana was part of the first cohort of states awarded the Co-Occurring State Infrastructure Grant (CoSIG) – an integrative project between the Office of Mental Health (OMH) and the Office for Addictive Disorders (OAD). The goal of this initiative was to address infrastructure changes required within the two program offices to better meet the needs of the co-occurring populations, which provided much of the framework for building an integrated outpatient behavioral health system. The initiative addressed ease of access to needed services, and required systematic changes to collaboratively improve treatment outcomes for persons with both mental illness and addictive disorders. The grant funded statewide trainings for all service providers within the Offices of Mental Health and Addictive Disorders to better screen, assess, engage, and treat individuals with co-occurring disorders.

As a result of the CoSIG grant, the Louisiana Integrated Treatment Services Initiative (LITS) was created. LITS was also a joint effort between the Office of Mental Health and the Office for

Addictive Disorders. The mission of LITS was to develop a system in which all mental health and addiction treatment programs are expected to be Co-Occurring Diagnosis Capable (CODC). Standards include screening all adults for the presence of co-occurring disorders, assessing the level of severity, and treating co-occurring disorders in a coordinated manner that is both seamless and person-centered. At the completion of the CoSIG initiative, the primary clinics in every Region and District were able to reach at least a status of Co-occurring Capability as defined by the Dual Diagnosis Capability Assessment Tool (DDCAT). Many of the COSIG supported clinics reached beyond this level and moved toward integrated care and the development of clinic operations that reached a status of Enhanced Co-occurring Capability

In an effort to provide distinction for those counselors who have achieved a specified level of expertise in the treatment of this population, the Louisiana Association of Substance Abuse Counselors and Trainers Certification and Examiners Board now offers the Certified Co-Occurring Disorders Professional (CCDP) credential and the Certified Co-Occurring Disorders Professional Diplomat (CCDP-D) credential. An increase in properly trained and certified personnel helps ensure better treatment for individuals with co-occurring disorders.

2011 Co-occurring Efforts

Execution of needed programmatic changes to integrate mental health and substance use disorder treatment clinically and administratively is a current priority of the newly created Office of Behavioral Health (OBH). In June 2011, the Center for Substance Abuse Treatment (CSAT) State Systems Technical Assistance Project (SSTAP) provided onsite technical assistance to the OBH to assist with the integration of co-occurring services in Louisiana. The goals of this technical assistance were to: (1) help OBH identify opportunities to integrate co-occurring services statewide; and (2) provide recommendations and options for improving the efficacy, adequacy, and quality of co-occurring services within the State. Using Region IV as a site model, the structural (facilities, licensure, funding, data management), programmatic and client level factors of integration efforts within the State were reviewed.

A primary recommendation of the review team is for the State to consider the development of a “framing document” specific to the issues of integrated services for individuals with co-occurring disorders that lays out the vision for the system and offers recommendations to Regions/LGEs on how to operationalize integrated mental health and addiction treatment services. The framing document could address elements that expand access to service, redistribute resources, enhance the efficiency of service delivery, and provide a vehicle for pursuing other funds. Sample documents to guide the OBH strategic planning for co-occurring service integration were provided to the State, as well as examples of integrated licensing standards from other states. This on-site technical assistance venue was also used to discuss options for bi-directional integration of behavioral health services and primary care, as well as recommendations on how OBH can **operationalize** the use of the Network for Improvement of Addiction Treatment (NIATx) model and Service Process Quality Management (SPQM) technologies to implement system and program enhancements within the behavioral health integration plan (see *Section F: Quality Improvement Reporting* for additional information on NIATx and SPQM).

Business Model and Treatment Clinical Protocol workgroups have been established and include leadership of the Deputy Secretary of Systems of Care, the Medical Director, OBH State office staff, and Regional administrative and clinical staff. These workgroups are charged with developing protocol to accommodate both mental health and substance use disorders in the same

treatment episode, as appropriate. As a component of this protocol, all regional providers will utilize the Dual Diagnosis Capability in Addiction Treatment (DDCAT) to assess their co-occurring capabilities.

During SFY 2011, OBH maintained the Red River twenty-seven (27) bed Co-Occurring Inpatient Unit in Pineville, Louisiana (Region VI). Red River was one of 6 facilities included in the current statewide plan for privatization of adult inpatient services that began in SFY 2010, as privatization is considered a more efficient means to deliver services. Through the RFP process, a contract was awarded to Pathways Community Behavioral Healthcare, Inc. and the facility was transferred to their operation in February, 2011. The Red River Co-occurring Inpatient Unit administered by Pathways will continue operations addressing all four (4) behavioral health quadrants - low mental health/low substance abuse, high mental health/low substance abuse, high substance abuse/low mental health, and high mental health/high substance abuse - for individuals diagnosed as having both mental health and addictive disorder needs.

Substance Use Disorder Treatment for Adolescents

The Office of Behavioral Health (OBH) offers inpatient/residential, halfway house, outpatient and intensive outpatient to Adolescents. The twenty-four hour facilities accept statewide admission. Outpatient programs are also available statewide.

OBH has continued to maintain specialized intensive outpatient treatment (IOP) programs for adolescents throughout the State until recent budget cuts reduced those services. Adolescent IOP programs are presently funded with state general funds, and several Regions/LGEs were unable to maintain their adolescent IOP programming due to budgetary cutbacks. At the time of this reporting, there are approximately six adolescent IOP programs statewide located in the following Regions/LGEs: New Orleans (MHSD), Houma/Thibodaux (SCLHSA), Lafayette (Region IV), Lake Charles (Region V), Monroe (Region VIII), and Jefferson Parish (JPHSA).

During SFY 2011, OBH maintained four (4) adolescent residential programs with a total statewide bed capacity for adolescents of 135. The Springs of Recovery Center - a state operated facility located in Greenwell Springs (CAHSD) - was privatized in March 2011 through a contract with Pathways Community Behavioral Healthcare, Inc. The remaining three facilities maintained the same contract provider as in previous years - Gateway Adolescent Treatment Center, Cavanaugh Center, and Odyssey House, located in the Alexandria (Region VI), Shreveport (Region VII), and New Orleans (MHSD) areas respectively.

The Springs of Recovery Center maintained fifty-four (54) inpatient beds (38 male beds and 16 female beds). Eight of the 38 male beds were transitional beds. Designated beds were utilized for either males or females dependent on need. If applicable, adolescents received additional services by transferring to the *transitional program* for an additional 45 to 180 days. Services provided in this program included: therapeutic services, social skills training, and educational services (GED). Males at the Springs of Recovery participated in the Boy Scouts Venturing Program, which is focused on fitness, good citizenship, leadership skills, outdoor activities, and service to the community. Eligible males and females received recovery support services through the Access to Recovery (ATR) program.

Gateway Adolescent Treatment Center continued to provide residential treatment services for twenty-six (26) adolescents, ages 12-17. Twenty of these beds were allocated as male beds and six

beds were allocated as female beds. The average length of stay at Gateway Treatment Center was between 45-50 days. Treatment was provided utilizing the psychosocial service model, with a strong cognitive behavioral approach. The facility utilized community resources to address the needs of the co-occurring population.

Cavanaugh Center maintained fifteen (15) residential beds. Designated beds were utilized for either males or females, dependent on necessity. The average length of stay at this facility was between 60-120 days. The facility admitted adolescents between the ages of 12 to 17. Cavanaugh utilized the Twelve Step Minnesota Model for Recovery as their primary therapeutic approach. The facility also maintained fourteen (14) halfway house beds for adolescents who were in need of a longer length of stay.

Odyssey House became fully operational in February, 2010 with forty (40) adolescent beds, which provided expanded capacity for adolescents in the greater New Orleans area. Odyssey House utilizes a cognitive behavioral model based on the Living in Balance Curriculum. The program operates on a Points and Level System, in which clients earn points that enable them to progress in curriculum levels. There are four levels to complete before a client may graduate, with each level lasting approximately two weeks. Clients can move up or down in levels depending on what goals are completed according to their treatment plans. While the program is structured to last eight weeks, the length of stay varies based on the need for each client.

Screening and Assessment (CASI)

The Office of Behavioral Health and its treatment providers continue to utilize an electronic version of the Comprehensive Adolescent Severity Inventory (CASI) for adolescents with a patient placement decision component. The assessment tool developed by Kathleen Meyers, Ph.D. incorporates best practices for adolescents and addresses the client's health status, stressful life events, educational status, social networks and support, peer relationships, sexual behavior, family relationships, legal issues and mental health status of the adolescent client and other pertinent issues. Clinicians also utilize a Decision Support Summary tool which is embedded within the Access to Recovery (ATR) and Louisiana Addiction Services Information System (LASIS) data systems. This tool guides patient placement decisions and provides an integrative summary based on six dimensional problem areas used by the American Society of Addiction Medicine (ASAM). Training and proficiency on the administration of the CASI is a requirement before a treatment provider can utilize the instrument.

Treatment Models Utilized for Adolescent Substance Use Disorder Treatment

Regions and LGE's have the opportunity to use one or more of the following EBP/curriculums dependent on needs of adolescents and families in their specific area:

- *Adolescent Community Reinforcement Approach (ACRA)* developed to promote abstinence from marijuana, drugs, and alcohol in the intensive outpatient level of care. This program emphasizes improved family relationships, positive peer relationships and improved functioning within the environment. It is designed for a minimum of twelve weeks with treatment extended as necessary.
- *Seven Challenges Model* targets adolescents with co-occurring disorders. It is an individualized program that incorporates a cognitive/emotional decision-making model. Participation is a minimum of twelve weeks. Treatment Improvement Protocol (TIP 32) by the Substance Abuse

and Mental Health Services Administration (SAMHSA) is a comprehensive review of best treatment practices and has specific information on assessment, placement factors and special considerations for the adolescent population.

- *Cannabis Youth Series (CYT)* was designed to target marijuana use amongst youth 12-18 years old. It is geared for individuals who may benefit for 1-14 weeks of outpatient treatment. It is available through SAMSHA.
- *The Matrix Model* is a new, intensive 16 week outpatient model available through Hazelden and addresses teen drug use of any type. It is presently in research regarding effectiveness and outcome measures.
- *Motivational Enhancement Therapy and Cognitive Behavioral Treatment Model (CBT/MET 5 and CBT/MET 7)* utilizes motivational enhancement and cognitive behavioral therapy. The program starts with 2 individual sessions of MET with emphasis on change and 3 or 10 supplemental group sessions of CBT. The focus of the CBT sessions is on learning to meet needs in ways that do not result in turning to marijuana and alcohol and the development of better coping skills. It is available through the Addiction Technology Transfer Centers with some cost associated.
- *Contingency Management (CM)/Motivational Incentives* is the systematic reinforcement of desired behaviors and the withholding of reinforcement or punishment of undesired behaviors. This program uses low cost reinforcement (prizes, vouchers, clinic privileges, etc), delivered in conjunction with onsite urine screening. It promotes higher rates of treatment retention and abstinence from drug abuse and is an effective strategy in the treatment of alcohol and other drug (AOD) use disorders.

ATR (Access to Recovery) Recovery Support Services (RSS) for Adolescents

Through the Access to Recovery (ATR) program, the Office of Behavioral Health has provided Recovery Support Services (RSS) to Children and Adolescents. Need for services are identified during the screening and assessment process and are included as part of the treatment plan. In Louisiana the following RSS are made available to children and adolescents:

Alcohol and Drug Free Social Activities - Activities that foster healthy relationships, involves little stress, and encourages clients to engage in new and constructive activities. Events may involve an array of activities such as ball games, picnics, holiday meals, and community services projects.

Care Coordination - Process of linking the client to recovery support services and appropriate levels of care.

Childcare - Daycare provided for the children of clients while they are in treatment.

Life Skills - Individual or group sessions with clients discussing such topics as parenting, anger management, healthy relationships, HIV/AIDS Education.

Pastoral Counseling - Individual counseling with a licensed ordained minister that incorporates spiritual support in the substance recovery process.

Recreational Therapy - Recreational therapy by a certified recreational therapist.

Transportation - Providing transportation for clients to and from treatment.

Significant Events in Substance Use Disorder Adolescent Services

Significant events which have direct impact upon Adolescent services have been the merger between the Offices of Mental Health and Addictive Disorders and the Louisiana Behavioral Health Partnership, Coordinated System of Care (CSOC) project. The State will also contract with a State Management Organization (SMO) who will determine eligibility and manage care for eligible children/youth in need of mental health and addictive disorder services, including children eligible for the CSOC. The merger of the two offices has enhanced access to services for Early Childhood Supports and Services (ECSS) and Early Periodic Screening and Treatment (EPSDT).

The Office of Behavioral Health is the recipient of the Early Childhood Supports and Services (ECSS) program. ECSS provides a coordinated system of screening, evaluation and referral services and treatment for children ages 0 through 5 years and their families. ECSS targets young children and their families that have been identified as being at risk of developing social, emotional, and/or developmental problems. The Department of Children and Family Services, a sister agency, provides partial funding for this program along with the Office of Behavioral Health. The program provides counseling, screenings, intervention and other services to children between the ages of infancy and five years of age who have certain risk factors for mental health problems. These factors include abuse, neglect, and exposure to violence, parental mental illness, parental substance abuse, poverty and having developmental disabilities. Children enrolled in the Early Childhood Supports and Services program are referred to the appropriate services as determined by their mental health provider. Services may include counseling, behavior modification programs, mental health screening, assessment and referrals, intervention to prevent child abuse and domestic violence and services to address the medical needs of the children.

KIDMED is the screening component of Louisiana's Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. EPSDT provides preventive health screening, diagnosis, and treatment services for suspected vision, hearing, dental and medical problems. EPSDT services are available to Medicaid-eligible children up to the age of 21.

The Louisiana Behavioral Health Partnership, Coordinated System of Care (CSOC) project is a multi-departmental planning and funding program which will address a population of Louisiana's at-risk children and youth with significant behavioral health challenges or co-occurring disorders in or at imminent risk of institutionalization. On March 10, 2011, State Plan amendments and home and community-based services waiver applications for the implementation of CSOC were submitted to the Centers for Medicare and Medicaid Services for review and approval.

Addressing Needs and Gaps-Future Planning

Adolescents are underserved in comparison to other populations in need of treatment. Of primary concern has been the absence of a full continuum of care for adolescents. Areas for program development include detoxification services for adolescents and an intensive residential level of care with a longer length of stay.

To address these needs, OBH has plans to expand services for adolescents through the Coordinated System of Care (CSOC) and the State Management Organization (SMO). Levels of care will be added for social detoxification, ambulatory detoxification and a therapeutic group home. Additionally, Recovery Support Services (RSS) will be expanded for more adolescents.

Collaboration/Coordination with Other Agencies

Central to the operational activities of OBH is the coordination of services with other agencies and additional collaboration between agencies to enhance internal resources and afford clients a wider scope of services (*SAPT Block Grant Federal Goal 12: Coordinate Services*). OBH continues to work collaboratively with the Office of Public Health, Office for Citizens with Developmental Disabilities, Department of Children and Family Services (formerly Department of Social Services), and other agencies/stakeholders, via cooperative agreements, contracts, task forces, training events and pilot projects to take full advantage of treatment resources and maximize service delivery to individuals. This collaboration allows OBH to be more actively involved in the community and to enhance the Office's input and knowledge of issues critical to client welfare.

Prevention Partners

OBH continues to work with the Louisiana Department of Education (DOE) to conduct the Louisiana Caring Communities Youth Survey (CCYS) for Louisiana School students in the 6th, 8th, 10th and 12th grades. Prevention Services also coordinates and collaborates with other agencies by serving as members of State, Regional and local Organizations to include but not limited to Louisiana Campaign for Tobacco Free Living, Children's Coalition, Office of Alcohol & Tobacco Control, Louisiana Department of Education, Office of Mental Health, Southwest Prevention Center, Addictive Disorders Regulatory Authority, Office of the Attorney General, Office of Youth Development, Drug Enforcement Administration, Office of Public Health, University of Louisiana system, Louisiana State University system, Southern University system, Louisiana National Guard, Highway Safety Commission, Louisiana Supreme Court, Louisiana Students Against Destructive Decisions (SADD), and the Louisiana Governor's Office.

Faith-Based Providers

OBH continues to work with faith-based and other recovery support providers to expand service capacity via the Access To Recovery (ATR) program. ATR utilizes an electronic voucher system that provides clients with freedom of choice for clinical and recovery support services. The ATR initiative is currently sustained by state general funds. ATR clinical and recovery support services are offered by both state-operated and private providers (including faith-based providers). Recovery support services offered through ATR include alcohol and drug free social activities, anger management, childcare, job readiness, life skills, pastoral counseling, spiritual support groups, recreational therapy, and transportation.

Office of Public Health

OBH and the Office of Public Health (OPH) continues to collaborate on training for HIV Rapid Testing, staff cross training, and counseling of HIV positive clients.

In addition, OBH and OPH's Maternal and Child Health Division coordinate efforts to improve statewide birth outcomes via ongoing implementation of the SBIRT/Birth Outcomes Initiative, aimed at enhancing statewide education and screening of pregnant women for addictions, depression, and domestic violence. The SBIRT project, now called the *Birth Outcomes Initiative*, has been elevated to a health care priority. One of the goals of the newly formed *Birth Outcomes Initiative* is to advance behavioral health screenings for alcohol and tobacco use in prenatal health care. OBH contributes \$233,000 per year to the project, provides consultation and to assures timely access to services for pregnant women. The focus of this project has expanded and includes reviews of medical practices, improved data collection, and (although not implemented yet) will provide for Medicaid reimbursement to private physicians for substance use screenings as part of prenatal care.

OBH maintains a Memorandum of Understanding with the Office of Public Health (OPH), Division of Maternal and Child Health to offer voluntary pregnancy testing to women entering, or re-entering treatment for addiction services on a statewide basis. This collaboration affords the Office of Public Health (OPH) the opportunity to reach one of their target populations (women with addictions), and OBH is able to provide more comprehensive care to women seeking addiction treatment. Women are encouraged to test at all levels of care and are educated on the harm of alcohol, tobacco, and drug use during pregnancy. Approximately 1,137 voluntary pregnancy tests were administered throughout the State by both state-operated and contract providers during SFY 2011. During this reporting period, OBH transitioned from manual reporting of pregnancy tests to electronic reporting in the Louisiana Addictive Disorders Data System (LADDS).

Department of Children and Family Services

OBH and the Department of Children and Family Services have joined forces for policy development regarding substance exposed newborns, and on the Temporary Assistance for Needy Families (TANF) Initiative, to expand services for TANF eligible women and children in need of addiction treatment. OBH maintained the TANF initiative during SFY 2011, although this initiative did experience an approximate 10% decrease in funding. OBH continues the screening and referral process at child welfare sites as well as the Families in Need of Temporary Assistance (FITAP) sites, located in each of the ten Regions/LGEs throughout the state. Services funded by TANF are utilized to bridge service gaps for pregnant women and women with dependent children. OBH continues to maintain support for seven residential facilities for women, pregnant women, and women with dependent children through TANF funding. Six of these facilities housed children on-site with their mothers and provided a drug free environment, thus preserving family unity and providing therapeutic services for the entire family.

Department of Corrections

During SFY 2011, OBH collaborated with the Department of Corrections to submit a grant proposal for wrap around services for incarcerated women before they leave prison, and made recommendations for improvement of substance use treatment programs at the Elaine Hunt Correctional Center for Women.

DHH Bureau of Health Standards

OBH continues to work collaboratively with the Louisiana Department of Health and Hospitals (DHH) Office of Management and Finance, Bureau of Health Standards, and the Regions/LGEs within the State to refine a proposed draft of licensing regulations, standards, and guidelines. Specifically, the Medical Director of OBH requested that staffing patterns congruent with ASAM recommendations be included in the licensing standards. These revised standards are currently under review by the Bureau of Health Standards and are being prepared for review by the public during SFY 2012.

Medicaid

OBH continues to work with the Louisiana Department of Health and Hospitals (DHH) Bureau of Health Services Financing Authority to obtain Medicaid funding for substance use disorder treatment services. In SFY 2011, DHH made the decision to include treatment services for substance use disorders in the Coordinated Care Network (CCN), for both adolescents and adults. OBH continues to collaborate with Medicaid to bring this plan to fruition, including revisions of service definitions. Through the Louisiana Behavioral Health Partnership (LBHP) and State Plan

Amendments that have been submitted to the Centers for Medicare and Medicaid Services (CMS), OBH has also requested that medication assisted treatment (methadone) for pregnant women be included as a reimbursable behavioral health service.

Provider Policy

Priority Admissions

Current agency policy states that all funded programs give priority admission and preference to treatment in the following order: pregnant injecting drug users, other pregnant substance abusers, other injecting drug users, and all others. (*SAPT Block Grant Federal Goal 9: Pregnant Women Preferences*). This approved policy has been posted on the agency SharePoint site whereby Region/LGE staff can access and review current policies as well as other resource documents. Priority admissions are included in the peer review process and on the peer review form documents. This has helped to confirm that priority admissions are handled in a timely manner and according to Block Grant mandates.

OBH state-operated and contract programs provide interim services to these priority populations within 48 hours, if comprehensive care cannot be made available upon initial contact with a waiting period of no longer than 120 days. Regional Administrators report an average waiting list period of seven to fourteen days for outpatient clients. Interim services are made available through individual sessions, phone contact and referral or linkage to self help groups and activities. Documentation of interim services and waiting period are discussed during annual peer reviews in each Region/LGE.

The Louisiana Addictive Disorder Data System (LADDS) generates a waiting list (as a component of the admissions and utilization report). All residential facilities report census information online, including waiting list data and the occupancy percentage, on a daily basis utilizing a database program on the OBH web page. This database produces a daily bed availability report which can be accessed on the web page for immediate review. The utilization report data is distributed to designated staff monthly for review and monitoring of facilities that have reached 90% capacity.

In fiscal year 2007, OAD requested and received on-site Technical Assistance (TA) from the Center for Substance Abuse Treatment (CSAT) to assess and provide recommendations for enhancing the daily census reporting system which tracks aggregate or duplicated capacity on the waiting list. The goal of the request was to establish mechanisms for tracking real-time statewide capacity and an unduplicated waiting list count for 24-hour facilities. Recommendations were made to develop a web-based system that would have ad-hoc reporting capabilities, as well as the ability to track individuals on the 24-hour waiting list and identify priority populations. Through a contract with Click Here Publishing, an enhanced capacity management system was piloted in Region V in March 2008. Since that time, OBH has continued to address identified barriers to further statewide implementation of the system which include: editing problems; assignment of security groups; and waitlists viewable by employees not assigned the task. Currently, OBH has included the specifications for wait list and capacity management functions within the Electronic Behavioral Health Record (EBHR) system initiative Request for Proposal (RFP) process (see *Planning Step Two* for additional information on the EBHR system initiative). The core features of the EBHR system will include admissions/discharge/transfer, screening/assessment, centralized scheduling, treatment planning/progress notation/discharge summary, service encounter recording, service utilization management, electronic prescribing, pharmacy, billing and accounts receivables, and clinical decision support.

Disclosure of Patient Records

OBH maintains its policy to ensure adherence to all confidentiality, privacy, and security guidelines, including HIPAA requirements, state licensing standards, and federal regulations (*SAPT Block Grant Federal Goal 16: Disclosure of Patient Records*).

OBH includes a confidentiality requirement (HIPAA Business Associate Addendum) in all contracts with providers. As part of licensure, OBH requires training of all staff to ensure adherence to confidentiality regulations in CFR42 Part 2, HIPAA requirements, state licensing standards, and federal regulations.

During SFY 2011, confidentiality training was provided or made available online to staff in both state operated and contract programs in OBH Regions/LGEs. DHH Policy Number: 7008-79 covers rules on disclosures of medical information as per CFR42 Part 2. This policy is available on the Louisiana Department of Health and Hospitals (DHH) Intranet and accessible by all DHH employees. Also, according to licensing guidelines, in order for a facility to be licensed, the facility must document that training on confidentiality is conducted at the time of employment and annually thereafter. Each OBH Region/LGE has a coordinator to ensure that training on confidentiality/HIPAA is conducted. OBH ensures that HIPAA training is provided to new employees in a timely fashion by keeping track of this on the new employee training checklist. Facilities make sure new employees are aware of HIPAA and confidentiality by educating them during employee orientation.

Charitable Choice

Beginning in SFY 2005, the Office for Addictive Disorders engaged in training activities geared toward implementation of Charitable Choice regulations (*SAPT Block Grant Federal Goal 17: Charitable Choice*). These regulations are federally mandated under 42 U.S.C. 300x-65 and 42 C.F.R. The goal of Charitable Choice is not to support or sponsor religion, but to ensure fair competition among providers of services whether they are public or private, secular or faith-based.

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

Agency policy has been created to ensure that providers adhered to Charitable Choice, and OBH implements this policy in all treatment facilities at all levels of care throughout the State. OBH has a non-discriminatory policy regarding faith based organizations. OBH accepts proposals from and awards contracts to faith based organizations, provided they are currently licensed by Health Standards, the state agency responsible for approving licensure for treatment agencies. Charitable Choice mandates are included in the Standard Provisions of all contracts, and Charitable Choice policy is documented on the agency policy website.

Hypodermic Needle Program

OBH enforces a statewide policy, inclusive of state-operated and contract provider programs, to prohibit the use of SAPT Block Grant funds to provide individuals with hypodermic needles and syringes (*SAPT Block Grant Federal Goal 14: Hypodermic Needle Program*). The standard provisions for provider contracts includes the stipulation that Block Grant funds may not be used for the purchase and distribution of sterile needs for injection of any illegal drugs, or bleach for the purpose of cleaning the needles. Adherence to this mandate is monitored as part of the contract monitoring and independent peer review processes. OBH continues to adopt the policy of terminating a contract with any provider that violates this stipulation.

Special Populations

Pregnant Women and Women with Dependent Children

OBH ensures that pregnant women are given preference in admission to treatment facilities; and, when the facility has insufficient capacity, ensures that the State Office is notified to assist in placement (*SAPT Block Grant Federal Goal 3: Providing Specialized Services for Pregnant Women and Women with Dependent Children*). If no such placement is available, it is OBH's policy to make interim services available within 48 hours, including a referral to prenatal care. OBH continues to maximize access to treatment for pregnant women by maintaining priority admission status for this client population. OBH-AD admits approximately 350 pregnant women annually and provides approximately 400 interim services to this population each year.

During SFY 2011, there were a total of 324 pregnant women admissions and 432 pregnant women served. OBH provided approximately 5,946 services to this client population. According to the Block Grant Set Aside Reports, OBH provided 345 interim services to pregnant women during SFY 2011. Interim services are provided until such time as the appropriate level of care becomes available for women needing services. Interim services include education or counseling concerning Fetal Alcohol Spectrum Disorders (FASD), HIV, STDs, the danger of sharing needles and the advantages of/need for prenatal care. Tuberculosis, STD and HIV screenings are also included in interim services, as well as referral for emergency medical services and prenatal care.

OBH also collaborates with the Office of Public Health to provide voluntary pregnancy testing and Fetal Alcohol Spectrum Disorder (FASD) education for all women entering the system. Approximately 1,137 women had voluntary pregnancy tests in SFY 2011.

According to LADDS, there were a total of 5,029 women with dependent children admissions and 6,530 women with dependent children served. OBH provided 92,973 services to this population during SFY 2011.

In urban areas, OBH may have more than one residential facility providing services in an area, such as in the New Orleans area. There are also a couple of Regions/LGEs that do not have residential treatment facilities within their service boundaries, such as the Florida Parishes Human Services Authority. In these situations, clients are referred to facilities in another Region/LGE where services are available.

OBH monitors pregnant women and women with dependent children services, using admission data generated by the LADDS Data System. Regional/LGE monitors review cases and admission patterns at facility levels to ensure adherence to OBH priority admission policy for pregnant

women. Priority admission guidelines are also addressed during the annual peer review process. Regions/LGEs and State Office staff also monitor the adequacy of efforts to meet the specific needs of women by reviewing admission data and census data (Monthly Production and Utilization Reports), which includes waiting list reports and field surveys.

OBH coordinates services with statewide Opiate Replacement Clinics to provide services to pregnant opiate dependent females. OBH promotes Buprenorphine and/or Suboxone treatment services to facilitate appropriate detoxification protocols, post-delivery. Pregnant women requiring services are assessed and, pending community based resources, referred to opioid treatment clinics or SAMHSA approved Buprenorphine and/or Suboxone physicians. Through the Louisiana Behavioral Health Partnership (LBHP) and State Plan Amendments that have been submitted to the Centers for Medicare and Medicaid Services (CMS), OBH has requested that medication assisted treatment (methadone) for pregnant women be included as a reimbursable behavioral health service.

The following residential programs served pregnant women and women with dependent children during SFY 2011:

- 1) CENLA Chemical Dependency Council, Alexandria (Region VI), maintained a bed capacity of fourteen (14) for women and children under the age of 12. This program provided a community-based rehabilitation program in a halfway house setting.
- 2) Odyssey House of Louisiana, Inc., (OHL), New Orleans (MHSD), provided substance use disorder services to high-risk pregnant women, single women, and women with dependent children in a multi-collaborative therapeutic community setting. OHL maintained its capacity to serve a total of twenty-seven (27) women and their children at any given time.
- 3) Grace House, New Orleans (MHSD), maintained fifteen (15) beds for women only. The average length of stay at this facility is between 3-6 months.
- 4) Rays of Sonshine, Rayville (Region VIII), maintained twelve (12) beds at this facility reserved for women, including pregnant women. This facility utilizes a therapeutic community model with some emphasis on the 12 Step Model.
- 5) The Alcohol and Drug Unit, Mandeville (FPHSA), is twenty-eight day inpatient unit for women and pregnant women, located on the grounds of Southeast Louisiana State Hospital. This facility is under the jurisdiction of the Florida Parishes Human Services Authority (FPHSA). Treatment services included group/individual counseling, gender specific groups, educational lectures, family sessions and relapse prevention programming.
- 6) Fairview Treatment Center, Houma (Region III), is another twenty-eight day inpatient facility that serves both male and female clients, including pregnant women. This facility uses motivational interviewing to meet the client at her level of need and integrates the Minnesota 12-Step Recovery Model in its therapeutic approach.
- 7) Louisiana Health and Rehabilitation Center-Options, Baton Rouge (CAHSD), provides services for women and pregnant women and/or women with dependent children in a residential setting, to foster emotional growth, encourage sobriety, and teach problem solving skills that are linked to positive lifestyle changes.

Injecting Drug Users

Injecting drug users (IDU's) are defined as individuals who, within the last year, have used drugs and presented themselves for treatment, and who used needles for injection of those drugs irrespective of the site or route of injection (*SAPT Block Grant Federal Goal 4: Services to*

Intravenous Drug Abusers). This definition has been incorporated into the Louisiana Addictive Disorders Data System (LADDS) glossary of terms, as well as the Block Grant Set Aside Reports submitted by each Region/LGE. OBH requires that state-operated and contracted programs providing services to drug users will give priority for admission and treatment to injecting drug users (IDU's) and that preference be given to clients in the following order:

- (a.) pregnant injecting drug users first
- (b.) other pregnant substance abusers second
- (c.) other injecting drug users third
- (d.) all other individuals fourth

OBH has established a policy to ensure that priority admission is granted to IDU's. OBH state-operated and contract programs admit IDU clients to treatment programs within 14 days of the request for admission and provide interim services to IDU clients, within 48 hours, if comprehensive care cannot be made available upon initial contact. The waiting period is not to exceed 120 days. OBH contract stipulations outline this policy requirement, and Regional/LGE contract monitors review this stipulation for compliance on a quarterly basis.

During SFY 2011, there were a total of 4,248 IDU client admissions and 4,830 IDU clients served across all levels of care. This population received approximately 31,914 services, as per the Louisiana Addictive Disorder Data System (LADDS). The Block Grant Set Aside Reports for SFY 2011 submitted by the Regions/LGEs recorded 1,719 interim services and 1,241 outreach services provided to this population.

42 U.S.C. 3000x-23 (a)(1) requires that any program receiving amounts from the SAPT Block Grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. To monitor program compliance with this statute, OBH conducts executive staff and quarterly meetings with Regional Administrators/LGE Executive Directors and generates special reports (Utilization Report, Productivity Report and LADDS Reports). State operated and contract programs utilize the web-based daily census to report and document when 90% capacity is reached or exceeded. OBH Regional Administrators/LGE Executive Directors and State Office staff also conduct periodic reviews and compare available data regarding capacity and IDU admissions.

IDU Outreach

All programs and treatment modalities (e.g., outpatient, detoxification, residential treatment, and halfway houses) are available to injecting drug users. OBH policy provides for priority admission to this population in both contract and state-operated facilities throughout the state. To comply with 42 U.S.C.300x23 (b) of the PHS Act, OBH continues to offer outreach services statewide using the Indigenous, Behavioral and/or other outreach models.

OBH provides and solicits training for staff on topics that pertain to IDU outreach that include preventing the transmission of HIV, confidentiality requirements (42 CFR, Part 2), and the relationship between injecting drug use and transmittable diseases. OBH providers educate staff, clients/patients, agencies and the general public on infectious diseases such as HIV/AIDS, Tuberculosis (TB), and sexually transmitted diseases (STD's). OBH networks and collaborates with contractors, state agencies and community-based organizations to provide outreach services in local communities. Outreach activities include education, prevention, condom distribution, clean

needle demonstrations (no cleaning supplies or needles provided), medical evaluations and referrals for treatment. Information and pamphlets are distributed and referrals are made in a variety of community and/or organization settings, including United Way, AA/NA groups, businesses, mental health clinics, health clinics, charity hospitals, barber shops, nail salons, correctional facilities and jails. Community health fairs as well as public and educational forums provide opportunities for the provision of outreach services also.

OBH completed staff training for IDU outreach as planned in SFY 2011 and encouraged the utilization of outreach models that are scientifically sound. National Community Health Partners, formerly known as Border Health Foundation, provided the training on Outreach, Engagement and Retention. This training was specifically geared towards the National Institute on Drug Abuse (NIDA) Community-Based Outreach Model. Approximately thirty-five staff participated in the training (between two and five staff members attending from each Region/LGE). Three trainings were held throughout the State: April 4, 2011 in Lafayette (Region IV); April 5, 2011 in Shreveport (Region VII); and April 7, 2011 in New Orleans (MHSD).

Primary Health Screening and Testing in Addictive Disorder Programs

Tuberculosis

OBH directly, or through arrangements with other public or private entities, routinely makes available tuberculosis (TB) services to each individual receiving addiction treatment and monitors TB treatment service delivery (*SAPT Block Grant Federal Goal 5: Tuberculosis Services*). A Memorandum of Understanding (MOU) between OBH and the Office of Public Health (renewed July 2009) has established a system to provide the necessary supplies for TB and STD services by the Office of Public Health. However, due to budgetary cuts, supplies are not always available from OPH, which has resulted in some Regions/LGEs purchasing supplies out of their budgets.

TB services are made available by the administration of a Sign and Symptom Screen (developed by the Office of Public Health) or by administration of the PPD (Purified Protein Derivative) Tuberculin Skin Test by a clinic nurse. The tuberculosis skin test or PPD test is used to determine if the individual has developed an immune response to the bacterium that causes tuberculosis (TB). This response can occur if someone currently has TB, if they were exposed to it in the past, or if they received the BCG vaccine against TB (which is not performed in the U.S.). When a client tests positive, the client is referred to the Office of Public Health and the Regional TB Nurse for ongoing evaluation and treatment, or to the client's private physician, when requested by the client. Clients with positive test results, or those with any number of signs and symptoms from a previous positive PPD, are not admitted for treatment until they have been cleared by the treatment facility's medical director and by the Office of Public Health. Protocol dictates that the medical director or the clinic physician clears the patient for admission.

During SFY 2011, OBH provided tuberculosis testing to 8,053 clients admitted to treatment programs and 204 (2.5%) yielded positive results. According to the Block Grant Set Aside Reports, OBH provided a total of 38,288 TB related services, with 24,442 of these services offered to TB positive clients.

TB educational groups are offered to clients and in-service trainings are offered to staff. Each Region/LGE has established an infectious disease control protocol or committee to track and record positives, as well as to create local policy.

Programs are monitored to ensure compliance with guidelines and requirements. Each Region/LGE submits quarterly reports to OBH-HQ documenting services provided which include number of services, number of tests and number tested positive. During compliance checks, if programs are cited, they must develop and submit corrective action plans to correct noted findings. OBH adheres to 42 CFR and all department confidentiality policies in providing TB services.

HIV Protocol

The Office of Behavioral Health provides treatment for persons with substance use disorders with an emphasis on making available, within existing programs, early intervention services for HIV in areas of the State that have the greatest need for such services and monitors such delivery (*SAPT Block Grant Federal Goal 6: HIV Services*).

At least 5% of Block Grant allocations are spent on HIV services. All clients are screened for risk behaviors and offered an HIV test. In SFY 2011, OBH tested 3,288 clients for HIV. Of those tested, 31 (<1%) were positive for HIV. OBH provided 32,585 HIV services to this population. Of those services, 18,906 were rendered to HIV positive clients.

Clients that are tested for HIV receive pre-test and post-test counseling services. If results are inconclusive, clients are re-tested with referrals and additional services provided as applicable. For those who test positive, clients receive on-going counseling and educational groups and are referred to local community based health clinics or OPH outpatient clinics for any additional services that are deemed appropriate. Clients previously tested that report high risk behaviors are assessed for re-testing as needed. Partners of HIV positive clients are also provided counseling. Client education is chiefly conducted during group sessions and/or individual sessions in OBH clinics and facilities. State operated and contract providers offered 2,717 pre-test counseling services and 2,432 post-test counseling services across all levels of care during SFY 2011.

Health clinics in all parishes also offer HIV testing capability. The Louisiana Department of Health and Hospitals, Office of Public Health HIV/AIDS Program (HAP) assures through their programs, community based organizations and contractors that treatment services are available for HIV/AIDS. OBH utilizes referral resources to access additional services for substance use disorder clients diagnosed with HIV/AIDS. OBH has established a working relationship with the referral entities and is able to monitor the needs of clients that have been referred. These referral resources include State and private hospitals, community based health clinics, and HIV community based grantees. Protocols for monitoring the needs of clients that have been referred vary from program to program. In some instances, staff may make the appointment, verify an appointment has been scheduled or utilize a continuity of care form (name may vary) to document activities

OBH and the Office of Public Health (OPH) continue to collaborate on training for HIV Rapid Testing, HIV/AIDS, prevention counseling, and other health issues of common concern to both agencies. OPH provides all OBH staff and contract staff training on pre-test and post-test counseling as well as HIV Rapid Testing administration. Trainings are scheduled through the *LA HIV 411* website, which allows for quick and easy registration. This website also allows all providers to obtain current information and other resources on HIV/AIDS. The website address is www.hiv411.org.

During SFY 2011, OPH and OraSure Technologies, Inc. conducted a 2-day training in order to assist each Region/LGE with increasing the number of HIV rapid tests administered. OPH presented statistical information on Louisiana's HIV/AIDS cases. This training was conducted in three areas of the State for all Regions/LGEs to participate: January 4 & 5, 2011 in New Orleans (MHSD); January 6 & 7, 2011 in Lafayette (Region IV); and January 10 & 11, 2011 in Shreveport (Region VII). Through an OPH contract with OraSure Technologies, Inc., OBH Regions/LGEs were able to receive a reduction to the HIV test kit cost. As more tests are used/ordered, tests kits become less costly, and this affords agencies a mechanism to increase testing capacity without increasing costs.

OBH monitored the implementation and delivery of HIV Rapid Testing and services statewide, via the Block Grant Set Aside Report. This report is one of the resources that Headquarters monitors to ensure that the Regions/LGEs are providing Rapid Testing and completing pre-test and post-test counseling. The Block Grant Set Aside Report has been revamped, in order to improve the monitoring of each state facility or state contract which submits quarterly set-aside numbers. This new report will be utilized for the FY 2012 reporting period.

Each Region/LGE has established an infectious disease control protocol and/or committee to track and record positive test results, as well as to create policy. OBH adheres to 42 CFR and all department confidentiality policies in providing HIV services. Programs are monitored through quarterly reports, chart documentation, contract monitoring and OBH Headquarters to ensure that they are in compliance with contractual agreements. Programs are monitored to ensure compliance of guidelines and requirements. During compliance checks, if programs are cited, they must develop and submit corrective action plans to correct noted findings. All Block Grant requirements are indicated in contractual agreements with language that address details related to termination of agreement due to lack of compliance.

At the local level, Regions and Districts capture data elements such as; the number of tests, number of services and number tested positive and report them to OBH-HQ. In addition, Quality Assurance and Contract Monitoring reports are completed every quarter in each Region and District.

Addictive Disorder Service Provider Independent Peer Review

The Office of Behavioral Health (OBH) implements an independent peer review process to assess and improve the quality and appropriateness of treatment services delivered by providers that receive funds from the SAPT Block Grant (*SAPT Block Grant Federal Goal 15: Independent Peer Review*).

OBH utilizes the peer review process to ensure and enhance the quality of treatment services in its state-operated and contracted programs. The peer review program is intended to share programmatic and clinical expertise across Regional/LGE administrations, programs and professional disciplines, and to identify strengths and weaknesses in the service delivery system. Peer review is a comprehensive process designed to enhance and improve administrative and treatment services, utilizing a multi disciplinary approach. The goals of the independent peer review process are to: 1) increase the quality of care and services; 2) make the service delivery system responsive to the needs of clients; 3) provide effective treatment services; and 4) deliver services in an efficient manner.

The treatment peer review process is an opportunity to share professional expertise, (both administrative and clinical) and is conducted with the overarching goal of quality improvement as well as sharing programmatic and clinical ideas. Key elements of the review process are:

- * OBH requires a minimum of one program per Region/LGE (total of 10 treatment programs reviewed annually). This represents approximately 21% of the total number of substance use disorder treatment programs and exceeds the 5% requirement for Peer Review;
- * The composition of the peer review team is dependent on the organization to be reviewed, but consists of a minimum of three (3) persons, including administrative and treatment staff, and a staff person or representative from Headquarters of OBH.
- * Facilities provide the review team with their Policy and Procedure Manual and description of the program being reviewed.
- * After the peer review, an exit interview summarizes findings and recommendations to enhance programming.

During 2011, due to travel restrictions and budget cutbacks, OBH obtained permission to use video conferencing as an alternative option to statewide travel and completed the annual peer review process as detailed in the table below.

Region/LGE (Reviewer)	Region/LGE - Program Reviewed	Date of Review
MHSD	FPHSA - Admin	6/2/2011
CAHSD	JPHSA - OP (Adolescent)	7/21/2011
SCLHSA	Region VIII – Administration	4/14/2011
IV	Region V - Administration	11/16/2010
V	Region IV – Administration	11/9/2010
VI	Region VII – Administration	3/22/2011
VII	Region VI - Administration	3/23/2011
VIII	SCLHSA - Administration	4/14/2011
FPHSA	MHSD - Administration	5/10/2011
JPHSA	CAHSD: OP (Adolescent)	7/14/2011

The Louisiana Peer Review model varies from the prototype provided by CSAT. The present theoretical framework used provides an exchange of information and processes regarding performance, without the burden of contracting with another agency. CSAT accepted this method since the technical requirements of the peer review guidelines are met. This process also includes a review of findings with written recommendations and corrective action plans to be implemented.

Peer review assignments are governed by the federal fiscal year. A new peer review process begins October 1 and ends September 30 of each year. OBH selects the Regions/LGEs and the Headquarters staff representative; Regional/LGE management selects the local reviewers. The objectivity of the reviewer was accomplished by having cross-regional members, with Headquarters staff being a non-critical observer.

Regions and LGEs are paired to review continuum of care components (outpatient, inpatient, detoxification, residential), including administrative services. Assessment tools are utilized for treatment and administrative services. The Regions and LGEs assigned are rotated. Each continuum

of care is reviewed before rotation. An OBH Headquarters staff person, the Regional/LGE Administrator and/or designee, staff or administrators of the program being reviewed, and persons deemed necessary and appropriate attend and participate in the review.

Workforce Development

The Office of Behavioral Health (OBH) strives to develop and implement an effective statewide workforce development plan for treatment and prevention staff and providers to ensure the use of best practices by state operated and contract providers (*SAPT Block Grant Federal Goal 11: Continuing Education*). Addictive disorder service providers are also expected to ensure that continuing education in prevention and treatment services are made available to staff who provide such services.

OBH maintains a web-based system (DHH Intranet) and application (Essential Learning) to identify current and/or immediate training needs at the State, Regional, LGE, Parish and Community level. Within its workforce development model, OBH targets Certified Clinical Supervisors and/or Senior Clinicians to participate in training opportunities. Participants are selected individually by Regional/LGE leadership, and must possess the leadership and communication skills required to transfer information and provide trainings to colleagues and other providers within their respective Regions/LGEs. All training attendees receive an overview of the newly established Knowledge, Skills and Attitudes (KSA³) Protocol, which is a mechanism also referred to as the “cascading” model. This model is not a Train the Trainer Model, but one that trains seasoned clinicians with the expectation of transferring the knowledge to subordinates, colleagues and other providers within their Region/LGE. During FY 2011 OBH provided the following trainings for the addictive disorder provider network:

TITLE	DATE	LOCATION	ATTENDANCE
Comprehensive Adolescent Severity Index (CASI)	August 4-5, 2010	Monroe	10
CASI (Follow Up Booster)	September 7, 2010	Monroe	7
Comprehensive Adolescent Severity Index (CASI)	August 19-20, 2010	Lafayette	16
Comprehensive Adolescent Severity Index (CASI)	October 18-19, 2010	Marrero	11
CASI (Follow Up Booster)	November 22, 2010	Marrero	11
NIATx Performance Improvement Network Initiative	November 5, 2010	Baton Rouge	13
Comprehensive Adolescent Severity Index (CASI)	February 17-18 2011	Marrero	6
CASI (Follow Up Booster)	March 21, 2011	Marrero	6
NASW-LA Annual Conference	March 16-18, 2011	Baton Rouge	12
Pharmacotherapy for Co-Occurring Disorder	March 24, 2011	Video Conference	6
Bipolar Disorder in Children & Adolescents	June 13, 2011	Statewide	6
4th Annual Children's Mental Health Summit	June 15, 2011	Baton Rouge	266
Total			370

OBH co-sponsors/sponsors trainings and conferences within the State, such as the annual National Association of Social Workers (NASW) Conference and the Louisiana Association of Substance Abuse Counselors and Trainers Annual Conference (LASACT), by presenting specified material during workshops as requested and providing in-kind services. The NASW conference was held in Baton Rouge Louisiana, on March 16-18, 2011. The theme for the conference was “Social Workers Change Futures”, with approximately 1,000 attendees. The LASACT conference was held in Baton

Rouge, Louisiana on July 24-27, 2011 with a participation of over 400 attendees. The theme for this year's conference was "Let's Give Them Something to Chart About: Preparing for a Managed Care World", aiming to broaden participant competencies in effective communication and record keeping during the prevention and treatment process and to assure professionalism not only for today, but also for the upcoming changes and challenges that the addiction prevention and treatment fields are facing.

OBH also maintains the web-based application Essential Learning to enhance access to continuing education hours in an efficient and effective manner. All OBH staff have access to Essential Learning (E-Learning) which offers online learning, staff compliance training and continuing education for behavioral health, mental health, addiction treatment, community health, developmental disability, community action and child welfare organizations. During FY2011, 401 individuals completed training courses utilizing E-Learning and received an overall total of 1,736 continuing education hours.

PLANNING STEP TWO: IDENTIFICATION OF UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

Comprehensive Behavioral Health Services – Needs and Gaps

Adults and Children/Youth

In the NAMI 2009 Report Card, Louisiana continues to maintain a poor grade of “D.” This ranking has not changed in the last several years with noted problems related to access and overutilization of the correctional system to house and treat the SMI population. In the NCHS Vital Statistics System, Louisiana ranked 28th in its crude rate of suicides. Per the Office of Applied Science at SAMHSA, Louisiana has been among the highest rankings across states for persons reporting substance dependence on or abuse of illicit drugs over the past year. This had maintained a high rating across survey years. Per the Kaiser State Health Facts 2010, approximately 32% of the adult population in Louisiana is reporting “poor mental health.” Services to adults are a critical area of need in the OBH system, as prevalence estimates indicate only a small proportion of the need is being met by existing OBH services. Of the 88,799 adults with serious mental illness (SMI) in Louisiana, OBH reported a caseload of 33,875 adults in 2011 (as of 6/30/11). Of the 290,914 persons aged twelve and older in need of substance use disorder treatment in Louisiana, OBH reported a total of 29,043 persons served in FY 2011.

In the Annie E. Casey Foundation Kids Count Data Book (KID Count, 2011), Louisiana continues to rank near the bottom of the nation in terms of child health and well-being, ranking 49th in the nation on their ten item index of children’s health status and wellbeing. This ranking has not changed from 2000 to 2008 despite many efforts made over the past decade in improving the wellness of children. A significant proportion of Louisiana’s children and their families suffer the consequences of multiple health, developmental, and social-emotional problems daily. Furthermore, the negative economic impact of the multiple disasters to the state compounds the challenges of building an effective system of care. The Block Grant has repeatedly revealed the poor performance of the state supported care in delivering effective and timely behavioral services to children and youths. . Of the 100,621 children with serious emotional/ behavioral disorders (SED) or Emotional Behavioral Disorders (EBD) in Louisiana, OBH reported a caseload of 5,929 children and youth in 2011 (as of 6/30/11), revealing that less than 6% of the estimated prevalence rate of children with serious emotional disturbances (SED) were served. The children’s behavioral health system is fractured with several child-involved agencies providing duplicative and inefficient behavioral health services in an attempt to overcome these failings.

Older Adults

Services to older persons with behavioral health disorders are a statewide area of need. Within the Department of Health and Hospitals, the Office of Aging and Adult Services collaborates with OBH to address the needs of older adults. Specific Regions and LGEs report having some programming that targets older citizens, however, the need is great, and the services are not consistently available across the state.

Cultural Competency

Cultural and diversity needs in the substance use disorder and mental health service delivery systems are under-developed, as are the special needs of the transitional age and older adult

population. Service providers with specialties in these areas are under-represented, and there is need for more staff training. These areas are receiving more emphasis.

Evidence-based Practices

OBH continues to explore its ability and capacity to expand the provision of evidence-based practices (EBPs) in behavioral health treatment. The state has isolated pockets where evidence-based treatment practices are in place; however, training to expand implementation of best practices on a state-wide scale has diminished due to budget reductions. The merger of the Offices of Mental Health and Addictive Disorders has intensified the need for cross-training among clinical staff statewide. Many of the local areas have embraced evidence-based practices and have recognized that integrated care should be the standard.

Recovery Support Services

Multiple mental health recovery support services are available persons with SMI/EBD statewide; however, the sole OBH initiative addressing substance use disorder recovery support services is the Access to Recovery initiative, which is not consistently available due to limited funding. The Louisiana Access to Recovery program has demonstrated that use of recovery supports like transportation, child care, parenting and life skills training increases positive outcomes by 20%. OBH intends to focus on the expansion of recovery support service development.

Transportation: Louisiana is a largely rural State, with 88% (56) of the State’s total (64) parishes being classified as rural according to the US Bureau of Census definitions, with approximately 25% of the total population living within these 56 rural parishes. Consumer surveys consistently rate transportation as a major impediment to the receipt of behavioral health services. The lack of transportation resources not only limits access to mental health and substance use disorder services, but also limits access to employment and educational opportunities.

Housing: Adequate, safe, and affordable housing for persons with serious mental illness and substance abuse continues to be a great need within the state. Aside from the dire need for rental subsidies and the increase of affordable available housing, there is a considerable need for community based support services to assist people with mental health and substance use disorders. At a minimum, an increase in available outreach programs, such as those provided through the Projects to Assist in the Transition from Homelessness (PATH), that include assessments, stabilization and preliminary treatment services, transportation, and advocacy is needed. Easy availability to resource centers for use as address and telephone communication sites are also needed.

According to the Louisiana Department of Children and Family Services (DCFS) 2008 annual Needs Assessment/Shelter Survey, 153 shelters within the State are able to serve approximately 30,000 homeless individuals. The sub-population breakdown is significant because it captures the count of those individuals who have co-occurring mental illness and addictive disorders and those who have a single disorder. The Shelter Survey data indicated the following for the sub-populations:

- Severely mentally ill- 3,927 (12.23%)
- Chronic homeless- 6,072 (18.91%)
- Dual Diagnosed- 4,942 (15.39%)

- Substance Abuse- 9,309 (28.99%)
- Veterans - 3,692 (11.5%)
- Elderly- 1,441 (4.49%)

The goal of having available, accessible rural mental health services and services for homeless consumers in each Region and Local Governing Entity (LGE) remains a challenge, and has become more so, given strained resources, staffing shortages, and the economy. Rural services, transportation, and services for the homeless populations will continue to be priorities for the State. Increased availability of recovery support services is necessary to fit the needs and individual aspirations of persons with severe mental illness and substance use disorders.

Fiscal and Workforce Constraints

Fiscal and workforce constraints have created a situation where there is demand for services beyond what the system is able to supply. The economic downturn has placed additional pressure to this vulnerable service system. Insufficient numbers of direct service providers to address basic treatment and support needs of the community service population continues to be problematic. The state has struggled with providing adequate access to services, and many citizens have not been served. The lack of treatment resources inhibits the ability of the State to provide as much in the way of outreach programming as would be ideal.

The per-capita expenditure for services remains below the national average despite exceptional efforts on the part of stakeholders to provide more sufficient funding levels for programs. The state of Louisiana, unlike other states, has not been engaged in proactive reforms that allow for improved leveraging of state dollars and has not consistently built paths for improving access to care. Clearly, creative and cost-effective ways of reaching increased numbers of citizens must be found. In summary, the challenges and ongoing crises that continue to affect the state of Louisiana offer the opportunity to re-build a *better* mental health system, and is a major goal of the Office of Behavioral Health.

Office of Behavioral Health System Data Epidemiology – Incidence & Prevalence Estimates

The Office of Behavioral Health (OBH) continues to make great strides in upgrading information technology and data systems to address the growing and changing business intelligence needs of the agency as the behavioral health service delivery system is rapidly being transformed. OBH information systems provide the means of capturing and reporting the number and characteristics of all persons served through behavioral health programs and services statewide. These OBH systems also provide the means for reporting the number of persons served relative to the estimated prevalence of need in the general population (discussed further below).

OBH currently operates several statewide computerized information and outcome/performance measurement systems covering the major service delivery and administrative processes. These systems provide a wide array of client-level data: client socio-demographic characteristics; diagnostic/clinical characteristics; type and amount of services provided; service provider characteristics; fiscal data. OBH is in the process of procuring one integrated, electronic behavioral health record (EBHR) system which will replace the separate existing legacy systems over the coming years. This EBHR initiative is described in further detail below.

When OBH was organized this past fiscal year, a Business Intelligence (BI) Section was created within the Central Office Division of Development, integrating the staff and organizational functions that were formerly separate under the former Offices of Mental Health and Addictive Disorders. The mission of the Business Intelligence Section is to provide: Information management and data standards development; decision support and support performance improvement initiatives; and computer/network technical support and assistance. The BI Section strives to transform data into actionable information for purposes of behavioral health service planning, quality improvement, and performance accountability. The BI group regularly provides information, training and technical assistance to regional, Local Governing Entity (LGE), clinic, facility, state office, and private provider staff/personnel on how to access and utilize program data.

Electronic Behavioral Health Record System Initiative

OBH is in the process of issuing a Request for Proposals (RFP) to procure and implement a certified, comprehensive electronic behavioral health record system (EBHR) for the five OBH Regions. This system will replace most of the major existing non-integrated, web-based system serving all OBH programs and services provided directly and through contracts. The core features of this system will include admissions/discharge/transfer, screening/assessment, centralized scheduling, treatment planning/progress notation/discharge summary, service encounter recording, service utilization management, electronic prescribing, pharmacy, billing and accounts receivables, and clinical decision support. The EBHR will provide the means for electronic client data exchange between OBH, the Local Governing Entities (LGEs), the Statewide Management Organization (SMO), and state health care systems (e.g., LSU Health Services, which operates EPIC). The system will meet all requirements for state and federal reporting (e.g., TEDS/URS/NOMS) and reporting required through the SMO. A requirement for selection will be that the EBHR meets the current Meaningful Use criteria. OBH is in the process of establishing a position for an EBHR manager to oversee the procurement, implementation, and operation of the statewide EBHR.

Louisiana is rapidly making a transition to EBHRs. Four of the LGEs have recently procured an EBHR, and the fifth LGE has operated an EBHR for the past two years. Metropolitan Human Service District has procured the Carelogic EBHR by Qualifacts, Inc. Three of the LGEs – Capital Area Human Service District; South Central Louisiana Human Service Authority; and Florida Parishes Human Service District – formed a purchasing collaborative and procured the Profiler EBHR by Unicare, Inc. JPHSA continues to operate Anasazi, which it has progressively implemented over the past two years. OBH is working closely and collaboratively with the LGEs in supporting transition from the state legacy systems to the EBHRs, assuring continuity of client data and service delivery operations.

OBH has established client level data standards and procedures for the upload of data sets from these LGE EBHR systems to the OBH data warehouse for continuity of integrated statewide reporting. These client level data standards identify the data sets and data elements that will be required to be extracted from each EBHR, translated as needed and uploaded monthly to enable continuity of state and federal reporting. The process and procedure for this required data submittal is modeled on the CMHS URS and CSAT TEDS process and procedures, and includes the steps of data element crosswalks and verification, data submittal testing, and then ongoing bi-weekly uploads to a secure FTP site. Data will then be automatically downloaded and integrated into the OBH data warehouse for use in statewide business intelligence functions and also for uploads of client data to meet federal reporting requirements. This process is described in further detail below.

OBH Data Warehouse/Business Intelligence System

OBH operates a comprehensive data warehouse/business intelligence system to provide access to and use of integrated statewide data and performance measures to managers and staff. The data warehouse is the main source of data for the URS/NOMS tables and for all statewide *ad hoc* reporting. All program data for community mental health centers, state psychiatric hospitals, regional acute units, and regional pharmacies are regularly uploaded into the data warehouse and are stored in a standardized format (SAS) for integrated access, analysis and reporting. Managers and staff have access to performance reports via a web-based interface called Decision-Support (DS) On-line, that provides a suite of tools for statewide reports and downloads for local analysis and reporting. This resource significantly enhances local planning, monitoring, and evaluation. The DS Online suite includes DataQuest, an easy to use (point-&-click) *ad hoc* reporting tool, which provides virtually unlimited views of the wide range of mental health performance data, displayed in easy-to-read, comparative (relative percentage) tables, with drill-down capability from the regional to facility and service provider levels. DS Online provides access to performance score cards and reports of consumer quality of care surveys by Region/LGE and CMHC. DS On-line also includes DataBooks, a section of electronic spreadsheets and reports, including latest population statistics organized by parish and LGE, and access to the annual URS Table reports which show LA in comparison to other states across a wide range of important performance dimensions. OBH is in the process of upgrading the data warehouse and business intelligence system by integrating the existing data for mental health centers and psychiatric hospitals with the addictive disorder clinic data from the Louisiana Addictive Disorders Data System (LADDS) and the data that will be uploaded from the LGE EBHRs as the LGEs discontinue operation of the legacy systems.

OBH is also in the process of planning a more comprehensive and integrated Data Warehouse/Business Intelligence System (DW/BI) to address the agency's needs for managing and evaluating the operations of the Statewide Management Organization (SMO) starting this Spring 2012. This more comprehensive DW/BI will build upon the foundation of the existing system. It

will need to address the wide-range of reporting requirements outlined in the Quality Management Strategy for the SMO. OBH has initiated a technical assistance and consultation request with the South Carolina Office of Research and Statistics to provide planning for the design, development and implementation of the OBH DW/BI system. The South Carolina Office of Research and Statistics has operated a comprehensive data warehouse for decades and has extensive expertise in integrating and reporting on data from a wide diversity of agencies and sources. OBH will be issuing a Request for Proposals (RFP) for an architect, developer, and operator of the OBH DW/BI system. OBH is also in the process of establishing a position for a DW/BI manager to oversee the procurement, implementation, and operation of the statewide system.

Data Definitions & Methodology

SMI and EBD Definitions: OBH SMI and EBD population definitions follow the national definition. However, Louisiana uses the designation SMI for what is more usually referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness.

Estimation Methodology: Mental Health - OBH uses the CMHS estimation methodology, applying the national prevalence rates for SMI (2.6%) and EBD (9%) directly to current general population counts to arrive at the estimated prevalence of targeted persons to be served. This method has been used since the revised rates were published in 1996.

Addictive Disorders - OBH uses the SAMHSA National Survey on Drug Use and Health (NSDUH) data, applying the most recent estimate for “*Past Year Alcohol or Illicit Drug Dependence or Abuse*” prevalence for Louisiana to current general population counts to arrive at the estimated prevalence of targeted persons to be served.

Admissions: Number of clients that have been admitted during the time period.

Caseload/ Census: Active clients on a specified date. Caseload assumes that when a case is no longer active, it is closed.

Discharges: Number of clients that have been discharged during the time period.

Persons Served: The number of clients that had an active case for at least one day during the time period. Persons served is the combination of the number of active clients on the first day of the time period along with the number of admissions during the time period.

Persons Receiving Services: (CMHC only) The number of clients who received at least one service at a CMHC during the time period. This includes CONTACTS who are not admitted.

Unduplicated: Counts individual clients only once even if they appear multiple times during the time period.

Duplicated: Duplicated counts episodes of care, where clients are counted multiple times if they appear in the same time period multiple times. **Note:** The duplicated number must always equal or be larger than the unduplicated number.

Target Populations

Mental Health Clients: Adult

An adult who has a serious and persistent mental illness meets the following criteria for *Age*, *Diagnosis*, *Disability*, and *Duration*.

Age: 18 years of age or older

Diagnosis: Severe non-organic mental illnesses including, but not limited to schizophrenia, schizo-affective disorders, mood disorders, and severe personality disorders, that substantially interfere with a person's ability to carry out such primary aspects of daily living as self-care, household management, interpersonal relationships and work or school.

Disability: Impaired role functioning, caused by mental illness, as indicated by at least two of the following functional areas:

- 1) Unemployed or has markedly limited skills and a poor work history, or if retired, is unable to engage in normal activities to manage income.
- 2) Employed in a sheltered setting.
- 3) Requires public financial assistance for out-of-hospital maintenance (i.e., SSI) and/or is unable to procure such without help; does not apply to regular retirement benefits.
- 4) Severely lacks social support systems in the natural environment (i.e., no close friends or group affiliations, lives alone, or is highly transient).
- 5) Requires assistance in basic life skills (i.e., must be reminded to take medicine, must have transportation arranged for him/her, needs assistance in household management tasks).
- 6) Exhibits social behavior which results in demand for intervention by the mental health and/or judicial/legal system.

Duration: Must meet at least one of the following indicators of duration:

- 1) Psychiatric hospitalizations of at least six months in the last five years (cumulative total).
- 2) Two or more hospitalizations for mental disorders in the last 12 month period.
- 3) A single episode of continuous structural supportive residential care other than hospitalization for a duration of at least six months.
- 4) A previous psychiatric evaluation or psychiatric documentation of treatment indicating a history of severe psychiatric disability of at least six months duration.

Mental Health Clients: Child/Youth

A child or youth who has an emotional/behavioral disorder meets the following criteria for *Age*, *Diagnosis*, *Disability*, and *Duration* as agreed upon by all Louisiana child serving agencies. Note: For purposes of medical eligibility for Medicaid services, the child/youth must meet the criteria for diagnosis as contained in Item 4 of the Diagnosis Section below; Age and Disability must be met as described below; Duration must be met as follows: Impairment or patterns of inappropriate behavior which have/has persisted for at least three months and will persist for at least a year.

Age: Under age 18

Diagnosis: Must meet one of the following:

- 1) Exhibit seriously impaired contact with reality, and severely impaired social, academic, and self-care functioning, whose thinking is frequently confused, whose behavior may be grossly inappropriate and bizarre, and whose emotional reactions are frequently inappropriate to the situation; or,

- 2) Manifest long-term patterns of inappropriate behaviors, which may include but are not limited to aggressiveness, anti-social acts, refusal to accept adult requests or rules, suicidal behavior, developmentally inappropriate inattention, hyperactivity, or impulsiveness; or
- 3) Experience serious discomfort from anxiety, depression, or irrational fears and concerns whose symptoms may include but are not limited to serious eating and/or sleeping disturbances, extreme sadness, suicidal ideation, persistent refusal to attend school or excessive avoidance of unfamiliar people, maladaptive dependence on parents, or non-organic failure to thrive; or
- 4) Have a DSM-IV (or successor) diagnosis indicating a severe mental disorder, such as, but not limited to psychosis, schizophrenia, major affective disorders, reactive attachment disorder of infancy or early childhood (non-organic failure to thrive), or severe conduct disorder. This category does not include children/youth who are socially maladjusted unless it is determined that they also meet the criteria for emotional/behavior disorder.

Disability:

There is evidence of severe, disruptive and/or incapacitating functional limitations of behavior characterized by at least two of the following:

- 1) Inability to routinely exhibit appropriate behavior under normal circumstances;
- 2) Tendency to develop physical symptoms or fears associated with personal or school problems;
- 3) Inability to learn or work that cannot be explained by intellectual, sensory, or health factors;
- 4) Inability to build or maintain satisfactory interpersonal relationships with peers and adults;
- 5) A general pervasive mood of unhappiness or depression;
- 6) Conduct characterized by lack of behavioral control or adherence to social norms which is secondary to an emotional disorder. If all other criteria are met, then children determined to be "conduct disordered" are eligible.

Duration: Must meet at least one of the following:

- 1) The impairment or pattern of inappropriate behavior(s) has persisted for at least one year;
- 2) There is substantial risk that the impairment or pattern or inappropriate behavior(s) will persist for an extended period;
- 3) There is a pattern of inappropriate behaviors that are severe and of short duration.

Addictive Disorder Clients: Adult and Adolescent

An adult or adolescent (age 12-17) who has a substance use disorder, including those populations identified as priority or targeted within the SAPT Block Grant provisions:

- Pregnant women who use drugs by injection;
- Pregnant women who use substances;
- Other persons who use drugs by injection;
- Substance using women with dependent children and their families, including females who are attempting to regain custody of their children; and
- Persons with or at risk of contracting communicable diseases; including
 - Individuals with tuberculosis
 - Persons with or at risk for HIV/AIDS and who are in treatment for a substance use disorder

Assessment of Need: Services and System Infrastructure

Louisiana Population and Prevalence Estimates

Over the last several years, Louisiana population figures have been extremely difficult to estimate based on the mass evacuations and relocations following Hurricanes Katrina and Rita in 2005, and Hurricanes Gustav and Ike in 2008. The *2005 American Community Survey Gulf Coast Area Data Profiles: September through December, 2005 (revised July 19, 2006)* was released in an attempt to measure the population post-hurricanes, and at that time there had been a dramatic loss in population. There were estimated to be 3,688,996 individuals in Louisiana (2,742,070 adults, and 945,926 children). The Population Division of the US Census Bureau recently published the *Annual Estimates of the Resident Population by Single-Year 7/1/2010 - State Characteristics Population Estimates (Released May 26, 2011)*. The most recent data is listed in the tables below. A comparison of these sets of figures shows that the trend is for Louisiana's population to once again increase, now having passed the 2005 levels. The 2010 numbers indicate that there were **4,533,372** persons living in the state, showing that the population has rebounded from the post-hurricane drop as compared to the 2000 Census, when there were a total of 4,468,978 persons living in Louisiana.

POPULATION BY AGE

State's Population By Age Range*		
Age Range	Number of Persons	Percentage of State's Population
0-17	1,118,015	25%
18+	3,415,357	75%
TOTAL	4,533,372	100%

*Based on Annual Estimates of the Resident Population 7/1/2010 Annual State Population Estimates by Demographic. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: May 26, 2011.

Mental Health: Population and Prevalence Estimates

According to the *2010 Annual Estimates of the Resident Population 7/1/2010 State Characteristics, Population Estimates Division, U.S. Census Bureau (released May 26, 2011)*, the total number of adults in Louisiana is **3,415,357**. Of these, according to national benchmarks, **2.6%** are expected to have Serious Mental Illness (SMI). That translates into a total of **88,799** adults with serious mental illness (SMI) in Louisiana based on national prevalence rates. According to the same census report, the total number of children and youth in Louisiana is **1,118,015**. Of these, according to national benchmarks, **9%** are expected to have an Emotional or Behavioral Disorder (EBD). That translates into a total of **100,621** children and youth with an EBD in Louisiana based on national prevalence rates.

Statistics show that 37,708 adults with SMI received outpatient services under the OBH umbrella in FY 2011 through Community Mental Health Clinics. Of the total number of adults served, both with and without SMI (48,237), 78% met the definition of Seriously Mentally Ill (SMI). Statistics show that 8,856 children and youth with EBD received outpatient services under the OBH umbrella in FY 2011 through Community Mental Health Clinics. Of the total number of children and youth served (11,339), 78% met the definition of EBD.

As the term is used in Louisiana, SMI is a national designation that includes only those individuals suffering from the most severe forms of mental illness. EBD is a national designation for children/youth that includes only those individuals suffering from the most severe forms of mental illness. Those who have any type of mental illness would increase the population figures, but not the numbers of individuals served, since Louisiana’s outpatient mental health facilities are designated to serve only those adults with SMI and children/youth with EBD. Therefore, individuals with SMI/EBD are considered to be the target population for these programs. These numbers reflect an unduplicated count within regions and LGEs.

Estimates of the prevalence of mental illness within the state, parishes, Regions, and LGEs for Adults and Children/Youth are shown in the following tables. Caution should be used when utilizing these figures, as they are estimates.

LOUISIANA PREVALENCE ESTIMATES*
July 1, 2010 - (Released May 26, 2011)

State-wide	Child/Youth = 9%		Adult = 2.6%		Total	
	Population Count	Prevalence Count	Population Count	Prevalence Count	Population Count	Prevalence Count
	1,118,015	100,621	3,415,357	88,799	4,533,372	189,420

* 2010 Annual Estimates of the Resident Population 7/1/2010 State Characteristics, Population for Parishes of Louisiana

Estimates Source: Population Division, US Census Bureau. Release Date: May 26, 2011.
<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

Prevalence Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**)
 Adult =18 Years of Age and Older Child/Youth =17 Years of Age and Younger

* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.

** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

Please note: Louisiana uses the designation SMI for what is more usually referred to as SPMI. SMI (SPMI) is a national designation that includes only those individuals suffering from the most severe forms of mental illness. Those who have all types of mental illness would increase the population figures, but would not increase the numbers of individuals served since Louisiana’s facilities are designated to serve those with SMI (SPMI).

Estimated State Population and Estimated Prevalence of Adults with Serious Mental Illness and Child/Youth with Emotional Behavioral Disorders by Region/LGE and Parish (July 1, 2010 Pop Est)*

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2010	TOTAL Prevalence Estimate
Metropolitan Human Service District (MHSD)	Orleans	73,215	6,589	270,614	7,036	343,829	13,625
	Plaquemines	6,329	570	16,713	435	23,042	1,004
	St. Bernard	9,177	826	26,720	695	35,897	1,521
Total for MHSD		88,721	7,985	314,047	8,165	402,768	16,150
Capital Area Human Service District (CAHSD)	Ascension	30,755	2,768	76,460	1,988	107,215	4,756
	East Baton	103,665	9,330	336,506	8,749	440,171	18,079
	East Feliciana	4,192	377	16,075	418	20,267	795
	Iberville	7,502	675	25,885	673	33,387	1,348
	Pointe Coupee	5,475	493	17,327	451	22,802	943
	West Baton Rouge	5,927	533	17,861	464	23,788	998
	West Feliciana	2,718	245	12,907	336	15,625	580
Total for CAHSD		160,234	14,421	503,021	13,079	663,255	27,500
South Central Louisiana Human Services Authority (SCLHSA)	Assumption	5,756	518	17,665	459	23,421	977
	Lafourche	23,666	2,130	72,652	1889	96,318	4,019
	St. Charles	14,208	1,279	38,572	1003	52,780	2,282
	St. James	5,701	513	16,401	426	22,102	940
	St. John the Baptist	12,356	1,112	33,568	873	45,924	1,985
	St. Mary	13,904	1,251	40,746	1059	54,650	2,311
	Terrebonne	29,123	2,621	82,737	2151	111,860	4,772
Total for SCLHSA		104,714	9,424	302,341	7,861	407,055	17,285
Region 4	Acadia	16,863	1,518	44,910	1,168	61,773	2,685
	Evangeline	9,167	825	24,817	645	33,984	1,470
	Iberia	19,842	1,786	53,398	1,388	73,240	3,174
	Lafayette	54,263	4,884	167,315	4,350	221,578	9,234
	St. Landry	22,680	2,041	60,704	1,578	83,384	3,620
	St. Martin	13,771	1,239	38,389	998	52,160	2,238
	Vermilion	15,477	1,393	42,522	1,106	57,999	2,499
Total for Region 4		152,063	13,686	432,055	11,233	584,118	24,919

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2010	TOTAL Prevalence Estimate
Region 5	Allen	5,894	530	19,870	517	25,764	1,047
	Beauregard	9,295	837	26,359	685	35,654	1,522
	Calcasieu	49,012	4,411	143,756	3,738	192,768	8,149
	Cameron	1,656	149	5,183	135	6,839	284
	Jefferson Davis	8,398	756	23,196	603	31,594	1,359
Total for Region 5		74,255	6,683	218,364	5,677	292,619	12,360
Region 6	Avoyelles	10,283	925	31,790	827	42,073	1,752
	Catahoula	2,350	212	8,057	209	10,407	421
	Concordia	5,233	471	15,589	405	20,822	876
	Grant	5,151	464	17,158	446	22,309	910
	La Salle	3,524	317	11,366	296	14,890	613
	Rapides	34,014	3,061	97,599	2,538	131,613	5,599
	Vernon	14,512	1,306	37,822	983	52,334	2,289
	Winn	3,442	310	11,871	309	15,313	618
Total for Region 6		78,509	7,066	231,252	6,013	309,761	13,078
Region 7	Bienville	3,341	301	11,012	286	14,353	587
	Bossier	30,034	2,703	86,945	2,261	116,979	4,964
	Caddo	62,654	5,639	192,315	5,000	254,969	10,639
	Claiborne	3,380	304	13,815	359	17,195	663
	De Soto	6,650	599	20,006	520	26,656	1,119
	Natchitoches	9,600	864	29,966	779	39,566	1,643
	Red River	2,313	208	6,778	176	9,091	384
	Sabine	5,922	533	18,311	476	24,233	1,009
	Webster	9,710	874	31,497	819	41,207	1,693
Total for Region 7		133,604	12,024	410,645	10,677	544,249	22,701

Region/LGE	PARISH	CHILD/ YOUTH (Age 0-17) Population Estimate	CHILD/ YOUTH (Age 0-17) Prevalence Estimate	ADULT (Age 18 and up) Population Estimate	ADULT (Age 18 and up) Prevalence Estimate	TOTAL Population Estimate JULY 1, 2010	TOTAL Prevalence Estimate
Region 8	Caldwell	2,374	214	7,758	202	10,132	415
	East Carroll	1,993	179	5,766	150	7,759	329
	Franklin	5,317	479	15,450	402	20,767	880
	Jackson	3,704	333	12,570	327	16,274	660
	Lincoln	9,605	864	37,130	965	46,735	1,830
	Madison	3,022	272	9,071	236	12,093	508
	Morehouse	6,918	623	21,061	548	27,979	1,170
	Ouachita	40,373	3634	113,347	2,947	153,720	6,581
	Richland	5,285	476	15,440	401	20,725	877
	Tensas	1,329	120	3,923	102	5,252	222
	Union	5,228	471	17,493	455	22,721	925
	West Carroll	2,858	257	8,746	227	11,604	485
Total for Region 8		88,006	7,921	267,755	6,962	355,761	14,882
Florida Parishes Human Services Authority (FPHSA)	Livingston	35,330	3,180	92,696	2,410	128,026	5,590
	St. Helena	2,763	249	8,440	219	11,203	468
	St. Tammany	60,136	5,412	173,604	4,514	233,740	9,926
	Tangipahoa	30,420	2,738	90,677	2,358	121,097	5,095
	Washington	11,863	1,068	35,305	918	47,168	1,986
Total for 9-FPHSA		140,512	12,646	400,722	10,419	541,234	23,065
Jefferson Parish Human Services Authority (JPHSA)	Jefferson	97,397	8,766	335,155	8,714	432,552	17,480
STATE TOTAL		1,118,015	100,621	3,415,357	88,799	4,533,372	189,420

<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

2010 Annual Estimates of the Resident Population 7/1/2010 State Characteristics, Population for Parishes of Louisiana

Source: Population Estimates Division, U.S. Census Bureau

Release Date: May 26, 2011

Prevalence Count = Estimated Prevalence Count (2.6% Adults*, 9%Children**)

Adult =18 Years of Age and Older Child/Youth =17 Years of Age and Younger

* Source for Adult prevalence estimate: Kessler, R.C., et al. *The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.*

** Source for Child prevalence estimate: Friedman, R.M. et al. *Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.*

**LOUISIANA OBH COMMUNITY MENTAL HEALTH CLINICS DATA
UNDUPLICATED COUNT OF PERSONS RECEIVING SERVICES
FROM JULY 1, 2010 TO JUNE 30, 2011 (OBHIIS & JPHSA)**

REGION / LGE	UNDUPLICATED PERSONS RECEIVING SERVICES		TOTAL
	CHILD (0-17)	ADULT (18+)	
REGION 1 CHILD/YOUTH CLINICS	1,285	.	1,285
MHSD	12	7,632	7,644
CAHSD*	2,372	6,594	8,966
REGION 3	834	7,029	7,863
REGION 4	696	5,037	5,733
REGION 5	440	2,344	2,784
REGION 6	459	2,912	3,371
REGION 7	751	2,564	3,315
REGION 8	334	3,472	3,806
FPHSA	1,743	5,881	7,624
JPHSA	2,613	7,923	10,536
TOTAL	11,539	51,388	62,927

Data Source: OBHIIS and JPHSA

Persons receiving services count is the number of clients who received at least one service at a CMHC during the time period. This includes CONTACTS who are not admitted. *CAHSD data includes School-based Services.

**INPATIENT & OUTPATIENT CASELOAD ON JUNE 30, 2011
WITH SMI/EBD; PERCENTAGE OF SMI/EBD**

CASELOAD ON June 30, 2011 for Inpatient and Outpatient Facilities	ADULT: SMI	CHILD: SED	OTHER		TOTAL
	COUNT	Percent	COUNT	Percent	
Child/Youth (Age 0-17)	4,641	77%	1,354	23%	5,995
Adult (Age 18+)	26,916	78%	7,687	22%	34,603
Missing	4	67%	2	33%	6
TOTAL	31,561	78%	9,043	22%	40,604

Data from CMHC data: OBHIIS and JPHSA (unduplicated within Regions) and PIP data

Louisiana Community Mental Health Clinics
ADULTS – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY10-11

Regions / LGEs	Adults with SMI Served (persons served)	Total Adults Served	% SMI
1-MHSD	6,397	8,116	79%
2-CAHSD	6,189	7,025	88%
3-SCLHSA	6,230	6,993	89%
REGION 4	4,099	5,504	74%
REGION 5	2,119	2,430	87%
REGION 6	1,777	3,144	57%
REGION 7	2,310	2,594	89%
REGION 8	2,704	2,969	91%
9-FPHSA	3,661	3,980	92%
10-JPHSA	2,222	5,482	41%
TOTAL	37,708	48,237	78%

Data Source: OMHIIS, JPHSA, MHR

Louisiana Community Mental Health Clinics
CHILD/YOUTH – CMHC PERSONS SERVED
UNDUPLICATED WITHIN REGIONS/LGEs FY0910

Regions / LGEs	Children/Youth with EBD Served (persons served)	Total Children/Youth Served	% SMI
1-MHSD	34	42	81%
REGION 1 CHILD/YOUTH CLINICS	931	1,114	84%
2-CAHSD	2,571	2,879	89%
REGION 3	591	744	79%
REGION 4	736	905	81%
REGION 5	475	486	98%
REGION 6	215	462	47%
REGION 7	714	804	89%
REGION 8	335	345	97%
9-FPHSA	760	1,183	64%
10-JPHSA	1,494	2,375	63%
TOTAL	8,856	11,339	78%

Data Source: OMHIIS, JPHSA, and MHR

CMHC ADULT CASELOAD SIZE ON LAST DAY OF FY2010 & FY2011

Region/LGE	FY09-10			FY10-11		
	Age 18-64	Age 65+	TOTAL 18+	Age 18-64	Age 65+	TOTAL 18+
MHSD	5608	237	5845	5393	213	5606
CAHSD	4943	251	5194	4569	256	4825
REGION 3	4839	267	5106	4839	263	5102
REGION 4	3786	173	3959	3866	181	4047
REGION 5	1174	30	1204	1666	39	1705
REGION 6	1905	63	1968	1939	70	2009
REGION 7	1428	29	1457	1619	24	1643
REGION 8	1772	79	1851	1938	70	2008
FPHSA	2761	135	2896	2610	135	2745
JPHSA	3362	107	3469	4065	120	4185
TOTAL	31578	1371	32949	32504	1371	33875

Data from CMHC data: OBHIS and JPHSA unduplicated within Regions

CMHC CHILD/ YOUTH CASELOAD SIZE ON LAST DAY OF FY2010 & FY2011

Region/LGE	FY09-10			FY10-11		
	Age 0-11	Age 12-17	TOTAL 0-17	Age 0-11	Age 12-17	TOTAL 0-17
SELH CHILD/YOUTH CLINICS	300	290	590	317	321	638
MHSD	.	8	8	.	2	2
CAHSD	815	1074	1889	751	980	1731
REGION 3	74	201	275	190	317	507
REGION 4	224	281	505	178	230	408
REGION 5	82	105	187	122	114	236
REGION 6	121	133	254	78	113	191
REGION 7	141	179	320	165	152	317
REGION 8	48	101	149	29	60	89
FPHSA	349	346	695	358	358	716
JPHSA	460	607	1067	530	564	1094
TOTAL	2614	3325	5939	2718	3211	5929

Data from CMHC data: OBHIS and JPHSA unduplicated within Regions

**CASELOAD SERVED COMPARED TO
PREVALENCE ESTIMATES AND CENSUS DATA
FY 2011**

Age Range	LA Population Estimated*	National Prevalence Rate	Est. Number of persons in LA Population with SMI/EBD
Child/ Youth* 0-17	1,118,015	9%	1,118,015 X .09 = 100,621
Adult** 18+	3,415,357	2.6%	3,415,357 X .026 = 88,799
Total	4,533,372	-----	189,420

*Based on Annual Estimates of the Resident Population 7/1/2010 Annual State Population Estimates by Demographic. Estimates Source: Population Estimates Division, US Census Bureau. Release Date: May 26, 2011.

Age Range	Est. Number of persons in LA population with SMI/EBD	Number of Persons with SMI/EBD in OMH Caseload*	Louisiana Percent of Prevalence Served*
Child/ Youth 0-17	100,621	4,641	4,641 / 100,621 = 4.6%
Adult 18+	88,799	26,916	26,916 / 88,799 = 30.4%
Total	189,420	31,561	31,561 / 189,420 = 16.7%

PLEASE NOTE: These figures do not include persons seen in the offices of private practitioners. These figures do not include persons seen in the Mental Health Rehab programs.

Prevalence Count = Estimated Prevalence Count (2.6% Adults*, 9% Children**)
Adult = 18 Years of Age and Older Child/Youth = 17 Years of Age and Younger

* Source for Adult prevalence estimate: Kessler, R.C., et al. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI). Mental Health, United States, 1996. U.S. Department of Health and Human Services pp. 59-70.

** Source for Child prevalence estimate: Friedman, R.M. et al. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. U.S. Department of Health and Human Services pp 71-89.

The goal to increase access to mental health services to persons with Serious Mental Illness/ Emotional Behavioral Disorder (National Outcome Measure (NOMS) Performance Indicator “Increased Access to Services”) has historically been reported by the State as the percentage of prevalence of individuals who have SMI/EBD who receive mental health services from the

Office of Behavioral Health during the fiscal year. The measure of this NOMS is now requested to be reported as simply the number of persons who have a mental illness and receive services.

The historical figures detailed below for this quantitative target should be interpreted with caution due to fluctuations and inaccuracies in population figures following the hurricanes of 2005. After Hurricane Katrina/Rita the population of the state decreased, and efforts to reach the SMI population intensified. Through these efforts it appears that the percent of prevalence in years after Hurricane Katrina/Rita increased somewhat. It also should be noted that the data collected are more accurate than in prior reporting. In the past, the caseload figures were inflated by cases that had not been “officially” closed, making it appear that more individuals were being seen than actually were. A new process in the clinics automatically cleans out information relating to clients who have not been seen for nine months. This change will cause the numbers of persons on the caseload to appear to be smaller than in past years.

ADULT POPULATION

- Numerator: unduplicated count of adults who have serious mental illness and who receive mental health services during the state fiscal year in an OBH community or inpatient setting.
- Denominator: prevalence of adults in Louisiana with serious mental illness during a twelve month period.

These figures for the Adult population for each of the preceding years were:

FY 2004	23,954/ 84,475 X 100 = 28.36%	FY 2008	27,619/ 83,555 X 100 = 33.05%
FY 2005	25,297/ 84,475 X 100 = 29.95%	FY 2009	29,189 / 85,873 X 100 = 33.9%
FY 2006	24,667/ 71,294 X 100 = 34.6%	FY 2010	24,368 / 87,586 X 100 = 27.8 %
FY 2007	25,604/ 71,294 X 100 = 35.9%	FY 2011	26,916 / 88,799 X 100 = 30.3 %

CHILD/YOUTH POPULATION

- Numerator: unduplicated count of children/youth who have emotional behavioral disorder and who receive mental health services during the state fiscal year in an OBH community or inpatient setting.
- Denominator: prevalence of children/youth in Louisiana with emotional behavioral disorder during a twelve month period.

These figures for the C/Y population for each of the preceding years were:

FY 2004	3,571/ 109,975 X 100 = 3.25%	FY 2008	4,286/ 97,160 X 100 = 4.4%
FY 2005	3,765/ 109,975 X 100 = 3.43%	FY 2009	4,317/ 99,718 X 100 = 4.3 %
FY 2006	3,552/ 85,223 X 100 = 4.17%	FY 2010	3,966 / 101,105 X 100 = 3.9 %
FY 2007	3,818/ 85,223 X 100 = 4.5%	FY 2011	4,641 / 100,621 X 100 = 4.6 %

Addictive Disorders: Population and Prevalence Estimates

The Office of Behavioral Health agrees to submit an assessment of the need for both treatment and prevention in the State for authorized activities both by localities and the State in general (*SAPT Block Grant Federal Goal 13: Assessment of Need*).

In order to determine current estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens, OBH collects and analyzes available national and state data sources. These data sources include but are not limited to: US Census Bureau, SAMHSA National Survey on Drug Use and Health (NSDUH), Centers for Disease Control and Prevention, Office of National Drug Control Policy, Louisiana State University, and Louisiana Department of Health and Hospitals. Distributions of the data collected by the Louisiana Addictive Disorders Data System (LADDS) is also analyzed to estimate the percentage of people who receive services and the percentage of people who are in need of treatment but not receiving services.

Estimates of the need for substance use disorder treatment, the prevalence of substance-related criminal activity, and the incidence of communicable diseases among Louisiana citizens within the Regions, and Local Governing Entities (LGEs) are detailed in the following tables. Caution should be used when utilizing these figures, as they are estimates. There are also several limitations in the methodology used for the estimate calculations for the *Treatment Needs Assessment Summary Matrix* and *Treatment Needs by Age, Sex, and Race/Ethnicity*:

- The NSDUH data used in calculating the number of people that are in need of treatment services and that would seek treatment does not include estimates for the population under 12 years of age; therefore, that segment of the population was excluded from the reported estimates.
- The NSDUH data estimates used for the calculations are only representative of the State as a whole (or U.S. geographic region as used for the injecting drug user calculations), and not necessarily specific to the Parishes that comprise the Sub-state Planning Areas.
- The NSDUH data estimates are not specific to gender, race or ethnicity.
- The estimates for Drug Related Arrests and Hepatitis B were calculated by applying a Statewide total to the Parish percentage of the total state population estimate, which results in figures that may not accurately reflect the Parishes comprising the Sub-State Planning Areas.

Treatment Needs Assessment Summary Matrix

Sub-state Planning Area	Population by area ¹	12+ Population by area ¹	Female 12+ Population by area ⁶	TOTAL POPULATION		INJECTING DRUG USERS		WOMEN		PREVALENCE OF SUBSTANCE-RELATED CRIMINAL ACTIVITY		INCIDENCE OF COMMUNICABLE DISEASE (per 100,000)		
				Needing Treatment Services ²	That would seek treatment ³	Needing Treatment Services ⁴	That would seek treatment ⁵	Needing Treatment Services ⁷	That would seek treatment ⁸	Number of DWI Arrests ⁹	Number of Drug Related Arrests ¹⁰	Hepatitis B ¹¹	AIDS ¹²	TB ¹³
MHSD	402,768	340,976	176,484	29,222	3,214	1,057	116	15,125	1,664	1,643	2,903	8	171	48
CAHSD	663,255	552,546	283,596	47,353	5,209	1,713	188	24,304	2,673	3,173	4,780	14	201	22
SCLHSA	407,055	335,455	171,346	28,748	3,162	1,040	114	14,684	1,615	2,868	2,934	9	33	14
Region 4	584,118	478,634	247,593	41,019	4,512	1,484	163	21,219	2,334	3,029	4,210	12	51	22
Region 5	292,619	241,456	122,050	20,693	2,276	749	82	10,460	1,151	2,074	2,109	6	43	4
Region 6	309,761	254,995	127,353	21,853	2,404	790	87	10,914	1,201	1,993	2,233	6	41	7
Region 7	544,249	451,201	235,548	38,668	4,253	1,399	154	20,186	2,221	3,388	3,923	11	81	25
Region 8	355,761	294,611	152,824	25,248	2,777	913	100	13,097	1,441	2,147	2,564	7	56	17
FPHSA	541,234	444,693	229,176	38,110	4,192	1,379	152	19,640	2,160	4,233	3,901	11	52	17
JPHSA	432,552	364,769	189,030	31,261	3,439	1,131	124	16,200	1,782	1,558	3,118	9	69	24
TOTAL	4,533,372	3,759,332	1,934,998	322,175	35,439	11,654	1,282	165,829	18,241	26,106	32,674	95	798	200

¹ The estimates for Total Population by Sub-state Planning Area (SPA) were obtained from the US Census Bureau’s 2010 Population Estimates dataset for Louisiana Parishes. To estimate the 12+ Population by SPA from the same dataset: the *Under 5 Years*, *5 to 9 Years*, and one-half of *10 to 14 Years* categories were excluded. <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

² Information from the 2008 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Population Needing Treatment Services by SPA. According to the 2008 State Estimates for Louisiana, the prevalence estimate for “Past Year Alcohol or Illicit Drug Dependence or Abuse” for the age group 12 and older is **8.57%**. The 12+ Population for each SPA was multiplied by **8.57%** to estimate the number of people needing treatment services. (*Table 38: Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, Serious Psychological Distress, and Having at Least One Major Depressive Episode in Louisiana, by Age Group, Percentages, Annual Averages Based on 2007-2008 NSDUHs*. <http://www.oas.samhsa.gov/2k8State/stateTabs.htm>)

³ According to SAMHSA-Center for Substance Abuse Treatment, the proportion of those needing treatment for addictions or abuse of multiple drugs and alcohol who either get treatment or attempt to get it is approximately **11%** in any given year. (Source: SAMHSA-Center for Substance Abuse Treatment; Hal Krause, Public Health Analyst - (240) 276-2897 - hal.krause@samhsa.hhs.gov). **11%** was used as the estimate to determine the Total Population that Would Seek Treatment by SPA.

⁴ Information from the *NSDUH Report: Demographic and Geographic Variations in Injection Drug Use (July 19, 2007)* was used to estimate the Number of IDU’s Needing Treatment Services by SPA. According to this report, the estimated rate for injection drug use in the South is .0031 (*Table 1. Past Year Injection Drug Use among Persons Aged 12 or Older, by Geographic Characteristics: Percentages, 2002-2005*. <http://www.oas.samhsa.gov/2k7/idu/idu.pdf>).

⁵ The 12+ Population for each SPA was multiplied by .0031 to estimate the number of IVDU’s needing treatment services. The estimate of **11%** that was used to calculate the number of people that would seek treatment was also used to determine the Number of IVDU’s that Would Seek Treatment.

⁶ An estimate for the Female Population by SPA was obtained from the US Census Bureau's 2010 Population Estimates dataset for Louisiana Parishes by Gender. The Female Population was estimated to include only those 12 years and older.

⁷ Information from the 2008 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total Number of Women Needing Treatment Services by SPA. The prevalence estimate of **8.57%** used to calculate the number of people needing treatment was used to estimate the number of women in need of treatment.

⁸ The estimate of **11%** that was used to calculate the number of people that would seek treatment was also used to determine the Number of Women that Would Seek Treatment.

A. ⁹ The estimates for Number of DWI Arrests for Calendar Year 2009 were obtained from the Louisiana State University, Highway Safety Research Group's *2009 DWI Arrest Report by Parish*. The Traffic Records Reports section of the Highway Safety Research Group is a compilation of databases submitted by state, sheriff and local police agencies. It contains specialized reports on DWI tests and arrests submitted in the Computerized On-line BReath Archiving system (COBRA). <http://lhsc.lsu.edu/Reports/DWITests/Default.asp?reportYear=2009>

¹⁰ Information from the Federal Bureau of Investigations, Crime in the United States, 2009 Report was used to estimate the Number of Drug Related Arrests for Calendar Year 2009. According to this report, there were 32,674 drug related arrests in Louisiana in 2009 (19,334 Drug Abuse Violations + 8,488 Driving Under the Influence + 2,274 Liquor Law Violations + 2,578 Drunkenness = 32,674). Parish estimates for the Number of Drug Related Arrests were calculated by multiplying this figure (32,674) by the Parish percentage of the total state 12 years and older population estimate. (Federal Bureau of Investigations, *Crime in the United States, 2009*, September 2010: <http://ww2.fbi.gov/ucr/cius2009/index.html>. Table 69 Arrests by State, 2009.).

¹¹ According to the CDC, Louisiana's incidence rate for Hepatitis B in 2008 was 2.1/100,000 (MMWR: Surveillance for Acute Viral Hepatitis – United States, 2008; Table 2b: Incidence per 100,000 population of acute, symptomatic hepatitis B, by state/area and year – United States, 1996-2008 <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5803a1.htm>). This estimates 95 cases (.000021*4,533,372) for the total population. Parish estimates for Incidence of Hepatitis B/100,000 were calculated by multiplying this figure (95) by the Parish percentage of the total state population estimate.

¹² According to the CDC, Louisiana's incidence rate for AIDS in 2009 was 19.4/100,000 (Surveillance Report: Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2008; Vol 21; February 2011 <http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/>). This estimates 869 cases for the total population. The 2009 HIV/AIDS Program Report published by the Louisiana Department of Health and Hospitals-Office of Public Health details the Geographic Distribution of AIDS Diagnoses in each Parish for 2009, which are provided in the estimates table. http://www.dhh.state.la.us/offices/publications/pubs-264/FINAL_2009_AR_PDF.pdf

¹³ According to the Louisiana Department of Health and Hospitals Tuberculosis Control Program, Louisiana's incidence rate for Tuberculosis in 2010 was 4.4/100,000 (Louisiana TB Morbidity Report – 2010: Louisiana Tuberculosis (TB) Cases/Rates <http://www.dhh.louisiana.gov/offices/publications/pubs-273/2010%20TB%20Morbidity%20Table%20-Louisiana.pdf>.) This estimates 200 cases (.000044*4,533,372) for the total population. The distribution of cases by Parish as published by the Tuberculosis Control Program are provided in the estimates table.

TREATMENT NEEDS BY AGE, SEX, AND RACE/ETHNICITY

Age	Total	White		Black or African American		Native Hawaiian /Other Pacific Islander		Asian		American Indian /Alaska Native		More than One Race Reported		Unknown		Not Hispanic or Latino		Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
17 & Under	19,135 (6%)	6,099	5,879	3,118	3,005	4	4	146	141	68	66	156	150	152	146	9,334	8,998	409	394
18-24	88,249 (27%)	27,767	27,477	14,194	14,046	19	19	665	658	310	307	710	702	690	683	42,493	42,050	1,863	1,844
25-44	85,540 (27%)	26,695	26,853	13,646	13,727	18	19	640	643	299	300	682	686	664	668	40,852	41,095	1,791	1,802
45-64	85,318 (27%)	25,980	27,429	13,281	14,021	18	19	623	657	291	307	664	701	646	682	39,759	41,976	1,743	1,840
65 & Over	39,998 (13%)	10,651	14,388	5,444	7,355	7	10	255	345	119	161	272	368	265	358	16,299	22,019	715	965
Total	318,240	97,192	102,026	49,683	52,154	66	71	2,329	2,444	1,087	1,141	2,484	2,607	2,417	2,537	148,737	156,138	6,521	6,845
		62.59%		32.0%		.04%		1.49%		.70%		1.59%		1.59%		96%		4%	

The estimates for Age categories were obtained from the US Census Bureau's 2010 Population Estimates dataset for Louisiana – tables used include Sex by Age, Race, and Hispanic or Latino by Race. The 17 and Under category estimates include only those 12 years and older. Information from the 2008 National Survey on Drug Use and Health (NSDUH) was used to estimate the Total in Need of Treatment for the Age categories.

According to the 2008 State Estimates for Louisiana, the prevalence estimate for Past Year Alcohol or Illicit Drug Dependence or Abuse is **6.04%** for the age group 12-17, **17.59%** for the age group 18-25, and **7.17%** for the age group 26 and older. (Table 38: Selected Drug Use, Perceptions of Great Risk, Average Annual Rates of First Use of Marijuana, Past Year Substance Dependence or Abuse, Needing But Not Receiving Treatment, Serious Psychological Distress, and Having at Least One Major Depressive Episode in Louisiana, by Age Group, Percentages, Annual Averages Based on 2007-2008 NSDUHs. <http://www.oas.samhsa.gov/2k8State/stateTabs.htm>)

TREATMENT ADMISSIONS AND PERSONS SERVED COMPARED TO PREVALENCE ESTIMATES AND CENSUS DATA SFY 2011

The tables below provide a comparison of the number of admissions and persons served to the prevalence estimates determined in the *Treatment Needs Assessment Summary Matrix* and the *Treatment Needs by Age, Sex, and Race/Ethnicity Matrix* for the state Total Population, Injecting Drug Users (IDU) and Women. The current National Survey on Drug Use and Health (NSDUH) prevalence estimate for “*Past Year Alcohol or Illicit Drug Dependence or Abuse*” for the age group 12 and older in Louisiana of 8.57% was used to determine the number of persons in each Region/LGE *needing treatment services* for the tables representing the Total Population and Women. The NSDUH estimated rate for injection drug use in the South of .0031 was used to determine the number of persons *needing treatment services* in the Injecting Drug Users (IDU) table.

It is estimated that approximately 11% of persons needing treatment services *would seek treatment*, according to SAMHSA - Center for Substance Abuse Treatment. Data collected from the Louisiana Addictive Disorders Data System (LADDS) for the total number of persons served during FY2011 is compared to the total estimated number needing treatment services to determine the *percent of prevalence served* in Louisiana.

TOTAL POPULATION

Regions/LGEs	<i>Needing Treatment Services</i>	That would seek treatment	Admissions*	<i>Total Served*</i>	Percent of Prevalence Served
MHSD	29,222	3,214	3,243	3,991	3,991 / 29,222 = 13.65%
CAHSD	47,353	5,209	3,412	4,414	4,414 / 47,353 = 9.32%
SCLHSA	28,748	3,162	2,293	3,125	3,125 / 28,748 = 10.87%
Region IV	41,019	4,512	2,458	3,060	3,060 / 41,019 = 7.45%
Region V	20,693	2,276	1,513	1,932	1,932 / 20,693 = 9.34%
Region VI	21,853	2,404	2,846	3,542	3,542 / 21,853 = 16.20%
Region VII	38,668	4,253	1,701	2,199	2,199 / 38,668 = 5.68%
Region VIII	25,248	2,777	3,066	3,999	3,999 / 25,248 = 15.83%
FPHSA	38,110	4,192	2,123	2,781	2,781 / 38,110 = 7.29%
TOTAL	290,914	32,000	22,655	29,043	29,043 / 290,914 = 9.98%

* Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Total Served figures do not include 4,371 clients engaged in ATR services in SFY2011.

INJECTING DRUG USERS (IDU)

Regions/LGEs	<i>Needing Treatment Services</i>	That would seek treatment	Admissions*	<i>Total Served*</i>	Percent of Prevalence Served
MHSD	1,057	116	1,124	1,230	1,230 / 1,057 = 116.36%
CAHSD	1,713	188	408	458	458 / 1,713 = 26.73%
SCLHSA	1,040	114	178	206	206 / 1,040 = 19.80%
Region IV	1,484	163	224	253	253 / 1,484 = 17.04%
Region V	749	82	144	158	158 / 749 = 21.09%
Region VI	790	87	423	487	487 / 790 = 61.64%

Region VII	1,399	154	148	185	185 / 1,399 = 13.22%
Region VIII	913	100	268	313	313 / 913 = 34.28%
FPHSA	1,379	152	365	442	442 / 1,379 = 32.05%
TOTAL	10,523	1,158	3,282	3,732	3,732 / 10,523 = 35.46%

* Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Total Served figures do not include 163 IDU clients engaged in ATR services in SFY2011.

WOMEN

Regions/LGEs	Needing Treatment Services	That would seek treatment	Admissions *	Total Served*	Percent of Prevalence Served
MHSD	15,125	1,664	986	1,183	1,183 / 15,125 = 7.82%
CAHSD	24,304	2,673	918	1,191	1,191 / 24,304 = 4.90%
SCLHSA	14,684	1,615	733	993	993 / 14,684 = 6.76%
Region IV	21,219	2,334	878	1,104	1,104 / 21,219 = 5.20%
Region V	10,460	1,151	543	694	694 / 10,460 = 6.63%
Region VI	10,914	1,201	1,040	1,307	1,307 / 10,914 = 11.97%
Region VII	20,186	2,221	689	888	888 / 20,186 = 4.39%
Region VIII	13,097	1,441	810	1,073	1,073 / 13,097 = 8.19%
FPHSA	19,640	2,160	836	1,074	1,074 / 19,640 = 5.47%
TOTAL	149,629	16,459	7,433	9,507	9,507 / 149,629 = 6.35%

* Unduplicated; Source: Louisiana Addictive Disorders Data System (LADDS) which does not include data for JPHSA; Total Served figures do not include 812 Women engaged in ATR services in SFY2011.

Race/Ethnicity and Age Compared to SFY2011 Population Profile

Race/Ethnicity	Needing Treatment Services	Population Profile
White	62.59%	61.7%
Black/African American	32%	36.1%
Native Hawaiian /Other Pacific Islander	.04%	.3%
Asian	1.49%	.3%
American Indian /Alaska Native	.70%	.6%
More than One Race Reported	1.59%	-
Unknown - Other	1.59%	1%
Hispanic or Latino	4%	2%
Not Hispanic or Latino	96%	98%

Age	Needing Treatment Services	Population Profile
17 & Under	6%	7%
18-24	27%	18%
25-44	27%	54%
45-64	27%	20%
65 & Over	13%	1%

Gender	Needing Treatment Services	Population Profile
Male	49%	67%
Female	51%	33%

Source: Louisiana Addictive Disorders Data System (LADDS)

State Epidemiology Workgroup

Workgroup (SEW) developed as a result of the Strategic Prevention Framework State Incentive Grant (SPF-SIG). OBH also continues to provide prevention and treatment data to the workgroup for inclusion in the State SEW Report. With the heightened awareness of substance abuse prevention activities and the data driven model that has been introduced to the prevention system in Louisiana through the Strategic Planning Framework, the State Epidemiology Workgroup (SEW) members began to re-evaluate their ongoing mission and, in particular, their membership. The need for members from every agency that houses data relevant to prevention activities began to be greatly reduced by both the establishment of relationships with the SEW and, more importantly, the creation and propagation of the Louisiana Drug Policy Board policy related to data sharing. The outcome is that when data are available within Louisiana's government agencies, they are usually readily shared with the SEW. This has reduced the burden on the SEW for data acquisition and allowed the SEW to focus more on providing analysis and guidance on the understanding and use of the data.

The Office of Behavioral Health Prevention and Treatment Services have a standing seat on the State Epidemiology Workgroup and attended four quarterly meetings during SFY 2011. These meetings focused on increased knowledge of the Strategic Planning Framework, implementation of State Epidemiology Workgroup Action Plans, updates on subcommittee progress (SEW Data Gaps, Sustainability and Community Level Data Collection). During SFY 2011 OBH Prevention Services updated the 2010 Caring Communities Youth Survey, the 2011 Higher Education CORE Survey and provided the resources to sustain the SEW web-based Community Needs Assessment Website.

<http://www.bach-harrison.com/lasocialindicators/Default.aspx>

See table for SEW membership on next page.

STATE EPIDEMIOLOGICAL WORKGROUP

Member	Agency
Albin, Stacie	Department of Children and Family Services (DCFS), Office of Family Assistance Program Policy Section
Asmus, Dr. Gary	University of Louisiana at Lafayette-Center for Child Development, SEW Co Chair
Balsamo, Dr. Gary	Department of Health and Hospitals (DHH), Office of Public Health (OPH), Infectious Disease Epidemiology, SEW Chair
Barnum, Layne	State Police
Blackmon, Bret	Louisiana State University (LSU) - Louisiana Center Addressing Substance Use
Blanchard, Bill	DHH, Office of Behavioral Health (OBH)
Bourgeois, Brandi	DHH, OPH, Bureau of Primary Care and Rural Health
Burns, Lillie	Department of Education
Cataldie, Louis	Coroner
Childers, Cathy	Louisiana Highway Safety Commission
Diez, Dawn	Governor's Office – State Prevention Enhancement Grant Project Director
Gettys, Vivian	Capital Area Human Services District, Project Manager, FASD Prevention Collaborative
Giroir, Annette	DHH, Office of Behavioral Health
Graves, Missy	Governor's Office of Safe and Drug-Free Schools
Harrison, Dr. Murelle	Southern University, Psychology Department
Lars, Sonya	Louisiana Commission on Law Enforcement
Richard-Griffin, Avis	DHH, OPH
Richardson, Henry	Drug Enforcement Administration
Roussel, Ellis	Governor's Office Safe & Drug Free Schools & Communities
Straif-Bourgeois, Suzanne	DHH, OPH, Assistant State Epidemiologist
Starszak, Robert	DHH, Office of the Secretary
Wilson, Ivory	DHH, OBH
Vacant	National Guard
Vacant	Governor's Office of Elderly Affairs
Of Counsel	Agency
Andrieu, Chris	LA Supreme Court
Freeman, Leslie	DHH, OBH
Cummins, Dortha	Louisiana Highway Safety Commission
Jackson, Danny	LA Sheriff's Association
Johnson, Felecia	DHH, OBH
Johnson, Mary	DHH, OPH
Lemoine, Dr. Randall	DHH, OBH
Patterson, Karen	Division of Administration – Electronic Services
Pugh, Audrey	DHH, OPH
Robinson, Dr. Billy	DHH, OPH, LSU Health Sciences Center
Schneider, Dr. Helmut	LSU ISDS Research for Highway Safety
Theall, Dr. Katherine	LSU School of Public Health
Thompson, Louis	Office of Alcohol and Tobacco Control
Wright, Nancy	DCFS

Prevention

Problem Assessment (Epidemiological Profile)

The criteria that OBH-AD Prevention Services uses for establishing primary prevention priorities requires that state epidemiological data support the decision to fund a given intervention. Only programs that are evidenced-based and on a federally recognized register, or have been presented in a peer-reviewed journal with good results, are considered. Further, there must be statistically significant outcomes achieved with a sufficient sample in the program research to yield a reliable evaluation.

The rationale for prioritizing primary prevention programs in Louisiana is to address the fundamental substance abuse-related issues in the State. The basis for judging the most pressing needs in Louisiana are found in the data. For instance, LifeSkills Training, Project Northland and Positive Action account for 77.5% of all enrollees in FY 2010. The proven outcomes for these programs are centered around alcohol, tobacco, family relationships, drugs, social functioning, crime and violence as indicated on NREPP. These programs have outcomes that address substance-abuse related problems in the State as revealed by data. Three of these data sources are the 2010 Caring Communities Youth Survey (CCYS), the 2011 CORE Alcohol and Drug Survey, which are both funded by OBH-AD, and the 2009 State Epidemiology Workgroup (SEW) report.

Using alcohol as an example of what the data reveals; the CCYS 2010 indicated that 22.8% of 6th grade, 46.5% of 8th grade, 64.9% of 10th grade and 73.5% of 12th grade students used alcohol in their life time. Additionally in CCYS 2010, 8.1% of 6th grade, 21.8% of 8th grade, 35.3% of 10th grade and 45.7% of 12th grade students reported using alcohol in the past 30 days. The SEW report sites data from the Louisiana Department of Education (DOE) that states there were 410 suspension and expulsions in schools for alcohol-related violations. Alcohol and drug consumption patterns tend to increase when students enter college. The CORE survey, a survey distributed to all two and four year Institutions/Universities in Louisiana, reported 78.3% of college students consumed alcohol in the past year and 62.6% of students consumed alcohol in the past 30 days. OBH-AD focuses prevention efforts on school age children based on the CCYS 2010 finding that the age of first use of alcohol in Louisiana is 11 or younger. Providing prevention programs to children should contribute to a downward trend in college consumption patterns over time.

OBH-AD maximizes the positive impact on citizens by funding primarily universal programs based on needs (indicated by data) and partnering with the DOE to deliver these services using a cost-effective school-based model. OBH-AD headquarters staff annually reviews epidemiological data with Regional, District and Authority staff. It is important to note that the three core reports that provide epidemiological data are collected bi-annually. In years that new data are available, additional training and technical assistance is provided on how to interpret the new information. OBH-AD has initiated training sub-recipients and staff on SAMHSA's Strategic Planning Framework. OBH-AD continues to move toward the goal of fully implementing the SPF process throughout the agency for making data-driven prevention decisions.

Prevention System Assessment (Capacity and Infrastructure)

OBH-AD Prevention infrastructure includes headquarters staff, field staff, and community-based providers through contractual agreements. The State is divided into ten (10) geographic service areas. SAPT Block Grant Funds are distributed to each of these 10 areas to fund programs, policies, and practices that are needed.

Statewide contracts are managed by headquarters staff and monitored monthly. Statewide contracts include the sponsorship and co-sponsorship of the Louisiana Caring Communities Youth Survey, CORE Survey for Higher Education, and Annual Synar Report. These statewide contracts provide necessary needs assessment data for OBH-AD and other state partners through the State Epidemiological Outcomes Workgroup. Other statewide contracts provide workforce development and outcome evaluation services.

Regions/Districts/Authorities enter into contractual agreements with community-based providers. These providers implement individual-direct services through evidence-based programs or population-based services through Community Synar Providers. In addition to Synar Providers, evidence-based program providers and OBH-AD staff provide population-based services. It is the goal of OBH-AD to fund at least 60 prevention programs annually through contractual agreement to include the following: 50 evidence-based program providers and 10 community Synar providers. Louisiana plans to use a minimum of 20% of its SAPT Block Grant funds for primary prevention activities, including funding the six primary prevention strategies with block grant funds.

All regional contracts are monitored monthly. Each provider is required to collect process data and enter it into the OBH-AD Prevention Management Information System (PMIS). A report is generated each quarter by the state analyzing services for each geographic service area, provider and program. This report is followed by a quarterly site visit by headquarters prevention staff to analyze and review findings in the report. A technical assistance assessment is completed at the end of each site visit. State and regional staff create a plan to fill existing needs using internal and external resources during the service delivery period.

Each provider of an evidence-based prevention program administers the pre- and post-test that was developed and validated by the developer of that particular evidence-based program. During the first quarter site visit, state, Regional/District/Authority staff and providers analyze annual outcome reports. Outcome reports and process data are used to make an informed decision as to whether a particular program will be continued. Resources are monitored and reallocated during the year as indicated.

OBH-AD Prevention Services has developed and remains involved in an extensive network of multi-sector state, regional and community partnerships. Statewide partnerships include the Governor's Office of Safe and Drug Free Schools and Communities, the Office of Public Health, the Department of Education, the Department of Social Services, Office of Alcohol and Tobacco Control, Louisiana Highway Safety Commission, and Institutions of Higher Education.

More specifically, OBH-AD headquarters staff serves on several formal committees and workgroups to include the Prevention Systems Committee, State Epidemiological Workgroup, Louisiana Drug Policy Board, Underage and High Risk Drinking Task Force and Coordinated Systems of Care workgroups.

OBH-AD State and Field Staff actively participate in and provide needs assessment data, technical assistance and resources to support a variety of broad-based community coalitions, including SPF-SIG Coalitions. Membership includes representation from state and local law enforcement, District Attorneys, Department of Education, Office of Public Health, local media outlets, Universities, citizens, youth, recovering community, elected officials, alcohol and tobacco industry, and community leaders.

Prevention System Capacity Development

Three primary needs assessment sources used by OBH-AD are the Caring Communities Youth Survey (CCYS), the CORE Alcohol and Drug Survey, which are both funded by OBH-AD, and the State Epidemiology Workgroup (SEW) report. OBH-AD in partnership with the Department of Education (DOE) and Louisiana Higher Education Coalition (LaHEC) will research and work toward increasing participation in the CCYS and the CORE survey. OBH-AD will actively support the SEW in the development of information systems that will collect data and identify data gaps where changes and enhancements are needed.

OBH-AD is in the process of expanding the implementation of a formal community readiness and resource assessment. These assessment tools will not only determine a community's awareness of substance abuse problems and related problems, but will also determine the community's capacity to address identified problems.

Mobilizing the existing infrastructure via partnership growth and expansion of the SPF planning process is the focus of change for the 2010-2011 and subsequent funding cycles. Mobilizing the state and community partners around the SPF training will increase community awareness and support around the consequences of substance use, abuse and addiction.

OBH-AD has learned that in order to effectively reach the citizens of the state, we cannot operate in isolation. For this reason OBH-AD has cultivated true partnerships with agencies whose focus aligns with the primary mission of prevention; to reduce substance use, abuse and addiction and related consequences. These partnerships allow us to avoid duplication of services and maximize existing resources. This change in the service-delivery model was possible through a partnership with the DOE, which allowed OBH-AD to move from funding infrastructure, and use these monies to provide increased service delivery to our citizens.

OBH-AD has an existing strong relationship with the Office of Alcohol and Tobacco Control and Office of Public Health, Tobacco Control Program in the implementation of Synar requirements and tobacco education. In the future, changes are planned to develop partnerships (in addition to tobacco) that target population-based prevention strategies including retail and social availability, enforcement, community norms and promotion. Implementation of these population-based prevention strategies will involve strengthening existing and creating new partnerships with additional agencies such as Highway Safety, State Police, the Attorney General, the Sheriff's association, institutions of Higher Education, and elected officials.

OBH-AD has required evidence-based strategies for several years and is cognizant of the benefits. By requiring contract providers to offer only evidence-based programs, OBH-AD has implemented a cost band, which allows for cost savings and waste reduction. OBH-AD continues to monitor evidence-based program's cost to develop a more fiscally responsible contract process.

Process evaluation is conducted at the state, regional, and provider level. Prevention staff and contract providers input information about direct and indirect individual and population-based services into PMIS. PMIS is available to all on a daily basis and real-time rollup reports are compiled for the state, regional or provider level. These reports allow OBH-AD Headquarters staff to support the field by assessing the State's current capacity and determining whether performance targets have been achieved. This provides a mechanism for staff to develop, intervene and implement corrective action in a timely manner.

In addition to tracking process data, OBH-AD is committed to a statewide system to evaluate outcomes. Each contract provider is required to obtain an external evaluator. Each provider administers the pre- and post-test that was developed and validated by each evidence-based program's developer.

During FFY 2011 and subsequent years, a state evaluator will compile regional and state outcome reports based upon each evidence-based program funded by OBH-AD Prevention services. In addition, perception of harm and positive attitudes toward substance abuse for youth age 12 and above will be measured.

OBH-AD faces numerous challenges in the coming year. The biggest challenge is the pending reduction in resources, staff, and funding by OBH-AD and partnering agencies. For example, the braiding of OBH-AD and DOE resources will be drastically reduced due to the elimination of Title IV funding. This will impact DOE staffing patterns and increases the workload of OBH-AD staff and providers to continue to meet statewide needs and provide necessary school-based services. The key resources that will be utilized to address resources, staff, and funding shortfalls will be the reliance on relationships that have been established and lessons learned through the previous Prevention streamlining efforts.

Another challenge is moving from the Risk and Protective Factor model to the Public Health Model. Delays in curriculum development and reduction in travel and training costs have impacted the formal rollout of the SPF planning process and training of OBH-AD field and provider staff. The forthcoming statewide rollout of the SPF curriculum and subsequent onsite SPF training and technical assistance visits by Southern University and OBH-AD Headquarters staff will permit the state to progress towards the goal of implementation of the Public Health Model.

There are several key contextual and cultural conditions that impact the State's prevention capacity and function. Louisiana's 4.5 million population is racially, culturally, and economically diverse. English is the dominant language, with an increasing use of Spanish; however, significant minorities of Louisianans continue to speak Cajun-French and Louisiana Creole French. Culturally competent and sensitive prevention services are offered with this cultural diversity in mind. Rural areas in Louisiana are much underserved and have higher than average poverty rates.

In Louisiana there is a "*Laissez les bon temps rouler*" or "*Let the good times roll*" attitude. The state culture promotes and is accepting of alcohol use by youth. There is an overwhelming belief that fairs, festivals, football games, and parades cannot be enjoyable without the sale and consumption of alcoholic beverages. Although the legal drinking age in Louisiana is 21 years, there is a loophole in the State's law allowing 18 year olds to enter bars and lounges where social availability of alcohol is common. In addition there are drive-thru daiquiri shops where only the driver is asked for identification for age verification. OBH-AD is cognizant of these conditions and strives to meet the unique needs of the state through innovative and proven interventions.

Implementation of a Data-Driven Prevention System

OBH-AD Prevention Services over the past four years has moved from a pattern of historical funding of prevention services to a Data Driven Planning Process. Annually, the 10 geographic service areas of the state review their funding of prevention services. The mechanisms by which funding decisions are made include needs assessments using the Louisiana Caring Communities Youth Survey, the

Higher Education Core Survey reports and the State Epidemiological Workgroup report. These documents are reviewed and serve as a link to intended state outcomes at the local level. These needs assessments are updated every two years. The capacity of the providers available is reviewed, along with the current resources available to the service area, including partnerships that braid funding, such as the local Department of Education.

At the sub-recipient level, allocation of resources and sub-recipient deliverables are strategically planned. Resources are reallocated as needed and a new action plan, a Statement of Work (SOW), is written. The action plan includes the provider, the provider's mission, goals, objectives, evidence-based program strategies, target population, performance indicators, and process and outcome evaluation.

After the proposed action plans are reviewed at the regional level, they are submitted and reviewed by State Office Prevention Staff. OBH-AD Prevention Services has established cost bands for direct universal and selective services. Indicated services are evaluated individually. Written recommendations are sent to the Regions for corrections. A third review is completed by the Regional Administrators, State Prevention Staff and State Fiscal Staff for corrections or to answer fidelity questions. Each action plan is required to use an external evaluator to determine statically significant outcomes. Corrections are made and the action plans are processed as a contract.

OBH-AD Prevention Services has been involved in the development of multiple strategic plans, including the SPF-SIG Strategic Plan, but does not yet have a formal Prevention Strategic Plan. OBH-AD recognizes the need for a formal Strategic Plan for prevention services. For this reason, OBH-AD, in partnership with the Governor's Office, has devoted the last four years to developing an innovative, State-specific SPF curriculum that incorporates lessons learned by SPF-SIG sub-recipients. In preparation for the SPF curriculum, OBH-AD has been committed to building its internal infrastructure capacity in the areas of needs assessment, development of action plans, implementation, monitoring, and process and outcome evaluation.

OBH-AD is excited to announce that the rollout of the curriculum is scheduled for January 2011. Tier 1 of the rollout will include the training of OBH-AD state and regional staff, Governor's Office staff, and SPF-SIG sub-recipients. Tier 2 will include the training of sub-recipients from community based partners, OBH-AD, Governor's Office, and Department of Education. Additional trainings will be made available to interested staff and partners as requested.

OBH-AD only funds evidence-based programs and strategies. The State funds programs that meet the following criteria: 1) Inclusion in a Federal List or Registry of evidence-based interventions, or 2) Being reported (with positive effects) in a peer-reviewed journal. Over the last two years, these action plans have become standardized based upon the evidence based intervention's developer.

The contracts (action plans) are monitored monthly on the regional level. Implementation of deliverables and process data is tracked through data collected in the State's web-based data management system, PMIS. A PMIS report is generated each quarter by the State Prevention Services detailing services and deliverables information for each Region, Provider and Program. This report is followed by a quarterly site visit by a State Office Prevention Staff member to provide Technical Assistance during the service delivery period. Resources are monitored and reallocated during the year as needed.

Evaluation of Primary Prevention Outcomes

Surveillance of new data, trends, and evidence-based programs, policies, and practices are researched by Headquarters Staff and disseminated to the field on an on-going basis. In addition, surveillance of Prevention staff activities and contractor deliverables is conducted through quarterly site visits by Headquarters Staff and on-going assessment of PMIS data to ensure integrity and validity.

OBH-AD Prevention Staff monitors contract providers on a monthly basis. Contract monitoring tools are specific to each evidence-based program funded to ensure fidelity of the program as outlined in the contract statement of work. The monitoring tool also includes a standardized program improvement plan and evaluation checklist.

Process evaluation is conducted at the state, regional, and provider level. Prevention staff and contract providers input information about direct and indirect individual services into PMIS. PMIS is available to all on a daily basis. Also collected are population-based services to include Synar unconsummated retail compliance checks, merchant education, identification and referral services provided through OBH-AD employee assistance program, and resource assessments at the community level. Real-time rollup reports are available at the state, regional or provider level. These reports allow OBH-AD to assess our current capacity and determine areas where additional progress is needed. These reports indicate whether performance targets have been achieved and allow staff to intervene and take corrective action in a timely manner.

In addition to monthly monitoring, a quarterly Prevention Service Report is published outlining direct and indirect, individual-based and population-based services. These reports are distributed to Executive Leadership and field staff. Through Headquarters Staff Meetings and quarterly site visits to each of the ten geographic service areas, these evaluation results along with monthly monitoring reports are used in the decision-making process. Review of these important documents is the driving force used to modify the implementation of direct contract deliverables, resource allocations, and performance targets.

Another outcome of the quarterly report and site visit is a summary report and the development of technical assistance plan to include workforce development, PMIS, contract negotiation, development, monitoring, and evaluation. Each technical assistance plan is tailored to each geographic service area.

In addition to tracking process data, OBH-AD is committed to a statewide system to evaluate outcomes. Each contract provider is required to obtain an external evaluator. Each provider will administer the pre- and post-test that was developed and validated by each evidence-based program's developer. During FFY 2011 and subsequent years, a state evaluator will compile regional and state outcome reports based upon each evidence-based program funded by OBH-AD Prevention services. In addition, perception of harm and positive attitudes toward substance abuse for youth age 12 and above will be measured. Evaluation outcomes will determine if there has been an increase, maintenance or decrease.

Prevention Needs Assessment

Louisiana census data places the total population according to the 2010 census at 4,533,572. There was a modest 1.4% (64,396) increase in the State population from the prior year estimates. To further describe the population you must first take into consideration the following statistics and tables. The medium income is \$42,460 per household with 17.6% of all persons living below the poverty level (*2010 Census Bureau Quick Facts*).

Louisiana

Race	Number	Percent
White	2,836,192	62.6
African American	1,452,396	32.0
Asian	70,132	1.5
Pacific Islander	1,963	-
Other	69,227	1.5
Two or More Races	72,883	1.6
Total population	4,533,372	100
Ethnicity	Number	Percent
Hispanic or Latino	192,560	4.2

Louisiana

Sex and Age	Number	Percent
Total population	4,533,372	100
Male population	2,219,292	49
Female population	2,314,080	51
Under 5 years	314,260	6.9
5 to 9 years	306,362	6.8
10 to 14 years	306,836	6.8
15 to 19 years	326,779	7.2
20 to 24 years	338,309	7.5
25 to 29 years	332,925	7.3
30 to 34 years	295,508	6.5
35 to 39 years	276,479	6.1
40 to 44 years	288,120	6.4
45 to 49 years	325,046	7.2
50 to 54 years	329,329	7.3
55 to 59 years	292,567	6.5
60 to 64 years	242,995	5.4
65 to 69 years	178,365	3.9
70 to 74 years	133,629	2.9
75 to 79 years	102,876	2.3
80 to 84 years	77,301	1.7
85 years and over	65,686	1.4

The use and abuse of alcohol, tobacco, and illicit drugs constitute a major public health threat to the State of Louisiana. Recent estimates suggest that approximately 8.1% of adults (195,409) drank heavily within the past month, 3% have used illicit drugs within the past month (102,649) and 10.2% (349,007) adults aged 18 and over in Louisiana need treatment to address problems related to compulsive or out-of-control substance use (Herman-Stahl et al., 1999, Kroutil et al., 1999). Substance abuse is widespread, affecting males and females of all ages in both upper and lower socioeconomic classes living in both urban and rural areas. In the State of Louisiana, the annual economic cost of substance abuse is approximately \$4 billion dollars, that translates into a cost of \$943 per every man, woman, and child. Included in this cost is medical, criminal, property damage, costs associated with accidents, loss wages, loss productivity and death of citizens.

Experimentation and often regular use of alcohol, tobacco and other drugs often begins during youth. A statewide youth survey conducted 2010 reflects lifetime and 30 day use among Louisiana youth in the tables below.

Caring Communities Youth Survey

Table 4. Percentage of Students Who Used ATODs during Their Lifetime

Drug Used	Grade 6			Grade 8			Grade 10			Grade 12		
	2006	2008	2010	2006	2008	2010	2006	2008	2010	2006	2008	2010
Alcohol	24.4	25.7	22.8	47.8	49.3	46.5	67.8	67.6	64.9	73.3	73.9	73.5
Cigarettes	14.5	12.6	10.6	30.0	27.7	24.6	41.7	38.4	34.9	48.0	44.3	41.9
Chewing Tobacco	5.8	5.6	4.7	11.4	10.8	10.9	15.8	15.6	15.3	17.9	15.7	17.6
Marijuana	2.0	2.0	1.8	9.1	9.6	10.2	19.8	20.2	22.0	27.9	27.5	30.3
Inhalants	7.2	8.9	7.6	10.5	12.1	11.7	9.0	10.3	9.0	6.3	6.8	9.5

(Formerly the Communities That Care Survey)

Caring Communities Youth Survey

Table 4. Percentage of Students Who Used ATODs during Past 30 Days

Drug Used	Grade 6			Grade 8			Grade 10			Grade 12		
	2006	2008	2010	2006	2008	2010	2006	2008	2010	2006	2008	2010
Alcohol	5.7	9.5	8.1	18.7	23.9	21.8	35.1	37.8	35.3	44.6	46.9	45.7
Cigarettes	3.1	3.0	2.3	8.8	9.0	7.8	15.0	15.3	13.1	21.1	20.7	19.7
Chewing Tobacco	2.1	2.0	1.7	5.1	5.0	4.9	7.2	7.7	7.5	8.0	7.7	8.8
Marijuana	0.6	0.8	0.7	3.7	4.2	5.1	8.1	8.9	10.6	11.4	11.2	14.6
Inhalants	2.6	3.7	2.8	3.9	4.4	4.4	2.2	2.5	2.2	1.0	1.2	1.2

(Formerly the Communities That Care Survey)

There is an approach which may help ease the burden of substance abuse within Louisiana – that of prevention. The target of prevention activities in the State of Louisiana are conceptualized at three levels based on the presence or absence of symptoms and risk factors:

- *Universal prevention* - refers to health promotions and disease prevention activities dispersed to the general population with no attempts made to differentiate those at greater risk;
- *Selected interventions* - targets' groups of individuals believed to be at greater risk of developing a problem due to the presence of risk factors which have been identified as precursors to substance abuse disorders; and
- *Indicated interventions* - focuses exclusively on those individuals already displaying mild symptoms indicative of a problem that is not yet severe enough to be classified as full-blown disorder (i.e., sub-clinical).

Although it is important to recognize that not all use is necessarily problematic, for some, experimental use will inevitably escalate to regular or heavy use. In fact, a study of Louisiana youth focusing on problem substance use found that approximately 13.5% of adolescents (57,503) may need some form of intervention to address high frequency or risky alcohol or drug use (Farrelly et al., 1998). In the 2010 CCYS survey 13.3% of Louisiana students met the criteria for substance abuse or addiction. Both prevention and treatment are necessary tools within the full range of service provision for attacking substance abuse problems.

Stakeholder Input

Historically, the Office of Addictive Disorders has conducted annual Public Forums in each of the ten Regions/Local Governing Entities (LGEs) in order to assess consumer needs, as well as to establish a common ground for providing information to the community and receiving input from stakeholders.

The newly merged Office of Behavioral Health continued this effort during FY 2011. A primary discussion topic at the Public Forums was the continuing merger and integration efforts of the Offices of Mental Health (OMH) and Addictive Disorders (OAD) within the newly formed Office of Behavioral Health (OBH). Additionally, the Public Forums included discussion about the significant impact that Federal Health Reform will have on the State and its service delivery system, as well as the Louisiana Coordinated System of Care (CSoC) initiative for children/youth with extensive behavioral health needs either in or at-risk of out-of-home placement. Stakeholders expressed concern that these substantial changes within the State could threaten the effective delivery of addiction treatment services and that substance use disorder clients would become “lost” within the behavioral health system and not receive the care that is needed. Another concern expressed at the Public Forums was the availability of social detoxification services, as there was a loss of publicly funded beds and some impact on access due to privatization. Stakeholders also indicated a need for increased involvement of family members in the client treatment process, as well as the need to ensure that family members receive care and/or referrals as appropriate.

To exercise its charge to monitor and review Louisiana’s mental health programs and to include its voice in the State’s 2012 Behavioral Health Block Grant Application, the Programs and Services Committee of the Louisiana Mental Health Planning Council polled its members on the strengths and weaknesses of state programs. Twenty-one Council members completed and returned the survey with feedback on the strengths and weaknesses of the State mental health care system. The table below reflects the results.

Positive Program Growth

Survey Item		Agree	Agree %	Disagree	No Answer
1	Clinicians are using <i>some</i> evidence-based treatment programs.	20	91%	1	1
2	Clinics offer <i>some</i> social services (information; assisting with benefit applications to other governmental and civic organizations, etc).	19	86%	2	1
3	Some clinics assist with whole health concerns (scheduling medical appointment, advising good health habits, peer support, WRAP, etc).	17	77%	4	1
4	LMPC is involved in the Block Grant Application; advocacy; review of needs; program assessment.	19	86%	2	1
5	<p>Other strengths: Add any points you feel should be included.</p> <ul style="list-style-type: none"> • CAHSD has implemented MHERE which has reduced hospitalization by 65%. • The state Planning Council provides a forum for the exchange of ideas. • The state Planning Council provides a safe environment for consumers to express their concerns and needs. • The state Planning Council can offer trainings on advocacy and other issues related to mental health and addictive disorders. • ECCS is a positive and much needed effort (though such services not in all areas of the state). • Treatment outcomes are too often poor, but are improving. 				

Critical Issues

Survey Item		Agree	Agree %	Disagree	No Answer
6	<i>Access:</i> serving only the most severely ill	14	64%	7	1
7	<i>Access:</i> serving a small number of children and youth in need of help; most youth enter through judicial intervention	20	91%	2	0
8	<i>Access:</i> shortage of hospital beds for critical care (large number of the available beds used by forensic patients)	16	73%	4	2
9	<i>Access:</i> excessive wait time for appointment with a psychiatrist, particularly long and alarming for newly	18	82%	3	1

	released jail and prison inmates				
10	<i>Access:</i> outcomes too often poor, frequent returns for critical medical help, costly abuse of social services	13	59%	7	2
11	<i>Access:</i> lack of family support contributes to poor outcomes	19	86%	2	1
12	<i>Access:</i> little or no access to supportive housing which contributes to poor outcomes	19	86%	2	1
13	<i>Fragmentation:</i> lack of uniformity in protocols for admissions; availability not uniform throughout Regions, etc.	16	73%	4	2
14	<i>Transportation:</i> consumers without means to travel beyond walking distance (missed appointments, medications not picked up)	21	95%	1	0
15	<i>Physical health:</i> twenty-five year longevity gap between population with a severe mental illness and population not suffering from mental illness	16	73%	2	4
16	<i>Financial burden on communities:</i> private hospitals receive underserved population in ER rooms and critical care units (reimbursement is problematic); crime and disturbance reports to law enforcement agencies rise; jails become overcrowded; heavy increase in case loads for courts and shelters	21	95%	1	0
17	<i>Unidentified and underserved children:</i> loss of critical years for development of social, academic, and employability skills	18	82%	3	1
18	<i>Privatization/contracting:</i> adds new layer of bureaucracy to service delivery; higher rate of employee turnover in private sector than civil service sector (lack of familiarity decreases patient confidence affecting outcome)	13	59%	7	2
19	<p>Other concerns: Add any points you feel should be included.</p> <ul style="list-style-type: none"> • The current provision of mental health services through public entities has serious gaps with some areas having limited if no community mental health services. • Stigma makes it difficult to get folks into mental health services. • Multiple hoops/delays to get to the first appointment ensures that some people will not get through the door. • Clinical environments are often bleak and unappealing. • Clients have had rude, insensitive, and even racist comments made to them within sessions. • There are disparities in how clients of different racial/ethnic groups are both diagnosed and treated. • Inability to get adults treated for their own mental health issues impacts parenting of at-risk children. (Several years ago OMH found that there were about 2500 children, age 5, whose parents were being treated for severe, chronic mental health issues. Such children are at high risk, thus effective preventive services are needed.) • There is a lack of expertise/willingness to treat perinatal mental health issues. • Children are hospitalized in different areas of the state, interfering with critical work with families. • There is an unmet need for respite services for children and adolescents. • The overwhelming treatment approach is medication, with limited or no education and therapy. • There is an overall need for preventive services. 				

Items Number 14 and 16 drew extraordinary consensus, each having only one negative rating. Thus, respondents were nearly unanimous in seeing lack of transportation for consumers and financial cost to communities as critical issues. Items Number 6, 10, and 18 garnered the largest number of negative votes. The two former items relate to access. There could be regional differences in admission standards, and individuals may have different expectations for the quality of outcomes. The latter item (# 18) relates to privatization of government safety net programs, and differences in opinion were predictable.

Each item on the survey was skipped by 0-2 respondents, except for Number 15 (on physical health of consumers). Four persons omitted an answer, probably not being familiar with the 25-year longevity gap statistic. Seven respondents marked answers disagreeing with 4 or more items. Of that group, 5

are employed by government agencies, or by agencies with significant government funding. It is mere speculation whether their answers showed bias toward government policies and programs, or whether they gave more informed answers as a result of their work.

PLANNING STEP THREE: PRIORITIZATION OF STATE PLANNING ACTIVITIES

The annual Louisiana Department of Health and Hospitals Business Plan and its transformational goals identified by the Office of Behavioral Health (OBH) have guided the prioritization of the State planning activities within the 2012 combined Block Grant application. Many of the identified service gaps and needs are addressed by the dramatic systems change currently underway in Louisiana, whereby OBH becomes a purchaser of services through a Statewide Managed Care network rather than a provider. This systems change promises to increase access and availability of behavioral health services, while increasing the funding potential of recovery support services through block grant funds.

Priority One: Behavioral Health System Transformation through Medicaid Reform

OBH at the central office level has entered into a new era of Medicaid reform that better leverages federal Medicaid funding and positions Louisiana to expand Medicaid reimbursement for substance use disorders, which will create a shared mental health and addictive disorder funding stream and broaden access to services. Entitled the *Louisiana Behavioral Health Partnership (LBHP)*, this is a comprehensive Medicaid reform package that integrates mental health and addictive disorder services, making them more accessible and efficient through the 1915(i), 1915(b), and 1915(c) Medicaid waivers, in addition to expansive State Plan Amendments. To forward this transformative initiative, OBH established the LBHP Implementation Task Force. To date, DHH has: prepared the criteria necessary to seek a qualified company as a Statewide Management Organization (SMO); submitted documentation for approval of the changes in the Louisiana Medicaid program; and has initiated numerous workgroups addressing LBHP operational strategies necessary for project implementation. An important facet of the Louisiana Behavioral Health Partnership is the **Coordinated System of Care (CSoC)**, which institutes a Wraparound Model of care for children and youth at risk for out-of-home placement. CSoC is best thought of as a state-of-the-art intensive community-based service system that is a part of the overall Medicaid transformation of behavioral health services in the state. It is a specialty system in that it is a multi-agency collaborative with a shared funding pool across OBH, DCFS, OJJ, and DOE; and it is designed to specifically target youths at risk for out-of-home placement.

When the Statewide Management Organization becomes operational, OBH will track the number of persons with low to no income who receive mental health and substance use disorder services and are not eligible for Medicaid. In addition OBH will monitor service delivery relative to SAPT and CMHS Block Grant target populations and Block Grant mandates through the SMO's management information system and through ongoing provider report. This data will inform the planning and allocation of how Federal funds will be used to support non-Medicaid eligible individuals who qualify for OBH-funded treatment and supports.

In order to promote wellness and recovery, the Office of Behavioral Health (OBH) will improve access to services, produce quality outcomes and reduce health care costs by partnering with individuals, families, providers, advocacy groups, local and state agencies within the Louisiana Behavioral Health Partnership.

Priority Two: Integration of Behavioral Health Services

Co-occurring substance use disorders are often under detected and undertreated in mental health settings, where the traditional separation between mental health and addictive disorder training programs and service delivery systems results in a lack of knowledge about co-occurring disorders and a seemingly inconsistent commitment to the treatment of the substance use disorder

component. Persons with co-occurring disorders are best served when screening, assessment, and treatment planning are integrated, addressing both substance use and mental health disorders. Historically, the Louisiana segregated service delivery system had not concentrated its screening and assessment activities for the detection of persons with both disorders. Through the efforts of the SAMHSA supported CoSIG opportunity and through the massive service system integration through Act 384, both addictive and mental health clinics are planning the upgrade of practice standards to support improved detection of persons with co-occurring disorders (COD).

Through the systematic improvement and creation of integrated screening and/or assessment procedures, the capacity for the Louisiana behavioral health system to provide improved detection of the COD population is becoming a reality. A systematic review of the state supported clinics' capacity to detect the COD population using the Dual Diagnosis Capability Addiction Treatment (DDCAT) and the Dual Diagnosis Capability Mental Health Treatment (DDCMHT) Fidelity Scales will be conducted to assess the current system's capacity to treat persons with COD. It is anticipated that, through improved detection, co-occurring disorders will be actively addressed in the newly developed OBH integrated treatment planning process. This process will prevent further exacerbation and interplay between the disorders, which typically leads to poorer outcomes and decreased quality of life.

With the merger of the Office of Mental Health and the Office of Addictive Disorders, the Office of Behavioral Health will review and develop clinical and administrative business practices that will efficiently and effectively integrate behavioral health services delivered to citizens across their lifespan.

Priority Three: Increased Efficiency in the Utilization of Inpatient Levels of Care

Over the last two decades, while other states were re-organizing their funding approach and moving to a greater proportion of high intensity community based programs, Louisiana continued to direct greater fiscal resources toward inpatient care. Efforts are underway to decrease reliance on more restrictive inpatient levels of care by establishing a structured protocol for admissions, continued stay and transition to the community. A comprehensive discharge planning process will support individuals as they re-enter the community. Commensurate with this initiative, reinvestment in the communities is needed to implement the necessary supports that are required for successful reintegration into the community.

The Office of Behavioral Health will identify, implement and monitor protocols for admissions and continued stay at Louisiana psychiatric hospitals, as well as transition to the community.

Priority Four: Comprehensive Behavioral Health Needs Assessment and Plan that addresses the SAPT and CMHS Target Populations

Prevalence and penetration data collected from both the mental health and substance use disorder treatment programs reveal additional gaps and areas of need that have not been historically analyzed in a formal, systematic protocol that informs integrated service delivery planning. A protocol for conducting a comprehensive behavioral health needs assessment will be developed to include both internal and external stakeholder input representative of substance use, mental health, and co-occurring disorders. Stakeholders include members of the newly integrated Behavioral Health Advisory Council as well as representatives from the Statewide Management Organization (SMO) and its provider network. The existing infrastructure of the Louisiana State Epidemiological Workgroup (SEW) will be central to guiding the analysis of

data necessary to determine need and guide service delivery planning. OBH's protocol will enhance collection of data from other State and local sources, including data related to the impact of service gaps on the community, hospitals, courts, jails, and shelters. Areas of focus will include the SAPT and CMHS Block Grant services and target populations, as follows:

Comprehensive community-based services for adults with SMI and children with SED:

- Children with serious emotional disturbances (SED) and their families
- Adults with serious mental illness (SMI)

Services for persons with or at risk of having substance use and/or mental health disorders

- Persons who are intravenous drug users (IDU)
- Women who are pregnant and have a substance use and/or mental disorder
- Parents with substance use and/or mental disorders who have dependent children

Services for persons with or at risk of contracting communicable diseases:

- Persons with or at risk for tuberculosis
- Persons with or at risk for HIV/AIDS and who are in treatment for substance abuse

Targeted services:

- Individuals with mental and/or substance use disorders who are homeless or involved in the criminal or juvenile justice systems
- Individuals with mental and/or substance use disorders who live in rural areas.
- Underserved racial and ethnic minority and LBGTQ populations
- Persons with disabilities
- Community populations for environmental prevention activities, including policy changing activities, and behavior change activities to change community, school, family and business norms through laws, policy and guidelines and enforcement.
- Community settings for universal, selective and indicated prevention interventions, including hard-to-reach communities and "late" adopters of prevention strategies

In addition to the target populations referred to previously, the OBH Behavioral Health Needs Assessment will expand in scope to include other individuals who are in need of behavioral health services.

- 1) OBH will estimate the number of individuals with low or no incomes who are currently uninsured but will be covered by Medicaid or private insurance both as a result of enhanced Medicaid coverage through Medicaid Waivers and through Health Care Reform in FY 2014. OBH will plan and report on the public behavioral health systems expansion of access and capacity.

- 2) OBH will identify who will not be covered after FY 2014 and how Federal funds will be used to support these individuals who may need treatment and supports.

OBH will develop a plan to address:

- Bi-directional integration of behavioral health and primary care services;
- Provision of recovery support services for individuals with mental or substance use disorders
- A combined expenditure of funds for the provision of services for individuals with co-occurring mental and substance use disorders.
- The inclusion of Olmstead planning work in the Block Grant Application, identifying individuals who are needlessly institutionalized or at risk of institutionalization

Based on a formalized comprehensive needs assessment, the Office of Behavioral Health will use internal and external stakeholder recommendations for improved service delivery to guide planning and implementation of prevention and treatment initiatives within the system of care.

Priority Five: Re-balancing Community Based Services

A critical component of “right sizing”, or reducing reliance on inpatient care (priority #3 above), is the intensive follow-up monitoring to assess how persons discharged from state civil psychiatric hospitals are faring in the community. OBH will monitor persons who are transitioned to the community to assure the necessary supports are available to make community living successful. So far, approximately 30% of discharged persons have been returned to a level of housing that is relatively independent in the community, while another 38% have been able to reintegrate through a more structured housing model with attendant staff and specialized housing supports.

The Office of Behavioral Health will monitor persons transitioned from public psychiatric hospitals to the community to assess and guide further development of community-based supports.

Priority Six: Electronic Behavioral Health System

OBH is in the process of developing a comprehensive electronic behavioral health record system (EBHR) for the five OBH Regions. This system will replace the existing non-integrated system. The EBHR will provide the means for electronic client data exchange between OBH, the Local Governing Entities (LGEs), the Statewide Management Organization (SMO), and state health care systems that will meet all federal and state mandates for reporting.

OBH is in the process of planning a more comprehensive data warehouse to address the needs for managing and evaluating the operations of the Statewide Management Organization (SMO) starting in the spring of 2012. This more comprehensive data warehouse will build upon the foundation of the existing one. OBH will research, design, and implement an integrated electronic data system that supports all clinical and administrative needs of Office of Behavioral Health including the Louisiana Behavioral Health Partnership.

The Office of Behavioral Health (OBH) will research, design, and implement an integrated electronic data system that supports all clinical and administrative agency needs, including the Louisiana Behavioral Health Partnership.

Priority Seven: Primary Healthcare

Prior to the development of overall Medicaid transformation within OBH, the Department of Health and Hospitals is developing primary care Coordinated Care Networks (CCNs) that will provide enhanced and coordinated primary care in a managed care environment. Behavioral health services are carved out from this model of care. CCN implementation is targeted to begin in the New Orleans metropolitan area by January 1, 2012. Other geographic areas of the state will begin implementation 90 days after implementation in the New Orleans area.

In concert with the Medicaid reform for physical health issues, OBH has simultaneously entered into a new era of Medicaid reform that addresses behavioral health disorders. It is the goal of the Louisiana Department of Health and Hospitals to support and improve behavioral health recipient access and engagement with physical health providers through relationships with the CCN. Further development of linkage and referral with the State's Federally Qualified Health Clinics (FQHCs) will be established as well. These linkages will take place through a referral system between the Statewide Management Organization (SMO) and physical health provider networks.

OBH will explore and identify ways to integrate behavioral health prevention strategies into primary healthcare. A committee has been formed to develop a plan to implement identified strategies.

The Office of Behavioral Health will assess and monitor the logistics and effectiveness of coverage for physical health conditions; particularly as this relates to the alignment of the Louisiana Behavioral Health Partnership with primary care through Federally Qualified Health Clinics (FQHCs) and the Community Care Network (CCN).

Priority Eight: Primary Prevention Services

The Office of Behavioral Health (OBH) works to prevent the onset and reduce the progression of substance abuse and other high risk behaviors in Louisiana's youth. By providing family-focused, evidence-based, outcome-driven and cost-effective services, OBH has made significant gains in the quality of prevention services and in the number of youth served. For example, OBH only funds Evidence-Based Prevention Programs (EBPs) that have been proven effective in universal, selective, and indicated populations.

Long-standing partnerships, cross-training, and shared resources with the Louisiana Department of Education and OBH-funded community prevention providers have allowed OBH to implement EBPs through school-based curriculum.

OBH has successfully tracked and monitored the delivery of primary prevention services and outcomes statewide, demonstrating an increase in the number of youth served each year in the last few years. This increase was achieved as more and more prevention providers delivered services at the school site and provider overhead was dramatically reduced.

In order to prioritize and promote primary prevention, OBH will continue to fund experienced, qualified providers who implement evidence-based programs. In this way OBH will help prevent the onset and reduce the progression of substance abuse and other high risk behaviors in Louisiana's youth.

Priority Nine: Preventing Access of Tobacco Products to Minors

The Synar Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts.

States are required to conduct annual, unannounced inspections to determine how accessible tobacco is to minors. States are required to maintain a non-compliance rate of no more than 20% or more specifically that no more than 80% of merchants can sell to minors. OBH has been successful in its efforts to reduce the access of tobacco products to minors by maintaining a non-compliance rate well below 10%. This has been achieved through long-standing partnerships with the LA Office of Alcohol and Tobacco Control (ATC) and local community coalitions.

OBH will continue to partner with the ATC to execute multiple random unannounced inspections of tobacco retailers statewide. By maintaining this partnership, Louisiana will continue to maintain low non-compliance rates. More stringent than the federal mandate, OBH will continue its commitment to no more than a 10% non-compliance rate.

In order to continue to reduce the access of tobacco products to individuals under the age of 18, OBH will coordinate and provide oversight of random, unannounced inspections of tobacco outlets.

**PLANNING STEP FOUR: DEVELOPMENT OF OBJECTIVES, STRATEGIES,
AND PERFORMANCE INDICATORS**

Priority One: Behavioral Health System Transformation through Medicaid Reform

In order to promote wellness and recovery, the Office of Behavioral Health (OBH) will improve access to services, produce quality outcomes and reduce health care costs by partnering with individuals, families, providers, advocacy groups, local and state agencies within the Louisiana Behavioral Health Partnership.

Goal:	Increase access to and capacity of the state-supported behavioral health system
Strategy	<p>Implement a Medicaid Managed Care System to manage all behavioral health services and effectively leverage federal dollars through a CMS 1915b waiver.</p> <p>Implement a Coordinated System of Care (CSoC) Model that will better coordinate and manage the behavioral health system for multi-agency involved children and youth through a CMS 1915c waiver.</p>
Performance Indicator	<p>Establish and implement the Statewide Management Organization (SMO). The SMO enrolls and reimburses for 100% of the number of mental health recipients in FY12 as compared to those currently served in FY11 through state-managed providers. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p> <p>Establish and implement the Statewide Management Organization (SMO). The SMO enrolls and reimburses for 100% of the number of substance use disorder recipients in FY12 as compared to those currently served in FY11 through state-managed providers. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p> <p>Estimate the number of individuals with low or no incomes who are not Medicaid eligible and who receive mental health and substance use disorder services.</p> <p>Ensure the maintenance of service delivery related to SAPT and CMHS Block Grant target populations.</p> <p>Establish and grow the CSoC collaboratives in the five pilot regions. The SMO enrolls 40 children and youth in each of 5 pilot CSoC sites within the first year of operation.</p>
Measurement	<p>The number of persons served and receiving mental health services through the management of the SMO in FY12. Data obtained from state-run electronic systems and the SMO electronic systems. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p> <p>The number of persons served and receiving substance use disorder services through the management of the SMO in FY12. Data obtained from state-run electronic systems and the SMO electronic systems. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p>

	<p>The number of non-Medicaid eligible individuals who qualify for OBH-funded mental health and substance use disorder treatment and supports.</p> <p>The number of persons served in each of the SAPT and CMHS Block Grant target populations.</p> <p>The number of children enrolled with the SMO and receiving CSoC waiver services in FY12. Data obtained from the SMO database system.</p> <p><i>This data will be collected from the data systems of OBH and the Statewide Management Organization (SMO).</i></p>
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Priority Two: Integration of Behavioral Health Services

With the merger of the Office of Mental Health and the Office of Addictive Disorders, the Office of Behavioral Health will review and develop clinical and administrative business practices that will efficiently and effectively integrate behavioral health services delivered to citizens across their lifespan.

Goal:	Integrate substance use and mental health disorder services in the state-managed clinics.
Strategy	<p>Continue to co-locate services and merge addictive disorder clinics with mental health clinics.</p> <p>Develop and implement integrated clinical protocols that are consistent with Dual Diagnosis Enhanced (DDE) models.</p> <p>Create and implement behavioral health clinic licensure standards.</p>
Performance Indicator	<p>Co-locate 75% of addictive disorder and mental health clinics to form behavioral health clinics.</p> <p>80% of co-located behavioral health clinics operate at a Dual Diagnosis Enhanced (DDE) level within two years.</p> <p>Increase the number of individuals receiving services in behavioral health clinics operating at a DDE level. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p> <p>100% of co-located DDE clinics meet behavioral health licensure standards.</p>
Measurement	<p>The number of addictive disorder and mental health clinics statewide that have co-located and formed behavioral health clinics</p> <p>The number of co-located behavioral health clinics that achieve DDE status by meeting the Dual Diagnosis Capability in Addiction Treatment/Dual Diagnosis Capability in Mental Health Treatment criteria.</p> <p>The number of substance use, mental health and co-occurring disorder clients served in behavioral health clinics operating at a DDE level. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p>

	<p>The number of co-located DDE clinics that obtain behavioral health licensure through the Louisiana Department of Health and Hospitals - Bureau of Health Standards.</p> <p><i>This data will be collected from the data systems of the Louisiana Department of Health and Hospitals - Bureau of Health Standards and the Office of Behavioral Health.</i></p>
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Priority Three: Increase Efficiency in the Utilization of Inpatient Levels of Care

The Office of Behavioral Health will identify, implement and monitor protocols for admissions and continued stay at Louisiana psychiatric hospitals, as well as transition to the community.

Goal:	Reduce reliance on and length of stay at the state-managed intermediate care psychiatric facilities.
Strategy	<p>Employ a comprehensive discharge process to build collaborative discharges and utilize system of care approaches that leverage community-based resources.</p> <p>Establish continued stay criteria for intermediate care psychiatric facilities.</p>
Performance Indicator	The average length of stay for intermediate care civil psychiatric patients admitted in the fiscal year demonstrates a decrease. <i>(DASHBOARD INDICATOR - see Section H of Application)</i>
Measurement	<p>Number of persons whose length of stay is greater than 6 months for civil patients admitted to intermediate care psychiatric facilities. <i>(DASHBOARD INDICATOR - see Section H of Application)</i></p> <p><i>This data will be collected from the data systems of the OBH inpatient facilities and the Statewide Management Organization (SMO).</i></p>

Priority Four: Comprehensive Behavioral Health Needs Assessment and Plan

Based on a formalized comprehensive needs assessment, the Office of Behavioral Health will use internal and external stakeholder recommendations for improved service delivery to guide planning and implementation of prevention and treatment initiatives within the system of care.

Goal:	To develop a formal protocol for identifying both mental health and substance use prevention and treatment needs in Louisiana, to include assessment of need related to SAPT and CMHS Block Grant priority and target populations
Strategy	<p>Ensure that the protocol addresses non-Medicaid OBH-funded service delivery related to SAPT and CMHS Block Grant priority and target populations and services for persons with or at risk of contracting communicable diseases, as well as Block Grant targeted services.</p> <p>Identify mental health and substance use state and local data sources by Region and Local Governing Entities (LGE) to be used to calculate need.</p> <p>Identify stakeholders to participate in consensus-building in the determination of</p>

	<p>the data collection elements necessary to conduct assessment.</p> <p>Ensure mental health representation on the Louisiana Drug Policy Board's State Epidemiological Workgroup (SEW).</p> <p>Achieve consensus and document formal protocol to determine need.</p>
Performance Indicator	<p>State Epidemiological Workgroup (SEW) membership will include mental health representation.</p> <p>A formal needs assessment protocol that addresses SAPT and CMHS Block Grant targeted populations and services will be developed by March 1, 2012.</p>
Measurement	<p><i>Among other data sources, OBH will utilize the existing Louisiana Epidemiological Workgroup and its state profile report to identify parish-specific information to be used in the needs assessment. In addition OBH will negotiate the collection of service and demographic needs assessment data with the newly procured Statewide Management Organization.</i></p>

Goal:	<p>To conduct a comprehensive behavioral health needs assessment to that addresses identified gaps and needs and informs the planning and allocation of how Federal funds will be used to support non-Medicaid eligible individuals who qualify for OBH-funded treatment and supports.</p>
Strategy	<p>Implement determination of need protocol according to established timeline.</p> <p>Conduct internal and external stakeholder review and evaluation of needs assessment, including the Behavioral Health Advisory Council.</p> <p>Formalize recommendations that address identified needs and gaps in the service delivery system for non-Medicaid eligible individuals who qualify for OBH-funded treatment and supports.</p>
Performance Indicator	<p>A formal and targeted needs assessment will be conducted with resulting recommendations by January 1, 2013.</p>
Measurement	<p><i>Using timelines outlined in the formal protocol, data will be collected from identified state and local resources, including the statewide management organization. Internal and external stakeholders, including the newly formed Behavioral Health Advisory Council, will review and analyze the data collected for the needs assessment. Stakeholder recommendations for improved service delivery will guide the system of care within Louisiana, as well as inform the development of the FY2014 Block Grant State Plan and application due in April 2013.</i></p>

Priority Five: Re-Balancing Community-Based Services

The Office of Behavioral Health will monitor persons transitioned from public psychiatric hospitals to the community to assess and guide further development of community-based supports.

Goal:	Maintain a robust community-based system of care that is able to adequately manage and support persons discharged from psychiatric institutional levels of care
Strategy	Provide quarterly tracking of the individuals discharged from psychiatric institutional levels of care. Provide preemptive and proactive redirection on discharged individuals who are experiencing signs of destabilization. Monitor hospital readmissions and crisis services provided to persons discharged from intermediate care psychiatric facilities.
Performance Indicator	Enhance recovery support services to stabilize persons in the community. Successful maintenance of at least 85% of the discharged population in the community.
Measurement	Percentage of persons discharged from intermediate care psychiatric facilities in the fiscal year who have remained stable in community settings. <i>This data will be collected from the Post Discharge Tracking Data System and Inpatient Hospital Database System (PIP).</i>

Priority Six: Electronic Behavioral Health System

The Office of Behavioral Health (OBH) will research, design, and implement an integrated electronic data system that supports all clinical and administrative agency needs, including the Louisiana Behavioral Health Partnership.

Goal:	Improve communications and information transfer for clients served by the statewide behavioral health provider network.
Strategy	Integrate the behavioral health electronic systems for state-managed providers in Regions into one uniform electronic behavioral health record (BEHR). Establish a statewide data management warehouse that maintains the data elements across all Regional and Local Governing Entity (LGE) data systems, as well as the Statewide Management Organization data system.
Performance Indicator	Complete a formal statewide RFP for an electronic behavioral health record and select vendor by September of 2011 in order to begin implementation in 2012. Two of the five Regions will have completed implementation of the selected behavioral health record by the end of FY12.
Measurement	Access technical assistance from other state systems, such as South Carolina, to develop an effective implementation plan for building the data warehouse that interfaces with the SMO. Number of Regions that have completed full EBHR implementation at the end of FY12. Percentage of files transferred from the SMO and EBHR into the newly developed data warehouse.

Priority Seven: Primary Healthcare

The Office of Behavioral Health will assess and monitor the logistics and effectiveness of coverage for physical health conditions; particularly as this relates to the alignment of the Louisiana Behavioral Health Partnership with primary care through Federally Qualified Health Clinics (FQHCs) and the Community Care Network (CCN).

Goal:	Improve behavioral health recipient access and engagement with physical health providers through relationships with FQHCs and the CCN.
Strategy	Establish an effective linkage/referral system between the Statewide Management Organization (SMO) and physical health provider networks. Identify behavioral health prevention strategies that can be implemented in primary healthcare.
Performance Indicator	Establish the baseline percentage of behavioral health recipients who also receive physical health care through the available resources in the state. Establish implementation plan for primary healthcare prevention strategies related to behavioral health.
Measurement	Number of behavioral health recipient referrals to primary health care made by the Statewide Management Organization (SMO). <i>This data will be collected through a crosswalk of the SMO database with the CCN database.</i>

Priority Eight: Primary Prevention Services

In order to prioritize and promote primary prevention, OBH will continue to fund experienced, qualified providers who implement evidence-based programs. In this way OBH will help prevent the onset and reduce the progression of substance abuse and other high-risk behaviors in Louisiana’s youth.

Goal:	Prevent the onset and reduce the progression of substance abuse and other high-risk behaviors.
Strategy	Implement evidence-based prevention programs in school-based settings through partnership with the Department of Education..
Performance Indicator	The number of individuals served in evidence-based prevention programs and outcomes achieved by these programs. Percentage of individuals served, ages 12-17, who reported they used alcohol, tobacco and other drugs during the past 30 days.
Measurement	The number of persons served in evidence-based prevention programs. This data will be collected in the Prevention Management Information System (PMIS). Responses to GPRA questions collected from pre-post tests administered to individuals served by evidence-based programs ages 12-17.

Priority Nine: Preventing Access of Tobacco Products to Minors

In order to continue to reduce the access of tobacco products to individuals under the age of 18, OBH will coordinate and provide oversight of random, unannounced inspections of tobacco outlets.

Goal:	Reduce the access of tobacco products to individuals under the age of 18.
Strategy	Oversee random, unannounced compliance inspections of tobacco retailers to determine Louisiana's non-compliance rate as required under the federally mandated SYNAR Amendment.
Performance Indicator	Maintain a non-compliance rate of no more than 10%.
Measurement	Annual SYNAR Retailer Violation Rate (RVR), as reported in Annual SYNAR Report.

LOUISIANA

FY 2012

Combined Behavioral Health Assessment and Plan

Part III

Use of Block Grant Dollars for Block Grant Activities

Part III: Use of Block Grant Dollars for Block Grant Activities

Services Purchased Using Reimbursement Strategy

(Table 4 of the FY2012 Block Grant Application)

In its current application guidance, SAMHSA requests that States consider using their *Community Mental Health Services (CMHS)* and *Substance Abuse Prevention and Treatment (SAPT)* Block Grant funds to develop reimbursement strategies that are currently used in other areas of healthcare. Reimbursement strategies may include risk-based payments, payments for episodes of care, and payment for outcomes. SAMHSA understands that services for most individuals are not purchased solely with CMHS or SAPT Block Grant funds but through a variety of funding sources (e.g. Medicaid, Medicare, private insurance, other Federal funds, State, local and private sources); however, States are encouraged to use CMHS and SAPT Block Grant funds to support efforts to develop reimbursement strategies that support innovation.

The table below outlines the reimbursement methodology for each service, prevention and emotional health strategy and system improvement that is purchased by the Office of Behavioral Health (OBH) with CMHS and SAPT Block Grant funds.

Services Purchased Using Reimbursement Strategy - Table 4

Reimbursement Strategy	Services Purchased Using the Strategy
<p><i>Encounter-based reimbursement</i> <i>{includes fee-for-service and other strategies that pay individuals or organizations a specific amount for a unit of service}</i></p>	<p><i>SAPT Block Grant</i></p> <ul style="list-style-type: none"> • Primary Prevention Services: Cost bands have been established for prevention services which are contracted at a fee-for-service rate schedule of \$75 for universal activities, \$100 for selective activities, and \$150 for indicated activities.
	<p><i>CMHS Block Grant</i></p> <ul style="list-style-type: none"> • Not Applicable
<p><i>Grant/Contract reimbursement</i> <i>{includes annual or periodic payments to individuals or organizations that provide services or system improvements}</i></p>	<p><i>SAPT Block Grant</i></p> <ul style="list-style-type: none"> • Primary Prevention Services: Professional Service Contracts are executed for Synar Program, Evaluation, and Workforce Development activities. • Treatment Services: Contracts are executed for the following: <ol style="list-style-type: none"> 1) intensive outpatient, outpatient, social detoxification, halfway-house, and residential/inpatient services; 2) services provided to priority populations – intravenous drug users, pregnant women, women with dependent children, persons with or at risk for contracting TB and/or HIV/AIDS; and 3) Recovery Home Outreach Workers.
	<p><i>CMHS Block Grant</i></p> <ul style="list-style-type: none"> • Adult: Contracts are executed for the following Adult service categories: <ol style="list-style-type: none"> 1) Adult Employment; 2) Advisory Council Support; 3) Assertive

	<p>Community Treatment (ACT); 4) Consumer Advocacy and Education; 5) Consumer Monitoring and Evaluation; 6) Consumer Support Services; 7) Crisis Response Services; 8) Mental Health Treatment Services; 9) Planning Operations and System Development; 10) Residential/Housing; 11) Respite; 12) Staff Development; and 13) Transportation.</p> <ul style="list-style-type: none"> • Child/Youth: Contracts are executed for the following Child/Youth service categories: <ul style="list-style-type: none"> 1) Advisory Council Support; 2) Assertive Community Treatment (ACT); 4) Consumer Advocacy and Education; 5) Consumer Monitoring and Evaluation; 6) Crisis Response Services; 8) Family Support Services; 9) Planning Operations and System Development; 10) Residential/Housing; 11) Respite; 12) School Based Mental Health Services; 13) Staff Development; and 14) Transportation.
<p><i>Risk-based reimbursement</i> <i>{includes but is not limited to capitated (per member per month) or case rate payment (monthly or other timeframe)}</i></p>	<p><i>SAPT Block Grant</i></p> <ul style="list-style-type: none"> • Not applicable <hr/> <p><i>CMHS Block Grant</i></p> <ul style="list-style-type: none"> • Not applicable
<p><i>Innovative financing strategies</i> <i>{includes, but is not limited to pay-for-outcomes or payment for an episode of care}</i></p>	<p><i>SAPT Block Grant</i></p> <ul style="list-style-type: none"> • Not applicable <hr/> <p><i>CMHS Block Grant</i></p> <ul style="list-style-type: none"> • Not applicable
<p><i>Other reimbursement strategies</i> <i>{States using other reimbursement strategies for services and activities should describe the methodology and the services and activities that are purchased using this methodology}</i></p>	<p><i>SAPT Block Grant</i></p> <ul style="list-style-type: none"> • Prevention Services: the salaries for Prevention Services staff are paid with Block Grant funds. • Treatment Services: state-operated facilities are reimbursed for services using a cost-reimbursement methodology <hr/> <p><i>CMHS Block Grant</i></p> <ul style="list-style-type: none"> • Adult and Child/Youth: certain personnel positions that support the delivery of Adult and Child/Youth services as listed in the categories above are funded by the Block Grant (i.e. Consumer Liaisons, court-based assessment & triage services, transportation drivers, etc.)

Projected Expenditures for Treatment and Recovery Supports

(Table 5 of the FY2012 Block Grant Application)

In the current environment of Health Reform and implementation of the Affordable Care Act (ACA), mental and substance use disorder prevention, early intervention, and treatment are acknowledged as integral components of improving and maintaining an individual's overall health. To provide guidance to States as they begin to incorporate behavioral health services into general health under the Affordable Care Act (ACA), SAMHSA has drafted the document *Description of a Good and Modern Addictions and Mental Health Service System* (current release date: April 18, 2011). Within this draft, SAMHSA outlines a comprehensive and effective addictions and mental health service system that is essential to public health and is available to consumers across their lifespan. This system should provide a continuum of integrated services that include physical healthcare, community supports, and prevention services. SAMHSA also states that the modern addictions and mental health service system should be "accountable, organized, control costs, improve quality, accessible, equitable, and effective."

In its *Description of a Good and Modern Addictions and Mental Health Service System*, SAMHSA proposes a continuum of services comprised of the following domains:

* **Healthcare and Physical Health**

Service Activity Examples: General and specialized outpatient medical services; Acute Primary Care; General Health Screens, Tests and Immunization; Comprehensive Care Management; Care coordination and health promotion; Comprehensive transitional care; Individual and Family Support; Referral to Community Services

* **Engagement Services**

Service Activity Examples: Assessment; Specialized Evaluation (Psychological and neurological); Services planning (includes crisis planning); Consumer/Family Education; Outreach

* **Outpatient Services**

Service Activity Examples: Individual evidence-based therapies; Group therapy; Family therapy; Multi-family therapy; Consultation to Caregivers

* **Medication Services**

Service Activity Examples: Medication management; Pharmacotherapy (including MAT); Laboratory services

* **Community Support (Rehabilitative)**

Service Activity Examples: Parent/Caregiver Support; Skill building (social, daily living, cognitive); Case management; Behavior management; Supported employment; Permanent supported housing; Recovery housing; Therapeutic mentoring; Traditional healing services

* **Recovery Supports**

Service Activity Examples: Peer Support; Recovery Support Coaching; Recovery Support Center Services; Supports for Self Directed Care

* **Other Supports (Habilitative)**

Service Activity Examples: Personal care; Homemaker; Respite; Supported Education; Transportation; Assisted living services; Recreational services;

Interactive Communication Technology Devices; Trained behavioral health interpreters

* **Intensive Support Services**

Service Activity Examples: Substance abuse intensive outpatient services; Partial hospitalization; Assertive community treatment; Intensive home based treatment; Multi-systemic therapy; Intensive case management

* **Out of Home Residential Services**

Service Activity Examples: Crisis residential/stabilization; Clinically Managed 24-Hour Care; Clinically Managed Medium Intensity Care; Adult Mental Health Residential; Adult Substance Abuse Residential; Children's Mental Health Residential Services; Youth Substance Abuse Residential Services; Therapeutic Foster Care

* **Acute Intensive Services**

Service Activity Examples: Mobile crisis services; Medically Monitored Intensive Inpatient; Peer based crisis services; Urgent care services; 23 hour crisis stabilization services; 24/7 crisis hotline services

* **Prevention (including Promotion)**

Service Activity Examples: Screening, Brief Intervention and Referral to Treatment; Brief Motivational Interviews; Screening and Brief Intervention for Tobacco; Cessation; Parent Training; Facilitated Referrals; Relapse Prevention; Wellness Recovery Support; Warm line

In October of 2010, SAMHSA requested States to submit an Addendum to the FY2011 CMHS and SAPT Block Grant Applications in order to provide information regarding Health Care Reform efforts, as well as estimated expenditures for treatment and support services as categorized by the good and modern addictions and service system model. In its *Report on State Responses to the FY 2011 Block Grant Addendum on Health Care Reform*, SAMHSA analyzed State funding distributions by service category and found the following trends:

- States distributed funds across all of the mental health service categories, and most did not spend more than 25 percent of their total funds in any one area. States tended to distribute a higher percentage of their funds for outpatient, community and recovery support, and intensive support services.
- For most substance abuse services, States did not spend more than 25 percent of their total funds in any one category. The exceptions were outpatient services and out of home residential services.

Louisiana's estimated expenditures for CMHS and SAPT Block Grant funds align with these current national trends. The tables below detail projected expenditures for the FY2012 CMHS and SAPT Block Grant Award for treatment and support services.

Annually, OBH Central Office and each of the ten Regional Advisory Councils (RAC) across the State Regions and Local Governing Entities (LGEs) develops an Intended Use Plan for their allocated portion of the CMHS Block Grant funding. The service categories used to develop these Intended Use Plans are compared with the service categories in Table 5a to project the

FY2012 expenditures for Treatment and Recovery Supports as defined by the *Good and Modern Addictions and Mental Health Service System*.

**Projected Expenditures of CMHS Federal Block Grant Funds
for Treatment and Recovery Supports - Table 5a**

Service Category	FY 2012 Award				
	<10%	10 -25%	26 -50%	51 -75%	Over 75%
Healthcare/Physical Health					
Engagement		✓			
Outpatient	✓				
Medication	✓				
Community Support		✓			
Recovery Supports		✓			
Other Supports	✓				
Intensive Support	✓				
Out of Home Residential	✓				
Acute Intensive	✓				
Prevention	✓				
System Improvement		✓			

Services defined within the Louisiana Addictive Disorders Data System (LADDS) are cross-walked with the service categories in Table 5b, and then analyzed with FY2011 admissions and services data to project the FY2012 expenditures for Treatment and Recovery Supports as defined by the *Good and Modern Addictions and Mental Health Service System*.

**Projected Expenditures of SAPT Federal Block Grant Funds
for Treatment and Recovery Supports - Table 5b**

Service Category	FY 2012 Award				
	<10%	10 -25%	26 -50%	51 -75%	Over 75%
Healthcare/Physical Health	✓				
Engagement		✓			
Outpatient			✓		
Medication		✓			
Community Support	✓				
Recovery Supports					
Other Supports					
Intensive Support	✓				
Out of Home Residential		✓			
Acute Intensive	✓				
Prevention		✓			
System Improvement					

Primary Prevention Planned Expenditures Checklist

(Table 6 of the FY2012 Block Grant Application)

In implementing a comprehensive primary prevention program under the SAPT Block Grant, Louisiana has used a variety of strategies including but not limited to the six strategies listed below:

- 1) **Information Dissemination**: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
- 2) **Education**: This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages) and systematic judgment abilities.
- 3) **Alternatives**: This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resort to the latter.
- 4) **Problem Identification and Referral**: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
- 5) **Community-Based Process**: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking.
- 6) **Environmental**: This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

In addition, prevention strategies may be classified using the Institute of Medicine (IOM) Classification Model of ***Universal***, ***Selective*** and ***Indicated***, as defined below.

Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.

Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.

Indicated: Activities targeted to individuals in high-risk environments who are identified as having minimal but detectable signs or symptoms foreshadowing disorder; or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

As a component of its responsibilities, Prevention Services also ensures that Louisiana complies with Synar legislation which requires States to: 1) enact laws prohibiting the sale and distribution of tobacco products to minors; 2) enforce such laws in a manner that can reasonably be expected to reduce the availability of tobacco products to youth under the age of 18; 3) conduct random, unannounced inspections of tobacco outlets; and 4) report these annual findings to the Secretary of the U.S. Department of Health and Human Services. The Tobacco Regulation for the SAPT Block Grant prohibits the use of Block Grant funds to enforce tobacco laws; however, funds from the 20% primary prevention set-aside allotment may be used for carrying out the administrative aspects of the requirements, such as conducting the random, unannounced inspections. The table below details the planned expenditures under the FY2012 SAPT Block Grant Award for Primary Prevention activities.

**SAPT Block Grant
Primary Prevention Planned Expenditures Checklist - Table 6a**

Strategy	IOM Target	BG FY2012	Other Federal	State	Local	Other
Information Dissemination	<i>Universal</i>	\$312,859				
	<i>Selective</i>					
	<i>Indicated</i>					
Information Dissemination Total		\$312,859				
Education	<i>Universal</i>	\$3,899,334				
	<i>Selective</i>	\$145,240				
	<i>Indicated</i>	\$167,000				
Education Total		\$4,211,574				
Alternatives	<i>Universal</i>	\$48,132				
	<i>Selective</i>					
	<i>Indicated</i>					
Alternatives Total		\$48,132				
Problem Identification and Referral	<i>Universal</i>	\$48,132				
	<i>Selective</i>					
	<i>Indicated</i>					
Problem ID and Referral Total		\$48,132				
Community Based Process	<i>Universal</i>	\$96,265				
	<i>Selective</i>					
	<i>Indicated</i>					
Community Based Process Total		\$96,265				
Environmental	<i>Universal</i>	\$96,265				
	<i>Selective</i>					
	<i>Indicated</i>					
Environmental Total		\$96,265				
Section 1926 Tobacco	<i>Universal</i>	\$328,768				
	<i>Selective</i>					
	<i>Indicated</i>					
Section 1926 Tobacco Total		\$328,768				

Currently, CMHS Block Grant funds are not used for primary prevention activities. The Louisiana Partnership for Youth Suicide Prevention (LPYSP) program focuses on reducing child and adolescent suicide includes primary prevention activities that are funded under the Garrett Lee Smith Memorial Act from SAMHSA. The planned expenditures for the primary prevention activities of the LPYSP program for FY2012 are outlined in the table below.

**CMHS Block Grant
Primary Prevention Planned Expenditures Checklist - Table 6b**

Strategy	IOM Target	BG FY2012	Other Federal	State	Local	Other
Information Dissemination	<i>Universal</i>		\$175,475			
	<i>Selective</i>					
	<i>Indicated</i>					
Information Dissemination Total			\$175,475			
Education	<i>Universal</i>		\$157,575			
	<i>Selective</i>					
	<i>Indicated</i>					
Education Total			\$157,575			
Alternatives	<i>Universal</i>					
	<i>Selective</i>					
	<i>Indicated</i>					
Alternatives Total						
Problem Identification and Referral	<i>Universal</i>		\$35,575			
	<i>Selective</i>					
	<i>Indicated</i>					
Problem ID and Referral Total			\$35,575			
Community Based Process	<i>Universal</i>		\$131,375			
	<i>Selective</i>					
	<i>Indicated</i>					
Community Based Process Total			\$131,375			
Environmental	<i>Universal</i>					
	<i>Selective</i>					
	<i>Indicated</i>					
Environmental Total						
Section 1926 Tobacco	<i>Universal</i>					
	<i>Selective</i>					
	<i>Indicated</i>					
Section 1926 Tobacco Total						

Other Federals: Garrett Lee Smith Memorial Act funding from SAMHSA

Projected State Agency Expenditure Report

(Table 7 of the FY2012 Block Grant Application)

The tables below detail the projected total expenditure for FY2012 CMHS and SAPT Block Grant Awards.

**CMHS Block Grant
Projected State Agency Expenditure Report – Table 7a
(State Expenditure Period – 10/1/2011 to 9/30/2013)**

Activity	Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds	State Funds	Local Funds (excluding Medicaid)	Other
State Hospital	---	---	---	---	---	---
Other 24 Hour Care	---	---	---	---	---	---
Ambulatory/Community Non-24 Hour Care	\$5,251,941	\$7,238,086	\$6,615,893	\$83,326,401	---	\$11,412,467
Administration (excluding program and provider level)	\$276,418	---	---	---	---	---
Total	\$5,528,359	\$7,238,086	\$6,615,893	\$83,326,401	---	\$11,412,467

Other Federal Funds: PATH Grant, Youth Suicide Prevention Grant, Title 18

Other: TANF, Bioterrorism, SSBG-LaBHP, Permanent Supportive Housing, Over-collection Fund, Self Generated Revenue

**SAPT Block Grant
Projected State Agency Expenditure Report - Table 7b
(State Expenditure Period – 10/1/2011 to 9/30/2013)**

Activity	Block Grant	Medicaid (Federal, State, and Local)	Other Federal Funds	State Funds	Local Funds (excluding Medicaid)	Other
Substance Abuse Prevention and Treatment	\$17,996,981	---	\$2,428,324	\$32,985,687	---	\$6,279,723
Primary Prevention	\$5,141,995	---	---	---	---	---
Tuberculosis Services	---	---	---	---	---	---
HIV Early Intervention Services	\$1,285,499	---	---	---	---	---
Administration (excluding program and provider level)	\$1,285,499	---	---	---	---	---
Total	\$25,709,974	---	\$2,428,324	\$32,985,687	---	\$6,279,723

Other Federal Funds: Title 18, Probation and Parole, Data Collection Grant, ATR Grant, State Outcomes Measures, SPF-SIG Grant, PPW Grant

Other: TANF, Statutorily Dedicated -Gambling, Self Generated Revenue, Drug Court

Resource Development Planned Expenditure Checklist

(Table 8 of the FY2012 Block Grant Application Guidance)

A State may plan to spend its CMHS and SAPT Block Grant funds on resource development activities. Expenditures on resource development activities may involve the time of State or sub-State personnel, or other State or sub-State resources. These activities may also be funded through contracts, grants, or agreements with other entities. Resource development activities are categorized as follows:

Planning, Coordination, and Needs Assessment: This includes personnel salaries prorated for time spent in planning meetings, data collection, analysis, writing, and travel. It also includes operating costs such as printing, advertising, and conducting meetings. Any contracts with community-based organizations or local governments for planning and coordination fall into this category, as do needs assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps.

Quality assurance: This includes activities to assure conformity to acceptable professional standards and to identify problems that need to be remedied. These activities may occur at the State, sub-State, or program level. Contracts to monitor service providers fall in this category, as do independent peer review activities.

Training (post-employment): This includes staff development and continuing education for personnel employed in local programs as well as support and coordination agencies, as long as the training relates to service delivery. Typical costs include course fees, tuition and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.

Education (pre-employment): This includes support for students and fellows in vocational, undergraduate, graduate, or postgraduate programs who have not yet begun working in programs. Costs might include scholarship and fellowship stipends, instructor(s) and support staff salaries, and operating expenses.

Program development: This includes consultation, technical assistance, and materials support to local providers and planning groups.

Research and evaluation: This includes program performance measurement, evaluation, and research, such as clinical trials and demonstration projects to test feasibility and effectiveness of a new approach. These activities may have been carried out by the principal agency of the State or an independent contractor.

Information systems: This includes collecting and analyzing treatment and prevention data to monitor performance and outcomes. These activities might be carried out by the principal agency of the State or an independent contractor.

The table below details the estimated, planned expenditures for resource development activities under the FY2012 CMHS and SAPT Block Grant Awards.

**CMHS and SAPT Block Grant
Resource Development Planned Expenditure Checklist – Table 8**

Activity	Prevention MH	Prevention SA	Treatment MH	Treatment SA	Combined	Total
Planning, Coordination, & Needs Assessment	-	\$300,000	\$203,111	-		
Quality Assurance	-	-	\$242,984	-		
Training (Post Employment)	\$100,000	\$40,000	\$536,937	-		
Education (Pre Employment)	-	-	-	-		
Program Development	-	-	\$127,132	-		
Research & Evaluation	-	\$150,000	-	-		
Information Systems	-	\$10,000	-	-		
Total	\$100,000	\$500,000	\$1,110,164	-		

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FY 2012 Combined Behavioral Health Assessment and Plan

Part IV Narrative Plan

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Section D: Activities that Support Individuals in Directing the Services

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their families/support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their family / supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. Families, other caregivers, and youth should be full partners in all aspects of the planning and delivery of their own services, including policies and procedures that govern care for children and youth. In the section below, please address the following:

- **Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s). States can describe how they define self-directed care in accordance with their own policies and structures.**

Currently, the Office of Behavioral Health (OBH) does not have policy and procedures governing directly the implementation of services inclusive of self-directed care. However, OBH is supportive of the recovery model as a whole, as evidenced through the statewide implementation of the Peer Support Service and Wellness Recovery Action Plan (WRAP) modalities of care within the mental health service array. The implementation of these services has resulted in the creation of over eighty-five Peer Support positions in Louisiana at a professional level of staffing and employment. As WRAP has become implemented in various service regions, it has been incorporated as part of the treatment planning service thereby placing control for treatment goals and care in the peer purview. In addition, in FY 2012 a program manual governing WRAP and

Peer Services will be developed which will stipulate the services as self-directed in nature in addition to a wellness and recovery base.

- **What services for individuals and their support systems are self-directed?**

The largest self-directed care service in Louisiana at this point in time is the Wellness Recovery Action Plan (WRAP) program. As peers develop and utilize WRAP to shape their wellness and recovery through the identification of wellness tools, triggers and early warning signs, they are able to define what works and what hinders their recovery. In addition, the crisis plan which provides a roadmap of care options has taken the place of a formal Advance Directive in some areas of the state. When peers are hospitalized, services and supports that have been identified during times of wellness allow for choice in care.

As of July 2012, Louisiana has trained 99 peers as WRAP Facilitators who have led over 300 WRAP classes statewide and have introduced the WRAP concept to approximately 1,700 peers. In November of 2012, an additional WRAP training will be held which will add 20 individuals to the cadre of WRAP Facilitators. November will also mark the first time in which Louisiana will lead the WRAP Facilitator training without the support of the Copeland Center for Wellness and Recovery. Lastly, aiding the spread of WRAP statewide and enabling its use of a self-directed plan of care has been the emphasis to cross-train employed Peer Support Specialists as WRAP Facilitators, thereby leading WRAP classes as part of their employment specifications.

- **What participant-directed options do you have in your State?**

The Office of Behavioral Health will begin implementation of a Coordinated System of Care for high risk adolescents in January 2012. The System of Care model is an organizational philosophy and framework that involves collaboration across agencies, families, and youths for the purpose of improving access and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for children and youth with serious behavioral health disorders and their families. Systems of care engage families and youth in partnership with public and private organizations to design behavioral health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.

Collaboration and partnership between families and service providers is recognized as the critical factor in the development of successful plans of care, programs, policies, and practices. The development of youth involvement in mental health systems of care closely follows the growth and acceptance of family peer-to-peer support and the broader family empowerment movement, as well as the growth of consumer-provided services. Support for and by family members within the system of care is a core strategy for improving the children's mental health system of care.

In Louisiana's Coordinated System of Care, youth and caregiver involvement, support and development, at all levels of the system, will be structured to support family involvement and engage the diversity of families affected by the system of care, including those families with children involved in the child welfare or juvenile justice systems. Family members will participate in the wraparound planning process. Family and youth will receive support from peers to support and train families being served by the CSoc. By featuring family members as full partners working within the system of care, the Louisiana Coordinated System of Care hopes to stimulate behavioral change across the system and support development of family-friendly policies and procedures within the provider agencies and among community partners. Three key constructs integral to the Louisiana Coordinated System of Care include:

Social support - Social support helps caregivers feel a sense of belonging and being valued, and also provides new resources, both tangible and intangible.

Broad social networks - Peer-to-peer support providers serve as links to broader social networks. Peer-to-peer support connects caregivers to community resources, people, or institutions and thus serves as a relationship or social network bridge-builder.

Empowerment - Empowerment will be supported through the peer-to-peer interaction. Caregivers and youth will receive peer-to-peer support to enhance resiliency and recovery to learn strategies and access resources to help deal with the child's and family's situation.

- **What percentage of individuals funded through the SMHA or SSA self direct their care?**

It is anticipated that a significant number of individuals funded through OBH will self direct their care in the coming two to three years. OBH strongly supports this philosophy and is actively implementing it in its initiatives and protocols.

- **What supports does your State offer to assist individuals to self direct their care?**

Currently, the Program Coordinator for Client Affairs at the Office of Behavioral Health (OBH) provides support and technical assistance to all certified peers in Louisiana as requested. In addition, peers working in the individual service region often serve as a point of contact for questions, support or even aid in resolving a crisis for peers in their community. These local leads also facilitate WRAP classes, which map out self-directed care options. In FY 2012, OBH will also be developing regional-based groups for WRAP Facilitators, Peer Support Specialists and advocates to identify key areas needed for change and plans of action. A statewide group to be housed at the OBH Central Office will be created as an adjunct to collect and consolidate all information received and present information to the central office outlining peer needs, such as the further introduction of self-directed care services.

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Section E: Data and Information Technology

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should be able to provide the service utilization (as reported in Table 5 in the Reporting Section of the Application). States should provide information on the number of unduplicated individuals provided each service purchased with Block Grant Funds. In addition, States should provide expenditures for each service identified in Table 5. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- 1) List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:**
 - **Provider characteristics**
 - **Client enrollment, demographics, and characteristics**
 - **Admission, assessment, and discharge**
 - **Services provided, including type, amount, and individual service provider**
 - **Prescription drug utilization**

OBH-IIS – The Office of Behavioral Health Integrated Information System is a web-based comprehensive information system capturing data for all OBH mental health clinics and contracted programs statewide. It captures the unique number of individuals admitted, receiving services, and discharged. All client socio-demographic data, assessment data, services provided, and provider data are reported. OBH-IIS is the major source of client-level data for the CMHS Uniform Reporting System (URS) data tables. OBH-IIS data are stored and processed in the OBH data warehouse, which is described below. OBH-IIS interfaces with the Level of Care Utilization System/Child and Adolescent Level of Care Utilization System web-based system (proprietary), providing the means for integrated level-of-care assessment for each client and level of care data for analysis/reporting. OBH-IIS also provides an electronic Continuity-of-Care document which transmits treatment-relevant data from one level-of-care to the next. OBH-IIS is supported under contract with Statistical Resources, Inc.

LADDS – The Louisiana Addictive Disorders Data System is a web-based comprehensive information system for all OBH addictive disorders clinics, contracted programs, and residential programs statewide. It captures the unique number of individuals admitted, receiving services, and discharged. All client socio-demographic data, assessment data, services provided, and provider data are reported. LADDS is the major source of client level

data for the CSAT Treatment Episode Data Set data tables, and produces a report of performance indicators for each of the National Outcomes Measurement System domains. LADDS data are stored and processed in the OBH data warehouse, which is described below. LADDS interfaces with LASIS, the Louisiana Addiction Severity Index System, a web-based system that supports electronic client assessment through the Addiction Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) (proprietary). The system generates a narrative report of the assessment for the clinician and an American Society of Addiction Medicine level of care for each client. LADDS is supported under contract with Click Here, Inc.

CRIS – The Crisis Response Information System is a web-based system that supports the Child and Adolescent Response Team (CART), a short-term mental health crisis intervention program operating statewide. The system captures individual client and service data on all crisis episodes and provides reports for providers, managers and central office staff. CRIS is supported under contract with Click Here, Inc.

PRISM – PRISM is the pharmacy management system operating in each of the regional OBH pharmacies. It automates prescription processing, inventory and management reporting, especially statewide monitoring of the utilization and costs of pharmaceuticals. Data are regularly uploaded to the OMH data warehouse for statewide reporting. These data are critical for reviewing and managing the ever increasing cost of pharmaceuticals. PRISM is seamlessly integrated with the M&D CARES system which automates and simplifies the Patient Assistance Program. PRISM and M&D CARES are proprietary systems supported under contract with New Tech Computer Systems, Inc.

ECSS-MIS – The Early Childhood Services and Supports (ECSS) Management Information System is a web-based information system for the ECSS program providing services and supports for children under five and their parents by parish statewide. It captures client, assessment, and outcome data, and provides reports utilized locally and at the central office level. ECSS-MIS is supported under contract with Click Here, Inc.

ATR – The Access to Recovery data system is a web-based voucher management and clinical case record system that captures the number of individuals admitted in and receiving treatment and recovery support services through the program. All ATR client data, assessment data, services provided, and outcomes are reported into this database. ATR is supported under contract with the Center for Business and Information Technology, University of Louisiana, Lafayette.

PMIS – The Prevention Management Information System captures the number of individuals enrolled in and receiving ongoing prevention services. In addition, PMIS captures the number of individuals that receive services in one-time prevention events (health fair, rally, etc). PMIS is supported under contract with Click Here, Inc.

PIP/PIF/ORYX – The Patient Information Program (PIP) is a comprehensive LAN-based information system for the state psychiatric hospitals and regional acute units operated by OBH. It is the primary source of counts of persons served, diagnoses, lengths of stay, and

bed utilization. These data are utilized for the URS tables and NOMS. The financial module (PIF) supports billing and accounts receivables, and the ORYX module supports performance reporting for Joint Commission accreditation, including the new core measures for reporting of screening (trauma, substance abuse), medication management (antipsychotic monotherapy), and continuity of care (reducing the time for needed care information to be sent to the aftercare service unit). The system also interfaces with a comprehensive incident reporting system. PIP/PIF/ORYX is supported under contract with LAN Services, Inc.

ARAMIS – The Accounts Receivable and Management Information System provides electronic accounts receivables for the community mental health clinics. ARAMIS data are uploaded to create a data warehouse through which statewide electronic Medicaid and Medicare billing is performed. ARAMIS modules have been progressively retired as functions have been replaced by OBH-IIS. ARAMIS is supported under contract with Statistical Resources, Inc.

OARS – The On-line Accounts Receivable System supports electronic accounts receivables and Medicare billing for the state addictive disorder clinics. NOTE: OBH is in the process of merging the functions of OARS and ARAMIS into one system to serve the needs of behavioral health clinics statewide. OARS is supported under contract with Trendsic Solutions, Inc. This vendor is performing the integration of ARAMIS and OARS. The integrated application will go live October 1, 2011.

MHR/MHS & UTOPIA - The Mental Health Rehabilitation/Mental Health Services system supports client, assessment, and service data collection for several OMH contracted mental health service program providers (mainly case management). The system is also now being utilized in OBH in the Pre-Admission Screening and Resident Review (PASRR) program providing data on mental health needs in the nursing homes. The Utilization, Tracking, Oversight, and Prior Authorization (UTOPIA) system, which is integrated with the MHR/MHS software, supports prior authorization of services and utilization and outcomes management at the state and area levels. MHR/MHS and UTOPIA are supported under contract with Statistical Resources, Inc.

2) As applicable, for each of these systems, please answer the following:

- **For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?**

National provider identifiers are required and collected for OBH-IIS only.

- **Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?**

All of the above listed systems utilize a unique provider identifier that provides the ability to aggregate information by provider.

- **Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?**

All of the above listed systems utilize a unique client identifier that allows for unduplicated counts of clients.

- **Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?**

OBH-IIS/ARAMIS, LADDS/OARS, and ATR collect service encounter data and support claims processing.

- **Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?**

OBH-IIS/ARAMIS, LADDS/OARS, and PRISM utilize ICD-10, CPT, and HCPCS codes.

3) **As applicable, please answer the following:**

- **Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?**

Yes; Social Security Numbers and Medicaid Identification Numbers.

- **Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?**

This has not been done routinely. There have been such efforts related to special ad-hoc reports. There is also an increased sharing of data, particularly fiscal projection data between Medicaid and OBH in preparation and development of the managed care system.

- **Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?**

There have been routine meetings and some planning at a departmental level that is examining the health care exchanges and federal standards related to information technology in light of the Affordable Care Act. The Louisiana Medicaid Office and the OBH have worked collaboratively over the last year in the design of State Management Organization and development of a behavioral health Medicaid managed care system.

- **Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?**

Yes, the Louisiana Health Information Exchange (LA-HIE). OBH participated in the strategic planning and has been kept informed during the implementation process. LA-HIE is managed through the departmental health information technology section.

- **Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?**

Yes. The State Medicaid agency has completed an RFP process to replace and modernize the MMIS. OBH has not been involved in this effort.

4) In addition to the questions above, please:

- **Provide information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.**

OBH is in the process of developing an RFP for an Electronic Behavioral Health Record (EBHR) system for each of the five OBH Regions. Four Local Governing Entities (LGEs) have recently procured an EBHR. One LGE implemented an EBHR two years ago. OBH has developed standards for uploading of client-level data from the EBHRs to the OBH data warehouse for purposes of state and federal reporting.

- **Identify the barriers that your State would encounter when moving to an encounter/claims based approach to payment.**

An encounter/claims based approach to payment is now being utilized.

- **Identify the specific technical assistance needs your State may have regarding data and information technology specifically in Section 3.k of this application.**

The Office of Behavioral Health is in need of technical assistance and consultation in establishing a comprehensive data warehouse and business intelligence system as the State transforms services to managed behavioral health care. The data warehouse will be the major resource for storage, analysis, and reporting of behavioral health data for state and federal reporting requirements, and for linking behavioral health data with other data sources such as Medicaid. OBH is presently in the process of consulting with staff of the South Carolina Office of Research and Statistics for this consultation.

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Section F: Quality Improvement Reporting

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction service delivery system. These processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the State's CQI plan should describe the process for responding to critical incidents, complaints and grievances.

Quality Management Strategy

Not only does the merger of the Offices of Addictive Disorders and Mental Health into the Office of Behavioral Health evoke the need for an integrated quality management strategy, but the new agency's role is also transforming into one of purchaser of a service network, rather than provider of services. As part of the OBH's efforts to further leverage funding and increase access through Medicaid reform, the state's services will be provided through a Statewide Management Organization (SMO), responsible for managing the care of individuals with behavioral health needs, including Medicaid and non-Medicaid eligible adult and youth. It is anticipated that this SMO will become fully operational in March of 2012.

The OBH will be the purveyor of the SMO and responsible for, in addition to other activities, the monitoring of the SMO for compliance with the contractually mandated deliverables. In addition, OBH will be required to implement a revised Quality Management Strategy (QMS) that will detail the process for OBH quality management of the SMO and will identify both performance indicators and outcome measures. This QMS is currently in draft form and is supplied as an attachment (see appendix - *Quality Strategy for the Louisiana Behavioral Healthcare Prepaid Inpatient Healthcare Plan Waiver; July 7, 2011*). This document will undergo successive revisions and may not reflect the final product, which is anticipated to be complete by March 2012.

In the interim, over the last two years, the OBH mental health and substance abuse providers have been participating in parallel quality improvement initiatives that have both demonstrated positive outcomes: 1) the Service Process Quality Management (SQQM) and 2) the Network for the Improvement of Addiction Treatment Services (NIATx).

Service Process Quality Management

To support more effective operations within the mental health clinics and to prepare these clinics for managed care and anticipated accreditation, the OBH District and Regional service providers have been involved in an on-going initiative supported by technical assistance through the National Council for Community Behavioral Health Care known as Accountable Care. This is an initiative focused on re-designing clinic operations into a care delivery system that utilizes

data-based decision making to guide day-to-day operations. The OBH has supported these activities through the utilization of an electronic business intelligence tool called the Service Process Quality Management (SPQM) system. OBH uses SPQM as a management tool that allows clinic managers and specially trained staff to access the OBH data in a way that allows the user to answer questions about staff productivity and clinic efficiency. By measuring such indicators as no-show and cancellation rates, managers can modify clinic schedules, staffing patterns and hours, clinic policies, etc., which would be designed to reduce or eliminate these periods of lost-productivity and maximize access to services for the clients.

Regional/LGE and central office staff members participate in monthly SPQM webinars conducted by David Lloyd, national Accountable Care expert, for purposes of advancing their competencies in data-based decision making and performance improvement, and reviewing and improving their local program operations. Clinical managers review service utilization, productivity results, and other critical indicators of provider effectiveness. Established standards for accessing care have also been adopted, including routine, urgent, and emergent care standards. In some cases, clinics have moved from having extensive waiting lists to using an access clinic model, where persons can walk in and be provided screening and assessment on the same day.

Network for Improvement of Addiction Treatment Services (NIATx)

The NIATx model emphasizes systems and process improvement using existing resources, and building efficiencies without the need for additional investment. This quick-turn-around model guides provider staff to transform business practices and the quality of care their clients receive. All NIATx initiatives are related to four aims: reduce waiting times; reduce no-shows; increase admissions; and increase continuation in care.

Following successful implementation of the NIATx model with six outpatient substance abuse providers in FY2009, a statewide expansion plan of the NIATx model was developed for FY2010. Entitled the Louisiana Performance Improvement Network Pilot Initiative, it targeted OBH state-operated and contracted providers and focused on client initiation, engagement and retention through use of the NIATx model. An informational workshop for state-operated and contract providers was offered across the state, after which interested providers submitted a Request for Application (RFA) to become one of the next six project cohorts. Selected cohorts participated in a kick-off meeting with the NIATx consultant and newly identified Louisiana NIATx Coaches. Providers received a face-to-face site visit and monthly coaching calls facilitated by the NIATx consultant, as well as on-going technical assistance from the state office Quality Improvement Division. Each cohort completed a NIATx Project over a six month period and reported outcomes of the project.

The NIATx expansion approach has since been revised due to the OBH merger and the multiple transitions occurring simultaneously within the Office. As the OBH implements strategic system integration and reorganization, NIATx will be utilized as a vehicle to help guide the development of business processes to effectively integrate administrative and clinical services. On June 20-21, 2011, the OBH received technical assistance from the Center for Substance Abuse Treatment (CSAT) to provide guidance on effective practices and processes of behavioral health service integration. This venue was used to discuss recommendations on how the OBH could

operationalize the use of NIATx priorities within the Office of Behavioral Health integration plan.

As behavioral health services are restructured in Louisiana through the Louisiana Behavioral Health Partnership (LBHP), Medicaid will require each agency to conduct two Performance Improvement Projects (PIPs) in the first year of business, and more in each successive year. The PIPs are the result of analyses of business practices conducted by OBH, the External Quality Review Organizations (EQRO), and the Inter-departmental Monitoring Team (IMT) that focus on issues related to compliance with Medicaid laws and state and federal reporting requirements. The NIATx model could be used as the framework for agencies to conduct the required PIPs. OBH is also exploring the integration of the Service Process Quality Management (SPQM) web-based tools and processes with the NIATx model of process improvement.

Through use of both the NIATx and the SPQM system, providers have realized a 25% to 35% improvement in show rates for treatment appointments and achieved approximately 30% decreases in drop-out rates.

Consumer Satisfaction and Perception of Care

The OBH currently uses two methods to survey its mental health service recipients for their satisfaction with services. Both methods use the national standard *Mental Health Statistics Improvement Project (MHSIP)* survey for adults and the *Youth Services Survey for Families (YSS-F)* survey for parents of youth. To collect adult surveys, a team of specially trained peer surveyors travels around the state and spends up to 3 weeks at a behavioral health clinic. During this time, the surveyors approach individuals who are in the clinic waiting room and ask them to participate in a satisfaction survey. This method has been used since the mid 1990's to collect data for performance improvement and to report to the federal government on required Mental Health Block Grant and NOMS indicators. The data collected using this method is rolled up into a standard report that is issued to the clinic manager for the local Performance Improvement plan and is also posted on the OBH website for review.

The second method of collecting data is through an on-line system, the Telesage Outcomes Measurement System (TOMS). This system allows service recipients to access the standard MHSIP and YSS-F surveys via a touch screen computer located in the waiting room of the clinics. The OBH uses this system to collect all of its youth satisfaction survey data and it is also used to supplement the data collected by the peer survey team for adults. The TOMS system enables providers to track individual client treatment outcomes at repeated intervals over the course of treatment and measures a wide range of relevant treatment outcomes. The TOMS website provides longitudinal aggregated reports of client data to support quality improvement and performance accountability and data related to changes in living status, employment status, and arrests that will be utilized in the client level NOMS reporting this fiscal year. OBH is exploring the options of extending the TOMS to provide standardized outcomes and quality of care assessments for addiction clients as well.

Addictive Disorder service providers continue to measure consumer satisfaction using a client self-administered survey that is uniform for most Regions/LGE's. Some Regions/LGEs have enhanced the survey instrument by adding additional questions. The satisfaction survey is

conducted at various points throughout the treatment process: at admission, during treatment and at discharge. The instrument includes a number of measures that assess client satisfaction with the overall treatment experience, scheduling convenience, performance of the counselor, partnership in the treatment process, cultural sensitivity, and more. The OBH staff review the results and use findings to inform provider technical assistance and training. Again, OBH is exploring ways to integrate the satisfaction survey process to include both mental health and substance use disorder clients.

Complaints, Grievances, and Critical Incidents

Complaints and grievances are received at the OBH clinics and reviewed by the clinic and Regional Managers. Analysis of these complaints is intended to generate local Performance Improvement/action plans.

At present, all critical incidents are immediately reported to the OBH executives and to DHH leadership by phone and via a standardized form. This immediate report is followed by submission of details of the incident on a standardized reporting form that includes a description of the plan of action. This is submitted within 24 hours of the incident. Finally, a follow-up report is submitted within 72 hours of the incident with any additional details and/or results of the plan of action. The immediate, 24 hour, and 72 hour reports are reviewed by two OBH Central Office directors. They evaluate the completeness, accuracy, and significance of the report. These directors can request additional information or require additional actions to be taken. In cases of a significant event, a Root Cause Analysis (RCA) can be ordered and when completed will result in further corrective action, along with a Performance Improvement plan. OBH keeps a central record of all critical incident reports and RCA reports for analysis to inform policy development. The current Critical Incident Reporting policy and procedure are being revised further at present.

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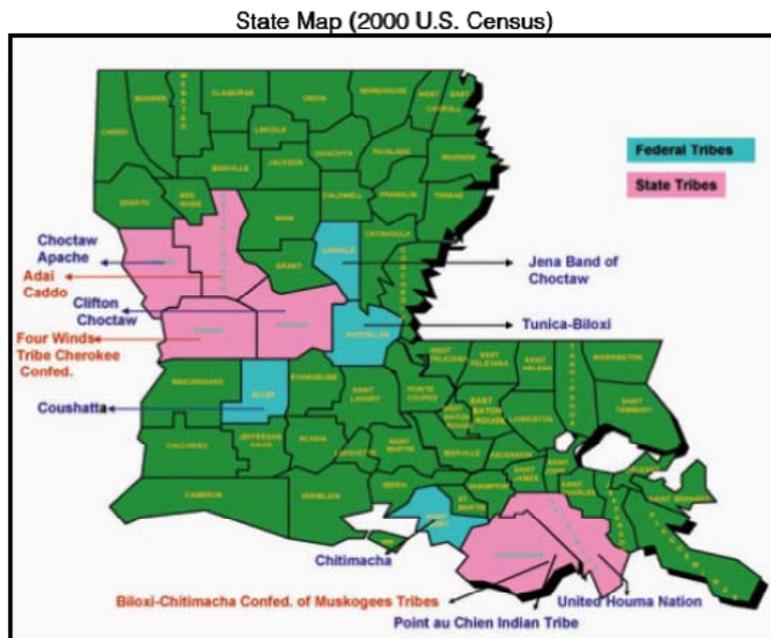
Section G: Consultation with Tribes

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee.

SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

In the state of Louisiana, there are four federally recognized Native American tribes that include the Chitimacha Tribe in Charenton, the Tunica-Biloxi Tribe in Marksville, the Coushatta Tribe in Elton, and the Jena Band of Choctaw Indians in Trout. According to the 2010 US Census, the Louisiana population is 0.7% Native American. In addition to the federally recognized tribes, Louisiana also has several state recognized tribes (figure). The Governor's administration has moved forward to establish the Governor's Office of Indian Affairs, which is charged with administering the programs relative to Louisiana Indian tribes. In an effort to provide an official voice and gather



input from the local tribes to the State government, the Office of Indian Affairs is further charged with collecting facts and statistics as well as conducting special studies of conditions pertaining to the employment, health, education, financial status, recreation, social adjustment, or other conditions affecting the welfare of the Indian people. This Office is expected to make recommendations to the governor and to the legislature for needed improvements and additional resources to promote the welfare of the Indians in the state. The Office of Indian Affairs submits an annual report to the legislature and to the governor to better inform State government and to establish a mutual exchange of ideas and information with the tribal entities. The Office of Indian Affairs is designated as the official negotiating agent of the State upon which federally recognized tribes in the State of Louisiana may serve notice of any request to negotiate state tribal compacts. Anticipated outcomes for this Office include: (i) improved coordination of services of all agencies in the state serving the Indians, (ii) provision of a venue for submitting compacts to the governor for approval, and (iii) adoption and promulgation rules and regulations that are deemed necessary to implement the provisions of this Chapter in accordance with the provisions of the Administrative Procedure Act.

In an effort to build collaborative relations with local Indian tribes and to comply with the requirements of the Americans Recovery and Reinvestment Act of 2009 (ARRA), the Department of Health and Hospitals has begun the process of building a communication forum and notifying Louisiana Indian tribes of the major healthcare reforms and current initiatives. The Louisiana DHH has identified and established key contacts and communications with tribal leaders in the federally recognized tribes. For several of these tribes, there are established collaborative relationships between the tribe and local levels of the state agencies. For example, the Jena Band of Choctaw Indians has worked closely with the Department of Child and Family Services foster children, private adoptions, schools, FINS (Families in Need of Services), and drug and alcohol rehabilitation. This tribe also works to connect its members to appropriate services within the tribal services and through referrals to state-managed agencies outside of the reservation. Specific areas of need and aspects of the service delivery system have been developed to target areas of domestic violence, child abuse prevention, access to substance abuse rehabilitation, counseling, delinquency and many other social problems. For each of the federally recognized tribal areas, there is a federally funded health center that provides some essential services. Some of these tribal areas have developed specialty treatment centers to target behavioral health issues.

With both the development of the physical health Medicaid reform package through the Coordinated Care Networks and with the behavioral health reform through the Louisiana Behavioral Health Partnership, the Louisiana Department of Health and Hospitals, specifically the State Medicaid Office, have reached out to the Native American Tribes in Louisiana. The four federally recognized tribes of Louisiana were invited to participate in public forums to discuss the opportunities and expectations with regard to these transformative operations. In attempts toward transparency and improved communication, all tribal nations were alerted to review all documentation on the DHH website and provide written or verbal feedback relative to the proposed Medicaid reform.

Within the Office of Behavioral Health, a committee structure has been tasked with increasing collaboration with the local Indian tribes and implementation of routine communications and

collaboration by building off of existing relationships at the local and state levels. A more specific needs assessment and further assessment of common goals relative to the tribal communities could help local communities better manage limited health resources and build stronger linkages for Louisiana citizens.

The Mental Health Planning Council in its efforts to re-design itself into an integrated Behavioral Health Planning Council has taken on the responsibility of reaching out to Native American representatives. The goal for the next year to two years is to recruit representatives from tribal communities to participate in the advocacy associated with the Planning Council activities. Further community level assessment is needed to determine the best approaches to reaching this population at a grass roots level.

As a critical phase of assessing need and planning relative to the outreach to the tribes, the OBH Block Grant Core Committee on Tribal Consultation will be partnering with the Department (DHH) Bureau of Minority Health Access, which has taken the lead in establishing a more consultative relationship with Louisiana's tribes. Both OBH and the State's Medicaid agency will be guided by Mr. Durand "Rudy" Macklin, who is the director of the Bureau of Minority Health Access and therefore is leading the outreach activities to the tribal nations. The Department's relationship with the tribes is in the relatively early stages of development, but DHH has contacted each of the chiefs associated with the Louisiana tribes. In turn, each of the chiefs has identified a point of contact within their respective tribal governments, who will offer comment on health care issues and initiatives. With regard to the Medicaid reforms and changes to the Medicaid State Plan, these initiatives and plans have been shared with each of the tribal nations. The tribes have not, at this time, offered any comment or concern relative to these health care changes that the State is pursuing. There have been some preliminary meetings with tribal leadership to discuss improved communications and collaboration with the tribes. Specifically, the DHH Medicaid Director and the Department's Undersecretary had visited the Coushatta Tribal Council. Results of these attempts have guided future efforts of the Department. The Department is focused on establishing a formal and uniform process and procedure for communicating health care issues. The next steps of these outreach activities include having DHH physical and behavioral health representatives partner with the Director of the Intertribal Council of Louisiana, Kevin Billiot, and the Director of the Governor's Office of Indian Affairs, Col. J Strickland. The Intertribal Council potentially offers a venue for routine interactions with all of the Louisiana tribes, both federally and state recognized. The OBH Block Grant Core Committee on Tribal Consultation is actively collaborating with the Department and is poised to participate in these ongoing tribal outreach efforts.

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Section H: Service Management Strategies

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services

Historically, the OBH has supported initiatives to improve service delivery and establish utilization management guidance to state-operated clinics. These initiatives including implementation of the Service Process Quality Management (SPQM) for mental health service providers and the Network for the Improvement of Addiction Treatment Services (NIATx) for addiction providers (see Section F – *Quality Improvement Reporting*). Both of these initiatives have helped to prepare state-supported behavioral health clinics become more streamlined and operate with increased efficiency; and thus, preparing clinics for accreditation and transition to a managed care environment with Medicaid reform through CSoC and LBHP.

In the coming planning period, the OBH will move into the position of purchaser and evaluator of the selected State Management Organization (SMO), which will administer and manage all behavioral health services for the state, both Medicaid and non-Medicaid. A key function of the SMO will be the implementation of a comprehensive utilization management system that will provide cost savings and allow more Louisiana citizens access to specialty behavioral health services.

2. The strategies that your State will deploy to address these utilization issues

The utilization management functions that is anticipated for future behavioral health services through the Louisiana Behavioral Health Partnership (LBHP) has been explicitly detailed in the overall care management section of the RFP related to the acquisition of the SMO. As described in this RFP, Care Management (CM) is defined as the overall system of medical and psychosocial management encompassing that includes utilization management, care coordination, discharge planning following restrictive levels of care, continuity of care, care transition, and Quality Management.

The SMO is expected to develop and maintain a care management function that ensures covered behavioral health services are available when and where individuals need them. The SMO is to provide services that are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The care management

system shall have sufficient licensed mental health provider care managers (CMs) to respond 24 hours per day, 7 days per week, and 365 days per year to Members, their families/caregivers, or other interested parties calling on behalf of the Member. The management of care is expected to follow the essential access standards defined as Emergent, Urgent, and Routine. Timely access to services for recipients must be followed per these standards. The CM of members enrolled in LBHP is also expected to meet certain standards related to referral and follow-up to co-occurring physical health concerns. Specifically, the CM standards mandated that members with LBHP will have an identified primary care physician inclusive of referrals to the Coordinated Care Network (CCN), that members have their overall healthcare coordinated through the SMO, and that the SMO document and track of well care visits. The SMO is also specifically charged with providing targeted coordination of higher risk members, who might include:

- Any individual with IV drug use, pregnant Substance Abuse users, substance using women with dependent children or co-occurring disorders;
- Children with behavioral health needs in contact with other child serving systems not eligible for CSoC;
- Children eligible for CSoC;
- Adults eligible for the Home and Community Based Services:
- Persons with acute stabilization needs
- Persons with SMI (federal definition of Serious Mental Illness)
- Persons with MMD (Major Mental Disorder).
- An adult who has previously met the above criteria and needs subsequent medically necessary services for stabilization and maintenance.

The clinical anchor for managing the care and applying utilization management parameters to members' services will be the treatment plan or Plan of care (POC) developed by the SMO. Within the CSoC where a Wraparound Agency (WAA) is available, the treatment planning is performed by the (WAA). For all other LBHP members identified as special needs individuals, the SMO, its staff or an independent community practitioner shall develop the POC.

For the managed care system implementation, the Utilization Management (UM) is to be based on the medical necessity of health care services criteria and practice guidelines to insure the right amount of services are provided when the member needs them. This UM system will focus on individual and system outliers that require review to assess if individual members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services. The SMO will be responsible for implementing a UM program that has sufficient licensed providers, including licensed addictions counselors (LACs), as well as a board-certified psychiatrist and a board-certified addictionologist as well as providers with specialization in children's and adults' care. The SMO's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings, including psychiatric residential treatment facilities. The UM plan will target utilization review of inpatient hospital and residential treatment centers. The SMO UM system will incorporate the Medicaid definition of medically necessary covered behavioral health services, service definitions, practice guidelines, and levels of care into provider

requirements documents, where applicable. Within this context, the SMO will manage the care and place appropriate limits on service delivery (applying criteria, such as medical necessity, or for utilization control), provided the services that are delivered can be reasonably expected to achieve their purpose. Develop and implement processes (based in part on clinical decision support, claims and outcome data and medical record audits) for each provider and the WAAs that monitor for under-and over-utilization of services at all levels of care, including monitoring behavioral health providers' utilization of services by race, ethnicity, gender, and age. When over- or under-utilization is detected, the SMO will be charged with developing and implementing strategies to bring utilization to the expected level. The SMO will specifically monitor and track utilization of the following services:

- Crisis services
- 24 hour levels of care, including inpatient and residential
- Out-of-home placements for children/youth
- Other intensive services, to ensure utilization is consistent with practice guidelines.

In addition, monitoring and analysis of pharmacy data for under-and over-utilization and potential inappropriate utilization will also be included in the new UM system. More specifically, the SMO will monitor for medication side effects, adverse drug interactions, medication adherence, and indications of possible abuse.

3. The intended results of your State's utilization management strategies

With the implementation of the SMO, the OBH will have a comprehensive UM system that manages all levels of care, all provider types, and pharmacy. Through this transformation, the OBH anticipates being able to provide greater access to more Louisiana citizens in need of behavioral health services with less reliance on the most restrictive levels of care. The new UM system will foster aspects of a good and modern system that allows for personal choice and guides care to be appropriate and based on strong clinical outcomes.

4. The resources needed to implement utilization management strategies

The Louisiana OBH in conjunction with other state agencies have made the commitment to share financial resources in order to build a comprehensive behavioral health system for children and youth that is able to appropriately and fully leverage federal resources. With the Governor's support, the OBH and the CSoC Governance Board have been able to direct resources for the start-up and initial operation of the LBHP and CSoC. Both personnel and consultative support has been required for the design of the LBHP and CSoC as well as the development of the SMO performance standards. An extensive number of man hours have been required by personnel in the participating agencies to develop the CMS Waivers and guidance documents. Continuing efforts are currently underway in finalizing the procurement of the SMO, the establishment of the Coordinated Systems of Care throughout the state, and the transition of state-operated service providers into the Medicaid environment.

5. The proposed timeframes for implementing these strategies

The vendor selection process for the selection of the State Management Organization is currently underway. The anticipated implementation for the SMO is March 1, 2012. The UM function of the behavioral health service delivery system will co-occur with SMO implementation.

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Section I: State Dashboards

Behavioral Health System Transformation through Medicaid Reform

As part of the Medicaid reform efforts of the Louisiana Behavioral Health Partnership (LBHP), the Office of Behavioral Health (OBH) will contract with a Statewide Management Organization (SMO) in order to improve access to services, produce quality outcomes and reduce health care costs. It is paramount that OBH continue to provide essential services and treat approximately the same proportion of citizens as it has in previous years, despite the large scale system redesign, staff reduction and reorganization occurring in the State. This is achievable through the improved access to services afforded by the Statewide Management Organization, its enhanced provider network, utilization management and enhanced Medicaid reimbursement. In its role as authority over the SMO, OBH will ensure that, at minimum, the same number of persons who have received treatment for mental health and substance use disorders in fiscal year 2011 will receive treatment in the first year of the SMO's operation.

1) *Dashboard Indicator: Access*

Establish and implement the Statewide Management Organization (SMO). The SMO enrolls and reimburses for 100% of the number of mental health recipients in FY12 as compared to those currently served in FY11 through state-managed providers.

Mental Health Measure: The number of persons served and receiving mental health services through the management of the SMO in FY12. Data obtained from state-run electronic systems and the SMO electronic systems.

2) *Dashboard Indicator: Access*

Establish and implement the Statewide Management Organization (SMO). The SMO enrolls and reimburses for 100% of the number of substance use disorder recipients in FY12 as compared to those currently served in FY11 through state-managed providers.

Substance Use Disorder Measure: The number of persons served and receiving substance use disorder services through the management of the SMO in FY12. Data obtained from state-run electronic systems and the SMO electronic systems.

Integration of Behavioral Health Services

Persons with co-occurring disorders are best served when screening, assessment, and treatment planning are integrated, addressing both substance use and mental health disorders. While still early on in the establishment of an OBH integrated behavioral health service delivery system, the preliminary evidence supports that the activities of co-location and merging of clinics have improved care, particularly related to the provision of co-occurring treatment. In the five regions of the state that are still managed through the central office of OBH, the first year of clinic integration activities marks just the beginning of the systems transformation into an integrated service delivery system. Fiscal Year 2012 priorities include movement towards Dual Diagnosis

Enhanced status as it relates to treatment for co-occurring disorders, while maintaining the unique features of both mental health and addictive disorder services.

A systematic review of the state will utilize the Dual Diagnosis Capability Addiction Treatment (DDCAT) and the Dual Diagnosis Capability Mental Health Treatment (DDCMHT) Fidelity Scales to assess the current system's capacity to treat persons with COD. The DDCAT/DDCMHT defines and measures multiple co-occurring disorder program dimensions such as program management, milieu, assessment, treatment, staffing patterns, and training. Through continued efforts, the OBH clinics are in a good position to move toward a "Co-Occurring Enhanced" status, which is defined as completely integrated mental health and addictive disorder care that is seamless to the client. In addition to the DDCAT/DDCMHT guided program assessment, the Office of Behavioral Health will review and develop clinical and administrative business practices that will efficiently and effectively integrate behavioral health services delivered to citizens across their lifespan.

3) *Dashboard Indicator: Integration*

Increase the number of individuals receiving services in behavioral health clinics operating at a DDE level.

Behavioral Health Measure: The number of substance use, mental health and co-occurring disorder clients served in behavioral health clinics operating at a DDE level.

Increased Efficiency in the Utilization of Inpatient Levels of Care

Over the last two decades, Louisiana has remained dependent on psychiatric hospital levels of care through the Disproportionate Share Hospital program. While other states were re-organizing their funding approach and moving to a greater proportion of high intensity community based programs, Louisiana continued to have greater fiscal resources directed toward inpatient care. Efforts are underway to decrease reliance on more restrictive inpatient levels of care. A comprehensive discharge planning process will continue to be utilized to support the discharge of individuals back into the community. Commensurate activities include the ongoing reinvestment in the communities to develop the necessary supports required for successful reintegration.

This OBH Mental Health Redesign and Hospital Discharge Initiative includes an intensive follow-up and tracking system to monitor how persons discharged from the state civil psychiatric hospitals are faring in the community. The Office of Behavioral Health is implementing protocols for admissions and continued stay at Louisiana psychiatric hospitals, as well as transition to the community.

4) *Dashboard Indicator:*

The average length of stay for intermediate care civil psychiatric patients admitted in the fiscal year demonstrates a decrease.

Mental Health Measure: Number of persons whose length of stay is greater than 6 months for civil patients admitted to intermediate care psychiatric facilities.

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Section J: Suicide Prevention

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Louisiana Partnership for Youth Suicide Prevention (LPYSP)

The Louisiana Partnership for Youth Suicide Prevention, funded by a SAMHSA grant, targets 15,000 youth and young adult ages 10 to 24 years old consisting of middle, high, and college students, as well as professionals that serve this population across the state of Louisiana (such as Office of Behavioral Health, Department of Education, and Veterans Administration staff, as well as 211 providers). A high priority of this program is early intervention, prevention and assessment services to youth and young adults who are at risk for mental or emotional disorders, or substance use disorders that may lead to suicide or suicide attempts. Through partnerships across systems, the integration of suicide prevention resources and services in schools, universities, juvenile justice systems, substance abuse and mental health programs, foster care systems and other child youth support agencies that target the at-risk youth population will increase their competence and awareness of youth suicide risk.

In 2006, Louisiana was awarded funds under the Garrett Lee Smith Memorial Act from the Substance Abuse and Mental Health Service Administration (SAMHSA) to implement statewide youth suicide intervention and prevention strategies. Applied Suicide Intervention Skills Training (ASIST), is one of several trainings which were initiated by this funding initiative. ASIST is a unique program that teaches a concise, face-to-face suicide intervention model that focuses on the reduction of the immediate risk of suicide. Participants in the training learn about their own attitudes concerning suicide, how to recognize and assess the risk of suicide, how to use an effective suicide intervention model, and about available community resources. ASIST is a model of suicide intervention for all gatekeepers and caregivers utilizing techniques and procedures that anyone can learn. The training is designed to increase skill levels, improve the ability to detect problems, and provide meaningful support to individuals experiencing emotional distress and serious mental health problems. The workshops are offered to those gatekeepers that serve this population, such as educators, law enforcement, mental health professionals, clergy, medical professionals, administrators, and volunteers. The program has been made

available to government agencies, consumer/advocacy agencies, emergency service providers, schools and families to help reduce the incidence of suicide in Louisiana. Since 2010, there are now 24 new ASIST trainers and 15 new safeTALK trainers available across the state. ASIST, safeTALK, and Suicide 101 Trainings have been conducted statewide. This series of evidenced-based trainings reached over 1,275 people in SFY2010. The LPYSP will also be providing ASIST training to personnel at Tulane and Southern University.

Through the successful development of five suicide prevention coalitions in Shreveport (Region VII), Lake Charles (Region V), Lafayette (Region IV), Jefferson (JPHSA) and Baton Rouge (CAHSD), the Partnership assisted communities to develop competence related to suicide risk identification and prevention activities; improved local collaboration; and promoted the coordination of culturally appropriate resources and services for the prevention of suicide. During SFY 2011, over 11,000 pieces of suicide awareness materials were distributed at events across the state; over 800 individuals participated at suicide awareness walks; over 12,300 individuals attended suicide prevention presentations given by coalition members; 450 youth participated in TeenScreen; and over 380 students from 36 schools participated in the poster and essay contest.

Discussion is currently taking place with the Department of Education (DOE) on implementing a suicide prevention curriculum in the schools of two regions that have the highest suicide/suicidal ideation rates. LPYSP is also partnering with DOE in FY 2012 to provide school personnel suicide prevention training for trainers (T4T) in these targeted regions. These trainers will then be responsible for training school personnel in other districts, meeting the Jason Flatt Act passed in 2008.

Louisiana Suicide Prevention Plan

In 2001, Louisiana released *STAR: The Louisiana Plan for Youth Suicide Prevention* (see attached – appendix). This strategic plan was developed by the Louisiana Task Force for Youth Suicide Prevention, appointed in 1999 following the U.S. Surgeon General’s Call to Action. Known as the STAR Plan, this comprehensive statewide suicide prevention plan for youth in Louisiana (under the age of 25, including university students) includes four key dimensions reflected in its acronym title – S: Suicide Prevention for all Louisianans; T: Training and Education; A: Awareness and Advocacy; and R: Research and Resources.

After receiving funding under the Garrett Lee Smith Memorial Act from the Substance Abuse and Mental Health Service Administration (SAMHSA) in 2006, the previously established Task Force transitioned into the Louisiana Partnership for Youth Suicide Prevention (LPYSP) which serves as the governing body to provide oversight, development, monitoring, and evaluation of program activities to reduce youth suicides and suicide attempts in Louisiana. The LPYSP is comprised of a broad range of public and private partners, and it expands the youth suicide prevention efforts of the 2001 Louisiana Youth Suicide Prevention Task Force across the entire state.

At the July 2011 meeting of its State Advisory Board, the LPYSP reviewed and discussed the need to update the STAR Plan. An updated strategic plan would focus on the sustainability of current suicide prevention efforts within Louisiana, and could include continued training of

gatekeepers in the ASIST and safeTALK models, development of suicide prevention coalitions in the remaining five Regions/LGEs that currently do not have one, and expansion of peer support resources within the school systems. LPYSP currently includes Veterans Administration staff in its training opportunities in order to reach the veteran population. The process to develop an updated strategic plan would also consider ways in which the State's suicide prevention efforts could be expanded to better serve military personnel and their families, as well as opportunities to reach American Indians, the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, and other underserved populations. The LPYSP State Advisory Board, which includes members of the original Task Force that developed the STAR Plan, supports the effort to develop a new strategic plan, and it is anticipated that a new plan would be complete by September of 2012.

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Section K: Technical Assistance Needs

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. Please also take into account cultural and linguistic needs. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Information Technology

The Office of Behavioral Health is in need of technical assistance and consultation in establishing a comprehensive data warehouse and business intelligence system as the State transfers the administration of services over to a managed care vendor. The data warehouse will be the major repository for behavioral health data for state and federal reporting requirements, for linking behavioral health data with other data sources such as Medicaid, and for providing ad hoc reporting and analyses. OBH is presently in the process of negotiating with staff of the South Carolina Office of Research and Statistics for this consultation.

Behavioral Health Advisory Council

Technical assistance will be necessary to transform the Louisiana Mental Health Planning Council into a Behavioral Health Advisory Council and to integrate balanced representation from both mental health and addictive disorder stakeholder communities. New stakeholders to identify as possible members of an integrated Council will also include those from the behavioral health prevention and primary care communities. OBH will aim to include representation from other target populations that traditionally have been underrepresented such as Native American/Indian, military and LGBTQ. Strategies related to both mental health and substance use disorder will need to be identified as it relates to the organization, defined roles, authority, and planning functions for the transformed Council and its new stakeholder composition.

Bi-directional Integration with Primary Care

OBH needs guidance in identifying ways to integrate primary care into the behavioral health provider network and to integrate behavioral health with primary care in a holistic way, utilizing best practices. This may include bi-directional integration with Federally Qualified Health Centers, as well as the DHH Coordinated Care Networks for primary care.

In September of 2011, the OBH Medical Director and other OBH physicians statewide will identify clinical integration strategies related to Primary Care and Behavioral Health. Together these physicians will gain consensus on initial dialogues with Louisiana's Federally Qualified Health Clinics. Then in October, 2011, OBH Executive Management and middle management staff will develop a plan for collaboration with DHH Coordinated Care Networks and Federally Qualified Health Clinics. Technical assistance, in terms of resources, best practices, other states' shared experiences and models of care would be very helpful to this collaboration.

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Section L: Involvement of Individuals and Families

The State must support and help strengthen existing consumer, family, and youth networks, recovery organizations and community peer support and advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- **How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coaches and or peer specialists, recovery community centers, consumer drop-in centers and recovery housing)?**

The Office of Behavioral Health (OBH) has actively recruited and trained peers in both Wellness Recovery Action Plan (WRAP) and Peer Support since 2008; as a result of these trainings there are now over eighty-five peers employed throughout the system of care to serve as hope builders who utilize strengths-based techniques in a peer-to-peer role. The programmatic structure and implementation was spearheaded by peers in collaboration with advocates, state employees and peer/family members. This was primarily accomplished by the WRAP/PSS Steering Committee, in operation since 2008, and by the regional leads who “bought into” the program from the outset.

OBH also supports the statewide peer organization, Meaningful Minds of Louisiana (MMLA), through a contract tied to block grant funds. MMLA provides educational trainings, support and advocacy alerts to peers statewide through its sub-chapter network. Also through the block grant, the OBH supports peer drop-in-centers in every Region/Local Governing Entity (LGE) except the Florida Parish Human Service Authority (FPHSA). OBH recognizes that peers can be included at an increased rate and level; therefore, in FY2012 the program coordinator for client affairs will begin the process of developing regional-based groups of WRAP Facilitators, Advocates and Peer Support Specialists who will provide input into and suggestions for the creation and enhancement of peer services. Individuals from these groups will be selected to form a statewide team whose purpose will be to provide input into and ultimately shape future services offered by OBH.

- **Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?**

The Office of Behavioral Health (OBH) currently offers Peer Support training based on the curriculum developed by Recovery Innovations of Arizona and Wellness Recovery Action Plan (WRAP) as developed by the Copeland Center for Wellness and Recovery, both of which are culturally competent and researched. In addition, both the National Alliance on Mental Illness (NAMI) and Mental Health of America offer advocacy trainings based on curricula created by NAMI national, coupled with state centered information. All trainings mentioned above are sensitive to and inclusive of peer needs emphasizing choice, self-advocacy and personal responsibility.

In FY 2012, the client affairs coordinator will also be offering a series of webinars tailored to the needs of Peer Specialists and WRAP Facilitators inclusive of peer needs in general. Trainings to be offered will focus on suicide recognition and prevention, co-occurring disorders, working with non-peer staff and identifying and responding to burnout. In addition, OBH will be partnering with Meaningful Minds of Louisiana (MMLA) to offer a one-day adult behavioral health conference which will focus on consumer empowerment and education. The conference will be held in May as part of Mental Health Awareness Month.

- **Does the State sponsor meetings that specifically identify individual and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?**

The State Mental Health Planning Council, originally established under PL 99-660 guidelines, is integrally involved in statewide planning and development of mental health services. The current Planning Council includes 40 members consisting of consumers, family members of adults with serious mental illness, family members of children with emotional/behavioral disorders, advocates, Regional Advisory Council representatives, local governing entity representatives, and state agency employees. The Planning Council also monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. The ten local Regional Advisory Councils (RACs), similar in purpose to the Planning Council, focus on the issues and needs specific to their respective geographic areas. The RACS are the lead agencies in advising how Block Grant funds will be allocated locally. RAC membership is reflective of that of the Planning Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/behavioral disorders, advocates, and state agency (Region or LGE) employees. In FY2012, the State Mental Health Planning Council will continue the process of transforming into a Behavioral Health Advisory Council to better address the identified needs of the behavioral health service system within Louisiana (*see Section O: State Behavioral Health Advisory Council*).

The OBH continues to support the annual Public Forums in each Region/LGE. Historically a function of the Office for Addictive Disorders, focusing on substance use disorder prevention and treatment, this series of statewide forums now includes increasing community awareness of behavioral health services, and obtaining local feedback from stakeholders regarding the behavioral health service system. The forum format offers an opportunity to assess consumer needs, as well as to establish a common ground for providing information to the community and for receiving input from stakeholders. During FY 2011, the Public Forum discussions

focused on the continuing merger and integration efforts within the newly formed Office of Behavioral Health (OBH), the significant impact that Affordable Care Act will have on the State and its service delivery system, as well as the Louisiana Coordinated System of Care (CSoC) initiative for children/youth with extensive behavioral health needs either in or at-risk of out-of-home placement. Stakeholder input is used, along with other needs assessment data, to guide the State planning process for service delivery priorities.

A goal of the OBH client affairs section is to develop consumer and family services meetings in FY 2012.

- **How are individuals and family members presented with opportunities to proactively engage and participate in treatment and recovery planning, shared decision making, and the behavioral health service delivery system and direct their ongoing care and support?**

In addition to the efforts of the aforementioned Peer Specialists and WRAP Facilitators network within Louisiana, the Access to Recovery (ATR) program offers individuals the opportunity to proactively engage and participate in their ongoing care. Supported by state general funds, ATR provides client choice among substance use disorder clinical treatment and recovery support providers, and expands client access to a comprehensive array of clinical treatment and recovery support options, including faith and community-based organizations. A key feature of the ATR program is that individuals have a free choice of treatment and recovery support providers through each level of their continuum of care. ATR providers facilitate individual choice and promote individualized pathways to recovery through the provision of evidence-based substance abuse treatment and recovery support services. Each client is issued a voucher for services that is based on his/her informed understanding and independent selection of providers from an available list of recommended options.

The philosophy of the soon-to-be-implemented Coordinated System of Care (CSoC) initiative is focused on self-directed treatment planning and care. CSoC will respond to the needs of Louisiana's highest-need young people and their families through wraparound services that will reduce the number of children and youth in detention and residential settings. The CSoC will institutionalize wraparound facilitation and involve children and their families in the development of an intensive, individualized care planning and management process. The family, the youth, and the family support network comprise the core of each family's team members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The organizations providing Wraparound Facilitation in Louisiana's CSoC are identified as Wraparound Agencies (WAAs). There will be one WAA in each region, with 3 WAA's operationalized by March 2012.

The WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children and their families. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team

planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. A critical component and source for the family-to-family supports is the creation of Family Support Organizations within each of the CSoc areas. Each local Family Support Organization (FSO) will be a family-run, nonprofit corporation governed by a board of directors known as its Local Coordination Council (LCC). The FSO is charged with building capacity and providing certified family support specialists and youth support specialists, who will participate in the child and family team process coordinated by the WAA. Through the FSO, system-experienced families and youths can work in partnership with the identified family unit. The FSO provides a unique and effective manner of ensuring that family involvement becomes routine as opposed to the exception.

- **How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

Currently, the state sponsors and provides technical assistance as requested to Meaningful Minds of Louisiana, Mental Health America and the National Alliance on Mental Illness utilizing, at least partially, block grant dollars. These organizations provide educational trainings, sponsor advocacy awareness events and serve as resources for peers and families in Louisiana. Examples of programs include BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support), Family to Family, and Behavioral Health Advocacy training. In addition, all trainings and continuing education opportunities for WRAP Facilitators and Peer Support Specialists are funded through block grant support for recovery support services.

The Office of Behavioral Health is committed to encouraging and supporting the development of recovery homes for persons recovering from a substance use disorder, through an ongoing partnership with Oxford House, Inc. Oxford House, Inc. is a non-profit corporation that serves as the umbrella organization connecting all Oxford Houses and allocating resources to duplicate the Oxford House Model where needs arise. An Oxford House describes a democratically run, self-supporting and drug free home. OBH contracts with Oxford House, Inc. to expand recovery home capacity throughout Louisiana, conduct outreach services in the community in order to engage referrals, and to conduct advocacy services in order to reduce stigma related to persons recovering from a substance use disorder. Oxford Homes are currently in all Regions/Local Governing Entities of the state with 58 operational homes, having a total of 432 beds.

OBH also continues to support National Recovery Day in September of each year. During FY2011, Recovery Day was promoted throughout the State in specific ways designed to

reach the Recovery Community and to reduce the stigma associated with Recovery. Each Region/Local Governing Entity (LGE) coordinated with the DHH Bureau of Media and Communications to release a news story through local media outlets featuring a success story of a community member in Recovery. OBH Headquarters also participated in Recovery Day by setting up a booth in the main lobby of the DHH building during Recovery Month to distribute information pamphlets on Recovery to employees and visitors, hosting a Recovery Luncheon at the OBH State Office to celebrate Recovery with all staff, and obtaining a proclamation issued by the Governor declaring September 2010 as Recovery Month in Louisiana.

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Section M: Use of Technology

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care and recovery support services. ICTS are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, telemedicine.

a) What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?

In an attempt to alleviate access problems, OBH has available teleconferencing systems at seventy-four sites across the State (*see table at end of this narrative section*), including Mental Health clinics, Early Childhood Supports and Services (ECSS) sites, Mental Health Hospitals, Louisiana Spirit, OBH regional offices, and OBH Central Office. Some sites have multiple cameras, with some of these cameras dedicated to Telemedicine (clinician/client session) while the others are used for Teleconferencing (meetings, education, etc). Other sites use their single cameras for both Telemedicine and Teleconferencing. The sites continue to upgrade their technology through the purchase of High Definition Cameras per Department of Health and Hospitals (DHH) regulations.

Telecommunication has become the primary mode for communication within OBH. In an average week there are multiple and sometimes simultaneous meetings conducted through teleconference and videoconference, including regular meetings of the Regional Management Teams, Medical Directors, Monthly Performance Improvement Team, Monthly Regional Advisory Council, Redesign/Hospital Discharge Regional Peer Specialists, and the Pharmacy and Therapeutics Committee. In addition DHH continues to use desktop video conferencing, the software interface that allows connection into the existing video network from individual desktop PCs.

OBH has utilized telemedicine extensively for the past several years primarily for psychiatric evaluations where a psychiatrist is not available. For example, forensic patients at East Louisiana Mental Health System (ELMHS) outside of Baton Rouge, Louisiana are assessed by Tulane University Psychiatrists in New Orleans. OBH Region IV has utilized telemedicine extensively given its severe shortage of psychiatrists. This service is now reimbursable by Medicaid. Two years ago, the state of Louisiana passed into law that persons can be evaluated for psychiatric hospitalization by a psychiatrist/psychologist via telemedicine as long as there is a mental health professional present with the consumer.

OBH Regional Meeting rooms have been setup for telemedicine and standard conferencing that can be launched from the sites to enable patient care, medication management

appointments and patient assessments. This is especially helpful in an emergency that happens outside normal work hours. Telemedicine has resulted in more efficient communication between various sites across the state.

b) What specific application of ICTs does the State plan to promote over the next two years?

OBH will promote the continuation and expansion of the use of Telemedicine.

c) What incentives is the State planning to put in place to encourage their use?

State contracts for providers of services via Telemedicine.

d) What support system does the State plan to provide to encourage their use?

OBH not only supports, but relies on technology to facilitate patient care and staff/stakeholder communication as described previously.

e) Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?

Although OBH has explored the use of ICTs, such as Telephone Monitoring and Adaptive Counseling (TMAC) and Life:WIRE, through the Access to Recovery Initiative, the primary barrier to pursuing the implementation of ICTs is lack of funding. This barrier also inhibits the expansion of telemedicine.

f) How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?

OBH utilizes telemedicine to link community based psychiatrists to assess patients in forensic psychiatric hospitals. These options may be explored once the healthcare systems have stabilized with regard to the transformative Medicaid reform for both physical and behavioral health services.

g) Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?

There are no plans at present to expand the use of ICTs for collecting data for program evaluation at both the client and provider levels.

The Office of Behavioral Health (OBH) will continue utilization of the Telesage Outcome Measurement System (TOMS) to collect data on client satisfaction with services rendered. This system allows service recipients to access the standard *Mental Health Statistics Improvement Project (MHSIP)* and *Youth Services Survey for Families (YSS-F)* surveys via a

touch-screen computer kiosks located in the waiting room of clinics. OBH uses this system to collect all of its youth satisfaction survey data and it is also used to supplement the data collected by the peer survey team for adults (*See Section F: Quality Improvement Reporting for additional information*).

h) What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

There are no plans at the present time.

OBH Video Conferencing Sites - July, 2011			
	Site	Parish	City
1.	Allen Behavioral Health Clinic	Allen	Oberlin
2.	Assumption Mental Health Clinic	Assumption	Labadieville
3.	Avoyelles Behavioral Health Clinic	Avoyelles	Marksville
4.	Bastrop Behavioral Health Clinic	Morehouse	Bastrop
5.	Beauregard Behavioral Health Clinic	Beauregard	DeRidder
6.	Behavioral Health Clinic of Central LA	Rapides	Pineville
7.	CABHC	Orleans	New Orleans
8.	CLSH (Education Room 103)	Rapides	Pineville
9.	CLSH (Education Room 128)	Rapides	Pineville
10.	CLSH (Admin Bldg)	Rapides	Pineville
11.	Crowley Behavioral Health Clinic	Acadia	Crowley
12.	Delta ECSS	Richland	Delhi
13.	Dr. Joseph Tyler BHC / Auditorium 1	Lafayette	Lafayette
14.	Dr. Joseph Tyler BHC / Auditorium 2	Lafayette	Lafayette
15.	Dr. Joseph Tyler BHC / Auditorium 3	Lafayette	Lafayette
16.	Dr. Joseph Tyler BHC / Conference Room	Lafayette	Lafayette
17.	ELMHS (Center Bldg.)	East Feliciana	Jackson
18.	ELMHS (Clinic)	East Feliciana	Jackson
19.	ELMHS (Forensic)	East Feliciana	Jackson
20.	ELMHS (Greenwell Springs)	East Baton Rouge	Greenwell Springs
21.	Jonesboro Behavioral Health Clinic	Jackson	Jonesboro
22.	Jonesville Mental Health Clinic	Catahoula	Jonesville
23.	Lafourche Mental Health Clinic	Lafourche	Raceland
24.	Lake Charles BHC / Regional	Calcasieu	Lake Charles
25.	Lake Charles BHC / Room 105	Calcasieu	Lake Charles
26.	Lake Charles BHC / Small Group Room Telemed	Calcasieu	Lake Charles
27.	LA Spirit	East Baton Rouge	Baton Rouge
28.	LA Spirit Orleans	New Orleans	Orleans
29.	LA Spirit Orleans (Desktop)	New Orleans	Orleans
30.	Leesville Behavioral Health Clinic	Vernon	Leesville
31.	Mansfield Behavioral Health Clinic	De Soto	Mansfield
32.	Mansfield Behavioral Health Telemed	De Soto	Mansfield
33.	Many Behavioral Health Clinic	Sabine	Many
34.	Many Behavioral Health Telemed	Sabine	Many
35.	Minden Behavioral Health Clinic	Webster	Minden
36.	Minden Behavioral Health Telemed	Webster	Minden
37.	Monroe Behavioral Health Clinic / Auditorium	Ouachita	Monroe

38.	Monroe Behavioral Health Clinic / Regional	Ouachita	Monroe
39.	Natchitoches Behavioral Health Clinic	Natchitoches	Natchitoches
40.	Natchitoches Mental Health Telemed	Natchitoches	Natchitoches
41.	New Iberia Mental Health Clinic	Iberia	New Iberia
42.	Northwest Regional CAD	Caddo	Shreveport
43.	OBH Children's Services / Midtown 2 nd Floor	Orleans	New Orleans
44.	OBH Children's Services / Midtown 3 rd Floor	Orleans	New Orleans
45.	OBH Children's Services / West Bank	Orleans	Algiers
46.	OBH Headquarters (12 rooms)	East Baton Rouge	Baton Rouge
47.	Opelousas Mental Health Clinic	St. Landry	Opelousas
48.	Orleans ECSS	Orleans	New Orleans
49.	Ouachita ECSS	Ouachita	Monroe
50.	Pines Treatment Center	Caddo	Shreveport
51.	Region 3 Office	Terrebonne	Houma
52.	Region 6 Office	Rapides	Pineville
53.	Red River Mental Health Clinic	Red River	Coushatta
54.	Red River Mental Health Telemed	Red River	Coushatta
55.	Richland Mental Health Clinic	Richland	Rayville
56.	River Parishes Mental Health Clinic	St. John the Baptist	LaPlace
57.	Ruston Mental Health Clinic	Lincoln	Ruston
58.	SELH / Admin. Bldg	St. Tammany	Mandeville
59.	SELH / Education Bldg	St. Tammany	Mandeville
60.	SELH / Telemed	St. Tammany	Mandeville
61.	SELH / Youth Services	St. Tammany	Mandeville
62.	Shreveport MHC/Children Services	Caddo	Shreveport
63.	Shreveport MHC / Room 111	Bossier	Shreveport
64.	Shreveport MHC / Room 145	Bossier	Shreveport
65.	Shreveport MHC / Room 218	Bossier	Shreveport
66.	Shreveport MHC / Room 117	Bossier	Shreveport
67.	Shreveport MHC / Room 115	Bossier	Shreveport
68.	St. Martin ECSS	St. Martin	St. Martinville
69.	St. Mary Mental Health Clinic	St. Mary	Morgan City
70.	St. Tammany ECSS	St. Tammany	Mandeville
71.	Tallulah Mental Health Clinic	Madison	Tallulah
72.	Terrebonne Mental Health Clinic	Terrebonne	Houma
73.	Ville Platte Mental Health Clinic	Evangeline	Ville Platte
74.	Winnsboro Mental Health Clinic	Franklin	Winnsboro

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Section N: Support of State Partners

The Office of Behavioral Health (OBH) is committed to partnering with other community, State and local governmental agencies in order to coordinate its service delivery with the provision of other appropriate services. These partnerships aim to enhance internal resources and afford clients a wider scope of services. Formally, the Office of Behavioral Health has the following established strategic partnerships which support the service delivery system as well as the priorities identified within the FY2012 Block Grant State Plan.

Louisiana Coordinated System of Care (CSoC) - Governance Board

The Louisiana Coordinated System of Care (CSoC) is led by the CSoC Governance Board, as established by Executive Order of Governor Bobby Jindal. The Governance Board is comprised of Executives of the Department of Children & Family Services (DCFS), the Department of Education (DOE), the Office of Juvenile Justice (OJJ) and the Department of Health and Hospitals (DHH), a representative from the Governor's Office, and family, youth and advocate representatives.

The Statewide CSoC Governance Board is responsible for establishing policy for the governance of the CSoC, as well as providing the multi-departmental oversight required to ensure adherence to that policy. The Governance Board also oversees the management of funding resources and directs the State Purchaser (OBH) contracting with a Statewide Management Organization (SMO). Quality assurance and improvement is another key role of the Governance Board, who is responsible for monitoring project outcomes including quality and cost.

As the State Purchaser, OBH has been delegated the responsibility for procuring, contracting, and managing the Statewide Management Organization (SMO) for the delivery of behavioral health services to children eligible for the CSoC. The OBH will assure that the SMO adheres to the goals and principles of the CSoC initiative and will provide performance, outcomes, and quality improvement data to the Governance Board.

At the first Governance Board meeting held on April 15, 2011, the Office of Behavioral Health entered into a Memorandum of Understanding with the Louisiana Coordinated System of Care (CSoC) Governance Board to outline the roles and responsibilities of each partner in the initiative (see attached in Appendix). This MOU has been submitted to the Office of the Governor for review and approval. A copy of the fully executed MOU will be submitted to SAMHSA upon completion.

Louisiana Coordinated System of Care (CSoC) – Partner Agencies

The four child-serving agencies that are partners in the financing of the Louisiana Coordinated System of Care (CSoC) include the Department of Children and Family Services (DCFS), Department of Education (DOE), Office of Juvenile Justice (OJJ), and Office of Behavioral Health (OBH). A Memorandum of Understanding that will outline the roles, responsibilities,

and commitment of each of these agencies is currently being drafted. This drafting process will also include a Memorandum of Understanding (MOU) between the four child-serving agencies and the Bureau of Health Services Financing - Medicaid. It is expected that these MOU's will be finalized and executed before full implementation of Phase I of the CSoC initiative on March 1, 2012.

Prevention

The OBH continues to partner with the Louisiana Department of Education (DOE) to conduct the Louisiana Caring Communities Youth Survey (CCYS) for Louisiana school students in the 6th, 8th, 10th and 12th grades. This partnership has historically been formalized through an Interagency Agreement process (see attached in Appendix). The Louisiana CCYS was originally designed to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors identified in the Risk and Protective Factor Model of adolescent behaviors. As the substance abuse prevention field has evolved, the CCYS has been modified to measure additional substance abuse and other problem behavior variables to provide prevention professionals in Louisiana with important information for understanding their communities. Some examples of these additional variables include the percentage of youth who are in need for alcohol or drug treatment, measures of community norms around alcohol use, and bullying.

Office of Public Health – Birth Outcomes Initiative

In November 2010, the State's Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative for pregnant women was elevated to a special project under the Department of Health and Hospitals' Office of the Secretary. Now called the *Birth Outcomes Initiative*, the primary purpose is to improve birth outcomes for women and children by reducing infant mortality rates, reducing C-section births, securing appropriate services for women in need of behavioral healthcare, and referring pregnant women for services at the appropriate level of care. In April 2011, the Office of Behavioral Health entered into an Interagency Agreement (IAT) with the Office of Public Health (OPH) for the sharing of resources and services for the *Birth Outcomes Initiative*. OPH serves as the lead agency for programmatic development and implementation of birth outcome improvement protocols and will be responsible for ensuring patient safety and quality, improved data collection, and utilization of Medicaid dollars to reimburse private physicians for substance use screenings as part of prenatal care. OBH will provide funding to Medicaid for use to draw down match for the reimbursement of Medicaid screenings for pregnant women relative to tobacco and alcohol and drug use (see attached in Appendix).

Office of Public Health – HIV/AIDS, TB, and STD testing

OBH will continue to collaborate with the Office of Public Health (OPH) on activities that address HIV/AIDS, tuberculosis (TB), and sexually transmitted diseases (STD's) through a Memorandum of Understanding that was executed in July 2009 (see attached in Appendix). OPH provides workforce development opportunities for OBH staff and providers on HIV/AIDS, HIV rapid testing, TB, and STD's, provides testing supplies, and serves as a referral resource for clients. OBH ensures that clients have access to HIV rapid testing with pre/post test counseling, access to TB and STD testing, and appropriate referral options.

Office of Public Health – Pregnancy Testing

Through an on-going partnership with the Office of Public Health (OPH), the Office of Behavioral Health (OBH) offers voluntary pregnancy testing to women seeking treatment. Through this agreement, OPH provides pregnancy tests and a written protocol for pre and post test counseling. OPH also provides training/technical assistance to OBH staff, and facilitates access to prenatal care at local Parish Health Units. OBH staff provides education to all female admissions on the advantages of pregnancy testing and abstinence from alcohol and drugs during pregnancy, as well as pre and post test counseling. A Memorandum of Understanding with Maternal and Child Health of the Office of Public Health to formalize this partnership is currently being negotiated and will be finalized by January 1, 2012.

Louisiana Department of Public Safety and Corrections – Adult Re-entry Program

This recently created MOU, effective July 2011, supports collaborative efforts to create an Adult Re-entry program for Department of Corrections (DOC) offenders released on anti-psychotic medications (see attached in Appendix). The goal of the Adult Re-entry Program will be to ensure the safety of the community and the well-being of participants, by providing uninterrupted behavioral healthcare to released offenders. Approximately 150 offenders from state prisons and local jails will meet criteria and be served each year. Anticipated outcomes are the reduction of relapse potential through expedited referral and appropriate referral to addiction services.

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Section O: State Behavioral Health Advisory Council

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

The Mental Health Planning Council has been receptive to the guidance from SAMHSA to move forward in its development of an Integrated Behavioral Health Planning and Advisory Council. In response to this request, the Mental Health Planning Council has moved forward methodically and has begun to assess their current organizational structure including aspects of the infrastructure that seem to be working well as well as considering aspects of the organization that require further evolution. In making these changes, the Planning Council has opted to move forward in a deliberative and strategic manner so as to ensure to maintain aspects of the Council's infrastructure but also developing partnerships and welcoming key contacts from the addiction population to assist with the planning process for the Behavioral Health Planning Council.

Historically, the Mental Health Planning Council has included 40 members consisting of consumers, family members of adults with serious mental illness, family members of children with emotional/behavioral disorders, advocates, regional advisory council representatives, Local Governing Entity (LGE) representatives, and state agency employees. The Council has been designed to have geographical representation of the ten Regions/LGEs in the state, and includes members from diverse backgrounds and ethnicities. The Planning Council continues to include four standing committees (Membership, Finance, Advocacy, and Programs and Services) that oversee each of the functions entrusted to the Council. In addition to providing guidance for the Block Grant Application/State Mental Health Plan, the Planning Council also monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. The Planning Council serves as an advocate for adults with serious mental illness, children with serious emotional disturbance, and other individuals with mental illness or emotional problems. This includes continued efforts toward public education, education of its members, and endeavors to reduce the stigma of mental illness throughout the state.

There is a local variation of a planning council within each of the Regions/ LGEs, known as the Regional Advisory Council (RAC). As independent Local Governing Entities are replacing the centrally managed Regions, there is even more emphasis on the need for the development and sustainability of the statewide Planning Council and the ten local Regional Advisory Councils

(RACs) to address needs for mental health services across the state. The RACs are similar in purpose to the Planning Council, but with interests specifically geared toward activities in their respective areas. The RACS are the lead agencies in advising how Block Grant funds will be allocated locally. Each Regional Manager (or LGE Executive Director) has been directed by the OBH Assistant Secretary (Commissioner) to allocate a minimum of \$5,000 yearly of Block Grant funding to their respective RACs to support the functioning of the Regional Advisory Councils. Regional managers have been instructed to work with the RACs to develop an annual budget. RAC membership is reflective of that of the Planning Council, in that it consists of members who are primary consumers, family members, family members of children with emotional/behavioral disorders, advocates, and state agency (Region or LGE) employees. Members of the Planning Council have emphasized the importance of Regional Advisory Councils (RACs) playing a more active role in initiating ongoing dialogue with their Regional Managers/Executive Directors. The RACs ideally are in communication with Regional/LGE leadership and contract monitors to support the use of best practices, and funding of programs that reflect the priorities of the Planning Council. It is through this personalized local/regional partnership that the Council can ensure that consumers are receiving the necessary access to services and best quality of care. Improved communication has been a continuing initiative, and each RAC reports on regional activities at quarterly Planning Council meetings.

With the development of an overall integrated Behavioral Health Advisory Council, there has been the additional consideration of moving the RACs into an integrated formulation with representation from individuals in recovery from addiction or relatives of persons with addictive disorders. In many of the Regions and LGEs that have already integrated clinic and service delivery, many of the RACs seem to be naturally forming. In the planning process toward integration, it is generally believed that some of the natural strengths and tendencies can be formalized and built upon.

Fiscal Review and Guidance

The functions of the Finance Committee and the Joint Block Grant Budget Review Committee of the Mental Health Planning Council have been instrumental in impacting change in Block Grant allocations and expenditures. The *Joint Block Grant Budget Review Committee* (JBGBRC), which was established by state policy in 2006 to monitor the expenditure of Block Grant funds, includes members of the OBH Planning Division, the OBH Fiscal Division, and the Finance Committee of the Planning Council. The committee is charged with overseeing Block Grant budget allocations and Intended Use Plans. During FY 2009, the Louisiana Block Grant was reduced by 11.7 percent, creating budgeting challenges throughout the state. The JBGBR committee was integral in the process of deciding how the budget reductions would be made within the Regions and LGEs. In May 2009, fiscal reviewers within the Mental Health Planning Council provided recommendations to the OBH Assistant Secretary regarding the allocation formula for Block Grant funds. After much study and review of alternate scenarios, the Special Committee, with the authority of the full Planning Council, recommended re-allocating Block Grant funds by awarding each Region/LGE an equal percentage of the Block Grant funds. The Assistant Secretary took the Special Committee's recommendation under advisement, and decided to accept their recommendation. In the past, Block Grant funds had been distributed unevenly based on historic practice.

In its continuing efforts as fiscal oversight, the Planning Council's Finance Committee has been requesting additional and more detailed information from the Central Office of OBH regarding the expenditures of Block Grant monies. More detailed information has been provided relative to the Block Grant expenditures within all of the Regions, which has provided meaningful information that the local RACs and local advocates could more immediately monitor for such things as goals and performance measures for contracts and programs. However, the Finance Committee has experienced some frustration in garnering a complete record based on their requests. The OBH Assistant Secretary applauded the Planning Council's diligence and dedicated interests in monitoring Block Grant funds. These requests remain highlighted and active attempts to provide a comprehensive protocol for review is being actively pursued. The Planning Council voted to appoint each RAC representative to increase communication with their Regional Managers/Executive Directors to gain a better understanding of the contracts and services in their regions that are supported by Block Grant funds. This effort has been marginally successful. Representatives, who are primarily consumers and family members of consumers, need continued support, encouragement, and education as to how to gain information in their regions and offer guidance and direction as advocates.

Movement toward an Integrated Behavioral Health Planning Council

With the development of the Office of Behavioral Health and with the complementary guidance from SAMHSA, the Council has the added task of assuring that they are advocating for the needs of individuals with substance use disorders as well as mental illness. The Council continues to express the need to become more fully engaged in planning by setting benchmarks and continuing to empower and educate members to review indicators. The current Planning Council Chair has developed a Planning Workgroup to develop clearly defined roles and timelines for Council members as well as each committee. Additionally, this group is addressing the need to expand the council in order to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders. This expansion will require amendments to Bylaws, changes in membership, and the formation of new committees, primarily those dedicated to prevention. At the most recent meeting of the Planning Council on August 1, 2011, the Executive Committee gave notice to the Council at large regarding the proposed changes in Bylaws, which will be necessary to move forward with our development into a behavioral health council. The Council will vote on these changes at their next meeting in November 2011.

In an effort to begin building partnerships, the Mental Health Planning Council Liaison extended an introduction to the Louisiana Commission on Addictive Disorders. The Commission had been created by Legislative Act 899 in 1984, is comprised of members appointed by the Governor with the purpose of advising OBH and other relevant Departments and Agencies on State policy regarding alcohol and drug abuse. The Commission also makes recommendations on the annual State Plan and serves as liaison to other governmental entities regarding addictive disorders. Commission members are supportive of the expansion of the current Mental Health Planning Council into a Behavioral Health Advisory Council and intend to offer support in its development.

As another step towards the goal of becoming a Behavioral Health Advisory Council, the current membership of the Planning Council was surveyed to determine specific qualifications for membership. We were pleased to find that 44% of the members sampled were family members of an adult in recovery from a substance abuse problem. Additionally, 4% of the members sampled were parents of a child or adolescent in recovery from a substance abuse problem. We will continue to strive to assist with both state and regional levels of organizational development, membership recruitment, and advocacy training, as well as substance use disorder education and cross training. The Council has recently requested that the Office of Behavioral Health provide the Council with additional funds to aid in this transition. Additionally, technical assistance for this transition has been requested from National Association of Mental Health Planning and Advisory Councils (NAMHPAC).

The Planning Council continues to employ an official (professional) parliamentarian to serve as a protocol advisor for business meetings and committee work. The parliamentarian has been integral in improving the structure and productivity of Planning Council meetings, as well as serving as a resource for Regional Advisory Councils (RACs). He has also been instrumental in assisting with the protocol for bylaw amendments and has provided suggestions as to how to best transition the current council into a behavioral health council.

The Planning Council Liaison continues to promote communication between OBH, the state Planning Council, and the RACs. The liaison organizes Planning Council meetings, maintains communication with Council members, and provides training, education, and support to Planning Council members as well as to RAC members. The liaison continues to educate Planning Council and RAC members, as well as regional administrators as to their roles and responsibilities in mental health planning, and now planning for substance abuse services. The liaison will provide direct support for securing training and education as both the state Planning Council and the Regional Advisory Councils evolve into Behavioral Health Advisory Councils.

Louisiana Mental Health Planning Council Membership List 2012-2013

Revised: May 19, 2011

KEY (ALL MEMBERS must be categorized according to these groupings):					
State Employee	Individuals in Recovery (from mental illness and/or addictions)	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Family Members of Individuals in Recovery	Others (Not state employees or providers)	Providers

Agency/ Org. Represented	#	Name	Type of Membership	Address, Phone & Fax/ Email
STATE AGENCY MEMBERS MANDATED BY FEDERAL REGULATION				
Mental Health	1	Darling, Ann	State Employee	Office of Behavioral Health 628 N. 4 th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-3564 (work) 225-342-1984 (Fax) Ann.Darling@LA.Gov
Education	2	Tyrone, Angela	State Employee	La Department of Education 1201 N. 3rd Street, 4 th Floor P.O. Box 9064 Baton Rouge, LA 70804-9064 225-219-0364 225-219-4454 (Fax) Angela.Tyrone@La.Gov
Vocational Rehabilitation	3	Dixon, Verna Pending	State Employee	La Rehabilitation Services 3651 Cedarcrest Baton Rouge, LA 70816 225-295-8952 225-295-8966 (Fax) VDixon-fletcher@lwc.la.gov
Housing	4	Brooks, Barry E.	State Employee	LA Housing Finance Agency 2415 Quail Drive Baton Rouge, LA 70808 225-763-8773 225-763-8749 (Fax) BBrooks@LHFA.state.la.us
Department of Social Services	5	Sam, Rose	State Employee	Office of Community Services 627 N. 4 th Street POB 3318 Baton Rouge, LA 70821 225-342-6509 225-342-0963 (Fax) RSam1@dss.state.la.us

Criminal Justice	6	Thomas, Michelle	State Employee	Dep't of Public Safety & Corrections 660 N. Foster Drive Baton Rouge, LA 70806 225-922-1300 225-291-9349 (Fax) Michelle.Thomas@la.gov
STATE AGENCY MEMBERS INVOLVED IN DEVELOPMENT OF BLOCK GRANT PLAN				
State Planner	7	Brown, Dr. Jessica	State Employee	Office of Behavioral Health 628 N. 4 th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-8605 225-324-1984 (Fax) Jessica.Brown@LA.Gov
Child State Planner	8	Lemoine, Dr. Randall	State Employee	Office of Behavioral Health 628 N. 4 th Street P.O. Box 4049 Baton Rouge, LA 70821-4049 225-342-8670 225-324-1984 (Fax) Randall.Lemoine@LA.Gov
STATE AGENCY MEMBERS MANDATED IN STANDING RULES				
Medicaid	9	Montgomery, Darrell Pending	State Employee	Bureau of Health Services Financing POB 91030 628 N. 4 th Street Baton Rouge, LA 70821-9030 225-342-1203 225-342-1972 (Fax) Darrell.Montgomery@LA.Gov
Alcohol & Drug Abuse	10	Beck, Michele	State Employee	Office of Behavioral Health 628 N. 4 th Street P.O. Box 3868 Baton Rouge, LA 70821 225-342-2623 225-324-3931 (Fax) Michele.Beck@La.Gov
Developmental Disabilities	11	Greer, Dr. Amy	State Employee	Office for Citizens with Developmental Disabilities 628 N. 4 th Street POB 3117 Baton Rouge, LA 70821-3117 225-342-0095 225-342-8823 (Fax) Amy.Greer2@La.Gov

Office of Public Health	12	Zapata, Amy	State Employee	Maternal and Child Health Program 1010 Common St. Suite 2710 New Orleans, LA 70112 504-568-3505 504-568-3503 (Fax) Amy.Zapata@LA.Gov
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ADVOCACY ORGANIZATIONS MANDATED IN STANDING RULES

Meaningful Minds of Louisiana	13	Glover, Carole	Individuals in Recovery (from mental illness and/or addictions)	1345 S. Willow St. #13 Lafayette, LA 70506 337-234-6291 CGlover211@bellsouth.net
Louisiana Federation of Families for Children's Mental Health	14	Bell, Maria	Parents or Caregivers of Children or Youth with Behavioral Health Problems	5627 Superior Dr. Suite A-2 Baton Rouge, LA 70816 225-293-3508 225-293-3510 (Fax) MBell@laffcmh.org
National Alliance on Mental Illness - Louisiana	15	Jantz, Jennifer	Other (not state employee or provider)	PO Box 40517 Baton Rouge, LA 70835 225-291-6262 225-291-6244 (Fax) namilajj@bellsouth.net namilouisiana@bellsouth.net
Mental Health America of Louisiana	16	Thomas, Mark	Family Members of Individuals in Recovery	5721 McClelland Drive Baton Rouge, LA 70805 225-356-3701 225- 356-3704 (Fax) MThomas@mhal.org
AARP Louisiana	17	Boling, John	Other (not state employee or provider)	3264 Seracedar Street Baton Rouge, LA 70815 225-293-9824 JRBoling@cox.net
The Extra Mile	18	Turner-Larry, Tonya	Parents or Caregivers of Children or Youth with Behavioral Health Problems	122 Raymond Drive Monroe, LA 71203 318-388-6088 318-388-6872 (Fax) theextramile@bellsouth.net

REGIONAL ADVISORY COUNCIL (RAC) REPRESENTATIVES

These individuals are either RAC Chairs or other representatives from the RAC One person per Region/ LGE.

MHSD	19	Miller, Rev. Donald	Individuals in Recovery (from mental illness and addictions)	5121 Easterly Circle New Orleans, LA 70128 985-626-6318 985-626-6640 (Fax)
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CAHSD	20	Kauffman, Steve	Other (not state employee or provider)	Advocacy Center 8225 Florida Blvd., Ste. A Baton Rouge, LA 70806 225- 925-8884 225-281-6131 (cell) skauffman@advocacyla.org
Region 3	21	Hadley, Joyce	Family Members of Individuals in Recovery	157 Twin Oaks Drive Raceland, LA 70394 985-537-6823 (work) 985-226-0584 (cell) Joyce.Hadley@LA.Gov
Region 4	22	Guillory-Williams, Joan	Individuals in Recovery (from mental illness and addictions)	522 Desiree Road Opelousas, LA 70570 337-543-2002 337-948-0226 (work) jguillorywilliams@yahoo.com
Region 5	23	Griffin, Carolyn B.	Family Members of Individuals in Recovery	2700 General Moore Ave. Lake Charles, LA 70615 337-477-8897 cargri@suddenlink.net
Region 6	24	Dennis, Jr. Victor B.	Family Members of Individuals in Recovery	257 Stilley Road Pineville, LA 71360-5934 318-473-2273 318-623-4547 (cell) vdennisj@bellsouth.net
Region 7	25	Bradley, Debra	Individuals in Recovery (from mental illness and addictions)	934 Unadilla Street Shreveport, LA 71106 318-868-6964 318-564-2853 DBradl6@bellsouth.net
Region 8	26	Goldsberry, Kristi	Individuals in Recovery (from mental illness and addictions)	108 Roxanna West Monroe, LA 71291 318-388-6088 (work) 318-791-7456 (cell) 318-388-6872 (fax) Kristiextramile@yahoo.com
FPHSA	27	Richard, Nicholas	Family Members of Individuals in Recovery	100 Saint Anne Circle Covington, LA 70433 985-626-6538 (work) 877-361-1631 (fax) NRichard@namisttammany.org
JPHSA	28	Noble, Rubye <u>Council Chair</u>	Family Members of Individuals in Recovery	POB 8857 Metairie, LA 70011 504-835-5427 504-835-5424 (fax) rubyenoble@ren.nocoxmail.com
INDIVIDUAL REPRESENTATIVES				
These individuals can be on the RAC, but do not have to be. One person per Region/ LGE				
MHSD	29	Adams, Shenicka	State Employee	New Orleans, LA 70117 520-245-3131 (work) 504-450-1401 (cell) Shenicka.Adams@LA.Gov

CAHSD	30	Mong, Stanley	State Employee	Baton Rouge, LA 70806 225-925-1768 225-922-2175 (Fax) Stanley.Mong@La.Gov
Region 3	31	Begue, Mary	Individuals in Recovery (from mental illness and addictions)	218 First Street Houma, LA 70364 985-857-3615 Ext. 123 (work) 985-991-7898 (cell) 985-857-3765 (fax) Mary.Begue@LA.Gov
Region 4	32	Bonnet, Lora	Parents or Caregivers of Children or Youth with Behavioral Health Problems	lorabonnet@yahoo.com
Region 5	33	Ledet, Catina	Parents or Caregivers of Children or Youth with Behavioral Health Problems	4001 East Walton Street Lake Charles, LA 70607 337-513-5410 (cell) 337-477-5415 (home) jaycatinaledet@att.net
Region 6	34	Cobb, Cynthia <u>Council Vice Chair</u>	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Alexandria, LA 71307 318-709-1575 (c) 318-443-1554 (h) Ccobblaff6@yahoo.com
Region 7	35	Davis, Gloria	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Shreveport, LA 71107 318-617-0320 gdavis2450@aol.com
Region 8	36	Bias, Yolanda	Parents or Caregivers of Children or Youth with Behavioral Health Problems	Monroe, LA 71203 318-388-6088 318-388-6872 (Fax) kayeextramile@yahoo.com
FPHSA	37	Gutowski, Cindy	State Employee	Mandeville, LA 70470 985-626-6488 985-626-6368 (Fax) Cindy.Gutowski@La.Gov
JPHSA	38	Stephens, Melanie	Parents or Caregivers of Children or Youth with Behavioral Health Problems	6416 Kawanee Avenue Metairie, LA 70003 504-343-9014 (cell) Ramslc@yahoo.com

INDIVIDUAL MEMBERS AT-LARGE				
At-large (CAHSD)	39	Landry, Freddie Pending	Other (not state employee or provider)	1901-B Airline Drive Metairie, LA 70001 504-833-4673 504-885-0400 (fax) freddiel@celebrationhopecenter.org
At-large (Region 5)	40	Raichel, Clarice	Family Members of Individuals in Recovery	POB 1824 Lake Charles, LA 70602 337-433-0219 337-433-1860 (fax) namiswla@bellsouth.net

Planning Council Support Staff

Donna Schaitel
5534 Galeria Drive
P.O. Box 40517
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225-291-6262 (phone) - 225-291-6244 (Fax)
namilads@bellsouth.net

Parliamentarian

C. Alan Jennings, P.R.P.

Planning Council Liaison

Melanie S. Roberts, M.S.
628 N. 4th Street
P.O. Box 4049
Baton Rouge, LA 70821-4049
225-342-8552 (phone) - 225-342-1984 (Fax)
Melanie.Roberts@La.gov

Office of Behavioral Health

Louisiana Department of Health & Hospitals
628 N. 4th Street, 4th Floor
P.O. Box 4049
Baton Rouge, LA 70821-4049

Jessica Brown, PhD
225-342-8605 - Jessica.Brown@LA.GOV

Louisiana Mental Health Planning Council

Composition by Type of Member 2012-2013

Revised May 19, 2011

Type of Membership	Number & Percentage of Total Membership	
TOTAL MEMBERSHIP	<u>40 #</u>	<u>100 %</u>
Individuals in Recovery (from mental illness and/or addictions)	6	
Family Members of Individuals in Recovery	7	
Parents or Caregivers of Children or Youth with Behavioral Health Problems	8	
Vacancies (individual & family members)	0	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	<u>25 #</u>	<u>62.5 %</u>
State Employees	15	
Providers	0	
Leading State Experts		
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	<u>15 #</u>	<u>37.5 %</u>

Notes:

1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council. Percentage of family members of children with SED to total members $8/40 = 20\%$.

2) State employee and provider members shall not exceed 50% of the total members of the Planning Council. Percentage of state employees and providers $15/40 = 37.5\%$.

3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support activities.

4) Membership is equally divided among the 10 Geographic Regions/ LGEs of the State, generally with two representatives from each Region/ LGE.

5) The council is committed to working towards diversity, and consideration is given towards representation of diverse groups in representation on the council

Louisiana Mental Health Planning Council

BYLAWS

Amended May 2, 2011

Article I: NAME

The name of this organization shall be: *Louisiana Mental Health Planning Council* (herein: “council”)

Article II: OBJECT

The object of the council shall be to serve the state of Louisiana as the mental health planning council provided for under 42 U.S.C. 300x-3 (State mental health planning council) and to exercise the following duties in connection therewith:

1. To review plans provided to the council pursuant to 42 U.S.C. 300x-4(a) by the state of Louisiana and to submit to the state any recommendations of the council for modifications to the plans;
2. To serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and
3. To monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.

Article III: MEMBERSHIP

Section 1. Statutory Requirements.

- A. The council shall be composed of residents of the state of Louisiana, including representatives of:
 1. The principal state agencies with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and the state agency responsible for the development of the plan submitted pursuant to title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*);
 2. Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

3. Adults with serious mental illnesses who are receiving (or have received) mental health services; and
 4. The families of such adults or families of children with emotional disturbance.
 5. With respect to the membership of the council, the ratio of parents of children with a serious emotional disturbance to other members of the council is sufficient to provide adequate representation of such children in the deliberations of the council.
- B. At least 50 percent of the members of the council shall be individuals who are not state employees or providers of mental health services.

Section 2. Classes of Membership.

Membership on the council shall be of two classes: Individual and Organizational.

1. Individual members shall be those persons who are not representatives of a state agency or a public or private entity.
2. Organizational members shall be those persons appointed from state agencies or a public or private entity.

Section 3. Composition.

- A. The council shall be composed of not more than 40 members.
- B. Members shall be those persons whose applications for membership are approved by the council.

Section 4. Term of Service.

- A. Term of service for members shall be four years. A member who has served two consecutive terms shall not be qualified for membership until the lapse of one year. Ex officio members shall not be term limited.
- B. In the event of the death, resignation, removal, or loss of qualification for membership, the council shall fill the vacancy thus created with a properly qualified person to serve for the duration of

the former member's term.

- C. A member may be removed from the council by a majority vote with notice, a two-thirds vote without notice, or a majority of the entire membership.

Article IV: OFFICERS

Section 1. Officers.

Officers shall be a chairman, a vice chairman, and a secretary. The chairman and vice chairman shall be members of the council.

Section 2. Duties.

Officers shall perform the duties prescribed by these bylaws and by the parliamentary authority adopted by the council.

- A. Chairman. The chairman shall preside at meetings of the council. The council, however, may suspend this provision and elect a chairman pro tempore at any meeting. The chairman shall appoint all standing and special committees except that nothing shall prohibit the council from appointing special committees on its own motion. The chairman may appoint persons who are not members of the council to serve on any committee the chairman is authorized to appoint. The chairman shall be ex officio a member of all committees except the nominating committee, and shall have such other powers and duties as the council may prescribe.
- B. Vice chairman. The vice chairman shall serve as chairman of the committee on membership and shall perform such other duties as the council may prescribe. In the absence of the chairman from a meeting, the vice chairman shall preside unless the council elects a chairman pro tempore.
- C. Secretary. The secretary shall be the custodian of the records of the council and shall keep or cause to be kept a record of the minutes of the meetings of the council. The secretary shall maintain an indexed book containing all standing rules adopted by the council. The secretary shall also be the custodian of the council seal, and shall attest to and affix said seal to such documents as may be required in the course of its business.

The secretary may appoint an assistant secretary who shall be authorized to fulfill the duties under the direction and authority of the secretary.

Section 3. Nomination and Election.

- A. The council shall elect officers at the regular meeting in the last quarter of each even numbered year.
- B. At the regular meeting immediately preceding the election meeting, the council shall elect a nominating committee of three members. It shall be the duty of this committee to nominate candidates for the offices to be filled. The nominating committee shall report its nominees at the election meeting. Before the election, additional nominations from the floor shall be permitted.
- C. In the event of a tie, the winner may be decided by drawing lots.

Section 4. Term of Office.

Officers shall serve for two years or until their successors are elected and assume office. Officers shall assume office at the end of the meeting at which they are elected.

Section 5. Removal from Office.

The council may remove from office any officer at any time.

Section 6. Vacancy.

- A. In the event of a vacancy in the office of chairman, the vice chairman shall succeed to the office of chairman.
- B. In the event of a vacancy in the office of vice chairman or secretary, the chairman may appoint a temporary officer to serve until the council elects a replacement.

Article V: MEETINGS

Section 1. Regular Meetings.

- A. Regular meetings of the council shall be held on the first Monday of the second month of each calendar quarter. The council may reschedule its next regular meeting at any regular or special meeting.

- B. The executive committee may reschedule a regular council meeting provided notice is given in accordance with the notice provisions required for special meetings.

Section 2. Special Meetings.

Special meetings may be called by the chairman and shall be called upon the written request of a majority of the members. The purpose of the meeting shall be stated in the call.

Section 3. Notice of Meetings.

- A. Notice of the hour and location of regular meetings, and notice of any change in the date, time, or place of any regular meeting shall be sent in writing to the members at least ten days before the meeting.
- B. Notice of special meetings of the council shall be sent at least ten days before the date of the meeting. The notice shall state the purpose of the meeting. In the event the secretary fails to issue, within a reasonable time, a special meeting call on the request of members of the council, the members who petitioned for the call may schedule the special meeting and issue the call and notice at the expense of the council.

Section 4. Quorum.

A quorum shall consist of twelve members.

Article VI: COMMITTEES

Section 1. Executive Committee.

- A. Composition. The chairman of the council shall be the chairman of the executive committee. The vice chairman, the secretary, and a state block grant planner shall be members of the executive committee.
- B. Duties and Powers. The executive committee shall, to the extent provided by resolution of the council or these bylaws, have the power to act in the name of the council. The executive committee shall fix the hour and place of council meetings, make recommendations to the council and perform such other duties as are specified in these bylaws or by resolution of the council.

But, notwithstanding the foregoing or any other provision in these bylaws, the executive committee shall not have the authority to act in conflict with or in a manner inconsistent with or to rescind any action taken by the council; to act to remove or elect any officer; to establish or appoint committees or to name persons to committees; to amend the bylaws; to authorize dissolution; or, unless specifically authorized by a resolution of the council, to authorize the sale, lease, exchange or other disposition of any asset of the council, and in no event shall it make such disposition of all or substantially all of the assets of the council.

- C. Meetings. The executive committee shall meet on the call of the chairman or the three other members. Notice of at least 24 hours shall be given for any meeting of the executive committee. Executive committee members may at any time waive notice in writing and consent that a meeting be held. The executive committee is authorized to meet via teleconference or videoconference provided that all members in attendance can hear each other. A quorum of the executive committee shall be a majority of its membership.

Section 2. Standing Committees.

- A. The chairman of the council shall appoint the following committees:
 1. Committee on Advocacy. The committee on advocacy shall report and recommend on matters involving the mental health advocacy program of the council.
 2. Committee on Finance. The committee on finance shall report and recommend on matters affecting the mental health block grant funds and the council operating budget.
 3. Committee on Membership. The committee on membership shall report and recommend on matters involving the membership recruiting and composition of the council.

- 4. Committee on Programs and Services. The committee on programs and services shall report and recommend on matters related to planning, development, monitoring, and evaluation of mental health programs and services in the state.
- B. A state block grant planner shall be ex officio a member of each standing committee.

Section 3. Duties and Powers of Standing Committees.

The council shall establish such specific duties and authority for each standing committee as necessary to carry on the work of the council.

Section 4. Other Committees.

Such other committees, standing or special, may be appointed by the chairman or by the council as may be necessary to carry on the work of the council.

Article VII: PARLIAMENTARY AUTHORITY

The rules contained in the current edition of *Robert's Rules of Order Newly Revised* shall govern the council in all cases to which they are applicable and in which they are not inconsistent with these bylaws, any special rules of order the council may adopt, and any statutes applicable to

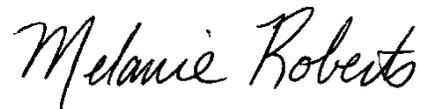
the council that do not authorize the provisions of these bylaws to take precedence.

Article VIII: AMENDMENT

These bylaws may be amended at any council meeting by a two-thirds vote, provided that the amendment has been submitted in writing at the previous regular meeting or notice of the proposed amendment is mailed to the members at least 21 days but no more than 30 days before the meeting at which the proposed amendment is to be considered. Additionally, in the case of a special meeting, notice of the proposed amendment shall be included in the call.

CERTIFICATE

I, Melanie Roberts, Secretary of the Louisiana Mental Health Planning Council, certify that the foregoing bylaws of the council are those as amended on May 2, 2011 at a regular meeting of the council.



Melanie Roberts
Secretary

**LOUISIANA MENTAL HEALTH PLANNING COUNCIL
STANDING RULES**

MEMBERSHIP COMPOSITION

SECTION 1. NUMBER OF MEMBERS

The number of council members shall be 40.

SECTION 2. COMPOSITION OF THE COUNCIL

The membership composition of the council shall be as follows:

A. Organizational members

1. Appointed from state agencies

a. Two members from OBH responsible for the preparation of the block grant plan.

b. Six members from state agencies as mandated by federal law, one from each of the following:

- (1) DHH Office of Behavioral Health (OBH)
- (2) Louisiana Department of Education (LDE)
- (3) DSS Louisiana Rehabilitation Services (LRS)
- (4) Louisiana Housing Finance Agency (LHFA)
- (5) Department of Social Services (DSS)
- (6) Department of Public Safety and Corrections (DPS&C)

c. Four other members from state agencies as follows:

- (1) DHH Bureau of Health Services Financing (Medicaid)
- (2) DHH Office of Behavioral Health (OBH)
- (3) DHH Office for Citizens with Developmental Disabilities (OCDD)
- (4) DHH Office of Public Health (OPH)

2. Appointed from mental health advocacy organizations:

Six members, one from each of the following:

- (1) Meaningful Minds of Louisiana
- (2) Louisiana Federation of Families for Children’s Mental Health
- (3) National Alliance on Mental Illness – Louisiana
- (4) Mental Health America of Louisiana
- (5) American Association of Retired Persons in Louisiana (AARP LA)
- (6) The Extra Mile

3. Appointed from OBH regional advisory councils (RAC):

Ten members, one from each RAC.

B. Individual Members

Ten members, one from each OBH Region or local governing entity (LGE).

Two members from the state at-large.

SECTION 3. QUALIFICATIONS

Council members shall fall into one or more of the following categories in order to be considered qualified for service on the council:

1. Adults with serious mental illness who are receiving or who have received mental health services, or
2. Family members of adults with serious mental illness, or
3. Children and youth with serious emotional/behavioral disorders who are receiving or have received mental health services and related support services, or
4. Parents and family members of children/youth with a serious emotional/behavioral disorder, or
5. Advocates for the severely mentally ill, or
6. Individuals, including providers, who are concerned with the need, planning, operation, funding, and use of mental health services and related support services.

NON-DISCRIMINATION POLICY

The council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy and parenthood, custody of a minor child, or physical, mental, or sensory disability.

AUTHORIZED REPRESENTATIONS

1. The council may officially represent itself, but not the office of mental health, the state of Louisiana, any state agency, or any individual member in any matter concerning or related to the council.
2. No council member shall make representations on behalf of the council without the authorization of the council.

COUNCIL AGENDA

1. The secretary shall prepare an agenda for each council meeting. Council members may submit motions in advance for placement on the agenda for consideration under the

appropriate order of business. Officers and committees reporting recommendations for action by the council shall submit the recommendations to the secretary at least 10 days before the meeting for entry on the agenda. The tentative agenda for all regular meetings will be available to all council members at least five (5) days prior to each council meeting. The secretary shall distribute the tentative agenda in advance to any member who requests it by the method requested by the member.

2. Nothing contained in this rule shall prohibit the council from considering any matter otherwise in order and within its object at any regular meeting.

Revised May 2, 2011

LOUISIANA MENTAL HEALTH PLANNING COUNCIL

SPECIAL RULES OF ORDER

ADOPTED NOVEMBER 5, 2007

ATTENDANCE

At the first regular council meeting after the second consecutive absence of a council member, the executive committee shall report its recommendation on the question of retention or removal of the member from the council.

PUBLIC COMMENT

1. At any time the council considers a matter on which a member of the public wishes to address the council, the council shall make reasonable efforts to provide the opportunity to a representative number of proponents and opponents on each issue before the council.
2. Each person appearing before the council shall be required to identify himself and the group, organization, or company he represents, if any, and shall notify the chairman no later than the beginning of the meeting by completing a basic information form furnished by the secretary.
3. To be certain that an opportunity is afforded all persons who desire to be heard, the chairman shall inquire at the beginning of any period of public comment on each matter if there are additional persons who wish to be heard other than those who have previously notified the chairman.
4. Subject to such reasonable time limits the council may establish for any public hearing or period of public comment, the chairman shall allot the time available for the hearing in an equitable manner among those persons who are to be heard. In no case, however, shall any person speak more than five minutes without the consent of the council.

**Mental Health Services and Substance Abuse Prevention and Treatment
Combined Behavioral Health Assessment and Plan
LOUISIANA - FY 2012**

Section P: Comment on the State Plan

Louisiana encourages and provides an opportunity for public input and comment on the Block Grant State Plan through a variety of means.

Historically, the Office of Addictive Disorders has conducted annual Public Forums in order to assess consumer needs, as well as to establish a common ground for providing information to the community and to receive input from stakeholders. The newly merged Office of Behavioral Health continued this effort and conducted Public Forums in each of the ten (10) Regions/LGEs throughout the State during FY 2011. Eight hundred forty-five (845) stakeholders/community members attended these Forums (see table below).

FY 2011 Public Forums

Region /LGE Attendance	Date/Time	Location	Regional Coordinator	OBH Representative
MHSD 56	3/30/2011 6:00 - 8:00pm	Holy Angels 3500 St. Claude New Orleans, LA 70118	Cathy Storm	Dr. Rochelle Dunham Dr. Anthony Speier Ivory Wilson Bill Blanchard Ann Darling
CAHSD 118	3/15/2011 1:30 - 3:30pm	State Archives Building 3851 Essen Lane Baton Rouge, LA 70809	Charlene Gillard Mike Fleming	Dr. Rochelle Dunham Dr. Leslie B. Freeman Felecia Johnson Cindy Rives Danita LeBlanc Megan D. Fontenot
SCLHSA 72	3/14/2011 10:00 - 12:00pm	Terrebonne Library North Branch 4130 West Park Avenue Gray, LA 70359	Theresa Hardin Misty Hebert	Dr. Rochelle Dunham Dr. Anthony Speier Jackie Romero Caren "Sam" Pourciau Tricia Hensarling
IV 88	3/28/2011 3:00 - 5:00pm	Clifton Chenier Center 220 B Willow Street Lafayette, LA 70501	Glenda Radar Joyce Ben	Dr. Rochelle Dunham Pete Calamari Brenda Lands Felecia Johnson Tricia Hensarling
V 70	3/29/2011 10:00 - 12:00pm	Central School of Arts and Humanities Center 809 Kirby St. Lake Charles, LA 70601	Charmaine Landry	Dr. Rochelle Dunham Pete Calamari Cindy Rives Caren "Sam" Pourciau
VI 97	3/4/2011 9:00 - 11:00am	Pineville Community Center 708 Main Street Pineville, LA 71360	Tremeka Johnson	Galen Schum Pete Calamari Felecia Johnson Tricia Hensarling

VII 60	3/3/2011 10:15 - 12:15pm	Brentwood Hospital 1006 Highland Avenue Shreveport, LA 71101	David S. Ogle Don Pledger	Galen Schum Pete Calamari Felecia Johnson
VIII 203	2/23/2011 10:00 - 12:00pm	First United Methodist Church 3900 Loop Road Monroe, LA 71201	Jean Hartzog	Galen Schum Pete Calamari Thomas Dumas Bill Blanchard
FPHSA 31	4/8/2011 9:00 - 11:00am	St. Tammany Parish Council Chambers 21490 Koop Drive Mandeville, LA	Jackie Lambert	Dr. Rochelle Dunham Pete Calamari Felecia Johnson Brenda Lands
JPHSA 54	2/24/2011 6:00 - 8:00pm	Celebration Church 2701 Transcontinental Dr. Metairie, LA 70006	Angela Henry Michael Teague	Dr. Rochelle Dunham Charlene Gradney Dr. Leslie B. Freeman Ann Darling
Total Attendance 845				

Members of the Louisiana Commission on Addictive Disorders are key attendees at the annual Public Forums. This Commission was created through Act 899 of the 1984 Regular Legislative Session, and its statutory duties and responsibilities include advising the State on policy with respect to addictive disorders, recommending program initiatives and goals, and serving as liaison among all State and Local Government Entities concerning addictive disorders. The Commission is comprised of clinical experts, providers, consumers, and/or persons in recovery, as well as members of the alcoholic beverage industry.

The Louisiana Mental Health Planning Council, consisting of 40 members representing all geographic areas of the State, is instrumental in assisting in the development of priorities and direction for the Block Grant State Plan each year. Input is solicited from consumers, family members, providers, and state employees who are all members of the Planning Council. As discussed earlier in this State Plan (*Section O: State Behavioral Health Advisory Council*), the Louisiana Mental Health Planning Council is in the process of expanding in order to advise and consult on behavioral health issues and services for persons with or at risk of substance abuse and substance use disorders.

OBH makes the Block Grant State Plan available for review, encouraging public comment and emphasizing that feedback and suggestions for improvement are welcomed. The draft Block Grant State Plan is made available via the Office of Behavioral Health (OBH) website. Email notices are sent to the Regional Managers, LGE Executive Directors, and Planning Council members when the Block Grant State Plan is initially placed on the website. The current draft of the Block Grant is placed on the OBH website publication link, with instructions for submitting comments to the Louisiana OBH Block Grant State Planner, Planning Council Liaison, and/or the Planning Council Chair.

In addition, during the spring of 2008, a Yahoo Groups Listserv was activated for the Planning Council. The listserv continues to provide a means for posting attachments and documents for the Planning Council; including drafts of the Block Grant application.

Plans submitted via the SAMHSA Web-based Block Grant Application System (BGAS) also provide another means of public access to the plan.

Bound hard copies of the plan are available at no charge to the public, and can be either picked up at the OBH State Office or mailed out by request.

**PUBLIC COMMENTS ON THE CONTENT OF THIS PLAN ARE WELCOMED
AND MAY BE SUBMITTED TO :**

LOUISIANA OFFICE OF BEHAVIORAL HEALTH

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LOUISIANA MENTAL HEALTH PLANNING COUNCIL LIAISON

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LOUISIANA MENTAL HEALTH PLANNING COUNCIL

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